Coventry and Warwickshire Care homes COVID-19 Outbreak Control Plan

1.Introduction

This document details the COVID-19 Outbreak Control Plan (OCP) for care (nursing and residential) homes and has been put in place in Coventry and Warwickshire, aiming to:

1) Reduce/maintain the number of new COVID-19 cases in care homes to zero
2) Reduce the impact of COVID-19 on care home residents and staff

This OCP is structured in the format of the overarching Coventry, Solihull and Warwickshire (CSW) COVID-19 Outbreak Control Plan.

1.1. Governance arrangements

The key organisational elements required, as identified nationally, for governance of developing and implementing the outbreak plan are shown in the diagram below. These fit alongside our local and sub-regional governance arrangements.

Figure 1: National key organisational elements

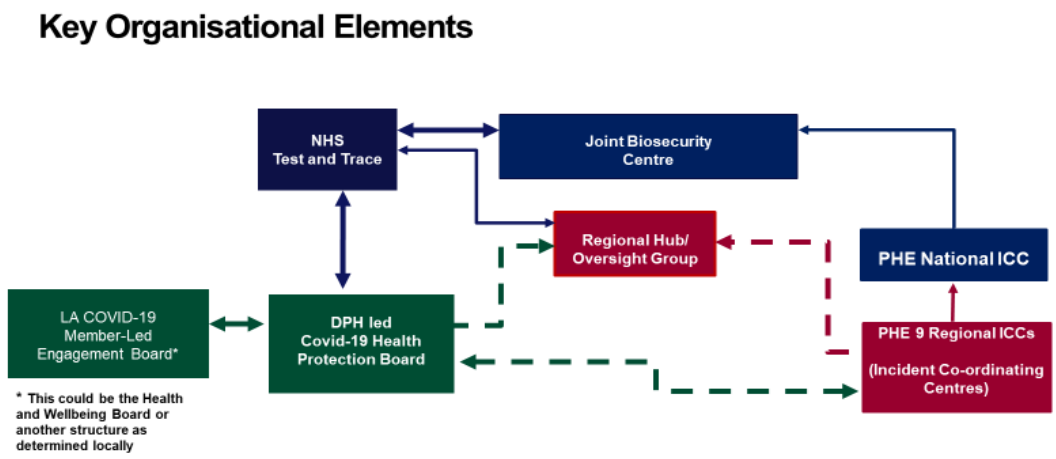
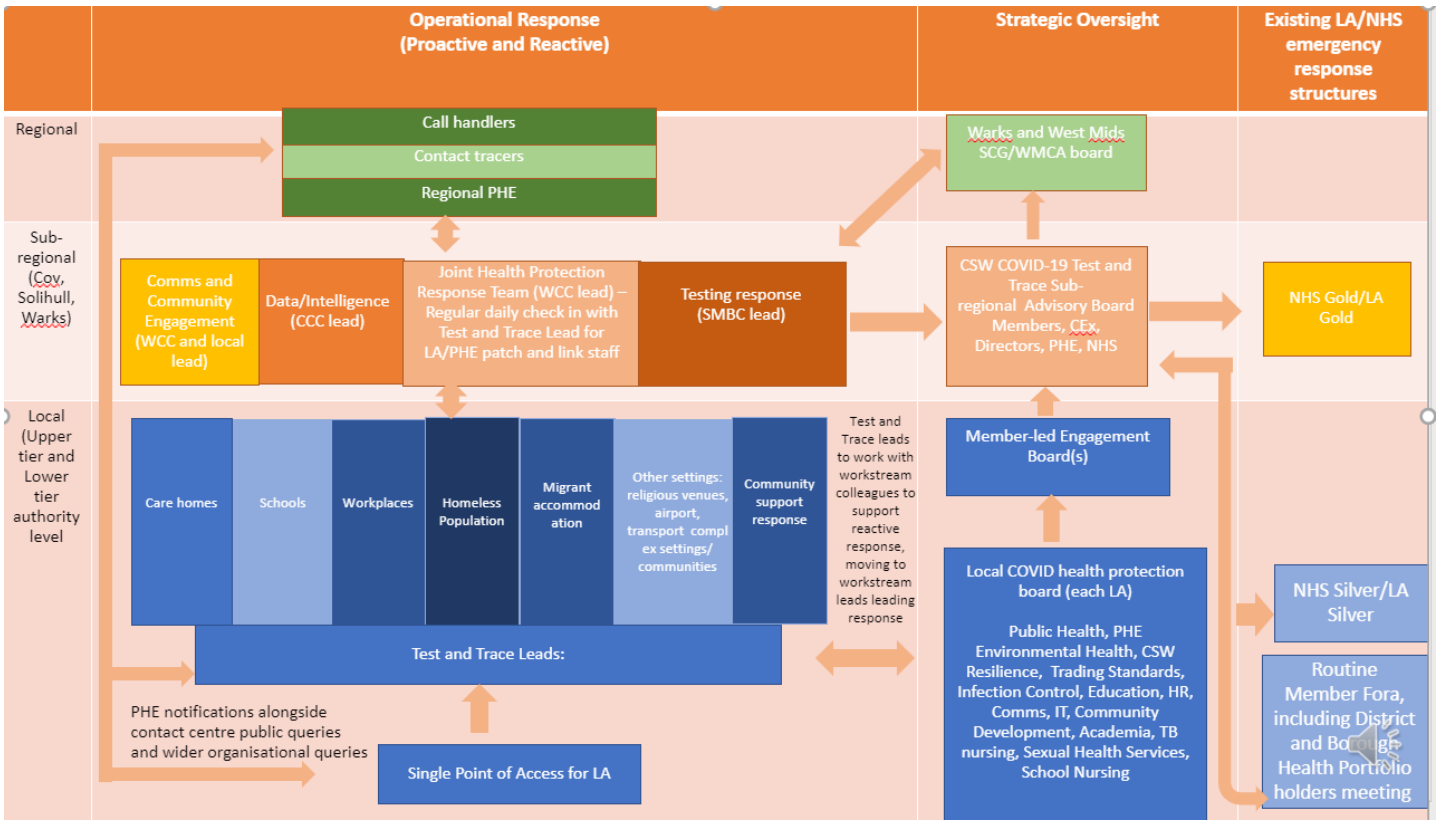


Figure 2: National, regional and LA Test and Trace Programme governance arrangements



As Figure 2 is showing, the Coventry, Solihull and Warwickshire Beacon Authorities have Test And trace leads for the different settings, one of which is Care homes settings. This level is overseen by the sub-Regional, Regional and National structures.

As part of wider governance there is a Preventing COVID in Care Homes group which feeds into the Care Incident Management Team, which then feeds into NHS Silver as part of the overall NHS and Care COVID response (the blue box “Care Homes”). This group has developed the Coventry and Warwickshire Care Homes Outbreak Control plan.

1.2. Operational response arrangements

Within our operational response we aim to:

- Standardise an operating protocol for all system partners in the event of an outbreak.

- Maintain a single point of contact in LA for each outbreak – this is in place (with out of hours arrangements being currently via the DPH on-call/Consultant in Health Protection, but with a move to a:
    - WCC – dphadmin@warwickshire.gov.uk
    - CCC – covid19testing@coventry.gov.uk
    - SMBC – contacttracing@solihull.gov.uk
- There are also single points of contact for the care home quality teams and infection prevention control teams as detailed in Appendix 5
- Ensure that there is a fast turnaround of testing results for all people in close contact with the outbreak location
- Ensure a safe visiting regime for relatives into the outbreak areas (can't keep people apart indefinitely)
- Ensure a supply of affordable PPE
- Provide robust clinical support to homes
- Have a comprehensive regime in place for infection prevention and control in high risk settings
- Ensure the provision of the latest scientific evidence and information in a manner that is easy to understand and apply
- Effective sharing of information
- Provide financial support if essential
- Support the well-being of the workforce

A SOP has been produced for PHE-LA joint management of any COVID-19 outbreaks in the West Midlands. A draft of this can be seen in Appendix 1.

Outbreak management

Outbreak management in care homes is being undertaking following the national care home guidance. The Preventing COVID in Care Homes group have agreed that previous outbreak management has worked well and we will continue to use the same model with the addition of contact tracing, while maintaining a focus on improving the efficiency and effectiveness of our management. The details of this can be seen below. However, there is a recognition that greater resource will be required, especially as we move into winter (see section 9).

Key definitions for care home outbreak management: As per national guidance

- **Confirmed case of COVID-19:** any resident (or staff member) with a laboratory confirmed diagnosis of COVID-19.

- **Possible case in a care home:** any resident (or staff member) with symptoms of COVID-19 (high temperature, new continuous cough, or loss of or change to the individual's sense of smell or taste), or new onset of influenza-like illness or worsening shortness of breath.

- Infectious period: From 48 hours prior to symptom onset to 14 days after AND afebrile for 48h/well (although cough and anosmia may persist) OR from 48 hours prior to the date test taken and for 14 days if the confirmed case was asymptomatic. This definition holds for care home residents given their vulnerability and likelihood that they may be infectious for longer.

However for healthy staff (who are not severely immunocompromised, or have not been in critical care, the infectious period is from 48 hours prior to symptom onset to 7 days after AND afebrile for 48h/well.

- **Outbreak:** 2 or more confirmed cases of COVID-19 or clinically suspected (possible) cases of COVID-19 among individuals associated with a specific setting with onset dates within 14 days.
    - If there's a single laboratory confirmed case, this would initiate further investigation and risk assessment.

- **End of outbreak:** The outbreak can be declared over once no new cases have occurred in the 28 days since the onset of symptoms in the most recent case, which is twice the incubation period

- **Cluster:** 2 or more cases (confirmed or suspected) in a setting within 14 days, where there are no identified (or unconfirmed) epidemiological links (e.g. cases that did not have contact)

- **Exposure (as defined on PHE case management system):** A single confirmed case in a setting

- **Issue:** A single possible case in a setting

- **Isolation period for residents and staff:** 14 days if contact of a possible confirmed case, but 14 or 7 days (and until afebrile for 48hrs/well) respectively if symptomatic. Test results may in some cases alter these isolation periods (please see flowchart below which is being kept under review), but generally a precautionary approach is taken to isolation.
  Flowchart guidance for care home staff and residents following COVID-19 testing

- **A contact:** A person who has had close contact with someone with possible COVID-19 or who has tested positive for COVID-19 anytime from 2 days before the person was symptomatic and up to 14 days from the onset of symptoms (if case is a care home residents), or 7 days (if case is a staff member who is not immunocompromised or been in critical care). Close contact is defined as:
    - spent 15 minutes or more within 2 metres OR
    - Had very close specified personal interaction for a shorter period of time (including face to face contact for any period of time) OR
    - Someone who had lived within the same household during a period of potential risk transmission

  Please note that full definitions of close contacts can be found in:

  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

- **Resident contacts**: any resident that meets one of the following criteria:
    - lives in the same unit or floor as a possible or confirmed case (for example, shares the same communal areas)

    - has had face-to-face contact (within one metre) of a possible or confirmed case, including being coughed on, having a face-to-face conversation, or having skin-to-skin physical contact
    - has had any contact within one metre for one minute or longer with a possible or confirmed case, without face-to-face contact
    - has spent more than 15 minutes within 2 metres of a possible or confirmed case

- **Staff contacts:** any staff member that has had the following contact while not wearing appropriate PPE or who has had a breach in their PPE:
    - has had face-to-face contact (within one metre) of a confirmed case, including being coughed on, having a face-to-face conversation, or having skin-to-skin physical contact
    - has had any contact within one metre for one minute or longer with a confirmed case, without face-to-face contact
    - has spent more than 15 minutes within 2 metres of a confirmed case
    - has cleaned a personal or communal area of the home where a confirmed case has been located (note this only applies to the first time cleaning the personal or communal area)
    - has been notified that they're a contact of a co-worker who has been confirmed as a COVID-19 case

Outline of outbreak management: Before testing, if appropriate

- Care home informs PHE and the Quality Assurance teams of any possible cases in residents or staff
- PHE will undertake a risk assessment with the home, request that testing is organised for those who are symptomatic and undertake contact tracing for residents and staff, with respect to contacts they have had within the care home. Note, the national contact tracing service will undertake contact tracing regarding household and close contacts outside of the workplace, for staff who test positive. PHE will check PPE stocks are adequate, discuss staffing, the home layout, provide advice and guidance, and are likely to advise the home closes to visitors during the outbreak as appropriate.
- Residents who are contacts will be isolated.
- Staff who have worn PPE according to guidance do not need to isolate. However, any staff members who have **not worn PPE, or had a significant breach in their PPE** (see staff contact definition above) **whilst in contact with a confirmed case** need to self-isolate for 14 days.
- PHE will work in collaboration with the CCG and LA. Whole home testing will be prioritised for homes with new outbreaks. Public Health in the LA will support the IPC and Quality Assurance teams as required.
- In the case of a straightforward outbreak then management will be taken over by the CCG and LA. However, should the outbreak become complex, these can be referred back to PHE.
- Complex outbreaks, such as those with a large number of cases, deaths or those with media interest will have an Incident Management Team called by PHE in collaboration with LA and other partners.

