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To: All Members of the Health and Wellbeing Board

Dear Member

Health and Wellbeing Board: Tuesday, 23rd June, 2020

Please find attached a **SUPPLEMENTARY AGENDA DESPATCH** of late papers which were not available at the time the agenda was published. Please treat these papers as part of the agenda.

Papers have been included for the following items:

B&NES LOCAL OUTBREAK MANAGEMENT PLAN

Yours sincerely

Marie Todd
for Chief Executive

If you need to access this agenda or any of the supporting reports in an alternative accessible format please contact Democratic Services or the relevant report author whose details are listed at the end of each report.

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MEETING	**B&NES HEALTH AND WELLBEING BOARD**
DATE	**23 June 2020**
TYPE	**Open public item**

Report summary table	
Report title	BaNES Covid-19 Local Outbreak Management Plan
Report author	Bruce Laurence 01225 394075
List of attachments	Appendices not included in paper going to HWB, as they are at a level of detail not necessary for understanding and signing off plan
Background papers	Local outbreak management plan briefing BaNES health protection incident response plan
Summary	All local authorities have been asked to prepare these plans to meet the needs of the response to Covid-19 in the future
Recommendations	The Board is asked to agree that: • It endorses this plan as a framework plan for BaNES and recommends it for approval by the Cabinet • It supports further work on developing detailed planning that will underpin this outline plan • It endorses the roles of the Covid-19 Health Protection and Local Outbreak Engagement boards and agrees to receive updates from those boards as required. • Members agree to use their influence to further the aims of this plan in their different organisations. • It supports in general the use of appropriate resources to enable the effective implementation of this plan, (but note that endorsing this framework plan does not commit to any specific expenditure).
Rationale for recommendations	Preparing this plan is a mandated responsibility of directors of public health working in local authorities.
Resource implications	There are no specific commitments in this draft. Effective implementation of the plan over the coming year will require resources, and £849.000 have been committed to the council for the purpose of supporting this plan.
Statutory considerations and basis for proposal	The Coronavirus act of 2020 has underpinned efforts to respond to and mitigate the effects of the Covid-19 outbreak and this plan is part of that response process subject to guidance from the DHSC. Councils' general duties as Cat 1 responders to major incidents are laid out in the Civil contingencies act of 2004.
Climate Change implications	Covid-19 will have major implications for lifestyles and economies across the world. Although at this early stage much has happened to reduce use of fossil fuels for transport and manufacturing, and in the former particularly there may be profound and lasting effects, it is far too early to understand all the implications with any accuracy.

Consultation	This has been prepared to a very tight time scale. So far members of the health protection board have been involved in the draft and members of CMT, the council leader, cabinet member for health and some local NHS leaders have seen a briefing paper about the development of the plan.
Risk management	A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision-making risk management guidance.

Please contact the report author if you need to access this report in an alternative format

Bath and North East Somerset Local Outbreak Management Plan for COVID-19

June 2020

Bath and North East Somerset Local Outbreak Management Plan for COVID-19

June 2020

Introduction

The Local Outbreak Management Plan is a framework document outlining the role of the Local Authority in the management of the COVID-19 outbreak in Bath and North East Somerset.

This framework provides a consistent set of principles and approaches by which B&NES will manage what is a very dynamic situation. Underneath this framework there will be a set of detailed plans that will also change and evolve.

The national situation

COVID-19, a disease that did not exist in humans before November 2019, has now killed over 40,000 people in Britain and given rise to almost 300,000 diagnosed cases, although the true number of people infected is likely to be many times that.

In addition to that great human toll, efforts to contain the spread of the virus have led to changes in how we live our lives unprecedented in peacetime, and which have had a massive impact on our economy and our society.

Bath and North East Somerset, in common with most of the South West, has been relatively lightly affected so far, with case and death rates well under half the national average, although still over 80 people have died here. This low impact, while obviously welcome, also means that most of the population will not have been infected and therefore not have gained whatever immunity that might afford.

In the past few months the focus of our national response has been to supress the outbreak, almost at all costs. Now however we want to move cautiously towards a more regular lifestyle, while at the same time ensuring that the outbreak is kept under control both to safeguard health and life, and to avoid overwhelming the health and care services.

The twin pillars of success

The only really good exit from this pandemic is the development and blanket use of an effective vaccine. Unless and until that happens, which will take from between several months to forever, we are likely to be on a constant knife edge between allowing the virus to spread again with the threat of new outbreaks, and having to return to more restrictive lives with all the associated costs to heath, wealth and wellbeing. Our collective task is to walk this line as skilfully as possible, and two things must happen if we are to achieve the best outcome.

Firstly, everything that we do now, whether at home, at work, at school, or in our towns and neighbourhoods, must be done with full attention paid to minimising the risk of viral transmission. This will be difficult to maintain over a long period of time, but the more careful we are in our daily ways of being, the more we can hold on to the wider freedoms to live something closer to our normal lives.

And secondly, we need to have a public system in place to identify and suppress possible outbreaks before they can gain momentum. This is the system of testing, tracing and self-isolating that is currently being set up and which is likely to take several months to reach full capacity and effectiveness. This will be explained in more detail in section chapter 5.

These are the twin pillars of success.

The role of the Local Authority

The Council has a role to play in ensuring the strength of both these pillars.

As an authoritative source of local community leadership, and through our many channels of communication, we can encourage and support residents and local institutions of all sorts to operate safely.

And, as the local base of public health, environmental health and adult care teams we have a key role in working alongside the national and regional parts of the test and trace system, to enable the whole to function as well as possible at a B&NES level. We also have a further specialist role in preventing local outbreaks though advice and training in vulnerable settings, particularly care homes, but also schools and certain other institutions.

The aim of the Local Outbreak Management Plan (LOMP)

The aim of the LOMP is to harness the capacity of the Council, working with a wide range of partners, to enable residents of Bath and North East Somerset to resume their normal lives as far as possible, while being protected from the threat still posed by COVID-19.

Principles of the LOMP

The principles to our approach are as follows:

Our plan will build on existing health protection processes, which are tried and tested.

Our plan will focus local and national efforts to coordinate a local system that ensures testing and tracing and where appropriate self-isolation occurs as thoroughly and as rapidly as possible.

The plan will ensure that we are quickly alerted to increases in cases overall as well as new outbreaks, and most particularly, outbreaks among the more vulnerable groups.

The governance arrangements associated with our plan will provide the structure and responsibility to enable an effective place-based approach in B&NES.

We will use an evidence base and local knowledge to steer a consistent approach to decision making.

Where it will strengthen efforts in B&NES we will work with neighbouring Local Authorities and other key partners such as the regional PHE unit, the local NHS and the LRF.

Note that B&NES' geographical position adds some complexity to the response plan. Our LRF alignment is with Avon and Somerset, while our NHS system incorporates Swindon and Wiltshire who share a separate LRF.

The themes of the LOMP

Nationally, seven themes have been identified as being essential to an effective outbreak management plan. The rest of this document will cover these themes.

