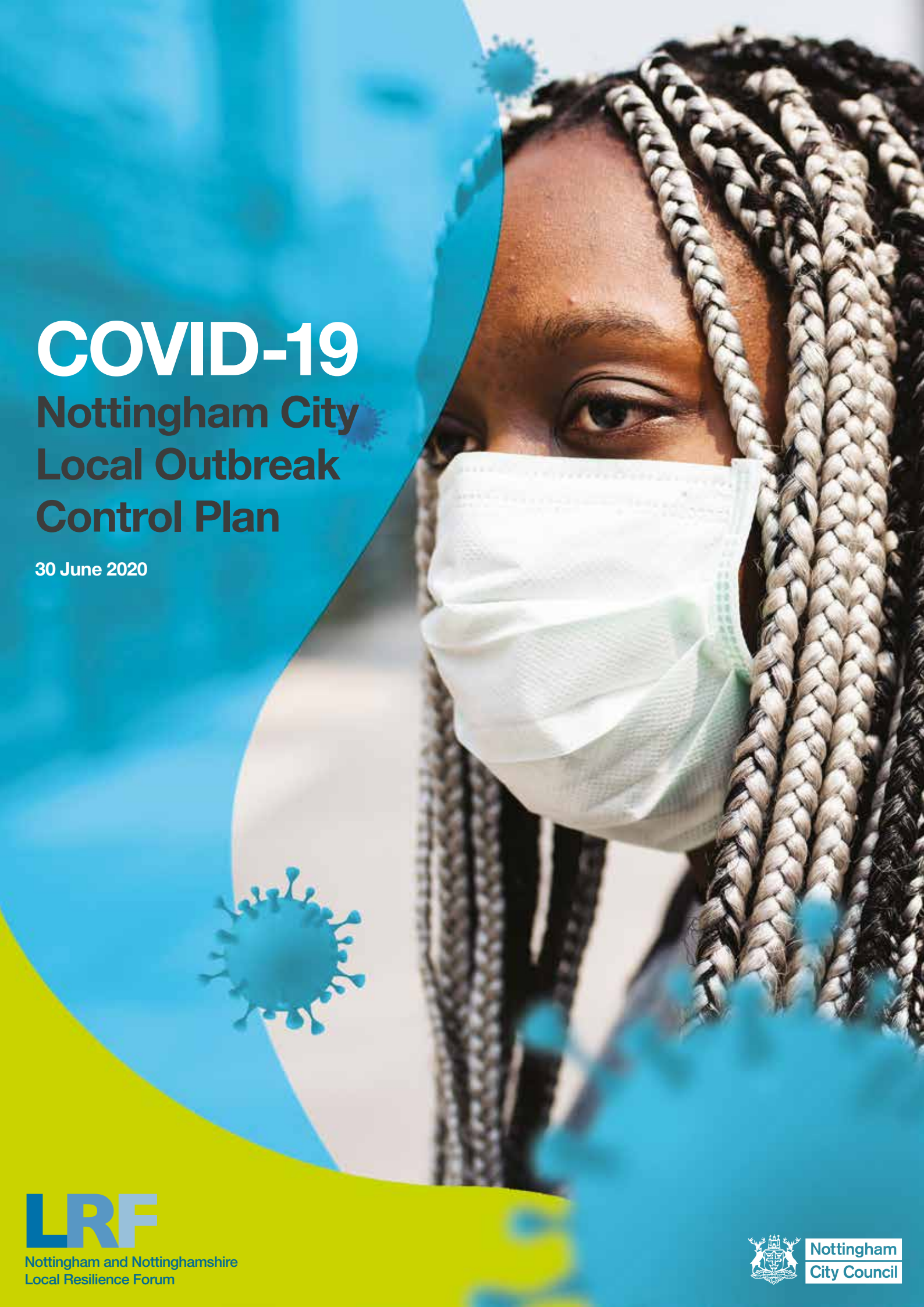


COVID-19

Nottingham City Local Outbreak Control Plan

30 June 2020

LRF
Nottingham and Nottinghamshire
Local Resilience Forum

Nottingham City Council

Contents

Part 1 – Introduction and context setting

1. Purpose

On 22 May 2020, Government announced that, as part of its national strategy to reduce infection from COVID-19, it would expect every area in England to create a Local Outbreak Control Plan (LOCP). Government expects that local plans, led by the Director of Public Health, will be produced by the end of June 2020.

Local outbreak plans have been developed to ensure a 'whole place' approach, enabling agencies in Nottingham and Nottinghamshire to prevent, manage, reduce and suppress outbreaks of COVID-19 infection across the local area. The plan covers seven themes:

(i) schools and care homes,
(ii) other high-risk locations,
(iii) deployment of local testing,
(iv) contact tracing in complex settings,
(v) data integration,
(vi) supporting vulnerable people and
(vii) establishing local governance, including engagement and communications.

The plan sets out the arrangements for surveillance of and response to local outbreaks and infection rates. There will be a process of continuous improvement and learning to improve the effectiveness of these plans and actions taken to manage outbreaks.

Nottingham City and Nottinghamshire County Councils are working closely together in the development of local arrangements, with aligned operating procedures and shared structures where possible. This will enable efficient use of capacity and resources. Individual sections of this plan identify where elements of operation will need to diverge between the two local authorities where a bespoke approach will be more effective.

2. Aims, objectives and guiding principles

The main aims of the Local Outbreak Control Plan (LOCP) are to:

a) Protect the health of people in Nottingham/Nottinghamshire from COVID-19 by:

- Minimising the spread of the virus
- Reducing the risk of small outbreaks leading to population level spread which requires wider action
- Early identification and proactive management of COVID-19 outbreaks
- Co-ordination of capabilities across stakeholders.

b) Provide confidence and assurance to the public and stakeholders by:

- Producing a local outbreak management plan
- Setting up a member-led governance structure
- Having a good epidemiological surveillance system
- Providing relevant, timely and accurate proactive and reactive briefings to local people through multiple organisations and media sources.

The following principles will help ensure the effective implementation of the LOCP:

- Building on existing public health experience and systems
- Following established emergency planning principles
- Utilising existing national and local partnership structures to ensure a responsive, effective and efficient whole systems approach
- Working to help make the public safe and earn their trust, confidence, consent and co-operation
- Ensuring everyone has the data and information they need to protect themselves and others
- Considering the economic, social and health-related impacts of decisions

The following good practice/guidance documents have been considered in the development of the Plan:

- *Public Health Leadership: multi-agency capability - Guiding Principles for Effective Management of COVID-19 at a Local Level* – ADPH/LGA/FPH/SOLACE/ UK CEHO Group
- PHE's *Communicable Disease Outbreak Management: Operational Guidance*
- National guidance with regards COVID-19, which can be found at **https://www.gov.uk/coronavirus**

3. Effective actions in managing outbreaks

The foundational context for local outbreak management is set out in the Public Health England and Association of Directors of Public Health joint statement *What Good Looks Like for Local Health Protection Systems*.

Building on this, the Local Outbreak Control Plan is a combination of:

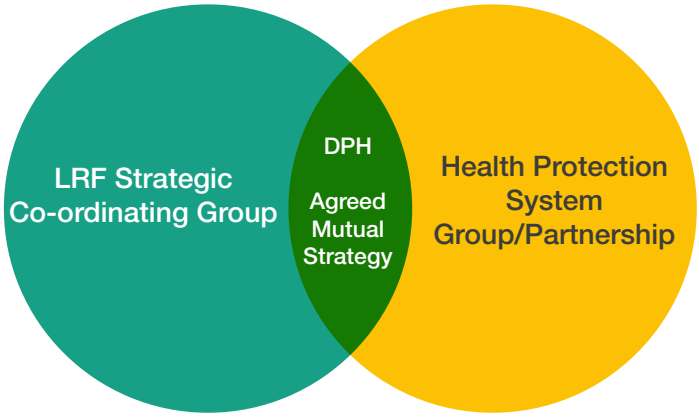
a. Health protection expertise and capabilities (local authority public health and environmental health and Public Health England)
   - Epidemiology and surveillance
   - Infection suppression & control techniques
   - Contact tracing
   - Evaluation

b. Multi-agency capabilities of organisations in supporting these efforts through the deployment of the necessary resources to deliver those health protection functions at scale where needed (for example the Local Resilience Forum, with community leadership provided by elected members).

The responsibilities of these two parts of the system are summarised in the diagram below:

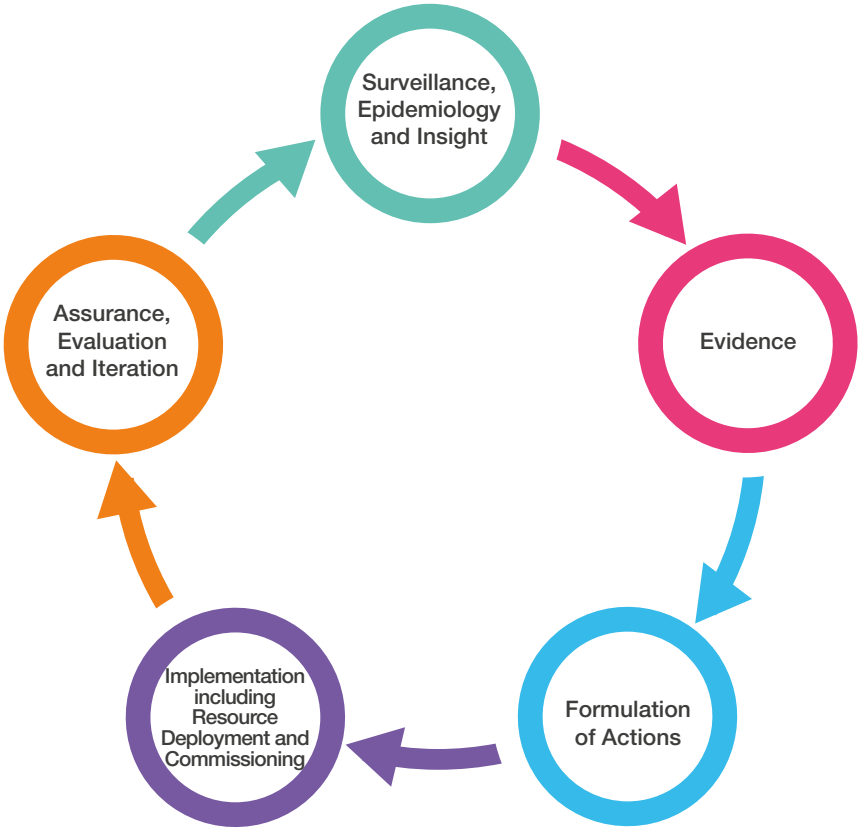
Overlapping Responsibilities

1 Bring all agencies together
2 Agree strategy for major incident and major demand
3 Agree multi-agency cells and actions and framework
4 Plan for recovery and hand back to normal



