Thurrock - An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future

Health and Wellbeing Overview and Scrutiny Committee

The meeting will be held at **7.00 pm** on **18 June 2020**

Due to government guidance on social-distancing and COVID-19 virus the Health and Wellbeing Overview and Scrutiny Committee on 18 June 2020 will be held virtually online. The press and public will be able to watch the meeting live online at the following link: https://www.youtube.com/user/thurrockcouncil

Venue: You can watch this meeting at YouTube: Thurrock Council, either live whilst in progress or later as a recording.

Membership:

Councillors Victoria Holloway (Chair), Shane Ralph (Vice-Chair), Fraser Massey, Sara Muldowney, Joycelyn Redsell and Elizabeth Rigby

Kim James (Healthwatch Thurrock Representative)

Substitutes:

Councillors Alex Anderson, Tom Kelly, Cathy Kent, Sue Sammons and Sue Shinnick

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Agenda

Open to Public and Press

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1. Apologies for Absence

2. Minutes **5 - 16**

To approve as a correct record the minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held on 5 March 2020.

3. Urgent Items

To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.

4. Declarations of Interests

5. Healthwatch

6. Health and Adult Social Care System COVID-19 Response **17 - 72**

7. Progress Update on Major Health and Adult Social Care Projects **73 - 82**

8. Work Programme **83 - 84**

Queries regarding this Agenda or notification of apologies:

Please contact Jenny Shade, Senior Democratic Services Officer by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **10 June 2020**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

Breaching those parts identified as a pecuniary interest is potentially a criminal offence

Helpful Reminders for Members

- *Is your register of interests up to date?*
- *In particular have you declared to the Monitoring Officer all disclosable pecuniary interests?*
- *Have you checked the register to ensure that they have been recorded correctly?*

When should you declare an interest *at a meeting?*

- **What matters are being discussed at the meeting?** (including Council, Cabinet, Committees, Subs, Joint Committees and Joint Subs); or
- If you are a Cabinet Member making decisions other than in Cabinet **what matter is before you for single member decision?**

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Does the business to be transacted at the meeting

- **relate to; or**
- **likely to affect**

any of your registered interests and in particular any of your Disclosable Pecuniary Interests?

Disclosable Pecuniary Interests shall include your interests or those of:

- your spouse or civil partner's
- a person you are living with as husband/ wife
- a person you are living with as if you were civil partners

where you are aware that this other person has the interest.

A detailed description of a disclosable pecuniary interest is included in the Members Code of Conduct at Chapter 7 of the Constitution. **Please seek advice from the Monitoring Officer about disclosable pecuniary interests.**

What is a Non-Pecuniary interest? – this is an interest which is not pecuniary (as defined) but is nonetheless so significant that a member of the public with knowledge of the relevant facts, would reasonably regard to be so significant that it would materially impact upon your judgement of the public interest.

Pecuniary

If the interest is not already in the register you must (unless the interest has been agreed by the Monitoring Officer to be sensitive) disclose the existence and nature of the interest to the meeting

If the Interest is not entered in the register and is not the subject of a pending notification you must within 28 days notify the Monitoring Officer of the interest for inclusion in the register

Unless you have received dispensation upon previous application from the Monitoring Officer, you must:

- **Not participate or participate further in any discussion of the matter at a meeting;**
- **Not participate in any vote or further vote taken at the meeting; and**
- **leave the room while the item is being considered/voted upon**

If you are a Cabinet Member you may make arrangements for the matter to be dealt with by a third person but take no further steps

Non- pecuniary

Declare the nature and extent of your interest including enough detail to allow a member of the public to understand its nature

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You may participate and vote in the usual way but you should seek advice on Predetermination and Bias from the Monitoring Officer.

Our Vision and Priorities for Thurrock

An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future.

1. **People** – a borough where people of all ages are proud to work and play, live and stay

    - High quality, consistent and accessible public services which are right first time
    - Build on our partnerships with statutory, community, voluntary and faith groups to work together to improve health and wellbeing
    - Communities are empowered to make choices and be safer and stronger together

2. **Place** – a heritage-rich borough which is ambitious for its future

    - Roads, houses and public spaces that connect people and places
    - Clean environments that everyone has reason to take pride in
    - Fewer public buildings with better services

3. **Prosperity** – a borough which enables everyone to achieve their aspirations

    - Attractive opportunities for businesses and investors to enhance the local economy
    - Vocational and academic education, skills and job opportunities for all
    - Commercial, entrepreneurial and connected public services

Minutes of the Meeting of the Health and Wellbeing Overview and Scrutiny Committee held on 5 March 2020 at 7.00 pm

Present:	Councillors Victoria Holloway (Chair), Shane Ralph (Vice-Chair), Fraser Massey *(arrived 8.11pm)* and Elizabeth Rigby Kristina Jackson, Healthwatch
Apologies:	Councillors Sara Muldowney, Joycelyn Redsell, Ian Evans and Kim James
In attendance:	Roger Harris, Corporate Director of Adults, Housing and Health Mandy Ansell, Accountable Officer, Clinical Commissioning Group Helen Farmer, Assistant Director for Integrated Commissioning for Children , Young People and Maternity Servicess Teresa Salami-Oru, Assistant Director & Consultant in Public Health Jenny Shade, Senior Democratic Services Officer

Before the start of the Meeting, all present were advised that the meeting may be filmed and was being recorded, with the audio recording to be made available on the Council's website.

40. Minutes

The minutes of the Health and Wellbeing Overview and Scrutiny Committee held on the 23 January 2020 were approved as a correct record.

41. Urgent Items

The chair agreed to receive an urgent item of business in regards to the Council's preparedness for Coronavirus to reassure residents that it was being managed and the Council were ready.

Teresa Salami-Oru, Thurrock Public Health Team, provided members with some context in response to the Coronavirus outbreak:

- 151 people tested positive in the UK
- 10 cases across the Eastern Region tested positive
- Working with Public Health locally and Public Health England on a daily basis
- Working to one version of the truth
- Working with the Emergency Planning Team and Clinical Commissioning Group
- Working with ports and airports
- Working with Local and National stakeholders

- Hertford largest number of cases reported in Eastern Region
- Working with the Essex Resilience Forum (ERF)
- Local Authority assured business continuity plans were up to date
- Emergency Planning Manager auditing and supporting departments that business continuity plans were fit for purpose and in place
- Providing Public Health England guidance to stakeholders which included schools, adult and children's social care
- Working with Public Health colleagues across region to share intelligence
- Looking at critical services
- Looking how to minimise risk to staff with working from home where appropriate

Roger Harris, Corporate Director of Adults, Housing and Health, confirmed that Thurrock Council's business continuity plans were very much up to date and had been tested over the last few months with the incidents at Eastern Avenue, Collins House and the chemical spillage in West Thurrock.

Roger Harris stated that there could be an issue with carers for the Adult Social Care services which may cause a risk if staff were off sick and cover could not be arranged but emphasised again that contingency plans were in place and information was being sought on a daily basis.

Teresa Salami-Oru stated that Council were carrying out a precautionary approach to ensure that everything was in order. That this was also an opportunity to remind residents of the importance of vaccinations and to reinforce the importance of personal hygiene.

The chair thanked officers for the update and reiterated the importance and how this would be a good opportunity to reinforce those areas.

Mandy Ansell stated that 111 were under immense pressure but residents were advised to still ring 111 rather than attend their local general practitioner surgery and stated that it was business as usual and hoped to receive some up to date HR advice with regards to travelling abroad especially with Italy being at the forefront of news.

Councillor Ralph asked what steps had been undertaken and what systems were in place with regards to local ports. Councillor Ralph was informed that this information would be available from the Emergency Planning Manager.

The chair thanked officers for their time and the communications received so far and would appreciate being kept up to date via email.

At 7.12pm, Teresa Salami-Oru left the committee room.

42. Declarations of Interests

No interests were declared.

43. Healthwatch

Kristina Jackson had no specific items to raise but would be making comments on agenda items.

The chair sent the committee's best wishes to Kim James.

44. Verbal Update on CCG Merger and Single Accountable Officer

Mandy Ansell provided the following statement:

At their September 2019 Governing Body meeting the five mid and south Essex CCGs each noted the requirements of the NHS national Long Term Plan and approved a recommendation:

to commence work on an application for merger of the 5 mid and south Essex CCGs to be submitted following engagement with stakeholders and final Governing Body approval prior to submission.

This briefing provides an update to the Health Overview and Scrutiny Committee on this work.

Progress – Engagement

A discussion document and survey, co-designed with local stakeholders and people, explaining the merger proposal and the application process was issued on 12 February 2020 to a very wide range of partners including councillors, patient groups and voluntary organisations. The CCGs are seeking views from local people, healthcare professionals and partner organisations on how to keep a strong local focus on ensuring health and care services are working for people at a place level, while also benefiting from the opportunities that commissioning services over a wider area may bring. There is also emphasis on a desire to maintain strong clinical leadership. Feedback can be given via an online survey. An easy read version of the document has also been prepared and shared with relevant stakeholders. The document is available in alternative formats and languages on request. Stakeholders have been sent a copy of the document and public meetings are being held in each CCG to allow a different way for local people to provide their feedback and have specific questions answered. The meetings are being advertised on CCG websites, social media and via posters locally.

The key purpose of this engagement is to listen and respond to the views of key partners and the wider public population and to capture the views, ideas and concerns re the proposals to merge into one commissioning organisation in line with the future direction set out in the 2019 NHS Long Term Plan.

Update on appointment of Joint Accountable Officer for Mid and South Essex

As some of you may be aware, at the conclusion of our initial recruitment process in January we did not appoint to the single role of Joint Accountable

Officer for the five Mid and South Essex Clinical Commissioning Groups and executive lead for the Health and Care Partnership. Subject to NHS England & Improvement's formal agreement, Anthony McKeever has since been appointed as interim Joint Accountable Officer for the five CCGs and STP Executive lead. Anthony has considerable experience in a variety of very senior NHS and non-NHS roles including as Chief Executive of several hospitals and most recently as Director General of Health and Community Services in the States of Jersey. The recruitment process for a permanent Joint Accountable Officer will re-commence in the near future.

45. CCG Merger Consultation: Working Together for Mid and South Essex

Roger Harris, Corporate Director of Adults, Housing and Health, presented the report and referred Members to the very limited Discussion Document. The document welcomed views on how NHS Clinical Commissioning Groups were proposed to work together in the future with a deadline for feedback of the 5 April 2020. Roger Harris stated there were real concerns with the proposal namely concerns of the Health Wellbeing Board, would there be one Health and Wellbeing Overview and Scrutiny process across all three areas, the Council's partnership with the Thurrock Clinical Commissioning Group had been strong, strategy and safeguarding arrangements and commissioning. Roger Harris also had concerns that the document would be hard to respond to as it contained very little detail.

The chair stated what had been presented was appallingly bad. The committee had raised concerns via letters, motions, joint health committees, through scrutiny and through the portfolio holder and questioned what more could local individuals do.

Roger Harris stated that he was meeting with Mr McKeever tomorrow and would raise the following concerns, some of which were the joint Managing Director post, assuring better care fund remained for Thurrock, health and wellbeing board, control totals across all boundaries, preserve the Thurrock pound and commissioning at local level, service commissioning at local level and tiers of commissioning.

The chair questioned whether Mr McKeever would be likely to be able to confirm these arrangements in his interim role or whether decisions would be made once the substantial role had been put in place and if so, when would this happen. Mandy Ansell stated that she was also meeting with Mr McKeever tomorrow but there were some challenges ahead. Mr McKeever was currently on a six month interim contract and there was a timetable for recruiting the substantial post. Mandy Ansell expressed concern that staff were being left in limbo and was hampering works.

The chair questioned whether there was anything else that could be done. Roger Harris stated at this stage there was not anything specific as the committee were not being formally consulted on as this was not a formal consultation. The chair stated that individual members could respond. Mandy Ansell stated it would be the votes of the membership (ie. general

practitioners) that would count and it had been hard selling the merger to general practitioners and potentially the process could be halted if general practitioners did not vote in favour of it.

The chair stated that the voices of general practitioners and that of the health and wellbeing overview and scrutiny committee should be heard.

Councillor Rigby questioned whether general practitioners voting against the process could sway the proceedings. Mandy Ansell stated that there would be five Clinical Commissioning Groups worth of general practitioners voting for this with Thurrock general practitioners being particular passionate and had a powerful partnership.

46. Specialist Fertility - Thurrock CCG

Helen Farmer, Assistant Director of Integrated Commissioning, Thurrock Clinical Commissioning Group, presented the item that outlined the new policy offer for couples on the NHS which would be two cycles of IVF opposed to the current three IVF cycles. Members were informed that Thurrock remained one of only 23% of Clinical Commissioning Groups that offered two cycles with 62% offering one IVF and recognised the importance and significant impact for those couples who required support with fertility.

The chair thanked officers for the report and questioned why this decision had been made. Helen Farmer clarified this was based on the evidence success rate cycle. That the older a woman got, repeated cycles lowered the success rate and that a small number of woman went on for the third cycle. The review identified a dramatic demand of 45% of the three quarters of last year and the continuation of figures rising which would not be sustainable. The costs in the report were a feature of the review but were not the main focus and in doing so had tried to make it fair, equitable and to improve the service that would be received.

Councillor Ralph stated that lots of mixed messages had been sent out and that the feeling of hope had been taken away and questioned whether there had been an increase of people aged 40 coming into Thurrock. Helen Farmer stated they had not seen an increase in the age range with the average referral age being 32 who would be completely eligible for two cycles. With the criteria becoming tighter, clearer and aligned. That frontline staff at Basildon & Thurrock University Hospital NHS Foundation Trust had been placed in difficult positions when referring couples with children from existing families who can go on to access IVF but have neighbouring ladies coming into the service who may not have any eligibility for IVF.

The chair asked for some clarification on the future age range criteria proposal compared to the current Thurrock criteria. Helen Farmer stated that the current criteria was for women only whereas the future proposal would apply for both woman and partner. This had been changed due to questions being raised on residential and to avoid any complication or misuse of the criteria.

The chair questioned whether women would need to live in the area for at least one year to which Helen Farmer confirmed this as correct.

The chair questioned whether the criteria was for couples to be considered. Helen Farmer confirmed that this criteria was for couples and not for a single woman on their own and whilst undertaking this work had raised some very difficult social questions. There would also be the ability for couples to apply through the exceptional panel where a particular scenario could be considered by the Clinical Commissioning Group if it fell outside the criteria. The chair understood the reasoning behind the decisions but stated that this was sad although the changes had been made socially that modern day living had not been recognised.

The chair asked for some clarification between the Clinical Commissioning Group definition and the NICE definition of a full cycle. Helen Farmer stated that a Clinical Commissioning Group definition was frozen embryo transfer and one live embryo transfer but a NICE guidance was three. This was common across all Clinical Commissioning Group criteria. Helen Farmer stated the NICE guidance was up to the age of 41 therefore all women over the age of 41 would not be eligible for this treatment.

The chair stated the breakdown of statistics was helpful.

Helen Farmer stated that under the policy there was no provision for transgender groups. Currently there was no guidance, with the Clinical Commissioning Group Board looking into how these groups can be supported.

Councillor Ralph questioned the criteria for same sex couples. Helen Farmer stated same female sex would fit the criteria where same male sex would not be included for fertility treatment. The chair stated that this was so sad and that further work was required in this area.

The chair questioned whether any other medical procedures and surgeries such as fallopian tube surgery would be changed or amendments made to the accessibility of those treatments. Helen Farmer confirmed that no other changes would be made.

The chair questioned the plans to implement within four weeks and stated this was short notice especially for those considering a third cycle and questioned when the Board would be meeting and when this date would change. The chair also asked how those affected would be informed of such changes. Helen Farmer stated that policy would remain for those that met the criteria by the end of the March 2020 and would be treated under the existing policy for a period of up to two years. Helen Farmer stated that waiting lists were quite short at Basildon & Thurrock University Hospital NHS Foundation Trust with the impact and disappointment levels expected to be low. That communication would be made through the specialist fertility unit with letters being sent to those affected, a helpline manned by specialist information

teams who would be able to answer any questions. The chair stated the response would provide some comfort as some considerable amount of time had been given.

The chair questioned what mental health support was currently available to women and couples going through the fertility treatment. Helen Farmer stated there was limited support and counselling facilities available for those couples facing these challenges but further work would be undertaken with service users to explore peer support networks.

The chair stated that she did not like to see reports that Thurrock Clinical Commissioning Group were being compared with or being asked to fall in line with other Clinical Commissioning Groups. The chair emphasised that Thurrock Clinical Commissioning Groups led not followed. That evidence provided clearly identified a need for mental health support and hoped that this would be provided for such a desperately sad issue.

The chair thanked Helen Farmer for attending this evening and asked for Members agreement with the recommendation to note the report.

Councillor Rigby questioned whether there was any concern that the increase in demand and therefore an increase in cost if the criteria was kept at over 40. Helen Farmer stated the change in demand had been based on the change in criteria rather than the cycle decreasing as they had been less woman taking up the third cycle offer. The age had been around alignment.

RESOLVED

That the Health and Wellbeing Overview and Scrutiny Committee noted the report.

47. Post 18 Autism Support Service

Roger Harris, Corporate Director of Adults, Housing and Health, presented the report that Adult Social Care and Education had undertaken significant work to establish the options available to deliver support to young people aged 18 to 25 with Autism and behaviour that challenged services. With the advent of the Autism Act 2014, local Autism Action Plan and Preparing for Adulthood Strategy 2019-2022 it was clear that community and service responses required significant development. A pilot had been developed and based on the positive outcomes of that pilot a service had been designed to offer a local provision. The same report would be presented to Cabinet on the 11 March 2020 as Adult Social Care and Education were now in a position to tender for the framework agreement to deliver these services within Thurrock.

The chair thanked officers for the report.

Councillor Ralph thanked officers for the successful report but questioned whether there would be problems housing individuals if there were no independent living facilities available. Roger Harris stated that residential and

supported accommodation offers had been expanded and this facility would allow individuals to live with family but would continue to look at the support and accommodation required going forward.

Kristina Jackson, Healthwatch representative, questioned what decision had been made on the number of potential providers to deliver on the specialist areas. Roger Harris stated that the main concern was the quality of the service being offered and this being a development area it may be a case of wait and see what providers came forward.

