ROTHERHAM COVID-19 OUTBREAK CONTROL PLAN

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www.rotherham.gov.uk

Rotherham Metropolitan Borough Council

Director of Public Health	Teresa Roche	teresa.roche@rotherham.gov.uk
Consultant in Public Health	Alex Hawley	alex.hawley@rotherham.gov.uk
Consultant in Public Health	Gilly Brenner	gilly.brenner@rotherham.gov.uk

Version	Amended by	Comments
Version 6.0	Alex Hawley,17/06/20	Amended following comments from Health Protection Board, 16/06; and comments from Emergency Planning. Submitted to SY peer review process 17/06/20
Version 6.0a	Alex Hawley, 18/06/20	Added reference to Equalities Assessment to be carried out
Version 7	Alex Hawley, 23/06/20	Amendments from TR, Cllr Roche, GB, and Peer Review.
Version 8	Alex Hawley, 24/06/20	Amendments from LA, WA Schools response flowchart added. Shared with Health Protection Board 24/06/20
Version 9	Alex Hawley, 24/06/20	Further amendment for WA Amended to reflect comment at Tactical MG. Amended in light of comments at Health Protection Board, and following completion of self-assessment for LRF SCG.
Version 9a	Alex Hawley, 25/06/20	Single amendment to version control table (V7 comments)
Version 10	Gilly Brenner	Minor amendment to p23, in light of comments Senior Leadership Team/Assistant Director Gold meeting

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STATUS OF THIS DOCUMENT

This plan is a high-level outbreak control plan, and the detail of its implementation is being developed in parallel, and will continue to develop in the light of real experience responding to outbreaks. This plan is also likely change to some extent over time, and it will be kept under review, and updated as appropriate. Everything that is included in the plan is therefore accurate at the date of the plan, but subject to change.

CHAPTER ONE
BACKGROUND

In May 2020, Directors of Public Health were mandated to develop a local COVID-19 outbreak control plan, to reflect an appreciation that a strong local response is essential if COVID-19 is to be successfully mitigated across the country.

The Local Outbreak Control plans are therefore seen as integral to the national Test, Trace, Contain and Enable strategy. However, their scope is much wider than simply implementing testing and contact tracing at the local level. National guidance identifies seven themes that should be addressed by the plan:

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, 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**	porting 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

Purpose and ownership of the plan

This plan provides a framework for Rotherham's multi-agency response to localised outbreaks of COVID-19 and shows how Rotherham's arrangements sit within with regional and national systems for prevention and control of the COVID-19 epidemic.

This plan is maintained and updated by members of the Rotherham COVID-19 Health Protection Board (formed on 9th June 2020), chaired by Rotherham's Director of Public Health, and is overseen by the Rotherham Local Outbreak Engagement Board, chaired by the Leader of Rotherham Metropolitan Borough Council.

Legislative context

In the majority of outbreak situations individuals, communities and settings cooperate fully in measures required to reduce risk of transmission. However, in complex outbreaks a range of restrictions might need to be made on individuals' movements or restricting access to areas. The enforcement of such restrictions will only be possible through the use of available legislation, which delegates powers to various individuals/bodies, including the Directors of Public Health and the Secretary of State for Health and Social Care.

The main legislation and regulations related to the roles and responsibilities involved in the management of a communicable disease outbreak or incident are:

- Public Health (Control of Disease) Act 1984 as updated by Health and Social Care Acts 2008 and 2012
- NHS Act 2006 as amended by Section 11 of the Health and Social Care Act 2012
- Civil Contingencies Act 2004
- Health and Safety at Work Act 1974
- Local Government Act 1972;
- Local Authorities (Public Health Functions and Entry to Premises by Local Health watch Representatives) Regulations 2013
- Health Protection (Notification) Regulations 2010 (SI 2010/659)
- Health Protection (Local Authority Powers) regulations 2010 (SI 2010/657)
- Health Protection (Part 2A Orders) Regulation (SI 2010/658)
- Civil Contingencies (Emergency Planning) Regulations 2005
- Coronavirus Act 2020
- The Health Protection (Coronavirus) Regulations 2020 (SI2020/129)
- The Health Protection (Coronavirus, Restrictions) (England) Regulations 2020 (SI2020/350).

Guiding principles

The plan will take a whole system approach to preventing and managing outbreaks of COVID-19 in Rotherham.

The most relevant, reliable and timely information, data and intelligence will be used to inform actions and monitor outcomes.

The plan works from the assumption that responding organisations will commit and contribute such resources as are required to enable the plan to be as effective as possible.

Existing roles and structures which are working well should be used in preference to creating new roles or disrupting current practice.

COVID-19 has a disproportionate effect on people who live in more deprived communities, older people, people with specific underlying medical conditions and those from BAME communities. All actions to prevent and manage outbreaks need to be designed with these factors constantly in mind.

Community engagement and communication with our residents will play a fundamental role in the prevention activity that underpins this plan.

Key aims

- Support our communities to continue to follow guidance, in order to keep numbers of cases of COVID-19 low.
- Help Rotherham's communities and its economy to return to a degree of normality until a vaccine is found, by keeping R (average number of onward infections per infection) as low as possible.
- Spot trends early and identify clusters of cases quickly, in order to intervene early to prevent spread.
- Provide system leadership for robust incident management.
- Reduce public anxiety and increase business confidence by demonstrating that there are robust arrangements in place to control outbreaks and reduce community transmission in Rotherham.

Objectives

- To provide a strategic framework for the Health Protection Board to identify the need for new resources and structures, to convene and task subgroups, and to implement actions to prevent and mitigate the transmission of COVID-19 in Rotherham.
- To provide a collaborative and coordinated approach to supporting Rotherham settings in managing COVID-19 outbreaks, including (but not limited to) adult care homes, children's residential care, domiciliary care, workplaces, schools, nurseries, homeless hostels, faith settings, asylum seekers.
- To reduce transmission; protect the vulnerable; and prevent increased demand on healthcare services.
- To streamline any follow-up needed in care settings by the Local Authority, Clinical Commissioning Group (CCG), the Rotherham NHS Foundation Trust (TRFT) and Public Health England (PHE) Health Protection Team (HPT).
- To provide consistent advice to settings.
- To provide a single point of contact between PHE HPT and Rotherham Public Health to facilitate effective communication and follow up.
- To ensure mutually agreed Standard Operating Procedures (SOPs) between PHE HPT and local authoritiy for prevention of and response to outbreaks, with clear divisions of responsibility, handover points, etc.
- To enable a joint response for outbreak management, including the provision of infection control advice, support for testing, contact tracing in the setting as required, and assistance with any consequence management issues in the setting.

- To develop and maintain a surveillance and monitoring system for outbreaks for COVID19, feeding in intelligence from local partners and national data sets.
- To develop local guidance on how to anticipate and prevent or respond to local increases in infection rates.
- To share outbreak information between PHE, Rotherham Council and partner organisations to facilitate appropriate measures to be implemented.
- To provide a strategic framework within which new COVID-19 governance structures can operate.
- To consider requirements for evaluation and review from the outset, including an assessment of potential impacts on equalities characteristics.