Testing of residents:

- Tests can be undertaken in two ways and will be supported by local IPC, Quality Assurance and Public Health teams:

    - Local testing using the provider Arley Medical Services. Results are sent to the CCG who then share these with care homes.
    - Care homes can request kits from the national portal. Results are sent directly to the care home manager.
- PHE receives test results from both mechanisms, but staff cannot always be linked with the homes directly if their home postcode has been used

Interpretation of results:

Flowcharts have been developed to assist care homes with the interpretation of testing results and are kept under review:

Flowchart guidance for care home staff and residents following COVID-19 testing

Contact tracing (after testing):

- Contact tracing is undertaken by CTAS (Contact tracing and advisory service)
- Staff that have a positive test results should follow national guidance and inform close contacts that they need to self-isolate.
- Residents who test positive are also contact traced and isolated (through PHE and Care home quality and Infection Prevention and Control (IPC) teams). There contacts are isolated if residents and staff not wearing PPE or those with PPE breaches are excluded for 14 days.
- CTAS will contact trace household and close contacts for staff OUTSIDE of care home settings. They will then pass the details over to PHE for contact tracing contacts in the care setting (discussions being had about local areas potentially taking on the latter role).

PHE role:

Outbreak management remains a shared responsibility.

PHE will not be able to follow up care settings on a routine basis after initial advice and actions have been taken, this will be the remit of the CCGs and LA.

After notification of a single case in a care setting PHE will follow up with the setting to determine if there are further cases.

If two or more cases are identified as linked to the care setting (and not linked to an existing situation) then contact will be made with the care setting to check for further cases and managed as an outbreak by PHE.

Where capacity does not allow for the above to be undertaken by PHE, a discussion will be had with CCG/LA for handover of the management.

At the time of an outbreak being declared then swabbing can be arranged for symptomatic residents.

In all situations infection control advice will be given, guidance shared, and adequate PPE and staffing will be ensured. A red flag system is in place within PHE so concerns can be raised and managed appropriately.

The following prompts may be useful for assessment of the situation:

- Any new resident cases overnight?
- Any residents worsening overnight?
- Any deaths overnight that could be COVID-19 related?
- Any new admissions to hospital or unexpected deaths overnight?
- Any new staff symptomatic?
- Cumulative total of staff off sick or self-isolating / total staff capacity
- Care setting position re: overall IPC & supply of PPE – is the care setting manager satisfied that infection control arrangements are appropriate & safe?
- Operationally is the care setting manager satisfied that there are enough staff on duty today to provide a safe service

Finally, a checklist for care homes has been produced for care homes to use should they have a suspected COVID-19 case. See Appendix 2.

1.2.1 Action plan going forward

- An Action card for outbreaks have been developed, with key actions that need to be taken by homes, CCG and LA, and this will be reviewed in the light of changing national guidance

2.Priority 1: Community engagement to build trust and participation

It is recognised that community participation in following public health guidance is key as it is important that the public, including service users and providers, fully understand the public health messages and feel involved in creating of public health guidance. The wider community engagement is an important aspect of the prevention and management of outbreaks in Care Homes in terms of care home staff and their families following this guidance.

Co-ordinated and sustained communication with Care Homes will be maintained through regular check-ins (see section 3.3). If an outbreak should occur this communication will occur daily.

Feedback from residents and families will be collected via the Quality Assurance process and the See, Hear and Act Strategy where families and residents can input info about provision via a QR code.

We are currently examining the best methods of engaging with care homes to gather views from both staff and residents on their experience of the COVID pandemic so far, and how we can improve our support to them. The Accommodation Quality Support Group is currently exploring how this can be undertaken, as an extension to their work examining the patient, family and care home experience of isolation beds.

To gain good understanding of this, we are conducting a series of interviews with care homes managers which will inform the survey we will conduct in the near future. It is envisaged that this survey will give us information on what we have done well in COVID outbreak management, what is it that we can and should do better. Together with the care providers and via this survey, we will plan and agree the best way to gain more insight into service user experience as well.

The data will be gathered in a systematic way so that it can be analysed , after which we will evaluate and update the plan as a result.

3.Priority 2: Preventing infection

3.1. Infection Prevention and Control in Coventry and Warwickshire

All homes are currently supported by the Care Home and WCC/CCC Quality Assurance teams on a daily basis. Our CCG Infection Prevention and Control (IPC) staff, are available for advice and support to all care providers across the system 7 days a week working closely with the Public Health WCC and CCC based staff, as well as PHE staff in and out of hours. This partnership working will continue as we move to the next phase of recovery and reset ensuring that infection prevention and control remains a priority and that the use of the IPC funding to care homes is being used appropriately for preparation of any further surges.

Our local IPC team as well as the Quality Assurance teams have been working in partnership with care homes and possess detailed local knowledge of issues that are relevant to all aspects of IPC that different homes may need. All information is populated onto a single database that all partners have access to making data collection for reporting seamless and timely. The weekly mutual aid calls with care homes ensures that issues can be escalated and addressed in a timely manner.

All information is populated onto a single database that all partners have access to making data collection for reporting seamless and timely. Weekly mutual aid calls with care homes ensures that issues can be escalated and addressed in a timely manner.

3.2. IPC training programme system and training uptake to date

England's Chief Nurse developed a national training programme for all care home settings to be delivered through local trainers. Coventry and Warwickshire Health and Care systems identified 256 providers that could be formally offered this Infection Prevention and Control practice training and 100% have been contacted. The training offered was designed to build on existing knowledge around the prevention of infections within teams focusing particularly on the management of residents with COVID-19 infection. This included information on isolating and containing any suspected/confirmed cases and why higher level environmental cleaning is imperative to them to build confidence in managing these residents safety.

The table below is the training data to date showing; the number of homes that accepted and completed the training, those homes that have accepted the training but it has been deferred until July and those declined training. For those that declined there were three potential categories that they could fall into:

1. Declined nationally – a provider part of a national organisation that declined to the chief nurse team.
2. They did not feel that they needed the training.
3. Have not responded to date

We can see that a total of 224 (88%) providers have accepted and completed IPC training. A total of 22 (9%) homes declined training or did not respond. Ten (4%) homes have accepted training but this has been deferred until July.

Table 1: The numbers of providers that have accepted and completed IPC training, declined the training, or for whom training has been deferred until July, by area. Correct as of 10th June 2020.

Area	Accepted	Declined	Declined - National	Deferred	Total
Coventry	73	6	3	9	**91**
North Warwickshire	23	0	0	0	**23**
Nuneaton & Bedworth	30	2	0	1	**33**
Rugby	30	1	0	0	**31**
Stratford	36	3	3	0	**42**
Warwick	32	2	2	0	**36**
Total	**224**	**14**	**8**	**10**	**256**

Source: Local IPC log

The table below shows the delivery method used for IPC training. We can see that 135 (60%) of homes received their training face to face, while the remaining 89 (40%) received their training virtually.

Table 2: The delivery method used for the IPC training, by area. Correct as of 10th June 2020

Area	Face to Face	Virtual	Total
Coventry	45	28	73
North Warwickshire	12	11	23
Nuneaton & Bedworth	16	14	30
Rugby	14	16	30
Stratford	25	11	36
Warwick	23	9	32
Total	**135**	**89**	**224**

Source: Local IPC log

The table below shows the numbers of staff that have trained in the 224 care homes that have received IPC training. We can see that a total of 1117 people have trained.

Table 3: The numbers of staff trained in homes that have received IPC training, by area. Correct as of 10th June 2020.

Area	Number of staff trained
Coventry	335
North Warwickshire	170
Nuneaton & Bedworth	127
Rugby	165

Stratford	137
Warwick	183
Total	**1117**

Source: Local IPC log

3. 3. Action plan for going forward

Phase 2 of the training programme has commenced with delivery of training in a similar method to domiciliary and supported accommodation providers that were not part of Phase 1. The training material has been adapted with the support of national and local IPC and PH colleagues to reflect the needs of this market as it is acknowledged the different requirements needs.

The training to providers will commence the week of the 29th July 2020 and is being offered virtually where providers have this capability and face to face in appropriate buildings to allow for social distancing. We will be expecting that a sitrep is going to be required by NHSE/I to assess progress within the system and as we have a data system already in place from phase 1 this will be replicated.

Following this training Phase 3 will be as part of the Recovery and Reset work that providers are offered a refresher IPC session at regular intervals that will continue ensuring that it covers outbreak management and managing covid-19 residents should we have another surge. It is important to note that we will also be updating staff on the readiness for flu season where symptoms can be suspected as covid-19 when it could also be seasonal flu. In addition, the flu vaccine campaign will also be supported by the IPC and Primary Care leads to ensure that all eligible residents have this in a timely manner.

The development of weekly 'check-in' calls to all Care Homes is currently under development across Coventry and Warwickshire. The aim of these calls is to ensure that all homes are fully supported with:

- PPE
- Infection control training
- Testing
- Utilisation of the ICF grant to ensure that staff are not working between homes and are being paid should they need to self-isolate.

The COVID resilience checklist is also a key part of the IPC action plan.

4.Priority 3: High risk settings and communities

4.1. Care settings in Coventry and Warwickshire; a description

4.1.1. Nursing home capacity and residential home capacity

There are 251 care homes in Coventry and Warwickshire. In Coventry 80% of care homes are residential homes, while in Warwickshire 68% are residential homes.

Table 4: Number of Nursing and Residential Homes in Coventry and Warwickshire

Location Local Authority	Nursing	Residential	Total
Coventry	15	61	76
Warwickshire	55	120	175
Total	70	181	251

Coventry and Rugby CCG has the largest number of care homes (107), made up of 21% (23) nursing homes and 78% (84) residential homes. South Warwickshire CCG has the greatest proportion of nursing homes (41%), while the Warwickshire North CCG and Coventry and Rugby CCG have a similar proportion of nursing homes (22% and 21% respectively).

Table 5: Number of Nursing and Residential homes in Coventry and Warwickshire CCGs

Location ONSPD CCG	Nursing	Residential	Total
NHS Coventry and Rugby CCG	23	84	107
NHS South Warwickshire CCG	33	48	81
NHS Warwickshire North CCG	14	49	63
Total	70	181	251

The total Care Home bed capacity across Coventry and Warwickshire is 7575, with 45% (3,380) being Nursing Home beds and 55% (4,195) being Residential Home beds. Coventry has 2077 bed capacity, made up of 37% (773) Nursing beds and 63% (1,304) Residential home beds. Warwickshire has a larger bed capacity of 5498, consisting of 47% (2607) Nursing beds and 53% (2891) Residential home beds.

Table 6: Total bed capacity; residential and nursing homes in Coventry and Warwickshire by LA

Location Local Authority	Nursing	Residential	Total
Coventry	773	1,304	2077
Warwickshire	2,607	2,891	5498
Total	3,380	4,195	7575

Coventry and Rugby CCG has the highest bed capacity (3067), with 39% (1,186) being nursing home beds and 61% (1,881) being residential home beds. South Warwickshire CCG has a total of 2830 beds, of

which 53% (1,494) are nursing home beds. Warwickshire North CCG has a total of 1678 beds, of which 42% (700) are nursing home beds.