The chair thanked officers for the report and stated although the financial implications could not be forgotten it was the service provision that was more important and questioned the timescales of when an update could be provided to committee. Roger Harris stated that the report was being presented to Cabinet next week, if approved the procurement exercise would commence and hopefully have a provider in place by the summer 2020.

RESOLVED

1. **That the Health and Wellbeing Overview and Scrutiny Committee are aware that the tender was progressing to establish a Framework Agreement for a Post 18 Autism Support Service for Thurrock.**

2. **That the Health and Wellbeing Overview and Scrutiny Committee had the opportunity to comment on the tender.**

At 8.08pm, Helen Farmer left the committee room.

48. Orsett Hospital Task and Finish Group Update Report - Report to follow

Roger Harris, Corporate Director of Adults, Housing and Health, presented the report on behalf of the Orsett Hospital Task and Finish Group that captured the key points of the group and summarised the functions that the group had undertaken.

At 8.11pm, Councillor Massey arrived into the committee room.

The chair thanked officers for the report and stated the reason the group had been set up was the potential changes of services and the decision to close Orsett Hospital. The group had questioned NHS partners, looked at logistics of the site and undertaken site visits so that this information could be used by members to reassure residents about the decision process. The chair stated that the group had achieved a lot and proposed that this item now be incorporated back into the scrutiny of the Health and Wellbeing Overview and Scrutiny Committee and recommended that a report to be presented at every other committee.

Kristina Jackson, Healthwatch representative, agreed that communication had been a big issue with residents as there was some uncertainty on the plans

for Orsett Hospital and the Integrated Medical Centres and there had been some confusion on Primary Care Networks.

Kristina Jackson questioned why the Musculoskeletal and Physiotherapy Services currently at Orsett Hospital would be moving from that site as of the 1 April 2020 when residents had been assured that no services would be moved until all the four integrated medical centres were open. The chair thanked Kristina Jackson for this very interesting news. Mandy Ansell would clarify whether this was a Basildon & Thurrock University Hospital NHS Foundation Trust service and would feedback but stated new Musculoskeletal services had been commissioned and was aware that these services was available in all Thurrock hubs. Mandy Ansell stated that Thurrock Clinical Commissioning Group offered the best musculoskeletal service when compared to other Clinical Commissioning Groups. Kristina Jackson thanked officers for the response and would appreciate a response on what services were moving and when so that residents could be kept informed.

Kristina Jackson also questioned why the People's Panel which had been set up September 2018 following a recommendation from Thurrock Healthwatch to provide an independent view on matters relating to the relocation of services from Orsett Hospital were not receiving any notice of decisions before they were being made. The chair stated that these concerns would be addressed and be reported back to the Health and Wellbeing Overview and Scrutiny Committee.

RESOLVED:

1. **The Memorandum of Understanding (MoU) core principle that was agreed back in 2017, by all parties, is reconfirmed – i.e. that all clinical services based at Orsett Hospital serving Thurrock residents should remain within Thurrock and be based in more local, community based settings.**

2. **All agencies need to accelerate the programme around the Integrated Medical Centres (IMCs) with a target to have all fully open by the end of 2023.**

3. **There has been insufficient communication with the wider community about the post Orsett Hospital Plans. The T&FG would like to see a joint NHS / LA communications and engagement strategy agreed within 3 months.**

4. **The transport and parking strategy around the IMCs is not sufficiently well developed. Coordination around bus routes, provision of adequate car-parking on all four IMC sites and the role of community transport is inadequate and we would like to see a full strategy developed within 6 months.**

5. **The T&FG would like to see a fully worked up de-commissioning plan for Orsett Hospital developed before the end of this calendar**

year. Orsett Hospital continues to provide valuable services for the people of Thurrock and will do so for years to come. For both patients and the staff that serve the hospital a clearly mapped out plan to ensure the hospital is functioning effectively during this period and people can see where their services are going to be re-provided is essential.

6. **The T&FG understands that the financing of the IMC programme is still under discussion. We would like this matter resolved urgently and greater clarity over how the whole programme will be funded as we see it as a vital part of supporting our wider ambitions over regeneration and supporting health and care expansion in Thurrock – especially with our growing population.**

49. Verbal Update Targeted Lung Health Checks

Mandy Ansell stated the soft launch at Orsett Surgery in February 2020 had generated some problems and issues which were now being addressed and those lessons learnt would be put in place for the Go Live launch that was on track for the end of March 2020. Members were reminded that the mobile unit would be a joint utilisation between Luton and Thurrock Clinical Commissioning Groups.

The chair questioned what percentage of general practitioners were recording residents smoking status to ensure that all legible would receive the same opportunity. Mandy Ansell stated that she did not have that number to hand but would report back.

Kristina Jackson stated there had not been too much reaction but Healthwatch had been proactive by providing letters giving the opportunity for residents to feedback on their experiences.

The chair requested that this item be added to the work programme for the 2020/21 municipal calendar for a report to be presented when appropriate.

50. Work Programme

Members agreed to add the Verbal Update Targeted Lung Health Checks to the 2020/21 work programme.

Members agreed to add the Orsett Hospital Task and Finish Group Update Report to the 2020/21 work programme with a report to be presented at every other committee.

As this was the last committee for this municipal year, Councillor Holloway thanked officers, colleagues and members for their input, energy and comments and that the committee had been a delight to chair.

The work programme for the next municipal year would be developed and agreed with the chair and vice chair.

The meeting finished at 8.25 pm

Approved as a true and correct record

CHAIR

DATE

Any queries regarding these Minutes, please contact Democratic Services at Direct.Democracy@thurrock.gov.uk

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18 June 2020	ITEM: 6
Health and Wellbeing Overview and Scrutiny Committee	
Health and Adult Social Care System COVID-19 Response	
Wards and communities affected: All	**Key Decision:** No
Report of: Les Billingham - Assistant Director Adult Social Care, Ian Wake - Director for Public Health, Roger Harris - Corporate Director Adults, Housing and Health **Contributions**: From Mark Tebbs - Thurrock CCG, Tom Abell - Mid and South Essex NHS Foundation Trust, Tania Sitch - NELFT and Sharan Johal Smith - EPUT	
Accountable Assistant Director: N/A	
Accountable Directors : Roger Harris, Corporate Director Adults, Housing and Health	
This report is Public	

Executive Summary

This report sets out the action taken by health, social care and VCS system partners due to the challenges which have been faced as a result of the COVID-19 pandemic. In its response to the challenges caused by this virus, and in line with Government guidance and legislation, action has been taken to suspend, alter and reduce specific aspects of delivery to ensure that key services can be provided and for staff and service users to be best protected from the risks posed by COVID-19.

1. Recommendation(s)

1.1 Health and Wellbeing Overview and Scrutiny Committee are asked to note and comment on the contents of this report which sets out the response of the Health, VCS and Adult Social Care systems in relation to the challenges faced during the COVID-19 Pandemic.

2. Introduction and Background

2.1 Over the past few years, Thurrock's Health and Well-being system has undergone significant transformation which has led to the emergence of the "Thurrock Model". The model has been identified nationally as 'leading

edge', and is often featured in sector publications. Local authorities and academic bodies regularly request to visit to understand how Thurrock's transformation and the principles underpinning it have been achieved.

2.2 The cornerstone of Thurrock's new model of care has been a place based approach. This is an approach that works in partnership with the communities it serves and focuses upon the strengths that someone has rather than the needs that they require support with; the philosophy being to do with and not for.

2.3 The principles underpinning Thurrock's transformation have shaped a system that is preventative in nature, manages demand by preventing crisis, and is highly collaborative by design, with the establishment of strong partnerships as a key feature.

2.4 Covid-19 has put pressure upon health and well-being systems across the UK to an extent never seen previously. The success of our model has been proven by the pace at which our community was able to respond to shielded and vulnerable citizens, alongside our success in ensuring no-one was delayed in Hospital throughout the pandemic to date.

2.5 Partners across the Health and Care system have implemented a number of measures to address the challenges which are being faced as a result of COVID-19, particularly in response to the announcement of the Government's 'Stay at Home' guidance on 23 March 2020. Since this time, system partners have taken action to protect the health and wellbeing of both its staff and the public from the risks posed by COVID-19, whilst ensuring that critical services could continue to be delivered for those who are most at need. Close attention has been paid to statutory responsibilities, new legislation and Government guidance which has, on occasion, changed quickly.

2.6 Local Area Coordinators and Social Workers embedded within our communities, alongside the fantastic working relationship that exists between our Community Development team and Thurrock CVS, has proved invaluable in identifying and supporting those made vulnerable by Covid-19.

2.7 The trust-based relationship already established with system partners has enabled a focus upon achieving the right outcomes for individuals, as opposed to unilateral organisational concerns, to be the dominant decision making criteria throughout the pandemic. Furthermore, the investment made by our contracts team in establishing strong partnership relationships with providers of social care has meant that we have avoided the issues around discharge from hospital that have emerged elsewhere.

2.8 It is important to note that system partners have not acted in isolation in developing its response to COVID-19 who have been represented on various forums including the Council's Tactical Coordination Group, Thurrock Stronger Together partnership, Thurrock Coronavirus Community Action (TCCA), the

Thurrock Integrated Care Partnership and a range of other cross-service, cross-directorate and cross-organisation groups and forums.

2.9 Therefore as we enter the next phase of learning to live with, and perhaps beyond, Covid 19, we should do so with a degree of confidence that the transformation of our services has proven to be successful in this most challenging environment. Furthermore, we must ensure that the lessons learned from the Covid period enhance rather than undermine our progress.

3. Understanding and responding to COVID-19

3.1 There has been a substantial and comprehensive efforts across the Health, Social Care and VCS systems to understand and respond to COVID-19.

3.2 As part of developing responses tailored to local need, while reflecting national guidance local partners have worked together to understand COVID-19. This has included considering national and local trends, Transmission and R value, data on local deaths across MSE and Thurrock**. Annex A** provides members with the Epidemiology for COVID-19.

3.3 Partners across the Health and Social Care system have taken action to reduce and scale back as well as stopping some services, enabling priority to be provided to responding to COVID-19. Summaries of key elements of responses are as follows:

- Annex B COVID-19 Central Incident Management Team
- Annex C Mid and South Essex NHS Foundation Trust
- Annex D Adult Social Care
- Annex E Thurrock Care Home Outbreak Management Protocol
- Annex F Provider Services – NELFT and EPUT
- Annex G Thurrock Coronavirus Action Group
- Annex H Testing Arrangements

4. Re-set: restarting services whilst minimising risk.

4.1 It is becoming clear that we will not see a quick end to the pandemic. As such we need to consider how we begin to provide some services that have been paused, in the context of the increased risk to older and vulnerable people caused by Covid-19.

4.2 Set against this is the emerging evidence of the detrimental impact upon the health of vulnerable people as a consequence of the isolation imposed to counter the virus. We also need to be mindful of the impact of service reduction on the health and wellbeing of family carers and their ability to be able to continue to provide levels of care required by loved ones. Reopening services such as day centres is therefore a necessity, especially as those families currently providing informal care in the absence of those services will need to return to work or require respite.

4.3 Adding to the need to reopen services is the impact of a large number of health professionals, such as community nurses, being re-deployed across the system to support the front line response to the pandemic. This has caused a growing backlog of service interventions the consequences of which have led to a growing number of health issues and the potential of an increased requirement for social care support. These services will need to be re-set in very different conditions to those that pre-existed Covid 19. How to deliver these much needed services safely, whilst living with the potential for another spike of the pandemic, will require an understanding of the risk and significant mitigation to be put in place. A system rather than service response will be key to responding effectively and safely to demand and unmet need.

4.4 There is evidence of potentially significant un-met need building up in our communities as a consequence of the changes necessarily enacted to meet the current crisis. This is potentially less the case in Adult Social Care, where most front line services have continued, than in health. However, it is a system issue that requires a whole system response. We will also need to be mindful of the ongoing impact following the pandemic as a result of the economic impact Covid-19 has had on our residents and service users.

4.5 Work is now beginning that seeks to understand the full extent of un-met need and the requirements of delivering a response in a world where Covid 19 is still with us. Locally the Thurrock Integrated Care Partnership, which has representation of all of the key partners including crucially Public Health, will lead the re-set programme. Our success in delivering a response to Covid 19 leaves us in a strong position to manage the re-set process effectively; there is however no room for complacency as this challenge is equal to that initially presented by the first wave of the pandemic.

5. Re-imagining: transforming the system in the "new normal".

5.1 The impact of the pandemic upon our transformation work locally has been significant. Whilst it is clear that the services we had in place stood up remarkably well to the impact of Covid 19 on the local system, this came at the cost of stopping the next phase of our transformation. This hiatus should not prevent us from prioritising and reviewing ongoing system change whilst we deal with the consequences of the virus – in fact the two are interlinked.

5.2 Prior to the pandemic, the Better Care Together programme board that governs the delivery of the local programme had identified the need for a new "case for change" (Case for Change II) to drive forward the next phase of the programme. Case for Change II will build upon the significant success we have enjoyed via such projects as the introduction of a new primary care workforce and place-based structure, the use of Well-Being teams as a replacement for traditional home care and the growing focus upon the broad use of technology in our Technology Enabled Care service, to create more integration across the health and social care workforce and provide more efficiency via increased demand management. Case for Change II also

recognises the ongoing significance of the community response and of the importance of the voluntary and community sector.

5.3 If anything the response to the pandemic has made taking forward the next phase of transformation crucial and in many ways has accelerated our understanding of what is possible – for example in key areas such as the use of technology and the support provided to care homes. Learning lessons as a system from the response to Covid 19, and bringing these into our transformation strategy, will be in the longer term more crucial than the response and re-set phases described above.

5.4 Our Transformation Strategy and Case for Change II will continue to focus on action taken to improve health and wellbeing outcomes for the population of Thurrock, as set out in Thurrock's Statutory Health and Wellbeing Strategy. We are currently planning the refresh of current 5 year Strategy which was launched in July 2016.

6. Reasons for Recommendation

6.1 The COVID-19 pandemic has tested almost every aspect of resilience and business continuity planning. This report serves as a record of the action which was taken to order to achieve the aim of maintaining a Housing service which continued to provide its critical services in the most challenging of times.

7. Consultation (including Overview and Scrutiny, if applicable)

7.1 System partners have contributed to the development of this report.

8. Impact on corporate policies, priorities, performance and community impact

8.1 Delivery models will continue to be reviewed to ensure that lesson's learned from COVID-19 inform the planning, commissioning and delivery of services to improve the health and wellbeing of Thurrock residents.

9. Implications

9.1 Financial

Implications verified by: **Jo Freeman**

Finance Manager

This report provides a summary of action taken by health and social care system partners. Funding provided by Central Government has been allocated to support a number of actions set out in the body of the report. Any ongoing funding requirements will be subject to system partner internal approval processes. The wider ongoing financial impact of the crisis on the Local Authority continues to be assessed and will be subject to a separate report.

9.2 **Legal**

Implications verified by: **Lindsey Marks**

Deputy Head of Legal Social Care and Education

There are no legal implications directly arising from this report.

9.3 **Diversity and Equality**

Implications verified by: **Becky Lee**

Team Manager, Community Development and Equalities Team

This report sets out the actions and whole systems approach taken by health, social care and voluntary and community sector partners in line with Government guidance and legislation owing to the challenges faced as a result of the COVID-19 pandemic.

The emphasis of the programme has been on protecting residents that are vulnerable to the virus regardless of their characteristics with a focus on reducing risk of infection and maintaining those individual's connections both with services and wider communities. Notably, the virus has had a disproportionate impact on individuals according to their age, ethnicity and long-term health conditions.

9.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder, or Impact on Looked After Children)

None

10. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

None

11. Appendices to the report - As set out at paragraph 3.3

Report Coordinated by:

Darren Kristiansen
Business Manager Adults Housing & Health

Annex A

Health and Wellbeing Overview and Scrutiny Report
Health and Adult Social Care System COVID-19 Response
Epidemiology of COVID-19

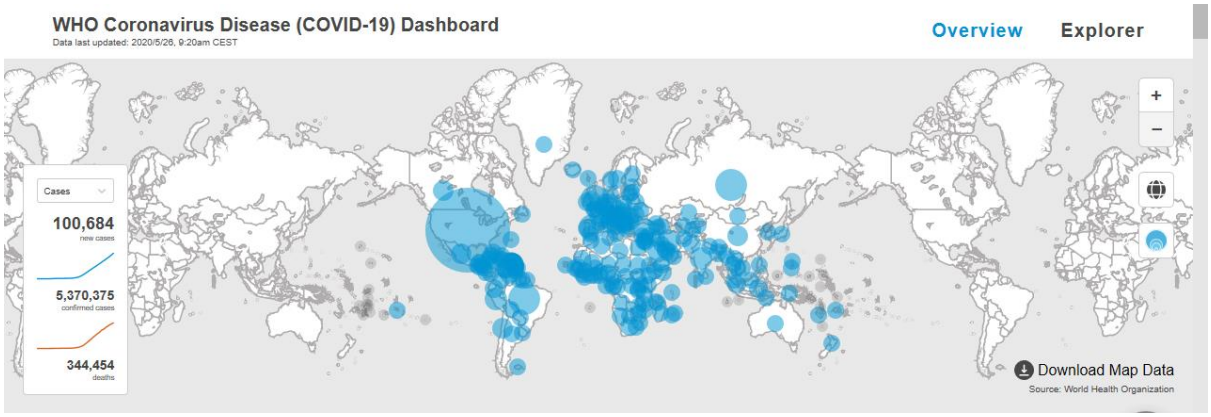
3.1 The World Health Organisation (WHO) were informed of a cluster of cases of pneumonia of unknown cause[1] detected in Wuhan City, Hubei Province, China on 31st December 2019. It was later announced that samples obtained and analysed from cases had identified a novel coronavirus[2] (12th January 2020). This virus is referred to as SARS-CoV-2, and the associated disease as COVID-19[3] (Named by WHO on 11th February 2020)

3.2 The source of the outbreak has yet to be determined. Preliminary investigations in China in January 2020 identified environmental samples positive for SARS-CoV-2 in Huanan Seafood Wholesale Market in Wuhan City, however, some laboratory-confirmed patients did not report visiting this market. A zoonotic source to the outbreak has not been identified yet, but investigations are ongoing.

