Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

BNSSG Multi-Agency
Standard Operating Procedure:
Care Provider Wraparound Support Team

Version Control

Version	Date	Author	Comment
0.1	28/04/2020	Harriet Soderberg	Initial draft
0.2	04/05/2020	Angela Perrett	Comments and addition of appendix: Sirona SOP
0.3	05/05/2020	Anne Clarke / Rosi Shepherd	Comments
0.4	07/05/2020	Harriet Soderberg	Incorporating comments. Additional appendices
0.5	20/05/2020	Lauren Oakes	Additions to address book
0.6	29/05/2020	Lauren Oakes	Further additions to SOP and address book

Contents

1. Vision

The care sector has a huge responsibility in supporting the Covid-19 emergency. The NHS and Local Authorities across Bristol, North Somerset and South Gloucestershire (BNSSG) recognise this, as well as the huge impact Covid-19 will have on our care providers.

The BNSSG health and social care partners are working together across organisational boundaries to support care providers to meet the needs and demands of this new challenge. This is to ensure that they are supported while they continue to provide care for our vulnerable population in different care settings.

The health and social care partners have developed a support package offer, for providers, comprised of five key elements:

1. Joint weekly updates from BNSSG health and social care partners to ensure providers have the most recent news and guidance
2. Access to a new online resource library which is reviewed and assured, weekly, by a newly established Clinical Reference Group
3. Access to a multi-disciplinary Wraparound Support Team (incorporating nurses, end of life care specialists, community pharmacists, learning disability teams, Public Health, infection prevention and control nurses, social workers and Commissioners) via a 24/7 Single Point of Access (SPA) telephone line for support and guidance
4. Rapid mobilisation of support when an outbreak is reported, the initial response being determined by a Local Response Team Meeting
5. Locally based staff from Sirona, the Local Authorities, Primary Care and the Clinical Commissioning Group making regular contact with providers to provide support, establish new relationships and build on what is already working well

2. Introduction

The purpose of this paper is to detail the process followed when a care provider contacts the Wraparound Support Team.

While care providers are encouraged to contact the Team via the 24/7 SPA telephone line, the BNSSG health and social care partners aim to ensure that calls from providers are always directed appropriately and that “no number is the wrong number”.

The Wraparound Support Team service was rapidly mobilised by Sirona, BNSSG CCG and Local Authorities in response to the Covid-19 pandemic.

The Wraparound Support Team provides proactive, pre-emptive and reactive non-emergency healthcare advice and general support to providers. During COVID 19 the team will make weekly contact with each care home to discuss any issues the home may have, not just those relating to Covid. The purpose of this contact is to:

- Provide support and advice to care providers in caring for residents
- Develop strong working relationships with care providers
- Early identification of issues and /or homes requiring targeted support
- Identification of training requirements
- Signposting homes to resources available including mental health and wellbeing support
- Provision of clinical support and advice regarding individual residents

We intend to bring GPs and Frailty Consultants on-board in the next stage.

All active members of the Wraparound Support Team are listed in the "Address Book" (which can be found at the end of this SOP), along with their contact details, operational hours and a summary of the types of issues they can assist providers with. This resource is a 'live' document and will be updated with each new iteration of the Wraparound Support Team to ensure that the SPA are able to triage calls appropriately.

3. Standard Operating Procedure

This standard operating procedure (SOP) recognises that there are variations across BNSSG organisational boundaries; this is found in commissioning structures, the roles of Public Health teams and relationships with providers.

For instance, in some areas, providers are likely to use the Local Authorities as the first point of contact for queries, rather than the SPA. Similarly, each of the local Public Health teams operate differently, based on historical factors, and their involvement in the SPA will be likewise affected.

In this section of the paper, the SOP will be detailed for each of the teams involved in the Wraparound Support Team.

a. Sirona

When a provider calls the SPA, the staff member answering will triage the call and either resolve the issue or direct the call to the appropriate team member in the Wraparound Support Team, using the "Address Book", or any other service as appropriate.

Upon receiving the call, the 'operator' (a clinical staff member), will capture the following information for consistent reporting (see appendix: "Point of Contact reporting template"):

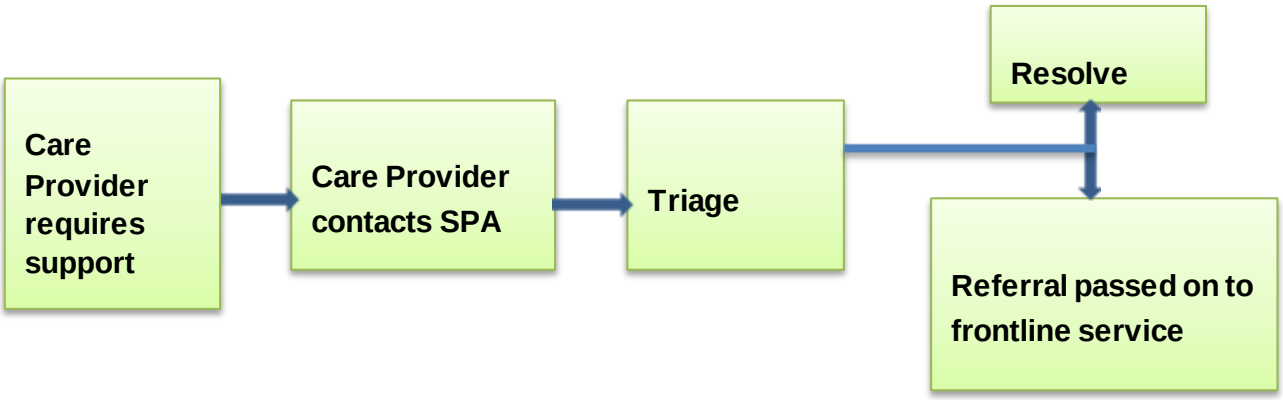
1. The provider (care home or extra care housing site or domiciliary care provider)
2. The reason for the call
3. Whether the call was resolved or triaged
4. If triaged, the team member(s) that the caller was signposted to

The Sirona element of the team are able to provide support with clinical concerns, PPE advice, policies and guidance advice including infection prevention control, training and education, staff health and wellbeing and signposting to other agencies/support where appropriate.

For those teams where a telephone number is provided in the "Address Book", the SPA staff will connect the caller through directly.

If the team have only provided an email address, or if the team are not available 24/7, then the SPA staff will contact the team to request that they contact the care provider.

