Department of Health and Social Care

Rheynn Slaynt as Kiarail y Theay

Integrated Covid-19 Community Care Response

Covid-19 Home Assessment and Treatment Team (CHATT)

Operational Review: July 13th 2020

Contents

Introduction

The Isle of Man Government's priority throughout the Severe Acute Respiratory Coronavirus-19 (Covid-19) outbreak has been to protect the health of the Island's community and help everyone to stay safe. The DHSC committed to supporting people across the Isle of Man and to keeping our most vulnerable sector of society safe from the Covid-19 virus.

As part of the Island's modelling and planning predictions there was a recognised need to provide home based health and social care to people who tested positive for Covid-19 (or highly suspicious thereof) enabling them to remain cared for in their own home and in turn relieving some pressure on the hospital system.

Isle of Man Covid-19 Context

On 16th March 2020, the Council of Ministers made a specific policy decision to move away from the Public Health England approach to Covid-19 and take a more robust stance to reduce the reproduction rate of the virus in the Isle of Man. In order to achieve certain elements of the new plan, the Queens representative on Island, the Lieutenant Governor declared a State of Emergency. This allowed the Council of Ministers to put emergency measures in place to tackle the threat of coronavirus to the Isle of Man.

The intent of the Council of Ministers was to flatten the rate of reproduction in order to protect the Island's health services. Reducing the rate of transmission reduces the number of people who are ill at any point in time which in turn reduces the demand on health and care capacity, particularly intensive care beds, to ensure they are available for those who need them. From this date, it was mandatory for all people arriving in the Isle of Man to self-isolate for two weeks. The Island's biggest event, the Isle of Man TT, was cancelled. Community testing was increased, including the creation of a new, dedicated drive through testing centre. The Island tested far more people per head of the population than the UK.

The Government's strategy[1] focussed on four main aims:

1. Preservation of life
2. Maintain critical national infrastructure
3. Maintain public safety and confidence
4. Support a controlled return to normality balancing social, economic & health impacts

These four aims were underpinned by a strategy of continued community testing supported by contact tracing. Hospital ICU capacity was increased from 6 to 16 beds, with two being held available for non-COVID-19 cases.

On 26th March 2020, the Government introduced the first phase of its three phase approach **'Stay at Home'** which provided a framework for further measures to be put in place to protect the community:

- Borders were closed to all inbound movement with certain exemptions for critical workers

[1] https://covid19.gov.im/

- New and more stringent measures on daily life were introduced, requiring everyone to stay home, except for very specific reasons, with a dedicated police team being established to enforce this
- Many businesses were closed
- The very vulnerable were told to stay home for at least 12 weeks
- Schools were closed, with exceptions for vulnerable children and those of key workers
- Community testing continued at an increased rate, supported by robust contact tracing
- On-Island testing capacity and capability was being developed

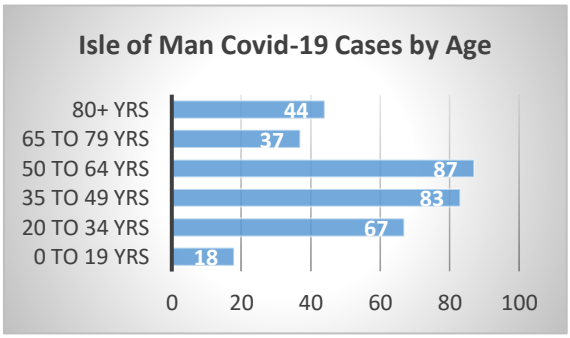
In response to the evidence on low case numbers, on the 23rd April 2020 the Government moved to the second phase of its approach **'Stay Safe'** which provided a framework to enable:

- health system readiness by maintaining suppression measures to avoid exponential growth of the virus,
- to respond to social pressures by staying safe and healthy,
- easing of economic pressures by facilitating a return to work where it was safe to do so.

Finally on the 15th of June when the Island reached day 26 of no new cases the third phase of the approach **'Stay Responsible'** was released by the Government. This framework provides an ongoing guide to remaining vigilant and prepared to react quickly if there is an increase in Covid-19 cases again.