They are as follows (Theme numbers as laid out in central guidance):

1. **Preparing outbreak response plans for the most common high-risk settings, particularly care homes and schools.**
2. **Identifying other local high-risk groups and settings, and preparing to be able to respond rapidly to outbreaks in such situations.**
3. **Understanding and coordinating the coronavirus testing system at locality level.**
4. **Understanding and coordinating the COVID-19 contact tracing system at locality level.**
5. **Data integration. Collating, analysing and presenting data with enough speed and detail to enable effective monitoring of COVID-19 in B&NES.**
6. **Protecting and supporting vulnerable residents, and particularly ensuring the welfare of those who are in a shielded group and are unable to look after themselves.**
7. **The governance of the whole COVID-19 response at locality level and the role of the local outbreak engagement board in communicating with residents and other stakeholders in B&NES.**

The rest of this plan will address these themes in a systematic, but sometimes interwoven way, and note that the document will not necessarily use the order above.

Chapter 1: Governance and Accountability

Governance

Two Boards will play complementary roles in managing the pandemic in B&NES through the next year. With a degree of simplification these boards will each take charge of one of the two pillars of success identified above.

A B&NES COVID-19 Health Protection Board, based on the existing Health Protection Board, will be in overall operational charge of outbreak control efforts. Its functions will include managing information and coordinating and supporting local efforts at preventing and minimising outbreaks. This all links closely to the testing and tracing system. This board will be chaired by the director of public health, and in his absence the consultant in public health with the lead for health protection.

Membership of this board will be flexible but will have a core group drawn from public health, environmental health, adult social care, the emergency team (EPRR), communications, informatics and the NHS. Links will be made to the Compassionate Communities Hub and other stakeholders as required.

The terms of reference for this board derive from those of the existing Health Protection Board which have been developed since the new public health system began in 2013. Approx.

A B&NES Outbreak Engagement Board, chaired by the Council Leader will play a critical role in ensuring that local residents and other stakeholders in the public, private and third sectors all understand and abide by the need to comply with rules and principles designed to prevent viral transmission. The main focus of this board will be outwards to the wider community.

The role of this board will be briefly discussed in chapter 6.

Reporting and accountability

The reporting structure underlying the governance of this outbreak needs to be effective but also realistic given the amount of time and effort that detailed reporting can take.

Both Boards will have representation on, and report into the B&NES Health and Wellbeing Board (HWB) which has an overall responsibility for all aspects of health and wellbeing in the locality. The HWB will also be the committee that signs off the LOMP.

The COVID-19 Health Protection board will also report regularly and where necessary to other important groups including:

- The B&NES Council senior management and corporate management teams
- The B&NES, Swindon and Wilshire NHS governance structures
- The Avon and Somerset Local Resilience Partnership

It is not yet clear what lines and processes of accountability and reporting will be set up with regional and national bodies, but there will be intensive national monitoring of all aspects of the pandemic across the country and the focus of reporting will probably change to reflect the changing situation and specific areas of concern at different times.

Chapter 2: Data Integration and Use

Data about the outbreak, including about testing, positive cases and contacts is essential for good local outbreak control. Managing data is a complex task with many different sources and streams with varying levels of timeliness and accuracy.

There are also particular issues arising from limited data flows still coming to local authorities.

In order to use data effectively and make sense of a wealth of statistics, we have adopted a "function led" approach in B&NES in which all information is seen as somehow answering one of three fundamental questions.

1. **How do we monitor the general level of the outbreak in B&NES and further afield?**
2. **How do we assure that the test and trace system is working well locally?**
3. **How do we identify localised outbreaks as early as possible?**

1. How do we monitor the general level of outbreak in B&NES and further afield?

There are **four recommended metrics** that should be used to track the local general level of outbreak/infection in Bath and North East Somerset, as follows:

a. **Individuals reporting symptoms** - by daily tracking using data from 111/GPs Primary Care of B&NES residents/registered [*possibly from the further development of the COVID-19 Capacity Threshold and Triggers Report, 1.2*].
b. **Positive swab test results** - by daily tracking of positive pillar 1 and pillar 2 test results provided by PHE (via. HPZone) [*from the daily MSOA and weekly postcode level Case Line Lists, 5.1 and 5.3 respectively*].
c. **Admissions to hospital** – by monitoring daily suspected, and later tested positive or already known to be positive in-patients (i.e. community acquired); as well as newly COVID-19 positive in-patients acquired in the RUH (i.e. nosocomial infections) [*possibly from the developing COVID-19 Capacity Threshold and Triggers Report, 1.2*].
d. **Deaths** – by tracking, preferably from the weekly internally supplied registered deaths [*2.5*], or alternatively weekly ONS death registrations releases [*2.3*].

All of these metrics are tracked on a daily basis, either by the BI Team through dashboards, or by BSW CCG through daily Sitreps.

In addition, a number of different alert systems are produced [*1.1,1.2 and 1.3*], particularly the PHE South West Early Warning for Confirmed COVID-19 Cases [*1.3*], are logged and tracked by the B&NES Business Intelligence team, but some occur after the release of daily positive test data [*5.1*].

2. How do we assure that the test and trace system is working well locally?

We should aim to understand the following metrics:

- Whether everyone who needs a test gets a test.
- Whether tests are turned around in an appropriate timescale, e.g. timely delivery and return of tests for home testing kits, as well as timely notification of results.
- Whether people with appropriate positive test results are contacted quickly; their close contacts are identified, tracked and traced in a timely manner; and everyone who should is self-isolating for the recommended period.

At present, local intelligence has been provided with information regarding:

- Testing in care homes (suspected cases recorded [*B&NES Care Home Sitrep, 3.2*] and tests completed [*PHE Line Lists, 5.1 and 5.3*].
- Summary contact tracing statistics from Department of Health & Social Care (DHSC), including:
    - how many confirmed cases have been referred;
    - how many contacts have been identified, and how many contacts have been completed; and
    - how many have been managed by Level 1 Health Protection Teams.

These data sets and statistical returns are reviewed on publication by the Business Intelligence team; and Adult Social Care, Adult Safeguarding and Public Health teams in the case of Care Home Sitreps.

The issue of publishing statistics to show how effectively the testing programme is being managed was raised by UK Statistics Authority on 2nd June: https://www.statisticsauthority.gov.uk/correspondence/sir-david-norgrove-response-to-matt-hancock-regarding-the-governments-COVID-19-testing-data/

It is not possible to further define the answers to these questions without considerable data development. This could be additional row level data being provided by the national NHS Test and Trace service or through the development of any local intelligence sharing/track and trace activities.

As this document is being written a lot of effort is being made to enable timely local answers to these questions, but the data flow will develop alongside the development and increasing capacity of the test and trace system itself.

3. How do we identify localised outbreaks as early as possible?

An outbreak can be defined as:

- two or more persons with the same disease or symptoms or the same organism isolated from a diagnostic sample, who are linked through common exposure, personal characteristics, time or location; or
- a greater than expected rate of infection compared with the usual background rate for the particular population and period.

(Hawker, Begg et al., (2012), *Communicable Disease Control and Health Protection Handbook*. 3rd edition)

Furthermore, the second part of this definition is covered in Q1 above, i.e. under wider surveillance.