Contacts relating to individual patients will be recorded in EMIS. The SPA will pass on information relating to care providers on a weekly basis. Care Home leads will record discussions with care providers that will be stored on Glasscubes (an on-line file sharing platform). Care Home leads will also maintain a record of the proactive calls made weekly to care homes (see appendix: "Care Home Liaison template").



b. Local Authorities

Bristol

There are two points of contact in Bristol City Council for providers, though one is more likely to be required:

1. The Locality Teams

These teams have been mobilised in response to Covid-19 and are responsible for responding to requests for emergency PPE, supporting the sustainability of services (for instance, assistance with staffing issues) and brokering mutual aid between services. They are also able to provide general support to adult social care providers.

An assigned lead for each Locality can be contacted 24/7 via the numbers in the Address Book.

Upon receiving a call, the Locality Team member responding, will capture the following information for reporting:

1. The provider (care home or extra care housing site or domiciliary care provider)
2. The reason for the call
3. Whether the call was resolved or forwarded to the SPA
2. The Adult Commissioning Team

This team is made up of strategic leads within the council who are responsible for the care sector. As such, it is unlikely that provider calls will need to be connected directly with the team and a generic mailbox address has been provided. This mailbox is monitored seven days a week and correspondence will be directed as appropriate.

If either of the Bristol City Council teams receive calls from care providers seeking advice and guidance that they cannot provide, particularly of a non-emergency clinical nature, they will connect the calls to the SPA for triage and appropriate support.

North Somerset

The Compliance Team have strong, historical relationships with the care providers in North Somerset. As such, it is expected that the majority of calls from providers will be directed to this team as a first point of contact.

The Compliance Team are able to provide support in accessing emergency supplies of PPE and general support to adult social care providers. Furthermore, the Team are the first point of contact for notifications of outbreaks and are closely linked with the North Somerset Public Health Team.

All non-clinical queries from care providers in North Somerset should be directed to the North Somerset Compliance Team.

If the Compliance Team receive calls from care providers seeking advice and guidance that they cannot provide, particularly of a non-emergency clinical nature, they will connect the calls to the SPA for triage and appropriate support.

Upon receiving a call, the Compliance Team member responding will capture the following information for reporting:

1. The provider (care home or extra care housing site or domiciliary care provider)
2. The reason for the call
3. Whether the call was resolved or forwarded to the SPA

South Gloucestershire

There are two points of contact in South Gloucestershire Council:

1. Commissioning/Brokerage

Both Commissioning and Brokerage teams are contactable via the generic mailbox, detailed in the Address Book, which is monitored seven days per week.

The Brokerage team are able to support with urgent care home placements or home care packages. The Commissioning team are able to provide incident support 7 days a week.

Both teams can provide general support to providers, information about the way that a service is commissioned, as well as identifying which residents are Local Authority commissioned.

2. Council

This team can be contacted for emergency PPE stock and available staff. They are also able to conduct visits to undertake risk assessments. This team can provide psycho-social support to staff (particularly if experience loss of life) until the Mental Health and Wellbeing response is instigated. They are able to discuss issues such as safeguarding and those involving the Mental Capacity Act/Deprivation of Liberties and to make onward referrals to specialist teams.

If either of the South Gloucestershire points of contact receive calls from care providers seeking advice and guidance that they cannot provide, particularly of a non-emergency clinical nature, they will connect the calls to the SPA for triage and appropriate support.

Actions at an organisational level of response will be logged contemporaneously, including any identified risk/decisions/next steps. Additionally, upon receiving a call, the South Gloucestershire Council team member responding will capture the following information for consistent reporting:

1. The provider (care home or extra care housing site or domiciliary care provider)
2. The reason for the call
3. Whether the call was resolved or forwarded to the SPA

c. Infection Prevention and Control Cell (IPCC)

As part of the BNSSG response to the COVID-19 epidemic, a specific Infection and Prevention Control Cell (IPCC) has been established. This is to enable issues relating to IPC to be managed effectively across the system and to be able to contribute to the system-wide response. The core function is to offer current evidence-based information and advice to professionals in specific health and care settings on the management of Covid-19.

The IPCC is a core member of the Wraparound Support Team, offering administrators, Nurse Managers, Quality Managers, Support Managers, Infection Prevention Nurses and specialists and a Pharmacist. The team are able to answer queries relating to infection prevention and control, PPE advice (for usage), risk management and peer support.

If contacted by a care provider, or if a call is received via the SPA, the IPCC triage callers using the SBAR framework (situation, background, assessment, recommendation):
Tier 1 - Direct to the guidelines and FAQ's
Tier 2 - Clinical queries answered by the IPC cell
Tier 3 - Specialist queries answered by specialist IPC practitioners

When contacted by a care provider, the responding IPCC member will capture the following information for consistent reporting:

1. The provider (care home or extra care housing site or domiciliary care provider)
2. The reason for the call
3. Whether the call was resolved or forwarded to the SPA
4. Any ongoing support needed by IPCC

d. Public Health

In BNSSG, the Care Providers Cell have advised care providers to follow the usual process that they would with outbreaks (such as influenza), when reporting suspected outbreaks of Covid-19, and to contact Public Health England (PHE)'s Health Protection Team (HPT). However, it is possible that calls may come via the SPA or other teams.

Bristol

<u>If a Bristol care provider calls the SPA or any member of the Wraparound Support Team to report a suspected outbreak, they need to be directed to the Public Health England Health Protection Team.</u>

The HPT escalate outbreak or incident issues to the Bristol Public Health team. The Bristol Public Health team then join either a PHE-led incident management team or outbreak control team.

There may be occasions where PHE decide not to hold a formal Incident Management Team meeting. In these circumstances, a Bristol City Council-chaired outbreak review meeting may need to be considered. This would not aim to replace or duplicate a formal PHE IMT, but can be useful in identifying issues, addressing concerns, and supporting institutions such as care homes that are managing an outbreak.

If a member of the Wraparound Support Team is needed to support a care provider with the Bristol Public Health Team, they are available via email.

If the Bristol Public Health team receive calls from care providers seeking advice and guidance that they cannot provide, particularly of a non-emergency clinical nature, they will signpost the provider to the SPA for triage and appropriate support.

If the Public Health team are contacted by a provider, the responding team member will capture the following information for consistent reporting:

1. The provider (care home or extra care housing site or domiciliary care provider)
2. The reason for the call
3. Whether the call was resolved or forwarded to the SPA
4. Any ongoing intervention that they will be providing

North Somerset

The North Somerset Public Health team work closely with the Council's Compliance team because the Compliance team have a very good relationship with the sector. As a result, the Compliance team are the first point of contact for notifications of outbreaks. They also provide the assurance and follow up with the homes to identify any issues, such as PPE.

Only outstanding issues are escalated to the Public Health team in North Somerset.