Table 7: Total bed capacity; residential and nursing homes in Coventry and Warwickshire CCGs

Location ONSPD CCG	Nursing	Residential	Total
NHS Coventry and Rugby CCG	1,186	1,881	3067
NHS South Warwickshire CCG	1,494	1,336	2830
NHS Warwickshire North CCG	700	978	1678
Total	3,380	4,195	7575

4.1.2. Step down isolation beds and discharge policies

We have established step down isolation community beds designed to shield both residential and nursing care homes from COVID+ admissions from hospital. 40 system beds, available to admissions from across Coventry and Warwickshire, have been commissioned across 2 sites in South Warwickshire. These pathway specific beds will take all admissions of COVID+ discharges from hospitals that would ordinarily be admitted to a care home. Established for 3 months, June-August 2020, the step-down isolation community beds have been implemented to provide time to build resilience in care homes. A key element of this approach is the development of a system wide COVID resilience assurance checklist that all care homes will be supported to achieve. Once a provider has achieved assurance status they will be able to take COVID+ admissions direct from hospital. See section 4.3 for further details.

4.1.3. Action plan for going forward

A COVID Resilience Checklist has been created as an assurance tool to support care homes with self-assessment of their current measures in place to prevent and manage COVID-19 cases and outbreaks. This tool then allows agencies to undertake desk based triangulation of individual homes IPC measures and then, where needed is supported by a visit from care home quality nurses. The Resilience Checklist will be piloted throughout June and subsequently reviewed with a view to further refinement as required. The finalised Resilience Checklist will then be shared with Care Homes across Coventry and Warwickshire, enabling us to tailor our support to care homes based on the results. The combined social care/health quality assurance resource will then roll out this process to ensure sufficient care home capacity is available to decommission the step down isolation beds over the next three months. This process will become part of the business as usual assurance approach moving forward.

4.2. Epidemiology of COVID-19 in Coventry and Warwickshire

4.2.1. COVID-19 outbreak occurrence in Care Homes in Coventry and Warwickshire over time

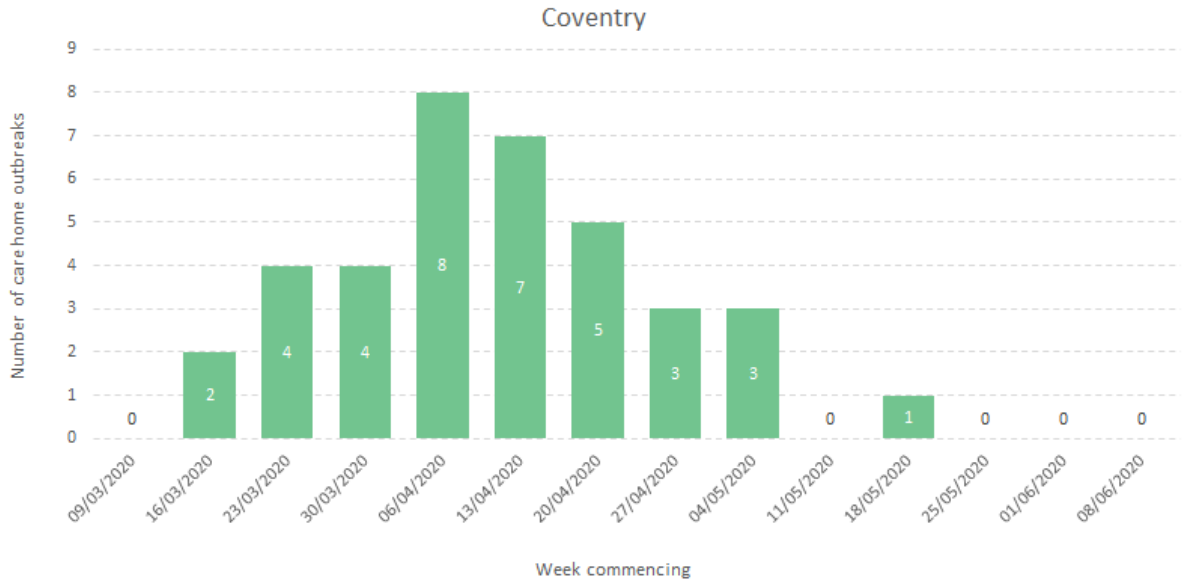
Public Health England releases weekly data on the number of care homes (including all supported living facilities such as residential homes, nursing homes, rehabilitation units and assisted living units) that have reported a suspected or confirmed outbreak of COVID-19. Any individual home is only included in

the dataset once. If a home has reported more than one outbreak, only the first is included – the dataset contains no indication of whether the reported outbreaks are still active or have been resolved.

To date there have been outbreaks in 37 (49.3%) of the 76 care homes in Coventry. There were no care home COVID-19 outbreaks reported in Coventry prior to week commencing 16th March. The numbers of new outbreaks peaked in Coventry (8 outbreaks) in week commencing 6th April.

The most recent data, for week commencing 8th June was released on 18th June – it is updated each Thursday. This release suggests that there were no new COVID-19 outbreaks in Coventry in that week.

Figure 3: Number of COVID-19 outbreaks in Coventry care settings week commencing 09/03/20 to 08/06/20*



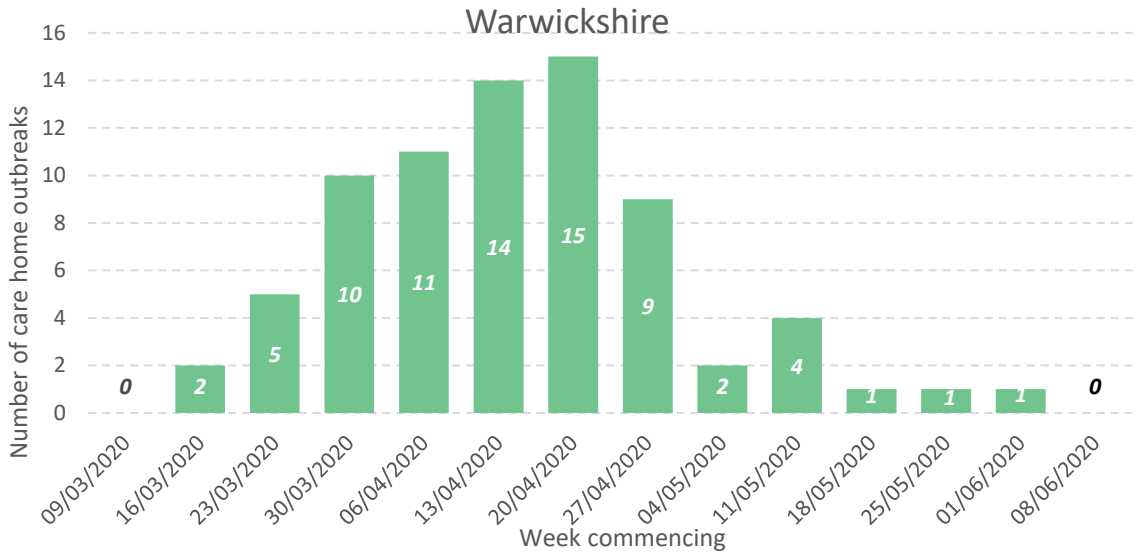
Source: PHE, COVID-19: number of outbreaks in care homes - management information

***Whole home testing was introduced on 18/05/20 and CTAS was launched 27/05/20**

To date, there have been outbreaks in 75 (42.9%) of the 175 homes in Warwickshire. There were no care home COVID-19 outbreaks reported in Warwickshire prior to week commencing 16th March.
The numbers of new outbreaks peaked in Warwickshire (15 outbreaks) in week commencing 20th April.

The most recent data, for week commencing 8th June was released on 18th June – it is updated each Thursday. This release suggests that there were no new COVID-19 outbreaks in Warwickshire in that week.

Figure 4: Number of COVID-19 outbreaks in Warwickshire care settings week commencing 09/03/20 to 08/06/20



Source: PHE, COVID-19: number of outbreaks in care homes - management information

***Whole home testing was introduced on 18/05/20 and CTAS was launched 27/05/20**

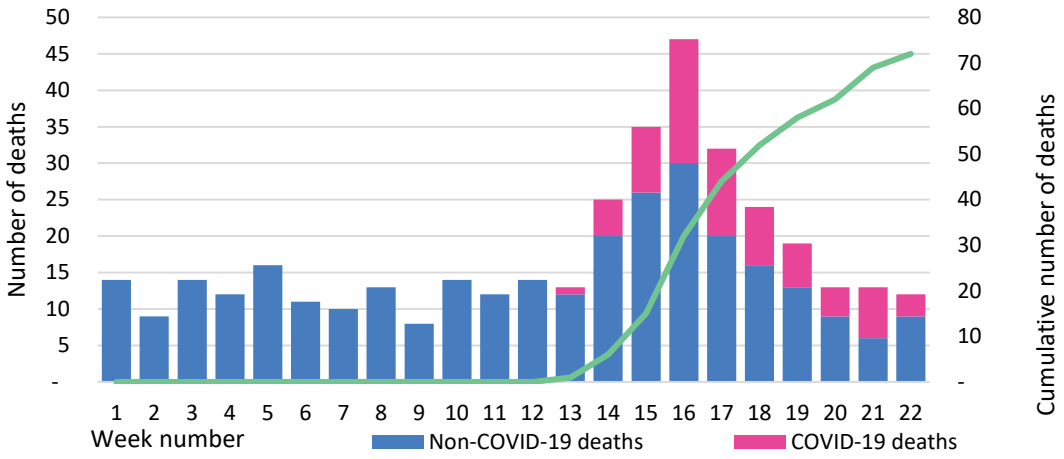
4.2.2. Trend in care home deaths by cause and cumulative COVID-19 deaths

Coventry

Up to 29 May 2020, there have been 1,510 deaths in Coventry of which 270 (17.9%) have been recorded as being COVID-19. There have been 380 Care Home deaths, of which 72 (18.9%) have been recorded as being COVID-19.

Trend data suggests that Care Home deaths across Coventry peaked at around Weeks 15-17 (weeks ending 10 April - 24 April).

Figure xx: Trend in number of deaths by cause and cumulative COVID-19 deaths, deaths that occurred up to 29 May but were registered up to 6 June, by week, where place of death was recorded as 'Care Home', Coventry



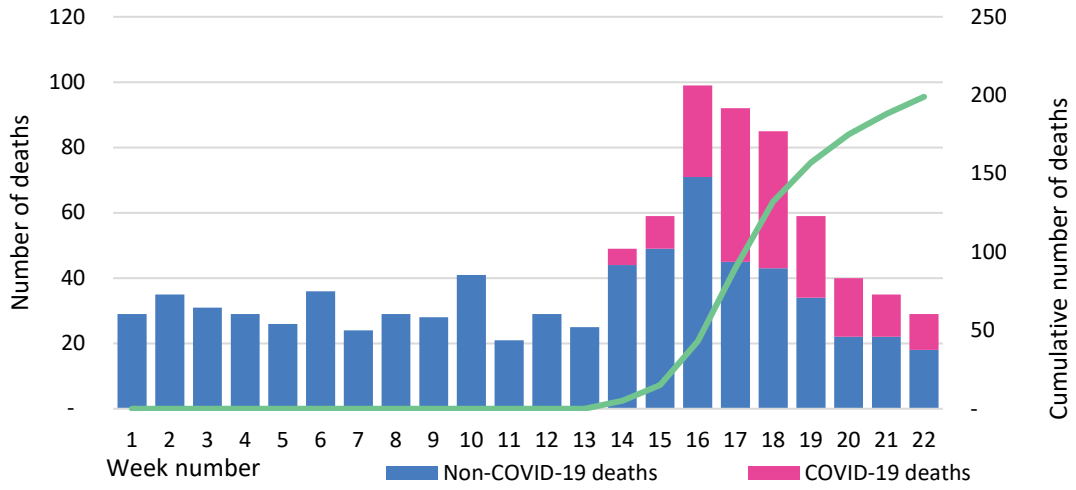
Source: ONS Death registrations and occurrences by local authority and health board

Warwickshire

Up to 29 May 2020, there have been 2,995 deaths in Warwickshire of which 516 (17.2%) have been recorded as being COVID-19. There have been 930 Care Home deaths, of which 199 (21.4%) have been recorded as being COVID-19.

Trend data suggests that Warwickshire Care Home deaths peaked slightly later than Coventry, at around Weeks 16-18 (weeks ending 17 April-1 May). Although, there appears to be a longer peak period in Nuneaton & Bedworth from Week 15-19 (weeks ending 10 April-8 May).