Critical to identifying localised outbreaks is the ability to access very timely data, preferably within 24 hours or sooner of a suspected case being identified. All sources identified in section 1 have the potential to provide an indication of the presence of a localised outbreak. In addition, standard health protection practice at level one (local authority) provides summary intelligence (not line level) regarding outbreaks.

The draft test and trace notification process will notify local authorities in the case of any of the following conditions being met:

- Any positive confirmed cases where an education or childcare setting may be involved.
- Any care home setting.
- The NHS Test and Trace Service identifying a positive confirmed case as:
    - occurring in a “complex setting” (e.g. shelter, hostel etc.);
    - cases which may have a local consequence (e.g. media interest, impact on public services); or
    - representative of a local increase in cases in a specific establishment (e.g. workplace).

As a consequence, whilst timely identification of an outbreak is possible at a general level; more details on the context surrounding the outbreak, including common features, demographic characteristics, employment or education factors which may significantly influence the outbreak will not be available until a Health Protection notification is received.

Data Integration and Future Options

The above review is developed from known data sources at the point of writing. To develop more sophisticated health surveillance methodologies it is essential that more detailed information is provided to local authorities by key stakeholders, particularly DHSC, PHE and the new **Joint Biosecurity Centre (JBC).**

On the basis of *parity of esteem*, this should include:

- NHS number and full address for positive cases.
- Detail of traced contacts at a personal level, including information about workplace or social commonalities.
- Any additional data sources used in the development of national surveillance programmes (e.g. Google mobility, DWP, etc.).
- To be made available in a manner that allows for automated, machine readable sharing and access.

The Joint Biosecurity Centre is a new unit specifically set up to advice central and regional bodies on the appropriate alert level, and to use data coming into the centre to help local bodies identify concerning trends in their localities.

Although it can be difficult to define benefits of this without access to the data, some options that could be identified are as follows:

- Near-instant reconciliation with Council held lists of vulnerable people (e.g. shielded, high risk children/young people and all adult social care clients) to manage risks to our most vulnerable residents.
- Integration with the Virgin Care Integrated Care Record (ICR), allowing both risk stratification (e.g. risk of hospitalisation) and effective live communication flow with key agencies (e.g. General Practice).

These methods would require appropriate data protection/privacy impact assessment.

Chapter 3: Prevention and Response Plans for Places and Communities

Introduction

It is clear from the progress of the outbreak so far, not only that staff and residents of care homes are among the most vulnerable groups in our community, but that they have also taken a big part of the burden of illness and death in the first wave of the outbreak. Furthermore there has been much discussion through national media about the degree to which this outcome was partly as a result of policies that protected the capacity of the NHS when there were fears that it could quickly become overwhelmed.

This level of illness and death must not be repeated, and detailed plans are now being put in place to monitor and protect these institutions. Indeed much good local work has been done already, including a lot of work training home staff in infection prevention and control.

Our schools, and also other early years settings like nurseries, are also places where very many people come together; children, teachers and other staff, who are also fully integrated into local communities.

Children themselves tend to have mild illnesses when infected by coronavirus, but they can spread infection to others, and so any outbreaks in schools must quickly be identified and steps taken to minimise wider risks of infection. And because schooling is so important to the wellbeing and future of our children schools must operate in ways which minimise the likelihood of having to restrict access again in the face of cases and outbreaks in the future.

Therefore a full theme of the LOMP is focused on these two settings. It should be noted that B&NES has two large **universities** and a multi-campus **college**, and we are also working with these locations to enable them to continue their important work in ways that minimise risks from coronavirus. Detailed plans will be developed as these institutions gear up for re-opening in the Autumn.

It should be also be noted that the other biggest area of concern in terms of specific settings with the largest danger of spread of infection is the NHS itself and particularly hospitals, such as the RUH. The reason that the LOMP is not asked to focus on NHS settings so closely is that the NHS has capacity of its own to manage these so called “nosocomial” outbreaks, although wherever this happens the local authority is still a key partner along with Public Health England.

In addition a further theme of the LOMP is to identify other high risk groups in the community whether by specific location or other community characteristics (eg homelessness). There are many such groups and places and so there will not be a specific detailed plan built for all possible eventualities. Rather the aim is to identify and be ready to react swiftly to concerns. This will depend on a good network of contacts and the application of our well-tested generic communicable disease outbreak control plans which we have developed with Public Health England.

A. Care homes

1. Relevance of this setting for outbreak prevention and control

Nationally, approximately 400,000 older people in the UK live in care homes. This is a bed base three times that of the acute hospital sector.

Most care home residents have some degree of cognitive impairment, multiple health conditions and physical dependency and many are in their last years of life. Many care home residents are particularly vulnerable to COVID-19 infection as a consequence of their complex medical problems and advanced frailty, and due to regular close contact with staff providing social, care and nursing support. Their vulnerability leads them to be particularly susceptible to infection with an increased likelihood of poor health outcomes and death.

As with other settings, robust, continuous and well-planned approaches to infection prevention and control can make significant differences which can reduce rates of infection. Key concerns relate to transmission between residents; and between residents, the staff who support and care for them and visiting friends and family.

2. Local provision

Care homes in B&NES include both nursing and residential provision with significant specialist provision for those with dementia, complex needs, learning disabilities, autism or mental health needs. The majority of residents are from the B&NES area. Care homes are run in the main by private businesses (18 separate companies) with 3 charitable/not for profit homes running 4 homes. Specialist homes (mental health and learning disabilities/autism) are run by 12 businesses.

Care homes	No. of homes	No. of residents (approx.)	No. of staff (approx.)
Nursing Homes	18	710	1000
Residential Homes	15	420	550
TOTAL	**33**	**1130**	**1550**

Specialist homes	No. of homes	Total bed space	No. of staff (approx.)
Learning disability/ autism - residential	21	196	
Learning disability/ autism - nursing	1	15	
Mental health	1	8	
TOTAL	**23**	**420**	**Estimated 60**

3. Responsibilities of the LA to providers

The LA has both direct and indirect responsibilities to support providers. Beyond COVID-19 support the LA retains ongoing responsibilities through the Care Act 2014 to maintain and support a market that delivers a wide range of sustainable, safe and high-quality care and support services. The contract held by the LA and CCG commissioners with care homes includes expectations on infection prevention and control practice.

In B&NES much support is given through an integrated arrangement through the Council, Clinical Commissioning Group (B&NES, Swindon and Wiltshire) and Virgin Care. The journey towards closer integration is set out within the Your Care Your Way programme, redesigning community health and care services and consolidating the commitment to invest in preventative services and to further develop integrated services with Virgin Care. Developing this integrated model has enabled B&NES to respond to the challenge of COVID-19 with well-coordinated support and has furthered commitments to increasing the speed of acute to community discharge.

It is important to note that the Council has been particularly impacted by the COVID-19 experience, having seen significant loss of income consequential to its role as a national heritage site. Savings will need to go beyond efficiency and on-going commitments to manage care costs.

A number of teams and organisations work with care homes to help homes prevent and manage cases of COVID-19 including the Adult Social Care commissioning team, GP practice, CQC, LA public health team, IP&C officers, community frailty practitioner, and the CCG IP&C lead.