The Public Health team can chair incident management teams for high risk outbreaks /escalation of unresolved issues in line with the RAG rating developed, and can provide public health support where required.

However, the first point of contact in North Somerset should be the Local Authority Compliance team.

South Gloucestershire

If a South Gloucestershire care provider calls the SPA or any member of the Wraparound Support Team to report a suspected outbreak, they need to be directed to the Public Health England Health Protection Team.

The South Gloucestershire Public Health team are able to provide support to the Wraparound Support team in terms of signposting and assurance.

The services in South Gloucestershire that the team can signpost to include:

One You South Gloucestershire https://oneyou.southglos.gov.uk/

One You South Gloucestershire is a healthy lifestyles and wellbeing service for adults to help make important, lasting improvements to their health. The service is offering tailored support and resources as part of the COVID-19 response.

Community Shielding team:
Telephone: 01454 864040
Email: Community.shielding@southglos.gov.uk

If the South Gloucestershire Public Health team receive calls from care providers seeking advice and guidance, they will connect the calls to the SPA for triage and appropriate support.

If the Public Health team are contacted by a provider, the responding team member will capture the following information for consistent reporting:

1. The provider (care home or extra care housing site or domiciliary care provider)
2. The reason for the call
3. Whether the call was resolved or forwarded to the SPA
4. Any ongoing intervention that they will be providing

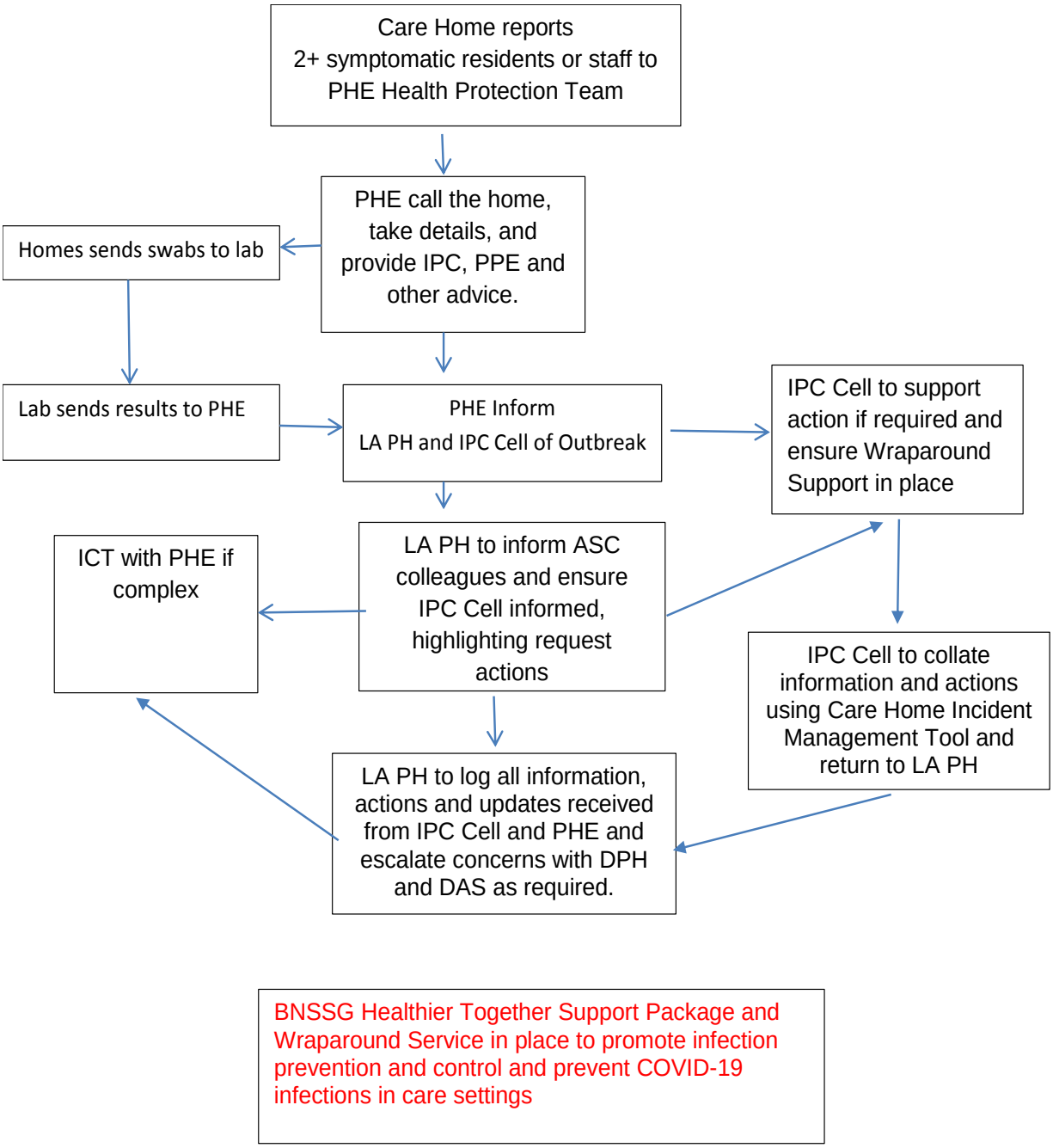


Figure 1: South Gloucestershire Public Health flowchart

e. Hospices

St Peter's Hospice

End of life care enquiries can be directed to the St Peter's Hospice 24/7 Clinical Advice Line. The staff on call are able to provide advice about providing care, symptom management, medication, supporting family/friends and having end of life planning conversations. The team are also able to answer enquiries from patients/residents/clients and their families, including psychological support.

The advice line is also open to the public so any queries through the SPA or other members of the Wraparound Support Team from informal carers, family carers, live in carers etc are also welcome.

If St Peter's Hospice receives calls from BNSSG care providers seeking advice and guidance that they are unable to provide, they will signpost the caller to the SPA for triage and appropriate support.

Additionally, the responding team member will capture the following information for consistent reporting:

1. The provider (care home or extra care housing site or domiciliary care provider)
2. The reason for the call
3. Whether the call was resolved or forwarded to the SPA
4. Any ongoing intervention that they will be providing

Weston Hospice

The 24/7 Weston Hospice advice line offers callers support from Community Nurse Specialists and members of the Medical Team via the Medical Secretaries during normal office hours and Registered Nursing staff on duty on the In-Patient Unit out-of-hours. A doctor is on-call if further advice if this is required and appropriate.

If Weston Hospice receives calls from care providers seeking advice and guidance that they are unable to provide, they will signpost the calls to the SPA for triage and appropriate support.

