Nottinghamshire County Council

Health and Wellbeing Board

Friday, 24 July 2020 at 10:30

Virtual meeting, **https://www.youtube.com/user/nottscc**

AGENDA

1	To note the appointment by Full Council on 23 July 2020 of Councillor Tony Harper as Chairman for the 2020-21 municipal year (subject to confirmation)	
2	Election of Vice-Chairman	
3	To note the membership of the Health and Wellbeing Board for the municipal year 2020-21, as follows: Councillor Tony Harper, Councillor Joyce Bosnjak, Councillor Ben Bradley, Councillor Glynn Gilfoyle, Councillor Francis Purdue-Horan, Colin Pettigrew, Melanie Brooks, Jonathan Gribbin, Councillor David Walters, Councillor Susan Shaw, Councillor Colin Tideswell, Councillor Henry Wheeler, Councillor Amanda Fisher, Councillor Neill Mison, Councillor Debbie Mason, Idris Griffiths, Dr Jeremy Griffiths	
4	Minutes of the last meeting held on 4 March 2020	3 - 10
5	Apologies for Absence	
6	Declarations of Interests by Members and Officers:- (see note below) (a) Disclosable Pecuniary Interests (b) Private Interests (pecuniary and non-pecuniary)	
7	Covid 19 Local Outbreak Control Plan	11 - 74
8	Review of the Better Care Fund Programme and Use of BCF Reserve for Short-Term Transformation Projects	75 - 98

9	Update to the Nottinghamshire Pharmaceutical Needs Assessment 2018-21, and COVID-19 Update on the 2021-24 Refresh (24-07-20)	99 - 106
10	Work Programme	107 - 108

Notes

(1) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(2) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(3) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Martin Gately (Tel. 0115 977 2826) or a colleague in Democratic Services prior to the meeting.

(4) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

Nottinghamshire County Council

minutes

Meeting	HEALTH AND WELLBEING BOARD
Date	Wednesday, 4 March 2020 (commencing at 2.00 pm)

Membership
Persons absent are marked with an 'A'

COUNTY COUNCILLORS

A Steve Vickers (Chair)
Joyce Bosnjak
A Glynn Gilfoyle
Francis Purdue-Horan
Martin Wright

SUBSTITUTE MEMBERS (COUNTY COUNCILLORS)

Muriel Weisz for Glynn Gilfoyle
Richard Butler for Steve Vickers

DISTRICT COUNCILLORS

A	David Walters	-	Ashfield District Council
A	Susan Shaw	-	Bassetlaw District Council
	Colin Tideswell	-	Broxtowe Borough Council
	Henry Wheeler	-	Gedling Borough Council
	Debbie Mason	-	Rushcliffe Borough Council
A	Neill Mison	-	Newark and Sherwood District Council
A	Amanda Fisher	-	Mansfield District Council

OFFICERS

A	Melanie Brooks	-	Corporate Director, Adult Social Care and Health
	Colin Pettigrew	-	Corporate Director, Children and Families Services
	Jonathan Gribbin	-	Director of Public Health

CLINICAL COMMISSIONING GROUPS

	David Ainsworth		Nottinghamshire CCGs
	Idris Griffiths	-	Bassetlaw Clinical Commissioning Group
A	Dr Jeremy Griffiths	-	Rushcliffe Clinical Commissioning Group (Vice-Chair)

LOCAL HEALTHWATCH

Sarah Collis - Healthwatch Nottingham & Nottinghamshire

NOTTINGHAMSHIRE POLICE AND CRIME COMMISSIONER

Kevin Dennis

OFFICERS IN ATTENDANCE

Dawn Jenkin	-	Consultant in Public Health
Edward Shaw	-	Public Health and Commissioning Manager
Martin Gately	-	Democratic Services Officer

OTHER ATTENDEES

David Pearson CBE	ICS Independent Chair
Andy Haynes	ICS Executive Lead
Amanda Robinson	PHM Programme Manager, ICS

NOMINATION OF CHAIRMAN

In the absence of the Chairman and Vice-Chairman, Councillor Martin Wright was nominated to act as Chairman following a vote.

MINUTES

The minutes of the last meeting held on 8 January 2020 having been previously circulated were confirmed and signed by the Chairman.

APOLOGIES FOR ABSENCE

Dr Jeremy Griffiths (NHS Rushcliffe Clinical Commissioning Group), Melanie Brooks (Nottinghamshire County Council), Councillor David Walters (Ashfield District Council), Councillor Susan Shaw (Bassetlaw District Council), Councillor Amanda Fisher Mansfield District Council), Councillor Neil Mison (Newark and Sherwood District Council) and Councillor Debbie Mason (Rushcliffe Borough Council).

DECLARATIONS OF INTEREST BY BOARD MEMBERS AND OFFICERS

None.

CHAIRS' REPORT

The Chairman highlighted the following topics from his report:
The merger of the Nottinghamshire Clinical Commissioning Groups (CCGs), the public information regarding novel Coronavirus (COVID-19), and the Royal Society for Public Health has compiled a list of public health achievements that have taken place in the last twenty years (for example, the 2007 ban on smoking in enclosed public spaces).

RESOLVED: 2020/008

That:

1) The contents of the report be noted, and any actions required by the Board in relation to the issues raised be considered.

UPDATE FROM THE NOTTINGHAM AND NOTTINGHAMSHIRE INTEGRATED CARE SYSTEM

David Pearson CBE (Independent Chair of the Nottingham & Nottinghamshire Integrated Care System) and Dr Andy Haynes (Executive Lead, Nottingham & Nottinghamshire Integrated Care System) provided a presentation on the Nottingham & Nottinghamshire Integrated Care System.

Mr Pearson explained that the ICS was a better way of meeting the needs of the population and ensuring that we are fit for the future. Increased life-expectancy has huge implications for the delivery of care, particularly where there are greater levels of long-term conditions. There is compelling evidence from across the world that the integration of services works. However, for the NHS it is a big departure, and it is crucial that policies are made and implemented locally.

The bodies comprising the ICS have the responsibility for transforming the system. This means the spending of the public pound will be agreed in Nottinghamshire. The ICS has no statutory powers beyond those of the constituent organisations.

The strokes pilot phase has prevented an estimated 75 strokes and 25 deaths, and an enhanced care in care homes pilot in Rushcliffe has resulted in a reduction in A&E attendances by 29% and hospital admissions by 23%.

The importance of collaboration with housing is also recognised. For example, the ASSIST partnership between Mansfield District Council, Clinical Commissioning Group

and Hospital Trust has improved outcomes and early discharges from hospital, seen a 400% return on investment and realised £1.4m savings for the NHS.

While the changes involved are complex, there is also an overlap with both City and County Health and Wellbeing Boards.

In response to questions from Members regarding funding and the flow of information from clinicians in the health service, Andy Haynes and David Ainsworth responded that there was genuine clinical leadership across Nottinghamshire, and that health information was far better than it was previously (e.g. the access that East Midlands Ambulance Service has to information while in a patient's home). However, it is necessary to accept that central funding is a given, and also take the opportunity the maximise funding where possible.

Jonathan Gribbin, Director of Public Health, made an observation on the wider context of the ICS trying to deliver improvement in healthy life-expectancy – the Marmot Report shone a spotlight on the evidence in relation to this. The depressing reality is that many people are living with ill-health, and for some, life expectancy has tapered off or reversed.

Responding to comments from Members regarding Primary Care Networks (PCNs), Dr Thilan Bartholomeuz of NHS Nottingham & Nottinghamshire CCG indicated that although there were different levels of PCN maturity across the system, GPs are very enthusiastic, well engaged and want to see an increase in levels of social prescribing.

Members will learn more about the Nottingham & Nottinghamshire and South Yorkshire plan at a future meeting.

RESOLVED: 2020/009

That:

1) A presentation on the Nottingham and Nottinghamshire Integrated Care System be received.

NOTTINGHAM AND NOTTINGHAMSHIRE INTEGRATED CARE SYSTEM'S APPROACH TO POPULATION HEALTH MANAGEMENT

Amanda Robinson, Population Health Management Programme Manager, Nottingham and Nottinghamshire ICS, provided a detailed presentation on Population Health, which is an approach aimed at improving the health and care of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population. It includes action to reduce the occurrence of ill-health, including addressing the wider determinants of health and care.

In order to measure the success of the programme a number of evaluations have taken place. The following findings were identified in the evaluations: variation in patient and citizen outcomes, variation in risk stratification approach, limited focus on prevention and upstream health and care management, incompatible systems data/information exchange between different healthcare professionals and providers, financial variation in integration and how funds are distributed/shared between organisations and providers, limited system oversight.

In response to an indication that one diabetes priority is to reduce amputations, Sarah Collis, Healthwatch Nottingham and Nottinghamshire stated that the voluntary and community sector had valuable contributions to make in this area, but they had received disproportionate cuts.

Andy Haynes, ICS Executive Lead, indicated that shifting from demand management into health planning was fundamental. Although the work is ground breaking, the system is not mature enough for all of this output all in one go. The strength of this is that it includes Public Health; in addition, the contribution of the voluntary sector is critical.

Board Members indicated they would like Population Health Management to be the topic for a future Health and Wellbeing Board Workshop.

In response to comments from Members, Amanda Robinson indicated that careful consideration would be given regarding implementing Type 2 diabetes education in care homes. In addition, data regarding diabetes can be broken down to GP practice level, and this will indicate people who have not had appropriate interventions.

RESOLVED: 2020/010

That:

1) A presentation on the Nottingham & Nottinghamshire Integrated Care System approach to population health management be received.

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2019

Jonathan Gribbin, Director of Public Health, presented his annual report to the Board, assisted by Dawn Jenkin, Consultant in Public Health and Nicole Chavaudra, Programme Director, Bassetlaw Integrated Care Partnership. The focus of the report was on health and work. The Board heard that there are 27,857 Employment Support Allowance claimants in Nottinghamshire. Fifty percent of claims are due to stress and anxiety with 11.4% due to musculoskeletal issues. In order to close the gap between Nottinghamshire and the England average we would need 36 more adults in secondary mental health care into employment, and 111 more adults with learning disabilities into employment.

Nicole Chavaudra emphasised the importance of building relationships with business forums, as well as engaging with local employers like Cerealto Siro.

In response to comments from Board Members, Colin Pettigrew, Corporate Director, undertook to provide a report on care leavers to a future meeting. He also reassured Members that the most recent inspection report had found care leaving to be transformed.

In response to comments from Members regarding disabilities, Dawn Jenkin stated that segmentational triaging of the population was necessary, because at the moment it tended to be one size fits all. It can be quite difficult to get an accurate number on levels of disability since most people tend not to disclose their disability. There is a need for high levels of support in some cases, but support back into work leads to fulfilling expectations.

RESOLVED 2020/011

That:

1) The 2019 DPH Annual Report be received and commented on.

2) Health and Wellbeing Board Members agree to contribute towards implementing the recommendations contained within the 2019 DPH Annual Report where applicable.

3) The progress on implementing the recommendations within the 2018 DPH Annual Report be noted.

BETTER CARE FUND PERFORMANCE AND PROGRAMME UPDATE (QUARTER 3, 2019/20)

Paul Johnson (Service Director: Strategic Commissioning & Integration) and Paul Brandreth (Better Care Fund Programme Co-ordinator) presented the report, the purpose of which was to set out the progress to the end of Quarter 3 against the Nottinghamshire Better Care Fund (BCF) budgets and performance targets.

Members heard that this time the metrics contained no red indicators at all, and this was a report to be celebrated. The Board has previously heard in detail about Delayed Transfers of Care (DTOCs) and the performance for these was now heading in the right direction.

In response to comments from Sarah Collis of Healthwatch, Paul Johnson indicated that Jane O'Brien would be keen to work with Healthwatch regarding dementia issues.

The Board noted that Paul Johnson was retiring and thanked him for all his work supporting the Board.

RESOLVED: 2020/012

That:

1) The Quarter 3 National Better Care Fund return (shown in Appendix 1) which was submitted to NHS England on 24 January 2020 be approved.

WORK PROGRAMME

The Board agreed that care leavers outcomes be placed on a future agenda.

RESOLVED: 2020/013

That:

1) The Board's work programme be noted, and consideration be given to any changes which the Board wishes to make.

The meeting closed at 16:34

CHAIR

Nottinghamshire County Council

Report to the Health & Wellbeing Board

24 July 2020

Agenda Item: 7

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

COVID-19 LOCAL OUTBREAK CONTROL PLAN

Purpose of the Report

1. To appraise the Health & Wellbeing Board of the Nottinghamshire COVID-19 Local Outbreak Control Plan.

Information

2. In the period to 19 June 2020, the deaths of approximately 646 people in Nottinghamshire County recorded as being due to COVID-19 represented a tragic loss to family and friends. Although the number of new confirmed COVID-19 cases in Nottinghamshire is now falling, Health & Wellbeing Board members will remain concerned to limit further loss of life.

3. In addition to preventing as many deaths as possible, there is also increasing need for Nottinghamshire to return to life as normal as possible for as many as possible, and to do this in a way that is safe and fair, protects our health and care systems, and supports our economy. Critical to that will be continued and renewed adherence to hygiene measures which received prominence early in the pandemic. Social distancing and other nationally mandated arrangements also remain as important as ever.

4. With the transmission of COVID-19 in the community now at a lower level, focus turns to the early identification of clusters of new cases and quickly containing outbreaks as they arise. It is in this context that upper tier local authorities were notified by HM Government that they should prepare a Local Outbreak Control Plan by the end of June 2020, to complement and link to the nationally delivered test and trace arrangements.

5. The Nottinghamshire County Local Outbreak Control Plan (appendix 1) was published online on Tuesday 30 June.

6. The purpose of the Local Outbreak Control Plan is to ensure the rate of COVID-19 transmission in Nottinghamshire is kept under control. The plan sets out how Nottinghamshire County Council will work with the NHS, district / borough councils, neighbouring councils and other partners to keep people safe and protected. It describes arrangements for controlling the rate of COVID-19 transmission to enable a return to life as normal as possible for as many as possible, and to do so in a way that is safe, protects the health and care system, and supports the economy. It summarises the local arrangements for data surveillance, testing and contact tracing, and outlines arrangements for preventing and managing

outbreaks in care homes, schools and other educational settings, and other high-risk and/or complex settings, such as prisons and detention centres, leisure facilities and high-risk workplaces.

7. The plan has been developed on the following principles:

    a. Locally produced – so that it is responsive to needs as they exist in Nottinghamshire.

    b. Collaborative – it builds on, and links into, established multi-agency partnership arrangements.

    c. Integrated – it provides a response that is co-ordinated across the geographies of county and city, and between the organisations across our local system.

    d. Member led – local political leaders oversee the plan and lead engagement with local communities about its implementation.

8. The focus of the Local Outbreak Control Plan on the early identification of clusters of new cases and the rapid implementation of testing, contact tracing, and self-isolation is reflected in the seven themes that guidance indicates the plan should be centred. These are summarised in Appendix 2.

9. Implementation of the preparedness and response elements is overseen by the Director of Public Health, working closely with Public Health England's local health protection arrangements, district / borough councils, and the Local Resilience Forum. Daily surveillance and action planning is overseen by a COVID-19 protection board, co-chaired by the Directors of Public Health for Nottinghamshire County and Nottingham City.

10. Political leadership in Nottinghamshire County (and separately in Nottingham City) is exercised through an Outbreak Control Engagement Board. The first meeting of the Nottinghamshire County Outbreak Control Engagement Board took place on Monday 29 June 2020 and obtained agreement between partner agencies to the Local Outbreak Control Plan before submission and sign off by the Joint Biosecurity Centre.

11. The Local Outbreak Control Plan has been developed in regard to *Guiding Principles for Effective Management of COVID-19 at a Local Level*. The process of development has been supported by eleven 'beacon areas' whose aim is to rapidly develop best practice and capture learning.

12. Achieving the objectives of the plan will depend not only on local collaboration but also on the role of HM Government in delivering reliable testing infrastructure and timely access to postcode level information about new cases.

13. Nottinghamshire County Council has been notified of an allocation of £3.8 million which is ringfenced for the purpose of COVID-19 local outbreak control.

14. Further information about the content of the Local Outbreak Control Plan and arrangements for governance and oversight will be shared with Health & Wellbeing Board members during the meeting.

Other Options Considered

15. None.

Reason for Recommendations

16. On 22 May 2020, HM Government requested that COVID-19 Local Outbreak Control Plans be developed by all upper tier local authorities by the end of June 2020.

Statutory and Policy Implications

17. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public-sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

18. There are no financial implications arising from this report.

RECOMMENDATION

1) That Health & Wellbeing Board members support the implementation of the Local Outbreak Control Plan.

Jonathan Gribbin
Director of Public Health
Nottinghamshire County Council

For any enquiries about this report please contact:

Jonathan Gribbin
Director of Public Health
Nottinghamshire County Council
Email: jonathan.gribbin@nottscc.gov.uk

Constitutional Comments (AK 17/06/2020)

19. The report falls within the remit of the Health & Wellbeing Board under its terms of reference.

Financial Comments (DG194 17/06/2019)

20. £3.8m has been allocated from the Revenue grant determination (Ringfenced) – Local Authority COVID-19 Test and Trace Service Support Grant.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- Nottinghamshire County Local Outbreak Control Plan (Tuesday 30 June 2020)

Electoral Division(s) and Member(s) Affected

- All.

Nottinghamshire County Council

Nottinghamshire County Council COVID-19 Local Outbreak Control Plan

Document Control

Name of document	Nottinghamshire County Council COVID-19 Local Outbreak Control Plan
Version and Date	Version 1.0 – 29.6.2020
Owner	Notts COVID-19 Engagement Board
Authors	NCC Public Health Team
Next review due	3 months

Quality assurance and approval

Date	Approval by
29 June 2020	Nottinghamshire COVID-19 Local Outbreak Engagement Board

Review

This document will be regularly reviewed and updated following the publication of new guidance or identification of local learning.