Figure 5: Trend in number of deaths by cause and cumulative COVID-19 deaths, deaths that occurred up to 29 May but were registered up to 6 June, by week, where place of death was recorded as 'Care Home', Warwickshire



Source: ONS Death registrations and occurrences by local authority and health board

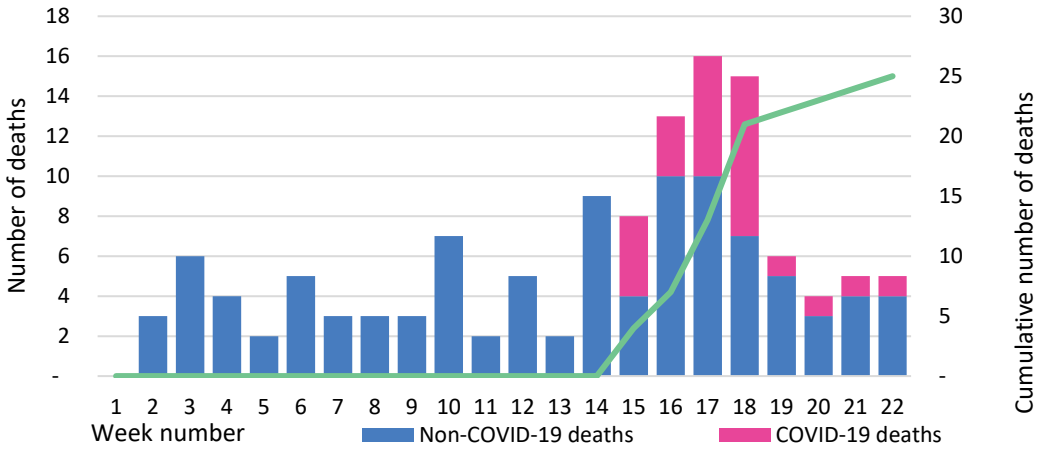
Districts and Boroughs

The following Figures for each District or Borough show the trend in number of deaths by cause and cumulative COVID-19 deaths.

North Warwickshire

Up to 29 May 2020, there have been 408 Care Home deaths in North Warwickshire of which 71 (17.4%) have been recorded as being COVID-19.

Figure 6: Deaths that occurred up to 29 May but were registered up to 6 June, by week, where place of death was recorded as 'Care Home', North Warwickshire

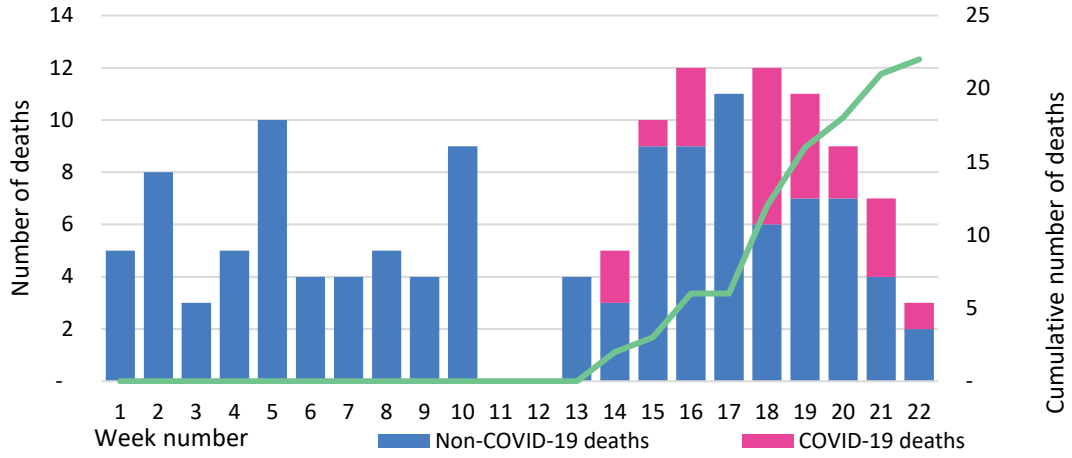


Source: ONS Death registrations and occurrences by local authority and health board

Nuneaton and Bedworth

Up to 29 May 2020, there have been 724 Care Home deaths in Nuneaton & Bedworth of which 127 (17.5%) have been recorded as being COVID-19.

Figure 7: Deaths that occurred up to 29 May but were registered up to 6 June, by week, where place of death was recorded as 'Care Home', Nuneaton & Bedworth

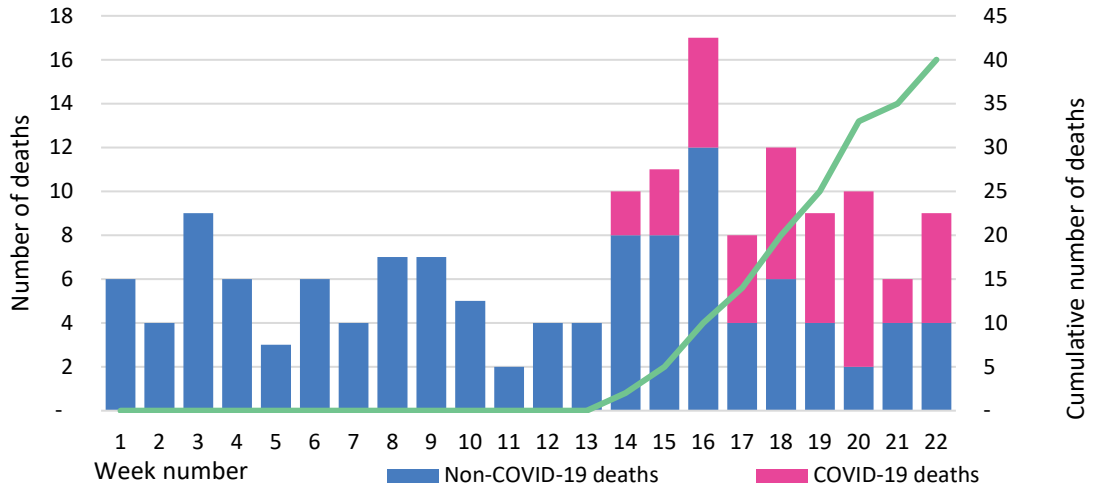


Source: ONS Death registrations and occurrences by local authority and health board

Rugby

Up to 29 May 2020, there have been 502 Care Home deaths in Rugby of which 70 (13.9%) have been recorded as being COVID-19.

Figure 8: Deaths that occurred up to 29 May but were registered up to 6 June, by week, where place of death was recorded as 'Care Home', Rugby

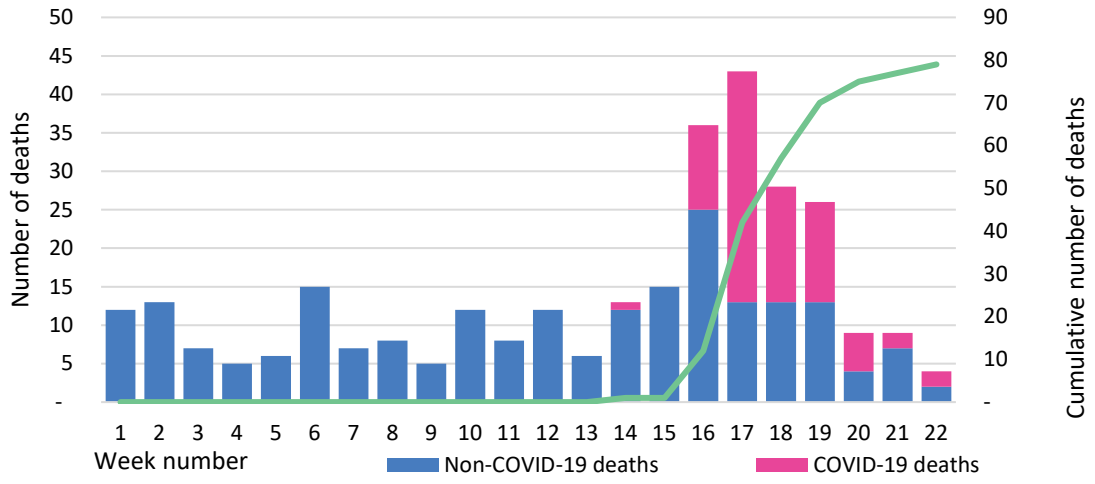


Source: ONS Death registrations and occurrences by local authority and health board

Stratford-on-Avon

Up to 29 May 2020, there have been 758 Care Home deaths in Stratford-on-Avon of which 159 (21.0%) have been recorded as being COVID-19.

Figure 9: Deaths that occurred up to 29 May but were registered up to 6 June, by week, where place of death was recorded as 'Care Home', Stratford-on-Avon

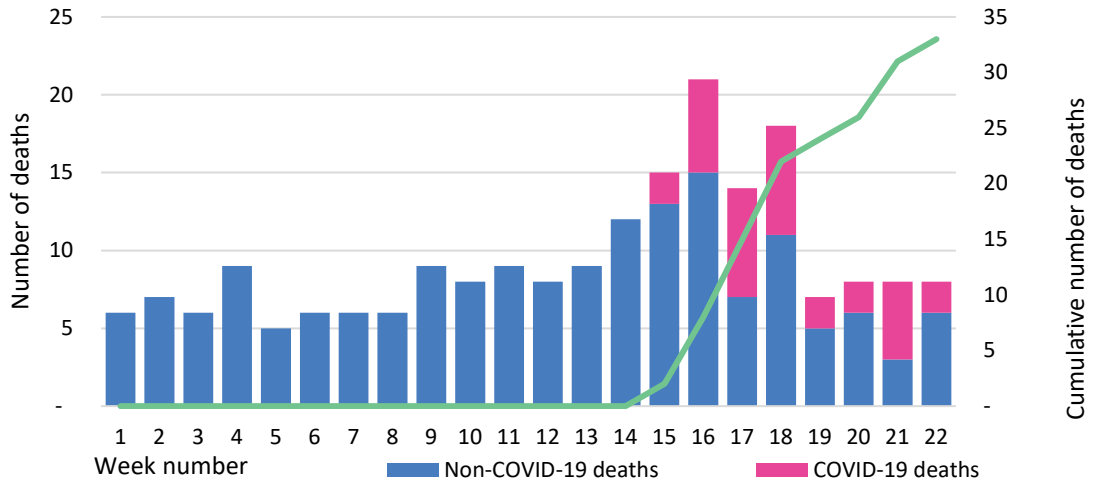


Source: ONS Death registrations and occurrences by local authority and health board

Warwick

Up to 29 May 2020, there have been 603 Care Home deaths in Warwick of which 89 (14.8%) have been recorded as being COVID-19.

Figure 10: Deaths that occurred up to 29 May but were registered up to 6 June, by week, where place of death was recorded as 'Care Home', Warwick



Source: ONS Death registrations and occurrences by local authority and health board

4.2.3. COVID-19 confirmed and suspected cases and deaths in care homes

The COVID-19 Care Home Impact Dashboard provides information on the numbers of suspected and confirmed cases of, and deaths from, COVID-19. It has two main caveats:

- This information is provided by the care homes themselves, but this is the best estimate that we have available to use.
- The data is collected and recorded by single cases, it does not distinguish between outbreaks and lone cases.

According to the Dashboard care homes in Coventry had the highest percentage of cases and deaths relative to occupied beds. There were 582 suspected or confirmed COVID-19 cases, which is the equivalent of 30% of occupied beds. There were 180 COVID-19 suspected or confirmed deaths, the equivalent of 9% of occupied beds.

This was followed by Stratford, which had 232 suspected or confirmed COVID-19 cases (equivalent to 21% of occupied beds) and 91 COVID-19 suspected or confirmed deaths (equivalent to 8% of occupied beds).

The remaining Districts and Boroughs had similar rates of COVID-19 cases when numbers are compared to occupied beds, ranging from 8% in Warwick to 12% in Rugby. Death rates compared to occupied bed numbers were also similar across the Districts and Boroughs, ranging from 3% in Warwick to 7% in North Warwickshire.