Additionally, the responding team member will capture the following information for consistent reporting:

5. The provider (care home or extra care housing site or domiciliary care provider)
6. The reason for the call
7. Whether the call was resolved or forwarded to the SPA

f. Learning Disability Teams

Bristol
The Bristol Learning Disability team also consists of support offers from Bristol Social Care, Care Direct in hours and Bristol Social Care Emergency Duty Team out of hours.

North Somerset
The North Somerset Community Team for people with Learning Disabilities offers both in hours (9am – 5pm) support from a Learning Disability Social Care Team and an out of hours emergency duty team including social workers for evenings and weekends.

South Gloucestershire
The South Gloucestershire Community Team for people with Learning Disabilities has an in hours team (9am-5pm), an emergency duty team both available in hours and out of hours at evenings and weekends and an intensive team available during evenings and weekends for crisis support.

g. Community Specialist Respiratory Team

This team offers an advice and guidance service for colleagues in general practice, care homes, the ambulance service and 111. This service is for all patients, regardless of whether they have / are believed to have Covid-19.

The number is staffed by specialist nurses and physios who are supported by specialist GPs and also have access to consultant advice on a daily basis, Monday to Friday.

h. Bristol Dementia Wellbeing Service

Bristol Dementia Wellbeing Service is a primary care service delivered in partnership between Devon Partnership NHS Trust and Alzheimer's Society, working with GPs, professionals and partners across Bristol, supporting all aspects of living well with dementia from diagnosis to end of life. The service works with all people registered with a Bristol GP both in the community and into Care and Residential Homes.

Within the service, its Care Home Liaison team works directly into Bristol's Residential and Nursing homes (General and Dementia Care), operating a person-centred 'whole home' approach to care. Within Nursing Homes, it also provides support for older adults living with non-complex mental health needs. Each home has an allocated named practitioner.

Bristol Dementia Wellbeing Service http://bristoldementiawellbeing.org/

If the service is contacted by a provider via its Access Point, the responding team member will triage to the most appropriate colleague. The service will capture the following information for consistent reporting:

1. The Care Home provider or referrer
2. The reason for the call
3. Whether the call was resolved or forwarded to the relevant agency
4. Any ongoing intervention that they will be providing

i. Skills for Care Advice Line

As part of our rapid response work to support registered managers, our new advice line and email inbox aims to support those managing CQC regulated adult social care services through the COVID-19 crisis. The advice line is open to all COVID-19 related questions from registered managers, service managers, deputy managers and nominated individuals.

The service can be contacted via telephone 9.00 – 17.00 Monday to Friday or email and has a webpage for FAQ's.

4. Wraparound Support Team Governance

The governance for the Wraparound Support Team is through the BNSSG Healthier Together Care Provider Cell and:

Mary Lewis: Director of Nursing, Sirona Care and Health
Anne Clarke: Chair of Care Provider Cell and Director of Adult Social Care, South Gloucestershire Council
Rosi Shepherd: Associate Director of Nursing, BNSSG CCG

The Care Provider Cell has also stood up a Clinical Reference Group to provide multi-agency oversight and sign off of any clinical guidance and policy documentation that is to be used by the Wraparound Teams. The Clinical Reference Group is a sub-committee of the Healthier Together Clinical Cabinet.

An Evaluation Plan, to iteratively monitor and evaluate the impact of the Wraparound Support Team, is being drafted by the CCG Business Intelligence and Evidence & Evaluation teams with Sirona and Public Health support. This plan will be agreed by the Care Providers Cell. This will also serve to provide a system overview of the COVID 19 impact across the care provider sector.

5. Appendices

5.2 Address Book

When the SPA staff receive a call from a care provider, they put the call through to one of the following teams, using the 'Address Book' to determine where an issue will be best addressed.

Area	Service/Team	Offer of support / issues that can be dealt with:	Contact details and availability:
Nursing	**Sirona HCP's**	• Clinical concerns with individual patients, e.g., falls/ weight loss/ mobility/ skin/incontinence/general deterioration/cognitive issues • Clinical concerns in general • Advice on correct use of PPE • Concerns/issues around policies/guidance • Training/education • Staff health & wellbeing • Medicines Advice line via SPA • Supporting advanced care planning/end of life care • Signposting to other agencies/services as appropriate	Sirona Single Point of Access/ Wrap Around Support number:- **0300 125 6789**

End of life	**St Peters Hospice**	Common queries include: • **End of life care queries** • Symptom control advice and use of medication (particularly during medicinal shortages • Use of syringe drivers/ PRNs and drug compatibility • Patient and family distress • Advanced Care Planning / decision making • Staff struggling with individual families and demands they may be facing • Simpler enquiries from patients and their families who have symptom issues, or need psychological support.	Available 24/7 telephone: **0117 915 9430**
	Weston Hospice	• End of life care queries (Community Nurse Specialists/ Medical team during office hours and Registered Nurses out of hours) • Doctor on call for further advice (complex matters)	Available 24/7 telephone **01934 423900**
IPC	**BNSSG IPC Cell**	• Infection Prevention and Control support (including complex cases) • Advice on current guidance from PHE on all issues related to COVID 19 • BNSSG coordinated advice in specific areas regarding PPE procedures such as PPE dressing/testing/isolation • Risk management • Peer support	IPC Cell: **07586 551 330** BNSSG.COVID.IPC@nhs.net 9-5 Monday to Sunday
Social Care Commissioners	**Bristol City Council Locality Teams**	• Requests for emergency PPE • Support to maintain the supply of services e.g. inform if staffing issues. • Broker mutual aid between services and connect with other support e.g. VCSE • General support to providers of adult social care services - Care homes/home care/supported living and Community support providers	**BRISTOL ONLY** North - Helen Pitches **07880475489** South - Lucia Dorrington **07555539819** Central and East - Kath Williams **07739188713**
	Bristol City Council Adult Commissioning	• For liaising with and getting support from the strategic leads within the council who are responsible for the care sector (not just care homes)	**BRISTOL ONLY** adultcommissioning@bristol.gov.uk 24/7