Date	Review by	Description of updates

Contents

Appendices

Glossary of abbreviations

ADPH	Association of Directors of Public Health
CCG	Clinical Commissioning Group
CEHO	Chief Environmental Health Officer
CQC	Care Quality Commission
DPH	Director of Public Health
FPH	Faculty of Public Health
GPRCC	GP Repository for Clinical Care. A data system for holding patient information.
HSE	Health and Safety Executive
ICP	Integrated Care Partnership
ICS	Integrated Care System
IPC	Infection Prevention Control
ITU	Intensive Therapy Unit. Colloquially known as intensive care.
LA	Local Authority
LGA	Local Government Association
LOCP	Local Outbreak Control Plan
LRF	Local Resilience Forum
MCA	Mental Capacity Act
MTU	Mobile Testing Unit
NEMS	Nottingham Emergency Medical Services. An out of hours provider.
NHCT	Notts Healthcare Trust
NHSE/I	NHS England & Improvement
NUH	Nottingham University Hospital
PHE	Public Health England
SFHT	Sherwood Forest Hospital Trust
SOLACE	Society of Local Authority Chief Executives
WTE	Whole Time Equivalent

Part 1 – Introduction and Context

1. Purpose

On 22nd 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 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.

It 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 diverge between the two local authorities where a bespoke approach will be more effective.

2. Aim, Objectives and Guiding Principles

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

a) Protect the health of people in 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 make the public safe and win 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

Appendix A provides more information about the local, regional and national roles and responsibilities in developing and delivering outbreak plans.

3. Effective Actions in Managing Outbreaks

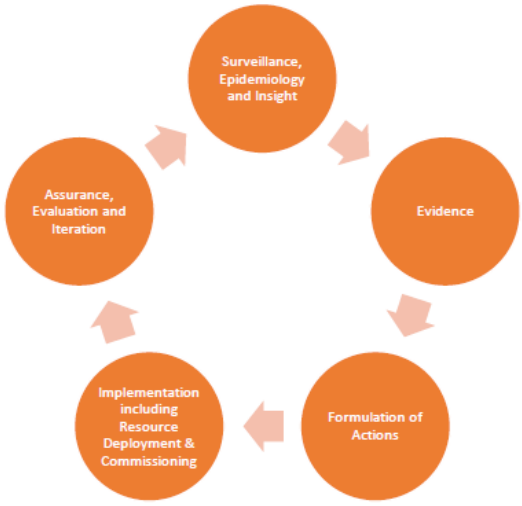
The foundational context for local outbreak management is set out in the Public Health England and Association of Directors of Public Health joint statement *What Good Looks Like for Local Health Protection Systems.*

Building on this the Nottinghamshire COVID-19 Local Outbreak 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 bodies in supporting these efforts through the deployment of the necessary resources to deliver those health protection functions at scale where needed (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:

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 that may be considered in response to a COVID-19 outbreak or incident, and the Legal powers that 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).
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 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.

Appendix B provides more detail on legal powers and their operation.

4. Roles and Responsibilities

This plan can only be delivered in Nottinghamshire 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 LA 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 CCGs

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

- 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 complex 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 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.

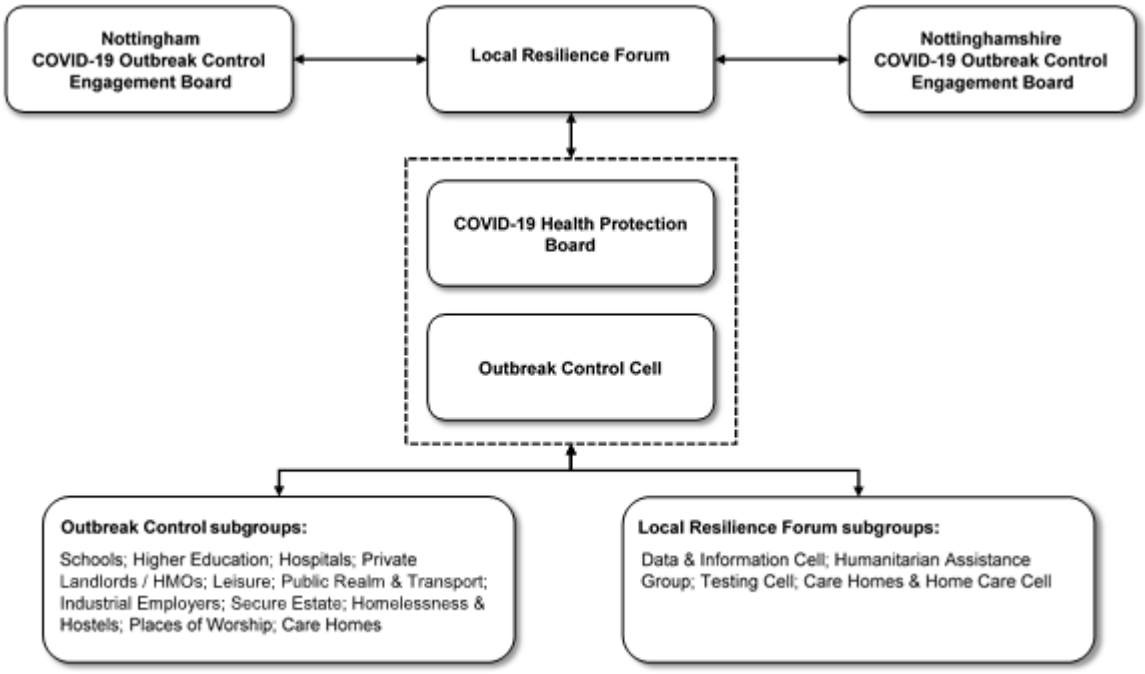
4.8 CQC

- 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.

5. Structure and Governance

The Local Outbreak Control Plan builds on the existing well-established and effective Local Resilience Forum (LRF) response structure – a diagram outlining the complete LRF structure can be found in Appendix C. 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, 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 Nottinghamshire County COVID-19 outbreak control engagement board

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

Its membership includes three senior elected Members of Nottinghamshire County Council, two leaders of District Councils, one for each of the north and south of the County, the County CEO and DPH, the MD of the Nottingham and Nottinghamshire ICS and the CO of Bassetlaw ICP (to give complete coverage of the whole geographical county), plus the Assistant Chief Constable of Nottinghamshire Police.

The Leader of the County Council chairs the Board. It reports to the Adult Social Care & Public Health Committee and as appropriate to Policy Committee of Nottinghamshire County Council as well as providing updates to the Nottinghamshire County Health and Wellbeing Board.

The Terms of Reference for the Board are attached at Appendix D.

6. Engagement and communications

The Nottinghamshire County 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 role will work closely with partner organisations and other agencies to coordinate activity and ensure consistent messaging. A separate

communications plan provides further detail to the implementation of proactive and reactive/responsive messaging.

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.

Effective communication 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 Nottinghamshire supported with proactive and responsive communication activity.

The key objectives of the communication plan are to:

- provide public confidence and assurance through relevant, timely and accurate information and sharing 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
- support engagement, co-production and communication to ensure residents, communities, businesses and key stakeholders (including local politicians) in Nottinghamshire have access to the information and support they need in a timely and effective way to protect themselves, their communities and the County
- localise national COVID-19 guidance especially for Nottinghamshire'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 that 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.

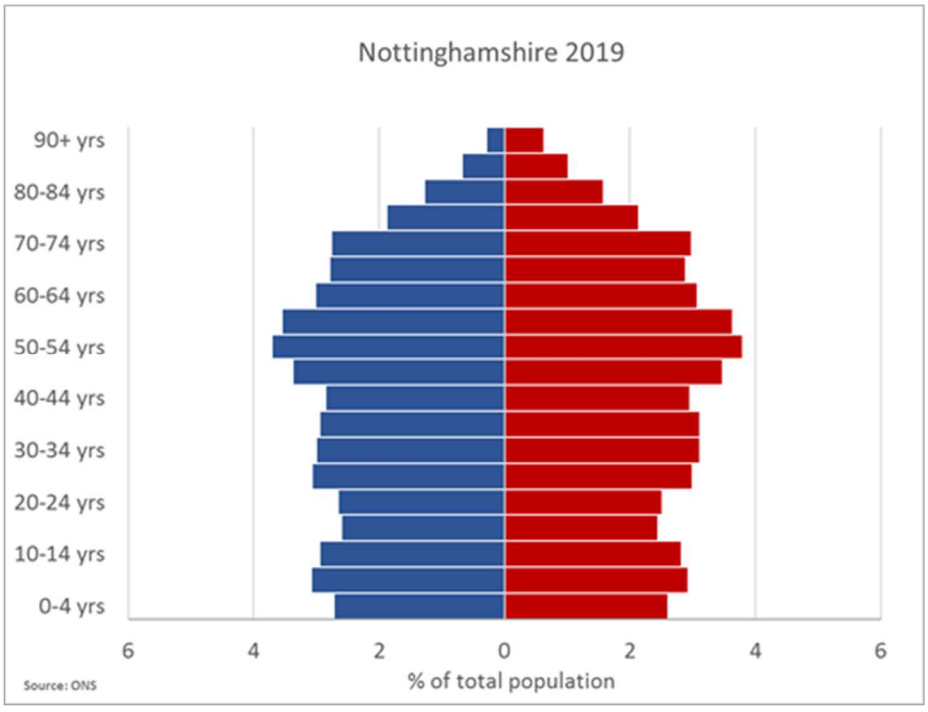
The communications plan will be developed through ongoing engagement with local communities, faith groups and the community and voluntary sector to promote guidance, model 'good' behaviours in communities and constructively engage with those people who may not comply with guidance.

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.

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. Nottinghamshire County Context

Nottinghamshire is a county with a mix of urban and rural areas. The total population is 828,224 (Source: ONS, 2019 mid-year estimate). The population age breakdown is shown below.



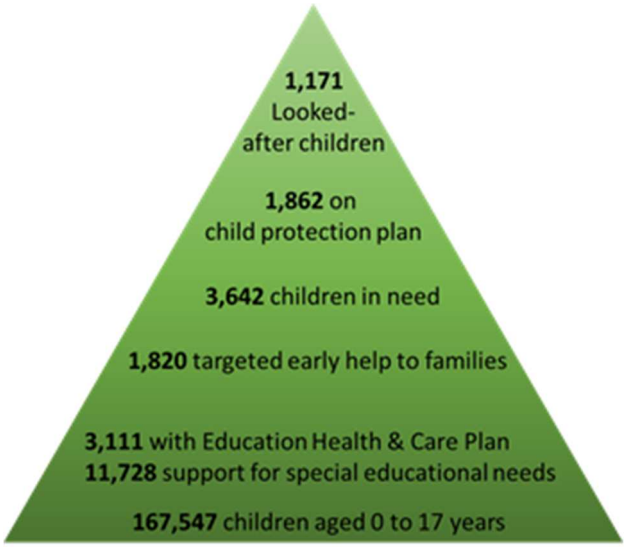
21% of Nottinghamshire's population is over 65 years of age. A high proportion of those aged over 75 will fall into the category of clinically extremely vulnerable people who will have been shielding. There is a relatively large older population and a proportionately large care sector supporting them. 5,760 people live in care homes, of which 2,860 have dementia.

Other care needs in the population include

- 155,600 people estimated to have common mental illness, of which 25,250 are aged over 65
- 4,846 adults with learning disabilities of which 2,119 are receiving long term local authority support

Vulnerable groups include 14,830 people with serious mental illness or behavioural disorder, 3,785 people in adult drug and alcohol treatment services, 2,700 people in three Nottinghamshire prisons, 1,300 homeless people (and 40 rough sleepers), and 1,880 people receiving support from domestic violence and abuse services. There are five refuges in the County and 261 beds.

Children age 0-17 make up 20% of the population. The numbers of vulnerable children are described in the graphic below:



81.7% of the working age population is economically active with 78.6% being in employment.

Nottinghamshire County Council is an upper tier local authority. Nottingham City Council is a separate upper tier authority. The County area, which excludes the City, has a two-tier local authority structure with seven district councils and two Integrated Care Systems. Nottingham and Nottinghamshire ICS covers Nottingham City plus the whole of the County, except for Bassetlaw. Bassetlaw is part of the South Yorkshire and Bassetlaw ICS. The relationships between stakeholders are good and co-operative.

Part 2 – Capabilities

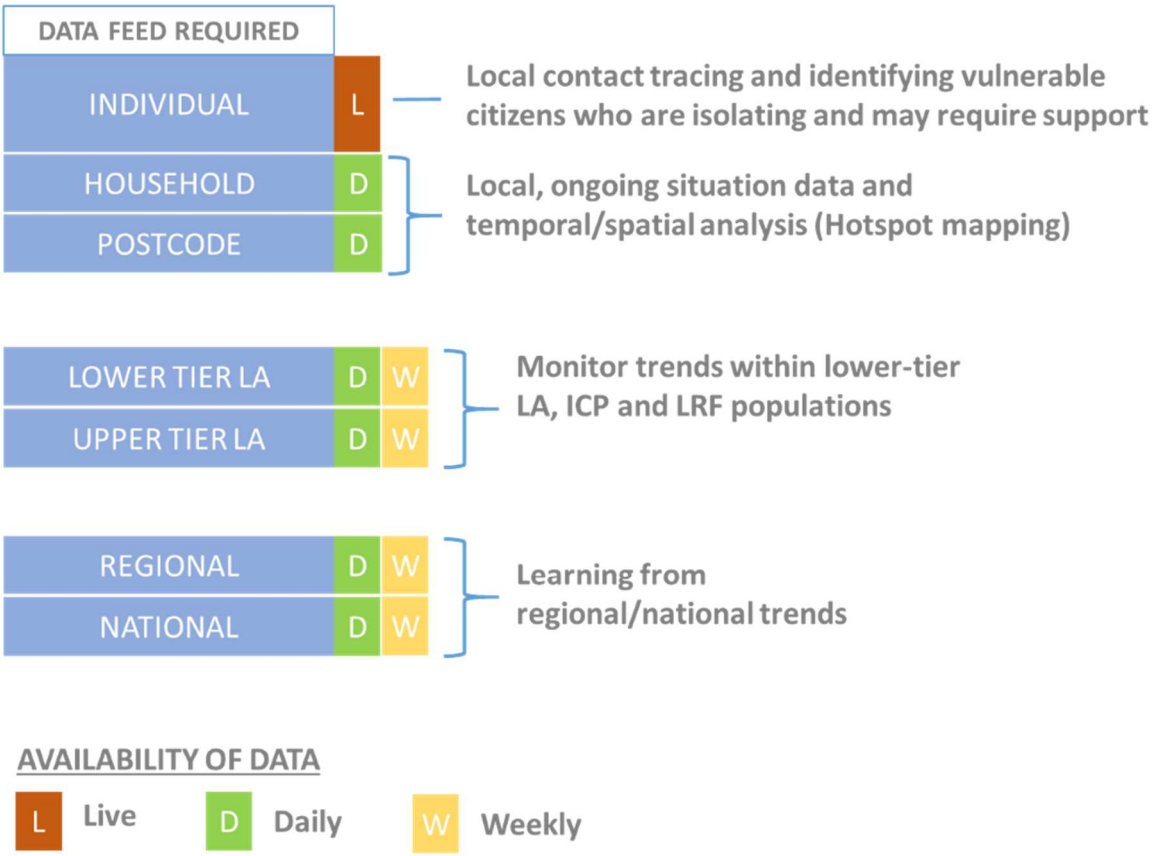
8. Data and Surveillance

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

The Nottingham and Nottinghamshire LRF data cell co-ordinates 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, and Nottinghamshire Healthcare NHS Foundation Trust. 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) 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 as localised outbreaks have greater significance in estimating R and the national lockdown rules are gradually relaxed and/or adherence becomes less. 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 & Notts)
Potential COVID-19 NHS 111 Telephone Calls (Nottingham & Notts)
Potential COVID-19 999 Calls (EMAS Nottinghamshire Division)
COVID-19 Pillar 1 (PHE/NHS Labs) Confirmed Cases (Nottingham & 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 & Notts)
COVID-19 Pillar 2 (Commercial Labs) Confirmed Cases (Nottingham & Notts)
COVID-19 Local Drive-Through Total Swabs (Pillar 2 Testing)
COVID-19 Hospital Deaths (NUH and SFH)
COVID-19 Total Deaths (Hospital & 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 heath 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 are 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.

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 Bio-security 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. (Further details in Appendix E).