1 Surveillance of outbreaks new and emerging
2 Identifying Public Health Action (clinical and non-clinical) to be taken and identifying lead agencies
3 Lead on Contact Tracing System
4 Scientific and Technical Oversight
5 Oversight of Actions
6 Assurance and closure

The Cycle of Health Protection Action:



The LOCP reflects the cycle of health protection action. The cycle starts from surveillance and epidemiology, through evidence of what is effective, the rapid formulation of actions, their implementation, assurance and evaluation and finally iteration as needed to prevent, suppress and reduce outbreaks of infection. This cycle remains the same regardless of setting. Each of these stages are necessary to manage outbreaks, even if they are extremely rapid in execution in practice.

3.1 Health protection: legal and policy context

The Director of Public Health (DPH) retains primary responsibility for the health of their communities. This includes being assured the arrangements to protect the health of the communities that they serve are robust and are implemented in a timely manner.

The legal context for managing outbreaks of communicable disease, which present a risk to the health of the public requiring urgent investigation and management, sits:

- With Public Health England under the Health and Social Care Act 2012
- With Directors of Public Health under the Health and Social Care Act 2012
- With Chief Environmental Health Officers under the Public Health (Control of Disease) Act 1984
- With NHS Clinical Commissioning Groups to collaborate with Directors of Public Health and Public Health England to take local action (e.g. testing and treating) to assist the management of outbreaks under the Health and Social Care Act 2012
- With other responders' specific responsibilities to respond to major incidents as part of the Civil Contingencies Act 2004
- In the context of COVID-19, there is also the Coronavirus Act 2020.

Interventions, which may be considered in response to a COVID-19 outbreak or incident, and the Legal powers, which underpin them, are set out in the table below.

Item	Legal powers
Public information	Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 - statutory duty to protect the health of the people of England from hazards and to prevent as far as possible those threats emerging in the first place.
Enhanced hygiene/ cleaning/ decontamination	Health Protection (Local Authority Powers) Regulations 2010; Public Health (Control of Diseases) Act 1984
Testing	Coronavirus Act 2020 – Schedule 21 (screening of potentially infectious persons)
Restriction of movement	Coronavirus Act 2020 – Schedule 21 (detention and isolation of potentially infectious persons) (relates to individuals) Part 2 of Civil Contingencies Act 2004 (for restrictions on movement of larger sections of the population in the form of local controls)
Restriction of access	Legal powers under public health, environmental health or health and safety laws allow local authorities to temporarily close public spaces, businesses and venues for a specific reason and period. Coronavirus Act 2020 (temporarily close schools or limit schools to set year groups - but only if these powers are delegated by the Secretary of State for Education).

Measures under Schedule 21 of the Coronavirus Act 2020 provide for the detention, isolation and the screening of potentially infectious persons, also allowing for the imposition of restrictions and requirements to such persons. It is important that all voluntary measures are taken before the powers are exercised. The agreed East Midlands processes will be followed for the exercising of the powers relating to testing and restriction of movement of individuals.

Local Authority Public Health teams will coordinate measures related to restrictions of access. Measures such as restriction of movement including local controls or restriction of access (e.g. closure of settings) may require local Elected Member approval. It expected that a consensus-based approach will be taken, involving consultation with key stakeholders.

Some local outbreaks may be of national significance (e.g. impact on national infrastructure, or on important sectors such as food production), or will require national resource prioritisation. In these cases, NHS Test and Trace Local Teams will liaise between the local and national arrangements to develop a joined up and collaborative approach, including joint decision making, to ensure that local authorities have access to the powers they need to contain outbreaks in these circumstances.

4. Roles and responsibilities

This plan can only be delivered in Nottingham with clarity about the roles and responsibilities of the main partners in its delivery, as set out below.

4.1 Nottingham & Nottinghamshire Local Resilience Forum (LRF)

The Strategic Co-ordinating Group of the Local Resilience Forum has responsibility to agree and co-ordinate strategic actions by Category 1 and 2 responders for the purposes of the Civil Contingencies Act in managing demand on systems, infrastructures and services and protecting human life and welfare. The SCG has crucial capabilities in aligning and deploying the capabilities of a range of agencies at local level in supporting the prevention and control of transmission of COVID-19.

4.2 Public Health England

- Category One responder under the Civil Contingencies Act 2004
- Statutory responsibilities related to health protection
- Regional Health Protection Team will lead in managing COVID-19 outbreaks in local care homes and schools in partnership with Director of Public Health.

4.3 Local authorities

- Category One responders under the Civil Contingencies Act 2004
- Unitary and upper tier authorities have statutory responsibilities in protecting and improving the health of the population
- The Director of Public Health has a statutory role for the Local Authority contribution to health protection, including preparing for and responding to incidents that present a threat to Public Health. Public Health teams provide support for these functions
- Unitary and lower tier authorities have additional health protection functions and statutory powers under various health protection, health and safety and food safety regulations. Environmental health teams in local authorities provide support for these functions.

4.3.1 Local Authority Public Health responsibilities

Strategic roles in relation to COVID-19 planning, resilience and response:

1. *Leading the public health response locally* at an Upper Tier Local Authority (UTLA) level through Directors of Public Health and Health Protection Boards, working closely with Public Health England. DPHs will be responsible for producing the plans as they hold the statutory responsibility for public health;
2. *Managing the deployment of broader resources* and local testing capacity to swiftly test local people in the event of an outbreak and liaising with the Joint Biosecurity Centre. This will be done by Chief Executives working through local emergency planning structures and Local Resilience Forums; and
3. *Ensuring political oversight* of the local delivery of plans through a member-led Board, and communicating and engaging with residents, communities, businesses and relevant stakeholder groups.

4.4 NHSE&I

- Category 1 responder under the Civil Contingencies Act 2004
- Central commissioning of primary care services and specialised services
- Direct commissioning of health and justice services, armed forces and veteran's health services
- Responsible for ensuring that contracted providers deliver an appropriate response to an incident which threatens public health

In relation to this plan:

- Lead the mobilisation of NHS funded services
- Assure the capability of the NHS response to the incident or outbreak

4.5 Clinical Commissioning Groups (CCG)

- Category Two responders under the Civil Contingencies Act 2004
- Principal local commissioners of NHS-funded acute, community health and primary care services
- Responsible for ensuring that their contracted providers (general practice, acute hospital, community health, mental health, out-of-hours etc.) will provide the clinical response to incidents that threaten the health of local population

In relation to this plan:

- Authorise assistance as required by a local provider of NHS funded care
- Provide support and advice to care providers
- Provide infection prevention and control advice and support to the population, including schools, care homes and high-risk settings

4.6 Healthcare (including public health) service providers

In relation to this plan:

- Provide assistance as required by a local commissioner including support to care settings, e.g. to schools through school nursing services
- Provide local surge capacity if required for complex situations

4.7 Health and Safety Executive (HSE)

- Category Two Responder under the Civil Contingencies Act 2004
- Protects the health and safety of the public by ensuring workplace risks are properly controlled, including infectious/communicable disease hazards

In relation to this plan:

- Collaborate with Outbreak Control Teams
- Inspect premises
- Regulate workplace risk assessment processes
- Exercise statutory powers under the Health and Safety at Work Act 1974