Related documents and supporting plans

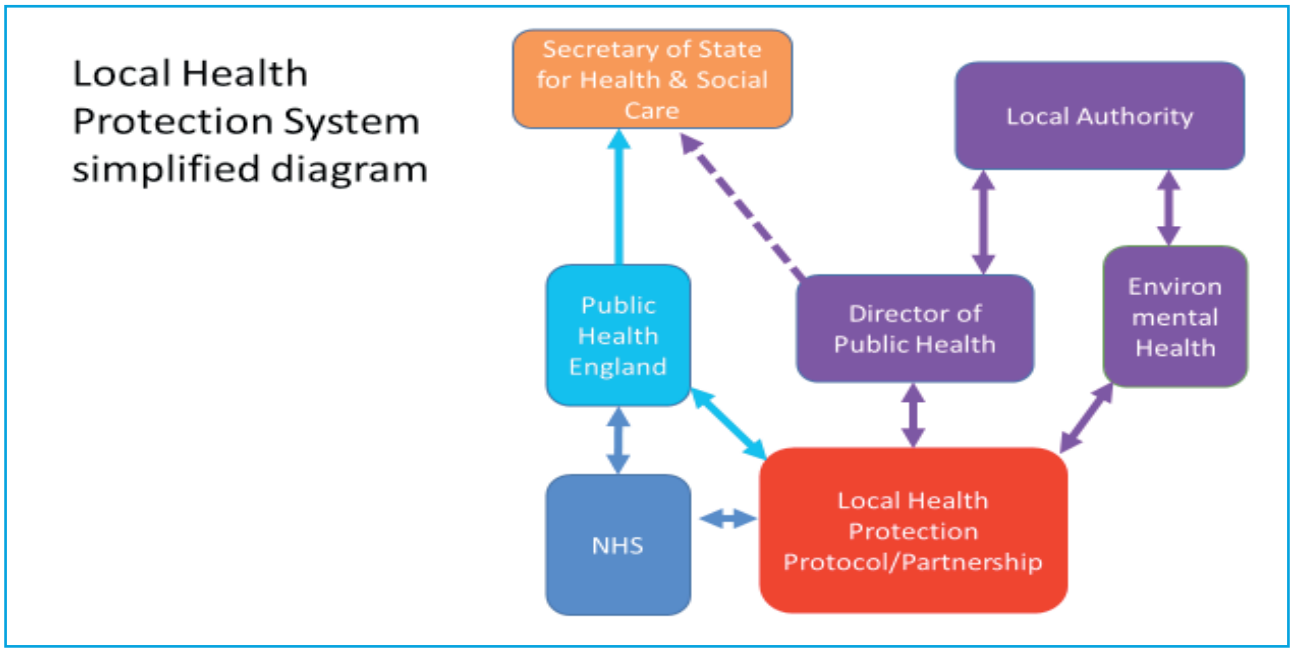
Rotherham's existing multi-agency outbreak plan will be reviewed and updated as part of this outbreak control plan, as will the mass treatment plan, in readiness for when effective vaccines or other treatments become available.

Other related plans include:

- Rotherham COVID-19 Prevention Service Operational Resource plan?
- Coronavirus Emergency Preparedness, Resilience and Response Plan
- Rotherham COVID-19 Recovery and Renewal Plan
- Rotherham Care Home Intervention Plan
- Rotherham COVID-19 Health Protection Board Terms of Reference (appended)
- Rotherham COVID-19 Local Outbreak Engagement Board Terms of Reference (appended)
- Joint working arrangements Standard Operating Procedures agreed between Yorkshire and Humber PHE and local authorities for a range of complex outbreak settings

CHAPTER TWO
CONTEXT AND GOVERNANCE

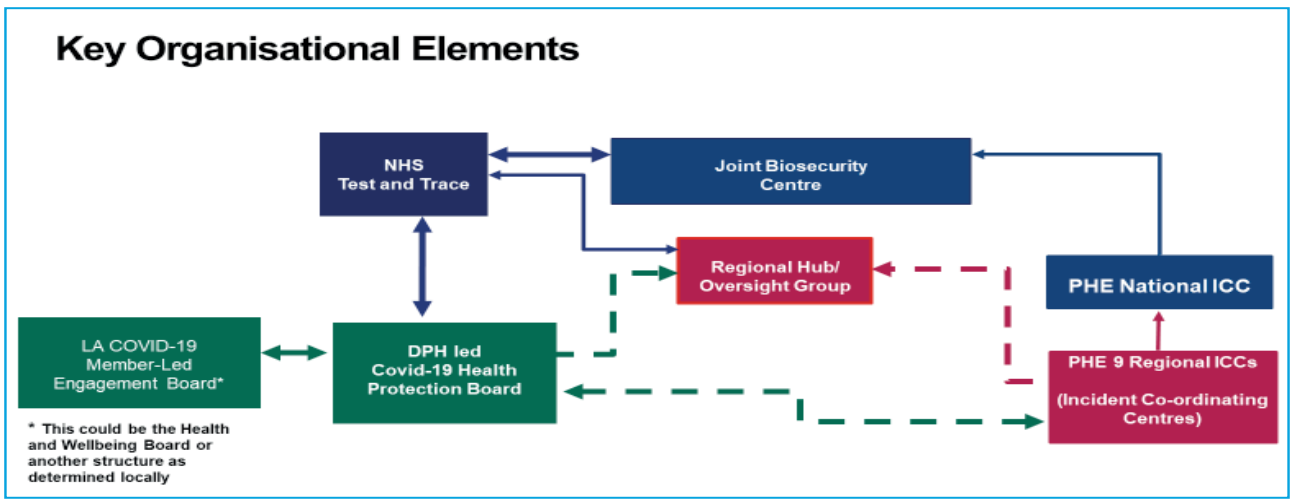
The foundational leadership role of the Director of Public Health in a local area, working closely with other professionals effectively forms a local health protection component of a national system.



For COVID-19 this health protection system has been boosted by the creation of a new national NHS Test and Trace service and a new National Joint Biosecurity Centre. This plan will integrate with the new national NHS Test and Trace service. Information flows from the National Joint Biosecurity Centre as well as information that may come from the potential development of the NHSX App.

At the local level implementation and oversight of this plan and the actions that flow from it will be governed by two new boards – a COVID-19 Health Protection Board (a temporary substitution for the existing Health Protection Committee), chaired by the Director of Public Health, and a Local Outbreak Engagement Board.

Their place within the wider regional and national COVID-19 health protection system is shown in this diagram:



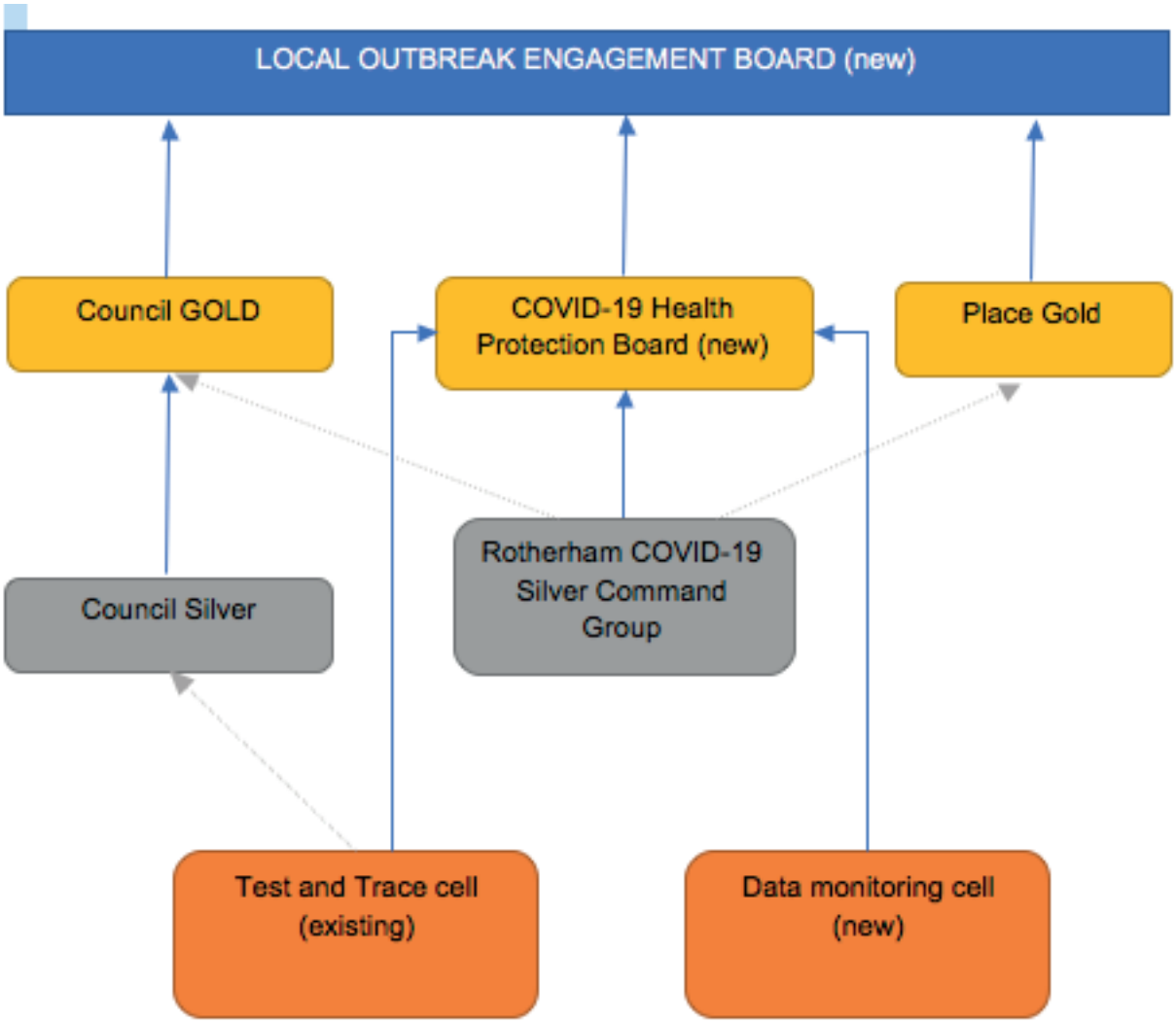
Within Rotherham, the new COVID-19 Health Protection Board will have a primary reporting line to the new Local Outbreak Engagement Board, and will also feed into existing Gold Command structures, by providing reports to the Place Gold meeting and to Rotherham Metropolitan Borough Council's Gold Command. RMBC partner members of the Board will also have similar reporting lines within their individual organisations.