	North Somerset Council Contracts & Compliance Team	• Access to emergency supplies of PPE • **The Social Care team are the first point of contact for notification of any outbreaks in North Somerset** • Providing assurance and follow up with providers • Identify and address any ongoing concerns or issues eg PPE , any outstanding issues for Public Health are escalated via this team	**NORTH SOMERSET ONLY** Social Care **-** asc.covid19@n-somerset.gov.uk 24/7
	South Gloucestershire Council Brokerage / Commissioning	• Support with incidents in care homes, supported living schemes and home care services • Provide information about the way the service is commissioned • Identify which residents are LA commissioned • Offer general support to the provider over the phone • **Brokerage** - support with urgent care home placements or home care packages • **Commissioning** - incident support	**SOUTH GLOUCESTERSHIRE ONLY** CAHBrokerage@southglos.gov.uk / tel: **01454 868201** Mon - Sun 08:30-17:00
	South Gloucestershire Council	• A small stock of PPE and staff available • Risk assessment tool for visits • Support from Senior Council management • We will provide bridging psycho-social support to staff in a home experiencing loss of life particularly over a weekend and until the MH and Wellbeing response is instigated. • We will support the home where a resident is unbefriended • We will provide a point of contact for other members of the WRAP who wish to discuss potential issues of Safeguarding or MCA/DoLS and then support initial information gathering and onward referral • Any actions relating to individuals will be recorded on the SGC AIS system . • Actions at an organisational level of response will be logged contemporaneously, including identified risk/decisions/next steps and passed to Sirona	**SOUTH GLOUCESTERSHIRE ONLY** Saturday - Lynne Guest – **0754006897 / 01454 866197** Sunday - Jose Thomas – **07500102353/ 01454 863331** Email:- hpitdutyemail@southglos.gov.uk
Public Health	**Bristol Public Health Team**	**All calls to report a suspected outbreak need to be directed to the Public Health England Health Protection Team 0300 303 8162.**	**BRISTOL ONLY** ph.healthprotection@bristol.gov.uk

	Local North Somerset Pubic Health Team	**All calls to report a suspected outbreak need to be directed to the Public Health England Health Protection Team 0300 303 8162.** • The first point of contact in North Somerset should be the Local Authority Compliance Team • The Public Health team can chair incident management teams for high risk outbreaks /escalation of unresolved issues in line with the RAG rating developed, and can provide public health support where required	**NORTH SOMERSET ONLY** Health.Protection@n-somerset.gov.uk
	Local South Gloucestershire Public Health Team	**All calls to report a suspected outbreak need to be directed to the Public Health England Health Protection Team 0300 303 8162.** • To get support from local public health • To provide support to the Wraparound Support team in terms of signposting to public health services in South Glos, such as One You (healthy lifestyles and wellbeing service) and the Community Shielding Team	**SOUTH GLOUCESTERSHIRE ONLY** publichealthsouthgloucestershire@southglos.gov.uk
Learning Disability Support	**North Somerset Community Team for People with Learning Disabilities**	Castlewood Office • Communicating with those who are non-verbal / struggle to communicate • Mental capacity assessments and best interest decisions • Challenging behaviour preventing successful healthcare outcomes • Reasonable adjustments in order to support access to healthcare services • Safeguarding issues • Healthcare issues that cannot be met by mainstream and require a specialist LD service (e.g. dysphagia / complex postural management etc.) • Hospital admission or discharge advice	**NORTH SOMERSET ONLY** Telephone: 01275 546888 - 9am-5pm (please leave a message if no answer) Email: ph.admin@nhs.net
		North Somerset Learning Disability Social Care Team • Communicating with those who are non-verbal / struggle to communicate • Mental capacity assessments and best interest decisions • Challenging behaviour preventing successful healthcare outcomes • Reasonable adjustments in order to support access to healthcare services • Safeguarding issues • Healthcare issues that cannot be met by mainstream and require a specialist LD service (e.g. dysphagia / complex postural management etc.) • Hospital admission or discharge advice	**NORTH SOMERSET ONLY** 9am-5pm 01934 427 600

		North Somerset Emergency Duty Team - Social Workers • Communicating with those who are non-verbal / struggle to communicate • Mental capacity assessments and best interest decisions • Challenging behaviour preventing successful healthcare outcomes • Reasonable adjustments in order to support access to healthcare services • Safeguarding issues • Healthcare issues that cannot be met by mainstream and require a specialist LD service (e.g. dysphagia / complex postural management etc.) • Hospital admission or discharge advice	**NORTH SOMERSET ONLY** 01454 615 165 - Evenings and weekends
	South Gloucestershire Community Learning Disability Service	Church House – base • Communicating with those who are non-verbal / struggle to communicate • Mental capacity assessments and best interest decisions • Challenging behaviour preventing successful healthcare outcomes • Reasonable adjustments in order to support access to healthcare services • Safeguarding issues • Healthcare issues that cannot be met by mainstream and require a specialist LD service (e.g. dysphagia / complex postural management etc.) • Hospital admission or discharge advice	**SOUTH GLOUCESTERSHIRE ONLY** Telephone : 0300 124 5888 - 9am-5pm (please leave a message if no answer) sirch.cldt.admin@nhs.net
		South Gloucestershire Council CSO Desk - South Gloucestershire Learning Disability Emergency Duty Team • Communicating with those who are non-verbal / struggle to communicate • Mental capacity assessments and best interest decisions • Challenging behaviour preventing successful healthcare outcomes • Reasonable adjustments in order to support access to healthcare services • Safeguarding issues • Healthcare issues that cannot be met by mainstream and require a specialist LD service (e.g. dysphagia / complex postural management etc.) • Hospital admission or discharge advice	**SOUTH GLOUCESTERSHIRE ONLY** Telephone 01454 868007 (9am-5pm) 01454 615165 (weekends & evenings)

		South Gloucestershire Intensive Team - Crisis support at weekends and evenings only • Communicating with those who are non-verbal / struggle to communicate • Mental capacity assessments and best interest decisions • Challenging behaviour preventing successful healthcare outcomes • Reasonable adjustments in order to support access to healthcare services • Safeguarding issues • Healthcare issues that cannot be met by mainstream and require a specialist LD service (e.g. dysphagia / complex postural management etc.) • Hospital admission or discharge advice	**SOUTH GLOUCESTERSHIRE ONLY** **Telephone number:** 0117 378 4250
Learning Disability Support	**Bristol Community Learning Disability Service**	New Friends Hall – Base • Communicating with those who are non-verbal / struggle to communicate • Mental capacity assessments and best interest decisions • Challenging behaviour preventing successful healthcare outcomes • Reasonable adjustments in order to support access to healthcare services • Safeguarding issues • Healthcare issues that cannot be met by mainstream and require a specialist LD service (e.g. dysphagia / complex postural management etc.) • Hospital admission or discharge advice	**BRISTOL ONLY** **Telephone : 01179 585 666** **Availability: 9am – 5pm**
		Bristol Social Care – Care Direct • Communicating with those who are non-verbal / struggle to communicate • Mental capacity assessments and best interest decisions • Challenging behaviour preventing successful healthcare outcomes • Reasonable adjustments in order to support access to healthcare services • Safeguarding issues • Healthcare issues that cannot be met by mainstream and require a specialist LD service (e.g. dysphagia / complex postural management etc.) • Hospital admission or discharge advice	**BRISTOL ONLY** **Telephone : 0117 922 2700**