9. Testing

Under the NHS Test and Trace programme, anyone with symptoms of coronavirus is encouraged to be tested by arranging a test on-line 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.
- Co-ordination 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 coronavirus 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 Stakeholder include;

- **Local settings/organisations:** Education providers, care home staff and residents, local businesses and other settings, including high risk and/or complex 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 Mobile Testing Units (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: is 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:

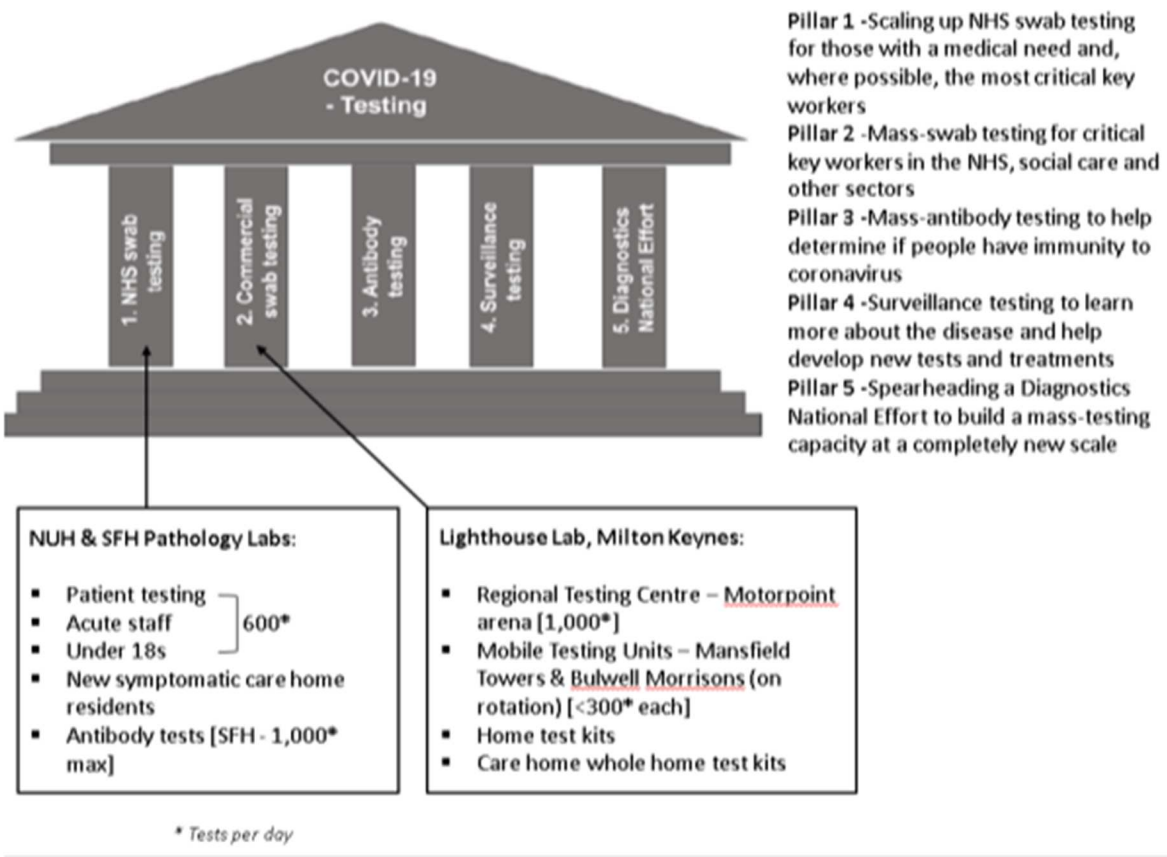
a) Local Testing Coordination Centre provides support and coordination for the testing of key workers, and whole care home testing, data management and sharing of testing intelligence for IPC, workforce and testing capacity planning.

b) Laboratory testing capacity provided by the Lighthouse Laboratory in Milton Keynes, PHE outbreak laboratories, and SFHFT and NUH 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 NHCT, in the County, and City Care 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 are provided by IPC teams at NHCT, City Care, 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



Local testing arrangements for complex 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 timeliness 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.
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.
Misinterpretation of the meaning of test results leads to anxiety or risky behaviour	Develop or adopt from other regions a range of standard communications material which supports individual interpretation of and response to a test result.
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 with 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

10.1 Overview

Contact tracing is an essential mechanism in controlling the spread of COVID-19 and containing local outbreaks to prevent transmission in to 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 programmed 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 that PHE has insufficient capacity to manage or an outbreak of sufficient magnitude to warrant decisions at a tactical or strategic level.

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 (see section 12).

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 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.

10.2 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 that 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

Support for vulnerable residents who need to self-isolate will be provided by the Nottinghamshire Coronavirus Community Support Hub, which is hosted by Nottinghamshire County Council and is organised by a dedicated Local Resilience Forum Community Support Hubs Cell consisting of representatives from both tiers of local government, the NHS and Community & Voluntary Sector.

The Hub enables residents to link with support near where they live. This support includes:

Support	Detail
Access to food	Help with food shopping, food delivery
Access to medicine	Help with collecting and delivering prescriptions, collecting medicines from 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, providing updates on what is going on in your local area regarding COVID-19
Physical wellbeing	Help to stay mobile and active - access to virtual gym sessions, advice about health
Transport	Help with getting to and from local places or help with running errands
Other- please specify	These would be picked up from the database and addressed by LRF partners

As of June 2020, there are 277 voluntary groups, 373 individuals, and 233 business offering support linked with the Community Hub.

11.2 Accessing the Support

The Nottinghamshire Coronavirus Community Support Hub provides an online database which enables residents in need of support to input their postcode and requirements via the webpage and be served up with a list of local groups and organisations able to meet those needs which they can contact.

Nottinghamshire Community Hub Website

https://www.nottinghamshire.gov.uk/care/coronavirus/nottinghamshire-coronavirus-community-support-hub

Nottinghamshire Community Hub Website Telephone contact

Tel 0300 500 8080 (open 8am to 6pm, Monday to Friday)

Alternatively, for residents who do not have internet access they can telephone the Community Support hub to be assisted by a Customer Advisor.

When a Community Hub form is completed by the resident or on their behalf, details are captured in a database available to all LRF Partner organisations so that the required staff can link them can help to coordinate their support. LRF partner organisations which are aiding the community response effort will ensure that staff can provide the required support in a coordinated way which minimises duplication and effectively uses resources.

11.3 Links to Social Care

Many of the people that are identified or self-identify as vulnerable during the COVID-19 outbreak will already be known to Social Care Services in Nottinghamshire. The Hub workflow includes check to ensure these needs continue to be met and any increased needs can be picked up and responded to.

Extremely Vulnerable People (EVP) (people who are Shielding)
Where the Hub receive lists of EVPs, these people will be contacted initially by staff at the Customer Services Centre who will discuss their needs with them and route them to the appropriate support. This could be to meet lower level needs through the database of volunteers or a referral for an assessment of additional social care provision
Self-identifying Vulnerable People
If someone accesses the Hub **via the web** they will be asked, "*Are you, or the person requiring support, currently receiving support from Adult Social Care or Children's Services or have a disability, mobility issues or a need for continuing healthcare?"* If they answer yes to this question, they are directed to the Customer services Centre (CSC) where their call will be taken by staff who have significant experience of triaging calls to identify any appropriate referrals for social care. If someone accesses the Hub **via phone** their call will be taken by the advisor and again triaged for any potential social care needs. If someone phones a District Council, staff there would be able to refer onto the Customer Services Centre if they pick up potential social care needs.

Example customer journeys are in Appendix F.

Part 3 – Preventing and managing outbreaks in complex settings

12. High risk settings, people & places

Nottinghamshire has a range of high-risk and/or complex settings including care homes (see section 13), school and early year 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 restricts 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 (PHEEM). PHE will remain the first point of contact for the notification of positive cases and outbreaks. It will be important that reports of confirmed cases in these settings are communicated by the setting owner to the PHE local Health Protection Team as quickly as possible using the agreed pathways. 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 complex 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.

Incident management plans are in place 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 case 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 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)

Nottingham City has estimated there are 6,700 HMOs within its boundaries, with occupiers sharing facilities including bathrooms and kitchens. 111 of the HMOs in Nottingham City are occupied by 9 or more households and these are considered to be of greater risk should an outbreak occur. Information is being collected from the County area.

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.

j) 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 for 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 and/or complexity 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 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 and report and understand needs in the care home and homecare sectors response to COVID-19.

The following sub-groups support to CHHC;

- CHHC operational support group: Tactical delivery, operational demand management and mobilisation
- CHHC short- and medium-term market management: Formulation of shared SOP's and agreements, development of shared risk assessments and process.
- 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 co-ordination 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 last 48 hrs. IPC send 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.

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

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.

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 that 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 need, 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 set out 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 complex 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 complex 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 below 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.

Table 2 details the number of educational settings within Nottinghamshire County.

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

Number	Maintained	Academy	Independent	Total
Children	59941	104905	3836	168682
Teachers and support staff	7148	11367	0	18515

Table 2. Academy, LA maintained and other educational settings in Nottinghamshire County

Educational Setting Type	Phase	No.
Academy	Primary[1]	100
	Secondary [1,2]	44
	Special	4
	TOTAL	**148**
LA Maintained	Primary	181
	Secondary	1
	Special	7
	TOTAL	**189**
Other	Further education	2
	Independent	9
	Independent special	10
	TOTAL	**21**

[1] Nottinghamshire has 2 Free Schools (which are a type of academy). One is a primary phase school, the other is secondary. These free schools are included in the academy group

[2] Nottinghamshire has an all through school and a middle deemed secondary school. These are both classed as secondaries for the purpose of this table.

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 Authorities boundaries	• Map settings/areas where we know this might be more likely • Educational and childcare settings in LA communication across EM and boarders 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	• Mapping exercises would need to take place as part of the development the plan, to identify possible scenarios that would need a tailored response.

both NCC and PHE). E.g. if multiple education and childcare settings outbreaks occurred.	• 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. Nottinghamshire County Council has 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 Coordination 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 on the basis of locally agreed reasonable worst-case scenarios.

15.3 Personal Protective Equipment (PPE)

In common with most of the country, Nottinghamshire County experienced significant difficulties in procuring the increased range and volume of PPE required by front line 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 the 6th of 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 C-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.

Appendices

A. Local, regional and national roles and responsibilities in developing and delivering outbreak plans
B. Legal Powers and enforcement
C. Structure of the Local Resilience Forum
D. Terms of Reference of the local COVID-19 Engagement Board
E. Information governance during the COVID-19 pandemic
F. Vulnerable people – Customer Journey examples (Notts CC)

Appendix A: Local, regional and national roles and responsibilities in developing and delivering outbreak plans

Level	Place-based leadership	Public health leadership
LOCAL	*LA CE, in partnership with DPH and PHE HPT to:* a) Sign off the Local Outbreak Plan led by the DPH b) Bring in wider statutory duties of the LA (e.g. DASS, DCS, CEHO) and multi-agency intelligence as needed including CCGs c) Hold the Member-led Covid-19 Engagement Board *(or other chosen local structure)*	*DPH with the PHE HPT together to:* a) Produce and update the Local Outbreak Plan and engage partners (DPH Lead) b) Review the daily data on testing and tracing c) Manage specific outbreaks through the outbreak management teams including rapid deployment of testing d) Provide local intelligence to and from LA and PHE to inform tracing activity e) DPH Convenes DPH-Led Covid-19 Health Protection Board (a regular meeting that looks at the outbreak management and epidemiological trends in the place) f) Ensure links to LRF/SCG
REGIONAL	*Regional Lead CE in partnership with national support team lead, PHE RD and ADPH lead and JBC colleagues:* a) Support localities when required when there is an adverse trend or substantial orcross-boundary outbreak b) Engage NHS Regional Director and ICSs	*PHE Regional Director with the ADPH Regional lead together:* a) Oversight of the tracing activity, epidemiology and Health Protection issues across the region b) Prioritisation decisions on focus for PHE resource with LAs c) Sector-led improvement to share improvement and learning d) Advice to NHS providers

	c) Link with Combined Authorities and LRF/SCGs d) Have an overview of issues and pressures across the region especially cross-boundary issues	e) Liaison with the national level
NATIONAL	*Contain SRO and PHE/JBC Director of Health Protection:* a) National oversight for wider place b) Link into Joint Biosecurity Centre especially on the wider intelligence and data sources	*PHE/JBC Director of Health Protection (including engagement with CMO):* a) National oversight identifying sector specific and cross-regional issues that need to be considered b) Specialist scientific issues e.g. Genome Sequencing c) Epidemiological data feed and specialist advice into Joint Biosecurity Centre

Appendix B: Legal Powers and Enforcement

LEGAL POWERS TO SUPPORT LOCAL OUTBREAK CONTROL

Purpose

1 This document describes the existing legal framework at local authority level to support the taking of action to deal with local outbreaks of Covid-19.

2 None of these powers are exercisable by the Local Outbreak Engagement Board itself. The powers are exercisable by local authorities and (in certain cases) individuals and where exercisable by local authorities will need to go through the internal governance arrangements of individual authorities.

Public Health Functions

3 Public health functions are vested in the County Council and are the particular responsibility of the Director of Public Health as a statutory officer.

4 Under section 2B of the National Health Service Act 2006, these functions include a duty to take such steps as the County Council considers appropriate for improving the health of the people in its area. This includes:-

- the giving of information and advice; and
- providing services or facilities for the prevention, diagnosis or treatment of illness.

5 Under Regulation 8 of the Local Authorities (Public Health and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 the County Council is required to provide information and advice to other bodies within the authority's area with a view to promoting the preparation of appropriate local health protection arrangements.

6 A Department of Health Factsheet on the role of the Director of Public Health issued when the new provisions can into force in 2012 states:-

"The director of public health, as the lead officer for these new functions, will need to have specialist public health expertise, and access to specialist resources, spanning the three domains of public health, health improvement, ***health protection*** *and healthcare public health (ie the population health aspects of NHS funded clinical services).*

The director and their specialist teams … will also lead on health protection, ensuring that appropriate arrangements are in place, escalating concerns and holding local partners to account. …"

7 Responsibility to advise on, lead and oversee the overall public health protection response therefore lies with the Director of Public Health. This role and accompanying statutory provisions do not, however, contain any specific power to enforce a lockdown in the sense of the types of measures to restrict business opening and movement that have been characteristic of the first Covid-19 lockdown period.

General Powers in relation to Disease Control

8 The basic local authority duties and powers in the control of disease are set out in the Public Health (Control of Disease) Act 1984 as amended and Regulations made under it in 2010.

9 The Regulations are the following (each made under section 45C of the Act)

- Health Protection (Local Authority Powers) Regulations 2010
- Health Protection (Part 2A Orders) Regulations 2010
- Health Protection (Notification) Regulations 2010

These Regulations set out the role of local authorities within the disease control system and in particular the Local Authority Powers Regulations set out the specific powers given to local authorities.

10 The 1984 Act defines a local authority in a two tier area as being the District Council (s1(1)(a) and (b)). Although the term "local authority" is not defined within the Regulations, by virtue of section 11 of the Interpretation Act 1978 the term when used in the Regulations will have the same meaning given to it in the Act. All these powers are therefore District Council powers.

Powers exercisable directly

11 The following powers under the Health Protection (Local Authority Powers) Regulations 2010 are exercisable directly by the District Council without a court order.

(a) Regulation 2 – power to require a parent to keep their child away from a school

(b) Regulation 3 – power to require that a headteacher provides it with a list of the names, addresses and contact telephone numbers for all the pupils of that school, or such group of pupils attending that school as the Council may specify

(c) Regulation 4 – power to disinfect or decontaminate, or cause to be disinfected or decontaminated, a thing where requested to do so by the owner.

(d) Regulation 5 – power to disinfect or decontaminate, or cause to be disinfected or decontaminated, a thing where requested to do so by a person with custody or control of it

(e) Regulation 6 – power to disinfect or decontaminate, or cause to be disinfected or decontaminated, premises where requested to do so by the owner

(f) Regulation 7 – power to disinfect or decontaminate, or cause to be disinfected or decontaminated, premises where requested to do so by the tenant.

(g) Regulation 8 - request that the person or group of persons do, or refrain from doing, anything for the purpose of preventing, protecting against, controlling or providing a public health response to the incidence or spread of infection or contamination which presents or could present significant harm to human health.

(h) Regulation 9 – power to serve a notice prohibiting any person from having contact with a dead body

(i) Regulation 10 – power to serve a notice prohibiting any person from entering a room in which a dead body is located.

(j) Regulation 11 – power to relocate, or cause to be relocated, a dead body to a place where the Council considers that the risk of the dead body infecting or contaminating people is reduced or removed.

12 These powers are limited by a number of conditions and can lead to differing consequences including criminal offences which are not detailed above. The list in paragraph 11 does, however give a picture of the nature and scope of powers directly exercisable by District Councils.

Powers exercisable through the court

13 Under Part 2A of the 1984 Act and the Health Protection (Part 2A Orders) Regulations 2010 a Justice of the Peace on application by a District Council can make a number of orders in relation to a person (P) as follows:-

(a) that P submit to medical examination;

(b) that P be removed to a hospital or other suitable establishment;

(c) that P be detained in a hospital or other suitable establishment;

(d) that P be kept in isolation or quarantine;

(e) that P be disinfected or decontaminated;

(f) that P wear protective clothing;

(g) that P provide information or answer questions about P's health or other circumstances;

(h) that P's health be monitored and the results reported;

(i) that P attend training or advice sessions on how to reduce the risk of infecting or contaminating others;

(j) that P be subject to restrictions on where P goes or with whom P has contact;

(k) that P abstain from working or trading;

(l) that P provide information or answer questions about P's health or other circumstances (including, in particular, information or questions about the identity of a related party).

14 An order under the above paragraph may also order a person with parental responsibility for P to secure that P submits to or complies with the restrictions or requirements imposed by the order.

15 A Justice of the Peace may also on application by a District Council can make a number of orders in relation to things as follows:-

(a) that the thing be seized or retained;

(b) that the thing be kept in isolation or quarantine;

(c) that the thing be disinfected or decontaminated;

(d) in the case of a dead body, that the body be buried or cremated;

(e) in any other case, that the thing be destroyed or disposed of;

(f) the owner of the thing, or any person who has or has had custody or control of the thing, provides information or answers questions about the thing (including, in particular, information or questions about where the thing has been or about the identity of any related person or the whereabouts of any related thing).

16 A Justice of the Peace may also on application by a District Council can make a number of orders in relation to premises as follows:-

(a) that the premises be closed;

(b) that, in the case of a conveyance or movable structure, the conveyance or structure be detained;

(c) that the premises be disinfected or decontaminated;

(d) that, in the case of a building, conveyance or structure, the premises be destroyed;

(e) that the owner or any occupier of the premises provides information or answers questions about the premises (including, in particular, information about the identity of any related person or the whereabouts of any related thing).

17 The powers in paragraphs 13 to 17 include power to make an order in relation to a group of persons, things or premises.

18 A Part 2A order may include, in addition to the above restrictions or requirements, such other restrictions or requirements as the justice considers necessary for the purpose of reducing or removing the risk in question.

19 In order for the Justice of the Peace to make an order they must be satisfied of a number of matters including that there is infection or contamination, that it presents or could present significant harm to human health, that there is a risk of onward contamination or infection and that it is necessary to make the order to remove or reduce that risk.

Specific Coronavirus Powers

20 In addition to the above general Disease Control powers a number of powers have been created specifically by the Coronavirus Act and Coronavirus Regulations. This includes enforcement powers for local government under the Health Protection (Coronavirus, Restrictions) Regulations 2020 in relation to the carrying out of certain specified businesses. District Councils also have powers to enforce certain provisions of the Health and Safety at Work etc Act 1974 which may extend to issues such as social distancing in workplaces.

Educational institutions and child care premises

21 Schedule 16 to the Coronavirus Act 2020 gives powers to the Secretary of State to direct the temporary closure of schools and other educational institutions and child care premises. However, the Secretary of State may also authorise the County Council to exercise any of the Secretary of State's functions in relation to one or more of the following—

(a) a registered childcare provider in the local authority's area;

(b) a school in its area;

(c) a 16 to 19 Academy in its area.

A school includes an Academy (including an alternative provision Academy.