The chart below illustrates these relationships. Structures are under constant review, and the need for further sub-groups to report into the Health Protection Board is likely to develop.

Links to Local Resilience Forum (LRF)

The existing Test and Trace cell in the chart below already links to the South Yorkshire LRF cell covering testing and tracing, and the proposed new data cell will link to the South Yorkshire LRF data cell.

The South Yorkshire LRF has also an established Information Sharing Agreement, across multi-agency partner organisations, with the purpose of enabling routine and effective information sharing between partner agencies.



Mutual aid

The South Yorkshire Directors of Public Health have implemented a peer review of local outbreak control plans to ensure they are fit for purpose, robust and where appropriate, consistent, to provide assurance to the LRF SCG, and to derive optimum benefit from a breadth of shared knowledge and expertise.

Funds have been allocated to support local implementation of Test and Trace in a way that is proportional to expected population need, based on the Public Health Grant formula. However, patterns of communicable disease are less predictable, and may well lead to disproportionate levels of intervention being needed within particular localities. Mutual aid has already been deployed across the LRF footprint to even out local disparities of need in previous phases of the pandemic response, and it is expected that this will continue through the testing and tracing phase. When numbers of daily infections are low, single importation events become more significant, and it will be in our mutual interests to suppress outbreaks across South Yorkshire.

Furthermore, a mutual response will be required for outbreaks with impacts that cross borough boundaries. Some large workplaces, for example, are likely to draw in staff from beyond the borough where the workplace is sited. It is anticipated that for outbreaks in such locations, all the relevant local authorities would be represented on related outbreak control teams (OCTs), and that information would be shared as required, and joint working (e.g. by communications teams) would take place outside such meetings, as required. We already have a good communication network and mutual aid arrangements.

Where control measures such as mass swabbing are required, systems which are in place across the LRF (including mass testing by Mobile Testing Units, for example) may need to be deployed.

CHAPTER THREE
ROLES AND RESPONSIBILITIES

This plan outlines the key responsibilities of responding organisations and professionals for prevention, mitigation and support. This includes agreed standard operating procedures for a range of settings with specific considerations for managing localised outbreaks of COVID-19 in Rotherham.

A number of organisations may be involved in the management of a communicable disease incident or outbreak in Rotherham. Most are permanent members of the newly formed Rotherham COVID-19 Health Protection Board.

Depending on the nature and scale of the outbreak, such organisations may include:

- Rotherham Metropolitan Borough Council
- Public Health England
- NHS England
- The Health and Safety Executive (HSE)
- Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)
- The Rotherham NHS Foundation Trust (TRFT)
- NHS Rotherham Clinical Commissioning Group (RCCG)
- Yorkshire Ambulance Service (YAS)
- Primary care services
- Voluntary sector and community groups;
- South Yorkshire Police
- Representatives of neighbouring Councils (in large and cross border outbreaks).

Local authorities and Public Health England (under the Health and Social Care Act 2012) have the primary responsibility for the delivery and management of public health actions to be taken in relation to outbreaks of communicable disease.

PHE is mandated to fulfil the Secretary of State's duty to protect the public's health from infectious diseases, working with the NHS, local government and other partners. This includes providing surveillance; specialist services, such as diagnostic and reference microbiology; investigation and management of outbreaks of infectious diseases; ensuring effective emergency preparedness, resilience and response for health emergencies. At a local level PHE's health protection teams and field services work in partnership with DsPH, playing strategic and operational leadership roles both in the development and implementation of outbreak control plans and in the identification and management of outbreaks.

The Director of Public Health has and retains primary responsibility for the health of their communities. This includes being assured that the arrangements to protect the health of the communities that they serve are robust and are implemented. The primary foundation of developing and deploying local outbreak management plans is the public health expertise of the local Director of Public Health, and local authority public health consultants and specialists.

The key practical responsibilities for the purposes of this plan are:

Public Health England Yorkshire and Humber Health Protection Team

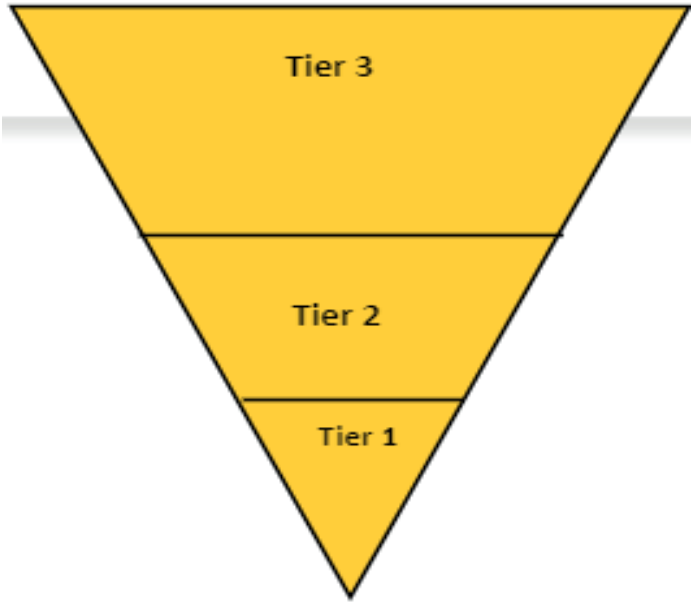
- Advise on swabbing and testing for symptomatic individuals when first aware of an outbreak in line with local arrangements.
- Undertake a risk assessment and give advice to the setting and the local system on the management of the outbreak.
- Provide advice on complex situations on request from local systems, including advice on closing and opening care homes to admissions and need for similar restrictions of movement in other settings.

Rotherham Metropolitan Borough Council

- Provide assurance that all current national recommendations to control COVID-19 are appropriate for Rotherham's population in the light of current information on local epidemiology.
- Provide local communication to support current national recommendations to mitigate COVID-19.
- Ensure the follow-up and support settings to continue to operate whilst managing the outbreak, including support with infection prevention and control.
- Continue to support individuals who are shielding and support those self-isolating if required.
- To agree jointly with Public Health England any actions required to mitigate COVID-19 in Rotherham that are additional to general national recommendations.