4.8 Care Quality Commission (CQC)

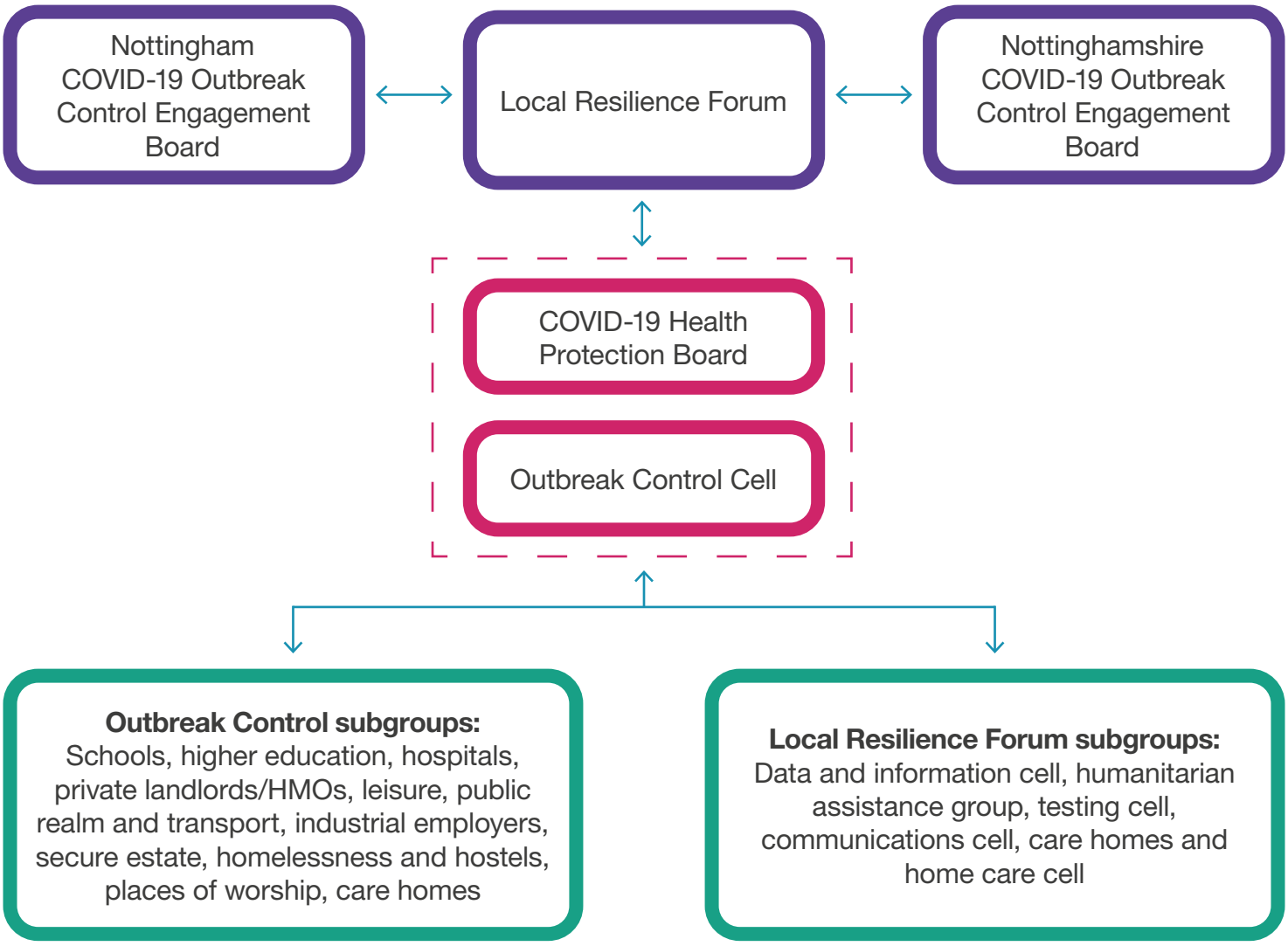
- Enforcement role in relation to regulated services such as care settings
- Responsibility to protect people who use regulated services from harm and the risk of harm, to ensure they receive health and social care services of an appropriate standard

In support of NHS England in discharging its EPRR functions and duties locally, the CCG is delegated to coordinate the health economy tactical coordination during incidents (Alert Level 2-4).

5. Structure and governance

The Local Outbreak Control Plan builds on the existing well-established and effective Local Resilience Forum (LRF) response structure. As indicated in the diagram below outbreak control will have interdependencies with parts of the existing structure including; the data cell, the testing cell, the communications cell, the care homes cell and the Humanitarian Assistance Group.

Local Outbreak Control Plan Governance Structure:



5.1 Outbreak control cell

A single outbreak control cell will facilitate the day-to-day operational delivery of the outbreak management plan. The cell will meet daily, chaired by a Public Health Consultant, with membership from PHE, Infection Prevention Control and data leads. A key function of the cell is ongoing surveillance and monitoring of the situation (see section 8). This will include the two-way exchange of daily situational reports between the Outbreak Cell and PHE's Health Protection Team to ensure a complete picture. This will enable emerging situations to be identified quickly and addressed. If an issue or concern is identified the Cell will either a) establish an Incident Management group to respond to that specific concern at which point all relevant stakeholders (including district and borough councils) would be alerted or b) escalate to the COVID-19 Health Protection Board if the concern is emerging rather than urgent. A standard weekly update report will be supplied to the COVID-19 Health Protection Board and subsequently made available to wider LRF partners.

5.2 COVID-19 Health Protection Board

A single COVID-19 Health Protection Board is being set up in Nottinghamshire. Its members will consist of senior officers from all relevant partner organisations (including PHE, LA Environmental Health, Nottinghamshire Police, health partners and relevant LRF Cell Leads). The Board will be co-chaired by the Directors of Public Health for Nottingham City Council and Nottinghamshire County Council. Functions of the board will include: providing oversight of the operational work undertaken by the Outbreak Control Cell, evaluating the effectiveness of the LOCP and identifying priorities for strengthening preparedness, and advising on trends and horizon scanning. This Board will act as the advisory board for the two local authority level Outbreak Control Engagement Boards.

5.3 Nottingham City COVID-19 Outbreak Control Engagement Board

The Board will ensure there is effective public oversight and communication of the COVID-19 Outbreak Control Plan.

Its membership includes senior elected Members of Nottingham City Council, the Council Chief Executive and Director of Public Health and other senior officers, Public Health England, Nottingham and Nottinghamshire ICS, Nottingham City ICP and Nottinghamshire Police. The Deputy Leader of the City Council chairs the Board.

6. Engagement and communications

The Nottingham City Council communications team will undertake the lead role for communications. Both for prevention communications and when responding to COVID-19 outbreaks or incidents locally. This will be in association with Public Health England communications, given their specific expertise and to ensure consistency of messaging across the region and with the local LRF Communications Cell.

The communications lead will work closely with partner organisations, community groups and other agencies to coordinate activity and ensure consistent messaging using pre-existing networks and community relationships. A separate plan will provide further detail about the implementation of proactive and reactive/responsive messaging. Effective communications and engagement with local communities will be an important part of both preventing, and if needed responding to local outbreaks. Communications will be utilised to ensure awareness and engagement among the public and key stakeholders about the Local Outbreak Plan for Nottingham.

The key objectives of the communication plan are to:

- provide public confidence and assurance through relevant, timely and accurate information and sharing information through relevant agencies
- build trust, participation, consent and co-operation
- inform key stakeholders when there is a local outbreak and what action they must take
- ensure local people know how to get the services and support they need to include test and trace and know how to report a suspected outbreak
- support engagement, co-production and communication to ensure residents, communities, businesses and key stakeholders (including local politicians) in Nottingham have access to the information and support they need in a timely and effective way to protect themselves, their communities and the city
- localise national COVID-19 guidance especially for Nottingham's diverse communities
- influence behaviour change and perceptions where necessary
- ensure suitable governance arrangements are in place utilising the Local Resilience Forum (LRF).

The communications plan covers two aspects:

a) Proactive communications:

The communications plan includes providing information and messaging to the public, amplifying and clarifying national messages, to promote adherence to the guidance and to support behaviours, which reduce the spread of COVID-19 and encourage cautious behaviour. Public Health prevention messages along with regular updates and responses to the public's concern will continue to be extensively communicated in this next phase of the pandemic.

Key messages include:

- The continued importance of staying safe by remaining cautions, social distancing and good hand hygiene
- The requirement for social distancing (two metres away from people as a precaution or one metre when you can mitigate the risk by taking other precautions) to reduce the chances of the virus spreading
- Raise awareness of and encouraging adherence to the NHS test and trace programme.

The communications plan will be developed through ongoing engagement with local communities, faith groups and the community and voluntary sector to promote guidance, model 'good' behaviours in communities and constructively engage with those people who may not comply with guidance.

b) Reactive communications in the event of an outbreak:

The communications plan considers how we will issue messages efficiently and effectively if there is an outbreak to support the effort to control any spread. This will consider communications with; cases, contacts, communities, businesses, stakeholders and local media. The communications response in the event of an outbreak will be flexible and tailored depending on the type and location/setting of the outbreak. Channels and messaging will be adapted to the audience, with a particular focus on ensuring vulnerable communities are communicated with e.g. deprived communities, travellers, BAME communities, people with English not as a first language, etc.

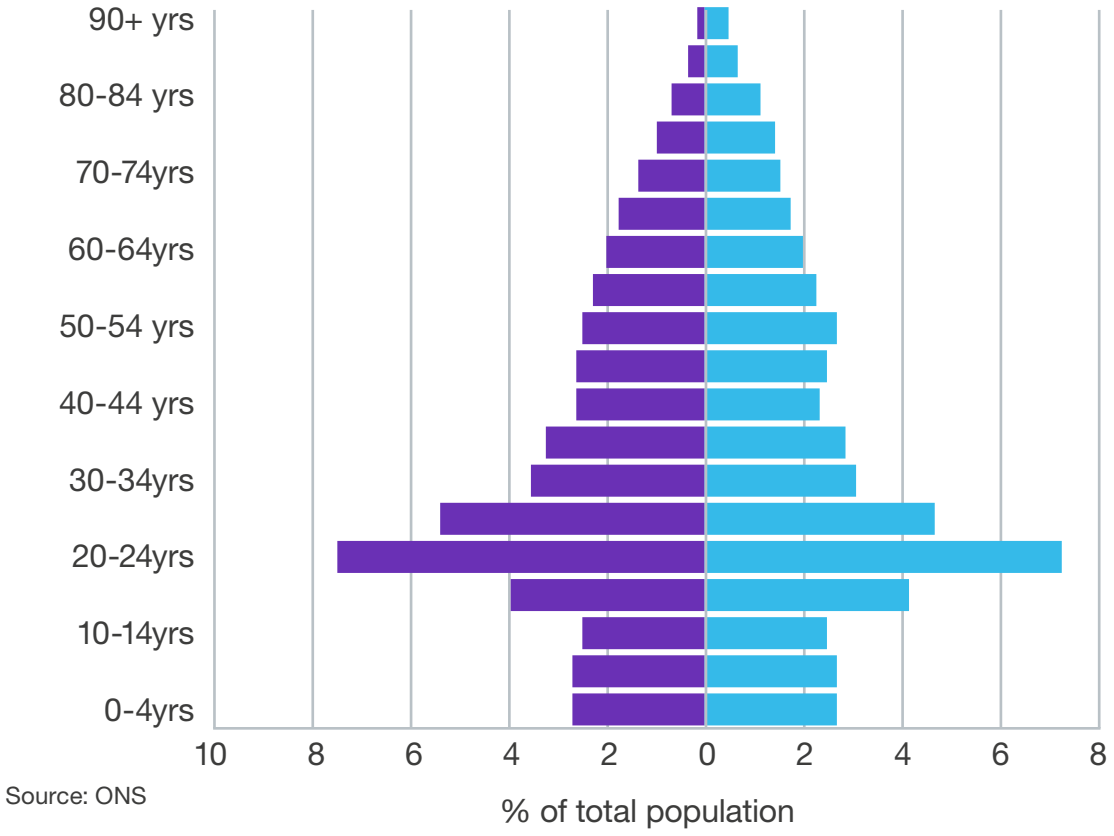
Where an Incident Management Group is convened - the communications lead and coordination of all press and media issues raised in relation to the incident or outbreak will be agreed with the Incident Management Group/Engagement Board. Spokespersons should be identified as appropriate to the nature of the incident but will likely include the Director for Public Health and Chair of the Engagement Board.