Isle of Man Covid-19 Data[2]

Confirmed cases	Hospital admissions
336	0
Total tests	**Concluded tests**
6022	5994
Awaiting results	**Awaiting tests**
28	0
Number of deaths	**Total active cases (community and hospital)**
24	0
Number of deaths in hospital	**Number of deaths in the community**
6	18



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Integrated Community Care Covid-19 Response

The community arm of the Manx Health and Social Care system, including the private and third sector organisations contracted to provide direct care, created an operational coordination group

[2] https://covid19.gov.im/about-coronavirus/open-data-downloads/

'Community Operational Bronze' to discuss key issues, challenges and ideas and collectively agree a way forward to present upwards to the clinical and governmental groups to approve. This group enabled a vision for the community care Covid-19 response to rapidly respond to real time learning to care effectively for current real time needs in the following areas:

Testing – Community Swabbing Team

Testing is undertaken by the mobile coronavirus testing unit. The unit, set up to take samples from members of the public operating during a two hour window from 10am to midday seven days a week.

In addition a drive-through hub for community testing opened at the Grandstand on 20 March 2020 and is designed to streamline the task of sample-taking in one location.

Staff test people referred to them on the day by clinicians at the COVID 111 helpline who have assessed their symptoms.

Contact Tracing

Under the oversight of Public Health and Environmental Health teams with strong collaboration from Government Technology Service, real time contact tracing was established from the first confirmed person with Covid-19.

The system grew from an initial Health Protection model on paper, to a large database integrated with information from the 111 call centre.

All people receiving a positive test result were contacted rapidly to gain details of their condition, timelines, travel and close contacts. All positive cases remained in isolation at home or in the hospital until the end of 14 days or negative test result. Investigation teams contacted all known contacts to decide level of infection risk from the known case. All high risk contacts then received a daily monitoring call for 14 days or until symptoms has ceased.

As the number of cases grew, the database enabled clearer monitoring of outbreaks and cross tracking of cases. The database also enabled the team to work remotely from home during the height of the outbreak, using Microsoft Teams as a tool to ensure members of the team were connected at all times

The contact tracing team was an integrated model of staff from across government, many of whom were shielding and unable to provide their normal frontline roles. Public Health, Environmental Health, GTS, Health Visitors, Social Workers, sports centre staff and many more joined during the journey.

Community Covid-19 Bed Facility

A number of community, bank and retired nursing staff revived a mothballed rehabilitation ward within the wider hospital grounds to create two wards specifically aimed at caring for people with Covid-19. The 50 bedded Covid-19 unit also included step up and step down support for people recovering and discharged from the main hospital.

A Standard Operating Procedure was approved which allowed the facility to admit people directly from care homes or their own home. This facilitated rapid admissions and care by GPs and care managers when people needed more care than their home allowed.

Sadly one of the main drivers for this being established was an outbreak in a care home where 50 residents tested positive, 20 of whom died from Covid-19. Residents were able to be moved into a safer clinical area, where staff from consultants to housekeepers rolled up their sleeves and provided person centred care at a difficult time.

Care Home Assessment and Rapid Response Team (CHARRT)

The Care Home Assessment and Rapid Response Team were created to provide proactive support to both DHSC, private and third sector owned care homes. The support was given through a series of assessments and discussions, infection control visits and medical reviews. Additional support to care homes was provided through a rapid response team in the event of a resident or service user contracting Covid-19.

The visits by the team assessed the resilience of the care home in the context of the COVID-19 outbreak and to provide any required support for inpatient care and for decision making. As the assessments are specific to the Covid-19 outbreak they fell out of the usual framework of Registration and Inspection.

Prior to the professionals visiting the homes, care home managers or the person with delegated responsibility was contacted to provide information including a completed infection control audit, and any Covid - 19 related policies, procedures and action plans the home had developed.

The CHARRT team was made up of Multidisciplinary group comprising Senior Nursing staff (Dementia specialist, Mental Health, Learning Disabilities, and Public Health) Infection Control Practitioners, Hospital Consultants (Gerontologists), GPs, and supported by an Administrative Officer to help coordinate all the visits and documents.

Covid-19 Home Assessment and Treatment Team (CHATT)

The CHATT was established on the 27th April 2020 to work alongside GPs and other community professionals to provide home based care to people who have tested positive for Covid – 19 (or highly suspicious thereof) and require some level of health and care support but not to the extent that an acute hospital bed is required. The team was assembled to divert demand away from the acute hospital, in order to protect capacity for those who were severely unwell requiring specialist intervention.

At that point “the curve” prediction was that there would potentially be up to 3,000 people requiring care and support. This figure was gauged by comparing the demographics of the Island population to other parts of the world, and using the Rockwood Frailty Scoring system to work out how many of the people affected would not be suitable for admission to ITU. For these individuals their underlying condition, ventilation and more aggressive treatments delivered within an Intensive Care setting would likely to be futile and therefore be more suitable to be cared for at home.

CHAT Team and Process

The team comprised of eight redeployed members of the Community Nursing Team and twenty Community Support Worker (Home Care) staff who were based within temporary premises. The team were allocated two Social Workers along with continuing referral access to all Community Services.