22 The County Council has not to date been authorised under this Schedule.

Potentially Infectious Persons

23 Schedule 21 contains a number of complex powers that can be exercised in relation to potentially infected persons. A person is potentially infected at any time if (a) the person is or may be infected or contaminated with coronavirus and there is a risk that the person might

infect or contaminate others with coronavirus, or (b) the person has been in an infected area within the 14 days preceding that time.

24 The powers are split into 3 groups

25 The first group is powers to direct or remove persons to a place suitable for screening and assessment. This includes power to

(a) direct the person to go immediately to a place specified in the direction which is suitable for screening and assessment,

(b) remove the person to a place suitable for screening and assessment, or

(c) request a constable to remove the person to a place suitable for screening and assessment (and the constable may then do so).

26 The second group is powers exercisable at a screening and assessment place. This includes powers to:-

(a) require the person to remain at the place for screening and assessment purposes for a period not exceeding 48 hours;

(b) require the person to be screened and assessed;

(c) require a biological sample or to allow a healthcare professional to take a biological sample by appropriate means; or

(d) require a person to answer questions and provide information about their health or other relevant matters (including their travel history and other individuals with whom they may have had contact).

27 The third group is powers exercisable after assessment. This includes powers to require a person:-

(a) to provide information;

(b) to provide details by which the person may be contacted during a specified period;

(c) to go for the purposes of further screening and assessment to a specified place suitable for those purposes

(d) to remain at a specified place (which may be a place suitable for screening and assessment) for a specified period;

(e) to remain at a specified place in isolation from others for a specified period.

28 It also includes powers to impose restrictions, for a specified period, on:-

(a) the person's movements or travel (within or outside the United Kingdom);

(b) the person's activities (including their work or business activities);

(b) the person's contact with other persons or with other specified persons.

29 The powers under the Act are conferred on Public Health Officers constables and immigration officers. For these purposes a Public Health Officer is either (i) an officer of the Secretary of State designated by the Secretary of State for any or all of the purposes of this Schedule, or (ii) a registered public health consultant so designated.

30 Therefore before an officer of any Council could exercise any of the powers under the Act they would have to be a registered public health consultant and be designated by the Secretary of

State for any or all of the purposes of the Act. Although the County Council employs public health consultants none of them have to date been designated by the Secretary of State for the purposes of the Act. At the current time therefore these provisions are only enforceable by national or regional Public Health England consultants.

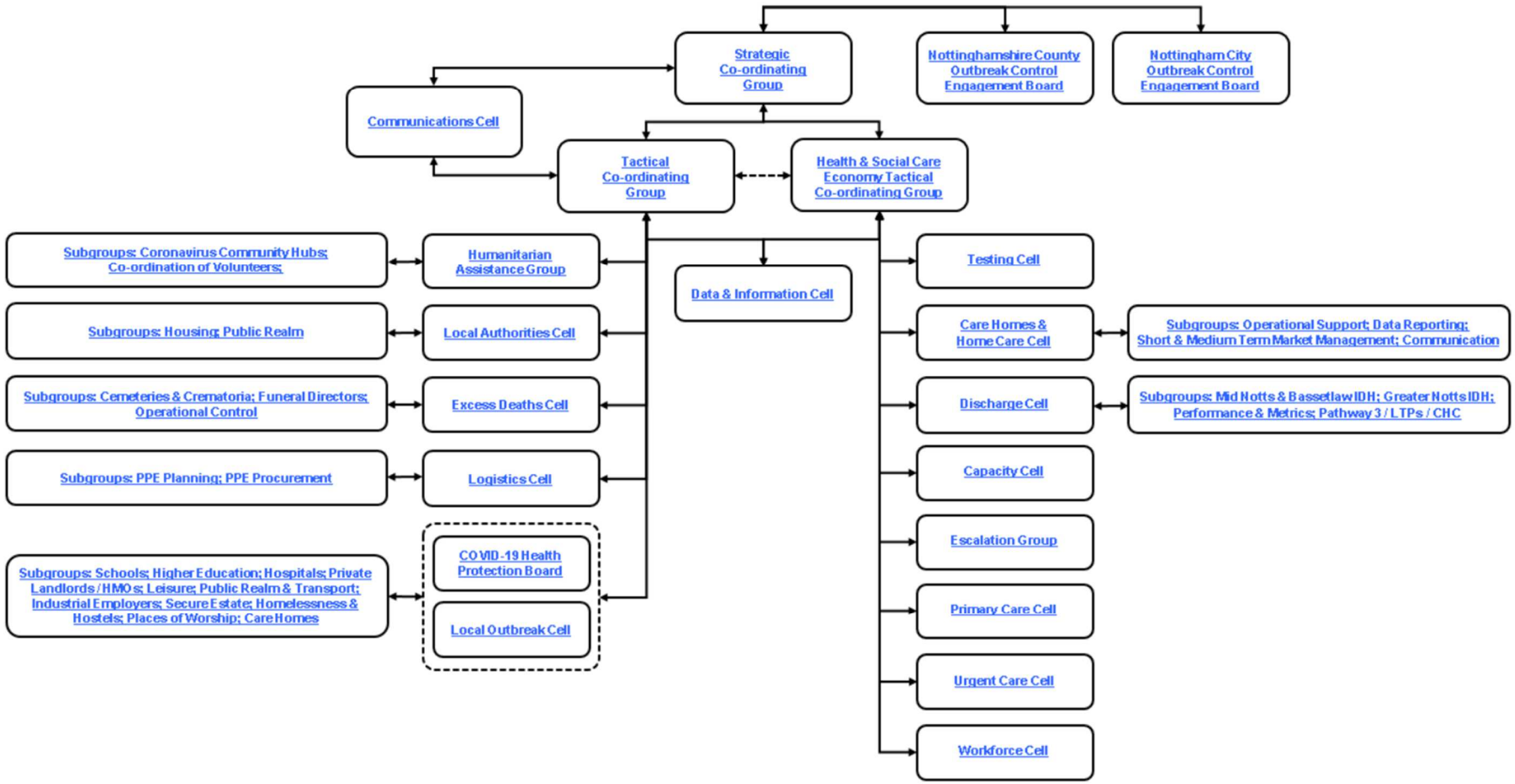
Conclusion

31 This document sets out the current (and some potential) powers of local authorities and their officers in relation to disease control and the ability to impose or enforce a local lockdown in response to Covid-19. The powers exercisable directly by local authorities are quite limited although the powers of a Justice of Peace on application by a local authority are more extensive.

Appendix C: Local Resilience Forum (LRF) structures

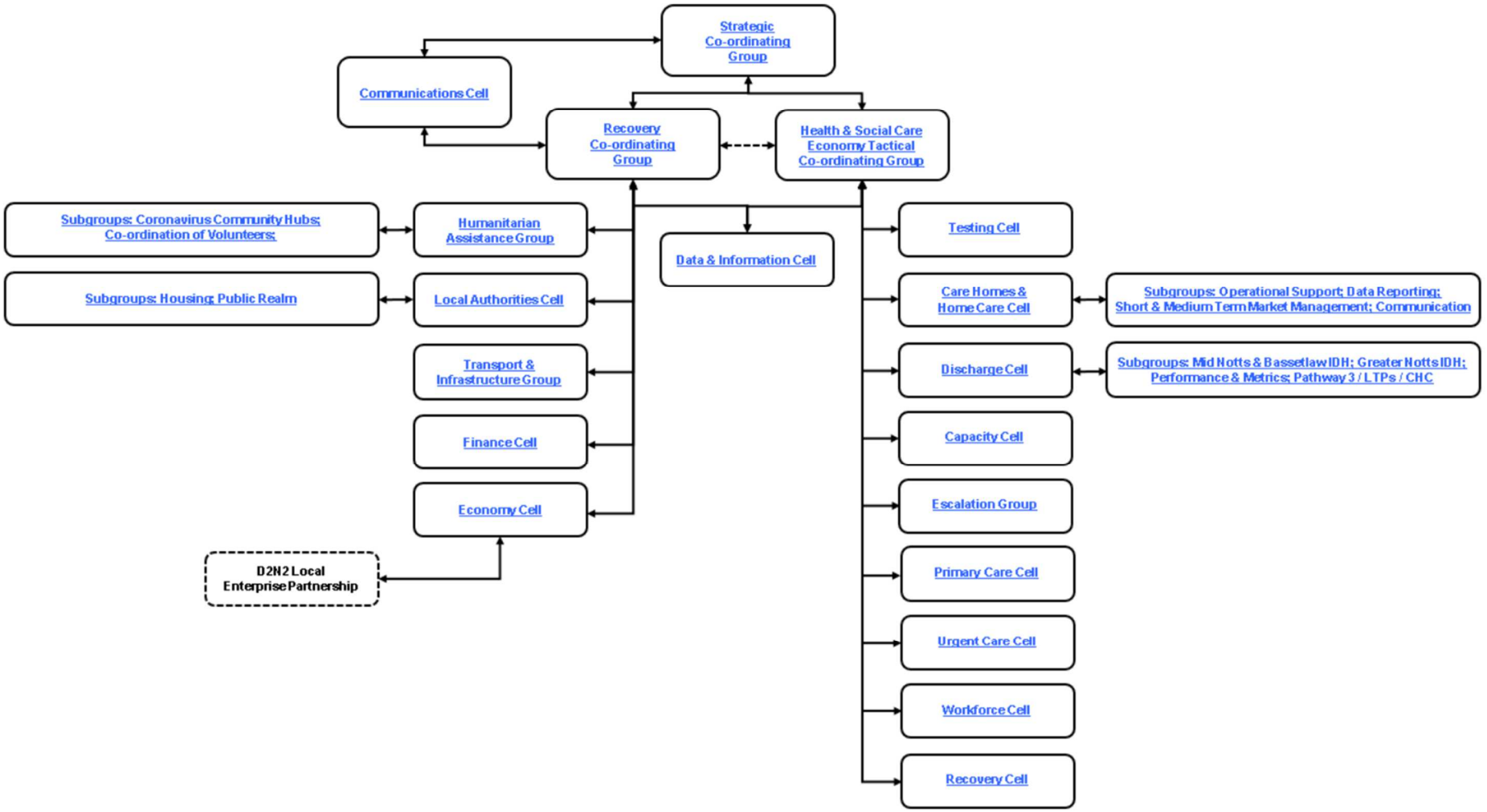
MULTI-AGENCY RESPONSE STRUCTURE (COVID-19)

Please note the response and recovery structures are running concurrently.



MULTI-AGENCY RECOVERY STRUCTURE (COVID-19)

Please note the response and recovery structures are running concurrently.



Appendix D: Nottinghamshire County COVID-19 Outbreak Control Engagement Board Terms of Reference

30 June 2020

Context

The UK government is overseeing a range of measures to protect people from COVID-19, safeguard critical services, release the economy, and enable people to live as normal a life as possible. Amongst these measures, the national Test & Trace programme is intended to deploy testing and contact tracing to individuals who report symptoms, in order to quickly isolate potential sources of infection.

Where the Test & Trace system identifies cases or situations of greater complexity it will link to local arrangements to oversee their management. These local arrangements are the focus of the Local Outbreak Control Plan (the Plan) which centres on seven themes (Appendix A).

Support for these arrangements across the county will be critical for their successful implementation. This will be achieved via the establishment of two new Boards:

- An officer led COVID-19 Health Protection Board, responsible for the development of the Plan, led by the Director of Public Health
- An informal member-led COVID-19 Outbreak Control Engagement Board, responsible for political oversight of the Plan and communication and engagement with the public.

Purpose of the Outbreak Control Engagement Board (the Board)

In accordance with government guidance, the Board has been established to:

a. Provide political ownership and governance for the local response
b. Obtain agreement between partner agencies to the Local Outbreak Control Plan before submission and approval by the Joint Biosecurity Centre
c. Ensure there is effective oversight and communication with the public of the Plan for Nottinghamshire County, and public facing engagement regarding the response to any outbreaks.

Objectives

- To review and confirm agreement to the Local Outbreak Control Plan which sets out the range of measures which may be needed in Nottinghamshire County, and the framework within which operational decisions about their deployment will be taken
- To shape and support the delivery of a communication plan which secures engagement from all communities and sectors to measures required to contain COVID-19
- To provide public oversight of the implementation of the Plan
- To support the work of the Local Resilience Forum in discharging the plan in a timely and effective manner
- To ensure that the Plans for Nottinghamshire County and Nottingham City provide a fully co-ordinated response for residents.

Outcomes

- To improve the speed of response to and effectiveness of control over local outbreaks

- To build on local knowledge and draw on expertise from across local governmental agencies, through established emergency response systems
- To improve co-ordination and effectiveness between local and national government
- To aid understanding and engagement from the public to the Plan to assist with its effective implementation.

Membership

- The Leader of Nottinghamshire County Council (Chairman)
- The Deputy Leader of Nottinghamshire County Council
- The Chairman of Nottinghamshire County Council's Adult Social Care & Public Health Committee
- The Chairman of Nottinghamshire County Council's COVID-19 Resilience, Recovery & Renewal Committee
- The Chairman of the Nottinghamshire County Health & Wellbeing Board
- The Elected Mayor of Mansfield District Council (Vice Chairman)
- The Leader of Bassetlaw District Council
- The Chief Executive Officer of Nottinghamshire County Council
- The Director of Public Health for Nottinghamshire County Council
- The Assistant Chief Constable of Nottinghamshire Police
- The Managing Director of Nottingham & Nottinghamshire Integrated Care System
- The Chief Officer of NHS Bassetlaw Clinical Commissioning Group.

In the event of an outbreak, the Board may identify other representatives whose leadership would strengthen its engagement in particular settings and communities.

The Leader of Bassetlaw District Council and the Elected Mayor of Mansfield District Council will represent all district / borough councils in Nottinghamshire.

Governance and reporting

The Board will be an informal partnership aimed at securing multi-agency support for the Plan and its implementation, and to oversee and secure effective public understanding and engagement with the Plan.

The Board will discharge its responsibilities by means of recommendations to appropriate governance boards and relevant partner organisations, where necessary.

Decision-making will lie with individual bodies and agencies who will act in accordance with their own governance arrangements, powers and duties in the taking of appropriate actions to manage any virus outbreaks. Many decisions required are likely to be achieved through established emergency planning structures and senior officer delegations within relevant bodies to ensure the ability to move at pace across all sectors.

Representatives of individual agencies and bodies at the Board may not bind or fetter the discretion of any agency in the exercise of their legal powers and duties by anything said or done at the Board.

The Board will provide progress reports and updates, as required, to Nottinghamshire County Council's Adult Social Care & Public Health Committee (as the Committee responsible for Public Health matters), Policy Committee (as the Committee responsible for Strategic and Policy matters, including local democracy and communications), and COVID-19 Resilience, Recovery & Renewal Committee. It will also provide updates to the Nottinghamshire Health & Wellbeing Board as necessary.

The Board will publish the Local Outbreak Control Plan on the website of Nottinghamshire County Council.

Appendix B sets out the proposed structure in Nottinghamshire, showing the Board's relationship with key structures, including the Local Resilience Forum.

Quorum

The Board shall be quorate if no less than four of the members are present. This must include one representative of Nottinghamshire County Council, one representative of a district / borough council, and one representative of the local health system. Deputies will be permitted where any member is unable to attend a scheduled meeting and must be notified to Nottinghamshire County Council as soon as reasonably practicable before the relevant meeting commences.

If a meeting of the Board is not quorate within 30 minutes of its starting time the business of the meeting will stand adjourned to the next meeting. Where the business is urgent, the Chairman will be approached to agree to the convening of an additional meeting.

Frequency and nature of meetings

The Board will meet fortnightly or as required. Additional meetings of the Board may be convened with the agreement of the Chairman.

The meetings of the Board will be held in private and may take place via remote means or where appropriate, in person (observing any applicable social distancing requirements).

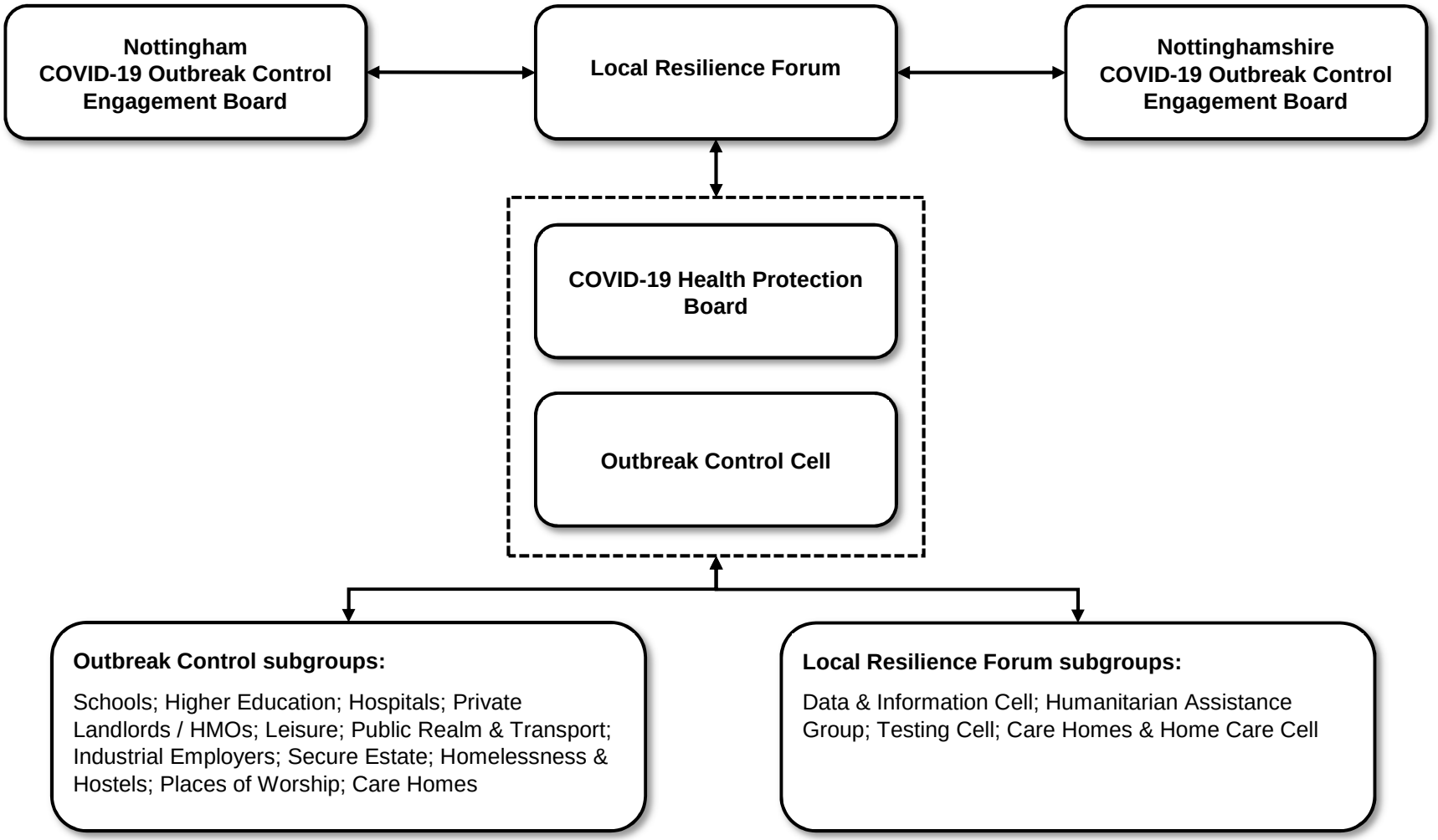
Meeting papers will be copied to the Leaders of all district / borough councils for feedback through their relevant representatives on the Board.