		Bristol Social Care Emergency Duty Team • Communicating with those who are non-verbal / struggle to communicate • Mental capacity assessments and best interest decisions • Challenging behaviour preventing successful healthcare outcomes • Reasonable adjustments in order to support access to healthcare services • Safeguarding issues • Healthcare issues that cannot be met by mainstream and require a specialist LD service (e.g. dysphagia / complex postural management etc.) • Hospital admission or discharge advice	**BRISTOL ONLY** **Telephone : 01454 615 165**
Pharmacy	**Sirona Medicines Advice Service**	• Pharmacist or Pharmacy Technician advice to Care providers about medication issues • Queries relating to medication storage • Medication administration • Ordering medicines • Medication issues identified with recent hospital discharges • **Please note**: Queries relating to EOL medication use for symptom control and syringe driver compatibility should be directed to the Hospices for specialist advice.	07970 778499 Monday-Friday (excluding Bank Holidays) 8.30-4 Outside of these times and if the call is non-urgent: SPA can send a message to sirona.moch@nhs.net for a pharmacist to follow up the next working day
AWP Mental Health Support	**AWP Mental Health**	**South Gloucestershire Service** • The AWP care home liaison services (CHLS) provides comprehensive mental health assessments for older people in care homes and to formulate person-cantered care plans. • It also supports, educates and trains care home staff in managing and caring for older people with mental health problems.	**SOUTH GLOUCESTERSHIRE ONLY** The service is operational Monday - Friday 09:00 - 5:00 pm and is contactable on 01173784640.
		North Somerset Service • Older adult mental health community services in North Somerset are provided to people living in their own homes and in care homes. • The Complex Intervention and Treatment Team (CITT) is an integrated CMHT for older adults. It works with people over the age of 65 with functional mental health	**NORTH SOMERSET ONLY** The services are operational Monday - Friday 09:00 - 5:00 pm and is contactable on

		problems and with all ages if there is a dementia diagnosis. • The Dementia Enhanced Support Team (DEST) works with people who have dementia and are experiencing a crisis.	01275 335300
		Bristol Service	
	The Community Specialist Respiratory Team	This team offers an advice and guidance service for colleagues in general practice, care homes, the ambulance service and 111. This service is for all patients, regardless of whether they have / are believed to have Covid-19. The number is staffed by specialist nurses and physios who are supported by specialist GPs and also have access to consultant advice on a daily basis, Monday to Friday. Queries could include such issues as a deteriorating NEWS score, managing acute breathlessness, oxygen weaning, management of COPD, non-compliance with medication etc.	Tel - 0333 230 1471 The line is open 0800 to 2000, 7 days a week
	Bristol Dementia Wellbeing Service	**The service supports the below in relation to the resident's dementia:** • Dementia-related clinical concerns with individual patients e.g. cognitive issues, behavioural and psychological symptoms • Support in developing best practice and managing safeguarding concerns • Support homes with advice around admissions, including admissions to Acute or Mental Health hospitals • Dementia-related medication advice via service's medics and non-medical prescribers • Supporting advanced care planning/end of life care • Training/education regarding dementia care and practice • Staff health & wellbeing and whole-home development • Promoting meaningful activity	**Bristol Only** Bristol Dementia Wellbeing Service Access Point (Mon – Fri, 8am to 6pm) **0117 904 5151**

		Signposting to other agencies/services as appropriate	
	Skills for Care Advice Line	As part of our rapid response work to support registered managers, our new advice line and email inbox aims to support those managing CQC regulated adult social care services through the COVID-19 crisis. The advice line is open to all COVID-19 related questions from registered managers, service managers, deputy managers and nominated individuals.	Our Information team will be supporting this with the help of a group of locality managers. The new web page and FAQs can be found at www.skillsforcare.org.uk Advice line Telephone: 0113 241 1260 - **9.00 – 17.00 Monday to Friday** Email:RMAdvice@skillsforcare.org.uk

5.3 Sirona Standard Operating Procedure

Wraparound Support Team

Version:	Draft v0.5
Name of originator/author:	Angela Perrett - Service Transformation Programme Lead (Adult Services)
Name of executive lead:	Mary Lewis - Director of Nursing
Date ratified:	
Review date:	This SOP will be revised in line with national guidance
To be read in conjunction with	Admission and Care of Residents during COVID-19 Incident in a Care Home Covid-19 Hospital Discharge Service Requirements March 2020 DHSC Covid-19: Our Action Plan for Adult Social Care v1 DHSC Responding to Covid-19: the ethical framework for adult social care Sirona Community Home Visiting SOP Healthier Together Care Provider Wraparound Support Team SOP Second Phase of NHS Response to Covid19 Letter 29 April 2020 COVID-19 response: Primary care and community health support care home residents 1 May 2020c NHSE/I The Framework for Enhanced Care in Care Homes v2 March 2020

Applicable to

Sirona staff

Executive Summary

The COVID-19 pandemic raises particular challenges for care providers as people receiving care are some of the most vulnerable people in our society.

BNSSG health and social care partners are working together across organisational boundaries to support care providers to meet the needs and demands of this new challenge. This is to ensure that they are supported while they continue to provide care for our vulnerable population in different care settings.

The health and social care partners have developed a support package offer, for providers, comprised of five key elements:

- Joint weekly updates from BNSSG health and social care partners to ensure providers have the most recent news and guidance
- Access to a new online resource library which is reviewed and assured, weekly, by a newly established Clinical Reference Group
- Access to a multi-disciplinary Wraparound Support Team (incorporating nurses, end of life care specialists, community pharmacists, learning disability teams and Local Authorities) via a 24/7 Single Point of Access (SPA) telephone line for support and guidance
- Rapid mobilisation of support when an outbreak is reported, the initial response being determined by a Local Response Team Meeting
- Locally based staff from Sirona, the Local Authorities and the Clinical Commissioning Group making regular contact with providers to establish new relationships or build on what is already working well

The Healthier Together Care Provider Wraparound Support Team SOP detail the process followed when a care provider contacts the wider Wraparound Support Team. It also details the support offered by the following members of the support team:

Local Authorities

Infection Prevention and Control Cell (IPCC)

Public Health

Hospices

AWP Mental Health

This SOP focuses on the Sirona elements of the team. The wraparound support does not replace business as usual arrangements; instead, it will layer on top of existing arrangements such as those provided by Local Authority Commissioning & Compliance teams, the interface with Primary Care Networks, Integrated Network Teams, Single Point of Access. It outlines Sirona services

contribution to the pre-emptive, proactive and reactive levels of support to Residential Homes, Care Homes, Domiciliary Care Providers, Hospices and Extra Care Housing.

