Doncaster Council

COVID Control Board Meeting Notes and Actions

Date Wednesday 18th November 2020
Time 15:00
Location MS Teams
Chair Rupert Suckling

Attendees: Rupert Suckling, Victor Joseph, Kathryn Brentnall (College), Susan Hampshaw, Steph Cunningham, Claire Scott, Tim Hazeltine, Fiona Campbell (National Education Union), Ken Agwuh (DBTH), Kevin Drury, Gill Gillies, Laurie Mott, Peter Doherty (College), Kate Anderson-Bratt, Mark Steward (St Leger Homes), Natasha Mercier, Emma Gordon, Clare Henry, Daniel Weetman, Hayley Waller, Olivia Mitchell, Catherine Needham, Simon Noble, Nasir Dad, Gill Scrimshaw, Nick Wellington, Cheryl Rollinson (DCCG), Debbie John-Lewis, June Chambers (PHE).

Apologies: Mary Leighton, Sarah Sansoa, Paul O'Brien (GMB Trade Unions), Lisa Devanney (DCCG), Andrea Lee (Prison's), Robert Ellis, Neil Thomas (SYP), Carys Williams, Andrew Russell (DCCG), Damian Allen, Leanne Hornsby, Victoria Shackleton, Paul Ruane, Louise Parker, Shannon Kennedy, Vanessa Powell-Hoyland, Jon Gleek, Andy Hibbitt (Doncaster Chamber), Jim Board, Mark Whitehouse, Dawn Lawrence, Karen Johnson, Jakki Hardy, Steve Waddington (St Leger), Scott Cardwell, Mark Wakefield.

No	Item	Key Decision / Action	Allocated to
1.	**Welcome and Introductions**	RS welcomed all to the meeting.	
2.	**Apologies**	RS noted apologies.	
3.	**Purpose of Meeting**	RS confirmed the key purposes of the meeting as follows: 1. Responsible for the development, exercising and testing of COVID Control Plan. 2. Provide assurance in terms of the managing of incidents and outbreaks through the daily IMT meetings. The purpose of IMT is to assess cases, clusters and outbreaks, ensure there are effective control measures in place and target preventative activity.	
4.	**Urgent Items for Attention**	None raised.	
5.	**Feedback from Covid Oversight Board** (Rupert Suckling)	RS reminded Covid Control board members that the Covid Oversight Board is a public facing meeting, chaired by the leader of the Council. The last meeting was held 11 Nov and colleagues provided the board with an update on the national position, data and intelligence as well as going through the Covid Control threat and risk register and the minutes from the last Covid Control Board meeting. RS noted that when the Covid Oversight Board met on 11 Nov the data showed plateauing of new cases, therefore in light of this there were no new asks for this period. RS added that the Oversight Board will want an update on where we are at with the equality impact assessment work when they next meet. FC, who also attended the Oversight Board, added that a number of issues had been picked up in other forums so were kept to a minimum during the meeting, what was covered was	

		comprehensive.	
6.	**TCG Update** (Gill Gillies)	TCG took place this morning – although levels starting to drop still very busy. GG provided the board an update on current issues: • Preparedness and forward planning next few months – likely change in restrictions going forward, unsure which way. Requesting teams to forward plan next few months and think about pressures on their services i.e. in the short term; winter weather, changes in behaviour. • Compliance and enforcement – plans being put in place for potential reopening of businesses before Christmas – looking at numbers of staff needed to cover compliance and enforcement. • Workforce resilience – supporting wellbeing across organisations. Looking at priorities, additional challenges and how this will be managed. • Business resilience and engagement – how businesses are adapting and how we are supporting them now and going forward. 80% businesses not fully operating (particularly in Town Centre) - having significant impact on economy and issues for people. • Children services –supporting vulnerable, rises in Domestic Violence, increases in child referrals. • Homelessness into winter In summary, there are significant continuing challenges and large pieces of work creating significant impacts (e.g. mass vaccinations and targeted testing). Conversations ongoing re data and clarity about what is adding value. Amending the strategy to reflect the needs of what it is we are delivering. GG noted that the next few weeks are critical in terms of impact on economy and people. GG added it is national safeguarding week and then International Men's day is tomorrow, big focus on mental health.	
7.	**COVID Outbreak Planning Update** (Chair)	RS raised four areas of plan to flag: • Tiers – waiting to hear what might replace this framework / how will be amended – will impact control plan and collective actions we take • Address inequalities and actions to address this • Planning grids/frameworks – informed by PHE this week they want to review them and see if need updating. • Testing and vaccinations: ○ Re roll out of technologies for asymptomatic individuals - there are number of approaches piloted and Deloitte is responsible for co-ordination of pilot of testing in Universities, Care Homes, some work places and NHS. RS noted	