Appendix A

Local Outbreak Control Plans will centre on 7 themes

1. **Care homes and schools**
   Planning for local outbreaks in care homes and schools (e.g. defining monitoring arrangements, potential scenarios and planning the required response)
2. **High risk places, locations and communities**
   Identifying and planning how to manage high risk places, locations and communities of interest (e.g. defining preventative measures and outbreak management strategies)
3. **Local testing capacity**
   Identifying methods for local testing to ensure a swift response that is accessible to the entire population (e.g. defining how to prioritise and manage deployment, examples may include NHS, pop-up etc).
4. **Contact tracing in complex settings**
   Assessing local and regional contact tracing capability in complex settings (e.g. identifying specific local complex communities, developing assumptions to estimate demand and options to scale capacity)
5. **Data integration**
   Integrating national and local data and scenario planning through the Joint Biosecurity Centre Playbook (e.g., data management planning, including data security, NHS data linkages)
6. **Vulnerable people**
   Supporting vulnerable local people to get help to self-isolate (e.g. facilitating NHS and local support, identifying relevant community groups etc) and ensuring services meet the needs of diverse communities
7. **Local Boards**
   Establishing governance structures led by existing Covid-19 Health Protection Boards in conjunction with local NHS and supported by existing Gold command forums and a new member-led Board to communicate with the general public

Appendix B


Nottingham COVID-19 Outbreak Control Engagement Board
Local Resilience Forum
Nottinghamshire COVID-19 Outbreak Control Engagement Board
COVID-19 Health Protection Board
Outbreak Control Cell
Outbreak Control subgroups:
Schools; Higher Education; Hospitals; Private Landlords / HMOs; Leisure; Public Realm & Transport; Industrial Employers; Secure Estate; Homelessness & Hostels; Places of Worship; Care Homes
Local Resilience Forum subgroups:
Data & Information Cell; Humanitarian Assistance Group; Testing Cell; Care Homes & Home Care Cell

Appendix E: Information Governance During the COVID-19 Pandemic

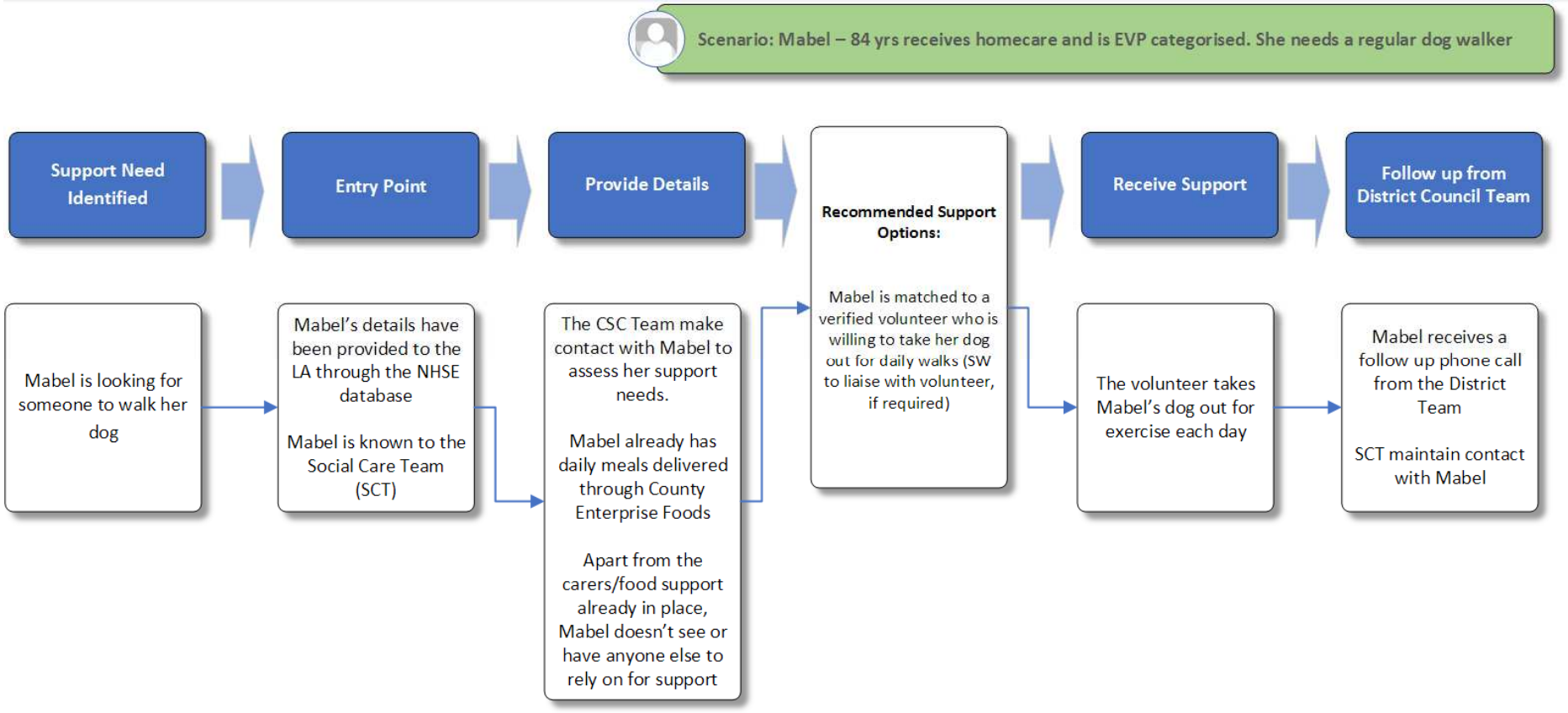
Agencies will assume they are required to adopt a proactive approach to sharing information by default, in line with the Instructions of the Secretary of State, the Statement of the Information Commissioner on COVID-19 and the Civil Contingencies Act.

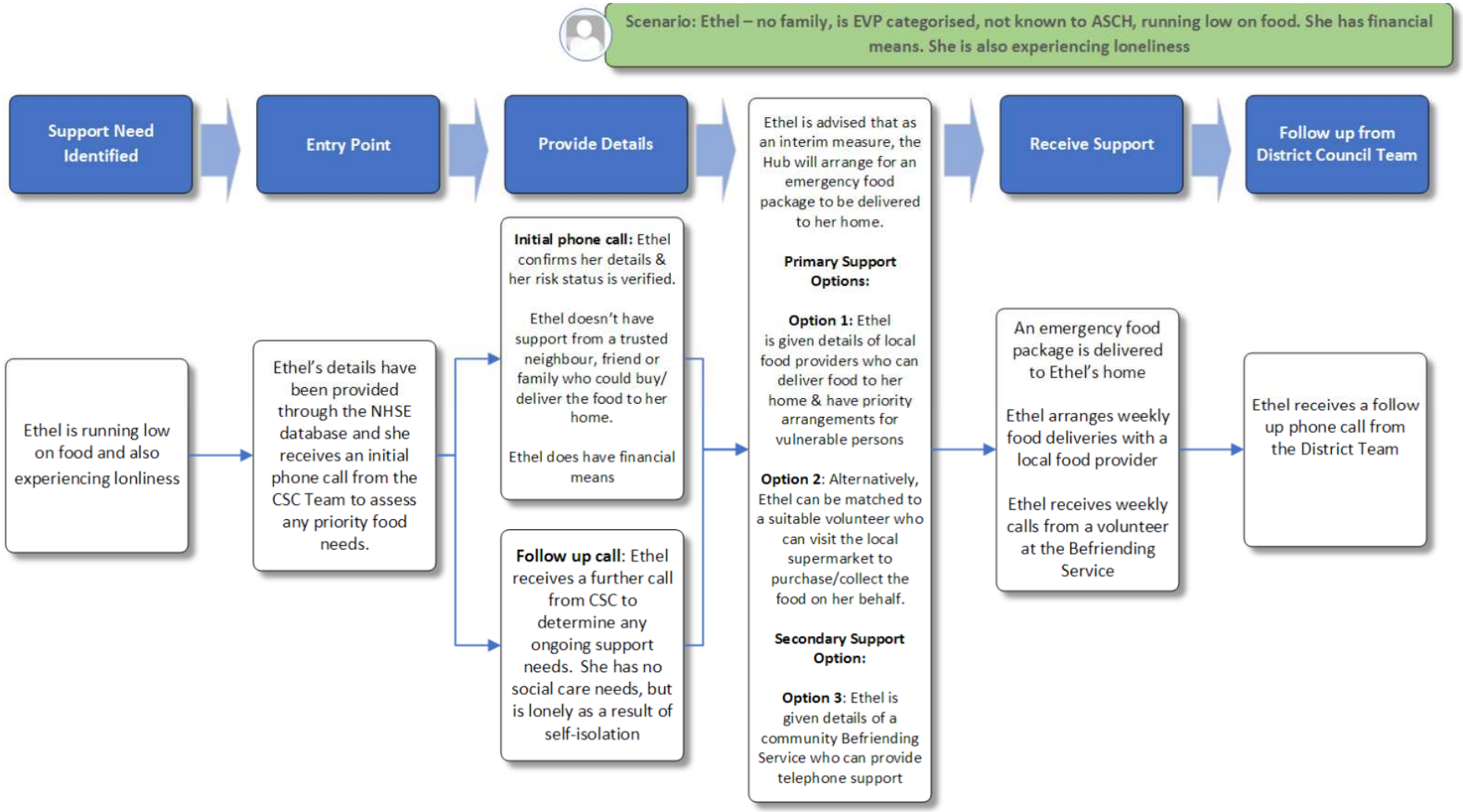
The Secretary of State has issued 4 notices under the Health Service Control of Patient Information Regulations 2002 requiring the following organisations to process information: NHS Digital, NHS England and Improvement, health organisations, arm's length bodies, local authorities, GPs. These notices require that data is shared for purposes of coronavirus (COVID-19) and give health organisations and local authorities the security and confidence to share the data they need to respond to coronavirus (COVID-19). These can be found here https://www.gov.uk/government/publications/coronavirus-COVID19-notification-of-data-controllers-to-share-information.

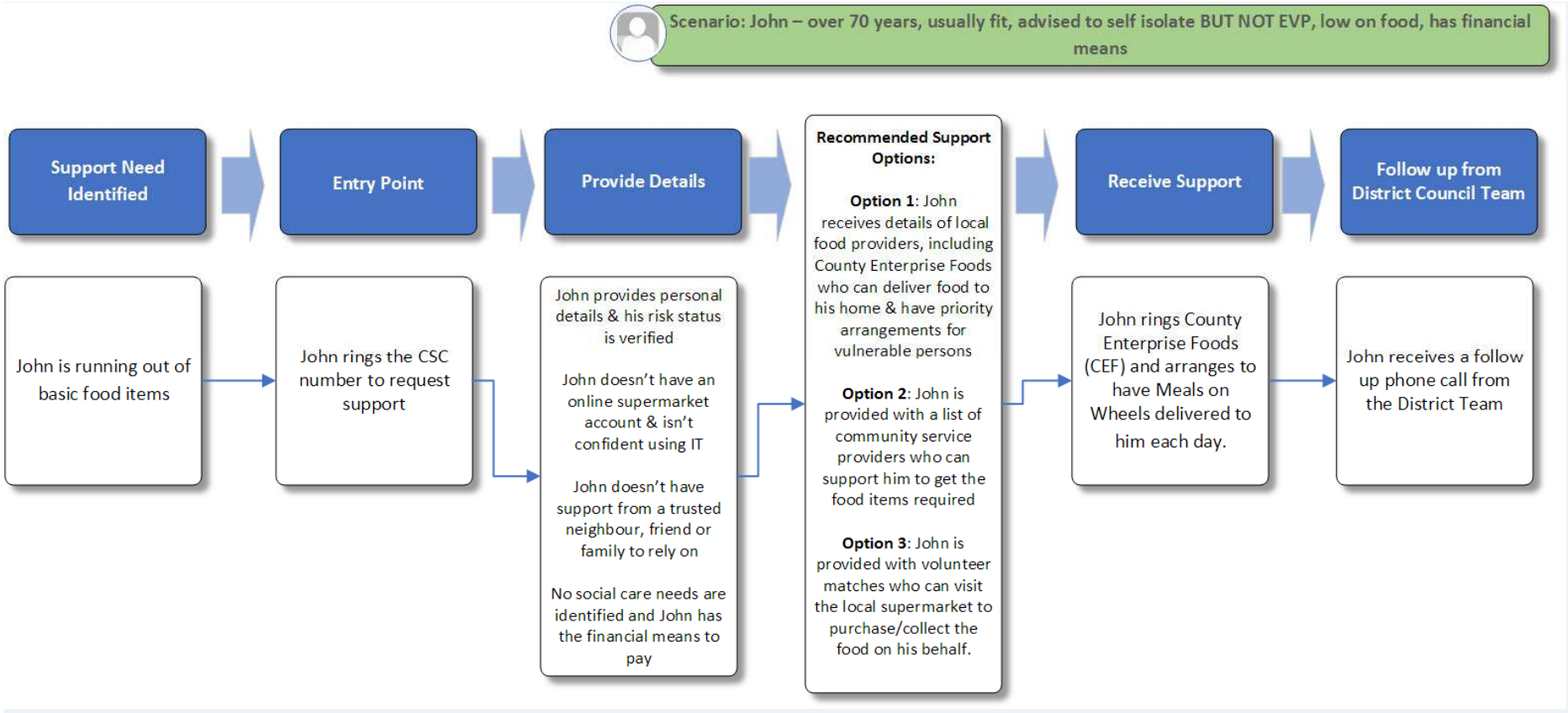
The data sharing permissions under the Civil Contingencies Act 2004 and the statement of the Information Commissioner all apply. Under the Civil Contingencies Act 2004 (CCA) and the Contingency Planning Regulations, Category 1 and 2 responders have a duty to share information with other Category 1 and 2 responders. This is required for those responders to fulfil their duties under the CCA.

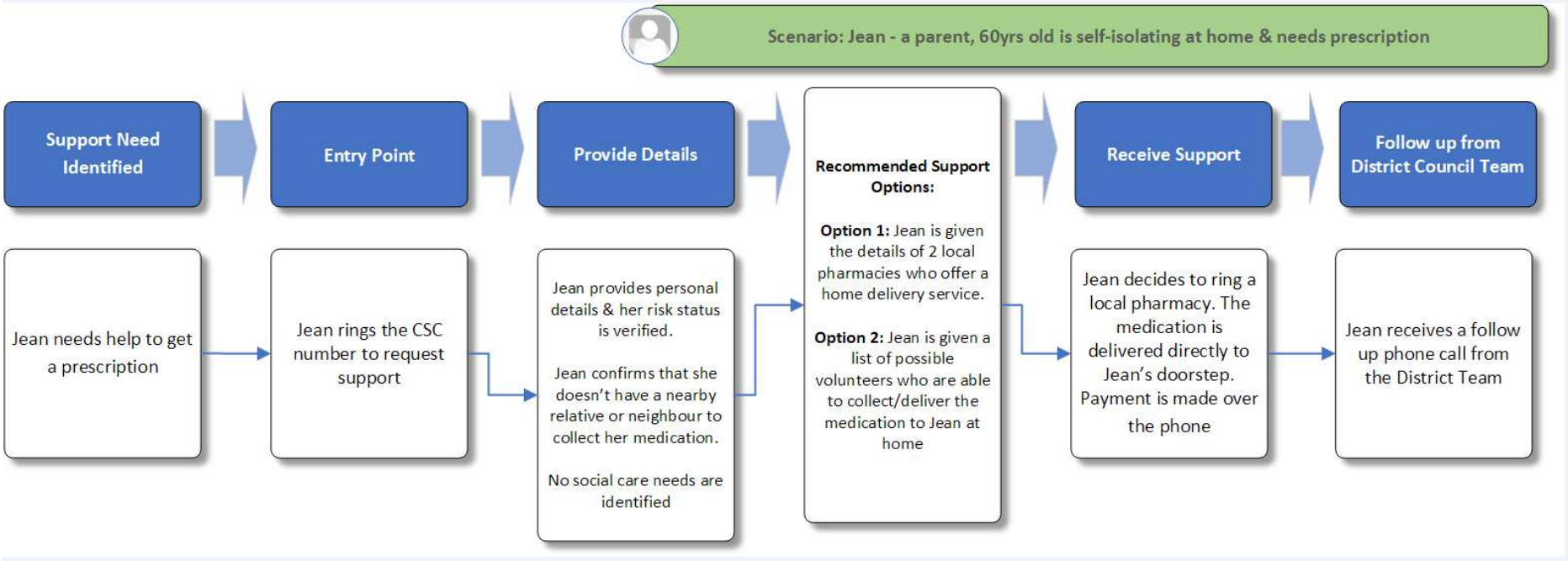
The Nottingham and Nottinghamshire LRF Constitution was approved through the LRF meeting on 20th March 2020 and covers the principles and approach to information sharing amongst partners (at Section 6) in a way which is compliant with data protection obligations. A more detailed but complementary LRF Information Sharing Agreement (ISA) has been drafted, circulated and is with partners for sign-off.