4. Outbreak management plan for care homes

- **Case definition**

Possible case: Any resident or staff with symptoms of COVID-19 (fever, new continuous cough, loss of normal sense of smell or taste, new onset of influenza like illness or worsening shortness of breath). Note: elderly people can often present with non-typical symptoms such as sudden decline in physical or mental ability, lethargy or change from usual demeanour without other explanation
Confirmed case: Any resident or staff with laboratory confirmed diagnosis of COVID-19.

- **Contact definition**

Resident contacts: are those that:

- Live in the same unit / floor as the infectious case (e.g. share the same communal areas) or
- Have spent more than 15 minutes within 2 metres of an infectious case

Staff contacts: care home staff that have provided care within 2 metres to a possible or confirmed case of COVID-19 for more than 15 minutes.

- **Outbreak definition**

Two or more cases which meet the case definition of a possible or confirmed case as above, within a 14-day period among either residents or staff in the setting.

- **Monitoring arrangements and the flow of test results**

Critical to identifying localised outbreaks is the ability to access very timely data, preferably within 24 hours or sooner of a suspected case being identified. Cases in residents and staff are identified in several ways.

The following section sets out the processes by which details of possible and confirmed cases are fed into the NHS Test and Trace system, and by which the LA is notified of such cases.

The HPT's Standard Operating Procedure for care homes sets out that care homes will notify the HPT of:

- a single suspected or confirmed case of COVID-19 in a resident (the HPT then arrange testing and give IPC advice)
- suspected outbreak of COVID-19 in the care home (the HPT then arrange testing and give outbreak control advice)
- more than 1 staff member off sick with symptoms of COVID-19 OR 1 staff member laboratory confirmed with COVID-19

In addition to the above, all care homes have been encouraged to take up the national 'whole care home testing' programme which enables testing for all residents (whether or not they have symptoms) and asymptomatic staff and the HPT are notified of any positive cases.

Symptomatic staff access testing through national self-referral or employer referral portals. The HPT are then informed of confirmed cases through the national NHS Test and Trace system and will carry out contact tracing with these cases.

The pathways by which local authorities receive data on possible or confirmed cases are developing all the time. At present, the local authority is made aware of possible/confirmed cases through the following routes:

- Notification from the Health Protection Team of possible or confirmed cases reported to them by care homes
- Notification from the Health Protection Team of confirmed cases identified through the Whole Care Home Testing scheme
- Numbers of COVID-19 possible/confirmed cases and deaths as reported by care homes to Adult Social Care daily (includes numbers of positive and negative results reported through Whole Care Home Testing)

- Daily line lists received about confirmed cases in B&NES providing information on age group, gender, MSOA
- Weekly line list received on confirmed cases in B&NES providing information on age, gender, and postcode (postcode usually identifies the care home)

The table below gives an overview of the multi-disciplinary response to different case and outbreak scenarios in care homes. A more detailed care home outbreak management development plan will be produced to sit behind this.

Scenario	Role of organisation/team					
	Commissioner	**LA Public Health/Comms**	**LA Infection Prevention and Control Officer**	**PHE Health Protection Team**	**LA Environmental Health team**	**BSW CCG**
No suspected or confirmed cases (prevention)	Offer support & advice on range of issues. Gather daily sitreps from care homes. Disseminate materials on prevention and comms guidance. Encourage take up of learning and testing opportunities. Facilitate PPE access. Seek assurance on preparation for dealing with positive cases. Co-chair regular IP&C MDT meetings to identify support needs of identified care homes.	Plan for strengthened IP&C. Localise & disseminate prevention and comms guidance. Encourage take up of learning and testing opportunities. Seek assurance on preparation for dealing with cases. Support PPE access. Develop risk assessment. Co-chair regular IP&C MDT meetings to identify support needs of identified care homes.	Maintain contact with care homes providing training, advice, problem solving. Follow up actions from IP&C MDT meetings with identified care homes.	Develop guidance and prevention materials and encourage take up of learning opportunities.		Plan for strengthened IP&C.
First report of one or more possible/ confirmed cases	As above. Encourage reporting to HPT.	As above.	Contact care home to offer support and draw in wider input as needed.	Follow national standard operating procedure. Notify LA.		
Escalation of cases and/or deaths	Contribute to outbreak control meetings. Offer mental health support as needed in collaboration with AWP.	Contribute to/lead outbreak control meetings.	Contribute to outbreak control meetings.	Follow national standard operating procedure. Notify LA and consider holding outbreak control meeting in collaboration with LA PH.	Contribute to contact tracing as required.	Contribute to outbreak control meetings. IP&C lead to visit home to review IP&C processes and offer support.

Prevention and Response Plans for Places and Communities

B. Schools and early years settings

1. Relevance of this setting for outbreak prevention and control

Outbreaks of infections of COVID-19 can occur in education settings due to the potential close contact between children and staff and the frequency with which shared surfaces in the closed environment are touched. However, the impact can be greatly reduced by following robust prevention practices (ensuring that symptomatic people stay at home, following social distancing guidance, practicing good hand and respiratory hygiene, and adopting good infection control practices), and recognising possible cases early and acting promptly.

Children can be infected with SARS-CoV-2 and become ill with COVID-19. However, evidence suggests that younger children (up to age 11 to 13 particularly) are less susceptible to infection than adults and their symptoms are generally milder. There is not enough evidence yet to say whether the susceptibility of older children is different to that of adults. There is no evidence to suggest that children transmit the virus any more than adults. A PHE study is underway to better understand the rates of transmission within schools.

The numbers of children and young people in B&NES are shown in the table below:

Age group	Approximate number
0-4 years	9,500
5-9 years	10,500
10-14 years	10,000
15-19 years	13,500 (including some term-time Higher Education students)

Nationally, approximately 7% of school children attended an education setting at the beginning of June. This percentage is expected to remain static until the end of term and then increase when schools re-open in September.

Some children and young people are particularly vulnerable to more severe illness from COVID-19 infection. PHE guidance states that vulnerable children and young people's attendance in education is expected where it is appropriate for them (that is, where there are no shielding concerns for the child or their household, and/or following a risk assessment for children with an EHC plan) so that they can gain the educational and wellbeing benefits of attending.

2. Local provision

- **School setting**

There are 81 maintained and academy schools in B&NES (63 primary, 12 secondary, 3 special and 3 studio). Schools vary hugely in size, with numbers of pupils in primary

schools ranging from just over 50 in the smallest to over 600 in the largest. For secondary schools the range is under 280 to over 1700. The risk of spread of infection in larger schools is substantially reduced through the protective measures schools have put in place to create safer environments.

Of the 81 schools, 71 are academies and 10 are maintained. There are thought to be 9 independent schools in B&NES spanning ages 3-18 years.

- **Early years sector**

The early years sector is made up of group-based provision in the private, voluntary and independent sectors (76), school=based nursery provision (16 providers), and childminding provision (112 providers) plus a small number of independent providers.

- **Communication with providers**

The Local Authority uses a range of methods to get its messages to education and childcare providers including regular meetings hosted by the Education Director with maintained and academy trusts.