		there is a call this afternoon with NHS re the rollout of asymptomatic testing in NHS locally. RS has no further information on other 3 programmes and whether anything happening in Doncaster but trying to get details. ○ Do have access to DPH led testing – met this morning with military planners across SY to look at potential groups we may want to offer testing too, and options for a further site. Looking at potential groups that will be eligible for this testing – people working in domiciliary care, working to support LD/Supported living, regular visitors to care homes not captured by whole home testing programme, schools (all staff) and residential schools. At early stages of identifying initial site to offer this testing – hopefully by early next week more to share on this. ○ Re mass vaccinations, this is NHS led – emphasis shifted to GP led vaccination carried out in non-healthcare premises. This is in early stages. It has been said NHS are to be ready to vaccinate for 1 Dec – expect unlikely to see this side of Christmas. CR commented if colleagues have any specific questions on testing and vaccinations happy to take back to CCG. <u>Questions/comments:</u> PD queried where College's sit in asymptomatic testing programme. RS response – assumption is Deloitte programme of University's does not include colleges on the basis that the concern is about students travelling across country when term ends. Would be local responsibility to include Colleges in programme of asymptomatic testing. RS had meeting with schools Head Teachers earlier in week and they were keen to look at asymptomatic testing and so were union colleagues. Happy to include Colleges. KB – very useful given size of population, please include us in discussion. RS noted that the asymptomatic testing process will start small and expand over time. National guidance still to be written. **Action: To include Colleges in discussion re programme of asymptomatic testing in Doncaster.**	**RS**
8.	**Data and Intelligence**	**7 day rate** Doncaster's official 7 day rate per 100,000 is 379.9 (5-11	

	Update • Including projection/modelling of hospital capacity	November). 9 consecutive days of falls, rate in past two weeks fallen consistently apart from some upticks. Rate lower than Barnsley and Rotherham, it is noticeable that both these areas have seen increases today. May start to see the effects interventions such as tier 3, national lockdown and half term have had on 7 day rate – filter through in next week. Doncaster's positivity rate is 14.1 – falling last couple weeks. Y&H rate increasing, Doncaster rate now lower than this. England rate increased too. Overall good news for Doncaster – falling 7 day rate. **Hotspots in the communities** LM presented hotpot of cases on a map on screen: • The data team has been identifying places in Doncaster with higher density cases in last 14 days. Currently areas with highest numbers – Carcroft, Bentley (New Village), Lower Wheatley, Intake, South Cantley, Old Rossington and New Rossington. • Apart from Intake (where number cases is neither falling/increasing), the number of cases is declining in these communities. • Slight concerns of Bawtry and Dunscroft where have seen increase in cases last 7 days. **Hospital activity** LM noted that the way we are monitoring hospital activity will change as we are now also monitoring hospital occupants receiving active care. Key points to note include: • Numbers receiving care in ITU remains around 15 – stable. • 70:30 discharge to deaths – same as first wave. • Registered deaths has increased markedly – over last 3 weeks have seen significant more deaths and large proportion of these deaths where Covid is mentioned on death certificate. Questions/comments: RS – re TCG, any mention of pressure on bereavement services? GG response – no risks flagged currently, coronial staffing issue raised through LRF. RS – re DBTH as a place, aware admissions higher than wave 1, anything we can do to help? KA response – more pressure through second wave as other hospital services have not been suspended this time around and number of Covid admissions is ongoing– difficulty in ability to manage number admissions. There are a number of staff who	

		have become positive too – adds to pressure. As previously mentioned there have been a number of outbreaks in the hospital as well which have been hard to effectively manage as new cases kept rising. **Covid Data Analysis and Modelling** DC shared a presentation on screen and took board members through Covid Data Analysis and Modelling that has been undertaken. **Action: Circulate presentation with meeting minutes.** DC presented a number of graphs on the current state (as of 12am Sunday 15/11) and then data based on 4 scenarios; scenario 1 (match wave 1 cumulative growth), scenario 2 (continue on current cumulative growth rate – last 7 day average), scenario 3 (mid-point between scenario 1&2) and scenario 4 (consistent 10% reduction). DC noted that the data is trying to compare day one of wave 1 to day one of wave 2. Data presented on bed pressures has removed some beds (i.e. maternity beds, paediatric) as cannot be used for Covid patients. DC also shared data on staff absence – shows a distinct relationship between hospital cases and Covid related absences for staff. Data plateaus at similar time. Allows us to use ratio relationship and map staff absences going forward. Data follows similar trend between Active Staff Covid Confirmed and Active Cases – raises query where staff picked virus up from, in hospital or community? Hopefully staff testing should remove asymptomatic people so may see this relationship change going forward. This data is discussed with data cell team once/twice per week – provided with community infection rates which is helping decide where we are and helps with curve generation. Questions/comments: RS – given the scenarios outlined, which are we most closely following? DC – for a while it has been scenario 1. RS – have any organisations on the call looked at staff sickness vs indicator of pandemic? I.e. 7 day rates? GG – data teams in PIC provide HR with workforce data which shows reasons for staff absence for business continuity. Currently this data doesn't include layering of 7 day rate but there is a lot of information DLT's are looking at across DMBC,	**OM**

