**Annex F**

**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.