3. Responsibilities of the LA to providers

The LA directly governs maintained schools and so has influence over how these schools follow outbreak control advice. Schools with academy status are governed by boards of trustees independent from the LA. The Regional Schools Commissioner (appointed by the Government) has direct responsibility for the academies and the LA has limited authority to expect academies to follow guidance and advice. However, the relationship between the CEO's of the trusts and the LA Officers is good and generally the academy trusts would look to the LA for advice. The LA have a duty to challenge schools and respond to parental complaints, this may involve directing concerns to the Regional Schools Commissioner and Ofsted

The Statutory duties of the LA can vary significantly between the different types of educational providers. There are several teams and service areas that provide advice and guidance to all parts of the educational sector including: Children Missing Education Service, SEN specialist support teams, School Improvement Advisory service, Education Psychology Service, and the Early Years Foundation Stage team.

The local authority has a role to support education and childcare settings in accessing local PPE markets and available stock locally. It is also responsible for organising and providing Home to School Transport. The Passenger transport team issues advice to schools and to coach and taxi organisations on outbreak prevention.

No major changes are anticipated in the provider landscape or local authority that would impact on the prevention or management of COVID-19.

- **Public Health team, B&NES LA**

Public Health provide relevant advice and guidance to education and early years settings (including private EY providers and academy and independent schools) on COVID-19. Specifically, but not exclusively, this relates to issues such as hygiene, social distancing, PPE, testing, tracing, case management, cleaning and waste disposal. Relevant documents are stored on the Public Health Programme pages of the Hub

http://thehub.bathnes.gov.uk/Page/11017 and where new guidance is published educational settings are alerted by email. The Public Health in Schools and Early Years Programmes provide audits, guidance and teaching resources on a number of public health areas.

Public Health receive notifications of possible and confirmed cases in education and early years settings and will be part of or lead outbreak control team meetings established as agreed in collaboration with PHE's Health Protection Team.

- **B&NES School Nursing Service, Virgin Care**

The B&NES Public Health School Nursing Service offer wellbeing support for children and young people during school closures and if self-isolating. This includes helping schools with individual health risk assessments for vulnerable children, support packages as required or onwards referral to partner agencies when appropriate. Young people are also able to speak to a school nurse via the texting service. A confidential telephone drop-in service for young people Monday to Friday from 12-2 pm is also available. A duty nurse is available for telephone support and advice for parents and carers Monday to Friday 9 -5 pm should they require any support with their school aged child.

- **Health Safety and Wellbeing (HS&W) team, B&NES Council**

The Council's HS&W team provide several services potentially relevant to the prevention and management of COVID-19 to those schools which contract with the service. This includes health, safety and wellbeing advice; access to online resources, newsletters, and a completed COVID-19 risk assessment for school opening. The team also carry out HS&W compliance checks and site visits which will be updated to include COVID-19.

4. Outbreak management plan for schools and early years settings

- **Case definition**

Possible case: A child or staff member with a fever, new continuous cough or loss of, or change to, smell or taste

Confirmed case: A child or staff member who has had a lab test result confirming COVID-19, with or without symptoms

- **Contact definition**

Direct close contacts: Face to face contact with a case for any length of time, within 1 metre, including being coughed on, a face to face conversation, unprotected physical contact (skin to skin). This includes exposure within 1 metre for 1 minute or longer. Children and staff within the class and/or bubble would fall into this category.

Proximity contact: Extended close contact (within 2 metres for more than 15 mins) with a case.

Travelled in a small vehicle with a case.

- **Outbreak definition**

Two or more confirmed cases of COVID-19 among children or staff who are direct close contacts, proximity contacts or in the same cohort or 'bubble'* in the school within 14 days".

* a cohort or ‘bubble’ might be a class, year group or other defined group within the school/college. This definition aims to distinguish between transmission occurring in the community versus transmission occurring within the school setting.

- **Monitoring arrangements and the flow of test results**

Critical to identifying localised outbreaks is the ability to access very timely data, preferably within 24 hours or sooner of a suspected case being identified.

The Health Protection Team in PHE will be informed about confirmed cases amongst children or members of staff through the national NHS Test and Trace system and will then carry out contact tracing with these cases. In those situations where children or staff become ill while in the setting, the HPT will know about these people as possible cases before any confirmation comes through the Test and Trace system as schools and early years providers are asked to notify the HPT of suspected cases of respiratory illness which could meet the definition for COVID-19 19.

Staff and children will be eligible for testing if they become symptomatic, as will members of their households. A negative test will enable children to get back to education or childcare, and their parents to get back to work. If a child or member of staff test positive for coronavirus and have been in the education or childcare setting during the infectious period, the relevant group of people within the school with whom the child has mixed closely (their cohort) will be sent home and advised to self-isolate for 14 days. Identification of the cohort will take place during discussion between the HPT and the setting. Extended swabbing/ outbreak investigation maybe recommended, following national guidance. There is no requirement for self-isolation of contacts of possible cases, only confirmed cases.

The pathways by which local authorities receive data on possible or confirmed cases are developing all the time. At present, the local authority is made aware of possible/confirmed cases through the following routes:

- Notification from the Health Protection Team of individual possible or confirmed cases in educational and childcare settings
- Daily line lists received about confirmed cases in B&NES providing information on age group, gender, Middle Layer Super Output Area
- Weekly line list received on confirmed cases in B&NES providing information on age, gender, and postcode

The table below gives an overview of the multi-disciplinary response to scenarios in the schools and early years settings. A more detailed schools and early years outbreak management development plan will be produced to sit behind this. Further information about schools and early years settings in B&NES are included in Appendix 2 attached to this document.

Outbreak management plans will be based around the following four scenarios:

Scenario	Role of organisation			
	LA Public Health/Health Safety and Wellbeing /Comms	**Virgin Care School Nursing Service (schools only)**	**PHE Health Protection Team**	**LA Environmental Health team**
No suspected or confirmed cases (prevention)	Disseminate prevention and comms materials and encourage take up of learning opportunities. Seek assurance on preparation for dealing with cases. Enable PPE access. Develop risk assessment.	Reinforce public health comms materials and encourage uptake of learning opportunities. Individual health assessments for vulnerable children returning to school.	Develop guidance and prevention materials and encourage take up of learning opportunities.	
Single suspected case	Disseminate prevention materials.	As above.	Follow national standard operating procedure. Notify LA.	
Single confirmed case	Contact provider to offer support.	As above.	Follow national standard operating procedure. Notify LA.	
Outbreak	Be part of/lead outbreak control team meetings. IP&C officer/health protection practitioner/EHO contact school to offer support.	As above. Contribute to incident management.	Follow national standard operating procedure. Notify LA and consider holding outbreak control meeting in collaboration with LA PH.	Contribute to contact tracing as required.