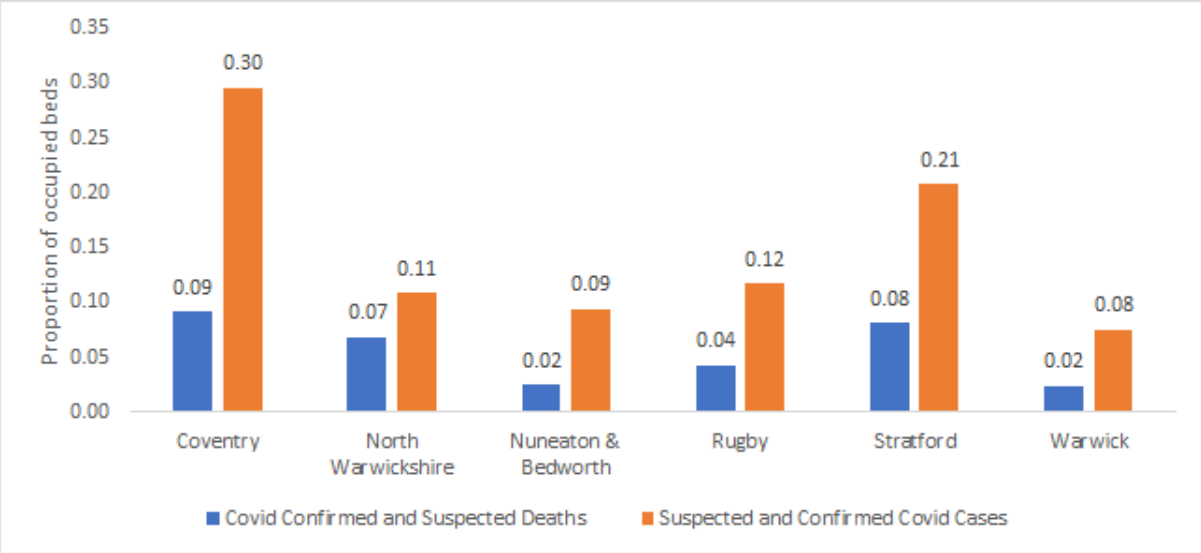
Table 8: COVID-19 confirmed and suspected deaths and cases between 09/03/20 and 10/06/20, and bed capacity and occupied bed numbers by area as at 10/06/20

Area	COVID-19 confirmed and suspected deaths	COVID-19 confirmed and suspected cases	Capacity (Total Available Beds)	Occupied Beds
Coventry	180	582	2252	1968
North Warwickshire	45	71	825	653
Nuneaton & Bedworth	18	68	853	725
Rugby	38	103	990	877
Stratford	91	232	1453	1117
Warwick	29	89	1388	1181

Source: COVID-19 Care Home Impact Dashboard and North of England Commissioning Support (NECSU) vacancies data

The figure below shows the same information as above but is a useful visual representation of the proportions of COVID-19 confirmed and suspected deaths and cases, compared to bed occupancy, as described above.

Figure 11: The proportions of COVID-19 confirmed and suspected and confirmed deaths and cases between 09/03/20 – 10/06/20 per occupied bed as at 10/6/20, by area



Source: COVID-19 Care Home Impact Dashboard and North of England Commissioning Support (NECSU) vacancies data

4.2.4. Action plan going forward

- Understanding this variation further, in order to target homes which may be at higher risk of further outbreaks will be considered by the Preventing COVID-19 in residential care settings group

5.Priority 4: Reducing health inequalities

We have named our Priority 4 as Reducing health inequalities, as opposed to Vulnerable People, as per the overarching outbreak plan. This is to avoid confusion about the term vulnerable, which is widely used

in the care setting as referring to those shielding or at higher risk of COVID-19 due to medical conditions and/or age.

5.1 Black, Asian and ethnic minority (BAME) groups

5.1.1 Overview

Latest evidence suggests that in the UK people from a Black, Asian and ethnic minority background may be more likely to contract COVID-19, more likely to have a more severe episode of COVID-19, and more likely to die from COVID-19 than their white British counterparts. The cause of this disparity is yet be confirmed in the research literature. However, as it follows a similar pattern to non-communicable diseases it is most likely to be socially and structurally mediated rather than as a result of biological or genetic factors. In Warwickshire, as of 2018 there are approximately 15,500 people working in the adult social care sector, of these 2% (310) are of mixed ethnicity, 5% (775) are of Asian ethnicity, 5% (775) are of black ethnicity, and 1% (155) describe themselves as “other”. This means a total of 1,860 (12%) of these workers are likely to be disproportionately affected by COVID-19 and as such there should be special provision to build and maintain their resilience to address disparities.

5.1.2 Race, Resilience and Covid-19

While there is a lack of direct evidence around building resilience specifically among black, Asian, and minority ethnic groups, there are some tentative recommendations emanating from The Fenton Report, Warwickshire’s report on Covid-19 risk, and Race and Health which can be instructive in developing action plans to ensure equity among the care home workforce. Key recommendations have been combined below, but collaboration and engagement with BAME members of staff should be a central guiding principle in applying these:

1. Risk assess staff and support managers to discuss the issue with staff from a BAME background.
2. COVID-19 recovery strategies should actively reduce inequalities caused by the wider determinants of health to create long term sustainable change
3. Be aware that people’s racial and ethnic identity may lead people to feel they are less entitled to speak up or seek help, managers should proactively ask team’s wellbeing and need for support at this time, rather than simply saying they are welcome to discuss these if they so wish
4. Consult black, Asian, and minority ethnic members of your organisation on the barriers to engaging wellbeing and resilience measures.
5. Equity audits can help to determine if policies and processes meet standards of equity and fairness
6. Use the general resilience checklist as mentioned in section 3.1.3 and BAME managers checklist (see Appendix 3 and 4)
7. Be aware that particularly vulnerable groups may find is stressful or difficult to discuss their experience and concerns, so it is important to allow a supportive space to discuss these without dismissal or avoidance, but equally it is important to honour their wish to not discuss them
8. Involve teams directly when developing a resilience plan, and ensure that vulnerable groups, such as black, Asian and ethnic minority groups have their voices heard.

9. Note that BAME team members may have an additional source of stress due to the current prominence of racial inequality discussion in the media

5.2 Learning Disabilities

The Learning Disability Mortality Review (LeDeR) is a national programme to improve health outcomes for this patient group through the review of every death of those with a Learning disability. These reviews are locally led and nationally co-ordinated.

During the three month period, 1st March 2020 – 31st May 2020, a total of 24 adults with a learning disability, from all settings, died – these deaths were all reported to the LeDeR programme and will be subject to full LeDeR reviews in line with the national programme. This number of deaths represents a significant increase when compared to the number of deaths that were reported in the same time period last year. For comparison purposes, a total of ten adult deaths in Coventry/Warwickshire were reported to LeDeR during March – May 2019. Thus, the 2020 figure represents a **140% increase**.

In total, 11 deaths were caused by a confirmed or suspected COVID-19 diagnosis. To date no deaths of people with LD that occurred during May 2020 have cited COVID-19 as the cause.

Of the 11 COVID-19 related deaths, eight of the individuals resided in a care home or nursing home as their usual place of residence. It should be noted that no care home had more than one COVID-19 related death of an LD resident.

Despite many of the individuals concerned living in care homes, the majority of the group died in hospital, only two dying in their care home residence. From the data available for review it is unclear whether care home residents who died in hospital contracted COVID-19 prior to or during their admission. Of two individuals who died in their care home, one was an LD resident in an older people's care home that reported a wider outbreak that coincided with the death and the other individual was on a palliative care pathway following a period of ill-health.

Information regarding underlying health conditions could be obtained for 8 of the 11 people who passed away – all had additional health needs which may have increased the risk that COVID-19 presented to them. These conditions included Diabetes, cancer diagnosis and advanced dementia. However, there are no specific trends evident within the data available.

This analysis has not identified any recurrent themes or trends. This rapid review did not consider the patient experience in the level of detail that the LeDeR review will, however, there has been no evidence to indicate any poor or discriminatory care. All of the COVID-19 deaths occurred during the early stages of the local outbreak.

This analysis suggests that the presence of COVID-19 is accountable for this notable increase in deaths amongst this vulnerable group as the non-COVID19 deaths account for very similar number of deaths as occurred during the same period in 2019.

Discussion with both Birmingham and Black Country based colleagues undertaking similar analysis has confirmed that they too have seen a significant increase in reports of deaths to LeDeR during this timeframe, accompanied by a number of COVID-19 deaths. Again, their reviews have not identified distinct trends or themes but a similarly sporadic incidence of the virus.

5.3: Maintaining resilience, wellbeing and mental health in care home staff

Care home staff working in homes that are affected by COVID-19 may experience high levels of stress that can affect emotional wellbeing. Anxiety around working and feeling safe within the care sector has been high. Care home staff may have witnessed illness and death that is deeply emotionally upsetting. For those working in homes that have experienced a high number of cases and deaths, the risk of this is higher. There are also great challenges brought about by the pandemic that cause anxiety through threatening their basic needs. There may be health concerns, or worries about loved ones' health, feelings of isolation from social distancing measures, children no longer being at school adds pressure on to families that need to work and there may be financial worries too.

The majority of people will be able to process their experiences without formal mental health input and can be supported with measures to increase resilience and mental wellbeing. However, a minority of people may need extra help and it is important that managers are aware of the signs of this so that they can recognise this in themselves and others and know how they can access help.

It is important that all staff are aware of what support is available to them, and that their mental wellbeing is a priority. There should be regular communication within teams including signposting to the options available, regular opportunities for structured reflection time which are appropriately managed and wellbeing initiatives to support staff.

5.3.1: Building and maintaining supportive teams:

- Managers should accept and validate that is an extremely difficult time and how much they value their staff.
- Managers should aim to be **visible, available and supportive**.
- Reinforce to staff that their wellbeing remains an utmost priority.
- Make sure basic needs are also discussed and considered, e.g. getting adequate rest, sleep, nutrition and exercise, connecting with friends and family.
- Promote self-care and wellbeing. Actively ask staff to share what they are doing to meet their self-care and wellbeing needs such as yoga, art, gardening or listening to music.
- Schedule regular de-briefing sessions and ensure people have the opportunity to use these. Normalise psychological responses e.g. 'it is ok not to be ok'.
- Ensure that regular one-to-one sessions are scheduled with managers and importance placed on these. If these are done in person consider if they could be done while walking outside together while maintaining social distancing.
- Encourage staff members to identify a 'buddy' and to use their buddy for peer support. Buddies should be encouraged to actively check in with each other.
- Encourage open and honest communication within the team. Promote connectedness, perhaps with a team check-in for ten minutes each morning.
- A whole team approach to prioritising wellbeing and building resilience
- Consider introducing Wellness Action Plans

5.3.2: Support for managers

There is an increasing body of evidence that the most effective way to influence the health of a team is through supporting managers to become skilled in having psychologically well-informed discussions. One way of doing this is through COVID-19 Psychological First Aid online training available here: https://www.futurelearn.com/courses/psychological-first-aid-covid-19

- It is essential that managers also prioritise their own mental wellbeing
- Model empathy, compassion and kindness, including kindness to yourself.
- The increased pressure and difficult decisions that managers are facing should be recognised and acknowledged
- Consider whether a buddy system could be set up with managers in neighbouring care homes, or with managers of homes that are similar in size or levels of support that they offer. An alternative is a peer support group that could be done virtually.
- Managers can be role models by adopting the simple measures to increase wellbeing, eg using the apps or websites suggested and feeding back how they found these. This should help with their own wellbeing while also encouraging their team to use them.
- Ensure managers are confident in how their team can access help, and how they can help those that are struggling, including themselves.
- Registered managers can find advice on maintaining resilience on the Skills for Care website. Skills for Care have also opened up their members facebook group and a new telephone advice line on 0113 241 1260 with email inbox RMAdvice@skillsforcare.org.uk to provide registered members with more support
- Registered manager networks also offer local support and are establishing WhatsApp groups for local registered managers to stay in touch.

A summary of the resources available, both nationally and locally for care home staff can be found in Appendix 4

.