Appendix F
Vulnerable people: customer journey examples




Scenario: Ethel – no family, is EVP categorised, not known to ASCH, running low on food. She has financial means. She is also experiencing loneliness
Support Need Identified
Entry Point
Provide Details
Ethel is advised that as an interim measure, the Hub will arrange for an emergency food package to be delivered to her home.
Primary Support Options:
Option 1: Ethel is given details of local food providers who can deliver food to her home & have priority arrangements for vulnerable persons
Option 2: Alternatively, Ethel can be matched to a suitable volunteer who can visit the local supermarket to purchase/collect the food on her behalf.
Secondary Support Option:
Option 3: Ethel is given details of a community Befriending Service who can provide telephone support
Receive Support
Follow up from District Council Team
Ethel is running low on food and also experiencing lonliness
Ethel's details have been provided through the NHSE database and she receives an initial phone call from the CSC Team to assess any priority food needs.
Initial phone call: Ethel confirms her details & her risk status is verified.
Ethel doesn't have support from a trusted neighbour, friend or family who could buy/ deliver the food to her home.
Ethel does have financial means
Follow up call: Ethel receives a further call from CSC to determine any ongoing support needs. She has no social care needs, but is lonely as a result of self-isolation
An emergency food package is delivered to Ethel's home
Ethel arranges weekly food deliveries with a local food provider
Ethel receives weekly calls from a volunteer at the Befriending Service
Ethel receives a follow up phone call from the District Team


Scenario: John – over 70 years, usually fit, advised to self isolate BUT NOT EVP, low on food, has financial means
Support Need Identified
Entry Point
Provide Details
Recommended Support Options:
Option 1: John receives details of local food providers, including County Enterprise Foods who can deliver food to his home & have priority arrangements for vulnerable persons
Option 2: John is provided with a list of community service providers who can support him to get the food items required
Option 3: John is provided with volunteer matches who can visit the local supermarket to purchase/collect the food on his behalf.
Receive Support
Follow up from District Council Team
John is running out of basic food items
John rings the CSC number to request support
John provides personal details & his risk status is verified
John doesn't have an online supermarket account & isn't confident using IT
John doesn't have support from a trusted neighbour, friend or family to rely on
No social care needs are identified and John has the financial means to pay
John rings County Enterprise Foods (CEF) and arranges to have Meals on Wheels delivered to him each day.
John receives a follow up phone call from the District Team


Scenario: Jean - a parent, 60yrs old is self-isolating at home & needs prescription
Support Need Identified
Entry Point
Provide Details
Recommended Support Options:
Receive Support
Follow up from District Council Team
Jean needs help to get a prescription
Jean rings the CSC number to request support
Jean provides personal details & her risk status is verified.
Jean confirms that she doesn't have a nearby relative or neighbour to collect her medication.
No social care needs are identified
Option 1: Jean is given the details of 2 local pharmacies who offer a home delivery service.
Option 2: Jean is given a list of possible volunteers who are able to collect/deliver the medication to Jean at home
Jean decides to ring a local pharmacy. The medication is delivered directly to Jean's doorstep. Payment is made over the phone
Jean receives a follow up phone call from the District Team

Appendix 2

Local Outbreak Control Plans will centre on 7 themes

1. **Care homes and schools**
   Planning for local outbreaks in care homes and schools (e.g. defining monitoring arrangements, potential scenarios and planning the required response)

2. **High risk places, locations and communities**
   Identifying and planning how to manage high risk places, locations and communities of interest (e.g. defining preventative measures and outbreak management strategies)

3. **Local testing capacity**
   Identifying methods for local testing to ensure a swift response that is accessible to the entire population (e.g. defining how to prioritise and manage deployment, examples may include NHS, pop-up etc).

4. **Contact tracing in complex settings**
   Assessing local and regional contact tracing capability in complex settings (e.g. identifying specific local complex communities, developing assumptions to estimate demand and options to scale capacity)

5. **Data integration**
   Integrating national and local data and scenario planning through the Joint Biosecurity Centre Playbook (e.g., data management planning, including data security, NHS data linkages)

6. **Vulnerable people**
   Supporting vulnerable local people to get help to self-isolate (e.g. facilitating NHS and local support, identifying relevant community groups etc) and ensuring services meet the needs of diverse communities

7. **Local Boards**
   Establishing governance structures led by existing Covid-19 Health Protection Boards in conjunction with local NHS and supported by existing Gold command forums and a new member-led Board to communicate with the general public

Nottinghamshire County Council

Report to the Health & Wellbeing Board

24 July 2020

Agenda Item: 8

REPORT OF THE CORPORATE DIRECTOR FOR ADULT SOCIAL CARE & HEALTH

REVIEW OF THE BETTER CARE FUND PROGRAMME AND USE OF BETTER CARE FUND RESERVE FOR SHORT-TERM TRANSFORMATION PROJECTS

Purpose of the Report

1. To seek approval from the Health & Wellbeing Board for recommendations to improve the implementation and oversight of the Better Care Fund programme in Nottinghamshire.

2. To seek approval from the Health & Wellbeing Board for the Adult Social Care & Health department to use Nottinghamshire County Council's Better Care Fund reserve to fund 16 proposed short-term transformation projects.

Background Information

3. The Better Care Fund programme (BCF) was established in June 2013 within the Government's Spending Review. It was described as creating a national £3.8 billion pool of NHS and Local Authority monies intended to *"join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.*" The programme was created to *"improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them integrated health and social care services, resulting in an improved experience and better quality of life."*

4. The BCF pooled budget consists of various existing funding streams to Clinical Commissioning Groups (CCGs) and local authorities, anticipated annual grants, and recurrent capital allocations. Each organisation has a specified minimum allocation that must be contributed to a BCF pooled fund.

5. Within the BCF pooled budget, the funding streams are:
    a. Protecting social care – to fund adult social care pressures
    b. Care Act 2014 implementation – to fund the cost of the new responsibilities required of Local Authorities
    c. Improved BCF – funding to reduce pressure on the NHS (including hospital discharge), and to stabilise the social care provider market

d. Winter Pressures grant – originally provided in Winter 18/19 to Adult Social Care to support increased demand over the winter, but then made recurrent from April 2019 (same amount over the full year)
e. CCG funding for community services (primary, mental health, community or social care), local authority delivery of reablement and carer support services.
f. Disabled Facilities Grants – capital funding for Housing Authorities to provide adaptations to homes and discretionary schemes that meet the aims of the BCF and support people to stay living independently at home creating a "joined up approach".

6. The value of the BCF pooled budget in 2019/20 was £92.2m for Nottinghamshire.

7. The partners involved in the BCF programme are:
    - Nottinghamshire County Council
    - All district and borough councils in Nottinghamshire
    - NHS Bassetlaw Clinical Commissioning Group
    - NHS Nottingham & Nottinghamshire Clinical Commissioning Group.

8. The BCF programme and associated work is subject to nationally set performance management targets largely established when the BCF was first initiated.

9. For further background about the BCF programme, please see Appendix 1.

10. The budget and partnership work programme is overseen by the BCF Steering Group which is made up of Officers from the core partners. A review of the BCF programme was carried out between September 2019 to March 2020. The findings were reported to the BCF Steering Group. The recommendations from this review are set out in the paragraphs below.

11. The Pooled Budget is fully allocated each year. When the full amount of allocated spend for the Adult Social Care & Health department is not utilised within any financial year, the spare funding is held in a Better Care Fund reserve. There are various reasons why the actual spend may not equal the allocated spend. For example, the service or project may not be fully staffed during the year or the original cost predictions may have been too high. A reserve of £2.6m has built up over the last two years. Reserves can only be used for one-off areas of spend.

The BCF Review

12. The context, scope and main findings of the BCF Review are set out in Appendix 2. In summary, it has been concluded there are some strong areas of integrated service provision across Nottinghamshire and 10 examples of services that are jointly commissioned with health. However, there are various national documents that offer best practice guidance about how to promote integrated approaches. Compared to this guidance, achievements to date in Nottinghamshire show a mixed picture.

The BCF review recommendations

13. To develop a vision for how residents who have a range of health, housing and care needs will be supported in future by services acting in more joined up ways. This vision will be based on stories about the recent experiences that people have had with our services, where they have a range of housing, health and care needs. This will help the BCF programme become more person-centred and make it clearer how integration can improve the experience for residents.

14. To agree and implement developments to improve working arrangements across partners in three priority areas:
    a. Housing responses to support hospital discharge – including homelessness.
    b. Assistive Technology: share best practice, learn about new developments, have compatible systems, use data more proactively to see where people have escalating needs.
    c. Digital integration across partners (e.g. automated workflows to speed up processes between OTs and DFG officers in district / borough councils, sharing information for a single view of the citizen, automated alerts between organisations).

15. To renew the governance structure and reorganise the work that we do together by replacing the BCF Steering Group with two BCF officer groups to focus on:
    a. Integration of Health and Adult Social Care – to provide oversight of existing arrangements and establish a vision, strategy and work plan to expand our integrated approaches in prioritised areas of provider services and commissioning activities.
    b. Housing Partnership – to provide oversight of key workstreams that are needed to coordinate action on issues related to housing, care and health as well as provide a communication channel for housing, health and care to discuss matters of interest as well as build trust and relationships.

16. To establish a BCF business group to manage the administrative aspects of the Plan and reporting requirements across the partners.

Progress since March 2020 and the impact of COVID-19

17. The BCF Steering Group received the review report in February 2020 and discussed the recommendations. A workshop was planned for the Nottinghamshire Health & Wellbeing Board on 1 April 2020 so that members could consider the findings and next steps in 2020/21. Due to the COVID-19 emergency, the Health & Wellbeing Board workshop was cancelled and further development work was paused.

18. A significant consequence of the COVID-19 crisis response was that many positive integrated approaches have developed very quickly across the BCF partners in Nottinghamshire. This was enabled by a variety of factors, including the imposed creation of the Local Resilience Forum structure, new national guidance, the strong working relationships already in place between partners, and the willingness at senior levels to push normal boundaries in order to rise to the crisis.

19. Examples of new integrated partnerships created to respond to COVID-19 include:
    - New virtual hospital discharge “hubs” in North and Greater Notts, where adult social care and community health staff work together seven days per week to agree on the best discharge arrangement for people who need support to leave hospital safely.
    - The Humanitarian Assistance Group and the Community Support Hubs, which link vulnerable people with a range of volunteer support.
    - Coordinated support from health and social care partners is being provided to care homes and home care providers, to help them to sustain their services safely during the emergency.

20. Over the last month, all health and care partners have been reviewing the new services that were put in place to respond to the COVID-19 emergency so that these models can be adapted appropriately as the recovery process continues.

21. The recommendations within this report will support Nottinghamshire to build on lessons related to integration from the COVID-19 emergency and sustain a strong recovery.

Proposed usage of the BCF Reserve

22. A list of proposed short-term transformation projects were developed in 2019/20 (i.e. before the COVID-19 emergency) by the Adult Social Care & Health department to utilise Nottinghamshire County Council's BCF reserve of £2.6m. The projects are summarised in Appendix 3. All the proposed projects were designed to enable social care to manage demand, meet its responsibilities, support the NHS to reduce its pressures, and stabilise the social care market.

23. Approval of the projects could not be sought from the Health & Wellbeing Board before this time as meetings were cancelled in response to the COVID-19 emergency. The projects have been considered in the light of the COVID-19 emergency and some changes have taken place to ensure they are still relevant and supportive of the direction that the Adult Social Care & Health department wishes to take as services move into the recovery phase. All projects will be monitored and evaluated so that any service implications and lessons can be considered towards the end of each project. The total spend allocated is £2.18m which leaves £0.420m remaining in the reserve.

24. The Health & Wellbeing Board are asked to note that the Adult Social Care & Health department will continue to review all actions and plans for recovery. This will be an ongoing exercise as services adapt to new ways of working, create new service offers and find ways to meet the resulting costs. Therefore, some changes may need to be made to the use of the BCF reserve over coming weeks and months.

25. NHS colleagues from NHS Nottingham & Nottinghamshire Clinical Commissioning Group and NHS Bassetlaw Clinical Commissioning Group indicated in March 2020 that they supported the use of Nottinghamshire County Council's BCF reserve for the purposes set on in Appendix 3.

26. The BCF programme will continue until 2023/24. It is recommended that any future underspend on the Adult Social Care & Health department's expenditure from the BCF will continue to be held in a reserve to fund future transformation projects.

Other BCF-related work impacted by the COVID-19 emergency

27. Financial work has continued to confirm overall Quarter 4 BCF expenditure, the Handy Persons Advisory Scheme expenditure in 2019/20 and Disabled Facilities Grant (DFG) expenditure by district / borough councils in 2019/20. Local authorities have been advised that the submission of Quarter 4 reports has been "paused" until the end of July 2020 and will be reviewed at that point.

28. Work to complete the Better Care Fund Section 75 Agreement for 2020/21 is progressing now, having been paused during April and May 2020. The BCF agreement will be varied to include the 2020/21 funding in addition to a new schedule to incorporate hospital discharge terms (as per government guidance in March 2020) and the merger of the Clinical Commissioning Groups.

Other Options Considered

29. The BCF review proposed some other topics that were not ranked as top priorities for countywide work by all members of the BCF Steering Group, as they felt these issues could be developed more effectively at a local level.

30. The BCF Review considered whether to recommend retaining the existing governance structure (i.e. the BCF Steering Group) and the requirement for all business cases for use of capital grant to be approved by the BCF Steering Group. These options were rejected as being less effective than the proposed option.

31. In addition to the proposed projects listed in Appendix 3, other projects were put forward for consideration by the Corporate Director for Adult Social Care & Health in January 2020. These other projects have either been rejected or proposed for funding from other sources.

Reason/s for Recommendation/s

32. The Health & Wellbeing Board is requested to approve the recommendations of the BCF Review because they present an opportunity to improve the effectiveness of the BCF Programme in Nottinghamshire and have received the support of the partners represented on the BCF Steering Group. The recommendations also support the sustainability of the integrated partnership developments that have been implemented to respond to the COVID-19 emergency.

33. The Health & Wellbeing Board is requested to approve that the proposed transformation projects should be funded from Nottinghamshire County Council's BCF reserve, as listed in Appendix 3. These projects will enable social care to manage demand, meet its responsibilities, support the NHS to reduce its pressures, and stabilise the social care market.

Statutory and Policy Implications

34. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

35. The total spend allocated to the transformation projects is £2.18m which leaves £0.420m remaining in the reserve.

Human Resources Implications

36. HR implications involve the following workforce changes:
    a. The temporary Programme Manager Partnerships post (1fte, Band F) within the Integrated Strategic Commissioning & Service Improvement Division to be extended until the end September 2020, to allow for further review of the future requirements for this role.
    b. The temporary Business Support Officer post (0.8 fte, Grade 3) to be extended to end in September 2020, to support recruitment and retention initiatives for front line roles in social care.

c. One Commissioning Officer post (0.8 fte, Band B) to be established for 12 months to implement the Dementia Advance Care Planning & Support project.

Implications for Service Users

37. There are a wide variety of implications for services users that will be delivered by the 16 proposed projects. The outcomes of these projects will benefit all service user groups including older adults, homeless people and people living with disabilities or who need reablement to recover from a health or care crisis. One project will also benefit carers and any other resident who needs access to general advice and information relevant to health and social care.

RECOMMENDATIONS

1) To develop a vision for how residents who have a range of health, housing and care needs will be supported in future by services acting in more joined up ways.

2) To agree and implement developments to improve working arrangements across partners in three priority areas:
   a. Housing responses to support hospital discharge
   b. Assistive Technology
   c. Digital integration across partners.

3) To renew the governance structure and reorganise the work that we do together by replacing the BCF Steering Group with two BCF officer groups to focus on:
   a. Integration of Health and Adult Social Care
   b. Housing Partnership.

4) To establish a BCF business group to manage the administrative aspects of the Plan and reporting requirements across the partners.

5) To approve the list of BCF-funded transformation projects, as set out in Appendix 3.

6) The BCF programme will continue until 2023/24. It is recommended that any future underspend on Adult Social Care & Health expenditure from the BCF will continue to be held in a reserve to fund future transformation projects.

Melanie Brooks
Corporate Director: Adult Social Care & Health
Nottinghamshire County Council

For any enquiries about this report please contact:

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Nottinghamshire County Council
Telephone: 0115 977 3017
Email: wendy.lippmann@nottscc.gov.uk

Financial Comments (OC 15/07/20)

38. £2.60m is currently in the BCF Reserves of which £2.18m of this has been allocated to the transformation projects for 2020/21, leaving £0.42m in the BCF Reserves.

HR Comments (SJJ 18/06/20)

39. The temporary contacts for the current incumbents in the posts of Programme Manager and Business Support Officer will be extended and the temporary Commissioning Officer post will be recruited to on a fixed term contract.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- Simple Guide to the Better Care Fund in Nottinghamshire (Appendix 1)
- BCF Review – context, scope and findings (Appendix 2)
- List of transformation projects (Appendix 3)
- BCF Review reports – first and second stage (available on request)

Electoral Division(s) and Member(s) Affected

- All.

Appendix 1

Simple Guide to the Better Care Fund (BCF) in Nottinghamshire

January 2020

1. Introduction – history and the current funding streams
2. What each area has to do to be granted the funding
3. Governance
4. What services are funded by the programme, by organisation and ICP

1. Introduction

1.1. History

The Better Care Fund (BCF) was announced in June 2013 within the Government's Spending Review. It was described as creating a national £3.8 billion pool of NHS and Local Authority monies intended to:

- support an increase in the scale and pace of integration
- promote joint planning for the sustainability of local health and care economies.

However, the funds that had to be put into the pooled arrangements were not new. This was money that was already funding frontline services in health, social care and local government. Therefore, there was only a limited sense of having a new opportunity to start doing things differently in partnership.

The national requirement was to put a "minimum" amount per CCG and Local Authority into this pooled fund. Partner organisations have the power to put additional funds into the pool.