Prevention and Response Plans for Places and Communities

C. Other high-risk places, locations and communities

This section covers high risk areas other than care homes and schools already covered in this chapter

1. Relevance of this theme

Some groups and locations within our communities are at higher risk of outbreaks. This may be due to a range of factors such as a greater number of people using a location and a difficulty in maintaining social distancing guidelines, as well as individual ones such as age or pre-existing health problems

For the purposes of our plan, we are using the following definitions:

Places	A discrete building-based setting (eg a place of worship, employment site, hotel or university).
Locations	A geographical area that may regularly attract groups of people or experience higher numbers of cases (eg. river swimming spots, informal green spaces, neighbourhoods).
Communities	Groups of people who are linked through social or geographical relationships (eg boaters, homeless people).

A key issue for responding to outbreaks linked to these contexts is that knowing the residency address of a positive case will help to identify clusters of cases, but will be insufficient for wider public health action and instead it will be crucial to identify these potential shared routes of exposure (work, place of worship, etc) during contact tracing. Data from a smart phone App on where exposure took place could add significantly to an ability to track shared sources of exposure in these contexts.

Care homes, schools, and early years settings are higher risk locations but are covered in detail elsewhere and are not discussed further in this section.

NHS Trusts (including mental health) and other local hospitals are also higher risk locations. However, there is a national and local expectation that they lead on prevention and outbreak control in their sites themselves. This is of course done in partnership with the wider system, especially in the event of an escalation in cases at an NHS Trust site.

A list of higher risk places, locations and communities is set out in Appendix 1 (in development). The list is not necessarily exhaustive and will be added to during the coming months if necessary

For each of these, the public health team holds a list of key contacts so that we are able to communicate swiftly with any or all of them following new guidance or in response to a case.

2. Description of the response so far in identifying and planning how to manage high risk places and communities in B&NES

As part of the system level approach in B&NES there have been regular communications to a wide range of stakeholders with relevant national and local information and also contact details for further advice and guidance. B&NES Council's public website has a dedicated webpage with the latest information and advice on coronavirus for:

- Individual residents
- Help for vulnerable people
- Information about Council services during COVID-19
- Help for residents
- Help for businesses
- Help for parents and carers

Information is proactively published on the Council's social media pages and there is also a dedicated email inbox COVID-19incidentcomms@bathnes.gov.uk the public, schools, employers and care settings can use for COVID-19-related questions. A stakeholder list has also been used for regular updates on local and national guidance and developments.

A key aspect of the local response has been the development of *Compassionate Communities B&NES*. More on this is provided in theme 6 later in this plan.

3. Description of the relationship with and responsibilities of the LA to the different types of providers in this setting

All of the actions described earlier in this section have been supported through ongoing liaison between:

- Specialist public health staff
- Wider Council, or CCG, officers who have direct links with particular groups and settings
- Representatives from relevant front line or local organisations.

B&NES Council, in partnership with BSW CCG, commissions Virgin Care to provide community heath and care services in B&NES and Virgin have worked within this remit to partner local third sector organisations and deliver the Compassionate Communities support described above.

The public health team of B&NES Council have worked closely within the B&NES COVID-19 Community Health & Care Multi-Agency Response Hub to provide both strategic and specialist health protection support to the local system.

4. Approach to prevention and management of COVID-19

The approach for each group or location will be very similar to that set out for care homes and schools.

Higher risk locations: other issues to be considered

Parks and outdoor spaces are generally low-risk but some will need to be considered specifically, for example playgrounds and those open spaces with limited room for spacing, or restricted points of access.

Community events, both indoor and outdoor, are important parts of the cultural and economic life of B&NES but may carry high risk depending on specifics of the events and the ability to manage then safely.

Finally streets with high density of student accommodation or private HMOs may require some attention.

Chapter 4: Supporting Vulnerable People who Need to Self-isolate

1. Relevance of this theme

Successful local outbreak control measures will rely on people self-isolating when asked to do so. This may be as a symptomatic case, a close contact or someone with a clinical, or other, vulnerability that means they must stay at home to reduce their potential exposure to coronavirus. Some people will have no problem in doing this through the help of friends or family. However, others may require external support with everyday needs such as food, care, medicines and income.

Additionally, there are a range of people who may be particularly negatively impacted by a period of self-isolation such as children at risk of violence or with special education needs, victims of domestic abuse and rough sleepers.

Some groups within our community are also at a higher risk of severe illness from COVID-19, mainly due to an underlying clinical condition. These groups were highlighted in Chapter 3, along with preventative measures and outbreak management strategies.

A summary of this range of groups is set out in Appx x This is based on the national COVID-19 guidelines and also from the PHE review of 'Disparities in the risk and outcomes of COVID-19'.

2. Why it's a priority to ensure that the groups in Appendix 1 can access support to self-isolate safely

Self-isolation is an important tool in the control of COVID-19 outbreaks and requires cases and contacts to follow advice on when and for how long to stay at home and apply careful distancing and shielding if necessary. There are a number of reasons to support particular groups of people in our communities when self-isolating.

1. People may need help with help to access food, medicines and other practical support and do not have friends or family who are able to help at a particular moment (for example because they are also having to self-isolate as contacts). Without this support, they may experience health impacts purely from isolation, regardless of whether they have COVID-19 or not.

2. If in need of help but unable to receive it, people may be forced to break their isolation (for example to buy food or obtain medicines) and potentially expose other people to infection with coronavirus.

3. People may experience negative impacts from isolation, particularly people who have been most isolated already because of their particular social, personal or health conditions and who will still be advised to apply the highest levels of caution National research from UCL shows that during the lockdown period in Spring of 2020, prevalence of anxiety and depression were both higher than normal and people and many people have felt isolated, some with thoughts of death. This has especially been the case for younger people, people on low incomes and people with a mental illness. Additionally, people become at higher risk of domestic abuse or withdrawal from daily drug use and these needs also require support.

3. Description of the response so far in supporting vulnerable groups in B&NES

The core of the B&NES response to the needs of vulnerable people has been provided by the very successful and rapid development of what has been called the Compassionate Community hub.

Virgin Care and B&NES 3SG, who represent 3rd Sector Organisations, have come together alongside B&NES Council and the CCG to offer an advice and support hub. Compassionate Communities is a B&NES-wide movement which recognises that there are people and organisations supporting each other who can step in as and when needed, with actual or virtual support.

The Compassionate Community hub seeks to assist those who are self-isolating or shielding and those that are clinically the highest risk people in our community, who are in need of help. The hub has combined resources to ensure that, as a service, they are able to provide sustainable and appropriate responses to meet community needs. This includes access to over 2,500 volunteers recruited, checked and trained by 3SG.

Examples of support needs are included below:

- you need to collect a prescription
- you need to access a coronavirus test
- you require an emergency food parcel
- you need a gas or electricity meter top-up
- you are feeling anxious or lonely and need to talk to somebody
- you are looking for advice to stay fit and healthy

- you need advice on money or employment rights
- you need transportation to medical appointments
- you need advice on your housing situation
- you are unsure about government guidelines and need some clarification

The support line is accessed by calling 0300 247 0050 is prioritised for people who have limited support through other routes, such as friends or family.

4. Description of the relationship with and responsibilities of the LA to the different types of providers in this setting

B&NES Council, alongside the B&NES Locality of BSW CCG, commissions Virgin Care to provide (or sub-contract) a wide range of community health and care services.