5.4 Actions moving forward

- Encourage all care homes to use the BAME managers checklist
- Support homes to reduce inequalities amongst their BAME workforce
- Ensure that routine testing for care homes has captured all LD providers and is also extended for supported living providers
- Ensure all LD providers of both care home and supported living have received infection prevention and control training, to ensure preparedness for any future wave
- Ensure that care homes know what mental wellbeing and resilience resources are available to them through regular communication
- Encourage care home managers to undertake COVID-19 Psychological First Aid online training

6.Priority 5: Testing capacity

Mass testing was rolled out nationally by DHSC and Coventry and Warwickshire currently has two options that care homes can access. This is either via the national portal where swab kits are delivered to the homes for them to swab both residents and staff and these are collected to be tested at regional/national Pillar 2 Labs.

The second option is via Arley Medical Services and they will attend the home and take swabs for all residents and asymptomatic staff which is then sent via local Pillar 1 testing to the UHCW lab. Local testing initially started on the 21st May 2020 and we are ramping this up with 2 teams to be able to process up to 300 swabs daily with UHCW. This service has been extended to support pathways of individuals moving between homes or moving from their own home to a care home setting. To ensure that the test remains current we have asked that these individuals remain isolated within their rooms/homes following swabbing whilst they await the results for transfer.

The table below shows the numbers and staff in care homes that have been tested via Arley, and their results. In Coventry there has been testing in 25 care homes. Within these 489 residents have been tested, 14 of which were positive. 489 staff were tested, of which 3 were positive. In Warwickshire there has been testing in 39 care homes. 844 residents were tested, of which 31 were positive. 931 staff were tested, of which 6 were positive.

Table 9: The number of residents and staff tested under the local Pillar 1 Pathway (via Arley Medical Services) and their results, correct as of 18/6/20

	Coventry	Warwickshire	Total
Number of Homes Tested	25	39	64
No. of residents tested	489	844	1333
No. of residents positive results	14	31	45
No. of residents negative results	451	751	1202
No. of inconclusive results/Pending	24	72	86
No. of staff tested	489	931	1420
No. of staff positive results	3	6	9
No. of staff negative results	328	949	1277
No. of inconclusive results/Pending	44	88	134

Source: Local IPC log

The results demonstrate a small percentage of residents that have been identified as COVID-19 positive. Many of these were already known to the IPC/PHE teams through our outbreak management support provided to homes. The numbers of staff with COVID-19 positive results have been relatively small and

advice on isolation was given. Overall the system is seeing a downward trend for individuals testing positive for COVID.

6.1: Action plan going forward

- Complete the swabbing for the remaining homes
- Planning for managing flu and COVID simultaneously is currently being discussed. Ideally during flu season the resident/staff member would be tested for flu and COVID simultaneously, but the details around this, including feasibility and whether this would be tested nationally or locally are still being worked out.
- The funding for Arley testing is set to run out in September – a plan as to whether funding can be continued is being discussed.

7.Priority 6: Contact tracing

For ease of reading contact tracing has been included within the operational response in Section 1.2

8.Priority 7: Data, dynamic surveillance and integration

We have created surveillance tool named the COVID-19 Care Home Impact Dashboard which consists of data from our local IPC log, the NECSU tracker data, the CQC directory and test results. This is updated daily and provides us with information for action. We are able to use this information to identify when there is a problem, and to monitor how we are doing in relation to the management we have instigated. This Dashboard enables us to support discussions with our stakeholders, DPH and other key decision makers, providing the information they require to support these decisions. The Dashboard is supplemented by information from provider surveys and qualitative information we gain as part of our work.

8.1 Action plan going forward

The development of the Dashboard and how we use this information in the future is currently being examined. As outbreaks in care homes are reducing in number cases are being identified through whole home screening, and these are generally single cases in either residents or staff. The Dashboard needs to allow these to be categorised as incidents/exposures rather than outbreaks.

9. Priority 8: Deployment of capabilities including enforcement

The Warwickshire and West Midlands Strategic co-ordinating group (SCG) will support regional coordination of the wider pandemic response going forward, including PPE distribution testing and recovery arrangements.

A detailed table of contacts for every aspect of care home outbreak management has been produced and can be seen in Appendix 5.

Mapping for the resource required to manage all outbreaks has been undertaken. This has identified the need for greater IPC capacity, Public Health capacity, and gaps around testing coordination, analytical capacity, project management, and evaluation skills.

Additional resource identified as being required:

PPE – while we currently have stock, we need to keep up stock levels for the foreseeable future and there is a risk we will not be able to meet future demand.

Local testing – the funding for Arley testing is currently only until September. While this is our preferred approach if funding were discontinued all testing would have to be through the national scheme.

Mutual aid system – this will require expanding to ensure that care homes are always adequately staffed.

Antibody testing: whilst NHS staff currently have access to this testing, the same is not true of social care staff. The CCG is currently looking into this, but at present there not enough phlebotomy capacity to undertake antibody testing.

Vaccine: The usual time to develop and produce a vaccine is very long. Should a vaccine become available then care home staff and residents would be in the vaccine priority group.

Home care: It is recognised that this plan focuses on care home settings in the main, but the importance of care provided in people's homes is widely recognised as an area which requires some urgent ongoing focus from an infection control perspective, to include many of the key elements in this action plan. Work is underway to tackle some of these gaps.

Standard Operating Procedure
PHE-LA Joint Management of COVID-19 Outbreaks in the West Midlands

(Acknowledgement: based on a model developed in the East of England for care home outbreaks)

Version 4: 30th June 2020 and will be kept under continual review

1. Overview

This provides a framework for working across PHE WM, public health structures in Local Authorities (LAs), Clinical Commissioning Groups (CCGs) and other relevant organisations for dealing with COVID-19 outbreaks in a variety of settings. It has been developed by Public Health England (PHE) WM and the Association of Directors of Public Health (ADsPH) WM as the basis for working together during the Test, Trace, Contain, Enable (TTCE) phase of the response to COVID-19.

It recognises both PHE's mandate to protect the public's health, and the specialist health protection service that PHE offers locally and regionally, and the LA duty to protect the health of the people it serves with DsPH providing the local public health leadership role for the management of outbreaks in their area

We recognise that there will be different capacities and capabilities across the region and that we will need to develop and implement the arrangements jointly across each area to make best endeavours using all the resources available both to PHE and the LA and local system partners.

This SOP will support the effective delivery of local COVID-19 outbreak control plans by defining the specific roles and responsibilities of individual arrangements in responding to outbreaks.

This SOP will be kept under review, in line with national guidance and changes in the capacity across the system. It is intended to be flexible and adaptable for local operation. Different local systems in WM have different support and outbreak management arrangements, including differing LA Public Health team roles, so this SOP is intentionally flexible to allow for that.

The suggested overarching joint approach to managing complex cases and outbreaks will be as follows:

- PHE will arrange swabbing and testing for symptomatic individuals when first advised of an outbreak (within a particular setting, or particular cohort), linked in with regional/local arrangements for testing.
- PHE will undertake the initial risk assessment, share the risk assessment with the LA and give advice to the setting and the local system on management of the outbreak. If relevant the local system will be informed of a single positive case eg in an education setting, other complex setting (emergency accommodation) or of a vulnerable individual.
- The local system, led by the DPH, will follow-up and support the setting to continue to operate (or not) whilst managing the outbreak, including support with infection prevention and control.
- Local systems will have responsibility for providing settings with infection prevention and control advice. PHE health protection teams (HPT) will support and advise the LA as necessary.

- PHE will work collaboratively with LAs both proactively and reactively to ensure two way communication about outbreaks, local intelligence, enquiries and wider issues/opportunities.
- PHE will continue to give advice on complex situations on request from local systems, including advice on closing and opening settings.
- Local authorities will continue to support individuals who are shielding and may also support those self-isolating if required.
- Local authorities will lead on media and communications, with support from PHE as appropriate.
- PHE and DsPH will also work closely together to monitor surveillance data and other intelligence to identify and investigate as appropriate, local exceedances in cases that may indicate community transmission of COVID

2a. Rationale for the joint SOP

I. To have a joint collaborative and co-ordinated approach to:

- supporting WM settings including care homes, extra care housing and supported housing, workplaces, schools, nurseries, emergency accommodation, faith settings etc. in managing COVID-19 outbreaks
- finding and supporting complex individual contacts that the national contact tracing system has been unable to advise fully, or where there are concerns raised regarding compliance with advice.

II. The aim of this joint approach is to reduce transmission, protect the vulnerable and prevent increased demand on healthcare services.

III. To streamline the follow up of WM care settings by the LA, CCG and PHE Health Protection Teams.

IV. To provide consistent advice to settings.

V. To have a single point of contact in PHE and each LA to facilitate communication and follow up.

VI. To provide a joint response for outbreak management, providing infection control advice and support for operational issues.

VII. To develop and maintain a surveillance and monitoring system for outbreaks for COVID-19, aligning with existing databases held by partners (LA and CCGs)

VIII. To share outbreak information between PHE, LA and CCGs to facilitate appropriate measures.

2b. Governance and Key Guiding Principles

i. PHE will fulfil its statutory duty as outlined below by receiving the notification of outbreaks (directly, or through testing data/local intelligence), undertaking the risk assessment and providing public health advice in accordance with national guidance or local SOPs such as the agreements that were developed for dealing with care home outbreaks. The LA will fulfil its statutory duty regarding assurance and lead the development of Local Outbreak Control Plans working through COVID-19 Health Protection Boards and in collaboration with emergency planning forums and a public-facing, member-led board. The LA will work jointly with PHE, through local health protection teams, to lead the work on managing outbreaks in complex settings and situations. This PHE-LA SOP will sit as an integral part of the Local Outbreak Control Plans to reflect the collaborative approach adopted by PHE and the LAs.

ii. PHE and the LA will work together to ensure timely and effective communication processes between themselves and when communicating with specific settings.

iii. As per this joint SOP and in line with the statutory roles outlined below, LAs or PHE will conduct follow up of these settings as a shared responsibility with CCGs and fulfil their statutory duty for safeguarding and protecting the health of their population:

iv. PHE has responsibility for protecting the health of the population and providing an integrated approach to protecting public health and addressing health inequalities through close working with the NHS, LAs, emergency services, voluntary and community sector, and government agencies. This includes specialist advice and support related to management of outbreaks and incidents of infectious diseases.

v. The health and social care system, together with local government, has a shared responsibility for the management of outbreaks of COVID-19 in the WM.

vi. Infection prevention control support and advice for each setting will be provided in line with local arrangements. (See appendix A for a summary of agreed local arrangements)

vii. Under the Care Act 2014, Local Authorities have responsibilities to safeguard adults in its area. LA responsibilities for adult social care include the provision of support and personal care (as opposed to treatment) to meet needs arising from illness, disability or old age. The Children Act 2004 places duties on a range of organisations, including Local Authorities, to safeguard and promote the welfare of children.

viii. Under the Health and Social Care Act 2012, Directors of Public Health in upper tier and unitary local authorities have a duty to prepare for and lead the LA public health response to incidents that present a threat to the public's health.

ix. Under the Health and Social Care Act 2012, CCGs have responsibility to provide services to reasonably meet health needs and power to provide services for prevention, diagnosis and treatment of illness.

x. Medical practitioners have a statutory duty to notify suspected and confirmed cases of notifiable diseases to PHE, under the Health Protection (Notification) Regulations 2010 and the Health Protection (Notification) Regulations 2020. PHE will also work with LAs on communication to specific settings (e.g. care homes, schools, workplaces) to ensure that notification of outbreaks occurs in a timely fashion.

xi. Under mutual aid arrangements, this collaborative arrangement creates a shared responsibility between the LAs and PHE in dealing with COVID-19 outbreaks.

xii. In practice the LAs and PHE HPT will work closely together to deliver the duty to collaborate as part of a single public health system to deliver effective control and management of COVID-19 outbreaks.