Cases (global and national)

3.3 As of 25 May 2020 (10:00am CET), 5.37 million cases have been diagnosed globally, with more than 344,000 fatalities. In the 14 days to 25 May, more than 1.28 million cases were reported. [4]

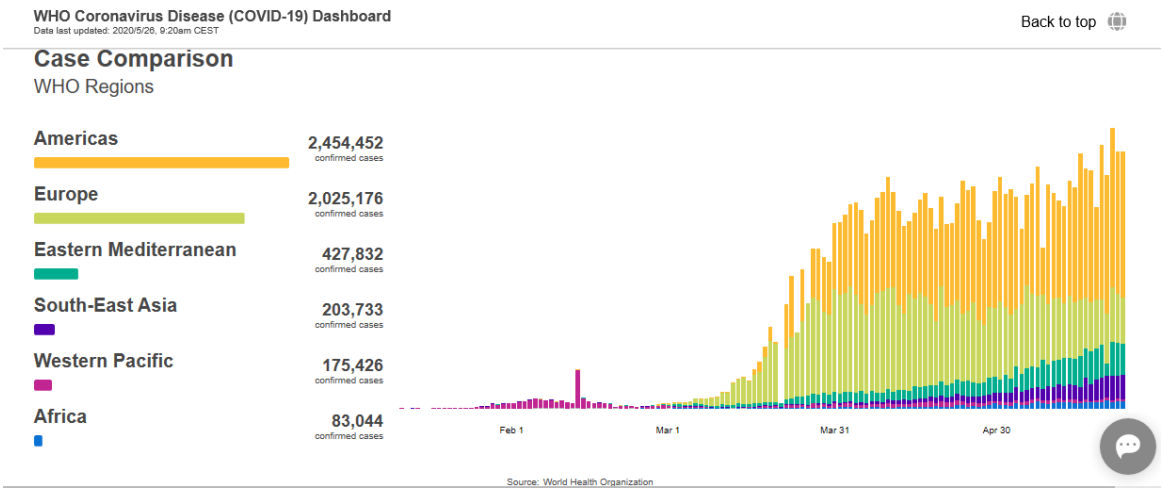
3.4 The WHO coronavirus dashboard has country by country information.[5] The figure below shows where most of the confirmed cases are prevalent.



3.5 While the number of confirmed cases is showing a decreasing trend in European countries due to policies put in place to minimise social interactions

[1] https://www.who.int/csr/don/05-january-2020-pneumonia-of-unkown-cause-china/en/
[2] https://www.who.int/csr/don/12-january-2020-novel-coronavirus-china/en/
[3] https://www.who.int/dg/speeches/detail/who-director-general-s-remarks-at-the-media-briefing-on-2019-ncov-on-11-february-2020
[4] https://www.ecdc.europa.eu/en/geographical-distribution-2019-ncov-cases
[5] https://covid19.who.int/

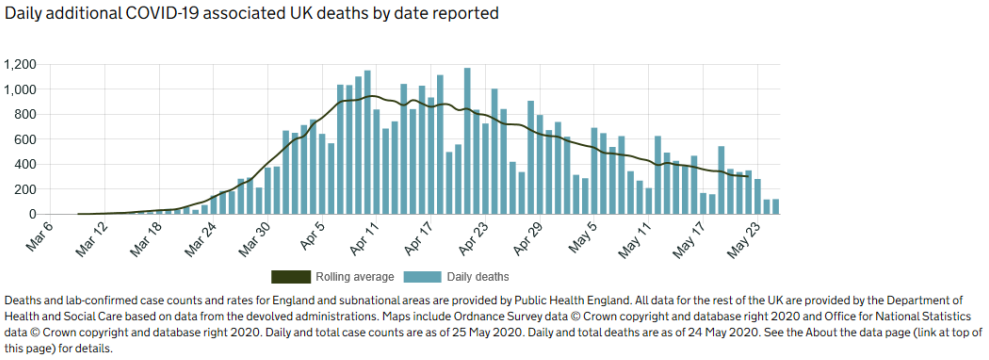
there is still an increasing trend in other parts of the world (The Americas, Eastern Mediterranean, South-East Asia and Africa).



3.6 WHO also publishes a daily international situation report.[6]. The total number of confirmed cases in the UK is published by the Department of Health and Social Care[7], and is available in a visual dashboard[8].

3.7 As of Monday 25th May 2020 there had been 261,184 confirmed cases in the UK (1,625 were confirmed on 25th May) and 36,914 COVID-19 associated deaths (121 on the 25th).

3.8 The death rate in the East of England is the 3rd lowest of the England regions, to date 221.8 per 100,000 population have died in the East of England. The number of deaths per day is now on the decline in England.



3.9 Unfortunately it is not currently possible to report on prevalence or incidence of the disease in England because we do not have adequate testing in place to do so. Confirmed cases relate mainly to those who have needed hospital care or who have died. It is estimated that a large percentage of infections are minor enough to be managed at home or are asymptomatic.

[6] https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports/
[7] https://www.gov.uk/guidance/coronavirus-covid-19-information-for-the-public
[8] https://coronavirus.data.gov.uk/?_ga=2.224717342.5029029.1590485935-284020855.1590485935

3.10 However, The Intensive Care National Audit and Research Centre (ICNARC) are producing reports that do tell us about those people who require Intensive Care due to the disease. Comparing the characteristic of those in Intensive care to what we know about the population: Men; people of Asian ethnicity; those in our most deprived communities; and people who are overweight or obese are disproportionately affected. This does not mean that they are more likely to become infected but that they are more likely to be intensive care with an infection. [9] The latest versions of the report suggest that ethnicity, deprivation and overweight/obesity are linked (confounders) in their increased risk (Table 3 of 22nd May report).

Local trends

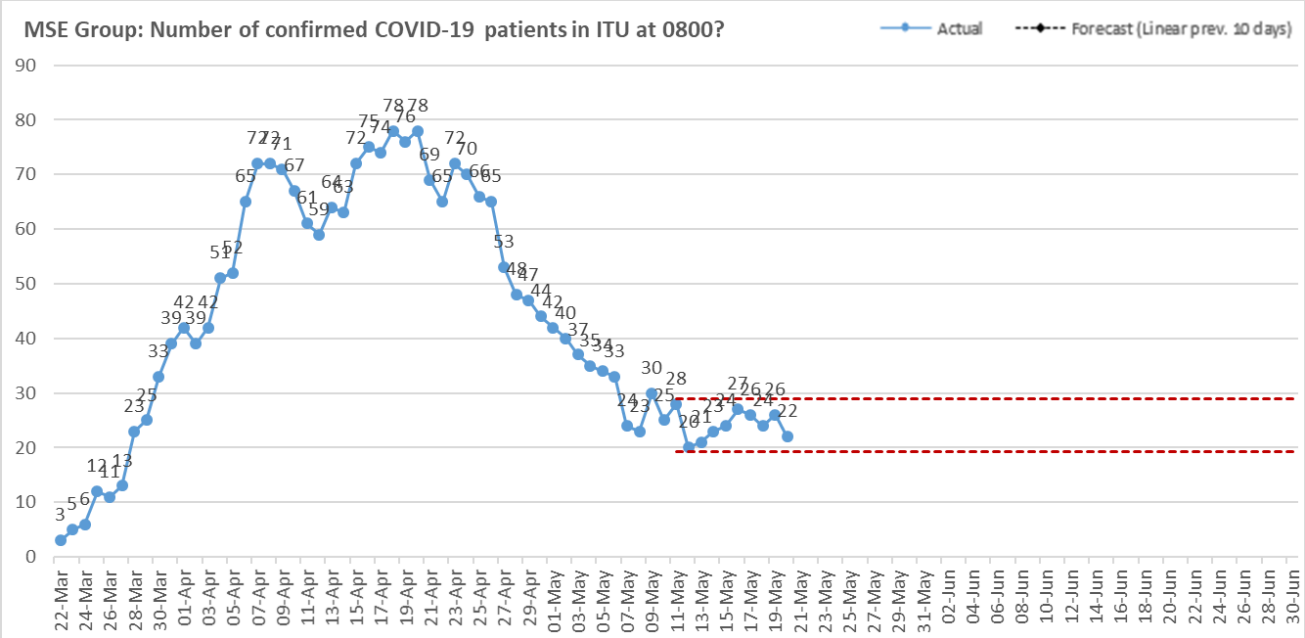
3.11 Locally it was decided that we should track trends based on the number of beds in use in Critical care in hospitals in MSE group. This is because there is a clear clinical threshold for the need to be in critical care whereas confirmed cases is poorly defined and hospital admission depends on more than the severity of the disease in each individual.

3.12 The figure below shows that during March there was a very steep upwards trend in the number of ITU beds in use this then plateaued/slowed in early – mid-April, peaking at 78 beds on around the 15th of April before showing a sharp decline. Since around the 7th may we appear to have plateaued again at between 20-30 ITU beds being in use across MSE group. This is being monitored on a daily basis.

3.13 Changes in the trend run approximately two to three weeks behind national policy changes due to the fact that the disease has an estimated average five day incubation period[10] before a person displays symptoms and local information suggests that before needing ITU most patients would have attempted to self-care for a week and then most would have spent some time in general and acute beds before being transferred to ITU. It is therefore important to note that recent relaxations to social isolation policies will not yet be impacting on data.

3.14 The current plateau suggests that around three weeks ago the local R value was around 1 where as previously it had been lower than 1 (the R value is explained in next section).

[9] https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports
[10] https://www.acpjournals.org/doi/10.7326/M20-0504



Transmission and R value

3.15 According to current evidence, the COVID-19 virus is primarily transmitted between people through respiratory droplets and contact routes.

3.16 Human-to-human transmission is occurring extensively. Hence, Infection prevention and control guidance support precautions to prevent human-to-human transmission are appropriate for both suspected and confirmed cases.[11]

3.17 In addition to respiratory secretions, SARS-CoV-2 has been detected in blood, faeces and urine.

3.18 Transmission of COVID-19 is not generally airborne. Airborne transmission may be possible only in very specific circumstances and settings in which procedures or support treatments that generate aerosols are performed.

3.19 The R value tells us the rate of spread of a disease in the population. It specifically tells us for each person infected, how many more people do they infect. When the R is higher than 1 it means that for each person infected they will infect more than 1 more person so the number of cases in the population will increase exponentially, an R of 1 would mean that for every person infected they then infect one other person, this would mean that the incidence would remain constant, and an R of less than 1 would result in the incidence reducing.

3.20 Estimates suggested that the R_0 was somewhere between 2 and 3 initially but as of 26 May 2020, nationally it is between 0.5 and 1 and that there are regional differences.

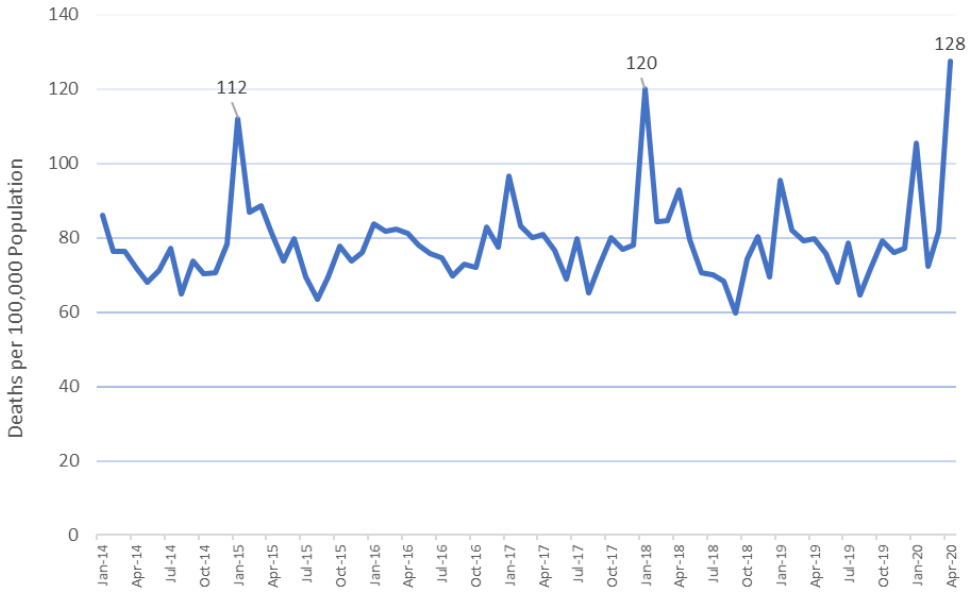
[11] https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

3.21 Locally our current plateau in occupied beds in ITU suggest that our R increased from less than 1 to approximately 1 between 17th and 24th May.

Local Deaths Data

3.22 Using historical death data and the weekly deaths figures released in 2020 by ONS it is possible to plot mortality rates for the Mid and South Essex STP from January 2014 to April 2020.

MSE Crude Mortality Rate, per 100,000 Population: January 2014 to April 2020



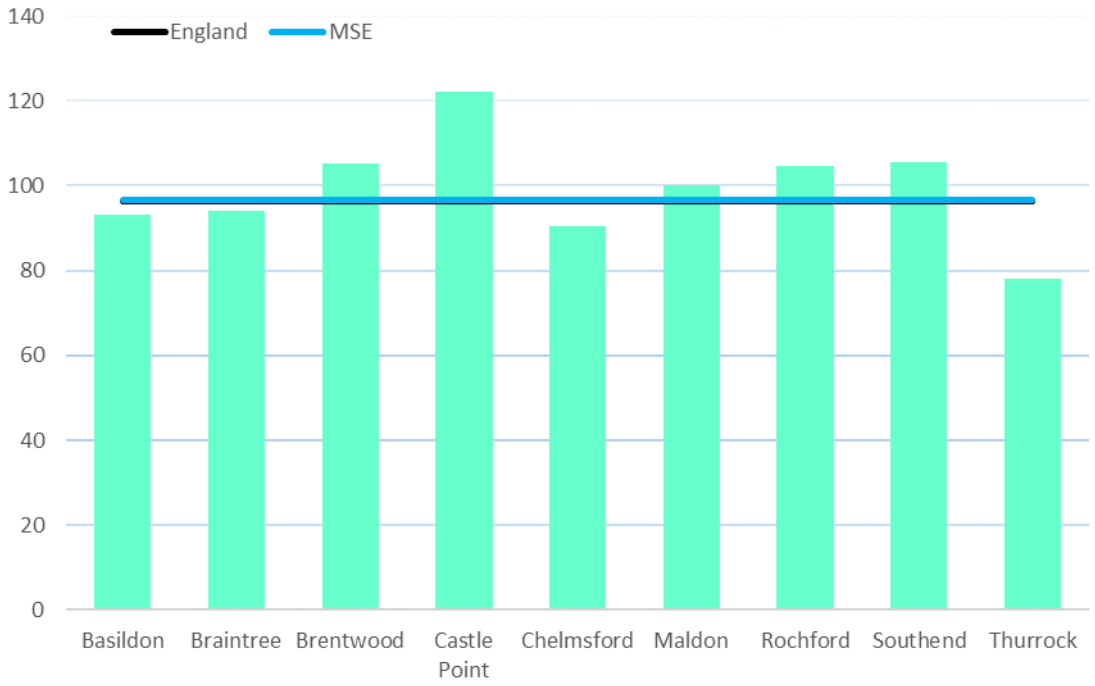
Source: ONS, PHE

3.23 When plotted from January 2014 to April 2020 we can see that the most recent estimated monthly mortality rate, for April 2020, is the highest figure throughout the period under analysis. With 128 deaths per 100,000 population, figures for April 2020 surpass those for all previous months since January 2014. The most recent figure is higher than that seen in both January 2015 and January 2018, when England experienced two fairly severe flu seasons.

3.24 For clarity, it is worth noting that April figures are an aggregation of ONS weekly data for weeks 15 to 18 inclusive and are therefore do not represent an exact match for April 1st to April 30th 2020. However, for the purposes of this analysis they represent a robust proxy.

Crude Mortality Rate, per 100,000 Population: January 2020 to April 2020 by Local Authority

Source: ONS, PHE



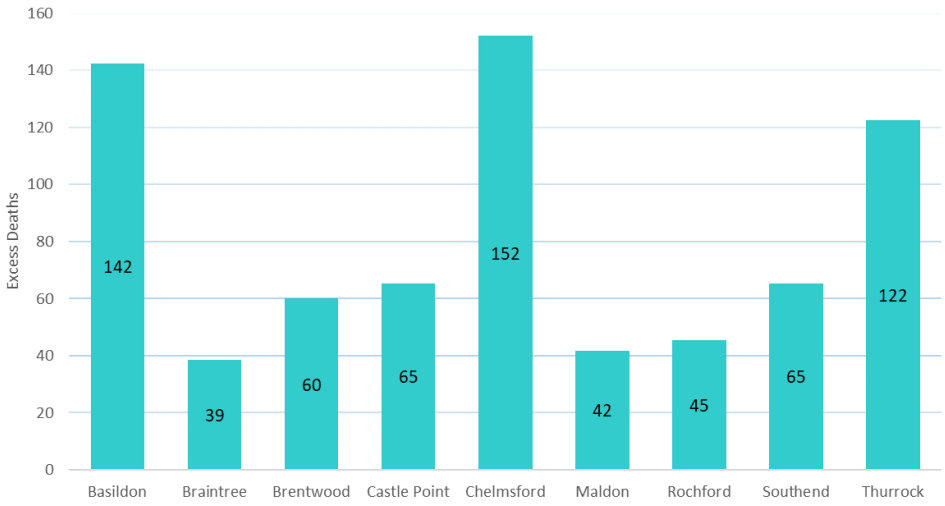
3.25 There is variation in mortality across the STP when adjusting for population size. Thurrock has the lowest crude mortality rate of 78 deaths per 100,000 population whilst Castle Point has the highest crude mortality rates at 122 deaths per 100,000 population.

3.26 What we have therefore seen from the figures above is that we are currently witnessing a dramatic increase in the level of mortality based on historical context across the STP, and that within the STP there is considerable variation in mortality between authorities.

3.27 Mortality data can also be shown in the form of excess deaths. This is a measure of the number of deaths being seen compared to the number of deaths we would expect to see. Across the constituent bodies of the STP there is a degree of variation in the absolute levels of excess deaths observed to date, and the components responsible for those excess deaths.