NHS Test and Trace process from testing to contact tracing

- COVID-19 cases are identified by taking specimens from people and sending these to laboratories around the UK to be tested.
- If the test is positive, this is a referred to as a lab-confirmed case. Community testing for COVID 19 is now in place through a variety of routes and is now open to anyone in England with compatible symptoms.
- In England, anyone who has a lab-confirmed case will receive an email, text or call from the NHS Test and Trace service (Tier 3). They will be asked where they have been recently and who they have been in close contact with.
- These contacts are then advised or required to take certain actions, such as self-isolation, with the aim of interrupting the onward transmission of communicable diseases. (Tier 3 for low risk contacts and Tier 2 high risk contacts)
- Tier 1 working with PHE Local Health Protection Teams delivering their usual responsibilities of investigation and control of complex outbreaks and situations working with local authorities.



Tier 3 Call handlers – Phone-based contact tracing, only low risk contacts will be contacted. (Contracted external provider).

Tier 2 dedicated professional contact tracing staff – Phone-based contact tracing. Risk assessment, follow-up and management of cases, contacts and situations without complexity (staffed through NHS Professionals).

Tier 1 PHE Health Protection team and Local Authority – Risk assessment and management of complex cases, contacts and situations e.g. care homes, schools and workplaces (PHE and LA).

For a consistent understanding of how Tier 1 work should divide between PHE and local authorities, a set of draft joint working arrangements has been agreed at Yorkshire and Humber level between Public Health England's local Health Protection Team and each local authority. Standard operating procedures (SOPs) for such joint working have been produced for outbreak control across a range of complex settings and scenarios: domiciliary care, education settings, underserved groups, vulnerable people in residential settings, workplaces and care homes.

Notification from Public Health England to RMBC of clusters, outbreaks or other situations of concern within a Rotherham settings will be provided through a single point of contact. For this purpose, a dedicated email inbox has been set up:

SPOC email address **testandtrace@rotherham.gov.uk**

These arrangements will provide a minimum level of assurance that situations requiring local action and support are being identified and escalated. Additionally, we will continue to develop local response pathways to augment this framework. These will provide a greater level of local assurance and support. To give greater clarity from the perspective of individual settings, these will be supplemented with local action cards for the type of setting – this will include how local outbreak data is to be fed back from settings, in order to build a local surveillance system. To begin with, these will be developed for care homes and schools (see section 8), but this will be an ongoing, iterative process based on learning and continuous improvement.

We will encourage local settings to contact the local authority directly, so that we have the earliest possible notification of developing incidents, outbreaks or other issues of concern. Initially this will be via the test and trace email address above. To facilitate this in a more convenient and standardised way, an online webform will be developed for this purpose.

CHAPTER FOUR
DATA AND INTELLIGENCE

Surveillance

The data flows from the national NHS Test and Trace programme, including testing datasets provided via the new interactive data dashboard, need to be integrated with local surveillance data to optimise our capability for a borough-wide early warning system. This section of the plan sets out the details of how such an early warning system for Rotherham will be established.

The aim is to establish a Rotherham outbreak data monitoring cell (borough-wide early warning system) to refine and monitor processes through collaborative development and constructive challenge. The key principle would be to analyse data in near real-time, using time series and trend/forecasting analyses with the aim of:

- Identifying local outbreaks and hotspots through data analysis and mapping
- Providing evidence to aid decision makers about local lockdowns
- Provide evidence to aid decision makers looking to redistribute resources and target communications and interventions
- Provide a cross-reference system where possible between identified cases and Council-held lists of vulnerable people to ensure appropriate offers of support can be provided where required to improve adherence to self-isolation and keep residents safe.

The outbreak data monitoring cell will need to ensure a process is implemented to receive, share and process data to and from a range of sources in a timely way to support delivery of all local COVID-19 outbreak management functions. This will include development of new local systems and IT solutions to receive notifications and track incidents, as well as integration with existing Council databases.

Rotherham Outbreak Monitoring Data Cell

Membership of the cell will largely comprise officers with an analytical role within their service or organisation.

ORGANISATION	ROLE	ATTENDANCE
RMBC	Director of Public Health	Optional but on comms list
RMBC	Consultant in Public Health	Required
RMBC	Corporate Performance and Business Intelligence (PBI) Manager	Required
RMBC	Other PH consultants	Optional but on comms list
RMBC	PH analyst	Required
RMBC	Adult Social Care PBI analyst	Optional but on comms list
RMBC	CYPS Performance manager tbc	Required
RMBC	Housing analyst	Required
RMBC	Customer and Digital Service analyst	Required
RMBC	Schools lead	Required
RMBC	Care homes lead	Required
TRFT	TRFT lead	Required
CCG	CCG analyst	Required

The cell will be responsible for producing a high-level executive summary extract of the full surveillance dashboard. The dashboard will be updated and reviewed daily.

The surveillance dashboard will consist of some overarching indicators. These will include the regional R value, national incidence and prevalence estimates, local deaths and hospital activity trends and testing data.

To improve understanding and provide assurance on local community transmission and outbreaks, locally collated exception reporting across a wide range of settings, will also be included, underpinned by risk profiles.

The settings could include:

- **Education** – nurseries, primary, secondary, tertiary and other sites
- **Workplace** – commercial, industrial, consumer, social, institutional
- **Travel and movement** – large gatherings (>500 people) – such as sports, theatre, museums, small gatherings (<500 people) - eg parks, leisure centres, places of worship, mass transport – buses, trains, taxis etc.

- **Personal** – residential such as hostel/temporary accommodation, hotel, holiday lets etc, home visits such as in-home worker, deliveries, shielded/vulnerable residents
- **Health and care** – hospital, mental health settings, primary care, community services, social care, care homes
- **Local geographical areas** such as wards.

Information will be presented using maps where needed and RAG ratings, indicating whether we are seeing stable trends; increasing trends; or falling trends relative to expected. These will be used to indicate potential trigger points for further investigation.

Online integrated reporting platforms will be developed and used to enable direct interrogation and interactive analysis.

A schedule and index of required datasets with associated RAG rating thresholds will be developed with relevant service leads to ensure information provided is useful and supports decision making at all levels.

There is an important role for soft intelligence to support the work of the cell. It is proposed this will operate as a weekly 'touch base' with the hospital (front door team, A&E) and adult health and social care and other colleagues to assemble a sense of what is happening on the ground in a range of settings.

Information Governance and Legal Basis

All organisations 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 2004.

The Secretary of State has issued four 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, and 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-covid-19-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.

CHAPTER FIVE
TESTING AND TRACING

Rotherham Place Testing and Contact Tracing Cell

Rotherham has an existing partnership cell to consider local actions to optimise testing and tracing across the place, and to link directly to the South Yorkshire LRF testing and tracing cell. This cell has been meeting weekly since 14 May 2020. With the formation of this plan and the new Board structures that oversee it, it is likely that the remit of the group may require review, but it is likely to continue as a tasked sub-group of the Health Protection Board, effectively leading on the work of Themes 3 and 4.

In particular, it will continue to consider the interface between local testing capacity and Pillars 1 and 2 of the national testing strategy. A need has already been identified to provide an agile local capability to provide rapid swab testing kits where needed, such as by people who are not mobile, and to deliver assisted swabbing where required.

It will continue to identify appropriate sites for the deployment of Mobile Testing Units (MTU) from the Pillar 2 programme, and to consider to more agile use of this capacity providing rapid testing capability on-site to respond to a large outbreak, or in distributing and collecting swabs to settings where individual drive-through testing may be prohibitive or inappropriate. An MTU is now available for deployment in Rotherham daily and this deployment can be rotated between pre-agreed sites across the borough as required. This provides an alternative to the permanent regional testing sites, the nearest being Meadowhall (Sheffield) and Doncaster Airport.

As part of a response to an outbreak, the group will have a role in supporting decisions made by the Health Protection Board or by an incident management team convened for the purpose on whether to carry out whole setting swabbing and testing, including considerations of value/risks of swabbing asymptomatic people, and the need for any re-tests as part of the ongoing outbreak management control measures. This will be informed by the SY LRF testing and tracing cell, and a consistent approach across South Yorkshire will be sought.