3. PHE Health Protection Team Role

A. Risk assessment of Complex Cases and Situations

i. Complex cases and situations include the following examples:
- situations where liaison with an educational setting or employer may be required
- complex and high-risk settings such as care homes, healthcare services, prisons, accommodation for asylum seekers or the homeless
- cases/contacts who are unable to comply with control measures
- situations which require further investigation locally

ii. On initial notification, the HPT will complete a risk assessment, involving local partners as appropriate.

iii. The HPT will give infection prevention control advice (verbal and email) to the individual or organisation to minimise spread of infection.

iv. The HPT will inform the local authority by daily summary e-mail (to agreed SPOC email) and by phone if urgent action required. The email will include the details of the setting, situation, a copy of the risk assessment and action already taken, also anything that was a cause for concern in the initial risk assessment (using the red flag system)

v. The LA will update PHE on the status of each outbreak at 14 days, unless an earlier alert is deemed necessary in complex situations, via the following email address wm.2019CoV@phe.gov.uk

vi. In complex situations a joint discussion on control measures will take place between LA/CCG lead and PHE. An example indicating poor outbreak control in a care home would include sudden high attack rate, increase in deaths or other operational issues. In other settings, for example, a school, poor outbreak control might be reflected by multiple cases in different 'bubbles'.

B. Swabbing/testing of new outbreaks (notified via all routes)

i. Swabbing will be coordinated by PHE in line with current arrangements e.g. A one-off swabbing of symptomatic residents and staff in a care home will be arranged by the HPT when the outbreak is first reported by the setting (or referred from the NHS Test and Trace system).

ii. The results will be provided by the organisation taking the sample. (See appendix A for further details)

iii. Further testing will be considered based on national decisions relating to the complex situation or cases and asymptomatic transmission risk. This will be arranged in conjunction with local teams via an IMT as necessary, including agreement about who will be tested and the approach for testing.

C. Regional co-ordination and support

i. PHE will:

- provide regional co-ordination eg sharing of best practice, solutions to complex problems etc
- provide regional advice and guidance where there are gaps in national guidance
- flag gaps / discrepancies in guidance to the national teams and support local teams while awaiting further guidance

ii. PHE, the regional convenor for TTCE, ADsPH WM and the regional lead for the new Joint Biosecurity Centre will provide regional oversight of the TTCE response, facilitating the sharing of best practice, good practice in data sharing, consistent upward reporting, and additional support to local systems as appropriate.

4. Operational Reporting to Local Systems

i. A daily summary table listing of situations in the West Midlands, as recorded by PHE's Health Protection database will be provided to DsPH and their SPOC to aid operational management.
ii. A daily line list of confirmed cases notified to the HPT each day will be shared with the DPH for the area and their nominated colleague(s).
iii. Reconciliation to take place by local teams using local intelligence and monitoring systems to ensure accuracy and assurance. Any issues to be raised with the PHE HPT and actions agreed.

5. Operational Enquiries

i. Enquiries received by the HPT relating to operational issues, such as listed below, will be forwarded to local systems' SPOC.

- Sourcing PPE
- Operational issues relating to staff capacity and other support to the organisation
- Removal of dead bodies
- Care provision
- Whistleblowing regarding poor workplace practices
- Housing and social support (e.g. provision of food)

ii. Enquiries received by the LA that require a policy understanding from PHE, will be forwarded to wm.2019CoV@phe.gov.uk

Local System Role

Local authorities have been working to support a range of settings (e.g. schools, care homes, workplaces) and communities, both proactively and reactively as part of the overall COVID-19 response. This activity will continue in the next test, trace and isolate phase of epidemic management, working closely with PHE. However, the focus of both the proactive and reactive work will need to change, as workplaces and schools open (requiring support with ensuring this is done safely), and as contact tracing programmes are established).

Local authority areas have been asked to develop local COVID "outbreak management plans" by the end of June 2020, which focus on the following 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. Identification of high- risk places, locations and communities, e.g. homeless shelters, migrant worker dormitories/accommodation for vulnerable migrants, high-risk workplaces (e.g. meat packing plants, slaughter-houses among others), places of

worship, ports and airports. Defining preventative measures and outbreak management strategies.
3. Local Testing Capacity – to prioritise and manage deployment of testing capacity quickly to the places that need it for outbreak management (e.g. NHS, pop-up, mobile testing units etc).
4. Local Contact Tracing – Led by PHE, but for LAs to consider mutual aid and support structures - identifying specific local complex communities of interest and settings. There is a need to develop assumptions to estimate demand, developing options to scale capacity if needed.
5. Data and integration – national and local data integration and ability to measure R number locally; links with Joint biosecurity centre work (to include data management planning, data security and data linkages)
6. Vulnerable people – supporting vulnerable people 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 and supported by existing Gold command forums and a new member-led Board to communicate with the general public.

The plans capture the themes above under 8 priority areas

Community engagement to build trust and participation
Preventing Infection
High Risk Settings and Communities
Vulnerable people
Testing capacity
Contact tracing
Data: dynamic surveillance and integration
Deployment of capabilities including enforcement

Local authorities will:

1. Continue with wider proactive work with particular settings and communities in order to minimise the risk of outbreaks/clusters of cases
2. Work with PHE to support complex cases and outbreak management (in a range of settings/communities) as highlighted in above SOP, looking to mobilise/re-purpose existing capacity within public health, environmental health, trading standards, infection control, education, as well as wider professional workforces as appropriate (school nursing, health visiting, TB nursing and sexual health services, academia).
3. Provide a single point of access for communication with the local authority on matters relating to the reactive response, as well as out of hours contact (through Directors of Public Health and Health protection leads, or other local arrangements as they emerge)
4. Establish regular proactive meetings with “link” PHE colleagues to discuss complex outbreaks, local intelligence, alongside enquiries being managed by local authorities, alongside wider issues/opportunities. This may be at both local and sub-regional footprints
5. Develop local COVID “outbreak” plans rapidly alongside PHE, ensuing appropriate PHE representation on COVID health protection boards/member-led Boards.

Underpinning this work will be a need to rapidly work jointly with PHE on a workforce plan to ensure capacity in the system for delivery of the above.

Contact details

WCC – Single point of access dphadmin@warwickshire.gov.uk

CCC – Single point of access covid19testing@coventry.gov.uk

SMBC – Single point of access contacttracing@solihull.gov.uk

Out of hours – via DPHs or Nadia Inglis (Health Protection lead for WCC/CCC) 07980501941 and Sangeeta Leahy (Health Protection lead for SMBC) 07983 978 412

Contact details for PHE are wm.2019CoV@phe.gov.uk

Contact details for LA
As above

Version Control

Version & Date	Amendments	Authors
V1.0, 14/05/20 V2.0, 25/05/20	Initial Draft Comments on initial draft and suggested local response	West Midlands Centre West Midlands Centre/LA
V3.0 18.06.20	Further comments from Regional Director	PHE Midlands (West Midlands)
V4.0 30.06.20	Included reference to regional convenor role and JBC	PHE Midlands (West Midlands)

V4.0 30.06.20	None	Liz Gaulton on behalf of DsPH

Appendix A – Roles by setting

	Setting									
	Care and residential homes (including LD)	Schools, College and Universities	Children's settings, Child care and nurseries	Workplace – not open to public	Workplace – open to public	Prison	Vulnerable people – Homeless, hostels	Faith Settings	Hospital and health care	Other, including Faith, Public Transport, Community settings
Receive notification	PHE – positive lab test LA – symptomatic possible cases (local notification)									
Gather information and undertake risk assessment	PHE (initial risk assessment) LA ongoing risk assessments – working with PHE where needed									
Arrange testing	Local Laboratories and via national scheme	PHE/national testing sites. Wider screening - TBC	PHE/national testing sites. Wider screening - TBC	PHE/national testing sites. Wider screening - TBC	PHE/national testing sites. Wider screening - TBC	PHE	Local service TBC	PHE/national testing sites. Wider screening - TBC	Local Arrangements	PHE
Provide advice and recommend control measures	PHE with support from LA for complex situations and groups LA to provide support for those self isolating									
Provision of results	Solihull – LA Cov & Warks CCG	Gov.uk/ TBC local arrangements	Gov.uk/ TBC local arrangements	Gov.uk/ TBC local arrangements	Gov.uk/ TBC local arrangements	CCG/ NHSE	Gov.uk/ TBC local arrangements	Gov.uk/ TBC local arrangements	Trusts	Gov.uk/TBC local arrangements
IPC follow up	Care Homes – CCG Dom care – LA/CCG	LA	LA	Regulatory Services (TBC)	Regulatory Services (TBC)	NHS E	LA with Districts	LA	CCG	LA with Support from districts

										(latter TBC)
Access to PPE	LA	LA	LA							
Chair IMT if required	PHE – all initial IMTs Then PHE/LA by agreement. For hospital trust, DIPC to chair.									

APPENDIX 2:

Checklist for care homes

Residents

Have there been any new residents with symptoms suggestive of COVID-19, since last contact with PHE? If so, how many?

What is the current number of residents with symptoms suggestive of COVID-19?

What is the total number of residents in the home currently?

What is the date of onset of the most recent symptomatic resident?

Have there been any deaths in residents where COVID-19 is the suspected cause, since last contact with PHE? If yes, how many?

Has there been any swabbing of residents undertaken in the care home? If yes, how was the testing arranged and how many residents are positive?

Staff

Have there been any new staff members off work due to symptoms of COVID-19? If yes, how many?

Have any staff been seriously unwell or admitted to hospital?

How many staff are off work?

How many permanent staff work at the home? (is it the same as previously recorded ..)

Are you currently managing to maintain safe staff levels?

Has there been any swabbing of staff undertaken? If so, how was this accessed? How many staff have tested positive?

Do you have any concerns regarding PPE for staff members?

Have these concerns been raised with LA/CCG/providers?

Do you have any concerns regarding infection control arrangements?

APPENDIX 3

Managers' Guidance – Support for BAME Employees

There is evidence to suggest that some groups may be disproportionately affected by COVID-19, including staff from Black, Asian and Minority Ethnicity (BAME) backgrounds. As we have staff across the CCGs from these backgrounds, we want to ensure that the support we provide has everyone in mind.

In order to ensure that all staff are suitably and proactively supported, managers must now arrange a private and sensitive conversation with any members of their team from BAME backgrounds. The aim of this discussion is to identify and manage any work-related risks that may apply, to understand any other specific areas of worry or concern and to encourage use of the various health and wellbeing support resources that are on offer. Your HR team will confirm to you which members of your team (if any) have historically identified themselves to the CCG as being from a BAME background. We will also advise you of any team members who chose not to disclose their ethnicity and encourage you establish a way of ensuring that any of these individuals have the ability to approach you for a discussion if they feel it is appropriate for them.

A communication is being sent out which advises employees of this course of action and includes a list of health and wellbeing resources together with details of how they can be accessed.

We appreciate that each conversation will be unique to the employee, taking into consideration factors such as their role with the CCG. However, we have developed a template to guide these conversations and for you to record details in. Please complete this template for each employee you speak to and send a copy to your HR team for retention on their personal file.

We would encourage you to keep an open and ongoing dialogue with employees to ensure that any changes to their circumstances can be considered and appropriately supported. If the individual would prefer to have this conversation with a member of their HR team they are of course free to do so (please let your HR team know if this is the case so that arrangements can be made).

We are also inviting members of staff who are not from BAME background themselves, but have loved ones or members of their households who are, to approach you for a confidential conversation. It is equally important for these colleagues to be supported. You do not need to complete and submit the attached from for these staff but please ensure that you do maintain a supportive ongoing conversation with them.

Should you have any queries regarding the above, please either speak to a member of your local HR team or email steve.copeland@nhs.net.

BAME Risk/Support Assessment

Employee details	
Name	**Job title**
Department	**Contact number**

Manager's detail	
Name	**Job title**
Department	**Contact number**

Question	Response	Notes
1. **Have you received a shielding letter?**	Yes/No	Employee should already be safely shielded at home. Please move to Q6
2. **Do you have an underlying health condition?**	Yes/No If yes, is the CCG already aware (of so who was advised and when?)	Details of health condition including how well it is controlled:
3. **Are you currently pregnant?** *Existing guidance identifies that pregnant women over 28 weeks should be regarded as at increased risk and recommended to stay at home. For pregnant women with underlying health conditions at any stage of pregnancy a more precautionary approach is required and ethnicity should be included in the consideration and discussion between healthcare staff and managers. Where pregnancy is under 28 weeks gestation working in a patient facing environment should be on the basis that the risk assessment supports this.*	Yes/No	
4. **Are you involved in healthcare delivery/support which may expose you to known or suspected COVID-19 patients?**	Yes/No	Is adequate PPE being provided? Do any other measures need to be taken to protect the individual e.g. a

		change of working pattern or location?
5. Does you work require you to have extensive essential close contact (less than 2 meters) with patients/members of the public/colleagues but who are not known or suspected COVID-19 patients?	Yes/No	Do any other measures need to be taken to protect the individual e.g. a change of working pattern or location?
6. Does the employee have any specific worries or anxieties related to COVID-19 that they would like us to be aware of? *You may also wish to explore with your team member whether they have family and/or other loved ones who live overseas; there may be added anxiety for these colleagues as COVID-19 infection rates are spreading at different rates across the globe. Those who sadly lose loved ones living overseas to the virus will also need support in attending virtual funerals; please support these by being flexible with working arrangements and using the special leave facilities within your CCG where appropriate.*	Yes/No	Is the employee accessing any of the supportive resources help with these? (If not, they should be encouraged to do so.) What else could be done to help? e.g. regular 'check-in' conversations with manager or trusted colleague

Agreed Actions

By signing below you consent to the sharing and storage of your personal information as set out above.