The plan will be continuously developed through regular communication from the Outbreak Control Engagement Board, both proactively and reactively, as part of outbreak management activities.

7. Local context

Nottingham City is an urban area with a population of 332,900 (Source: ONS, 2019 mid-year estimate). The City's population continues to grow with the main reasons for this being international migration and natural change.

As shown below, Nottingham has a young age-structure, with 29.7% of the population aged 18 to 29. Full-time university students comprise about 1 in 8 of the population.



Source: ONS

Despite its young age-structure, Nottingham has a higher than average rate of people with a limiting long term-illness or disability. A high proportion of those individuals will fall into the category of clinically extremely vulnerable people who will have been shielding.

Approximately 27,363 residents are aged 70 or over, with 1,625 older people living in care homes in the City (770 of whom have diagnosed dementia). The wards of Nottingham with the highest proportion of older people are Bulwell Forest, Wollaton West and Bilborough.

Nottingham is a diverse city with the 2011 Census showing 35% of the population as being from Black and Minority Ethnic groups. This was an increase from 19% in 2001 and is likely to have increased further since.

Ethnic Group	Number	Percentage
Asian/Asian British	40,039	13.1
Black/African/Caribbean/Black British	22,185	7.3
Mixed/Multiple ethnic groups	20,265	6.6
Other ethnic group	4,493	1.5
White	218,698	71.5

Analysis of the 2011 Census shows that the main BAME groups have quite different geographical distributions and in two Nottingham wards: Hyson Green and Arboretum, and Radford the proportion of the population who are from BAME groups is more than 50%.

Nottingham is ranked 11th most deprived district in England in the 2019 Index of Multiple Deprivation (IMD). 34% of children and 25% of people aged 60 and over live in areas affected by income deprivation. Deprivation is known to underpin unfair inequalities across many health outcomes, and this has been the case with COVID-19.

Nottingham City is a unitary local authority. Within the wider county of Nottinghamshire there is a two-tier local authority structure with a county council and seven district councils. Nottingham City falls solely within the Nottingham and Nottinghamshire Integrated Care System (ICS) and the local authorities' boundaries are matched by the same boundaries of the dedicated Integrated Care Partnership, enabling strong and effective relationships with partners across the health and care system.

Part 2 – Capabilities

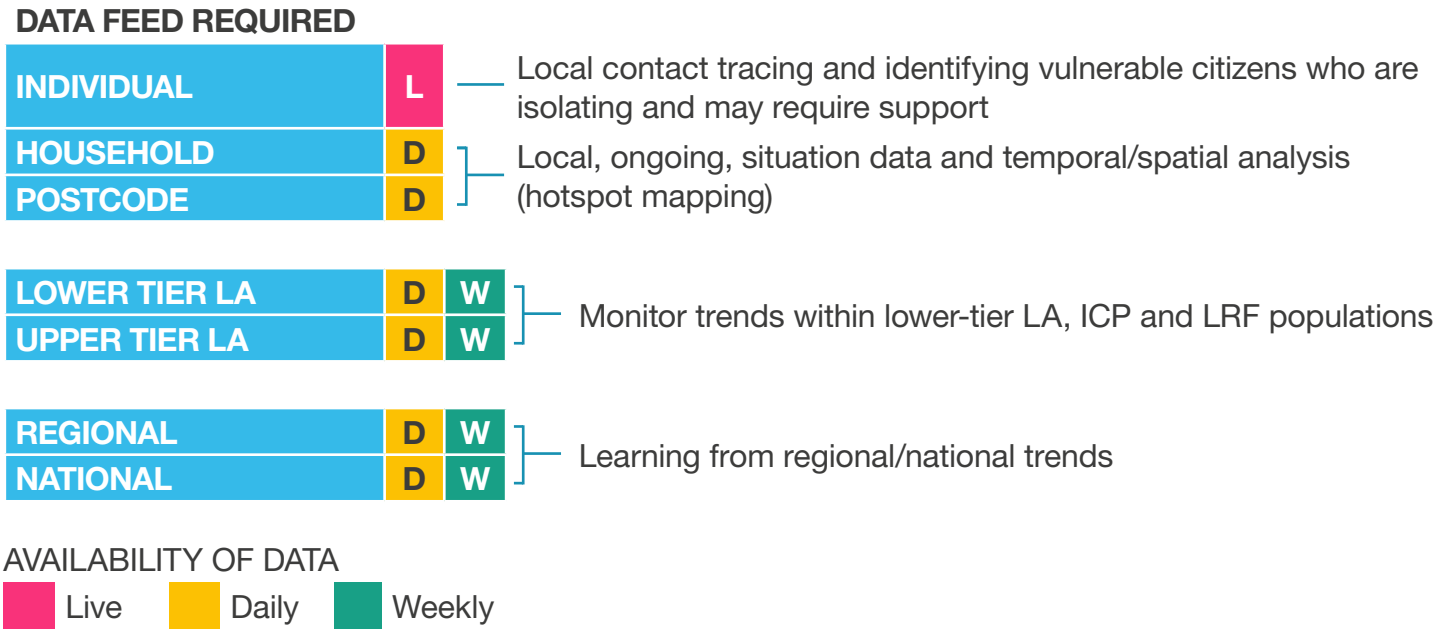
8. Data and surveillance

8.1 What is the purpose and importance of data linkage?

Integration of national, regional and local data is required to enable the continuous monitoring of the frequency and the distribution of disease, and death, due to COVID-19 infections.

In addition, effective management of notified outbreaks, contact tracing, and self-isolation relies on the flow of data between key stakeholders and between those at the front line of infection prevention control.

The summary below outlines the level of data we will require for various aspects of surveillance and case management.



8.2 How are stakeholders currently working together on local intelligence?

The Local Resilience Forum is a multi-agency partnership made up of representatives from local public services and a range of other organisations, such as transport operators, utilities providers, community organisations and voluntary sector bodies. This has provided the opportunity to build new ways of working and sharing data and soft intelligence.

The Nottingham and Nottinghamshire LRF data cell coordinates the work of analysts from the Integrated Care System, CCG, General Practice, City and County Councils, Nottingham University Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust, University of Nottingham and Nottingham Trent University. Where needed, the data cell has also formed task and finish groups to draw on local clinical expertise.

Pre-existing partnerships with private organisations (i.e. Experian data lab) have been used to provide specialist expertise to local modelling and data from regional and national partners (i.e. PHE, ONS) and to feed weekly local data updates.

8.3 What surveillance data are we currently using and how will it be used to inform local decision making?

We have developed a local surveillance system to monitor a number of indicators providing useful intelligence on the spread of the virus locally. This surveillance system makes use of a range of data sources including NHS 111 and 999 calls, COVID-19 hospital admissions and summary data about confirmed laboratory cases (Pillar 1). The Outbreak Cell will receive monitoring updates at its regular meetings with a full surveillance report being reviewed weekly with escalation of key issues to the Health Protection Board.

The LRF Data Cell currently estimates R on a weekly basis using confirmed cases of COVID-19 in addition to data from NHS 111 services and hospital admissions as a proxy for cases. As the level of infection becomes smaller, R will naturally gravitate towards 1. This is because localised outbreaks have greater significance in estimating R as the lockdown rules are gradually relaxed and/or adherence lessens. The Health Protection Boards will require a range of data sources to inform their decisions. The current list of indicators is outlined below; however, these will change as new data sources become available:

Current Indicators
Estimated local R_e number
Apple Mobility Trends (Nottingham)
Google Mobility Reports (Nottingham and Notts)
Potential COVID-19 NHS 111 telephone calls (Nottingham and Notts)
Potential COVID-19 99 calls (EMAS Nottinghamshire Division)
COVID-19 Pillar 1 (PHE/NHS labs) confirmed cases (Nottingham and Notts)
COVID-19 NUH lab confirmed cases (NUH Total Trust)
COVID-19 hospital admissions/inpatients (NUH and SFH)
COVID-19 patients occupying ITU beds (NUH and SFH)
COVID-19-like symptoms A&E attendances (Nottingham and Notts)
COVID-19 Pillar 2 (commercial labs) confirmed cases (Nottingham and Notts)
COVID-19 local drive-through total swabs (Pillar 2 testing)
COVID-19 hospital deaths (NUH and SFH)
COVID-19 total deaths (hospital and community)

Laboratory Confirmed Cases: Public Health England (PHE) publishes daily data on laboratory confirmed cases (**https://coronavirus.data.gov.uk/**). This data only includes tests carried out in Public Health England and NHS Trusts laboratories, which mainly cover hospital inpatients and critical health workers (Pillar 1 testing). Until recently, this picture has remained incomplete, with Pillar 2 data recently becoming available to DPHs on a confidential basis. Daily exceedance and surveillance reports using lab confirmed cases are also provided by Public Health England. The use of this data is currently limited, as it is not reported at an individual level.

Primary care surveillance: In Nottingham and Nottinghamshire, e-healthscope offers a route to access a range of data held in the GP Repository for Clinical Care (GPRCC) alongside social care data shared by local authorities. This helps provide a complete picture of an individual's care across different services and interventions. This linked dataset has allowed us to map 'at risk' populations.

Secondary care surveillance: Currently secondary care data is being used to monitor COVID-19 hospital admissions/inpatients (NUH & SFH); COVID-19 patients occupying ITU beds (NUH & SFH); COVID-19 hospital deaths (NUH & SFH); and Emergency Department attendances with COVID-19-like symptoms.