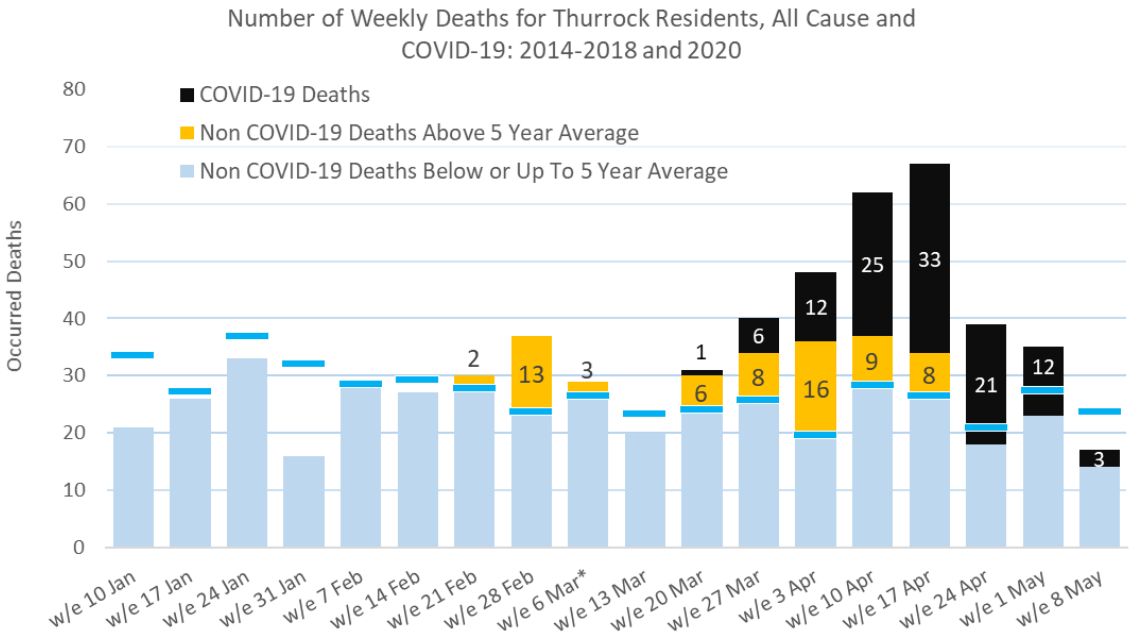
3.28 Below we can see the total number of excess deaths in 2020, as of week ending 8th May, by authority. These deaths are considered excess to 2014-2018 average figures for the same time period.

Total number of excess deaths, week ending 10th January 2020 to week ending 8th May 2020



Source: ONS, PHE

These figures show us that all authorities have seen an excess of deaths, but that Basildon, Chelmsford and Thurrock have seen the most excess deaths in Mid and South Essex to date. Given the relative population sizes of the authorities this is to be expected. However, Southend has seen a relatively small number of excess deaths when considering its population size.



Source: ONS, PHE (*based on leap year calendar)

Figure above shows the total number of deaths at Thurrock level. What this chart demonstrates is that in the first few weeks of the year, through to week ending 14th February, Thurrock saw low levels of deaths in a historical context.

3.29 From week ending 21st February the number of deaths rose above the level expected for the first time, before week ending 20th March signalling a consistent period of excess deaths lasting through to week ending 17th April.

3.30 The degree to which these excess deaths was based upon COVID-19 or Non COVID-19 deaths has changed over time. Deaths from the week ending 20th March through to week ending 17th April saw a significant number of Non COVID-19 related deaths, alongside COVID-19 deaths, whilst for the weeks ending 24th April and 1st May all excess deaths could be attributed to COVID-

19. This could be as a result of coding/data collection/testing issues or it could be a result of reduced access to other health services during this crisis. In due course we will receive data that allows us to break this down further to look at specific cause of death.

3.31 For the week ending 8th May data suggests no excess deaths occurred in Thurrock, however as the most recent data available this is more susceptible to retrospective amendment so should be viewed with some caution.

3.32 Deaths have exceeded the 2014 to 2018 average in 7 of the most recent 8 weeks in Thurrock, although, with the caveat above, in the most recent week death numbers had fallen below the 5 year average. The vast majority of the excess deaths have been attributed to COVID-19, however there are a sizeable number of deaths which are not COVID-19 related.

3.33 We can also see that in the most recent three weeks for which data is available, the number of Non COVID-19 excess deaths has reduced to zero, leaving COVID-19 deaths to bring figures up to, and above, the historic norm in week ending 24th April and 1st May, and closer to the historic norm in week ending 8th May.

3.34 One final note of caution, the presence of the two fairly severe flu seasons within the 5 year average period should also be considered when looking at these excess deaths in a historical context. It is likely that the occurrence of these flu deaths has increased the 5 year average number of deaths for the year's earlier weeks to a level that may be higher than would be expected if we were averaging over a longer period of time. The net consequence of this is that the difference between this year's observed deaths throughout January and those expected in January may not be as great as demonstrated. There may even have been some excess Non COVID-19 deaths in some districts. However, it is not possible to ascertain this with the data currently available.

3.35 As the current "lockdown" continues it is likely that we will continue to see an excess in mortality due to COVID-19 and non COVID-19 causes, however in the short-medium term, as the NHS begins to return to some form of normality it is hopeful that this will reduce. In the longer term it is likely that we will experience excess mortality as the impacts of the lockdown on the economy, and individuals mental and physical health manifest as longer term health conditions. It's quite possible that these will exceed the numbers seen by the disease itself. We do not have a way of estimating those impacts currently.

Annex B

Health and Wellbeing Overview and Scrutiny Report
Health and Adult Social Care System COVID-19 Response
System responses - COVID-19 Central Incident Management Team

4.1 COVID-19 Central Incident Management Team – the wider NHS Structure

4.1.1 Following the declaration of COVID19 as a Level 4 National Incident on 30th January 2020 Thurrock CCG, working closely with neighbouring CCGs and other partners, has had to respond to the incident management in line with their established Emergency Preparedness, Resilience and Response Plans (EPRR).

4.1.2 This is a summary for Thurrock Council's Health Overview & Scrutiny Committee of the briefing paper received by Thurrock CCG Board in private sessions held on 22nd April and 27th May 2020. The briefing paper provided detail of the local management of the COVID19 incident covering the governance of the incident and the main decisions made by the incident management team and various supporting workstreams.

Incident Management

4.1.3 A central incident management team was operational from early February 2020 initially on an Essex wide basis before becoming focused on mid and south Essex following the NHS declaration of a Level 4 national incident on 30 January 2020. By early March the basic structure of the management of the incident had been established across the whole Health & Care Partnership (HCP) as shown below.

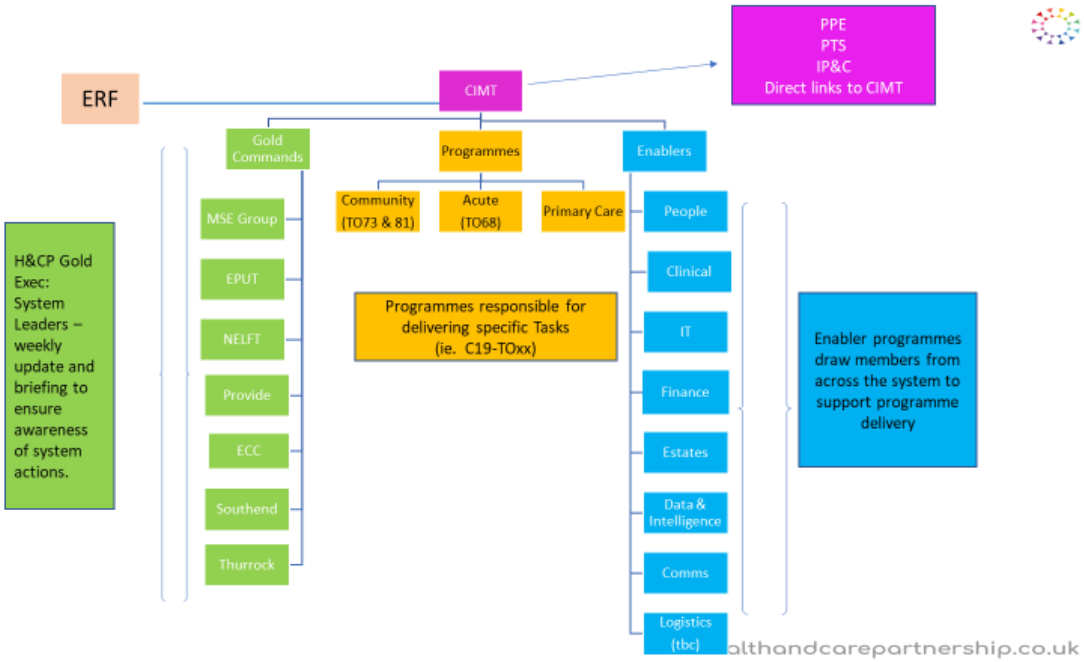


Figure 1 Incident Management Structure.

4.1.4 In addition to the workstreams shown above each of the four places across the HCP – Basildon & Brentwood, Mid Essex, South East Essex and Thurrock – continued to operate. The beginning of the incident management coincided with the appointment of an Interim Joint Accountable Officer and handover from existing Accountable Officers. Each place has a named Deputy Accountable Office allocated to manage local place-based incident management. For Thurrock this is Mark Tebbs, formerly the Director of Commissioning for the CCG and for Director of Mental Health Commissioning for the Joint Committee of the CCGs.

4.1.5 CCG governance leads, liaising with CCG Audit Chairs and CCG Chairs, provided advice for how CCG governance would be maintained during the incident. This was to support reducing administrative needs and allow the redeployment of staff to the incident management with the balance of supporting rapid decision making. Agreement was made that board meetings held in public would be suspended in line with national guidance until such time that social distancing rules would allow them to be re-established. Alternatively a technological solution may be found to allow meetings in public to be held on-line. Each CCG board would continue to meet to review and approved decisions taken by the Central Incident Management Team and would have a common agenda. Finance, performance and quality committees would continue to meet to review their areas of work but to make this easier to support they would meet in common. This means the committees meet at the same time via video-conference, with the same agenda and same supporting information and a minimum quoracy of each committee in attendance, allowing CCG Board members including local GPs and lay members to review decisions and provide support and challenge to the executive teams managing the incident.

4.1.6 CCG teams met on 16th March to decide what work was business critical to the incident management, what routine work which could be scaled back and what routine work could be paused. This was complemented by the work of the Human Resources workstream that supported the redeployment of CCG staff from their existing roles to ones that supported the management of the incident.

4.1.7 The actions detailed above allowed the CCGs to meet the guidance issued by NHS England & Improvement (NHSE&I) on 28th March entitled *Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic* which aimed to ensure that maximum resource was allocated to managing the incident and paused work on other NHS priorities such as delivering the NHS Long Term Plan. All guidance issued by NHSE&I throughout the incident can be accessed at https://www.england.nhs.uk/coronavirus/

4.1.8 On 29th April NHSE issued further guidance on the second phase of the NHS's response to COVID19. This asked local health systems to continue to have surge capacity as lockdown measures were relaxed, to ensure that local systems could step up non-COVID19 urgent work (e.g. two week wait referrals) and to start routine elective work again where capacity allowed.

Routine referrals commenced again in Mid & South Essex Hospitals from 13th May.

4.1.9 The guidance also asked that the NHS "*should also take this opportunity to 'lock in' beneficial changes that we've collectively brought about in recent weeks. This includes backing local initiative and flexibility; enhanced local system working; strong clinical leadership; flexible and remote working where appropriate; and rapid scaling of new technology-enabled service delivery options such as digital consultations*."

4.1.10 This has led the Mid & South Essex Health and Care Partnership to establish a Re-Set Programme across all partners, including Thurrock Council, that allows for the CCG Central Incident Management Team to focus on remaining matters that need managing within the incident framework such as support for care homes. As of 26th May the Re-Set Programme is being established and a further update can be presented to a future meeting of the Thurrock HOSC.

4.1.11 The Re-Set Programme recognises that COVID19 will be an issue to be managed for the foreseeable future and that it will not be possible to simply "return" to old ways of working. Rather new ways of working must be found to accelerate the delivery of the 5 year strategy to deliver better outcomes and reduce health inequalities. The main principles of this programme are to be:

- **Patient/resident focused** - with the aim of achieving a better understanding of the health and care needs of residents, which are often chronic and comorbid, and make it easier for individuals to take personal responsibility for their health and wellbeing.
- **Clinically/professionally-led** – nominated consultants, GPs and professional leads will be given authority to transform and continuously improve services so that they respond to demand, supported by a SRO (Director) from one organisation to deliver the agreed changes, reporting to the Partnership Board.
- **Results oriented** – with the aim of redefining the parameters within which our system will operate in future and defining clear quality and performance expectations.
- **Value-based** – with the aim of investing / recycling resource into areas that increase value to our residents.

4.1.12 As noted above the programme is still being developed and will be reviewed in light of further NHS guidance for the Phase 3 response to COVID. It is presented here for information and a full report on the re-set programme will be provided to CCG Boards in June 2020 which can be discussed with Thurrock HOSC after that date.

Human Resources

4.1.13 The HR Workstream's key deliverables over the first month of incident management has been:

- the redeployment of staff to support frontline services (i.e. supporting hospital discharge; nurses to wards within the hospital sites of Mid and South Essex Hospitals Foundation Trust; admin and project staff to the hospital sites and resilience staff to the hospitals and other providers
- completion of a Memorandum of Understanding across all organisations in the Health and Care Partnership so that temporary re-deployment of staff can happen safely – the aim is that there is proper observance of clinical governance requirements, while avoiding unnecessary bureaucracy which may impede the movement of staff such as duplicating NHS employment checks.
- internal redeployment of staff to support incident workstreams and Place
- continued work to ensure robust data and capture the correct information about where staff are placed, who is self-isolating/sick and who remains 'available'
- skills audit of all staff denoted as 'available' to understand what transferable skills they have
- production of Pandemic People Policy for agreement by CCGs and unions and ratification by the CCG Remuneration Committees
- production of updated frequently asked questions for staff and information for managers on key workers, hotel accommodation and managing childcare commitments
- recommendation to CCG Remuneration Committees regarding payment of overtime or enhancements to salary for certain CCG staff that falls outside of Agenda for Change. CCG Remuneration Committees approved this proposal.

4.1.14 A key focus for the workstream was to ensure that place-based Deputy Accountable Officers had sufficient resource to implement some of the changes described in the rest of this paper; this will mean re-deploying or repatriating staff from CIMT workstreams to place based teams as we begin to move into the reset phase whilst still managing the response to the pandemic.

Data and Intelligence

4.1.15 The key deliverables for the data and intelligence workstream has been

- Establish joint working and data sharing across all organisations within the Health and Care Partnership, especially between CCG based business intelligence teams, Mid and South Essex Hospitals Foundation Trust and public health teams across all three local authorities

- Deliver an epidemiology model that forecasts most likely COVID 19 demand to support capacity planning across all the whole system
- Generate a daily dashboard that can be shared across all system partners giving both an update on the modelling estimate and a daily view of capacity across community and hospital services.

4.1.16 The modelling work was led by Thurrock Council's public health team under the leadership of Dr Ian Wake, and modelled possible scenarios for capacity across the three hospital sites. This modelling has proved to be very accurate so far and correctly modelled that about 20 days after lockdown (around the 13th April) that cases requiring access to critical care beds would start to fall. As at 20th May (the last day of verified figures at the time of writing) 78% of critical care capacity was available for non-COVID cases allowing for the resumption of non-COVID related services.

4.1.17 The workstream keeps the dashboard contents under review continually and has expanded to include community and social care capacity. It will be further refined to incorporate primary care data as required to give CIMT members a full picture of demand and activity during the incident. CCG boards noted that the dashboards in the last week of April were showing that bed occupancy rates across the hospital sites in Mid and South Essex Hospitals Foundation Trust was around 50%. This is in line with the incident management plan to ensure that hospitals had capacity to receive patients; the dashboard also shows that in the peak weeks of the incident in April critical care beds were over 70% occupied with confirmed COVID patients.

Primary and Community Interface

4.1.18 A significant focus of work for CCG staff has been revising how primary care and community based services work together to ensure they are best placed to manage the needs of residents during the incident.

4.1.19 Cooperation and rapid decision making across CCGs, NELFT, EPUT and Provide as providers of community services, GPs as providers of primary care and local authorities as commissioners and providers of social care support has been the key to this. This work has been supported by several workstreams most notably estates, human resources, primary care and community care as well as input from multiple agencies including police, fire and army.

4.1.20 The core of the revised community bed model is the bringing together of beds, equipment and staff at two sites – Brentwood and Braintree – to ensure there is a robust and resilient service delivery with available resources to meet expected demand.

4.1.21 The CCG boards at their meeting in April considered and approved

- staffing criteria for the two reorganised sites at Brentwood and Braintree

- admissions criteria for step up, step down and stroke beds
- creation of a single Urgent Community Response Team to bring together the existing unplanned admission avoidance referral services into a unified service (RRAS (Thurrock), SPOR (BB), Swift (Southend and CP&R) and ESDAR (Mid))
- the range of additional support going into care homes across health and social care.
- the increased focus on advanced care planning to manage end of life pathways
- the decisions being considered to meet national guidance regarding the prioritisation of certain community services

4.1.22 A new workstream focusing solely on supporting care homes has been generated from the general re-modelling of community services to respond to the COVID19 incident. The main deliverables for this workstream fall under the headings of supplies, including Personal Protective Equipment (PPE), equipment, staffing and training and continued partnership development.

4.1.23 Key to the quality oversight and support to Thurrock care homes has been the development of the Thurrock Care Home Hub. The ambition of this Care Home Hub is to lead and positively influence the provision of care local level. The Care Home Hub is a multi-disciplinary team drawn from local authority, CCG, community and primary care providers. The current Thurrock care home priorities have focused on the screening process in care homes for symptomatic and non-symptomatic residents and staff, enhanced infection control training for all Thurrock care homes, the roll out of digital “vitals” equipment (such as pulse oximeters and blood pressure monitors) and implementation of the local enhanced primary care service to support all care homes with a nominated GP.

Communications

4.1.24 Underpinning all efforts to manage the incident has been a coordinated communications response- both managing incoming requests for information from stakeholders, media interest, MPs and local councillors and ensuring a constant flow of consistent information across the Health and Care Partnership. It has also delivered bespoke communications to primary care, care homes, internal CCG staff and a Partnership Brief which is sent every Friday highlighting the unified response across mid and south Essex. These are available on the CCG website.

Quality

4.125 As highlighted in the revised governance arrangements and NHSEI guidance of 28th March CCG Quality Committees continue and focus on incident management and quality matters.