The ability to redeploy staff was established by Community Nursing reducing to essential work only and the transfer of Community Support Worker services to a third sector provider thus releasing these staff. CHATT services were provided from 8am to 10pm in line with the working hours of the 111 service, seven days per week, with nursing resources organised centrally and community support worker resources organised geographically.

It was agreed to utilise a learning disabilities day centre that had closed during the pandemic as temporary premises. The building was suitable, as there were appropriate showering, changing and catering facilities for staff. Department pool vehicles were sourced and were set up with all appropriate equipment meaning that everything which would be needed was easily accessible for the team and the GPs.

The equipment included everything that would be needed to provide care and support to a patient, family and carer at home. In conjunction with our pharmacy and Hospice Isle of Man colleagues we researched medication and found that small doses of the usual End of Life drugs could also be effective for Covid -19 patients in symptom management; for example, Morphine for pain and Midazolam for the anxiety. See Appendix A, Standard Operating Procedure (SOP) for Clinical Triage, Assessment and Treatment of Covid-19 in the Community.

Additional Just In Case boxes were purchased and set up with thermometers, pulse oximeters, stethoscopes, for initial diagnosis, patient self-management and on- going care. The decision was made to use paper documentation rather than electronic systems to facilitate the recording of shared patient information enabling the multi-disciplinary team, including family carers to access all relevant patient information. Documentation and equipment was to be stored in the patients' homes for individual use therefore reducing the risk of cross contamination.

Traditionally, despite previous efforts, community Registered Nurses on the Isle of Man have not been trained to verify expected death. As part of CHAT team preparation, it was envisaged that some patients would be end of life care and die at home. To facilitate integrated working with the GP and Manx Emergency Doctors Service (MEDs), the Registered Nurses within the CHATT were trained in Verification of Expected Death. In order to lessen the number of staff in contact with Covid-19 patients, the expectation was that the team would work outside of their normal roles.

Communication was essential, as this was a newly formed team who hadn't previously worked closely together and had been created very quickly; some of the team were anxious about Covid-19, the patients that they might be seeing, uncertainty of what they may have to undertake. In order to reduce the anxiety we established what their concerns and fears were and provided bespoke one to one and group training and updates in Personal Protective Equipment, Covid-19 signs and symptoms and End of Life Care.

There was a weekly meeting of CHATT on Microsoft TEAMS to cascade information both ways to escalate any concerns from the team and to inform of emergency changes by the Department and the wider Government. This ensured that the team could adapt and respond accordingly and in a timely manner.

Appendix 1, 2 and 3 of the SOP determines the process to be followed by the multi-disciplinary team.

The launch of the CHAT team coincided with a significant downturn of cases following the initial surge from mid-March to late-April. Of the 336 cases of Covid -19 identified on the Isle of Man since testing began, only 28 cases have been diagnosed from the date of launch of the CHAT team to the writing of this report. As a result, the demand on the CHAT team has been low, with only eight individuals requiring support by the CHAT team since its launch.

Repatriation of Manx Residents

The Isle of Man closed its borders very rapidly and early on in the pandemic which left some Island residents unable to return; when the Government commenced repatriation this also included 14 days quarantine for those Manx residents returning home.

Manx residents returning to the island are obliged to make an application to the Government to seek authorisation to return and as such limited sailings from the UK back to the island commenced in early May 2020. Initially repatriated residents were required to stay at a local hotel in isolation for the 14 days, the CHAT Team were tasked and responsible for the provision of healthcare, and wellbeing checks to those repatriated residents. This gave all repatriated residents the opportunity to receive welfare phone calls/ checks at their own request.

Another significant change occurred when the Government allowed Island residents, who were able to self-isolate in their own homes, to return there. Provision of welfare checks and support continued for these people if and when required. This change resulted in a noticeable decrease in the support required, as repatriated residents appeared more resilient in their own surroundings. And the island community and local businesses had responded to this crisis with home deliveries and the emergence of a stronger compassionate community.

CHATT Outcomes

Eight individuals who were suspected of being Covid-19 positive were referred to the team and were supported in their needs. This included various dressings, venepunctures, infection control, Covid 19 swabs, medication advice and domiciliary support including collection of medication and shopping.

Two hundred and ninety five repatriated residents were offered support in a variety of ways including phone calls, text messages, emails and individual visits. The needs of these residents included specialist equipment, liaising with hotel accommodation, welfare checks and onward referrals, medication advice, dressings, including double leg ulcers, by registered nurses. The team also acted as advocate for the repatriated residents in choice of specialist diet for medical conditions and the unsuitability for some residents of the exercise area they were allocated.