This data ensures that local NHS capacity can be considered by the Health Protection Board, alongside all other surveillance data, when making decisions on the need for local action.

Mortality surveillance: In addition to the mortality data collected by local NHS Trusts, the data cell has utilised its links with local authority registry offices to receive timely updates on all deaths noting COVID-19 on death certificates.

The LRF data cell also monitors excess all-cause mortality. This tracks the number of deaths of any cause occurring in Nottingham and Nottinghamshire and whether they exceed the expected level for this time of year. This is an important indicator of the direct and indirect (e.g. through national lockdown measures) impact of COVID-19 on mortality. Excess deaths is an important measure for the Health Protection Board as it is a reminder that decisions on outbreaks, self-isolation and local controls also come with opportunity costs that must be considered.

Alongside the value of the insights we can gain from these hard data, we also recognise the importance of soft intelligence from local sources, e.g. anecdotal intelligence from a variety of sources about what appears to be happening in particular communities. The outbreak cell and COVID-19 health protection board will seek to capture and consider soft intelligence of this sort alongside more formal surveillance data by working with the communities where we already have established and effective relationships and will continue to develop these given the importance.

8.4 How will data be used to support outbreak management?

There are a number of existing data sources that can be used to monitor outbreaks:

- PHE East Midlands daily list of ongoing COVID-19 situations
- PHE East Midlands daily surveillance report including outbreaks/clusters notified to PHE
- Infection Prevention Control Team daily updates on ongoing care home outbreaks

It is anticipated the Joint Biosecurity Centre will also provide a dashboard identifying outbreaks and clusters including those escalated to Public Health England's regional teams. We will work with PHE colleagues to adapt the above data feeds to best meet the needs of the outbreak cell and supersede or supplement with data from the Joint Biosecurity Centre.

8.4.1 Supporting vulnerable citizens

We have already used the GP database, e-healthscope, to identify vulnerable individuals (e.g. frail, living alone, receiving informal care and/or falling outside shielding criteria but with co-morbidities) in order to help local authorities provide appropriate community support. In this next phase, data on individual cases and contacts will be cross-referenced with this list to continue a targeted support offer.

8.5 What additional local analysis of local clustering can be conducted?

Local analysis requires individual level data. It is, as yet, unknown if this will be provided.

Postcode level data on individuals with a positive test result and/or GP data (e-healthscope) in Nottingham and Nottinghamshire have the potential to allow monitoring of cases by geographical, demographic and clinical factors. This could support the identification of non-geographical clusters or emerging infection trends within local communities. As such, this data will support pro-active action to support the Health Protection board in its communication and prevention efforts.

8.6 What unknowns remain and what information would support local surveillance and action?

The level of granularity of data that will be provided by the Joint Biosecurity Centre remains largely unknown. Examples of where the availability of data from national databases will guide our ability to act include:

- Information on all those accessing the Test and Trace system regardless of results would be required to understand more around the equity of access to testing within local communities. This is important as it guides community engagement plans and allows us to consider attack rates when looking at and interpreting 'hot spots'
- Data fields that identify those who have tested positive but who the Test and Trace system have been unable to contact would be required if we wish to mobilise local contact tracing support to fill this gap.

In addition, we are continuing to explore the infrastructure required to support case management and work flow. Data flow with stakeholders is key criteria in assessing the appropriateness of existing and new systems.

8.7 What resource considerations need to be made?

As stakeholders within the LRF return, in part, to business as usual, the resource coordinated by the LRF data cell may become stretched. As such, we are exploring with partners how best to resource the surveillance and data management

8.8 How will data be protected?

Information governance will be of great importance as this situation continues. Data protection officers and information compliance leaders for both councils will be involved to ensure appropriate data sharing agreements and arrangements for data processing by partner organisations are in place.

9. Testing

Under the NHS Test and Trace programme, anyone with symptoms of coronavirus is encouraged to be tested by arranging a test online at **www.nhs.uk/coronavirus** or calling 119. The test is most effective if it is taken within 3 days of symptoms developing. It involves taking a swab of the inside of the nose and back of the throat using a long cotton bud, and then this swab is sent to the laboratory for testing. The results are then sent back to the person. If tested positive, close contacts will then advised to self-isolate accordingly. In addition, testing arrangements are also in place for NHS patients and staff, care home residents and social care staff and other local essential key workers.

Local testing arrangements will also be available to ensure a fast and accessible response to support the management of outbreaks, including in high-risk or complex settings or specific geographical areas, which require more bespoke arrangements.

9.1 Aims and objectives

- To ensure anyone with symptoms of coronavirus (COVID-19) can be quickly tested to find out if they have the virus. This includes:
  - Existing symptomatic testing available via the NHS Test and Trace service
  - Community in-reach testing for complex cases and those individuals who experience barriers in accessing the NHS Test and Trace service provision
  - Community in-reach testing support in residential care settings
- To provide targeted testing quickly to anyone without symptoms in an outbreak, to find out if they have the virus, where a risk assessment determines it necessary
- To provide rapid testing results to support the investigation of local outbreaks where necessary
- To provide mass testing in the event of an outbreak
- Coordination of all testing options available (regional and local) to ensure swift and accessible testing, targeted and prioritised according to need.

Box 1: Definitions

Testing in the context of Test and Trace refers to swab testing (also known as antigen testing), which detects whether a person has COVID-19 at the time of the test. For the purposes of outbreak management, only antigen testing is currently considered. Antibody testing is currently only used for surveillance purposes.

9.2 Key stakeholders

Key stakeholders include:

- **Local settings/organisations:** education providers, care home staff and residents, local businesses and other settings, including high-risk places, organisations and communities.
- **Local government:** directors of Public Health, Nottingham City Council, Nottinghamshire County Council, District LA partners, elected members and MPs.
- **NHS Trusts and organisations:** NHSE/I, SFH Foundation Trust, NUH Hospitals Trust, Nottinghamshire Healthcare Trust, City Care, NHS Bassetlaw CCG, Nottingham and Nottinghamshire CCG, NEMS, NHS 111, GP practices, hospitals, out of hours and urgent care/ walk-in centres.
- **Health Protection:** PHE East Midlands.
- **Testing:** Pillar 1 (PHE and NUH, SFHFT Pathology Services) and Pillar 2 (Lighthouse Laboratory Milton Keynes) testing provision, Deloittes RTU and MTU military testing provision, Nottinghamshire COVID-19 Testing Co-ordination Centre, all teams involved in swabbing testing and administration of the system.
- **Media:** local, regional and national
- **Government departments - all other:** members of the public, local essential workers, NHS and care home staff and residents

9.3 Current infrastructure

A system-wide testing framework has been established, with strategic oversight, operational co-ordination and supporting task groups working across Nottingham and Nottinghamshire. A combination of regional and local testing infrastructure is currently in place.

9.3.1 Regional and National Testing Infrastructure

This includes:

a) **Regional testing sites:** Drive-through testing is available at the Motorpoint Arena in Nottingham city centre. This centre forms part of the national testing programme, with testing available to anyone booking a test using the national website. Capacity for 1,000 tests per day.

b) **Mobile testing sites:** 2 MTUs offer drive through testing to symptomatic individuals. These are located at the Morrison's car park in Bulwell and Towers Hotel in Mansfield. A third facility in Newark was stood down due to minimal use from the local population, with testing capacity redeployed to other areas across the region. Combined capacity for 600 tests per day, with ability to extend to 1,000.

c) **Whole care home testing:** Available via a dedicated national care home testing portal, with swabs delivered and returned via courier service.

d) **Home testing:** A postal service for swabs to be sent to individual homes is also in place.

9.3.2 Local Testing Infrastructure

A responsive and high-quality local testing system is in place for the population of Nottingham and Nottinghamshire. This includes:

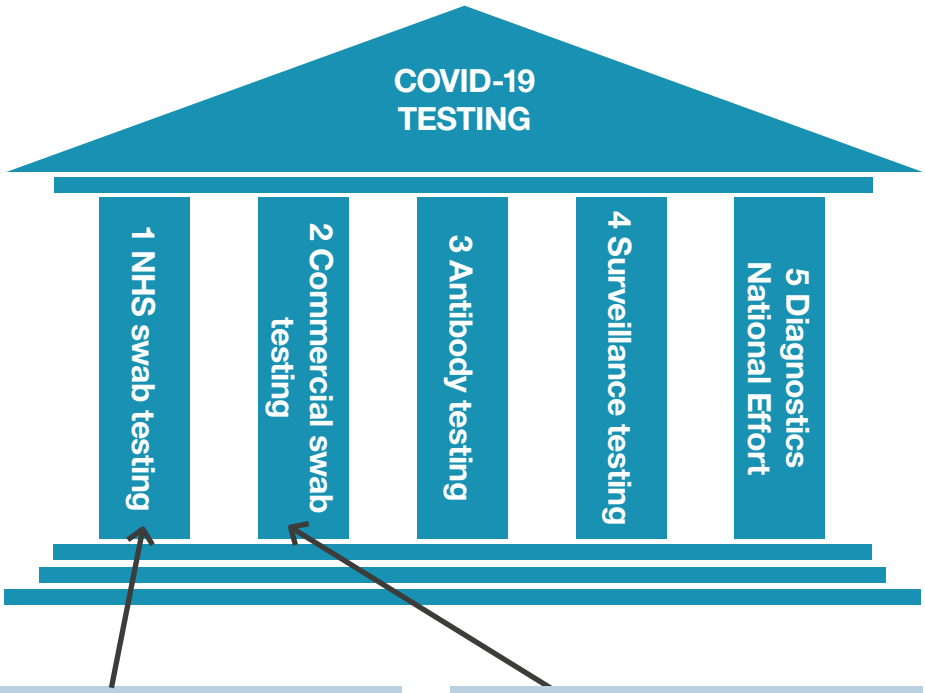
a) **Local Testing Coordination Centre** provides support and coordination for the testing of key workers, and whole care home testing, data management and sharing of testing intelligence for IPC, workforce and testing capacity planning.

b) **Laboratory testing capacity** provided by the Lighthouse Laboratory in Milton Keynes, PHE outbreak laboratories, and Sherwood Forest Hospitals and Nottingham University Hospitals pathology services (600 tests per day for acute staff, under 18s, new symptomatic care home residents, plus capacity for maximum of 1,000 antibody tests per day).

c) **Local in-reach and whole care home testing** (on request) delivered by Nottinghamshire Healthcare Trust in the County, and CityCare in the City has been in place to support delivery of the whole care homes testing programme, as well as symptomatic testing. In addition, specialist IPC advice and training is provided by IPC teams at NHCT, CityCare, and NHS Bassetlaw and NHS Nottingham and Nottinghamshire CCGs.

d) **Local direction of mobile testing units.** The testing resource available through the mobile testing units will be directed locally in line with the emerging picture of greatest need. The MTU can be redeployed to different locations within the County to respond to emerging hotspots and local community outbreaks, or redeployed to provide dedicated on-site support in the event of a large-scale testing requirement at the site of an outbreak, to aid in containing it. Redeployment of an MTU can be tasked within 24 hours.