4.1.26 All quality teams have had a number of redeployments in response to the COVID 19 pandemic, with some members forming part of the Critical

Incident Management Team and many of our nurses working on the frontline.

4.1.27 Quality assurance visits and face to face meetings with providers have been suspended by the Joint Committee's Quality Team. Quality assurance remains through monitoring with providers continuing to submit their monthly dashboards summarising performance against quality indicators in 2019/2020. 2020/21 quality negotiations with providers have been suspended.

4.1.28 Across all CCGs, in light of no national guidance, an agreement with providers to pause all incidents currently being investigated is now in place, releasing clinical investigators for other duties. For all new serious incidents, the CCGs will require providers to complete the72-hour report template but this can be submitted anytime up to seven days. The report MUST be comprehensive and contain lessons learned and include actions that have been taken to reduce the risk of a similar incident occurring again. With mutual agreement with the respective CCG and provider, this process can apply to the historical low to moderate harm serious incidents which are

4.1.29 Harm reviews are continuing at each site within Mid and South Essex Hospitals Foundation Trust with arrangements adjusted to accommodate the workforce at each site.

4.1.30 Thurrock CCG has retained the statutory oversight for Thurrock Adult and Children's safeguarding during Covid19 pandemic. All CCG safeguarding teams continue to work in collaboration with other designated professionals across Southend, Essex and Thurrock, in order to give consistency in the delivery of statutory safeguarding functions across all provider services, including primary care. The teams are very aware that safeguarding processes must continue throughout incident management.

4.1.31 Anecdotal evidence from the Safeguarding Adult National Network and the Regional Safeguarding Adult Network suggests there has been a significant decrease in the number of referrals being received across SET. It is anticipated that this increase will maintain for some time with referrals returning to pre Covid-19 levels and beyond as "lockdown" measures are relaxed. Current concerns that Thurrock CCG adults safeguarding team is supporting are relating to reported poor hospital discharges. The children's safeguarding team are currently involved with reviewing complex children's presentations and pathways as an MDT.

Finance

4.1.32 The Systems Finance Leaders Group (SFLG) meets every two weeks and is a key financial meeting to make collective decisions and implement national guidance across the Health and Care Partnership. This is chaired by the Chief Finance Officer from Mid and South Essex Hospitals Foundation Trust. The SFLG has coordinated the system finance response to COVID19. As with other workstreams there has been an aligned approach across all

system partners.

4.1.33 On the 26th March 2020 NHSEI produced guidance on the ‘Revised arrangements for NHS contracting and payment during the COVID-19 pandemic’. This has been implemented in full.

Health and Wellbeing Overview and Scrutiny Report
Health and Adult Social Care System COVID-19 Response
System responses - Mid and South Essex Foundation Trust

4.2 Mid and South Essex NHS Foundation Trust

4.2.1 The response of the Trust has followed a number of stages, key elements of our response are set out below:

Stage 1: Preparation

4.2.2 The vast bulk of routine activity including routine outpatients, diagnostics and elective operations were ceased. A risk assessment was undertaken of all patients affected was undertaken and for patients who required time critical assessment or treatment, this was continued. Software to support virtual consultations was rolled out across all services.

4.2.3 The Emergency Departments of all hospitals were split with separate routes and areas put in place for patients suffering from suspected COVID and for other patients where COVID was not suspected.

4.2.4 We developed a multi-stage surge plan for each hospital site which outlined how COVID capacity would be expanded for patients across the categories of level 1 (standard oxygen support), level 2 (non-invasive ventilation and level 3 (mechanical ventilation).

4.2.5 Clinical staff were all provided with ventilator and PPE training in preparation for redeployment to provide care to COVID patients.

Stage 2: Response

4.2.6 A single 24/7 command structure was activated across the Trust to link into the NHS national command and control arrangements and the Essex Resilience Forum.

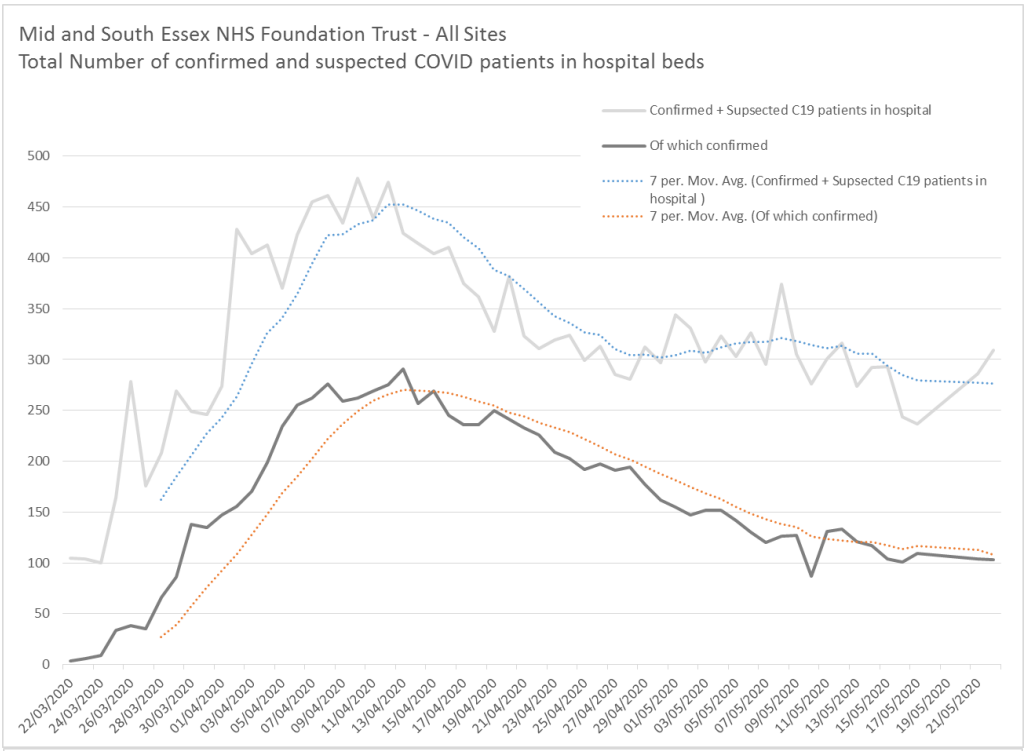
4.2.7 The surge plans were activated by site with formal operational check points being undertaken 3 times per day.

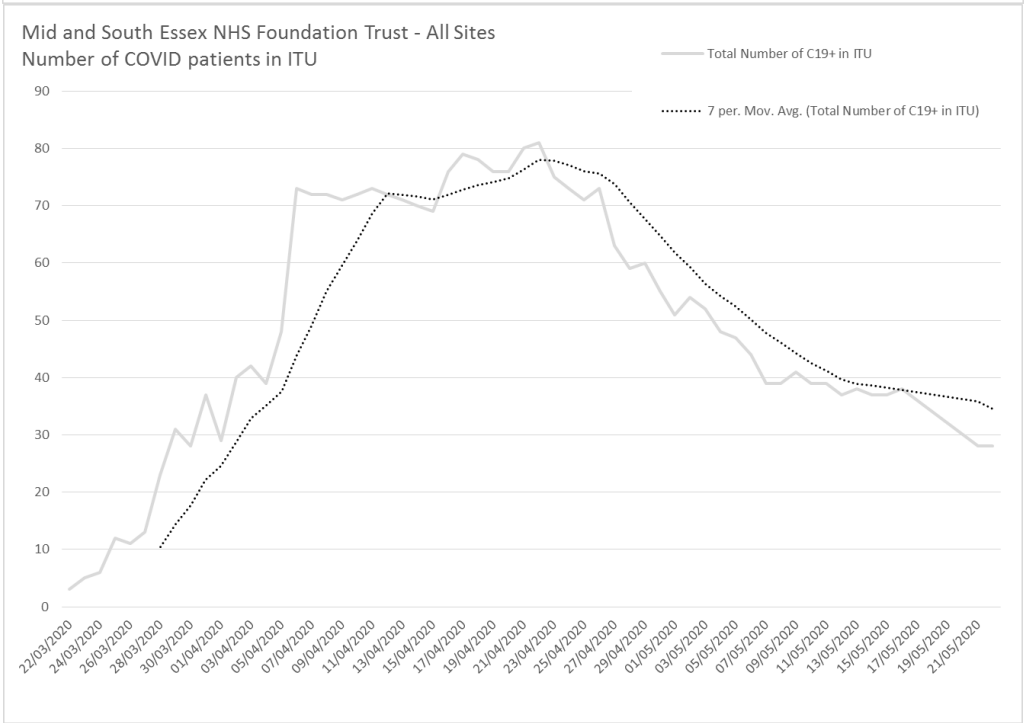
4.2.8 A 7 day transfer service was put in place to support the transfer of COVID patients between the three hospitals to balance out differential load between the individual hospital sites on a day to day basis to ensure best possible quality of care.

4.2.9 For non-COVID time critical elective patients we made use of the national arrangement with the Independent Sector to treat these patients in these hospitals.

4.2.10 We created ‘wellbeing’ centres for staff in all three hospitals to provide support to staff members.

4.2.11 The figures below show the daily number of patients with COVID in hospital across the Trust and the number receiving mechanical ventilation between 22nd March and 21st May.





Stage 3: Recovery

4.2.12 Given that COVID activity is now reducing we are re-starting as much clinically urgent non-COVID work that we are able to whilst maintaining separation between COVID and non-COVID areas and providing sufficient capacity headroom should we experience a second peak in demand.

4.2.13 We have also put in place psychological support services to provide ongoing staff support.

4.2.14 Alongside this we are developing a longer term plan for implementation this summer on where we provide services in order to support a broader range of business as usual services alongside managing COVID demand for the next 18-24 months. Where possible we are considering whether we can accelerate our clinical strategy through this process.

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Health and Wellbeing Overview and Scrutiny Report
Health and Adult Social Care System COVID-19 Response
System responses – Adult Social Care

4.3 Adult Social Care

COVID-19 Outbreak Prevention and Management in Care Homes

4.3.1 In early May 2020, central government devolved responsibility for arrangements relating to testing staff and residents in care home down to Local Directors of Public Health. Around the same time, the Essex Public Health England Health Protection Team also requested the help of local authority Public Teams in the clinical management of outbreaks in care homes.

4.3.2 Thurrock Public Health, Adult Social Care Staff and CCG clinical staff responded by rapidly producing a Thurrock Care Home Outbreak Prevention and Management Protocol linked to a multi-agency Thurrock Care Home Hub meeting to manage its implementation.

4.3.3 The protocol, provided in full at Annex E, sets out clear roles and responsibilities across four domains:

- Preventing Outbreaks from occurring
- Rapidly identify and provide a coordinated response to care homes where outbreaks occur to prevent their spread
- Supporting care homes to provide the best possible care to COVID-19 positive residents to facilitate their recovery
- Provide high quality integrated on-going clinical support to care homes to support them during the COVID-19 crisis.

4.3.4 The Thurrock COVID-19 care home hub and wider NHS clinical in-reach services have delivered a range of high quality interventions to support care homes including:

- A three weekly call to every care home to ascertain and respond to individual support needs with daily direct support provided by qualified public health staff during outbreak situations
- Provision of regular testing of all staff to check their COVID-19 negative status and ensure that any asymptomatic COVID-19 positive staff are identified quickly and asked to self-isolate
- An offer of infection control training for staff working within care homes
- Regular testing of all staff and residents where outbreaks occur as part of on-going outbreak management support
- The option to ‘step up’ positive COVID-19 residents to specialist provision at Oak House to reduce the risk of outbreak spread and provide the best possible care
- Specialist integrated clinical support through a GP Locally Enhanced Service and Enhanced Community Health Team including

individualised care planning, medicines management support, regular clinical review of all residents, specialist community geriatrician support and vital signs monitoring.

Support provided to Care Homes

4.3.5 Thurrock's Adult Social Care department (ASC) responded quickly to provide additional finance, utilising the money provided by central government to pay all care homes a 10% resilience payment for sixteen weeks. This payment was designed to protect care homes from the impact of additional financial pressures, such as increased requirements for Personal Protective Equipment (PPE) and staff absence caused by Covid 19. In addition, our Finance Department agreed to payment up front for are homes to ease cash flow.

4.3.6 Adult Social Care's Contracting Team have a long-established close working relationship with all providers. This proved invaluable in enabling a support function to be put in place without delay. The support function entailed regular contact with all care homes, at least three times per week, to gauge their status with regard to cases of Covid 19, PPE stocks, staffing and other issues. This enabled an accurate situation report to be produced three times per week and meant that ASC Management were able to respond quickly to off-set emerging pressures.

4.3.7 Support has been constant, initially through the supply from our stocks of PPE as this proved very difficult for Care Homes to source. An extensive support package to control care home outbreaks has also been put in place by our Public Health team which includes a programme of training, testing and infection control support to ensure any outbreak is managed and contained. Care Homes were also able to provide isolation areas to support containment where necessary.

4.3.8 Within Collins House, the local authority-managed care home, a separate isolation unit was put in place immediately to assist with outbreak control and enable Covid-positive hospital discharges to be facilitated. This had a significant impact on Thurrock's ability to minimise any delayed discharges. The unit was supported by a "Covid Team" of carers, working with enhanced PPE and provided with specialist training to ensure effective management of residents.

4.3.9 The Department also took over a home that had recently closed. Oak House was opened as a step up/down facility for Covid 19 positive patients to ensure capacity for hospital discharge or relocation from other care homes could be arranged, thereby further containing spread of the virus. This Home was also supported by the Covid team from Collins House. It was a remarkable collective effort to get this home open in a few weeks – including health and safety checks, QC registration staffing in post etc. Thanks should be given to the whole team that oversaw this and this service has been invaluable and continues to operate as a step down facility from hospital for COVID positive patients

4.3.10 To date these initiatives have proved remarkably effective in containing the virus within our homes. As at the 27th May the total number of deaths with care homes in Thurrock stood at 35. Of course, every death is very regrettable and especially upsetting for family and friends, even more so at this time as it has been necessary to severely restrict visiting in to the homes. The number of deaths is, however, relatively low given the level of frailty that exists within our homes. No care home has had a significant outbreak which become unmanageable and where there have been a number of Covid positive residents identified the homes have done a remarkable job ensuring spread has not occurred.

Hospital Discharge

4.3.11 There have been no delays in discharge in Thurrock throughout the entire Covid period - despite the accelerated target put in place to protect critical care beds within hospitals. An early decision to maintain a hospital social work team presence within the hospital and the swift mobilisation of the hospital and placement teams to move to a 7 days a week extended hours service, have been the main cause of this success. In support of these decisions the creation of step down facilities already highlighted above, along with the close working relationship we have with our providers, enhanced our ability to discharge effectively. These decisions have not been replicated by other local authorities, who have produced poorer discharge performances.

Personal Protective Equipment (PPE)

4.3.12 Despite early concerns around the supply of PPE we have managed to maintain supplies locally. Deliveries from central sources have been sporadic but of a level that has enabled us to support the local care market. We have ensured supplies have been maintained at safe levels by putting in place a central management structure within our own provider service function and through significant support from the Council's Emergency Planning team. Some external providers have struggled to source PPE within their own supply chains and our ability to provide them with stock has ensured that have maintained safe working practices for staff.

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Health and Wellbeing Overview and Scrutiny Committee. Annex E

Proactive Prevention and Management of COVID-19 Outbreaks in Care Homes

A proposed model for Thurrock

19th May 2020

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1. Introduction and Rationale

Outbreaks of COVID-19 in care homes present a significant and on-going public health challenge both locally and nationally as the COVID-19 epidemic progresses.

Recent modelling by Public Health England suggests that 90% of residential care homes nationally will experience an outbreak of COVID-19 in the next six weeks.

Initial concerns about COVID-19 related demand outstripping NHS capacity led to national PHE guidelines that recommended COVID-19+ patients to be discharged back into residential care homes.

As the epidemic has progressed, through a combination of increasing NHS capacity and achieving 'suppression' of transmission (an R0<1) through 'lockdown' measures, the NHS capacity risk has been mitigated, and there is currently sufficient capacity at all levels of the NHS locally to meet COVID-19 demand.

Conversely, the residential care sector both nationally and locally has faced significant challenges related to COVID-19 including:

- A number of COVID-19 outbreaks
- Lack of access to PPE
- Lack of access to prompt testing

Outbreaks in residential care settings present a high public health risk for several reasons:

- Residents are often at significant increased risk of COVID-19 related complications due to their age and/or underlying comorbidities
- The close proximity of infected and uninfected cases can allow infection to spread rapidly
- A lack of testing capability both in terms of speed to test and limiting of testing availability to symptomatic residents only has made it difficult to identify all cases and take appropriate action
- It is difficult in some circumstances to ensure PHE guidelines on isolation of cases when identified are followed, for example where residents have dementia and may wander between rooms.

Thurrock has already developed a comprehensive offer to care homes, but in light of the above, a more proactive and preventative approach to management of COVID-19 is required to reduce the risk of future outbreaks. This slide pack describes the work to date and makes recommendations on what else should be done to reduce future outbreak risk.

2. Inclusion criteria

Care homes included within this model can be defined as Older Peoples Care Homes. There are thirteen care homes of this type in Thurrock. Older Peoples Care Homes (OPCHs) provide personal care and accommodation, for short or long periods. Qualified nursing care is also provided within OPCHs to ensure that the full needs of the person using the service are met. Examples of services that fit under this category are:

- Residential homes
- Rest homes
- Convalescent homes
- Respite care
- Mental health crisis houses
- Therapeutic communities.

3. Exclusion criteria

- For the purposes of this protocol extra care facilities will not be treated as care homes and so a COVID+ resident in an extra-care facility will not automatically trigger a ‘suspected outbreak’ definition under the terms of this protocol.

- Where a resident in an extra care facility is Covid +ve efforts will be made to ensure a separate team of carers are employed to carry out the care of the COVID+ve resident, to mitigate the risk of transmission. If a separate team cannot be identified, extreme care must be taken to ensure all other enhanced infection control measures are put in place.