Within South Yorkshire, an MTU can be deployed to an outbreak setting, where mass swabbing is seen to be useful. Decisions to make use of this option will be on the merits of each case and would be informed by the availability of Pillar 2 test results data to inform outbreak management, as well as the potential risks and benefits of mass swabbing. Not all test results provide useful information - the more important issue is that those who are contacts should self-isolate for 14 days (irrespective of test result), and those with symptoms should get tested. A negative result in someone who is asymptomatic does not change the need to self-isolate if identified as a contact, and a positive result in someone asymptomatic is not always proof of infectivity. Added to this are considerations of the rates of false results that may be obtained due to sensitivity and specificity of the test.

What is contact tracing?

Contact tracing is a process of identifying the contacts of people who have confirmed or suspected infection. These contacts are then advised or required to take certain actions, such as self-isolation, with the aim of interrupting the onward transmission of communicable diseases.

Local contact tracing

Discussion with PHE's HPT has established that contact tracing outside the national NHS Test and Trace programme is not a specific requirement of this outbreak control plan, but as part of leading a response to an outbreak, assurance will be sought that case finding and contact tracing has been comprehensive, and this may result in a need to carry out some contact tracing by exception, or to do investigative work to obtain more detail about the context of any exposure that has taken place.

For example, some further local investigation may be required in order to better understand whether cases arising in colleagues at the same workplace is coincidental, or might relate to exposure between colleagues whilst at work (i.e. when working in proximity of below two metres for a period of 15 minutes or more). This intelligence will inform the accuracy of the declaration of a cluster or outbreak, and the control measures that follow from that.

Contact definitions

A 'contact' is a person who has been close to someone who has tested positive for COVID-19 anytime from two days before the person was symptomatic (or two days before a test if no symptoms) up to seven days from onset of symptoms (this is when they are infectious to others). For example, a contact can be:

- people who spend significant time in the same household as a person who has tested positive for COVID-19
- sexual partners
- a person who has had face-to-face contact (within one metre), with someone who has tested positive for COVID-19, including:
  - being coughed on
  - having a face-to-face conversation within one metre
  - having skin-to-skin physical contact, or
  - contact within one metre for one minute or longer without face-to-face contact
- a person who has been within two metres of someone who has tested positive for COVID-19 for more than 15 minutes
- a person who has travelled in a small vehicle with someone who has tested positive for COVID-19 or in a large vehicle or plane near someone who has tested positive for COVID-19

Further information can be found here:

https://www.gov.uk/government/publications/guidance-for-contacts-of-people-with-possible-or-confirmed-coronavirus-covid-19-infection-who-do-not-live-with-the-person/guidance-for-contacts-of-people-with-possible-or-confirmed-coronavirus-covid-19-infection-who-do-not-live-with-the-person

CHAPTER SIX
VULNERABLE PEOPLE

Rotherham Community Hub

As part of RMBC's response to the developing COVID-19 crisis, as the government advice moved to greater restriction of movement, the Rotherham Community Hub was established on 30 March 2020.

The purpose of the Rotherham Community Hub is to provide support to any Rotherham resident who is affected by the COVID-19 crisis, such as people who may be self-isolating and have no other support networks available to them. Support is co-ordinated centrally by the Council and is delivered by council officers, volunteers, elected members and community organisations.

Following its rapid mobilisation and deployment during the lockdown phase of the national response, a review of the hub's functions has recently been conducted, using the learning to date to inform options for future provision and to contribute to the Council's forward strategic thinking.

A key aspect of this review is the consideration of changes in demands locally arising from recent changes in government guidance to ease lockdown measures, and most significantly the introduction of the new Test and Trace system.

A conclusion of the review is that the Hub will continue to operate for the foreseeable future and at least until March 2021. There is an expectation that there will be further demands for dedicated staff, as recovery of normal council services continues to roll out.

The hub currently has a number of components, including a helpline, a triage function assessing need, a brokerage function matching need to support, and support for shielded residents. The support to shielded residents is expected to be the principal role for the Hub in this next phase, which will include the need to follow up emergency food cases and undertaking any complex needs assessments. The demand on local support, following the cessation of national support for shielded individuals expected at the end of July will be closely monitored.

Assessing new demands arising from contact tracing is at an early stage. Whilst this will have a staffing requirement, there will be other implications arising for the ongoing functions of the Hub.

These are expected to include the following:

- The role of the helpline team in receiving calls from the public and referring people to the appropriate support.
- Dedicated staff and other resource requirements to support and operate test and trace functions that cannot be accommodated within current establishments. This will include contacting people as part of test and trace.
- Referrals from test and trace activity through the Hub systems into other services.
- Any changes required to systems forms and case management arising from requirements associated with test and trace.
- Any changes required to database construction, collection of data and reporting.

The development and resourcing of the Rotherham Community Hub is therefore seen as being an integral part of this outbreak control plan, and a representative from the Hub will attend the COVID-19 Health Protection Board meetings, and data from the Hub will be fed into the local surveillance data considered by the Board.

CHAPTER SEVEN
PUBLIC HEALTH CONTROL MEASURES

Interventions

It is important to acknowledge that outbreak control is just one tool within a combined strategy to reduce the transmission of COVID-19. Up to this point, severe restrictions on movement have played an important role in reducing the number and rate of infections. It should not be assumed that testing and tracing on its own will be sufficient to enable the relaxation of other measures. A recent study in The Lancet found that in the absence of other measures, a high proportion of cases would need to self-isolate, and a high proportion of their contacts to be traced. The same study found that testing and tracing has a higher chance of success in combination with physical distancing. www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30457-6/fulltext

In any event for the purposes of this plan, outbreak control is seen as having a far wider and more upstream scope than simply testing and tracing in response to outbreaks in complex settings. In this context, a range of interventions are available in planning the response to an outbreak or other situation of concern and controlling the identified risks. These include:

- Public information
- Cohort affected personnel
- Enhanced hygiene including deep cleaning
- Infection prevention and control
- Restriction of movement
- Restriction of access
- Decontamination
- Vaccination
- Prophylaxis.

Public information

The provision of advice and information to the public is a core function of public health.

Communication for health protection incidents may be proactive, where new specific or reinforced general messages are deemed to be necessary; or reactive, where it is identified that communications will be contingent to events that occur as a result of the situation, such as reporting within the media, for example.

A communications plan will form part of the response planning for particular scenarios or settings, and a number of existing resources will be compiled pre-emptively, such as shared by Public Health England, both to learn from past experience in Rotherham and elsewhere and to ensure a rapid and efficient response is possible.

The Local Outbreak Engagement Board will have the principal role of determining and implementing key community-wide communications and will be advised on this through the Health Protection Board.

Enhanced hygiene

An outbreak control plan is not simply about response to situations as they occur. It is also about doing whatever is achievable to prevent such outbreaks, and in particular, during a pandemic, it is important not to lose sight of the population-level interventions that can have most impact on preventing transmission events. An overall communications and community engagement plan will continue to reinforce these messages, which were pre-eminent in the media at the start of the pandemic, particularly as people emerge from lockdown. While social distancing is essential for reducing the risk of direct droplet spread, it is essential to instil the message that frequent and thorough hand washing is the best way to prevent infection occurring via contaminated surfaces.

Restriction of movement

Currently there is no vaccine for COVID-19, and prophylaxis and treatment options are limited, so restriction of an individual's movements for the prevention of transmission of infections may be necessary for severe infections. Health protection legislation, in particular the Public Heath (Control of Diseases) Act 1984 and associated Regulations provides a number of options for restricting the movements of individuals in this way:

- Requests to cooperate for health protection reasons/infection prevention and control
- Part 2A orders which can be used to isolate cases and effectively quarantine contacts.

The Health Protection (Coronavirus) Regulations 2020 supplement the health protection regime contained in the Public Health (Control of Diseases) Act 1984 during the coronavirus pandemic. These Regulations provide powers in relation to the screening, detention and isolation of individuals where there exists serious and imminent threat to public health. The use of this legislation requires a declaration by the Secretary of State, which is currently in force.