Overview of existing antigen testing (swabbing) capacity, for Nottingham and Nottinghamshire, June 2020



Pillar 1 - Scaling up NHS swab testing for those with a medical need and, where possible, the most critical key workers

Pillar 2 - Mass-swab testing for critical key workers in the NHS, social care and other sectors

Pillar 3 - Mass-antibody testing to help determine if people have immunity to coronavirus

Pillar 4 - Surveillance testing to learn more about the disease and help develop new tests and treatments

Pillar 5 - Spearheading a Diagnostics National Effort to build a mass-testing capacity at a completely new scale

NUH & SFH Pathology Labs:

- Patient testing
- Acute staff
- Under 18s
- New symptomatic care home residents
- Antibody tests (SFH - 1,000* max)

Lighthouse Lab, Milton Keynes:

- Regional Testing Centre - Motorpoint Arena (1,000*)
- Mobile testing units - Mansfield Towers and Bulwell Morrison's (on rotation) (<300* each)
- Home test kits
- Care home whole home test kits

*Tests per day

Local testing arrangements for high-risk settings, including schools, homeless and rough sleeper populations, are currently being explored and developed as part of the local outbreak planning response, in partnership with relevant Incident Management Teams.

9.4 Risks and mitigations

Risks	Mitigations
Workforce capacity to support community symptomatic testing and residential care in-reach testing will reduce as staff deploy back into usual roles	Expected capacity demands are being modelled under small-, medium- and large-scale outbreak assumptions to allow recruitment of necessary and proportionate capacity
Reliability, accessibility and timelines of test results to enable effective outbreak management	◆ Close working relationships with PHE on individual outbreaks to improve real-time management ◆ Development of improved postcode-level data reporting flows from national testing programmes via PHE

Risks	Mitigations
Some vulnerable populations may be subjected to multiple testing rounds such as care home residents, for example when winter flu testing for care homes commences	◆ Work with care home settings to develop proportionate and risk-assessed approaches to testing ◆ Raise question with laboratories and nationally regarding dual use of swabs for flu and coronavirus testing
Insufficient capacity and budget to support effective, efficient, timely and coordinated communications	Ensure dedicated communications resources and expenditure budget to support the implementation of engagement and communications activity as set out in the overall LOCP communications plan
Testing provision or test result turn-around may be insufficient to meet demand in the event of a large outbreak or multiple simultaneous outbreaks	Reasonable testing capacity and capability assumptions are being collated within incident management plans for all defined high-risk settings. Scenario modelling will define likely testing demand and allow for escalation of requests for increased mobile testing unit capacity

9.5 Priorities for local action

The priorities for local action include:

- Establishing a responsive blended model of local outbreak testing provision to give equitable access across our population; using a combination of trained frontline worker expertise, dedicated in-reach testing capacity; deployment of MTUs.
- Provision of testing for residents in Nottingham and Nottinghamshire who may experience language, cultural or logistical barriers to accessing national testing provision. This includes, but not limited to: homeless/ rough sleeper populations, BAME communities, Roma, Gypsy and Traveller communities, individuals with no recourse to public funds, refugees and asylum seekers.
- Specialist testing support for those requiring Mental Capacity Act assessment and Best Interests assessment.

9.6 Interdependencies

There are clear interdependencies across the whole programme to ensure accessible testing is available, with timely results, for all priority groups.

Protocols are needed to establish how local testing and national testing provision will be utilised in the event of local outbreaks, including how testing capacity will be targeted in response to need.

There are cross-cutting priorities relating to data and intelligence to ensure data flows are in place to provide rapid and timely reporting from Pillar 1 and Pillar 2 testing to support outbreak management. Effective clinical management at individual level in the event of a positive test is tied to the timely access of this test result within GP information management systems, which relies on a national IT solution.

Delivery of testing to support local outbreak control is also dependent on the continuous availability of laboratory and testing capacity from national or regional provision, including the rolling whole homes testing programme, mobile testing unit and PHE outbreak laboratory testing.

10. Contact tracing

Contact tracing is an essential mechanism in controlling the spread of COVID-19 and containing local outbreaks to prevent transmission into the wider community. The national NHS Test and Trace programme will identify positive cases from all members of the public who access testing and provide immediate isolation advice. They will seek information from confirmed cases about their recent close contacts and inform the contacts to go into isolation for a 14-day period and to seek testing only if they become symptomatic. More information about this programme can be found at: **https://www.gov.uk/guidance/nhs-test-and-trace-how-it-works#how-test-and-trace-helps-fight-the-virus**

If the NHS Test and Trace service identifies that a case or contact may present a more complex picture, requiring additional risk assessment and outbreak management support this will be escalated to Public Health England's (PHE) regional health protection team. Following initial risk assessment of the referred situation PHE will escalate on to the local outbreak management arrangements if required via arrangements for the Outbreak Control Cell. Reasons for escalation might include a volume or complexity of outbreak control measures, which PHE has insufficient capacity to manage, or an outbreak of sufficient magnitude to warrant decisions at a tactical or strategic level. Complex cases may also be directly notified to the local Incident Coordination Centre.

There are a range of scenarios where contact tracing may be more complicated and require a local approach, for example:

- Positive cases within a group of transient workers with no fixed accommodation or point of contact
- Inadequate recording of contact information of visitors to a premises e.g. night time / visitor attraction economy
- Individuals do not use a phone, are difficult to contact or do not want to be traced
- Language barriers or poor communication skills

Additional complexities have been identified with the specific Incident Management Plans for high-risk settings.

In addition to the PHE and local authority public health teams, Environmental Health Officers are trained and experienced in undertaking contact tracing. Joint working protocols and procedures are in development to ensure this is sufficient capacity to resource both forward and backward tracing in complex scenarios and settings across Nottingham/Nottinghamshire. The LRF partners will continue to operate as a whole system, deploying and sharing resources as required to meet the need across the footprint. Surge capacity requirements will be built into the planning based on a reasonable worst-case scenario i.e. an outbreak of significant size/complexity or multiple concurrent outbreaks.

10.1 Exemptions

There may be settings where upon considering the balance of risk it is determined that staff do not need to self-isolate if they have been identified as a contact of a confirmed or suspected COVID-19 case (e.g. via national test and trace or local testing arrangements or hospital inpatient testing). In these instances, the Director of Public Health (DPH) will be responsible for making a decision to apply an exemption, on a case-by-case basis. It will be the responsibility of each Nottinghamshire local outbreak control plan sub-group to present the required information to inform a recommendation, including any conditions that apply, to the DPH in a timely manner. Decisions will be recorded on an exemption log.

Exemptions for care home staff are outlined in the letter from the Director General for Adult Social Care dated 29/05/2020. Locally exemptions can also be requested to the DPH for other settings, which are of

a similar nature and apply the same standards as care homes, around use of PPE, social distancing and IPC. This will include, but not be restricted to, the following settings in Nottingham and Nottinghamshire:

- Children's residential homes
- Other residential homes
- Sheltered accommodation
- Mental health supported accommodation
- Hostels

11. Supporting vulnerable people

11.1 Overview

The Nottingham City Council Customer Hub will provide support for vulnerable residents who need to self-isolate. The Hub brings together call handlers, community support teams and volunteers to provide support to vulnerable citizens.

The Hub enables residents to link with support near where they live. To date, over 18,000 citizens have been contacted and benefited from support, including:

Support	Detail
Access to food	Delivery of emergency food parcels, signposting to local food suppliers offering deliveries and support to register for online supermarket delivery slots
Access to medicine	Help with collecting and delivering prescriptions, collecting medicines from pharmacies and supermarkets
Dog walking	Help with walking the dog(s) for those unable to get out of the house
Befriending/social wellbeing	Friendly chat via phone for those who are self isolating, providing updates on what support services are available in your local area regarding both COVID-19 and to promote general wellbeing.
Physical wellbeing	Help to stay mobile and active - access to virtual gym sessions, advice about health, mental health support
Transport	Help with running errands
Other - please specify	These would be picked up from the database and addressed by LRF partners

11.2 Accessing the support

The Nottingham Customer Hub provides a dedicated telephone number – known as the Golden Number – for citizens to contact regarding any support requirements. The team will also proactively contact citizens known to be medically or socially vulnerable to assess their needs and respond as required. Alternatively, support can be requested by completing an online form. Following contact, the team coordinate the appropriate support and volunteers.

Nottingham Customer Hub Online Request Form
https://www.nottinghamcity.gov.uk/coronavirus-covid-19/help-for-residents-self-isolating

Nottingham Customer Hub Telephone contact
Tel 0115 915 5555 (open 9am to 5pm, Monday to Friday)

11.3 How it will link with Test & Trace and the Local Outbreak Control Plan

This Customer Hub will support the individuals who are self-isolating due to testing positive for COVID-19 or being identified from contact tracing. Whilst the model may change going forward, to reflect changes to the shielding guidance, NCC will retain assurance that if there are subsequent waves, the Council can quickly mobilise support functions including; secondment of nominated colleagues into designated support positions, calling on local voluntary networks, and utilising property and other assets for food or other emergency provision.