4. Evidence Base

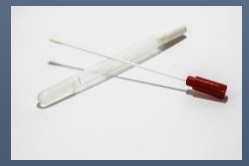
The Centre for Evidence-Based Medicine recently undertook a systematic review of the evidence base on how pandemic spreads can be prevented and contained within residential care homes considering the role of human resources, nursing activities/medications and external visitors. The findings can be summarised below:

Hand Hygiene

- Little evidence that education programmes alone change behaviour
- Compliance is improved where sanitisers are readily available in work areas and where line managers check/enforce compliance
- Education + regular reminders to staff + issuing each staff member with a personal pocket-sized sanitiser has been shown to be most effective

Staffing

- Larger care homes are at greater risk of pandemic outbreaks than smaller ones
- Staff are a key source of outbreaks, including staff entry/re-entry, community nurses working across multiple locations, and staff continuing to work whilst symptomatic.
- Inadequate access to PPE and lack of staff adherence to PPE guidelines contributes to outbreaks
- Temporary bank staff used to replace staff on sick leave pose a particular threat
- Limiting movement of staff between care homes and reducing reliance on temporary staff reduces the risk of outbreaks



Testing

- Prompt identification of an outbreak is required to coordinate an effective response
- Delayed recognition of COVID-19 cases in both staff and residents through limited testing availability and/or identification of COVID-19 through symptoms only contributes to outbreaks in care homes
- Rapid identification of cases among both staff and residents through testing may facilitate a coordinated response that minimises within-care home spread.

Environmental decontamination

- Regular disinfection of high-traffic surfaces reduces infection spread

Residents

- Limiting social contact through isolation procedures and use of PPE by staff can cause residents distress, particularly residents with dementia
- Education of residents on the reasons behind changes can aid compliance with mitigation strategies and address considerations of quality of life and anxiety

5. Aims and Objectives of Thurrock Model

AIM:

- Provide a proactive care home offer that reduces the risk of COVID-19 to care home residents whilst supporting them to function effectively during the epidemic

OBJECTIVES:

1. Reduce the risk of COVID-19 outbreaks in care homes
2. Rapidly identify and confirm a COVID-19 outbreak when it does occur and provide a coordinated response to reduce the threat of transmission to COVID-19 residents
3. Support residential care homes to provide the best possible care to COVID-19 positive residents to facilitate their recovery
4. Support care home staff to continue to provide high quality care

DEFINITION OF A SUSPECTED OUTBREAK:

- One or more residents or staff members with COVID-19 related symptoms of a high temperature and/or a new persistent cough, or loss of, or change in, normal sense of taste or smell (anosmia*) in isolation or in combination with any other symptoms.
- A positive COVID-19 test result in a member of staff, regardless of symptoms

DEFINITION OF A CONFIRMED OUTBREAK:

- At least one resident with a positive COVID-19 PCR test result

** People/household contacts of people who develop anosmia even if this is the only symptom should self-isolate as per current guidelines and qualify for a test on the grounds of anosmia if they also fall into a population group who can access tests when they have COVID-19 symptoms.*

6. Thurrock COVID-19 Care Home Hub

In order to rationalise and co-ordinate support to care homes, we will form a multi-agency Thurrock COVID-19 Care Home Hub. The responsibility of the hub will be to coordinate an integrated support offer to care homes including proactive measures to prevent outbreaks including infection control and prevention, managing outbreaks when they occur, and on-going clinical and care support during the COVID-19 to support care providers to deliver the best care possible to our residents, as specified on the next five slides.

The heart of the hub will remain the Thurrock Council Contracts, Brokerage and Placement Team who are already undertaking liaison with Care Homes three times a week, through which all proactive support to care homes will be made. Additional support to care homes will be provided from a range of health, public health and care professionals including more proactive outbreak prevention and management functions, and for ongoing clinical care of residents. The group will be administered by the Thurrock Council Public Health Team. The group will initially meet daily. Once assurance is reached that the outbreak is under control meeting frequency will change to bi weekly. Please see slide 14 for governance structure.

The Thurrock COVID-19 Care Home Hub will comprise of the following people:

- Assistant Director of Public Health, Thurrock Council (Chair)
- Contract Compliance, Brokerage, Placements and Blue Badge Manager, Thurrock Council
- Strategic Lead, Public Health Improvement
- Director/Head of Primary Care, Thurrock CCG
- Deputy Chief Nurse, Thurrock CCG
- Strategic Lead, ASC Commissioning, Thurrock Council
- Strategic Lead, ASC Provider Services
- Commissioning Manager, ASC
- Hospital Social Work Team Manager, Thurrock Council
- Head of Long Term Conditions, NELFT

Objective 1: Reduce the risk of COVID-19 outbreaks in care homes

Thurrock Care Home COVID-19 Hub will undertake the following actions to deliver Objective 1

1.1 Undertake a call with each residential care home provider three times a week to capture data and provide proactive support and guidance

1.2 Develop a self-assessment checklist for compliance with national guidance on PPE and Infection Control.

1.3 Identify care homes who would benefit from enhanced IPC support and offer an enhanced support / training package

1.4 Offer an enhanced IPC training offer to care homes through a cascade training model to assist homes to deliver best practice around infection and prevention control and use of PPE.

1.5 Work with care homes to investigate barriers to implementation of guidance/IPC measures.

1.6 Undertake root cause analysis to better understand and mitigate the reasons that lapses in care/infection prevention and control occur

1.7 Develop and deliver training to care home staff on use of self-swabbing testing kits when these become available to staff.

Residential Care Homes should undertake the following actions

1.8 Ensure 100% compliance amongst staff to self assessment checklist

1.9 Ensure high staff compliance with hand hygiene including:

- Staff training on hand washing technique and frequency
- Availability of hand sanitation/hand washing facilities in work areas
- Compliance regime overseen by managers
- Individual hand sanitisers issued to each staff member

1.10 Where ever feasible, ensure that staff work only in one residential care home and avoid use of bank staff

1.11 Facilitate digital solutions for in reach clinical care for residents in care home that may reduce the need for face to face contact

1.12 Prohibit all visits to care homes by residents' friends and relatives. Encourage technology enabled contact

1.13 Facilitate discussion of measures between staff and residents to reduce resident anxiety and increase resident compliance

1.14 Avoid re-admitting residents treated in hospital for COVID-19 before confirmation of a negative COVID-19 PCR test.

1.15 Regularly (ideally at least once a week) undertake swabbing of staff for COVID-19 to confirm negative status regardless of symptoms. Tests can be ordered via the Care Home Testing Portal. The process is set out on **page 10.** Should any staff test positive, they should immediately self-isolate for 14 days from date of swab test and the situation should be treated as a suspected outbreak.

Objective 2: Rapidly identify and confirm a COVID-19 outbreak when it does occur and provide a coordinated response to reduce the threat of transmission to COVID-19 negative residents

A *Suspected Outbreak* is defined as either:

- **One or more residents or staff members with COVID-19 related symptoms of a high temperature and/or a new persistent cough**
- **A positive COVID-19 test result in a member of staff, regardless of symptoms**

Thurrock Care Home COVID-19 Hub will:

2.1 Ensure a local contract is in place with Commisceo to provide for the regular swabbing of all residents and staff in an outbreak situation

2.2 Identify suspected outbreaks during the three times a week call with each care home provider.

2.3 Check that the care home has notified Public Health England Health Protection Team of the suspected outbreak and that swabbing of all staff and residents has been arranged.

2.4 Coordinate on-going management of the outbreak in the care home through the using the protocol on the next slide including repeat testing of staff and residents

2.5 Discuss the feasibility of 'step up' arrangements of COVID+ residents to Oak House with the care home and where deemed desirable, facilitate this.

2.6 Support the care home to continue to operate throughout the outbreak in order to manage and sustain capacity including coordination and brokering of clinical advice and support and infection control

2.7 Agree with the home, when the outbreak is over.

2.8 Review data on the number of cases, number of deaths and staffing levels across all care homes in Thurrock as on-going surveillance of the epidemic in order to inform a strategic view across the borough.

Public Health England Health Protection Team will:

2.9 Take responsibility for the initial health protection response to the outbreak including IPC advice, recording/reporting and handover to the Thurrock Care Home hub to organise swabbing of staff and residents. **Please see page 16 for the LA and PHE Standard Operating Procedure**.

Thurrock Council Public Health Team (Assistant Director of PH) will:

2.10 Take responsibility for Health Protection outbreak control follow up measures and compliance against protocol on next slide, working through the Thurrock Care Home COVID-19 Hub

2.11 Act as the communication link between the hub and Public Health England, obtaining specialist advice where necessary.

Care Homes should:

2.12 Comply with the protocol on the next slide including ongoing testing of staff and residents

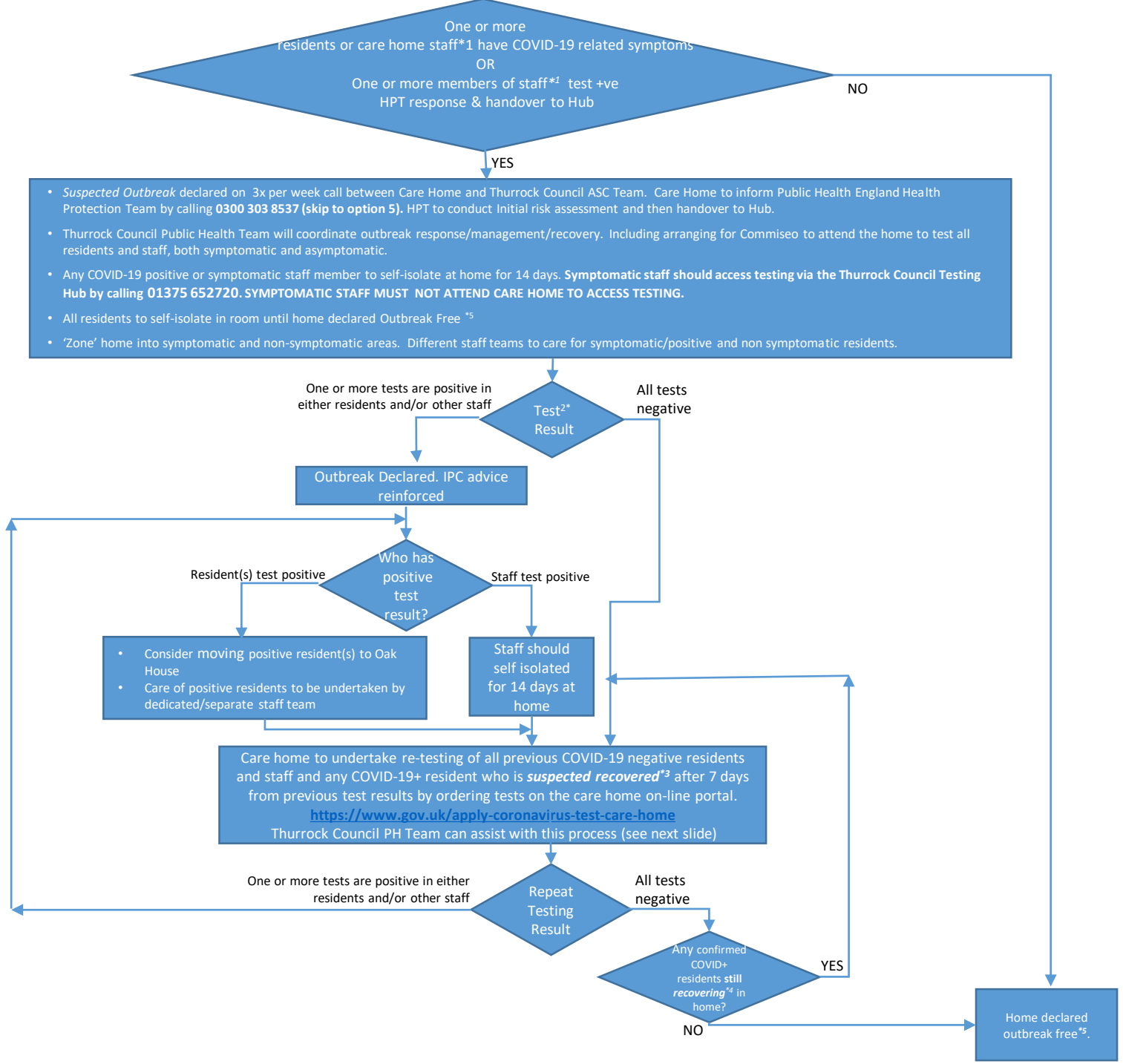
2.12 Ensure all residents self-isolate in their rooms for 14 days

2.13 Ensure all symptomatic staff self-isolate at home for 14 days from either day of first symptoms or day of first positive test (whichever is earlier) and do not return to work until after 14 AND at least 48 hours after last symptoms of fever (whichever is longer)

2.15 Consider moving COVID+ residents to Oak House where feasible and where not feasible, 'zone' the care home to separate COVID-19 positive/suspected and COVID-19 negative residents **with different staff teams assigned to care for different zones.**

2.16 Close to new admissions until the outbreak is over.

Objective 2: Care Home Outbreak Protocol



*1 - Care Home Staff includes NHS Community and Primary Care Staff offering direct in-reach into home. HPT response will include IPC advice and risk assessment, including deep cleaning advice. HPT must be informed of all outbreaks to take initial action before handover to hub.
*2 Commiseo to communicate results to the Care Home
*3 – '*Suspected Recovered*' defined as no-longer having an on-going temperature in the last 48 hours, and onset of first symptoms was over 7 days ago.
*4 – *Still Recovering* defined as a resident whose last test was positive OR who has had previous COVID+ results and still has a temperature
*5 – *Outbreak free* is defined as no new cases in 28 days from initial confirmation

Process for ordering Self-Swabbing tests using the care home on-line portal

Outbreak Situations

During an outbreak situation, initial testing of all residents and staff will be undertaken by Commisceo who will attend the care home and undertake the swabs. This will be organised by Public Health England when the care home reports a suspected outbreak.

For follow up testing in an on-going outbreak situation, care homes can access further tests through the new Care Home Testing Portal. The portal provides swabs through a courier service directly to the care home. The Thurrock COVID-19 Care Home Hub should be informed and can support you to manage this process as part of on-going outbreak management support.

Care homes should organise repeat testing immediately after they receive the results of the initial testing undertaken by Commisceo as the process from order to delivery of swabs takes three days.

The portal is accessed using the web link below and pressing the **Start now >** button.

https://www.gov.uk/apply-coronavirus-test-care-home

The process is as follows:

- Care home receives an email confirming successful ordering of tests
- Care home receives second email from the portal confirming tests kits have been scheduled for delivery
- Test kits courriered to care home
- A competent person at the care home undertakes swabbing of staff and residents between 6am and 4pm. Training on swabbing will be provided by the Thurrock COVID-19 Care Home Hub. The staff member undertaking the swab must use appropriate PPE. The Thurrock COVID-19 Care Home Hub can advise on this.
- Care home registers each completed swab on-line through the portal and records the bar code/URN number against the name of each person swabbed
- Courier collects completed swab samples between 4pm and 9pm
- Care home receives test results by email within 72 hours and notifies resident/staff member and Thurrock COVID-19 Care Home Hub
- Outbreak continues to be managed in line with protocol on page 9

Ongoing Screening in non Outbreak Situations (from page 7)

Care homes should consider regularly screening all staff including NHS staff providing clinical in-reach to the home for COVID-19 to check COVID-19 negative status

Ideally this should be done at least once a week

The screening portal and above protocol should be used to order and return swabbing kits

Objective 3: Support residential care homes to provide the best possible care to COVID-19 positive residents to facilitate their recovery

Thurrock Care Home COVID-19 Hub will:

3.1 Ensure dedicated care home /nursing provision for COVID-19 positive residents is available at Oak House and Collins House in 'isolation units' with separate teams of care staff available to provide care.

3.2 Liaise with care homes to arrange 'step up' of COVID-19 positive residents to Oak House where a local decision is made that this is in the best interest of residents and care homes.

3.3 Support care homes to provide dedicated zones to separate COVID-19 positive and negative residents and provide separate dedicated staff teams to care for both groups

3.4 Monitor and support the on-going needs of care homes who have COVID-19 positive residents

3.5 Ensure that all residents admitted from hospital to care homes have received a negative COVID-19 test prior to care home admission, and arrange for 'step down' to Collins House and Oak House isolation units for patients discharged from hospital who remain COVID-19+. Tests will be arranged by the hospital or community referrer as part of the patient discharge plan.

3.6 Ensure that care home residents are stepped down from Collins House/Oak House, only in line with the protocol on the next slide

3.6 Ensure high quality integrated care of COVID-19+ residents through the GP, GP LES (see next slide) and NELFT Enhanced Community Care Home Support including and MDT where clinically appropriate

Care Homes should:

3.7 Consider stepping up COVID-19 positive residents to Oak House where appropriate

3.8 Care for COVID-19 positive/symptomatic residents in a different 'zone' within the care home where this is possible

3.9 Use a separate, dedicated staff team to care for only COVID-19 positive residents

3.10 Readmit residents to the home once they receive a COVID-19 negative test results.

3.11 Manage outbreaks in line with the protocol in Objective 2

3.12 Act on clinical advice provided through the GP, GP LES arrangements, MDT, NELFT Enhanced Care Home support to ensure the best possible care for COVID-19+ residents

3.13 Assess COVID-19 risk in BME staff

3.14 Participate in the IPC training offer and outbreak management advice from he COVID-19 Care Home Hub.

Objective 3: Protocol to step down previously COVID-19+ residents back into care homes

All patients discharged from hospital who have tested COVID-19 positive and have not had a COVID-19 negative test result prior to discharge should be stepped down to Collins House/Oak house

All patients who have previously tested positive for COVID-19 and who are in Collins House/Oak House:
Patients will only be stepped down back into their usual place of care only if one of the two criteria below is met:

- The patient has tested negative for COVID-19 **AND** had a normal temperature for at least 48 hours **OR**
- At least 14 days have elapsed since date of first COVID-19 symptoms **AND** they have not had a temperature for 48 hours

Patients who have previously tested COVID-19 positive and who are discharged from hospital with a COVID-19 negative test result

- Should be discharged to Collins House/Oak House if they have had an elevated temperature within in the previous 48 hours
- Can be discharged back into their usual place of care if they have not had a temperature for 48 hours
- Should still self-isolate within their usual place of care for 14 days since onset of first symptoms
- If any symptoms consistent with COVID-19 occur at any stage, the individual should be retested and self isolate. Management should be undertaken in line with Objective 2 in this pack.
- If the patient's usual care home cannot self-isolate them for 14 days since first onset of symptoms, that patient should be discharged to Oak House/Collins House.