The Health Protection (Coronavirus, Restriction) (England) Regulations 2020 (also introduced under the Public Health (Control of Diseases) Act 1984) have allowed for the movement of individuals to be restricted across the country during the coronavirus pandemic. Further Regulations and/or amendments to the current Regulations will be required to enable similar restrictions to be applied at a local level.

Emergency Powers exist under Part 2 of the Civil Contingencies Act 2004 which would allow for the movement of individuals to be restricted; however, to enable the use of these powers there would need to be a development of further Regulations.

Restriction of access

In addition to the restriction of the movements of individuals, restrictions can also be placed on the access to certain premises, or things, under the health protection legislation. Specifically, these include:

- Requirements to keep infectious children away from school
- Request to control/manage the number of visitors to health and/or social care premises
- Requests for cooperation for health protection purposes where employees are asked to refrain from attending work
- Part 2A orders which can be made in relation to premises or things to prevent or limit access and therefore exposure to health hazards.

The Coronavirus Act 2020 introduced requirements to deal specially with the current coronavirus pandemic, including the requirement for the closure of schools. Whilst other powers exist that could potentially be utilised to close individual schools, the ability to require the closure of all schools in the local area would require further legislation and/or an amendment to the current legislation.

The Health Protection (Coronavirus, Restriction) (England) Regulations 2020 have required the closure of businesses across the country during the current pandemic. Further Regulations and/or amendments to the current Regulations will be required to enable similar restrictions to be applied at a local level.

Existing legislation, such as the Health and Safety at Work etc. Act 1974 and Food Safety legislation would enable officers to require the closure of certain premises by the service of a prohibition notice, but only where very stringent conditions are met. Such notices can also be used where there is a failure of a business to comply with social distancing requirements; however the ability to enforce the social distancing requirement in the UK is missing from the legislation enacted in the UK for the purposes of the current pandemic.

Decontamination of infective material

The Health Protection (Local Authority Powers) Regulations 2010 allow Local Authorities to make arrangements to disinfect a thing or premises upon the request made by the owner or custodian of the thing or premises. A Part 2A order may be required where decontamination is required but consent is not forthcoming.

Cleaning practice and records of such are likely to be a common piece of information sought from a premises during an outbreak investigation. In particular, the regular cleaning with an appropriate disinfectant of high frequency contact points in a building, as well as targeted decontamination of rooms or areas where transmission events are thought to have occurred.

Infection prevention and control nurses will advise of the most appropriate method of decontamination. This should also be taken through the COVID-19 Health Protection Board.

Vaccination

Vaccination is an important means of primary prevention, providing a level of acquired immunity in the individual. Through community (herd) immunity, vaccination also protects susceptible individuals within a population once a minimum level of coverage has been achieved.

There is currently no vaccine for COVID-19. If/when a vaccine is developed or appears to be near to being deployed, this will become a key agenda item for the Health Protection Board.

A framework providing more specific information regarding how a mass treatment programme may be activated and delivered can be found in the Rotherham Multi-agency Mass Treatment and Assessment Plan, and this will be reviewed in expectation of the successful development of a vaccine or other antiviral treatment for COVID-19.

Additionally, the Health Protection Board has responsibility for considering other non-COVID-19 health protection concerns, during the period while the Health Protection Committee is in abeyance, and a key concern will be to maximise the coverage of the seasonal flu vaccination programme, in order to protect health service from a winter season when it is conceivable that a second COVID-19 epidemic may develop.

Prophylaxis

Prophylaxis is the administration of treatment such as antimicrobials or vaccines, for primary prevention of infection in contacts or the secondary prevention of disease in cases of infection. This can either be provided to possible contacts in advance of exposure (pre-exposure) or to probable or confirmed contacts once exposure has taken place (post-exposure).

There is currently no proven effective prophylaxis for COVID-19.

Local outbreak response

A set of SOPs showing joint working arrangements between Public Health England and RMBC for a range of complex settings will inform our outbreak response. Rotherham will develop local flowcharts for response that sit beneath these SOPs and to provide for situations where local intelligence is superior to that available through the national NHS Test and Trace system for identifying a local situation of concern.

This may not always be an outbreak within the strict definitions adopted by PHE, and/or they may not reach the threshold for complexity that PHE apply, but there may still be a locally perceived need for some investigation, intervention, support or communication, for example.

These will be developed and refined iteratively, but work has already been done to produce local response plans for care homes and schools (as identified in Theme One of the seven themes), and these are included below.

CHAPTER EIGHT
COMPLEX SETTINGS – TRIGGERS AND RESPONSE

Complex settings

Outbreaks can obviously occur in any setting where there is opportunity for transmission, either because of the proximity of people or because of frequent contact with surfaces that might be contaminated.

Public Health England's joint working arrangements SOPs have pointed to the potential for local outbreak control interventions to be required in complex settings such as domiciliary care, education settings, underserved groups, vulnerable people in residential settings, workplaces, and care homes.

In reality complexity might be evident within any setting, which might include a range of educational settings, workplaces such as industrial, offices, retail and institutional settings, recreational and other spaces where large numbers of people may gather, modes of transport, residential, visiting and hospitality settings, and health and social care.

Multi-agency response

Rotherham's multi-agency outbreak plan will be reviewed and updated as part of this outbreak control plan, to include specific triggers and actions relating to particular outbreak scenarios. The response to outbreaks will always be based on a partnership of the most appropriate organisations and professions, based those best placed to deal with the immediate response in the acute phase, and those better placed to work with communities at the neighbourhood or locality level in the consequence management phase. In reality, these phases are likely to overlap.

We will adopt and adapt a framework for triage, trigger points, outbreak and incident teams, control measures and communications to supplement the joint working SOPs to suit the local Rotherham context. This will begin with the key settings of care homes and schools and will be applied to other settings both in a pre-emptive and a responsive manner, according to local and wider intelligence on types of flare-up and outbreak and level of risk within Rotherham.

Draft response flowcharts for care homes and for schools are included below and should be deployed in harness with the PHE/LA standard operating procedure for care homes, included in the appendix. These will be refined iteratively in the light of experience, and the latest versions will be made available via a URL. Work is ongoing to provide response flowcharts for other key settings – a first draft of a primary care flowchart has been produced, and work is ongoing to produce one for workplaces.

In addition to response flowcharts, action cards will be developed for particular settings. These are documents to be used by the setting, which will describe the process they should undertake and what they should expect the actions to be when a case/suspected case is identified. A draft action card for schools has already been produced

Each response chart will include step-down of the incident response, but the detail that underpins this will be partly based on the merits of the case and individual judgment. Guidance for some types of outbreaks already includes criteria for declaring the end of an outbreak (e.g. 28 days with no new infections in the setting), but it is unlikely that the same level of response activity will be needed up until this point. The scale and complexity of each live situation will be reviewed regularly (initially daily) by the core team, and in the light of new information, to decide whether further investigation and action is required, or whether a watching brief is sufficient, or indeed if an incident can be closed altogether.