		may just need to be looked at differently to see such patterns. **Action: PIC Data team to look into plotting staff absence against 7 day average.** VJ – close mirroring of data re hospital admissions and staff absence, looked at graph presented and seemed to be number of cases as opposed to rate? DC response – it is cases vs cases in terms of patient cases in hospital and staff cases. One graph showed confirmed Covid cases and another showed staff absent for reasons related to Covid, it may not be because they have Covid.	**PIC Data Team**
9.	**Daily Incident Management Team Update**	**CN offered the board an overall summary and included;** Today's rolling 7 day average is 165.6, a decrease from last weeks reported figure of 181.3. CN noted this average has consistently and consecutively dropped in last 9 days. CN added that IMT has approx. 30 current live incidents /outbreaks to review for possible closure, therefore expect same downward trend with rolling average over next couple days. Last 7 days, IMT has opened 14 brand new cases (note this does not count those cases which had been previous outbreaks, were then closed and reopened in 28 day period). Main concentration current live outbreaks - 51 in primary schools, 14 in businesses, 12 in Older People Care Homes, 7 in Learning Disability Homes, 10 in Domiciliary Care and 9 in Early Years provisions. Over the last 7 day period, IMT has closed 68 cases. Have seen influx of closures in last 7 days, closed significant number in primary schools, also in early years, Older People Care Homes, Learning Disability Homes and businesses. 56/68 closed as came to end of monitoring period. CN added that the same data is now fed into the locality bronze groups but spread over communities – links with targeted activity.	
10.	**Impact on inequalities** (Susan Hampshaw)	RS noted that understanding the impact on inequalities is important as some groups are disproportionately affected by Covid. RS added there were questions asked at previous Covid Oversight Board around whether we had an equality impact assessment and have we driven action on impact of inequalities through our outbreak plan. SH shared an update on Covid inequalities work. Key points to note include: • At the daily epidemiological meetings we are able to drill down to look at cases in older people, CEV, Black/Asian minority ethnic population – there is a real focus daily to see if there is anything in the data to make us curious. This information can also be used in the locality meetings. • In the epidemiological pipeline meeting we want to add an	

		additional page for an inequalities dashboard across the system. • Re the EDI work, completed draft report and this can be accessed via the link in the presentation which will be circulated to members with minutes. Also in process of developing actionable recommendations – initial focus is the Bronze Locality work. • Re the BAME action plan, we have a COVID Community Link Co-ordinator with a BAME and health inequalities focus. The four Community link workers will take a co-productive, asset based community development approach (within the BAME community) that aims to engage, strengthen and build resilience in light of Covid. • SH noted there will be an evaluation of work and the extension of embedded researcher work will focus on this. **Action: Circulate update on inequalities work with minutes of the meeting.** LM presented ethnicity report on screen. Key points to note include: • LM raised a number of exclusions in the data before presenting. • Slide 3 – Tests. Shows same mix of ethnicity between those tested and the breakdown of the 2011 census. • Slide 4 – Cases. Shows a similar story, if remove unknowns then 9% are from BAME community – relatively similar to census ratios • Slide 5 - Change over time (Test). Slight concern is that number tests from BAME community in October is much smaller. Over past few months the proportion of BAME community testing has fallen – by October just over 5%. • Slide 6 - Change over time (cases). Shows a similar story – fall to only 6.1% in October for BAME community. • Slide 7 – Distribution by Age Groups (Aug, Sept, Oct). • Slide 8 - Conversion (for every 1000 tests, how many positive cases). Data shows that for every 1000 tests, found 44 positive cases in White British and 55 amongst BAME community. Slight difference in inequality. **Action: Circulate ethnicity data analysis with minutes of meeting.** NM introduced herself as the new Covid Community Link Coordinator and is in post to 2022. The role includes leading team of 4 community team workers; engaging and building resilience in light of Covid, working with stakeholders to ensure public health approach is reflecting across local service planning for BAME community. Work plan is aligned with outbreak and BAME plan – plan includes action from the last BAME needs assessment. NM added that initial tasks are to take action to prevent Covid in	**OM** **OM**