An online process is in place to record and manage the flow of critical information from a number of different sources (incoming calls, outbound calls, Government Shielding lists, online enquiries), alongside Business Intelligence dashboards to present live data and progress updates. Daily reports are generated for the current situation and an audit trail is available for this data.

Part 3 – Preventing and managing outbreaks in complex settings

12. High-risk/complex settings, people and places

Nottingham has range of high-risk settings including care homes (see section 13), school and early years settings (see section 14), prisons and detention centres, housing with multiple occupancies and homeless shelters. These settings have been identified for one or more of the following risk factors:

- The physical environment means close proximity to others is more likely
- Regular exposure to people with disease is more likely e.g. in hospitals
- The presence of population groups who are known to be at increased risk of contracting the disease and/or developing serious illness – including older people and BAME groups
- Groups accessing the settings face barriers to accessing information testing or maintaining social distancing.

Outbreaks in these settings will be managed through a whole system approach in collaboration with PHE East Midlands. PHE will remain the first point of contact for the notification of positive cases and outbreaks. It will be important that the setting owner to the PHE local Health Protection Team as quickly as possible using the agreed pathways communicates reports of confirmed cases in these settings. A standard operating procedure has been agreed regionally with PHE, which details the link between PHE and Local Authority Public Health Teams

Working groups combining public health, environmental health and setting-specific expertise have been established to identify individual high-risk settings and develop robust incident management plans for each group. These working groups will support specific Incident Management Groups in the coming months as and when they are required to mobilize.

Working groups have been established for the following settings across Nottingham and Nottinghamshire:

a) Higher Education/Universities

Nottinghamshire is home to two universities; the University of Nottingham and Nottingham Trent University, with approximately 67,000 students living and studying at number of campuses across the County. University students make up around 14% of Nottingham City's total population. Many students live in shared accommodation – either within halls of residence or shared private rented accommodation.

b) Prisons and Secure Settings

The LOCP recognises the need for prompt identification and management of COVID-19 incidents in prisons and secure settings. This includes HMP Nottingham, HMP Lowdham Grange, HMP Whatton and HMP Ranby with a combined capacity of 3,595 prisoners. The plan includes consideration of the significance of the demographic profile and characteristics of detainees and prison residents, as well as movement restrictions and flows, particularly where relevant to the wider surrounding community.

c) Leisure Settings

This includes local authority leisure centres, sports clubs, community centres and private settings of which there are over 1,000 across Nottingham and Nottinghamshire. The scope will be expanded to include cinemas, theatres and similar settings.

d) Rough sleeping, temporarily housed and socially vulnerable individuals

The scope of this Incident Management Plan includes, but is not limited to; rough sleeper locations, homeless hostels (16), domestic violence refuges (9), winter night shelter, drop in/day centres e.g. soup kitchens (8), houses with multiple socially vulnerable occupants (e.g. those that have experienced or are at risk of becoming homeless). The plan considers the complexity of these specific settings and the socially vulnerable groups health and social care support needs.

e) Places of worship

There are approximately 667 formal places of worship across Nottingham and Nottinghamshire. Faith groups and buildings are at the heart of many communities, providing space for worship as well as community spaces and services including foodbanks, soup kitchens, playschemes and more. We will continue to work with faith leaders to communicate key messages across the outbreak plan.

f) Hospitals

Across Nottingham and Nottinghamshire there are 4 NHS general hospitals, numerous specialist NHS sites as well as private and independent hospitals, which may provide NHS services alongside private health care. Hospitals are busy places, with vast numbers of staff, patients and visitors accessing sites each day. Many patients have underlying conditions or frailty for which they are seeking healthcare, putting them at increased risk of serious illness from COVID-19. Risk mitigation measures have been in place since the start of the pandemic.

g) Houses in Multiple Occupation (HMOs)

In Nottingham City there an estimated 6,700 HMOs, with occupiers sharing facilities including bathrooms and kitchens. 9 or more households occupy 111 of the HMOs in Nottingham City and these are considered of greater risk should an outbreak occur. The majority (72%) of these HMOs are included in one of the HMO Licensing Schemes within the City, which means we know the location of these properties and already hold the names and addresses of all property owners, landlords, managers and licence holders and other interested partners.

h) Public realm and transport (delivered through the relevant Nottingham & Nottinghamshire LRF Local Authority Cell subgroups)

Public realm – this includes open access and open-air visitor attractions in which citizens live, work and play such as urban centres, playgrounds, parks (6 in Nottingham City, 5 in Nottinghamshire County), National Trust Land (Clumber Park), Forestry Commission parkland (Sherwood Pines).

Transport – Whilst active travel is being positively promoted as an alternative, public transport needs to be maintained for essential users and, where possible, to meet demand from education and business. Buses, trams and trains, as well as railway, bus and train stations and stops are within scope for this Incident Management Plan.

i) High-risk workplaces

There is emerging evidence that meat and poultry processing/production sites are particularly high-risk workplaces. In total there are approximately 700 people employed in these activities across Nottinghamshire (300 in Nottingham City and 400 in Nottinghamshire County). Existing databases allow the relevant businesses to be identified and contacted so that Incident Management Plans can be put in place.

Whilst the focus of incident management planning to date has been on the above settings, not all higher risk or complex scenarios will occur within a specific setting. It will also be important to recognise that there will be higher levels of risk within some communities and places. Local authorities will continue to engage closely with the Voluntary and Community Sector, local community groups and communities themselves to communicate key messages and gather local soft intelligence as to emerging concerns and issues that may need to be addressed within specific areas or groups.

13. Care homes and similar settings

Nottingham and Nottinghamshire recognised the potential crisis in the care home and home care sector due to the COVID-19 pandemic. This was leading to more citizens being infected, rising death rates and was affecting the delivery of high-quality care. With increasing pressure, this could result in significant provider failure and potentially destabilise the system. A system response was developed, maximising the collective resource and effort of partners.

13.1 Aims and objectives

A care home and homecare multi-agency cell works to minimize the COVID-19 infections and related deaths in care homes and homecare settings in Nottingham and Nottinghamshire by:

- Ensuring the establishment of effective multi-agency responses
- Ensuring effective communication across the partnership
- Assessing the impact on, and the need to support, business and communities, both in the acute and recovery phases of the outbreak

The well-established care homes and home care (CHHC) strategic cell drives the system-wide response to COVID-19 in care homes and homecare providers. Their role is to manage, focus on enhancing capacity, coordinate and implement, assess, report and understand needs in the care home and homecare sectors response to COVID-19.

The following sub-groups support the CHHC:

- CHHC operational support group: Tactical delivery, operational demand management and mobilisation
- CHHC short- and medium-term market management: Formulation of shared SOPs and agreements, development of shared risk assessments and process.
- CHHC communication group
- CHHC data reporting group: One version of the truth

13.2 Scope

It is known that COVID-19 poses a greater risk to elderly and those with underlying medical conditions as such the outbreak management response to date has primarily been targeted at care homes and homecare providers.

The initial scope of this work has been focused on care homes and homecare providers, however this will be broadened to include any care setting with shared communal spaces where 2 or more people are resident and in receipt of care. In practice, one resident case triggers a risk assessment and early response in the setting from PHE and IPC teams.

13.3 Stakeholders

The following stakeholders have been engaged:

- CCGs: chief nurse, quality, commissioning and analyst teams
- Local authorities: adult social care, quality and market management, public health teams
- Testing coordination centre
- Infection prevention control teams: City, mid and south Notts and Bassetlaw
- Care home and homecare providers
- GP clinical leads / primary care
- CQC and PHE colleagues

13.4 Demand

In Nottingham and Nottinghamshire there are 364 care homes, residential and nursing, registered with the Care Quality Commission.

An indication of the number of care settings within scope are included below:

	Nottingham	Nottinghamshire
Care Homes	75	277
Homecare providers	28	70
Care, Support and Enablement outreach providers	35	24
Care Support and Enablement supported living	29	205
Day and evening services	56	tbc
Extra care	5	13
Shared lives	25	69

There are 76 Ofsted-registered children and young people's residential settings. Young adults (<21) also receive support in semi-independent living across circa 120 different settings. N.B. These figures are for the whole of Nottingham and Nottinghamshire.

13.5 Current processes and responsibilities

An outbreak in a care home or homecare setting may be identified to the local system via a number of routes: PHE, care home / homecare provider, Acute Trusts daily COVID-19 alerts, Daily swabbing call / adult social care for Pillar 2 test results.

The local system works collaboratively to provide a robust response of advice, guidance and support lead by the IPC teams who:

- contact home to gather information on situation and potential impact using agreed checklist
- complete outbreak summary for sharing with relevant partners
- agree isolation and IPC measures required, review PPE use and stock, review staffing levels and advise in relation to self-isolation and testing for symptomatic staff, advise closure to new admissions and visitors. Share guidance, information and training materials if required. Give contact details for in and out of hours support
- liaise with testing cell and arrange testing via local swabbing team. Testing cell logs request for Pillar 2 testing of asymptomatic staff and residents
- complete paperwork and alert PHE and acute/community providers to outbreak

- contact home daily as part of outbreak management measures and complete a daily outbreak summary report for sharing with healthcare providers, the LA and CQC
- monitor swab results and notify care home of results. If all other tests are negative and all others well, an outbreak is not declared and home can open for admissions. If 2 or more tests are positive outbreak management measures continue
- outbreak management measures continue until the outbreak stabilises and there is confidence in its management: IPC calls may reduce across this period in agreement with the home
- outbreak is considered over once there are no new cases, 14 days have elapsed, and all residents are recovering with no residual fever in the last 48 hours. IPC sends notification to healthcare providers, the LA and CQC and the home can reopen to admissions.

The full enhanced support offer is summarised below and is used both proactively to increase resilience in the care homes and homecare sector and reactively to respond to emerging demand.