Rotherham COVID-19 Response Flowchart for Care Homes

(based on PHE Yorkshire and Humber Joint working agreements for local response to COVID-19 – Care Homes)

Version 1. This algorithm will be refined and updated as required

Information sources

Local Daily Care Home Sitrep

PHE sitrep or other HPT notification

Named Contract Compliance Officer (CCO)

Care Homes Group

Risk status of care home

Care home dashboard

Care home manager

Asymptomatic Testing Pathway

Test and Trace service

Trigger Points for IMT

- Any deaths due to COVID
- Two or more laboratory positive cases of COVID-19 in staff/residents with/without symptoms of COVID-19
- Two clinically suspected cases of COVID-19 in one home with onset dates within 14 days
- Notification by PHE HPT
- Daily Care Home Report Red RAG rating
- High Staff sickness on tracker (>20 %) or large change in staff absence trends unless otherwise explained

Trigger Points for Risk Assessment

- Single laboratory positive case of COVID-19 in staff/residents with/without symptoms of COVID-19
- Daily Care Home Report Amber RAG rating
- Contract Compliance Officers or IPC concern
- Concerns raised by CQC – Emergency Support Framework
- Absent care home manager/deputy manager
- Low Staff sickness on tracker (<20 %) or small change in staff absence unless otherwise explained
- PPE concerns

Further investigation and risk assessment membership overleaf

IMT Actions

- Convene IMT – membership overleaf
- Capture information on template
- identify any other residents/staff with positive results/symptoms and give self-isolation advice
- Give Guidance on prevention measures
- Inform PHE HPT if not aware by phone/secure email to
  - o Determine leadership of IMT
  - o Undertake their own risk assessment
  - o Advise on further swabbing and testing
  - o Give any further advice on IPC
- Household and community contacts of positive staff should be followed up by NHS Test & Trace Tier 3

Stepping Down

- No new cases/positive tests
- IMT/IPC actions complete

Risk Assessment

To involve

- Public Health
- Rotherham CCG lead
- Adult Social Care Commissioning Team (CCOs)
- Infection Prevention & Control
- CQC Inspection Officer

Incident Management Team

To involve

- Public Health
- Rotherham CCG Lead & GPs
- Adult Social Care Commissioning Team
- Infection Prevention & Control Team
- RMBC and CCG Comms – Diane Clarke/Gordon Laidlaw
- Administrative Support
- The Rotherham NHS Foundation Trust (TRFT)

Resource Requirements

(PHE provides guidance on relevant resources which need activating/deploying)

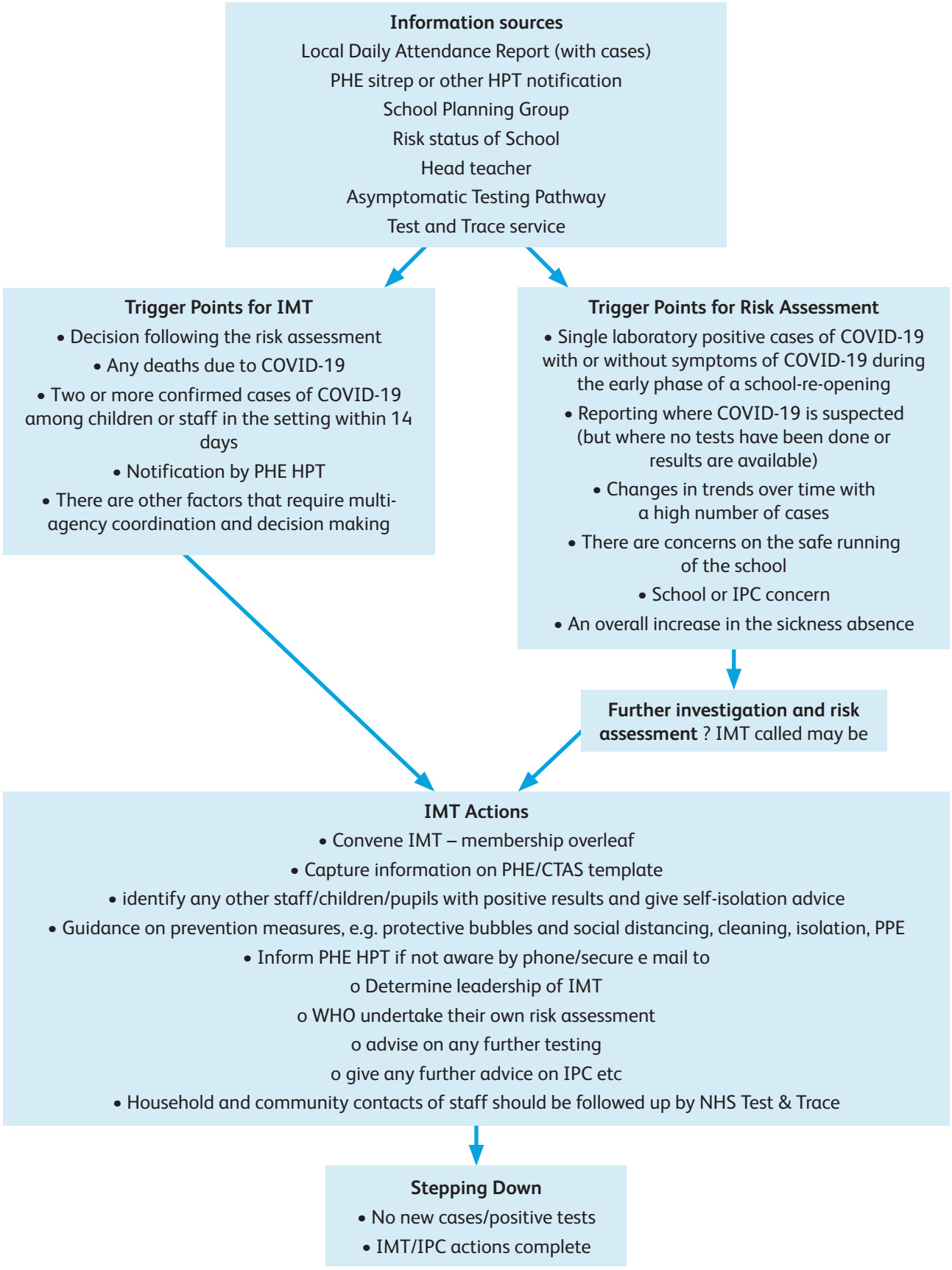
- **Arrangements to access relevant swabs** from PHE
- **Deployment of staff to take swabs:**
  - Care Home staff with training and support from multi-agency Care Home Support Team
  - Advice from GPs, District Nurses
- **Personal Protective Equipment** – PHE/ PH advise on use of PPE and public health control measures with wider support from
  - IPC Team TRFT, District Nurses
  - IPC Lead Nurse (CCG) GPs
- **Provide results and follow-up** PHE will advise on Courier service to receive and return swabs (to Leeds) and further follow up (to be determined by the ICT accordingly)
- **Deployment on-going support and additional staff to support the Care Home**
- **Collection and transportation of specimens** by courier service at predetermined time convenient to Care Home

In extreme circumstances the use of the Care Home Closure Policy may be enacted (held by Council Commissioners).

Rotherham COVID-19 Incident Response Flow chart in an Education Setting

(based on PHE Yorkshire and Humber Joint working agreements for local response to COVID-19 in Education Settings)

Version 1. This algorithm will be refined and updated as required



Risk Assessment

To involve

- PHE/Public Health
- Local Authority Education Commissioners
- Facilities Management
- Call on Infection Prevention & Control advice and Senior staff /Head Teacher as required

Incident Management Team

To involve

- PHE/Public Health
- Local Authority Education Commissioners
- The Rotherham NHS Foundation Trust (TRFT) Infection Prevention & Control Team (TRFT)/ 0-19 services
- Senior staff/Head teacher of education establishment
- Comms lead
- Administrative Support
- Consider Early Help Support if appropriate

Resource Requirements

(PHE provides guidance on relevant resources which need activating/deploying)

- **Agree who is going to be the main school contact**
- **Arrangements to ensure signposting to further tests**
- **Interpreter support (Early Help)** contact Head of Service (LA) if required
- **Deployment of other staff to provide further support:**
  - Nurses in 0-19 Services
  - Multi-agency Support team
- **Personal Protective Equipment** – PHE/PH to advise and discuss with the education establishment if appropriate
- **Provide results and follow-up** – PHE/PH will advise on further follow up determined by the IMT
- **Environmental cleaning** PHE/PH to advise Facilities Manager and/or Head teacher to liaise with cleaning/ facilities staff

CHAPTER NINE
COMMUNICATIONS AND ENGAGEMENT

Public Cooperation

Reducing rates of transmission in a pandemic is contingent on the extent to which people are prepared to modify behaviour, often with substantial short-term costs, in order to reduce the risks to themselves, their circle of family and friends and the wider population.