The Standard Operating Procedure for repatriation Appendix B

Appendix C demonstrates the welfare checks and Support given to repatriated residents

CHATT Summary and Next Steps

As the Isle of Man Government commenced its transition back to business as usual with services recommencing, staff that had been redeployed needed to return to their posts to resume services. Adaptability and flexibility have been key drivers throughout this pandemic; all staff involved were prepared to make changes on not only a daily basis but at times hourly.

The preparation, delivery and evaluation of CHATT will enable future planning to occur in a more propitious manner in the event of a future outbreak occurring.

See section below on lessons learnt and for more comprehensive data.

Lessons Learnt

The team met on the 1st July 2020 to debrief and discuss the processes and lessons learnt for future planning. Below is the feedback from the staff involved. The team were thanked for their hard work, energy, creativity throughout this time and that they should be proud of what they have achieved and their feedback will be essential should the team be required to be re set up as well as for future plans for Integrated Care

What went well?

- Everyone was keen to get the job done
- New challenges
- Great location and facilities
- Lots of discussion rather than email correspondence, which was facilitated via teams effectively without the need to actually be in the same room.
- Can do/will do attitude
- Fast response to queries/questions
- Integrated response from community services- willingness to help & work together.
- Willingness to share equipment cars etc.
- CHATT had the ability to be responsive – patients seen within 4 hours, in practice this was often much quicker
- Use of Microsoft teams & telecommunication for meetings & to support dataset
- Initial set up – shows what can be achieved in a short time
- Great team work x2
- Open team communication and support for each other
- Team flexibility and adaptability x2
- Communication
- Positive approach by everyone involved e.g. barriers were not an issue, roles
- Willingness to work together x2
- Adaptability to adapt to quick changes
- Referral process was simple
- Most people volunteered – reduced fear
- Access to equipment
- Most had worked together in the Western Wellbeing Partnership)
- Team met to plan
- Positive relationships (approach of Integrated working)
- Collective team decision making (reduced red tape)
- Speed of team set up – positive thinking easy to adapt in new challenges
- Can do attitude of the DN team
- Team working Hospice / GP/ DN's/ Integrated Care – all contributed to the SOP
- The initial meeting to scope out the service using a typical patient journey
- Engagement with MEDS and 3rd sector
- Mobilisation of resources – cars, PPE, facilities, IT for referrals and monitoring of outcomes
- Integrated care happened between all services, social workers, nurses, community support workers. Dieticians, O.T's x2

- Bespoke training
- Some bureaucracy about written referrals disappeared

What didn't go so well?

- Poor referrals from MEDS GP. Lack of GP understanding of SOP
- Felt like too many managers at one time
- Direction changed frequently- this was unavoidable due to the situation
- Review of service hours felt very slow to happen. As practitioners, we could see this wasn't required and could of happened much sooner. It was difficult to cover shifts from such a small team, resulting in lots of weekend's worked- tired staff!
- GP understanding of the team
- Did we ever receive the coroners ok to perform verification of death – very slow response to this had this been required?
- The organisational agenda / objectives and motives were not shared with the wider team. The organisational leads appeared to be looking forward to the future of community service provision which confused the objectives and needs that needed to be met now
- My ending – I was directed to another section
- TEAMS connection
- Staff rotation in and out of CHATT reduced the team's chances of bonding, establishing and developing as effectively as it could have. Constant change in team purpose also prevented team development. (Forming, storming, norming, performing)
- My line manager not always aware of what's happening, but this is understandable due to quick changes (not a criticism)
- Delay between clinical recommendation and enforcement by Bronze command x2
- Engagement from wider GP community
- Direction of CHATT changed taking on repatriation residents didn't require DN's for this- expensive service for most of what we were doing
- Initially restrictive criteria
- Very costly in comparison to its usage
- Not clear leadership , direction of team changed sometimes on a daily basis
- Documentation didn't seem to be accessible to all, we used several platforms, EMIS and paper which caused duplication of entering data
- Shift patterns weren't great due to small team, days off were often split, this was ok in the short term but if it had gone on – it could have resulted in tiredness

What would be better if?