This model has been successful due to the collaboration and partnership working from key stakeholders involved. All partners share information and intelligence effectively and efficiently to ensure outbreaks can be managed and providers supported.

Box 2: Key features of local enhanced care support offer

- Infection prevention control training
- Personal Protective Equipment training
- Infection Prevention control advice and guidance
- Rapid in-reach swabbing support and whole care home swabbing support
- COVID-19 emergency staffing supply offer
- COVID Care call line and a clinical call line incl. out of hours support
- Management of admissions and discharges, recognising and responding to deterioration and medications and symptom management
- Supported by care home and homecare toolkit (next slide) and Enhanced Clinical Response Teams
- Supported by communications: webinars, daily information bulletin, forums, regular support calls from ASC quality teams.
- Public health teams provide advice, support and guidance responding promptly to national guidance

13.6 Resource implications

The care home and homecare enhanced support offer and toolkit went live in April 2020 driven by local IPC teams. Sufficient resource was identified to meet the need, supported by redeployed clinicians. As services move into restoration, the available pool of clinicians reduces. It is essential that teams can continue to be flexible to meet demand.

The established systems and processes are well placed to manage the majority of older adult care home outbreaks effectively. The LOCP task and finish group for care homes and similar settings will focus on identifying any additional capacity and capability, which may be needed to expand outbreak management to meet the needs of all residential care settings, and sustain prevention and support activity in the longer term.

13.7 Priority actions and potential barriers

- Workforce resilience: explore expansion and continuation of staffing support offer and skill mix
- Resource implications for IPC and swabbing teams
- Engage additional stakeholders in light of agreed scope
- Consider prevention offer for all settings

14. Schools and other educational settings

Whilst the risk to children appears to be reduced, as schools and other education settings continue to increase the numbers of students in attendance, it is important plans are in place to mitigate/respond to any potential outbreak in order to protect the health of staff, students and their families.

14.1 Aims and objectives

The education and childcare setting task and finish group provides the strategic lead and partnership forum for planning mitigations and interventions for incidents and outbreaks of COVID-19 in these settings in Nottingham and Nottinghamshire. The Incident Management plan will identify the escalation and activation triggers for an outbreak or incident within these settings and the interventions and response that would be put in place, including risk assessment, testing and contact tracing, reporting, and communication to contain and suppress the spread of COVID-19.

The plan aims to provide assurance that, if needed, systems are in place to effectively respond to and manage outbreaks in schools and similar settings, in a timely way.

The objectives are:

- To enable the system to respond to outbreaks of COVID-19 in education and childcare settings in a timely way
- To ensure the incident management plan is produced for education and childcare settings and that it is tailored to the local context & the needs of local communities
- To share good practice and build on existing plans and skills within education and childcare settings
- To implement engagement and communications activity as outlined in the overall LOCP communications plan.

14.2 Scope

The group covers early years, nurseries, schools (primary, secondary, independent, academies, free schools, maintained, special schools, boarding schools and alternative provision) in Nottingham City and Nottinghamshire County. This includes all staff and students in these settings, regardless of resident address. The scope of the group will continue to be reviewed.

14.3 Stakeholders and interdependencies

The following stakeholders have been engaged: Local authority public health (City and County) and environmental health (City and districts), Public Health England, Education and early years services and Health and Safety.

This group has strong links to the universities high-risk setting task and finish group, which includes further education and higher education, including universities. Links to public transport and leisure and hospitality settings also need to be considered. Children's residential settings, including secure estates

will be covered in other high-risk setting groups. The education and childcare setting workstream will also need to link closely with the data, testing and communication work areas. The group recognises that these interdependencies may change over the course of this task.

14.4 Demand

Table 1 overleaf summaries the estimated total number of staff and students in educational settings across Nottingham City and Nottinghamshire (data collated by LRF data cell). There are approximately 100 in Nottingham City and 340 in Nottinghamshire County Council, plus alternative provision schools. Tables 2 details the number of educational settings within Nottingham City.

Table 1. total number of children and staff in educational settings across Nottingham City and Nottinghamshire

Number	Maintained	Academy	Independent	Total
Children	59,941	104,905	3,836	168,682
Teachers and support staff	7,148	11,367	0	18,515

Table 2. Academy, LA maintained and other educational settings in Nottingham City

School Type	Phase	No.
Academy (Inc 1 Sec Free School)	Primary	47
	Secondary	17
	Special	3
	Alt Provision	2
	TOTAL	70
LA Maintained	Nursery	1
	Primary	29
	Secondary	0
	Special (Inc Hospital School)	3
	TOTAL	33
Other	AP Free school	2
	TOTAL	2

Early Years (including Childcare) Settings

Table 3 below gives the total number of early years settings for Nottingham City and Nottinghamshire County, including in that total how many are registered childminders.

Table 3. Early years settings in Nottingham City and Nottinghamshire County.

Local Authority	Group Providers	Childminders	Total
Nottinghamshire County	270	640	910
Nottingham City	76	198	274

14.5 Accountability and governance

The education and childcare task and finish group feeds into Nottingham and Nottinghamshire's Local Resilience Forum Outbreak Control Cell, which, in turn, feeds into the Nottingham City and Nottinghamshire County Covid-19 Health Protection Board and the Local Resilience Forum Tactical Control Group.

14.6 Current processes

An outbreak in an education or childcare setting may be identified to the local system via a number of routes including: notification from Public Health England, the education/childcare provider or local surveillance/analysis. Settings are aware to notify the Public Health England East Midlands Health Protection team through the usual routes, in and out of hours, who provide advice including risk assessment and infection control advice.

14.7 Potential challenges and mitigations

Potential challenges	Mitigation
Siblings in different settings and households mixing poses an increased risk, including those that cross over local authority boundaries	◆ Map settings/areas where we know this might be more likely ◆ Educational and childcare settings in LA communication across EM and borders via DsPH/PHE EM
There is a risk that educational settings take independent action before consulting the relevant bodies (e.g. contrary to national guidance)	◆ Ensure all settings know they must wait for advice before acting and develop relationships to enable timely advice ◆ Completed plans clearly communicate the stages of the implementation of the incident management plan, including when to take action ◆ Utilise Joint Biosecurity Centre (JBC), action cards when developed ◆ Ensure clear route for settings to access timely Public Health advice
Insufficient capacity and budget to support effective, efficient, timely and coordinated communications	◆ Ensure dedicated communications resources and expenditure budget to support the implementation of engagement and communications activity as set out in the overall LOCP communications plan
In- and out-of-hours requirements and implications of the situation needs consideration, including staffing arrangements to cope with demand (capacity required from both NCC and PHE). E.g. if multiple education and childcare setting outbreaks occurred	◆ Mapping exercises would need to take place as part of the development the plan, to identify possible scenarios that would need a tailored response ◆ Undertake a desktop exercise to test the IMP
Other services that are linking with educational and childcare settings and families may communicate alternative messages that could contradict the process identified in the plan	◆ Ensure the members of the task and finish group update relevant services/partners accordingly ◆ Ensure the completed plans are shared widely on a local level

Part 4 – Mobilisation

15. Mobilisation planning

15.1 Resources

Local authorities have been allocated grant funding to support the delivery of this plan in relation to the mitigation against and management of local outbreaks of COVID-19. Nottingham City have been allocated £3,126,717. Nottinghamshire County have been allocated £3,802,915. This funding will be used to resource the increase capacity requirements for community engagement, testing, contact tracing, infection control, support for vulnerable people, enforcement and specialist expertise. The plan must be sufficiently resourced to deal with outbreaks at an unprecedented scale if required, including across multiple locations and settings simultaneously.

15.2 Incident Co-ordination Centre

Currently the outbreak management function is delivered through a close working relationship between PHE East Midlands, Nottinghamshire and Bassetlaw CCGs' Infection Prevention Control teams and the City and County Council's public health teams. In order to fully mobilise the LOCP an Incident Coordination Centre will be established to facilitate the delivery of the Outbreak Control Cell's operational functions and support the implementation of setting specific Incident Management Plans. With senior Public Health manager oversight, this will provide a single point of contact for queries and the notification of concerns as well as co-ordinate the resourcing and deployment of Infection Prevention Control expertise, local testing and contact tracing. Flexibility will be required to scale the level of resource up and down as required, dependent on the local situation at any given point in time. Surge capacity will be planned for based on locally agreed reasonable worst-case scenarios.

15.3 Personal Protective Equipment (PPE)

In common with most of the country, Nottingham City and Nottinghamshire County experienced significant difficulties in procuring the increased range and volume of PPE required by frontline services in the early days of the pandemic. This cross-organisational risk was raised with the LRF and action plans put in place under the oversight of a dedicated PPE Cell, stood up on 6 April and supported by the Logistics Cell. This Cell has been successful in coordinating LRF drops of PPE and providing mutual aid. The local authorities have worked together to procure and distribute PPE for their internal services, care homes and home care providers. Procurement and distribution of PPE is now stable and LRF has the PPE risk set at "low" based on the assessment provided to them by the PPE Cell.

In addition, the Cell has worked together to communicate national guidance and ensure it is understood across the system including providing question and answer sessions for providers. The Cell continues to operate and is a core component in reducing outbreaks as well as in supporting the safety of staff engaged in outbreak management activities.

16. Assurance

16.1 Monitoring the effectiveness of the Plan

The Covid-19 Health Protection Board has overall responsibility for assurance and evaluation. The Plan will be reviewed regularly to ensure it is up to date, with consultation with leads for the individual sections.

Arrangements will be made to test the Plan.

Performance in relation to the implementation of the Plan will be monitored and reviewed, along with the continuing suitability of the systems and processes in place, through the COVID-19 Health Protection Board. A central lessons-learned log will be set up and a system developed to allow Task and Finish Groups to report lessons learned. The central log will be scrutinised for lessons learned and decisions made on communication of these by the COVID-19 Health Protection Board.

Serious Incidents

The activities undertaken as part of the Plan will be subject to existing Serious Incident management arrangements already in place within the NHS and the local authority.