Ensuring a good level of continued public cooperation requires a level of trust in the advice and messages coming from local government and other public agencies. This may be a more particular challenge as lockdown is eased, and the actions that are being sought need to become more targeted.

Communications is not separately identified within the seven themes but is clearly a vitally important component of all actions to control the virus. The key body identified in the seven themes for engaging with the public is the Local Outbreak Engagement Board, and the Head of Service for RMBC Communications will be a permanent member of that Board.

Outbreak response

However, communications will also need to be considered at every point in the course of a response to an emerging outbreak or situation of concern - from the triage and risk assessment phase, through to the control measures, and to prepare for any consequence management that result, such as reporting through formal or social media, for example.

Communications officers will frequently be invited to attend Incident Management Team meetings for this purpose, and close liaison between Rotherham Council Communications function and their equivalent in other partner organisations, especially Public Health England, and across the SY LRF footprint will be essential to ensure consistent and appropriate messaging is provided to the correct audience.

Given the potential equality concerns arising from patterns of outbreaks within the community, it will be essential to be able to provide key advice and messages in languages other than English and provide opportunities for community engagement

For some specific types of outbreak setting, it is likely a single channel may need to be used for disseminating messages, with schools being one example. For this reason, our local response plans will also consider routes for communications. There will be a mixture of generic and targeted communications taking into consideration the issue and whether the messaging needs to be delivered in particular neighbourhoods or communities of interest.

Communications and Engagement plan

The Health Protection Board will produce a communications plan as a sub-document of this plan. This will include providing clarity on consistent terminology to be adopted in lay communications and will also provide a glossary of technical terms to aid general understanding.

CHAPTER TEN
EQUALITIES

COVID-19 does not impact on people equally. A recent report by Public Health England has attempted to quantify the disparities in risks of infection and poorer outcomes, and has shown that older people, those from black and minority ethnic backgrounds, and those living in more deprived areas, for example, have a greater risk of a negative outcome from COVID-19.

Whilst the greatest level of protection to all is derived by a whole population approach, there are some within our community who will require targeted interventions and protection that is commensurate with a higher degree of risk.

One of the four guiding principles of this plan is that the most relevant, reliable and timely information, data and intelligence will be used to inform actions and monitor outcomes, and a key dimension of this intelligence will be the impacts on disadvantaged and most at-risk communities.

In particular, outside of lockdown, more will be asked of individuals in respect of short- or even longer-term behaviour change, whether it be to protect their own health or for the protection of the wider population. All of our decision-making should take account of where individuals are being expected to endure a level of inconvenience or economic hardship that might be inequitable, and will adopt an ethical approach to decision-making, based on the relative direct and indirect risks and benefits to individuals and communities.

The consideration of the need for social or economic assistance to enable desired behaviour change will be an integral part of the design of our response process.

Ethical issues in decision-making

In the vast majority of cases where the behaviour of a person, or group of people, is putting the health of others at risk, advice and support to the person, or those responsible for their care, can be effective. Most people will comply without the need for further action. Only when advice and support fail to alter the behaviour that puts the health of others at risk should legal health protection measures be considered.

The approach to reducing the risks associated with COVID-19 will be prioritised through awareness raising and key messaging supported by work with key community representatives and influencers as well as organisations within local communities. This will be underpinned by effective outreach and community engagement and will require joint working across the public, private and voluntary/community sectors.

Powers which impose restrictions or requirements must be used in a way that is proportionate to the risk to human health posed by a health threat in particular circumstances. They should only be used once a critical assessment of the available options to achieve the health protection outcome has concluded that other options can be discounted. This may be because voluntary cooperation is not forthcoming or has failed, because other options are not practical, or because there are good reasons to believe that they will not work. In effect, these health protection powers should be viewed as a last resort.

Equalities Assessment

One of the stated principles of this plan is to ensure that all actions to prevent and manage outbreaks need to be designed in the light of COVID-19's disproportionate effect on people who live in more deprived communities, older people, people with specific underlying medical conditions and those from BAME communities.

With this is mind, an equalities assessment will be carried out to inform the design of processes and resources to operationalise this high-level plan, and that this will become an ongoing process of monitoring and review.

CHAPTER ELEVEN
ACTION AND RESOURCE PLANNING

Three phases

An action planning template will be used to plan and monitor progress against this high-level outbreak control plan. This will identify SMART actions and will have appropriate metadata including: Owner; Milestones; Due Date; Update; RAG rating.

The seven themes will be used to organise the presentation of the actions. Overview lead officers for each theme from organisations across Rotherham will also be identified, which will include a Public Health lead and an operational lead.

The broad plan will have three phases – SETUP; STOODUP; ESTABLISHED. For obvious reasons, some of the actions within the SETUP phase will already have been completed by the time the first draft of this high-level plan is complete. For example, actions to constitute two new Boards to establish the governance framework for the development and implementation of this plan are virtually complete.

The three phases partly represent learning from the experience of the Rotherham Community Hub, which needed to be established within a very short lead time, and which is now entering its second phase, following a review of its operations, resources and future demands, which should serve to put it on a more sustainable footing.

In addition to these three phases of the plan, the Health Protection Board will give further consideration for the step-down phase, once the service is no longer required. Consideration will be given regarding the criteria for making this decision, but is likely to include rates of infection, the availability and deployment of a vaccine, estimates of levels of immunity within the population.

Workforce and resource planning

Rotherham's local outbreak control plan is the principal expression of its role within the national system for testing and contact tracing, and as such can call upon a share of a fund of £300 million that has been made available to ensure that this critical part of the strategy for releasing lockdown measures meets with success. Rotherham's share of those funds has been announced as £1.5m.

There are likely to be three types of need that will draw on those funds – one-off start-up or infrastructure costs; workforce costs as new systems become properly embedded; and community support needs.

With respect to the specific workforce requirements, there is likely to be a mixture of a need for new resources and redeployed resources, or resources that are effectively "on call" should the specific scenario or need arise. To some extent, this may mean that some of the costs of local outbreak control are actually indirect costs, resulting from prioritising local outbreak control over other services, at least for a short period. The existence of wider "on call" resources will also create some surge capacity, where the key consideration might more to do with scale and/or number of incidents, rather than specific types. Mutual aid may also be sought from LRF partners, where a significant local pinch point is likely to occur.

Rather than attempt to articulate such needs up front this stage, the strategy is to use the project management and action planning process to identify needs as the detail begins to be worked through.

However, workforce considerations may well include some element of a service model, using need for new and redeployed resources.

A three-component model may be adopted, e.g.:

- Data and intelligence resource
- Core response team – including project management, admin, trainers, technical advisors including Environmental Health and Health and Safety officers, links to the Rotherham Community Hub, Public Health specialists/consultants and other subject or setting specialists, including Infection Control nurses.
- Wider team to call on as required, including setting-specific officers such as homeless team etc

The first action that has taken place to identify a new resource to facilitate this process has been the appointment of a project manager to oversee implementation, who is identifying key leads against components of the plan to enable this to take place, and is mapping the processes for outbreak triage, risk, assessment, investigation, control measures, and community support, which will inform human and other resource needs to put the outbreak control process on a sustainable footing.

Within the SETUP phase of the plan, before any additional resources have been secured, optimum use of existing resources will be essential. Outbreak control training will be a part of enabling this. Internal training for members of the Public Health team will be provided, in order to widen the resource base for people able to contribute directly to outbreak risk assessment, data collection and recording, and engagement in formal incident management or outbreak control meetings.

This will help to standardise processes for assessment and response and will inform organisational planning and understanding of any shortfall in personnel capacity or gaps in specialisms.

A precautionary principle in responding to situations has been adopted in the run up to the implementation of this plan, which has already informed resource and process planning. However, as a growing number and range of incidents are responded to, following the plan going live, it is expected that greater familiarity with a “new normal” will inform future triage considerations, and may allow for a raising of the threshold for level of escalation or intervention required.

APPENDICES

Terms of reference for HPB will be appended

Terms of reference for Local Outbreak Engagement Board will be appended