Since 2013, the focus of the BCF has developed as more funding streams have been added to support social care and allocations have been increased for DFGs. The nature of the national targets have been changed slightly and the NHS targets themselves have been increased each year.

1.2. Current position in 2019/20

The BCF pooled budget is made up of a number of existing funding streams to Clinical Commissioning Groups (CCGs) and Local Authorities, anticipated annual grants, alongside recurrent capital allocations. Each organisation has a specified minimum allocation that they have to contribute to a BCF pooled fund.

The funding streams are:

a) CCG funding for

- community services (primary, mental health, community or

social care)
- local authority delivery of reablement
- carers to receive breaks from caring and other support

b) **Protecting social care** – to help adult social care manage demand and fund services for people with social care needs

c) **Care Act 2014 implementation** – to enable adult social care to fund the cost of meeting the new responsibilities of this legislation

d) **Disabled Facilities Grants** – capital funding for Housing Authorities to provide adaptations to homes and discretionary schemes that meet the aims of the BCF and support people to stay living independently at home creating a "joined up approach". Innovative approaches are welcome. The provision of information and advice about housing issues can also be funded.

e) **Improved BCF** – funding to meet adult social care needs, reduce pressure on the NHS (including hospital discharge), and stabilising the social care provider market

f) **Winter Pressures grant** – originally provided in Winter 18/19 to Adult Social Care to support increased demand over the winter, but then made recurrent from April 2019 (same amount over the full year)

2. What the BCF area has to do to be awarded the funding

Every year, the Department of Health & Social Care and the Ministry of Housing, Communities & Local Government publish a "Policy Framework" for the Better Care Fund. In addition, these two organisations and NHS England publish "BCF Planning Guidance" each year. Both documents are developed in partnership with ADASS and the LGA.

Key messages from the Guidance and Policy Framework for 2019/20 are:

a) It is expected that local areas will be considering how provision across health, local government, social care providers and the voluntary sector can support the shared aims of providing better care at or close to people's home and a clear focus on prevention and population health management.

b) The BCF will continue to provide a mechanism for personalised, integrated approaches to health and care that support people to remain independent at home or to return to independence after an episode in hospital.

c) There are 4 national conditions that must be in place to receive the funds:

- ***There must be an agreed Countywide plan*** (most recently to 31 March 2019) signed off by the local Health & Wellbeing Board. Local plans must align with the BCF national conditions and demonstrate measurable progress in respect of key outcomes.

- ***Investment to maintain provision of social care services*** must be agreed

- ***A specific proportion of the funding must be invested in NHS commissioned out-of-hospital services***

- ***There must be a plan in place to manage transfers of care out of hospital, based on the "High Impact Change Model".*** This Model describes eight themes that are important for having effective patient discharge from hospital. BCF areas must assess themselves against this model as there are 5 stages of maturity. They must be planning to increase their maturity over time. Areas should be at the 3rd level "Established" across all 8 themes as a minimum.

d) As long as these conditions are satisfied, the BCF partners can use the available funding as they choose but must be able to show how the spending is helping them to meet the four national targets set out below.

e) The four national targets are:

1. ***Level of emergency/unplanned admissions to hospital*** – per 100,000 population

2. ***Annual rate of admissions to residential and nursing homes for older adults*** (aged 65+)

3. ***Effectiveness of reablement services*** (proportion of older people discharged from hospital who receive reablement services and are still at home, 91 days after discharge)

4. ***Delayed transfers of care*** – how many days of delay in hospital were experienced by people after they were well enough to be discharged

These targets have stayed the same since the BCF was established to allow comparison of progress over time.

The level of Targets 1 and 4 are set nationally. Targets 2 and 3 are set by the local area.

f) Expected output measures must be shown in the BCF plan.

Service	Unit
Domiciliary care	Packages/hours of care
Reablement/rehabilitation	Packages/hours of care
Bed-based intermediate care Step up/step down	Number of beds
Residential placements	Placements
Personalised care at home	Packages

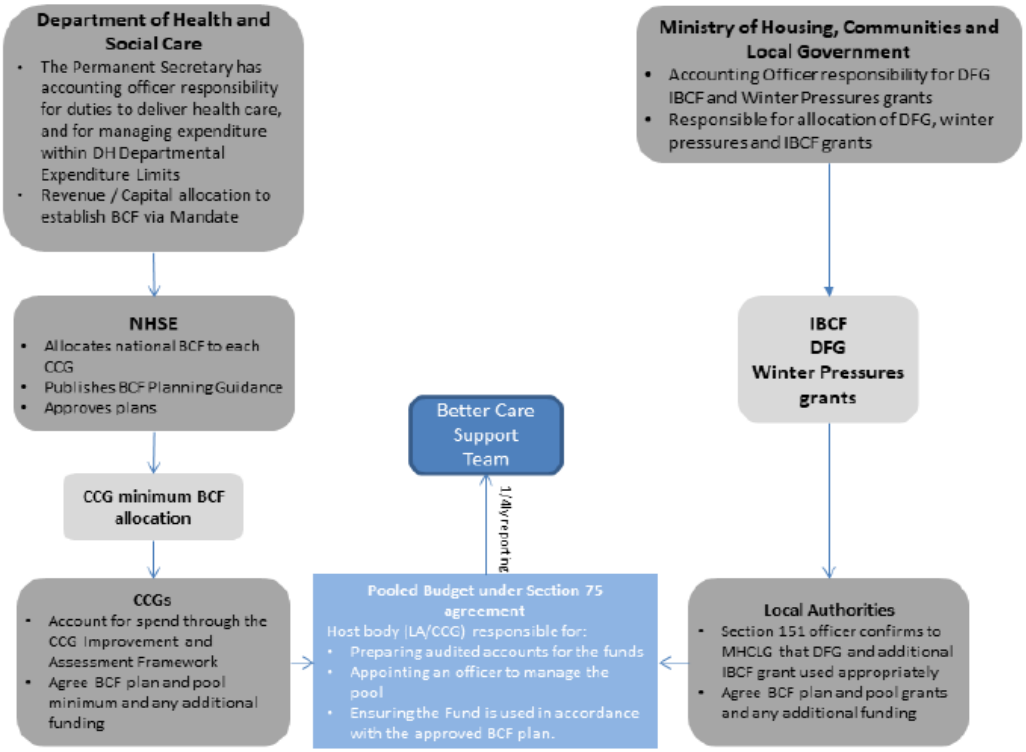
g) The DFG grant must be spent in accordance with the BCF plan. In two-tier areas, decisions around the use of DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions.

h) As part of their programme to join up services and improve delivery of services to meet the four national targets, it is expected that BCF areas will also want to use their plan to:
   a. Develop delivery of 7-day services across health and social care
   b. Improve data sharing between health and social care
   c. Ensure a joint approach to assessments and care planning
   d. Address health inequalities in their area and reduce inequalities for people with protected characteristics under the Equality Act 2010.

i) Local areas should also ensure that the financial planning and overall approach to integrated care within BCF plans is aligned to their local ICS plans, as these plans are also required to plan for the integration of service delivery across local systems.

3. Governance – how the BCF programme is managed and changed

3.1. The national funding cycle

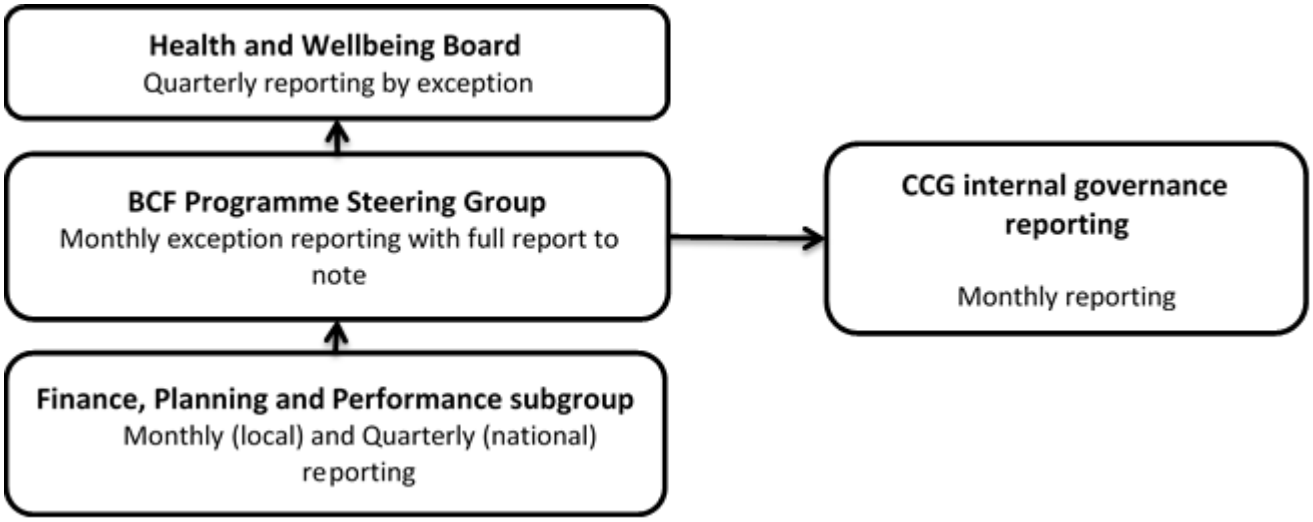


3.2. Local oversight and monitoring

The Health & Wellbeing Board is accountable for the administration and agreement of the BCF. A governance structure has been put in place to undertake work on behalf of the Board.

The purpose of the BCF Steering Group is to provide system leadership to ensure delivery of the BCF plan to improve outcomes for the people of Nottinghamshire. The Steering Group reports to the Health & Wellbeing Board, with the main focus being upon delivery assurance and proactive performance management of the agreed County-wide plan.

The purpose of the BCF Finance, Planning and Performance subgroup is to report and monitor progress in implementation of the BCF plan in terms of scheme delivery, delivery of the national and local performance and finance metrics, and delivery of the pooled budget. The group monitors risks to delivery and identify mitigating actions at unit of planning level.



Note – the BCF Steering Group has been meeting quarterly during 19/20. The Finance Planning and Performance sub-group has been meeting every 6 weeks rather than monthly.

3.3. Changes to the Plan

The BCF Plan has to be agreed each year by all the partners and approved by the Health & Wellbeing Board. The timing of this is dependent on when the national guidance is received for developing the Plan. Usually the Plan for the following year is developed between January to March and submitted to the Health & Wellbeing Board between April to June. This is the main point at which investment and scheme arrangements are changed.

If local areas want to change or decommission schemes, or invest in new schemes during the year, the plan must be jointly agreed and resubmitted to the Health & Wellbeing Board. Then it must be resubmitted nationally with an explanation of the changes.

4. BCF Funding and local service provision – 2019/20

4.1. Overall funding

Running Balances	Income £ m
Minimum CCG Contribution	55.3
iBCF	26.5
DFG	6.9
Winter Pressures Grant	3.5
Additional LA Contribution	£0
Additional CCG Contribution	£0
Total	£92.2

Required Spend	Minimum Required Spend £ 000s
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£15,703
Adult Social Care services spend from the minimum CCG allocations	£21,452

The minimum CCG contribution includes funds that allocated to NHS services (community, mental health and primary care) as well as funds that are passed to the County Council to make up the following funding streams:

Protecting Social Care	£ 17.9m
Care Act Implementation	£ 2.2m
Support for carers	£ 1.3m

Therefore in total, the County Council has £ 51.4m to spend using BCF funds. (i.e. the above 3 funding streams from the CCG, iBCF and the Winter Pressures grant). The CCGs have £ 33.9m to spend and the District and Borough Councils have £ 6.9m to spend.

4.3. Services being funded by the Clinical Commissioning Groups

Bassetlaw

Theme	Description	Value £ 000s
Discharge/Assessment Inc. Intermediate Care	Rapid Response, Falls Team, Discharge Team at Bassetlaw Hospital, ICELS (community equipment and aids), Intermediate Care, Discharge to Assess schemes, Mental Health intermediate care, Prevention LES, Care of the Elderly scheme	3437
Neighbourhood Teams and 7 Day Access To Services	Community staffing in Integrated Neighbourhood Teams, social prescribing, other costs within the Nottinghamshire Healthcare NHS Trust block contract, Care Home LES	1068
Mental Health Liaison	MH liaison staff to support people in crisis to avoid hospital admission and street triage scheme	466
Respite Services	Funding of Bluebell Wood short breaks home	21
Improving Care Home Quality	QIF scheme	31
Telehealth	Packages of telehealth for individuals	20
Total		5043

LESs are Local Enhanced Service arrangements, generally between the CCG and a GP. They are effectively a mini contract with quite a tight objective.

QIF is the Quality Initiative Fund. This scheme is to incentive primary care to work with Care Homes to help ensure residents do not attend hospitals unnecessarily.

4.4. Services being funded by the District and Borough Councils

The DFG funding is capital money which can be used for a variety of purposes including:

a) Major adaptions to the person's home (e.g. to introduce a level access shower, downstairs wet room or toilet, lifts). Normally schemes would not exceed the £ 30k level but Councils have a discretionary power to fund an additional amount, currently agreed as £ 10k. Beyond this level, the County Council has a statutory duty to meet additional costs. Some schemes for disabled children are very expensive (e.g. £ 60-90k).

b) Minor adaptations including stairlifts, ceiling track hoists, ramps

c) Contribution to the countywide HPAS service (Handy Persons Adaptations Scheme)

d) Assistive Technology schemes

e) Warm Homes on Prescription schemes

f) Independent Living capital builds

g) Other relevant capital schemes (e.g. dementia bungalows, temporary accommodation for hospital discharge patients with housing needs)

This table shows planned expenditure for 19/20, including carry forward from 18/19.

District	DFG Schemes	HPAS	WHOP	AT	Independent living	Other	Total
Ashfield	807	75	141				**1023**
Bassetlaw	810	95	50			225	**1180**
Broxtowe	802	70	35			271	**1178**
Gedling	959	85	90	10		135	**1279**
Mansfield	1210	102	100	40		35	**1487**
N & S	851	83	105	50	39		**1128**
Rushcliffe	547	54	54		12		**667**
Total	**5986**	**564**	**575**	**100**	**51**	**666**	

Please note that this information has been provided by the relevant partners or gleaned from existing spreadsheets.

Wendy Lippmann
Programme Manager: Partnerships
Nottinghamshire County Council
17 January 2020

Nottinghamshire County Council

Report to the BCF Steering Group

27 February 2020

Agenda Item:

REPORT OF PROGRAMME MANAGER PARTNERSHIPS

EXECUTIVE SUMMARY, BCF REVIEW – SECOND STAGE

Purpose of the Report

The purpose of this report is to:

1. Review the effectiveness of the BCF Steering Group to drive strategic transformation across health, housing and social care partners
2. Clarify how the outcomes being achieved by the BCF investment compare to national requirements
3. Explore how the BCF programme relates to the Health and Wellbeing Board (HWB)
4. Set out how well we are meeting our duties to integrate service provision
5. Develop three priority work topics supported by the BCF Steering Group in January 2020
6. Recommend how to increase the effectiveness of the BCF partnership

1. How well does the BCF Steering Group drive strategic transformation?

a) The BCF steering group is only delivering transformational change in one part of our system. This is enabling more consistency of practice about the use of DFG grants.

b) What the steering group does well is to provide an administrative mechanism for approving BCF spend, plans and noting performance against the BCF national indicators.

c) The steering group does not have the remit or authority to challenge how the BCF is spent by health and social care partners. It does have the remit and authority to challenge use of DFG by District and Borough Councils for one-off capital spend but there is no consensus from members that this is an appropriate use of the group's influence and time.

d) Success with projects and services funded by BCF is not being reported to the steering group so there is no opportunity to understand benefits, learn lessons and encourage countywide consistency.

e) The steering group cannot and does not hold other groups and Boards to account for performance against BCF national targets. For example, performance against the BCF Delayed Transfer of Care target has remained below target for the last 3 years.

2. Outcomes being achieved by services funded from the Better Care Fund

a) Based on an analysis of the number of schemes which support each of the national BCF requirements, the most commonly supported BCF criteria are:
   - Reduction in unplanned admissions to hospital – 46 schemes
   - Prevention services (to prevent escalation of need) – 44 schemes

- NHS commissioned out of hospital care – 38 schemes

b) The least commonly supported BCF criteria across all the schemes are:
   - Maintenance of social care services – 8 schemes
   - Population health management – 5 schemes
   - Data sharing between health and care – 3 schemes

c) An analysis by amount of funding would produce a different ranking. However further detail is needed to enable this analysis.

d) It is difficult to draw any conclusions from this analysis because there is no agreed framework to suggest that particular criteria should be supported more than any other criteria, either in qualitative or quantitative terms. In addition, BCF schemes are only a subset of the schemes that deliver the BCF criteria and as such does not represent the totality of transformational change and spend.

3. Health and Wellbeing strategy implementation

a) The Health and Wellbeing Board (HWB) has **five legal duties** which include to improve the health and wellbeing of the people of Nottinghamshire, to reduce health inequalities and ***promote the integration of services***. The Joint Health and Wellbeing Strategy for Nottinghamshire 2018-2022 has been developed to realise these duties.

b) To implement this strategy, the Healthy and Sustainable Places Coordination Group (HSPCC) oversees agreed actions against the 17 priority themes (e.g. homelessness, physical activity, mental wellbeing including dementia, warmer and safer homes, stronger and resilient communities, carers).

c) There is no workstream which focuses on integration of services across health and social care or the development of partnerships related to housing, health and care. These are gaps in our strategic framework.

4. Work underway in Nottinghamshire to integrate services

a) The Health and Wellbeing Board has a legal responsibility to promote integration across services and the BCF Steering Group is the only forum that meets countywide with officers attending from health, adult social care and all District and Borough Councils. This puts the HWB and the BCF Steering Group in a good position to develop a vision for integration and oversee integration developments.

b) Despite this context, the BCF steering group has not acted as a driver for integration and there is ***no clear statement that sets out a strategic vision*** to guide the development of service integration across Nottinghamshire.

c) Even though there is no agreed vision for integration, progress has been made across the County to develop 11 areas of integrated working at the front-line of health and social care, and in some cases, integrate with housing services as well. There are 10 examples of joint or integrated commissioning happening in Nottinghamshire. However, the services commissioned through these arrangements are relatively small.

d) Although these pockets of integrated practice exist, there is no strategic oversight to coordinate the direction of travel, ensure that progress is maintained, barriers are addressed quickly and that lessons are learnt and shared. This kind of strategic oversight and agreed vision is recommended by national guidance documents about integration.