- Limitations of a spreadsheet, in hindsight a database would have been much easier for everyone to enter data into, much more secure and provide better analysis of data. However at the time of the team set up and the spreadsheet we didn't realise the demand and a spreadsheet was the quickest option.
- Bigger premises so could have had the community support workers based with us; this could have released DN staff back to DN teams sooner. However, we were very restricted due to social distancing.
- Appropriate referrals from other services e.g. MEDS / GP's. As the team purpose changed dramatically from EOL care (as per initial SOP) to nursing care of isolating residents and welfare support, the team itself struggled to identify its role and purpose therefore, it is not

surprising some referrals were inappropriate. Band 5/6 staff lacked confidence in rejecting referrals as the teams purpose was unclear / constantly changing

- Team development and performance would be better next time if CHATT needed to reform, the team role and population needs should be clearer after this experience. The team would be better informed, with clearer direction, purpose and aims
- More consultation with GP's prior to writing SOP and reassurance of roles and responsibilities
- Referrals / IT and outcomes to be measured and improved through experience
- We were all on one system, communication would have been faster
- Location was brilliant but the office was small, often staff were not 2 metres apart

What would you recommend others to take note of and learn from?

- One clear lead for team & project (one role)
- React to demand or lack of a little quicker
- Grab the opportunities that crisis/ change offer. This was great for personal development, networking with new and old colleagues, working with other disciplines and redeployed staff, adaptability, compromise, conflict resolution, working outside of your comfort zone, leadership development. We all have something/ skills to bring to a new project
- Importance of Integrated working / relationships
- Trust of the team
- Ability to allow the team to develop freely
- The ability to mobilise a new service within a very short time frame
- More stringent referral criteria moving forward
- Having the ability to change direction quickly and take on roles that wouldn't normally do
- Removing barriers between professionals, allowing referrals without using channels
- Community support staff (CSS) could have staffed CHATT as well as their main service, and could have done that with immediate effect. However CSS were not involved in discussion/ planning
- Build the service in response to the need rather than go to maximum capacity straight away

Any other comments?

- Altogether a very positive experience,
- That whilst the covid-19 did not impact as was initially anticipated (Thank God)
  Without such planning in place and had covid-19 impacted the vulnerable in our community, Clinical areas would have been stretched beyond capacity.

  The Chat initiative was necessary when initially we were all faced with the '**what ifs?'**
  We have been very fortunate on the island to be as far forward with local elimination of Covi-19
  And that is a credit to everyone

- I didn't understand the rules of this team. For me this was a negative. It is the reason why I opted to go back to my usual role after 6 weeks. After 6 weeks I was unsettled and even questioned if I still wanted to be a nurse. Fortunately these thoughts dissolved after 1 shift back with the DN's
- Looking forward to growing as a team as and when required
- Ability to maintain connections for the future

- It's been a great success and I very much hope it can continue in some form.
- I struggled getting back into my normal work after CHATT as I finished on the Sunday and straight back into the DN team on the Monday

Team member's comments:-

- Feel excluded from their normal place of work/ team, insecurity
- Feeling guilty as the CHAT team quiet and should be back to our busier teams, however higher organisational leaders wanted CHATT to remain in place
- Bored, frustrated, can't stay in tenh team indefinitely doing "nothing"
- We were mentally prepared for a busy, emotional and challenging role but this did not transpire leading to a rollercoaster of feelings

Key words in relation to this experience

Adaptability
Innovation
Flexibility
Networking
Compassion for colleagues
New skills
Transformation
Courage
Resourcefulness
Support for others
Improvise
Knowledge sharing
Rapid response to change
Conflict resolution
Anxiety / Fear
Challenging
Guilt
Emotional
Stress

Next steps

At the time of writing, as the Island has not seen a positive test for Covid -19 since the 20th May 2020. Health and Care services are beginning to get back to normal, with services being recommenced and staff members redeployed returning to their original jobs – this includes the standing down of the CHATT and CHARRT teams, testing facilities and Covid – 19 Inpatient beds.

However we are mindful that new cases may arise as our border control policy begins to relax and free travel to and from the Island begins again, and that the initial aims and objectives of our Covid response may need to be reactivate

As such, we must be ready to restart our Community Covid- 19 response plans should we start to see new cases arising on the Island and an increase in the reproduction rate of the virus. This includes

- Reduction in some services to release staff and space to dedicate to Covid-19 community services
- Recommencement of CHATT services
- Re- engagement of CHARRT services including a review of prior reports and actions of all care and learning disability homes to ensure sustained readiness for any further peaks in the virus
- Re- opening of dedicated Covid -19 inpatient capacity to ensure the hospital is protected from excess demand and avoid significant service reductions that have previously been observed
- Increase in testing capacity to ensure that our Test and Trace strategy can be effectively implemented to control spread of the virus and keep reproduction numbers as low as possible

Appendix A. SOP for CHATT

Appendix B. SOP for Repatriation

Appendix C. CHATT Data Collection