Management plan

The focus of this theme will be maintaining and developing this model of support for vulnerable people during periods of isolation, recognising that such needs may continue for many months during which other health and care services will seek to re-start or re-normalise services that have been curtailed during the first wave of the outbreak.

Other issues

COVID-19 and the response to it has meant many people have lost incomes, businesses have closed and the future of some parts of community life is uncertain. These issues are being dealt with as part of the district's wider renewal plans and so are not included in this more specific local outbreak control plan.

Chapter 5: Testing and Contract Tracing: Responding to Outbreaks in Complex Settings

1. Introduction

Following the unprecedented population-wide measures that have been in place over the preceding weeks, the country is expecting to return to a stage where the identification of cases and the management of the case and their contacts will again be key. This is because:

- Identification and self-isolation of the case prevents any further spread of the infection
- Self-isolation/quarantining of the contacts prevents spread, even during the pre-symptomatic stage, or in the case of very mild symptoms
- Understanding where infection may occur in the community can enable a wider identification of contacts and potentially reduce the spread in future through interventions for infection control and sharing of lessons learnt

2. NHS Test and Trace Service

The NHS Test and Track Service has been put in place to help return life more to normal by replacing national lockdowns with individual isolation and, if necessary, local action where there are outbreaks. This service:

- ensures that anyone who develops symptoms of coronavirus (COVID-19) can quickly be tested to find out if they have the virus, and also includes targeted asymptomatic testing of NHS and social care staff and care home residents
- helps trace close recent contacts of anyone who tests positive for coronavirus and, if necessary, notifies them that they must self-isolate at home to help stop the spread of the virus

3. National testing structure

Tests for COVID-19 are carried out through different routes:
Pillar 1: swab testing in Public Health England (PHE) labs and NHS hospitals for those with a clinical need, and health and care workers *(includes testing of suspected cases in a care home, school, or other community settings that are reported through to the Health Protection Team)*

Pillar 2: swab testing for the wider population, as set out in government guidance *(includes whole care home testing, and symptomatic individuals in the community who access drive-through regional testing sites, drive-through mobile testing units, or home testing kits)*

4. The local need and response

Asymptomatic and pre-symptomatic spread is a recognised risk to the ability to contain transmission of COVID-19. This means that delays to testing need to be minimal, and tests need to be as easy as possible for the population that needs it to access. The nearest regional testing site to B&NES is at Bristol airport. This is not easy to access as it requires a car to get there, and for many people would involve driving for up to an hour when not feeling well. So we will look to have sites for Mobile Testing Units and identify other ways of making testing more easily available in situations where the national testing structure does not meet local need, as well as promote testing uptake. We will use recommendations from the engagement and communications part of the LOMP to develop this work.

A B&NES Testing Group will be set up to identify whether and how we can have testing capacity and flexibility in our system to deploy tests locally on occasions where they are needed but the national testing structure doesn't meet that bill, and to make sure we are in a position to use Mobile Testing Units (MTUs) when we need them. This group will report to the B&NES COVID-19 Health Protection Board.

It will:

- Identify and operationally prepare locations in B&NES suitable for hosting mobile testing units when needed
- Plan for testing capacity that can be swiftly mobilised (eg, pop ups, mobile testing squad, NHS etc)
- Ensure clear oversight of tier 1 and tier 2 testing

- Plan to promote testing through engagement and communications
- Understand the flow of testing results
- Participate in the LRF and regional testing governance structure
- Ensure that the needs for testing of vulnerable groups and vulnerable settings are addressed
- Make recommendations to the B&NES Test and Trace Group

5. National Contact Tracing System

There are three Levels of contact tracers.

- Level 1 includes the Regional PHE Health Protection Team. This level deals with the most complex cases and outbreaks. PHE are themselves building up significant extra capacity to meet the challenges of the next phase of the pandemic.
- Level 2 comprises of 3,000 health care professionals and EHOs recruited to carry out contact tracing work of cases identified as part of the pillar 2 testing work.
- Level 3 comprises of 15,000 people who will be tasked with contacting those who have been in contact with a someone who has tested positive for COVID-19.

The NHS tracing app: Another component of the tracing system will be provided by the NHS contact tracing app. This is currently in development and it is unclear when it will be in use. The potential importance of the app is that it gives the possibility of identifying contacts who a case would have no means of identifying, for example someone with whom they shared a train carriage or sat near to in a bar. It is not impossible to find such contacts by other means but would be extremely difficult and labour intensive.

There have clearly been difficulties in developing and rolling out this app, but it is hoped that by the time risks of outbreaks increase towards the end of summer something will be ready to roll out across Britain. Of course when this happens it also depends on people being willing to download the app and enter relevant information when they are identified as a possible case.

6. The Local Authorities Contact Tracing role

The Local authority's role is two-fold.

The first is to provide support to the local PHE, Public Health Tier 1 team, in the investigation of complex outbreaks if, and when, the local team is overwhelmed and requires additional resources.

This work will be undertaken by our in-house EHO's and health practitioners.

The EHOs in the Health, Safety and Food team, routinely carry out contact tracing work as part of their normal duties, albeit, currently this is primarily for the investigation of Single Case Infectious Disease investigations. In addition the Health Practitioners in the public health team are available to support this work.

The second role is one which relies on the local knowledge and support that the Local Authority can provide when dealing with complex issues in residential settings such as care

homes, hostels, as well as schools and workplaces, for example liaison between schools and parents of pupils or employers and employees.

The Local Authority will not be asked to routinely carry out COVID-19 contact tracing, as they have already been asked to support PHE by carrying out other ID investigations to free up PHE to deal with COVID-19 -19. However, when a local outbreak occurs in a local care home, school or workplace the LA will be notified by the Level 1 Contact Tracing team, and in some cases, officers will be asked to contact the cases and identify contacts.

Issues that will need to be resolved are

- Hours of operation. The Level 1 team provide a 24/7 response, whilst the Local Authority traditionally operates on a Monday to Friday 9-5. In order to be able to support the demands it is recommended that an out of hours on -call system will need to be set up. Part of this might operate on the basis of partnership with other local authorities if it leads to needs in B&NES being managed more efficiently.
- Sharing of personal data - Confirmation is still required on how contact details will be shared between HPE and the LA, as the LA does not currently have access to HP Zone. ID information is currently shared by PHE with EHOs by secure email exchange, and it is expected that as a minimum, this will be extended to colleagues in the Public Health team to deal with the COVID-19 response. The case's contact details will be forwarded onto the Level 3 contact tracing team for follow up.
- Amount of Additional Resource required. – Contingency arrangements are to be put in place with other EHOs and public health professionals working within B&NES to assist if an outbreak occurs.

Chapter 6: Communications and Engagement

Introduction

Many individuals and groups will need to play their parts in communicating effectively with stakeholders, of whom the most important for the purposes of controlling COVID-19 are the residents of B&NES themselves.

A key role in this process will be the B&NES Outbreak Engagement Board chaired by the Leader of the Council. This board has now been established, based on a group already set up by the Leader to engage with a group of representatives of local bodies including the Council, police, fire and rescue service, our two universities, CURO and different parts of the health and care system.