5. Potential work topics supported by BCF partners from the First Stage report.

a) The BCF Steering Group discussed possible key areas for partnership work topics at its January 2020 meeting and proposed the following:
- Housing responses to support hospital discharge
- Assistive Technology
- Digital integration to improve frontline working across partner agencies

b) Immediate action will be taken to start conversations about housing pathways for hospital patients. A countywide working group on Assistive Technology has started to meet, coordinated by Connected Notts. Digital integration between adult social care (ASC) and Housing Authorities will be developed through the use of available BCF reserve available to ASC in 20/21. Digital integration between ASC and health providers will continue to develop into 20/21.

6. Recommendations of the BCF Review Second Stage:

1. To renew the way we do business together in order to achieve the aims of the Better Care Fund more effectively. This work could be organised as an overall Health, Housing and Care programme that has two main elements:

   a. **Integration of Health and Adult Social Care** – to provide oversight of existing arrangements and establish a vision, strategy and work plan to expand our integrated approaches in prioritised areas

   b. **Housing Partnership -** to provide oversight of key workstreams that are needed to coordinate action on particular issues related to housing, care and health as well as provide a communication channel for housing, health and care to discuss matters of interest as well as build trust and relationships.

   c. **Plus a BCF business group** – to manage the administrative aspects of the Plan and reporting requirements across the partners

The BCF steering group could be replaced by new oversight Boards to shape and implement these programmes. A workplan would be agreed to take forward key priorities in 20/21.

2. To implement these activities which support this partnership agenda:

   a) Gather stories about resident experiences with our services – good and not so good – to inspire us to develop our vision and address barriers to integration.

   b) Establish a time-limited group to focus attention on the Nottinghamshire BCF Delayed Transfers of Care target, to address continued low performance

c) Take forward the actions set out in section 5 above linked to housing and hospital discharge pathways, Assistive Technology and Digital Integration.

Appendix 3
Better Care Fund, budget proposals for use of reserve

Ref	Theme	Bid Name	Description of proposal	Which Nottinghamshire residents will benefit from this project ?	Cost 1 year £ 000s
1	Supporting the NHS to manage pressures	Making Our Place a Great Place to Grow Old in - front door Social Workers	2 social workers to be based at Front Door at NUH and Bassetlaw Hospital, 5 days pw to support admission avoidance, advise on safeguarding etc.	People attending Emergency Departments who need social care support and do not need to be admitted to hospital	118.0
2	Managing social care demand	Managed change in social work culture and practice.	Engage a change management consultant to work alongside ASCH workforce to develop innovation sites that change culture and practice.	All residents supported by ASCH using a strengths based approach	250.0
3	Supporting integration and partnership working	Partnerships Programme Manager Post	Work with partner agencies to implement a revised BCF Programme of transformational change which enables the NHS, social care and district councils to provide services in ways that are not being addressed by other initiatives. Work with joint commissioners in CCGs to explore the opportunities for joint commissioning across health and ASCPH. Manage the staff within the Partnerships Team.	All residents who have both health and social care needs, where services need to operate seamlessly together	40.0
4	Managing social care demand	Temp BSO to support recruitment & retention initiatives.	Temporary Business Support Officer post to support Recruitment and Retention initiatives for front line roles in social care. Agreed to use BCF reserve to fund a 6 m extension of this post until the BSO review is completed. We want the post to be funded recurrently within the Departmental budget.	All residents who need support and service from ASCH front line staff	10.4
5	Managing social care demand	Social Care Accommodation Investment Plan.	Employ specialist skills to support the development of a Social Care Accommodation Investment plan. This plan will develop a range of new housing solutions utilising council assets to help vulnerable people access good quality, affordable and suitable accommodations.	All residents who may need more appropriate housing options in the future	60.0
6	Supporting self-care and prevention	New Platform for Notts Help Yourself.	Develop and migrate the Notts Help Yourself website to a new platform and develop its functionality.	All residents who need information about social care provision and advice about how to stay independent and well	100.0
7	Supporting self-care and prevention (housing)	DFG Preliminary Test of Resources Online Calculator	An online calculator that can give an indicative idea of whether a person would be grant eligible or must pay a contribution to the cost of works. Alongside this, information and signposting advice for housing options and other information relating to simple environmental changes, e.g. Handy Persons Advisory Service	All residents who are considering having an adaptation to their home	3.0
8	Supporting the NHS to manage pressures and managing social care demand	Extra Home First Capacity to mitigate the withdrawal of EDASS (Emergency Department Admissions Avoidance Service)	Funding of additional packages from Home First to compensate for loss of EDASS from July 20.	All hospital patients who need urgent support to enable them to leave hospital quickly with the right support	329.2
9	Supporting the NHS to manage pressures and managing social care demand	Dementia Advance Care Planning and Support.	Using a co-production approach, implement a standardised countywide package for people living with dementia and their carers to engage with advance care planning, map dementia pathways and make recommendations for improvement.	All residents who have dementia and their carers	48.6
10	Supporting integration and partnership working	ICT Partner Integration Programme.	Deliver a series of products and services building on the output from the initial ICT Health Integration Programme (2017-2020). This proposal sets out an ambition to work with other partners such as the Ambulance Service (East Midlands Ambulance Service), Nottinghamshire Healthcare Trust (NHCT), GPs, District Councils, Care Homes and Home Care Providers, building on the work done to date.	All residents who are supported by external partners, where those partners would benefit by sharing information with ASCH	345.0
11	Supporting self-care and prevention	Community Assets developments	Funding to invest in a range of projects that will encourage community asset development in support of ASC aims and objectives, once a strategy has been produced to guide this investment.	All residents who would benefit from having support available in their local community, to stay well and independent	466.0
12	Managing social care demand	Additional Assistive Technologies.	Introduce fast-track monitoring system assessments for people with dementia. Enable access to enhanced activity monitoring systems for people with dementia. Provide mobile phone support for people without landlines. Provide specialist equipment to meet currently unmet needs.	All residents with dementia and other people who need to use assistive technology but do not have a landline.	97.0
13	Managing social care demand	System development and new tablet devices to enable new working processes within START	Processes developed by the START Efficiencies Programme require tablet devices to work effectively - smart phones and/or laptops do not meet the requirements.	All residents supported by Start Reablement.	210.0
14	Managing social care demand	OTAGO Falls Prevention Training	Train 40 ASCH OTs & CCO/OTs on the 4-day OTAGO falls prevention course to enable them to demonstrate this exercises to their reablement clients, improving their strength & balance and helping prevent falls. Note - OTAGO is a particular brand of exercise methodology.	All residents who have balance and mobility problems that affect their risk of falling.	22.0
15	Supporting the NHS to manage pressures	Clinical monitoring and early intervention in home based care	Working with a lead home based care provider to develop and provide enhanced training to care workers to enhance their knowledge on the early recognition and early intervention of clinical deterioration and ill health - preventing hospital admission or readmission. A further element could be for the home based care provider to develop a Clinical Lead linked to the Assessment Workers to provide initial clinical input where appropriate. (8 months only)	All residents supported by a particular home care provider who have complex and unstable health needs.	58.7
16	Supporting the NHS to manage demand and managing social care demand	Review of Homelessness Support Services	Independent consultancy review of the support provided to adults experiencing homelessness or at risk of homelessness in Nottinghamshire - to inform recommendations to improve commissioning and strategic response for single adults at risk of homelessness, preventing exacerbation with high associated health and social care costs.	All homeless people in Nottinghamshire.	25.0
				Total	**2183**
				Available	2602
				Remaining	420

17.6.20

Nottinghamshire County Council

Report to the Health & Wellbeing Board

24 July 2020

Agenda Item: 9

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

UPDATE TO THE NOTTINGHAMSHIRE PHARMACEUTICAL NEEDS ASSESSMENT 2018-21 AND COVID-19 UPDATE ON THE 2021-24 REFRESH

Purpose of the Report

1. To seek approval for the publication of a Supplementary Statement to update the Pharmaceutical Needs Assessment (PNA) 2018-21 for Nottinghamshire, based on changes to services from October 2019 until March 2020.

2. To provide an update on the requirement to produce a refreshed PNA being delayed from April 2021 to April 2022, due to COVID-19.

Information

3. The Pharmaceutical Needs Assessment (PNA) 2018-21 for Nottinghamshire was published in April 2018 following approval by the Health & Wellbeing Board in March 2018.

4. The PNA describes available pharmaceutical services across Nottinghamshire County and assesses whether these services meet the needs of the population.

5. Pharmaceutical services include contracted 'essential services' such as providing prescription medicines and safe disposal of medicines. In addition, community pharmacies are important providers of supplementary health services to their communities such as medicines reviews, health promotion and self-care services (such as emergency hormonal contraception and minor ailments).

6. The PNA provides NHS England with robust and relevant information to support decisions around new and altered pharmaceutical services. The Health & Wellbeing Board is included in the consultation for these pharmacy applications.

7. The PNA is governed by Regulations issued by the Department of Health & Social Care. These Regulations require that periodic Supplementary Statements are prepared and published where there are changes to pharmaceutical services which do not warrant a complete review of the PNA.

8. Changes to pharmaceutical services from October 2019 until March 2020 are summarised in Appendix 1.

9. The majority of the changes relate to changes of supplementary hours which are those offered by pharmacies over and above the core hours required (i.e. 40 hours per week). There have been two closures of pharmacies during this period.

10. The PNA does not identify any significant gaps in pharmaceutical services for the Nottinghamshire County population and these changes do not impact on that assessment.

Pharmacy applications

11. There have been no new pharmacy applications during this period.

Pharmaceutical Needs Assessment Refresh delayed from 2021 to 2022

12. The current Pharmaceutical Needs Assessment (PNA) was due to be refreshed and published by April 2021. As a result of COVID-19 this has been postponed to April 2022 following an announcement from the Local Government Association on 21 May 2020: "*Due to current pressures in response to the COVID-19 pandemic, the Department of Health & Social Care has today announced that the requirement to publish renewed Pharmaceutical Need Assessments will be suspended until April 2022. Your Health & Wellbeing Boards will retain the ability to issue supplementary statements to respond to local changes and pharmaceutical needs during this time. The NHS Pharmaceutical and Local Pharmaceutical Services Regulations 2013 will be updated in due course*".

13. The Nottinghamshire County and Nottingham City multi-agency PNA Steering Group established to deliver this work have since paused their current project plan and agreed to resume meetings in late 2020 to align with the new timescales.

14. A paper outlining the approach to the PNA refresh in more detail will be presented to the Health & Wellbeing Board in the middle of 2021, once the PNA Steering Group has resumed meetings and revised project plans have been developed. Quarterly Supplementary Statements will continue to be produced until the PNA refresh is completed.

Other Options Considered

15. An assessment of need was undertaken during the preparation of the PNA 2018-21.

Reason/s for Recommendation/s

16. The Pharmaceutical Needs Assessment is a statutory responsibility of the Health & Wellbeing Board. Supplementary Statements are a requirement of the Regulations where changes do not warrant a full refresh of the PNA.

Statutory and Policy Implications

17. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty,

safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

18. There are no financial implications arising from the contents of this report.

RECOMMENDATIONS

1) The Health & Wellbeing Board approves the Supplementary Statement to the Pharmaceutical Needs Assessment 2018-21, for the period October 2019 until March 2020.

2) The next Supplementary Statement for the period April 2020 to September 2020 is presented to the Health & Wellbeing Board for approval in January 2021.

3) The Health & Wellbeing Board approves the planned approach to the 2022-25 Pharmaceutical Needs Assessment refresh with a more detailed paper outlining a project plan being presented to the Board in mid-2021.

Jonathan Gribbin
Director of Public Health
Nottinghamshire County Council

For any enquiries about this report please contact:

Lucy Hawkin
Public Health & Commissioning Manager
Nottinghamshire County Council
Email: lucy.hawkin@nottscc.gov.uk

Constitutional Comments (SS 19/06/2020)

19. This report is appropriately presented to the Health & Wellbeing Board.

Financial Comments (DG 19/06/20)

20. There are no financial implications arising from the contents of this report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Nottinghamshire Pharmaceutical Needs Assessment
www.nottinghamshireinsight.org.uk

Approval of the Pharmaceutical Needs Assessment
Report to the Health & Wellbeing Board
March 2018

Pharmaceutical Needs Assessments: Information Pack for Local Authority Health & Wellbeing Boards
Department of Health & Social Care
May 2013

Electoral Division(s) and Member(s) Affected

- All.

Appendix 1

Nottinghamshire Pharmaceutical Needs Assessment 2018 - 2021

Supplementary Statement for October 2019 - March 2020 (Q3-Q4)

The information contained in this supplementary statement supersedes some of the information provided in the original Pharmaceutical Needs Assessment 2018-2021 for Nottinghamshire and should be read in conjunction with that document.

Statement Number	Date of effect	Pharmacy Name and address	Details of change	Other details
1	01/10/2019	Lloyds Pharmacy Sainsburys Store Nottingham Road Arnold NG5 6BN	Change of supplementary hours **From**: Mon – Sat: 8am - 9am / 12pm - 2pm / 5pm - 10pm Sun: 10am - 11am / 3pm - 4pm **To:** Mon – Sat: 8am - 9am / 12pm - 2pm / 5pm – 8pm Sun: 10am – 11am / 3pm – 4pm	
2	05/10/2019	Well Pharmacy The Ropewalk Southwell NG25 0AL	Permanent closure of pharmacy.	
3	30/12/2019	Peak Pharmacy Kings Medical Centre King Street Sutton-in-Ashfield NG17 1AT	Change of core hours **From**: Mon – Fri: 8.30am – 12.30pm / 1pm – 5pm **To:** Mon – Fri: 8.30am – 1pm / 1.30pm – 5pm Change of supplementary hours **From**: Sat: 9am – 1pm **To:** Mon – Fri: 5pm – 6pm Sat: 9am – 12pm	

Statement Number	Date of effect	Pharmacy Name and address	Details of change	Other details
4	04/01/2020	Gilbody Pharmacy Mansfield Road Skegby Sutton In Ashfield NG17 3EE	Change of supplementary hours **From:** Sat: 9am-1pm **To:** Sat: nil	
5	27/01/2020	Brinsley Pharmacy 1 Brynsmoor Road Brinsley NG16 5DD	Change of supplementary hours **From:** Fri: 9am – 6pm Sat: 9am – 12pm **To:** Fri: 9am – 7pm Sat: Nil	
6	30/01/2020	Well Pharmacy 2 The Square Keyworth NG12 5JT	Change of supplementary hours **From:** Sat: 8.30am – 1pm **To:** Sat: Nil	
7	29/02/2020	Superdrug Pharmacy 36 Stodman Street Newark NG24 1AW	Permanent closure of the pharmacy.	
8	23/03/2020	Well Pharmacy Crown Farm Way Forest Town Mansfield NG19 0FW	Change of supplementary hours **From:** Mon – Fri: 8:30am – 9am / 1pm – 2pm / 6pm – 7pm **To:** Mon-Fri: 8:30am - 9am / 1pm – 2pm / 6pm – 6.30pm	
9	29/03/2020	Well Pharmacy 22a Main Road Radcliffe on Trent NG12 2FH	Change of supplementary hours **From:** Sat: 9am – 2pm **To:** Sat: Nil	

Statement Number	Date of effect	Pharmacy Name and address	Details of change	Other details
10	29/03/2020	Well Pharmacy Rainworth PCC Warsop Lane NG21 0AD	Change of supplementary hours **From:** Sat: 9am – 12pm **To:** Sat: Nil	
11	29/03/2020	Well Pharmacy 2 The Square Keyworth NG12 5JT	Change of supplementary hours **From:** Mon, Tues Wed & Fri: 1pm – 2pm / 6pm – 6.30pm Thu: 12pm – 1pm / 6pm – 6.30pm **To:** Mon, Tues Wed & Fri: 1pm – 2pm Thu: 12pm – 1pm	This is the second change within this quarter
12	29/03/2020	Well Pharmacy 130-132 Forest Road Annesley Woodhouse NG17 9HH	Change of supplementary hours **From:** Mon, Tue, Thu & Fri: 6pm – 6.55pm Sat 9am - 1pm **To:** Mon, Tue, Thu & Fri: 6pm – 6.15pm Sat: Nil	

Please note that due to COVID-19 pharmacies should be following the Standard Operating Procedures (SOP) guidance which advises pharmacies to reduce operating hours to maintain safety. Following this and other individual circumstances such a staff sickness, pharmacies opening hours are likely to be frequently changing during this current time and these supplementary statements will not be able to reflect this. During this time individual pharmacy websites are likely to provide the most up to date information regarding opening hours.

Nottinghamshire County Council

Report to Health and Wellbeing Board

24 July 2020

Agenda Item: 10

REPORT OF THE SERVICE DIRECTOR, CUSTOMERS GOVERNANCE AND EMPLOYEES

WORK PROGRAMME

Purpose of the Report

1. To consider the Board's work programme for 2020/21.

Information

2. The County Council requires each committee, including the Health and Wellbeing Board to maintain a work programme. The work programme will assist the management of the committee's agenda, the scheduling of the Board's business and forward planning. The work programme will be updated and reviewed at each pre-agenda meeting and Board meeting. Any member of the Board is able to suggest items for possible inclusion.

3. The Health and Wellbeing Board's work programme has been disrupted by the COVID-19 pandemic. The work programme is therefore being reviewed and reprioritised, and a revised draft will feature on the agenda of the next Board meeting.

Other Options Considered

4. None.

Reason/s for Recommendation/s

5. To assist the Board in preparing its work programme.

Statutory and Policy Implications

6. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

1) That the Board notes that the work programme is currently under review.

Marjorie Toward
Service Director – Customers, Governance and Employees

For any enquiries about this report please contact: Martin Gately, x 72826

Constitutional Comments (HD)

1. The Board has authority to consider the matters set out in this report by virtue of its terms of reference.

Financial Comments (NS)

2. There are no direct financial implications arising from the contents of this report. Any future reports to the Board will contain relevant financial information and comments.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All