		communities of interest and support communities of interest to get tested. Data shows numbers low for testing, however having spoken with community leaders in BAME (who have regular contact with hard to reach BAME members) this doesn't seem to be case anecdotally – feedback is quite positive in that the community is coping well and there are not many symptomatic cases currently. The next challenge is mass testing and communities – next week starting with relevant people in relation to this work. RS summarised – through the work SH described we have a mechanism to catch data, the ethnicity data LM presented illustrates discrepancy of people coming through for testing and NM is working with these communities to understand barriers. GG - been on LRF National Chairs call and there is some useful information and learning to share re Leicester comms. Will forward onto colleagues.	
11.	**Threats and Risks Register and Exception updates from members**	Updates from: **Environmental Health** NW – colleagues currently in meeting with HSE re projects relating to surveys of warehouses and care homes – will update hopefully at IMT tomorrow. Proposed work is in relation to surveys of their Covid resilience systems in place – may be doing calls/visits but yet to be decided. Some issues with warehouses in borough, work with HSE may help understand how transmission getting in. **Schools** FC – given numbers cases/rate falling, what is position with numbers in schools? KD – there continues to be positive cases in staff/pupils. In response to the last couple weeks, KD and colleagues in public health have had meetings with schools asking more detailed questions. This has helped develop a fuller picture, we have seen the changes schools are making as they respond to cases, very insightful. There is no doubt there are continuing positive cases but work being done in schools to control and reduce risk – the work they are doing is fantastic and feel they are responding to our advice. We are taking a proactive, unified approach to keeping positive cases down. KD added that a key issue being raised in these meetings with schools is around transport and that schools cannot control what happens when pupils leave premises. We have sent out e-posters to schools today outlining expectations of pupils travelling to and from school and their responsibilities. FC – with these controls, is it having impact or too early to tell? KD response – too early. Due to better T&T in schools and processes being followed, schools have better grip now. A lot of work and time is going into this work – previously we had bubbles/year groups 'bursting' but we do not have as much of	

		this now, particularly in Secondary Schools. VJ raised that number of enquiries coming through re schools are not as high as they once were. Also, from outbreak control meetings can see schools following processes. **Care Homes** KAB –feel situation is slightly improving. 9 Care Homes have larger outbreaks – we are meeting with homes regularly, IPC continue to support them. 2 of these 9 Care Homes have seen increase in cases this week due to routine testing, we have ensured they have appropriate outbreak controls in place. A number of services and care homes isolation periods have now completed. KA – re care homes, we receive many results between 5-11pm out of hours and at DBTH we are struggling to manage – is there a way of making process of notifying Care Homes of results more efficient and less labour intensive? VJ – we continue to discuss how we prioritise testing and have discussed how we can check and speed up testing in homes/other settings where required and how to make more efficient i.e. some settings do not complete correct info which causes delays. KAB suggested setting up task and finish group to look at this. **Action: Establish small task and finish group as part of the testing cell to look at efficiency of process in managing Care Home testing / results.** **Localities and Communities** RS referred to the data LM presented on CEV – total is currently 15,546 individuals. KJ and team are working on approach to support CEV. GS – the CEV data has been sorted into localities and we are prioritising those identified as CEV along with individuals classed as shielded previously – we are making the proactive welfare calls to provide support to these individuals and so far the response is people are much more prepared practically in lockdown 2.0 i.e. with access to food. There are some raising issues with isolation and a couple have been referred to wellbeing services up to this point. **Threats and Risks** • Impact on Health Service - risk to remain VERY HIGH • Management of Outbreaks in High Risk Settings - risk to remain VERY HIGH • PPE - risk to remain MEDIUM	**KAB/VJ**

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		• Testing and Contact Tracing - risk to remain VERY HIGH • Welfare of Vulnerable People needing to self-isolate - risk to remain HIGH • IPC Capacity - risk to remain HIGH • Resourcing of core IMT - risk to remain MEDIUM • Second wave - risk to remain VERY HIGH • Outbreaks across Doncaster Border - risk to remain MEDIUM	
12.	**Highlight Reports** • Covid Control Board • Contact Tracing	RS noted that Covid Control Board and Contact Tracing Highlight Reports had been previously circulated with the agenda.	
13.	**Communications**	SCu provided an update on current comms activity: • New ways to nuance messaging – harder messages asking people to follow guidance and then through to softer comms in 'Let's do it for Doncaster' • Recently tried different route to humanise messaging – 'My Covid Reality' campaign. Involves asking people in communities for a short video of their Covid reality, we are finding this is helping people and getting people to be more empathetic. SC commented that colleagues are welcome to get involved in videos. • SC noted that this year's Winter Booklet will focus on winter and Covid and will be delivered to every home in Doncaster from middle of next week. SC shared the booklet on screen and quickly took all through the pages. SC added that the booklet can be condensed to 'easy read' version which is currently being worked on. RS noted this is good as there is evidence 'easy read' is a good method of communicating with some groups.	
14.	**AOB**	None raised.	
15.	**Date and Time of Next Meeting**	**Wednesday 2nd December 3:00-4:30pm.** RS raised that at the next board meeting we should have more of an update on mass testing and potentially an update on mass vaccinations.	