Objective 4: Support residential care homes to continue to provide high quality care

Thurrock Council Contract, Brokerage and Placement Team: provides a single point of contact for the Thurrock COVID-19 Care Home Hub, including care home management including guidance, advice, outbreak notification and PPE
Telephone 07860 779416. Email: adultbrokerage@thurrock.gov.uk

Ongoing COVID-19 Outbreak Support and Follow Up: is provided by Thurrock Council Public Health Team who will also advise on on-going testing. Contact via the Council Contract, Brokerage and Placement Team

Thurrock First: acts as the first point of contact for health, mental health or any ongoing health concerns for residents.
Telephone 01375 511000. Email: thurrock.first@thurrock.gov.uk

Urgent Health and Social Care Response is provided by the Rapid Response Assessment Service (RRAS) for residents who are experiencing a crisis or may be at risk of an immediate crisis. RRAS can be contacted by calling Thurrock First or directly by calling 01375 896 037

Emergency Duty Team Out of Hours Service provides social work support out of office hours. Telephone 01375 372 468.

Dementia Crisis Support Team provides specialist support for people with dementia during periods of crisis.
Telephone 01277 696 110.

Primary Care:

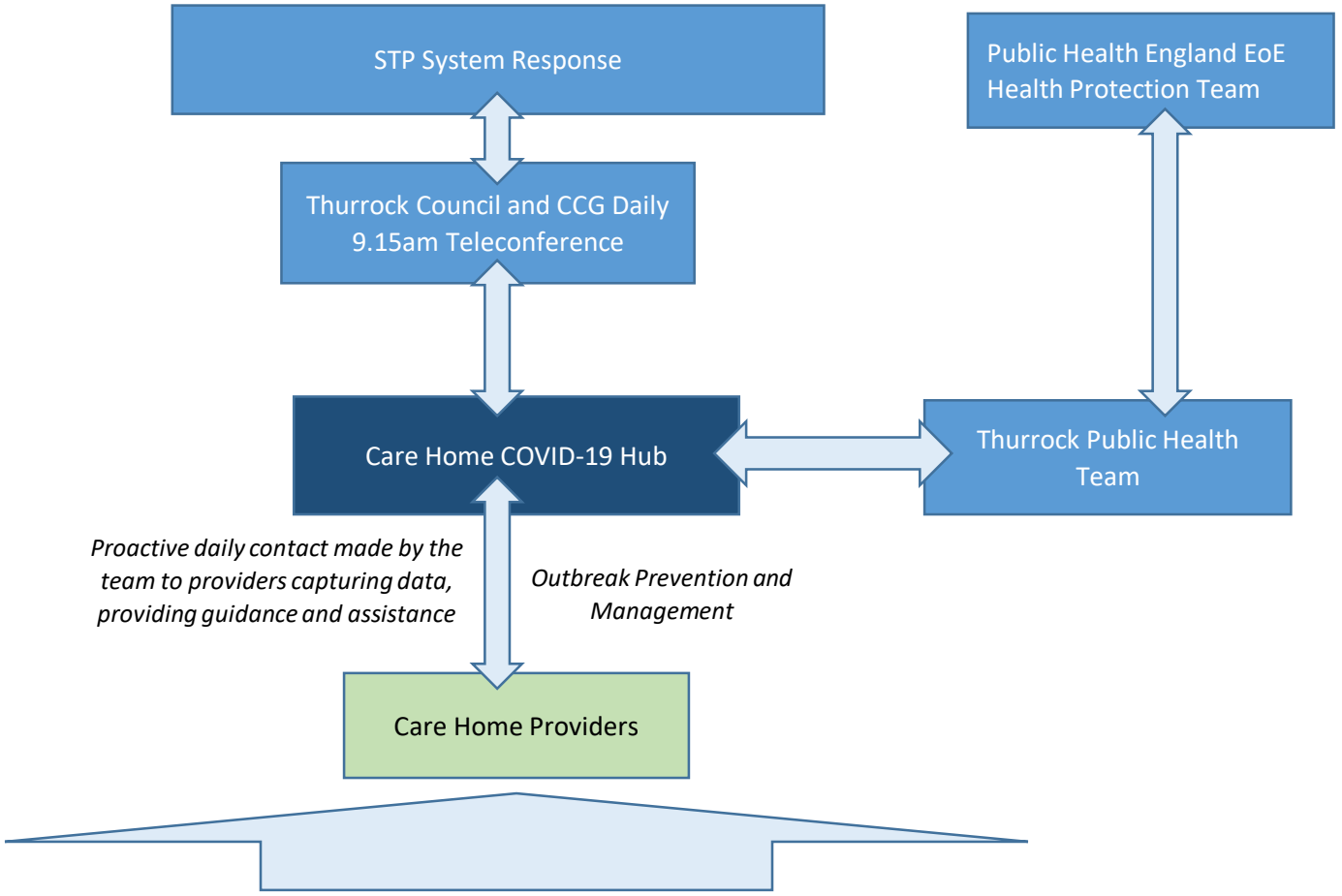
- GPs will assist with routine clinical care and during a crisis.

- **Primary Care Network Local Enhanced Service (LES) for Support to Care Homes** aims to provide additional proactive clinical support to care homes and reduce variation in current provision including medical assessment of new admissions, an individualised care planning approach for each resident, regular clinical review of residents and medicines management support, care coordination between NHS partners including MDT where appropriate. Support can be accessed through a dedicated GP or pharmacist, nominated by each Primary Care Network.

Enhanced Community Health Care Home Support (NELFT) provides a geriatrician and community nurse service to assist with and supply of vital signs monitoring equipment including blood pressure, thermometers etc.
Telephone: 01375 896 037

Infection Prevention and Control (IPC) provide IPC advice
EmailMeccg.essex.carehomes@nhs.net

5. Process Map for Support for Residential Care Homes in Thurrock



PHE and Thurrock Local Authority Standard Operating Procedure

This is currently being updated and will be available from 22nd May 2020.

Health and Wellbeing Overview and Scrutiny Report
Health and Adult Social Care System COVID-19 Response
System responses – Provider Services

Provider Services, NELFT and EPUT

4.4 NELFT

4.4.1 NELFT were in a good position to work with system partners to prioritise and work together during the Covid 19 Pandemic due to previous good relationships formed as part of the Thurrock Integrated Care Partnership and Better Care Together transformation work.

4.4.2 As all Community Health Providers we were required to prioritise their services in accordance with a letter from Matthew Winn (NHS) which set out which services should be prioritised and which should be partially stopped and some stopped altogether, in order to be able to respond to the increased demand on services.

Review of Services

4.4.3 All of our services were reviewed with Crisis, Hospital Discharge and local Community Teams taking priority and essential and complex care being the focus. NELFT led on an increase in Community Hospital Bed provision with beds being consolidated on two sites (Brentwood 158, Braintree 49) across the STP area, and additional wards being mobilised at a fast pace to support the acute hospitals.

4.4.4 This meant that Mayfield ward on the Thurrock Hospital site has been temporarily closed in order to maximise medical and nursing resources and all community NHS beds for the South West sector are based at Brentwood Community Hospital. The position of Mayfield ward will be reviewed in due course and HOSC will be consulted as part of that process. This all required a large estates and workforce programme. Many staff from non-essential services being redeployed to wards and those other services deemed a priority.

4.4.5 The task of stopping and partially stopping services was carried out alongside Community Health Providers in the Mid and South Essex STP to avoid a difference in approach and timing. It was important to work with local Primary Care and other partners to ensure any changes had minimal impact on people and changes were well communicated.

Supporting people

4.4.6 We have used staff unable to work face to face to keep contact with people the services are not seeing as regularly due to prioritising of services. We have also focused on working with Primary Care and other partners to support Care Homes and the most vulnerable ‘shielded’ people in the Community.

4.4.7 Our teams have aimed to provide virtual care where appropriate and possible using video conferencing and telephone support, but a large majority of care to people in the community has remained face to face.

Next Steps

4.4.8 Next steps will include working with our partners to reset the system. The Chief Executive of NHS England – Simon Stevens, has set out in a letter to all NHS organisations NHS England's priorities and pace for the reset programme.

4.4.9 A lot has been learnt about how we can communicate with patients and work in a more integrated way to make the best use of services and this must not be lost. The directive for Community Health Organisations is:

- Sustain Hospital Discharge Services
- Identify patients post discharge and recovering from Covid who need ongoing community health support
- Essential community health services must be prioritised (based on the phasing of returning of other services when capacity allows)
- Prioritise home visits where there is a child safeguarding concern

4.5 EPUT

4.5.1 Following declaration of Level 4 incident, the Trust initiated Emergency Response measures, including establishment of Gold, Silver, Bronze command structure and an Incident Response Room function.

4.5.2 Service Changes and priorities are outlined below. The Trust response is underpinned by the needs of our patients and communities and we have actively engaged with system partners and voluntary/third sector organisations throughout.

Mental Health Inpatient

4.5.3 The following action was taken which focussed on Mental Health Inpatient priorities:

- Inpatient capacity was reduced to 50%: Opel1/2;
- Our Emergency Operational Plan was implemented;
- Inpatient Principles were defined and in place. These are in accordance to Government guidance and include social distancing measures, isolation/barrier nursing, leave for exercise once daily, visiting allowed for EOL only;
- We devised and issued Restrictive Practice Guidance/tool;
- We updated our Isolation, Segregation & Seclusion/MHA Guidance;
- A COVID care plan introduced;
- Daily COVID Safety huddles have taken place on all wards;

- A post discharge 72hr follow up is planned for 100% of patients by Home Treatment Team or the patient's Care Coordinator.

4.5.4 The following action was taken which focussed on Mental Health Community Services:

- No MH Community services have stopped. Existing patients remain supported under the care of care coordinator/team.
- Crisis 24/7 has been launched across the Trust;
- ED Diversion service is in place;
- Our Community/Leadership Principals have been defined and are in place;
- RAG Rating in place across teams, this also helps to identify and align support for vulnerable patients;
- Transformation programmes have been prioritised, focussing on an integrated alliance approach to primary care, crisis and community mental health;
- Virtual working established: AccuRx and Microsoft teams being used where individual risk assessment identifies to be appropriate.

Support for staff

4.5.5 In addition to pre-Covid 19 support (e.g. EAP), increased support provision has been mobilised, supported by the psychology service. This includes the staff helpline and Wellbeing Toolkits. Access has been promoted to staff at partner Trusts across the system.

4.5.6 Daily communication bulletins and weekly live online Q&A sessions have been hosted by the Executive Team and support is also in place from the Chaplaincy service.

Next Steps

4.5.7 At this stage the National Incident status remains at Level 4 and the Trust is required to retain EPRR incident coordination functions. It is anticipated there will be peaks and flows over the longer term with wider economic/social repercussions on the longer-term demand on services.

4.5.8 Core recovery principles are defined as follows:

- Patient focussed
- Adaptation rather than recovery
- Build on the positive achievements to date
- Recovery of our workforce
- Monitoring & surveillance

4.5.9 A governance structure has been agreed in parallel to the EPRR structure; this is in-line with the national response being sustained at Level 4 at this stage. A trust-wide Recovery & Reset Steering Group has been established with representation from key stakeholders including patient experience, HR and operational leads.

4.5.10 Working groups/enabler work-streams have been identified in-line with system recovery plans. Working groups serve separate core functions but also have a shared scope and focus to:

- Undertake SWOT analysis to identify which of the changes we have made should be kept, modified or abandoned;
- Consider restoration of non-Covid19 care;
- Stepping up services to meet unmet demand/projected future demand;
- Identify opportunities to embed and foster innovation and transformation/new ways of working;
- Identify any potential changes to roles/responsibilities required;
- Propose services in the context of public health and societal response.

Health and Wellbeing Overview and Scrutiny Report
Health and Adult Social Care System COVID-19 Response
System responses –Testing

5. Testing for COVID-19

5.1 There are a number of different routes that key workers and residents can get a COVID-19 test. Some of these are determined by national protocols and in the case of care homes through our locally determined protocol (see care home section of this report). As of 27 May 2020 only the antigen (swab) test, that seeks to detect active COVID-19 is available although central government have promised to make an antibody test that seek to determine whether someone has had COVID-19 in the past and recovered available to frontline NHS and care staff in the near future.

National COVID-19 Testing Arrangements

5.2 Anyone can apply to be sent a postal kit if they are within the first five days of symptoms. Kits can be provided either through the post or the individual can access one of the government drive in testing services. Our nearest one is at Stanstead

5.3 In addition the Ministry of Defence provides 'pop up' drive through testing facilities are various sites. The times and dates when these are available are advertised on the COVID-19 testing section of the GOV.UK website, and this facility has been provided at Blackshots Leisure Centre.

Local COVID-19 Testing Arrangements

Drive through testing for NHS and LA staff including care home staff

5.4 The Mid and South Essex Hospital Group has developed local drive in locations at Basildon, Southend and Chelmsford for health and local authority workers including all care home staff. For council staff and care home staff (including private sector care home staff) these are booked using the Council's Testing Hub. To be eligible, staff must have had symptoms five or fewer days ago. Local NHS staff can book a test through a similar local NHS booking hub.

Care Homes

5.5 In an outbreak situation (one or more residents and staff with COVID-19 symptoms), we commission a company called Commisceo to attend care homes and swab all residents and staff. Tests are booked by the council's Public Health team as part of outbreak testing with on-going testing for all residents and asymptomatic staff each week until everyone tests negative and the home is declared outbreak free. Central government has also launched a dedicated care home testing portal that couriers tests directly to and from the care home and relies on care home staff to undertake self-swabbing or

swabbing of each other. Where the care home is not experiencing an outbreak we are using this testing mechanism to undertake regular testing of all staff to confirm that they remain COVID-19 negative and are safe to work (see section 4.3 on care homes for more details).

4.6 Thurrock Coronavirus Community Action

4.6.1 Thurrock Coronavirus Community Action (TCCA) was established 23 March 2020 to ensure a strong partnership approach to supporting residents through the Coronavirus pandemic. The Partnership between the council with Stronger Together and Thurrock CVS launched to support anyone self-isolating at home without friends or family to help with tasks such as shopping or collecting prescriptions, or befriending.

TCCA Call Centre

4.6.2 A dedicated call centre was established and staffed by staff from council services who had been affected due to lockdown, such as those working in libraries. Staff quickly learnt the skills to be able to open and manage a call centre and online enquiry form seven days a week. A dedicated number was issued to those 'shielding' and a public number and web enquiry form was publicised to anyone with a need for support to self-isolate at home. As of 28th May 3191 interactions have been made with Thurrock residents requiring support in order to self-isolate

Community Shielding

4.6.3 Prior to April 1st 2020 support focused on our most vulnerable residents identified by the NHS who are following Government shielding guidelines and are completely self-isolating for 12 weeks because they are at very high risk of severe illness from COVID-19 (we have referred to them in other internal documentation as 'Category A' residents). The Council is receiving a number of different datasets pertaining to these individuals and strong partnership working arrangements between Public Health, TCCA and service colleagues have meant we have been able to respond quickly where needs have been identified (see further detail below).

4.6.4 By 1st April 2020 the TCCA Call Centre had made contact with and delivered essential items to over 250 people in this category ahead of food boxes being delivered by central government. Initially the number of residents in Thurrock identified as shielding was 3,026 – this number has been updated on four occasions since first being released and at the time of writing, this figure is now 9,735. This large increase in shielded individuals since the generation of the initial list is reflected nationally, and is due to a number of factors, including national review of clinical criteria and reviews of specific patient lists by all GPs and hospital clinicians. It should be noted that between iterations of the shielded list, a number of patients have also been removed where their cases were no longer found to meet criteria (those patients have been notified).

4.6.5 A dedicated phone number to help this group to stay at home was launched and all in contact with TCCA through calls relating to food deliveries, or requesting support, were advised to call this number. Thurrock's GP practices also been sending a local text message out to their shielded patients as they are identified, which provides this dedicated phone number.

4.6.6 When first identified as someone who should shield at home, a person is contacted by NHS England to confirm they are within this group. The person is asked to register with a national portal to indicate if they have any needs to access food, medicines and social contact or basic care. As people register, information is released to their Local Authority to assist support when someone has indicated there is a need.

4.6.7 Each day the TCCA call centre contacts people new to the list who have identified a support need. Calls relating to basic care are made by Thurrock First. As of 28 May 2020 1,535 residents in Thurrock have indicated a need with accessing essential supplies including food. In mid-March a food distribution centre was established with bulk purchased supplies to help those shielding. To date, 435 Council purchased food boxes have been provided to residents shielding. 29 have been provided to people in an emergency situation and considered likely to meet the criteria for shielding status prior to the registration being confirmed. The total distributed to date is therefore 464. Data is supplied by central government on the status of centrally-supplied food deliveries, and TCCA follow up locally in cases where it was recorded that the centrally-supplied box was not delivered – e.g. due to access issues with the property.

4.68 Not all residents who are shielding and contacted to register with the national helpline have done so. There are almost5,000 residents in Thurrock who have yet to register with the national portal at the time of writing. Central government is keen to ensure as many as possible register their needs centrally and commissioned a national call centre to contact those who had yet to register. From May 7th, councils were asked to contact those who the national call centre failed to contact, and to report back on the outcome of contact made. Data on failed contacts is flowing to Councils on a daily basis. , and we have so far received information relating to over 1,300 failed calls requiring a further action. Council has agreed a process for contacting these residents. 683 residents were sent letters mid May and to date, 139 had either registered or been removed from the shielding list by their GP or clinician. A further 651 letters were sent May 27th 2020.

TCCA Volunteer Response

4.6.9 Essential to the ability to support residents is the volunteer response organised and managed via Thurrock CVS. Volunteers were encouraged to register their interest prior to a short recruitment process to verify identity and seek character references. Once recruited, volunteers would be contacted with appropriate tasks to support in the community including shopping, collecting prescriptions, befriending and even dog walking requests.

4.6.10 As of 28th May, 520 volunteers had registered with Thurrock CVS, and a total of 1411 tasks supporting local residents had been supported. These include:

- 712 shopping requests
- 77 befriending requests
- 432 medicine collections
- 76 food bank collections
- 3 utility top ups and
- 3 dog walking request.

4.6.11 The willingness of local residents to volunteer to help others at a time of need was amazing. Many wanted to do so much more than they were asked to help with due to the numbers who offered their support. Those who did help others spoke with pride about the contribution and difference they were able to make at such a difficult time.