Engaging the public in an effective way will be vital to our collective wellbeing in the next months and even years, but will be no simple task for at least three reasons. One is the great variability in people's personal situations, understanding of, and attitudes towards the outbreak and its control. The second is that the rules and principles that must be applied in the future are going to be much more complex than the simple, if onerous, rules of

lockdown, and will be subject to local change as the outbreak ebbs and flows and restrictions may need to change to keep the population safe. And the third is that this pandemic may last for a long while yet and while people will, to some extent, get used to incorporating careful habits into their daily lives, they will also naturally get weary of having to do so.

Planning

This task has begun but will need to be reinforced and refined as the pandemic continues and as messages become both more complex, and more localised. Particular challenges will occur whenever rules change and particularly if new restrictions need to be put in place. Even in this early stage of the easing of lockdown there is a lot of criticism of a lack of clarity of national messaging.

The Council needs to work through all its channels of communication. These include media and social media, information put on its and partners' websites and through broadcasting of Council meetings, special activities such as webinars (like that one put on with the BID on the opening up of B&NES town centres) and ad hoc leafleting campaigns such as have been undertaken by the 3SG group.

In addition, all existing representative groups in B&NES have a role to play, and some important ones like area forums and parish councils have expressed their desire to be useful agents in this effort, and will be most valuable because of the focused and deep local knowledge and networks they represent.

There is also a role for all ward councillors who are trusted figures in their communities. Much may depend on the degree to which they can both explain and re-enforce the need to take care over social distancing and the application of necessary rules while also being a channel through which residents can express their concerns and seek clarification.

The Council has a small core communications team, which has been working extremely hard, and one question in the future will be whether there is any need for reinforcement either from within the Council or from outside.

The themes in this part of the LOMP will need to be worked out in more detail in the as the pandemic continues, because of the scale of the challenge, but much has already been achieved and there is a strong foundation on which to build.

Chapter 7: Resources

Introduction

There are many types of resources, but two key ones are always people and money.

The pandemic has already asked a lot of people working in all parts of the Council in many personal and professional ways, and the same for the wider community and groups across the public, voluntary and private sectors.

Equally COVID-19 has had an unprecedented effect on national and local economic life and may continue to do so for a long while yet, even if we are able to relax some of the most economically damaging restrictions.

B&NES has been particularly vulnerable to these effects with its reliance on tourism and commercial estate rents and despite amounts of money coming from central government the Council is having to look for immediate savings on a huge scale.

This chapter will focus more narrowly on the extra resources that might be needed to help the Council play its role in the implementation the rest of this plan.

1. New resources associated with the plan

Extra resources have come down to the Council from the centre to help implement this plan. B&NES received £849.000 of a national sum of £300M for all upper tier local authorities. there is relatively little guidance so far about how this is to be used but given the activities in the plan one can sketch out areas where it might be deployed

2. Possible areas for deployment of resources

a. Adding to outbreak coordination and response capacity within Council. There is now an expectation that the Council will maintain a 24/7 on call health protection capacity. This will require a consultant level rota and the ability to call on other health protection trained staff to reinforce efforts of the nationally and regionally based teams. Much work can be done by PHE and the different levels of the testing and tracing system, but at times this capacity might be overloaded by the number of outbreaks in the region and need more support from localities. This could take the form of managing outbreak control teams, chasing up tests and results, tracing contacts and communicating with and supporting sites of local outbreaks.

It is too early to say exactly which staff and how many, could best be employed or re-deployed, both because the whole system of test and trace is only really now coming into being and building up to capacity and also because we are in discussion across the region and across BSW to decide where the best balance is of locally and sub-regionally employed staff.

But the categories of staff who might be added to existing capacity are **public health consultants** and **health protection officers** who could be **from public health, environmental health** or in some cases **clinical** backgrounds.

In relation to mobile testing units there may also be a small continuing call for support with traffic control and this may require a small amount of resourcing.

b. Adding to **informatics** capacity. B&NES has an exceptionally good but very small capacity to manage the torrent of COVID-19-related information that is coming into the Council. The ability to process complex multi-source data in real time will be critical to success. Extra capacity from public health and health protection trained information officers may be valuable, or even essential, although such staff are hard to find.

c. Adding to **communications and engagement** capacity. A lot will be demanded of our small core team both in putting out information and in managing the roles of the many different people and groups who need to be part of this effort. Some reinforcement of this team for the duration of the outbreak may be one of the most valuable things we could do.

d. Adding **support to the humanitarian effort**. The role of the compassionate community hub will continue to be important throughout the pandemic but it will also have to change to balance both COVID-19-related and other activities as services get back to some sort of normality. Adding some expertise and capacity to the coordination role of the hub to ensure that the most vulnerable are protected is a further option.

These are not the only possible uses for the funds that have been earmarked and it is likely that further guidance will come out as to what this can be used for and what not, but this is the beginning of a planning process to strengthen the Council's ability to manage the next stage of the pandemic.

Chapter 8: Conclusion to the Local Outbreak Management Plan

It will be apparent in reading this report that a great deal of planning has been done in a very short time by a range of subject leads and others, across the organisation. But it is also clear that this is by no means a complete plan for every situation and eventuality, and that such plans can only really emerge as the wide and complex systems underlying "test, trace and isolate" develop and reach full capacity and as we identify our specific roles alongside those of others. That will only happen fully over the next few months.

Local outbreak management that began before the first COVID-19 case occurred in Britain, but this plan is in response to a realisation that all the national efforts and work that is planned for the post-first wave control of the virus , local engagement and coordination is needed if we are to achieve success in open up our lives and institutions again while keeping the virus under sufficient control.

This framework plan is therefore the start of the next round of planning and should be seen as an ever-evolving document in which core principles may change little but practice develop on a rapid timescale.

As such comments are always invited from stakeholders in B&NES whether in the Council or partner organisations… and especially where they provide solutions!

Appendix 1: High Risk Groups and Settings in B&NES, and Representative Organisations

Higher risk groups (representative organisations)

3SG (B&NES 3rd Sector Group partnership)

Avon & Wiltshire Mental Health Partnership

Bath Mind

Boaters

Care Forum

Drug & Alcohol Services (DHI, SDAS)

Gypsy and other travellers

Housing & homeless

Julian House

Julian House Food Bank

Mentoring Plus

Project 28

Riverside Sexual Health Clinic

SDAS

Visit Bath

Other voluntary sector groups

Carers Centre

Higher risk locations

Services for those with complex needs

Services for the over 70's

Avon Local Pharmacy Committee & Pharmacies

Bath College

Bath Area Play Project

Bath Bid

Bath City Farm

Bath Spa University

Bath Tourism Plus

Bath University

Care providers

Children's Centres

Curo and other housing providers

Domestic abuse refuge

Family Nurse P'ship Virgin Care

Food retailers and restaurants

Genesis Trust & Bath Food Bank

GWR Bath Spa & Bus Station

Independent Guest Houses

Library

Places of worship

Riverside Sexual Health Clinic

Saltford Business Assoc.

Somer Valley Food Bank

South Side Family Centre

Sports clubs, grounds and gyms

Visit Bath

Wider employers (retail, tourism, taxi, bus)

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