Implementation

The Wraparound Support Team service was rapidly mobilised by Sirona, BNSSG CCG and Local Authorities in response to the Covid-19 pandemic through the Care Provider Cell.

Version Control

Version	Updated By	Updated On	Summary of changes from previous version

1. Introduction

The Wraparound Support team is part of the Bristol, North Somerset & South Gloucestershire (BNSSG) health & social care community. It comprises of health and social care staff from across BNSSG providers working in collaboration to provide a wraparound support package to all care providers.

2. Definition

The Wraparound Support team is a community based team providing support and advice to care providers regarding health and social care to protect their staff and residents, ensuring that each person is getting the right care in the most appropriate setting for their needs. The Wraparound Support team will help to ensure care providers have access to the right knowledge, skills and resources, so they are equipped to deliver care in this challenging time. Local Authority Compliance & Contracting teams will provide the foundation upon which the MDT health support will be wrapped around. To prevent duplication, a key contact for each home will be identified from the most appropriate member of the BNSSG MDT. The Sirona elements of the team are shown in purple below.

3. Access to the Team

The wraparound support package will take the form of three different levels. At all times, care providers can access additional support from Sirona services via the Single Point of Access (SPA).

3.1 Pre-emptive Support

A baseline assessment of all care homes will be carried out using the Care Home Liaison Covid19 template (Appendix 1). This will enable homes to be RAG rated to identify and agree the level of support required.

3.2 Proactive Support

The key contact will offer a weekly contact to each care home to discuss any issues the home may have, not just those relating to Covid. The purpose of this contact is to:

- Provide support and advice to care providers in caring for residents
- Develop strong working relationships with care providers
- Early identification of issues and /or homes requiring targeted support
- Identification of training requirements
- Signposting homes to resources available
- Provision of clinical support and advice regarding individual residents

3.3 Reactive Support

More frequent contact with care homes will be provided where further needs are identified. This may be in response to other MDT members raising concerns about individual care providers which the team may be asked to follow up from a healthcare perspective.

An Incident Management template (Appendix 2) may be completed to indicate the required measures and actions to be put in place to support the care provider from the wider MDT. The Healthier Together Care Provider Wraparound Support Team SOP describes the process to be followed in the event of an outbreak.

4. Roles and Responsibilities

The Wraparound Support team is a virtual team comprising of a range of health and social care professionals and support staff across BNSSG. The roles and responsibilities of the Sirona elements of the team are as follows:

4.1 Care Home Lead

Each geographical area will have a named Care Homes Lead whose role and responsibilities include:

- Provision of coordinated support and advice to health & social care professionals across a geographical area
- Provision of support and advice on current guidance in relation to care providers
- Signposting care providers to support resources including the Virtual Support Library
- Matrix working across system organisations to maximise partnership working to provide strong, joined up coordination between all partners in relation to care providers
- Support MDT working
- Act as Key Worker for designated care homes in conjunction with MDT
- Oversee and map development needs of care providers in response to issues raised by care providers
- Highlighting and escalating needs, as appropriate in relation to care providers
- Signposting to relevant training and education
- Signposting to resources to support staff health and well-being
- Contribute to the development of resources in response to emergent needs
- Input into individual Care Home Incident Review processes
- Input into Incident Review Meetings for residential settings within a specific area

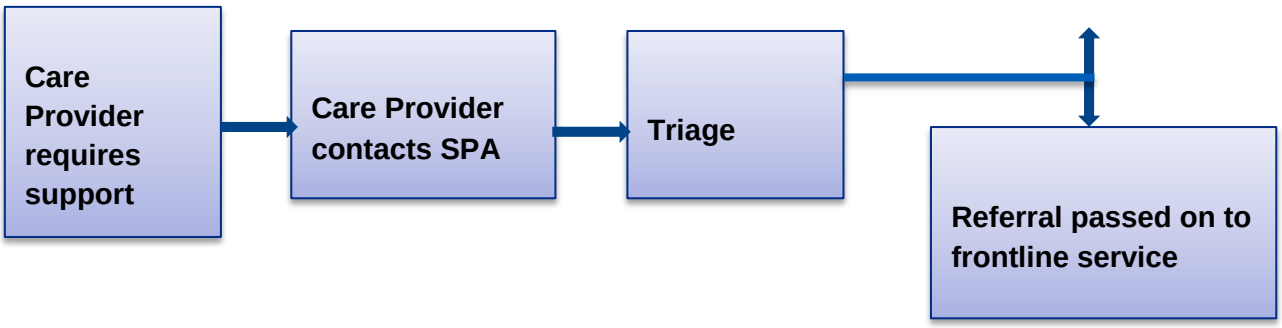
4.2 Community Teams

Community Teams are organised around the 18 Primary Care Networks (PCNs) across BNSSG. Each PCN will have a named clinical lead for each Care Home. Many GP practices and/or PCNs provide regular support to care homes; some have dedicated Practice Nurses across a number of homes. The wraparound support team will layer on top of these existing arrangements.

4.3 Single Point of Access for access and follow up

Care providers will be able to access additional support via the Single Point of Access. (SPA). The SPA is the number clinicians use to refer people into community health services no matter where they live in Bristol, North Somerset and South Gloucestershire, including GP urgent referrals that require a response within 2 hours.

The SPA will triage the call and resolve the issue or direct the call to the wraparound support team or any other service as appropriate.



4.4 Community Learning Disability Team

Each geographical area has a Community Learning Disability Team (CLDT) providing specialist health care service for people with learning disabilities to enable and support them to participate in daily activities and increase or maintain levels of independence. The CLDT works closely with individuals and their carers, to help maintain or improve their quality of life, health and wellbeing. They also support carers, other health professionals and providers with managing people's health needs. The team will be the main point contact for Learning Disabilities homes.

The team will provide a regular contact to care providers of Learning Disabilities services. It will provide learning disabilities support and advice as part of the wider wraparound support team. Each geographical CLDT will work with the relevant Care Home lead to ensure that support is structured in the most appropriate way to prevent duplication.

4.5 Medicines Management

Providers will be able to access the Medicines Advice Line via the SPA who will have access to medicines support Monday - Friday (excluding Bank Holidays) 8.30-4.00. Outside of these times and if the call is non-urgent: SPA can send a message to sirona.moch@nhs.net for a pharmacist to follow up the next working day. Pharmacists will offer support with queries about medication orders, storage of medicines, administration of medication, issues with hospital discharge summaries. Specialist advice about the use of EOL medication should be directed to the Hospice Advice lines.