I can confirm that the information captured above is reflective of the conversation held and agreement reached:

Employee's signature……

Date……..

Manager's signature……

Date……..

APPENDIX 4

Maintaining resilience, wellbeing and mental health in care home staff

The majority of people will be able to process their experiences without formal mental health input and can be supported with measures to increase resilience and mental wellbeing. However, a minority of people may need extra help and it is important that managers are aware of the signs of this so that they can recognise this in themselves and others and know how they can access help. The pyramid below highlights the different levels of support:

*Wellbeing, self-care and mental health resources and information on local services available via: https://www.warwickshire.gov.uk/information-coronavirus/mental-health-advice-coronavirus-pandemic/1 and https://www.mentalhealthatwork.org.uk/toolkit/ourfrontline-socialcare/

1.0: General wellbeing measures

It is important that all staff are aware of what support is available to them, and that their mental wellbeing is a priority. There should be regular communication within teams including signposting to the options available, regular opportunities for structured reflection time which are appropriately managed and wellbeing initiatives to support staff.

1.1: Building and maintaining supportive teams:

- Managers should accept and validate that is an extremely difficult time and how much they value their staff.
- Managers should aim to be **visible, available and supportive**.
- Reinforce to staff that their wellbeing remains an utmost priority.
- Make sure basic needs are also discussed and considered, eg getting adequate rest, sleep, nutrition and exercise, connecting with friends and family.
- Promote self-care and wellbeing. Actively ask staff to share what they are doing to meet their self-care and wellbeing needs such as yoga, art, gardening or listening to music.
- Schedule regular de-briefing sessions and ensure people have the opportunity to use these. Normalise psychological responses eg 'it is ok not to be ok'.
- Ensure that regular one-to-one's are scheduled with managers and importance placed on these. If these are done in person consider if they could be done while walking outside together while maintaining social distancing.
- Encourage staff members to identify a 'buddy' and to use their buddy for peer support. Buddies should be encouraged to actively check in with each other.
- Encourage open and honest communication within the team. Promote connectedness, perhaps with a team check-in for ten minutes each morning.
- A whole team approach to prioritising wellbeing and building resilience
- Consider introducing Wellness Action Plans

1.2: Support for managers

There is an increasing body of evidence that the most effective way to influence the health of a team is through supporting managers to become skilled in having psychologically well-informed discussions. One way of doing this is through COVID-19 Psychological First Aid online training available here: https://www.futurelearn.com/courses/psychological-first-aid-covid-19

- It is essential that managers also prioritise their own mental wellbeing
- Model empathy, compassion and kindness, including kindness to yourself.
- The increased pressure and difficult decisions that managers are facing should be recognised and acknowledged
- Consider whether a buddy system could be set up with managers in neighbouring care homes, or with managers of homes that are similar in size or levels of support that they offer. An alternative is a peer support group that could be done virtually.
- Managers can be role models by adopting the simple measures to increase wellbeing, eg using the apps or websites suggested and feeding back how they found these. This should help with their own wellbeing while also encouraging their team to use them.
- Ensure managers are confident in how their team can access help, and how they can help those that are struggling, including themselves.
- Registered managers can find advice on maintaining resilience on the Skills for Care website. Skills for Care have also opened up their members facebook group and a new telephone advice

line on 0113 241 1260 with email inbox RMAdvice@skillsforcare.org.uk to provide registered members with more support

- Registered manager networks also offer local support and are establishing WhatsApp groups for local registered managers to stay in touch.

2.0: National mental health and wellbeing resources

2.1: Support package specifically for social care staff

The government have developed an emotional, psychological and practical support package for all adult social care staff during the COVID-19 response that can be found here Wellbeing and mental health support package for social care staff. The support package currently includes free access to:

- **Daylight app:** a smart-phone based app that helps people experiencing symptoms of worry and anxiety using cognitive behavioural techniques, voice and animation
- **Sleepio:** a digital sleep improvement programme using cognitive behavioural techniques to improve poor sleep
- **SilverCloud Health:** a dedicated website to provide wellbeing support, including measures to help with managing the challenges presented by COVID-19, sleep improvement and stress reduction.
- **Bereavement and Trauma Line:** Specialist counsellors and support workers are available for all social care staff that have:
    - have experienced a bereavement
    - whose wellbeing has been affected by witnessing traumatic deaths as part of their work
    - to discuss any other anxiety or emotional issues they are experiencing as a result of the coronavirus epidemic.

  The service is available seven days a week, 8am-8pm on **0300 303 4434**
- **Samaritans support line for adult social care staff:** This is a confidential emotional support line specifically for social care staff. It is available for free from 7am to 11pm seven days a week on **0300 131 7000**

- There is also national wellbeing guidance for social care staff. The main parts have been summarised within this document, the guidance in its entirety can be found here: COVID-19: Health and wellbeing of the adult social care workforce

2.2: National resources:

- MindEd is a Coronavirus Staff Resilience Hub for all frontline staff including care staff. It was created by NHS Health Education England and has advice and tips based on their large panel of international experts.

- Every Mind Matters have produced top tips to look after mental health and wellbeing, that includes relaxation techniques, audio guides to manage anxiety or low mood, links to workouts, advice on sleep and much more.

- National guidance for the public on mental health and wellbeing during COVID gives key tips on building and maintaining your wellbeing and is another useful resource for staff.

- Mental Health at work: Our Front Line this resource offers round the clock 1:1 support for front line workers by call or text, and has resources tips and ideas to look after your mental health

- There is further **national bereavement help** during COVID-19 from Cruse, who provide advice and support around bereavement and grief and At a Loss which signposts to other services that can provide resources and support to those bereaved.

- **Keeping active:** Public Health England provides easy Ten minute workouts that can be done at home, and the NHS Fitness Studio also has a collection of accessible exercise videos.

3.0: Warwickshire specific resources for mental health and wellbeing

3.1: Warwickshire County Council Employee Assistance Programme (EAP)

This open to all commissioned care homes, supported living providers and domiciliary care providers. All staff employed by these organisations will have access to the Employee Assistance Programme for an initial six months period from June 1st. As part of this programme staff have access to information, support and guidance (including coaching and counselling where appropriate) on a wide range of topics including work/career, relationship/family, money management and debt and health and well being.

In addition, there is also a 24/7, easy to access, confidential and free of charge helpline for practical and emotional support including access to counselling services. All staff can access this service directly and confidentially without manager involvement.

This will be made available to care homes by direct communication. It is a highly focused discrete piece of closed work that is limited by budget and remains under review. It is not to be advertised.

3.2: TRiM – Trauma Risk Management

TRiM is a trauma-focused peer support system designed to help people who have experienced a recent (within the last two weeks) traumatic, or potentially traumatic, event. A business case for TRiM has been approved, but the details, including the offer to care home staff are still being worked through.

3.3: Bereavement:

This WCC handbook Support for people bereaved during COVID-19 pandemic contains information and advice on coping with bereavement during this uncertain time, and the services offering support still available to you in Warwickshire.

APPENDIX 5

PHE and Local Authority COVID-19 Care Home/Domiciliary Care Offer

Local Authority & CCG: Coventry City Council, Warwickshire County Council, Coventry Rugby CCG, Warwickshire North CCG, South Warwickshire CCG

PLEASE NOTE THAT URGENT QUERIES NEED TO BE ESCALATED THROUGH THE USUAL ON-CALL MECHANISMS OUT OF HOURS

Key contact completing this form: Nadia Inglis, Consultant in Public Health

ACTION	OWNER	CONTACT DETAILS	NOTES
Initial risk assessment of individual care home situations and **immediate** advice regarding swabbing, PPE use and operational issues within the home	*PHE West Midlands COVID-19 cell*	Tel: 0344 225 3560 op0 op2 Email: WM.2019CoV@phe.gov.uk	*Care homes, LAs and CCGs should preferentially use the new online reporting tool (but telephone is also absolutely fine if needed):* https://surveys.phe.org.uk/TakeSurvey.aspx?SurveyID=n4KL97m2l
Undertake swabbing of care home residents in potential outbreak	*CCG*	Email: warnoccg.resiliencecovwarks@nhs.net This is the email address of the Co-ordinating Incident Control Centre for the CCGs who will organise swabbing. We may move to an approach where the testing provider is contacted directly. Can also contact Arley Medical Services direct (see protocol)	Local protocol for testing symptomatic residents and for local whole home outbreak testing (click on link – need to download word document to get to embedded documents). Looking to prioritise those homes with new outbreaks for whole home testing.

Symptomatic staff swabbing	*Care agencies/WCC/CCC*	**Warwickshire** Lynnbassett@warwickshire.gov.uk **Coventry** covid19testing@coventry.gov.uk	Providers can signpost staff to national portal https://www.gov.uk/apply-coronavirus-test-essential-workers OR do via themselves as employers OR come via WCC/CCC (contact details to left)
Response to PPE supply issues	*CCG/LA*	**Coventry** Email: PPEProviderRequests@coventry.gov.uk 5 day service 9am-5pm, but requests up to 1pm on Friday will allow PPE to be distributed for the weekend. Aiming to be a 7 day service. **Warwickshire** Email: cv19ppe@warwickshire.gov.uk 7 day service 9am-5pm. Checked periodically on Saturday and Sunday but not constantly.	
Response to other general queries, including public health enquiries (for both domiciliary care and care homes)	*LA/PHE* *For local authority (including public health) support*	**Coventry in hours** SocialCareCommissioning@coventry.gov.uk **Warwickshire in hours** cv19supplierfaq@warwickshire.gov.uk (Specific public health questions will be forwarded through to the public health team)	

Provision of clinical management support systems to care home residents	*CCG*	**Please note the below support is in-hours only** **Care Home Quality Nurses** **Coventry Rugby CCG** Email:sandra.fulton@coventryrugbyccg.nhs.uk Tel: 07825218774 **South Warwickshire CCG** Email: lorna.wheeler@southwarwickshireccg.nhs.uk Tel: 07795386076 **Warwickshire North CCG** Email: sandra.milbourne@warwickshirenorthccg.nhs.uk Tel: 07717695360	*Three clinical nurses offer clinical support across all care provision in Coventry. Including home support, supported living and care homes*
Provision of ongoing infection prevention and control advice for care homes (for domiciliary care – go via local authority contacts)	*CCG/LA*	Email: warnoccg.resiliencecovwarks@nhs.net This is the email address of the Co-ordinating Incident Control Centre for the CCGs who hold the Infection Prevention and Control (IPC) rota for Coventry and Warwickshire (this rota is staffed 8am to 8pm 7 days a week, as is the Incident Control Centre inbox). Out of hours queries re infection control that are not picked up by the care home quality nurses (see box above) are picked up by the IPC team	

		For in hours advice – the CCG Care Home Quality nurses (see box above) should be contacted.	
Provision of ongoing general follow up with simple advice	*LA*	Tel: Please see response to "Response to other general queries" **Coventry in-hours** Social Care Commissioning SocialCareCommissioning@coventry.gov.uk **Warwickshire in-hours** Social care Quality/Commissioning cv19supplierfaq@warwickshire.gov.uk	
Provision of ongoing general follow requiring repeat risk assessment or more complex advice	PHE West Midlands local patch team / PHE West Midlands COVID-19 cell	Tel: 0344 225 3560 op0 op2 Email: WM.2019CoV@phe.gov.uk	