4.6.12 In order to capture this level of community spirit and ensure it is sustained beyond the lockdown period, CVS has worked with Stronger Together of which council is a partner to develop OurRoad – a digital platform that encourages and supports residents to mobilise and support others in their area through simple acts of kindness with varying degrees of commitment or time required. OurRoad will launch in Volunteers Week 1- 7th June, a national opportunity to reflect on the dedication of people willing to give their time to help others.

Impact

4.6.13 As well as the practical tasks completed to help people self-isolating whether through the effort of volunteers, or through the delivery of essential food boxes, it is clear that TCCA has achieved so much more while supporting local residents.

4.6.14 Countless individuals and family members have shared their gratitude and thanks with CVS and council either direct or via social media channels.

4.6.15 Emergency food boxes have been described as a life line. People have shown their appreciation not just for the food and provisions provided, but also for the time taken to check in with residents at an appropriate social distance by redeployed staff delivering these across the borough.

4.6.16 Shopping provided to be a huge challenge, especially in the early days of lockdown when priority internet slots had yet to be issued. CVS was quick to devise a safe and efficient way for people to have their shopping carried out by a volunteer and to pay for the goods they chose, retaining dignity at a time of need. Numerous social media posts have thanked individual volunteers and CVS for supporting this need, as well as with other practical tasks such as collecting medicines.

4.6.17 The strength of partnership working in Thurrock between the voluntary sector and council is a further example of the impact from the response to

Covid 19. As soon as it was clear that the virus would have an unpresented impact on our communities, CVS and Council discussed the scope of a local approach, looking to each other's strengths to lead where appropriate. The Stronger Together Partnership provided an appropriate channel to galvanise the support and buy in from a wider partnership which, for the period of the emergency response, expanded to support discussion around local challenges and appropriate support.

18 June 2020	ITEM: 7
Health and Wellbeing Overview and Scrutiny Committee	
Progress Update on Major Health and Adult Social Care Projects	
Wards and communities affected: All	**Key Decision:** Not applicable
Report of: Les Billingham - Assistant Director Adult Social Care / Detlev Munster, Assistant Director Property, Regeneration and Development	
Accountable Assistant Director: Les Billingham, Assistant Director Adult Social Care / Detlev Munster, Assistant Director Property, Regeneration and Development	
Accountable Director: Roger Harris, Corporate Director Adults, Housing and Health	
This report is Public	

Executive Summary

The Council and partners in the health sector have been working together to develop a new model of care and support that will see services offering an integrated health, social care and community services, delivered from modern, high quality premises able to attract the best staff. Four new Integrated Medical Centres (IMCs) are planned with the intention of locating the new model of care in the heart of the communities that they serve, thereby bringing a greater range of health and care services under one roof so as to improve and simplify care pathways for patients. Good progress continues to be made with the IMC development programme despite the restrictions relating to the emergency period.

Work is also being undertaken to address the future need for residential care in the Borough, including intermediate care to avoid hospital admissions and to enable timely discharge. Designs are well advanced on the 21st century residential care facility on the Whiteacre / Dilkes Wood site in South Ockendon and a planning application will be submitted at the end of the summer. In addition work is being undertaken on the future possible upgrade options for Collins House.

Wider transformation initiatives that reinforce the importance of planning and providing services that are tailored to the needs of local communities, have been established. Primary Care Enhanced Teams involve working across the collective practice within localities by working with the GPs and existing practice staff across their locality to ensure people can be seen by the most appropriate person in a location which is close to where they live.

Wellbeing Teams provide a tailored service to individuals to help them live well and be part of their community. Wellbeing Teams integrate three key elements of care and support to create true wellbeing:

- Ensuring that people are safe and well
- Supporting people to do more of what matters to them
- Helping people to stay connected to others and their community

Community Led Support provides a new approach to Adult Social Care, initially introduced in the Tilbury and Chadwell area. The service offers the opportunity to have a face to face discussion with a member of the team in a convenient location close to where they live. This approach aims to bring adult social care out into the community and ensure more accessible support is made available to people.

We will be launching our Technology Enabled Care Strategy later this year which will consider how the use of telehealth, telecare, telemedicine, telecoaching and self-care for people with long term conditions that is convenient, accessible and cost-effective. Our Technology Enabled Care Strategy will drive forward a transformation in the way people engage in and control their own healthcare, empowering them to manage their care in a way that is right for them.

Thurrock is part of a wider health and care system: Mid and South Essex Health and Care Partnership. This cover's the 5 CCGs of Thurrock, Basildon / Brentwood, Southend, Mid-Essex and Castlepoint / Richford. This complex health and care partnership arrangement is developing into something called an Integrated Care System (ICS). ICS's will cover every part of the country and seek to ensure improved outcomes where services can be better developed at scale.

For some time we have been working with our partners in the ICS to get the right balance between what is done at place – i.e. Thurrock and what is done at system i.e. Mid and South Essex. Good progress has been made on this and we are hoping that a Memorandum of Understanding will be agreed soon that states these roles and responsibilities very clearly.

1. Recommendation(s)

1.1 Health and Wellbeing Overview and Scrutiny Committee is asked to consider and comment on this report.

2. Introduction and Background

Integrated Medical Centres

2.1 The Health and Well-Being Overview and Scrutiny Committee are aware that the Council entered into a Memorandum of Understanding with Basildon and Thurrock Hospitals NHS Foundation Trust (BTUH), Essex Partnership University NHS Foundation Trust (EPUT), North East London NHS Foundation Trust (NELFT), and Thurrock Clinical Commissioning Group (the CCG). This underpinned our local strategy of improving the health and well-

being of the population of Thurrock by moving from outdated facilities and fragmented services, improving the capacity and capability of primary, community and mental health care, and delivering an integrated health, social care and community/third sector care model with Thurrock's residents at its heart. In July 2019 after consulting with the Independent Reconfiguration Panel the Secretary of State confirmed the decision of the five CCG's Joint Committee and agreed Orsett Hospital should close, but only after the alternative plans for the services to move out – i.e. the 4 Integrated Medical Centres – were up and running.

2.2 The IMCs will serve local populations and will be located in:

- Tilbury - to primarily serve Tilbury and Chadwell;
- Corringham – to primarily serve Stanford and Corringham;
- Grays – to primarily serve Grays but also to act as a Central Hub for the whole of Thurrock; and
- Purfleet – to primarily serve Purfleet, Aveley and South Ockendon.

2.3 In a report to HOSC on 5 March 2020 the Orsett Hospital Task and Finish Group recommended "All agencies need to accelerate the programme around the Integrated Medical Centres (IMCs) with a target to have all fully open by the end of 2023." Each of the IMCs present specific challenges and consequently are at different stages of development. This report provides a progress update on the IMC development programme, and will provide Committee with proposed designs for two of the four sites. Work on plans for the Grays IMC have been particularly affected by the priorities in the emergency period, including the relocation of Mayfield Ward.

2.4 The Council has ambitious plans for development and improvement in the Borough, including ensuring the growing numbers of older people have genuine accommodation choices that meet their aspirations for later life, and high quality integrated care when they need it. To complement the Council's HAPPI housing for older people at South Ockendon and Tilbury, and its well-regarded care home in Corringham, in January 2019 Cabinet approved the development of a new facility, fit for the 21st century, to provide high quality specialised accommodation for older people with on-site social care and nursing care, as a means of meeting growing need through a desirable and effective alternative to additional care home provision.

2.5 Designs for the new residential care facility on the Whiteacre / Dilkes Wood site are progressing well and Committee is invited to comment on the designs prior to a planning application being submitted in late summer. Unfortunately plans for a series of workshops to engage local stakeholders, including the South Ockendon Centre, as well as public meetings to discuss the development with local residents have had to be abandoned because of restrictions during the emergency period. In view of this Committee is invited to comment on the proposed use of the Consultation Portal and other virtual channels to reach out to the local community and to seek their contribution to the design of the facility.

2.6 The report to Cabinet in January 2019 also instructed officers to work with Basildon and Thurrock University Hospitals NHS Foundation Trust (BTUH) and other NHS partners to outline the options for a possible future upgrade to Collins House. To this end the Council engaged architects Pollard Tomas Edwards to examine the constraints and opportunities of Collins House and the Councils neighbouring land holdings. Although no easy solutions were identified in this work it has been agreed a number of opportunities should be explored in detail under the direction of the Housing and Regeneration Group.

Wider Transformation Agenda

2.7 The Better Care Together Thurrock (BCT) Partnership, a sub-group of Thurrock's Integrated Care Alliance and Health and Wellbeing Board drives forward wider transformation programmes, discussed in this report, that include:

- Primary Care: Enhanced Team (PCET)
- Introduction of Wellbeing Teams
- Community Led Support Teams
- Technology Enabled Care and Solutions

3. Issues, Options and Analysis of Options

Integrated Medical Centres

3.1 Work on three of the four Integrated Medical Centres is progressing well during the Covid-19 pandemic: This has been possible because design work can be undertaken remotely, and to date little work on site has been necessary. The current status of the IMCs is as follows:

<u>Corringham IMC (Graham James site)</u>

- The site is owned by NELFT and on 24th March 2020 the Trust Board signed off and approved the Full Business Case for the development.
- In recognition of the priority on public health communications, NELFT and the IMC Strategic Programme Board have agreed to pause any external communication during the emergency period.
- The Programme plan has been updated and reviewed. As the development has already received planning consent, construction is expected to start on site in November 2020 ensuring full compliance with guidance on construction during the COVID-19 pandemic. It is anticipated the IMC will be operational by February 2022.

Tilbury IMC: (Civic Square site)

- Architects Pick Everard are working with the Schedule of Accommodation, agreed by the Council and its health partners in February 2020, to produce a feasibility layout.
- The integrated vision for the Tilbury site includes a circa 6,000 list size surgery, a suite of flexible clinical rooms to enable various health and care services to make use of the facility, along with community elements such as the library and community hub.

Purfleet IMC: (Purfleet Town Centre)

- The developer, Purfleet Centre Regeneration Limited, is working with the Schedule of Accommodation agreed by the Council and its health partners in February 2020 and liaising closely with the Director of Primary Care Estates for the STP.
- Initial design options and floor plans for the IMC are being developed. An on-line community design panel held on 12 May engaged 30 local people.
- Site investigations have resumed after a pause and ensuring full compliance with guidance on construction during the COVID-19 pandemic. The Government recently awarded the project £75m from the Housing Infrastructure Fund.

Grays IMC (Thurrock Community Hospital site)

- The IMC at Thurrock Community Hospital was always going to be a slightly different offer – the site already has an extensive range of existing services, and it is likely to be the site chosen for those services which can only realistically be offered in one location – e.g. potentially an Urgent Care Centre and Renal Dialysis.
- A Master Planning exercise for the whole the current site has been undertaken, and a range of options have been considered. The layout of the site is felt to lend itself to the zoning of two main areas: a "Health Village", incorporating quieter and more long-term activities, and a "Day Hub", the space where patients would come for appointments and more short term activities.
- Thurrock Community Hospital has played a key part in the local health response to Covid-19 and consequently work on the Grays IMC has been paused since mid-March, although work to plan the IMC's development is expected to resume in June.

21st century residential care (Whiteacre / Dilkes Wood site, South Ockendon)

- Work is continuing with design to RIBA stage 2/3.
- The design solution being pursued at Whiteacre / Dilkes Wood, is a 21st Century solution to residential care with the majority of units self-contained (into which social and nursing can will be delivered by the on-site team). This may make the facility more acceptable / attractive to frail older people - they could benefit from the on-site social and nursing care while avoiding communal living if they chose or if that was deemed necessary.
- Site investigations and surveys are continuing and the site has been hoarded in response to health and safety risks identified.
- A Planning application will be submitted in late summer and the facility is expected to be completed in summer 2023.

Wider Transformation Agenda

3.2 Updates on key wider transformation agenda projects that support our place based support model, providing services within the community, tailored towards their needs.

Primary Care: Enhanced Team (PCET):

- Primary Care paramedics from the PCN were redeployed to support the enhanced RRAS service during the COVID crises, which has proved hugely successful. Lessons have been learned as a consequence of new ways of working that need to be considered before any final decision is taken on future deployment of the team.
- New pathways and SOPs are still to be developed with the team – workshop postponed in March 2020. To be rescheduled at an appropriate date.
- Evaluation to be developed and supported by PHT to measure the impact of the team – postponed as the team are not operating at this time

Introduction of Wellbeing Teams

- As the teams are place based, they have built strong relationships with health, social care and the community so they can provide a better all-round approach.
- Decision taken to extend until March 2021 to cover the disruption caused by Covid.
- An evaluation will be carried out at the end of the year to test the impact and to identify next steps
- Next steps will include looking at how to extend the scope of the team to add value and cost effectiveness. This will further enhance integration at place and contribute to the continuing development of new models of care.

Community Led Support Teams

- There are now four placed based social work teams covering the whole of Thurrock.
- Teams have built solid relationships with organisations and the community in the areas they cover e.g. GP surgeries, LACs, Wellbeing Teams etc. All teams attend MDTs at local surgeries to promote a joined up approach
- Ability to know communities has enabled the teams to work well in place over the Covid period
- The approach to streamlining bureaucracy and processes has served them well during the pandemic as they were able to find solutions in the most appropriate way.
- Work to consider expansion to include specialist teams will be re-introduced as part of the recovery plan.

Technology Enabled Care and Solutions

- Robot Cats provided for dementia sufferers in care homes with some very positive early results – used over the Covid period which is particularly useful with increased anxiety for people not being able to see their relatives and being in a different routine
- Testing of Docobo at Collins House Care Home – monitoring of vital signs to reduce hospital admissions-was delayed and will need to be picked up post-Covid.
- Testing new forms of technology – Brain in Hand – to manage anxiety of a number of people testing the technology and enabling them to have greater independence. Very successful.
- Improved use of technology across the broader system to enable virtual communication will be explored for potential benefits as part of recovery.

4. Reasons for Recommendation

4.1 The development of the Integrated Medical Centres, and the 21st century residential care facility and future upgrade options for Collins House are significant opportunities to improve health and well-Being in the Borough. In line with the Council's commitment to Stronger Together, the development need to be informed by the needs and aspirations of local residents.

4.2 Opportunities for face to face information sharing, engagement and consultation are necessarily restricted during the emergency period and so alternative channels are required including the Councils consultation portal. Overview and Scrutiny Committee have a particularly important part to play at this time to ensure local requirements are understood and fully addressed.

4.3 Our key wider transformation programmes focus on place based services across Thurrock. It is particularly important for Committee members to be

provided with updates and progress reports on the impact of new models being delivered at community levels.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 Public consultation is usually a significant part of the planning process and the Council is committed to starting engagement early in the design development process, so that community views can influence proposals at a formative stage. Unfortunately plans for workshops with key stakeholders, including the South Ockendon Centre, scheduled for March had to be cancelled. Open events planned to enable local people to hear about and comment on the plans prior to a planning application being submitted are unable to proceed at this time. Alternative channels of communication are therefore needed and until restrictions are lifted it is proposed that the Council's consultation portal should be used as a primary channel levels of engagement, supplemented as appropriate by consultation letters and leaflets, media releases and social media.

6. Impact on corporate policies, priorities, performance and community impact

6.1 These developments support all three subsections of the 'People' element of the Council's corporate vision and priorities.

6.2 The developments also support the four principles stated in the Thurrock Health and Wellbeing Strategy 2016-2021 and has a specific reference under 'Goal 4 Quality care, centred around the person'.

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Strategic Lead, Corporate Finance

This report presents details of the current proposals for the development of 4 integrated medical centres and wider transformation agenda initiatives. Any financial implications related to the proposals in this report will be considered at the time decisions related to the proposals are to be taken, although initial feasibility funding, and cost estimates for the Tilbury Integrated Medical Centre, and the 21st Century care home are included with the existing capital programme

7.2 **Legal**

Implications verified by: **Tim Hallam**

Deputy Head of Law and Deputy Monitoring Officer, Law and Governance

This report presents details of the current proposals for the development of 4 integrated medical centres and wider transformation initiatives. Any legal implications related to the proposals in this report will be considered at the time decisions related to the proposals are to be taken.

7.3 **Diversity and Equality**

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring Officer

The IMC programme is crucial in addressing the health inequalities currently experienced in some areas of the Borough. Similarly, the development of residential care facilities fit for the 21st century will play an important role in the health and well-being of frail older people. All buildings developed as part of the programme will need to comply with equalities legislation and pay attention to the particular needs of the service users, a high proportion of whom are likely to be vulnerable.

Our wider transformation agenda provides services that are tailored towards the needs of individuals in locations that are local to where they live.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

The development of the Tilbury IMC will allow staff from several Council departments to work in the community that they serve improving public access to vital services. There is a clear health benefit to pursuing this programme of work.

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright): None

9. Appendices to the report

Designs for the Integrated Medical Centres, Whiteacre / Dilkes Wood and options for Collins House will be circulated to Members separately.

Report Author:
Christopher Smith, Programme Manager, Adults, Housing & Health

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Health Overview & Scrutiny Committee
Work Programme
2020/2021

Dates of Meetings: 18 June 2020, 3 September 2020, 5 November 2020, 14 January 2021 and 4 March 2021

Topic	Lead Officer	Requested by Officer/Member
18 June 2020		
HealthWatch	Kim James	Members
Health and Adult Social Care System COVID-19 Response	All	Members
Progress Update on Major Health and Adult Social Care Projects	Roger Harris, Mark Tebbs, Les Billingham	Officers
3 September 2020		
HealthWatch	Kim James	Members
2019/20 Annual Complaints and Representations Report – Adult Social Care	Lee Henley	Officers
Update on Orsett Hospital / IMC	Roger Harris	Members
Update on CCG Merger and Single Accountable Officer	Roger Harris / Mark Tebbs	Members
5 November 2020		
HealthWatch	Kim James	Members
Update on Orsett Hospital / IMCs	Roger Harris	Members
Verbal Update Targeted Lung Health Checks	Mark Tebbs	Members

14 January 2021		
HealthWatch	Kim James	Members
Adult Social Care - Fees & Charges Pricing Strategy 2021/22	Roger Harris	Officers
Update on the Whole Systems Obesity Strategy Delivery and Outcomes Framework	Helen Forster / Faith Stow	Members
Personality Disorders and Complex Needs Report	Mark Tebbs / Andy Brogan	Members
4 March 2021		
HealthWatch	Kim James	Members
Update on Orsett Hospital / IMCs	Roger Harris	Members

Clerk: Jenny Shade
Last Updated: May 2020