5. Information Sharing

All care homes are inputting information into the national Capacity Tracker which collects information around care home vacancies, workforce and business continuity issues. In addition, local authority commissioning & compliance teams are collecting daily sit reps from care providers. We will work with partners to explore how we can share data and information to work in the most efficient way and prevent overburdening care providers.

We will work with BNSSG to create and develop a database of care provider contacts across BNSSG. The database will provide one master list and map key contact for each provider and which mem

6. Record Keeping

Contacts relating to individual patients will be recorded in EMIS.

Records of discussions with care providers will be stored on Glasscubes

7. Virtual Resource Library

A virtual library of resources, including accessible resources, has been created to provide care providers with guidance and resources to help deal with the COVID-19 outbreak. The virtual library is accessible via:

Sirona Care & Health

https://www.sirona-cic.org.uk/advice-information/covid-19-resources/information-for-care-providers

BNSSG

https://bnssgccg.nhs.uk/clinicians/resources-care-providers-during-covid-19/

On-line training and education sessions will be offered to care providers as part of the wraparound support offer.

8. Reporting Arrangements

Care Home Leads will report on their activity weekly using the Care Support Team Liaison Reporting template (Appendix 3). The data collection will be amended in line with NHSE/I sitrep requirements. Calls to the wraparound support team will be logged to capture advice/decision making/follow up and analysed for key themes by the Care Home Leads on a weekly basis. Emergent key themes will be reported to the Care Providers Cell.

Concerns/issues will be reported via incident reporting systems and processes.

5.4 Point of Access Reporting Template

Caller (Provider / Care Home site) ***Free Text***	**Issue** ***Drop down***	**If other, what** ***Free Text***	**Resolved?** ***Drop down: Y/N***	**Triaged** ***Drop down: Y/N***	**Triaged to** ***Drop down***

5.5 IPC Care Provider Incident Management Tool

Date: **Name of person making contact**	
Care Home: **Name of contact** **E mail details**	
How many residents?	
What type of residents?	
How many residents/recorded deaths / C19 confirmed / symptoms	
Staff affected –C 19 / symptoms.	
Staff testing – process in place and increased access. Note 1-5 days. Staff guidance and template complete. E.g. Bristol Airport. Numbers and results.	
Do patients have dementia care or mental health concerns that mean patients/ residents could wander? How is this being managed; do they have a recent MCA; DoLs issues' potential to invoke PH restrictions base on 'risk to others'? Care plan review with identified risk assessment in place, specific actions and escalation plan? An agreed contract disused and signed about social distancing where possible. Can intense packages of care be delivered?	
What is the geography of the unit and how are residents managed: e.g. low dependency patients on the top floor, single rooms on the first floor and patients with dementia on the ground floor. Could C 19 clients/symptomatic be hosted cohorted together with same contingent of staff? If residents are isolated are they in en suite?	
What does the staff team look like? What is the skill mix ratio? Can patients /staff be cohorted? Would this indicate an increase in staffing/skills numbers if they required 1:1 care?	

What PPE stocks and how are these accessed? Has there been an assessment of the consumption of PPE? Could the BNSSG CCG PPE tool be used? Is there assurance of the effective use of PPE? Is training being given to staff-? increased training packages for all staff? Correct donning and doffing and waste process? E.g. Enough PPE but locked in the manager's office so only released according to needs per shift of duty?	
What does staffing look like going forward? e.g. Is the care provider dependent on agency? **Note** increasingly agency staff not reliably turning up or leaving. **Agency** – block booking recommended to stop agency going to other care homes. Same policy /training etc. as above sign declaration to compliance.	
Should we be testing staff if absent? Clarity over :- • Staff that are shielded , • Staff with Symptoms (1-5 days) • Staff self-isolating • Staff refusing to attend work as they were afraid. • Staff who are family members with symptoms • Testing process for family as well. • Ability to access the Bristol site possible postal tests.	
Checking understanding of guidance: PPE, IPC , Laundry uniform Guidance relating to washing of uniforms and waste disposal to be reaffirmed. IPC training reviewed to all staff. Signed statement of compliance and updated training WebEx from Care home team available / library resources signposted.	
Staff wellbeing: Hydration and food available. Ensure staff are resting and sufficient down time MH support , Apps , MH SPA contacts	

Increased cleaning regime Is an increased cleaning regime in place and training package for cleaners and HCSW overnight. **Uniform policy** – do not arrive in uniform. Change at the home Laundry at the home **Laundry of uniform** – at the home or double bagged and washed immediately highest possible and tumble dry.	
Safeguarding: Are there any safeguarding triggers or concerns? If so, please identify these and refer appropriately. Risk assessment identified in the care plan in relation to management of the resident with C19 or symptoms	
Other : Any other issues raised	

M Ingham (BNSSG CCG) V4.

5.6 Sirona Care Home Liaison Template

(Information required on initial contact with Care Home)

Date:

Name and Designation of staff member completing form

Name of Home : **Address:** **Named Contact:** **Deputy Named Contact :** **Telephone Number:** **Email Address:** **Wi-Fi access:** **Best way to contact home:** **How often would the home like to be contacted by Care home team:**	
GP Practice linked with Home:	

Any staffing Issues? *If COVID related go to Gov.uk website* ***Care staff wellbeing*** Availability of food and drink whilst at work. **Mental health concerns** Resources on Sirona Intranet **Any Concerns?**	
Any Patient concerns currently? *If COVID related go to Gov.uk website* **Any clinical concerns with individual patients?** Falls/ weight loss/ mobility/ skin/incontinence/general deterioration/cognitive issues *If clinically indicated signpost to GP or* ***SPA 0300 125 6789***	
Any PPE issues? Are they following current guidance? (face mask, gloves and apron), when providing support or within 2 metres of resident **Stock issues?** *Emergency supply* *Contact National supply distribution line* *Tel 08009159964* *supplydistributionservice@nhsbsa.nhs.net* *But continue to order routine stock from*	

own supplier	
Any concerns regarding policy/procedure?	
Any other comments? **What's working well?** **Any anticipated challenges in the weeks ahead?** **Who provides staff training in the home and are there any urgent training needs that are Covid 19 related?**	

5.7 Sirona Care Home Liaison Reporting Template

Area	
Period Covered	
No. of Homes contacted (proactive)	
No. of contacts contacted (reactive)	
No. homes reporting Covid cases	
No. MDT Meetings	
No. Training/Education sessions	
No. Individual care reviews	
No. Care Home Review Meetings attended	

Summary of Key Issues Discussed	
Issues/Concerns	
Actions	

Feedback from Homes	