Health and Community Services
Director General

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Chair, Public Accounts Committee
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States of Jersey
By Email

9 March 2022

Dear Deputy Gardiner

Public Accounts Committee (PAC) - COVID-19 Response Review

Thank you for your letter dated 24 February 2022 in relation to the COVID-19 Response Review PAC is undertaking.

You have kindly agreed to extend the deadline for submission to 10 March and to be satisfied with a partial response in case not all questions could be answered in that timeframe.

Please find appended to this letter answers to your questions.

Further details relating to question 7 and 8 are to follow in due course.

Yours sincerely,

Caroline Landon
Director General of Health & Community Services

1. Please detail how decisions were made about staffing levels in the wards at the General Hospital dealing with COVID-19 patients?

Normal operational staffing level procedures continued throughout the pandemic. These include daily operational and staffing meetings which are facilitated by lead nurses and ward nurse managers to ensure safe staffing is maintained throughout. At these meetings sickness, vacancies and other absences are considered in conjunction with the SafeCare tool (an IT system) which determines staffing demand based on patient acuity. During the pandemic, other aspects of staffing were considered as well, for example, outcomes from individual staff risk assessments.

Individual staff risk assessments were undertaken to ensure their safety to continue to work. This resulted in some staff having to shield as per public health guidance at the initial phase of the pandemic. Risk assessments were also undertaken in relation to working on a ward with 'Covid' patients (Hot Wards). Staff assessed as high risk were moved to work on wards with no 'Covid' patients (Cold Wards).

To provide further support in relation to staffing, a workforce cell was set up during the first phase of the pandemic. In addition, concerns regarding staffing levels were escalated to, and discussed at the daily bronze meetings. Mitigating actions were taken and included, for example, moving staff and/or providing additional bank or agency staff to meet staffing requirements.

As outpatient services and elective surgical lists were reduced and/or halted early in the pandemic, staff were redeployed from these departments to the wards and to the Urgent Treatment Centre to provide further resilience.

To increase critical care and nursing capability and capacity, specific training was provided. For example,

- 200 staff who were working in areas such as main theatres attended critical care surge training
- Simulation training continued throughout the pandemic to support those working in critical care
- Physiotherapists and Occupational Therapists were provided with training in basic nursing skills which allowed them to work alongside and support the ward nurses to deliver care, as appropriate.

2. How did managers determine where staff should be deployed during the busiest points of the pandemic for the hospital?

As with the management of any busy periods within HCS, such as winter pressures, staff were temporarily redeployed to areas of greatest need, dependent on their skill set. This was and continues to be supported by the SafeCare tool which determines staffing demand based on patient acuity. Please see also answer to question 1 for more details.

During phase one, wards were organised in a way to comply with Public Health and infection control advice and guidance. This included the separation of Covid-19 positive patients (hot wards) and Covid-19 negative patients (cold wards). Taking personal risk assessments into account, staff were allocated to either a hot or cold ward to minimise the transmission of infection.

Additionally, the number of beds was reduced on each ward to allow additional spacing between
patients as per Public Health and infection control advice and guidance.

3. What was considered to be the minimum required number of nurses per patient on wards containing COVID-19 patients and, separately, in the Intensive Care Unit (ICU)?

HCS operates its staffing in line with the NICE guideline on safe staffing[1]. This was also applied throughout the pandemic.

The guideline states, *"there is no single nursing staff-to-patient ratio that can be applied across the whole range of wards to safely meet patients' nursing needs. Each ward has to determine its nursing staff requirements to ensure safe patient care."* As recommended, we are using a range of factors to systematically assess the need at ward level to determine the nursing staff required every day. As recommended and as explained in answer to question 1, we are doing on-the-day assessments of nursing staff requirements to ensure that the nursing needs of individual patients are met throughout a 24-hour period.

In the general hospital, each ward (except ICU) has a staffing establishment which is based on a 1:6 (1 registered nurse to 6 patients) staffing ratio during the day and 1:10 at night. However, it is important to note that this is further uplifted if the acuity requires it but can also be reduced where acuity does not require the established ratio in accordance with the NICE guideline. These principles were applied throughout the pandemic.

For the ICU establishment HCS follows the national guidelines for staffing which is based on acuity of patients i.e. ventilated patients should have a ratio of 1:1 (1 critical care nurse to 1 patient) and 1:2 for other critically ill non-ventilated patients, supported by health care assistants and a supernumerary nurse in charge. However, as above for general hospital wards, the staffing level is always provided according to patient need and not the number of beds.

a. Were there any requirements for a minimum number of nurses and other healthcare staff to be present on wards with patients diagnosed with COVID-19?

As explained above, the staffing levels for each ward have been assessed on a daily basis and the required staffing was determined using the SafeCare tool which determines staffing demand based on patient acuity. An additional factor that was taken into account was the requirement for staff to put on the required personal protection equipment (PPE) and to put it off/change it ('donning and doffing of PPE'). Additional PPE breaks were included when considering the staffing establishment to support the wellbeing of staff.

[1] Nice Guidance: Safe staffing guideline [SG1]: Safe staffing for nursing in adult inpatient wards in acute hospitals https://www.nice.org.uk/guidance/sg1/chapter/1-recommendations -

As a result, the staffing levels were increased for both registered and non-registered staff if due to the number of Covid-19 patients, their care needs on the ward or due to additional PPE break times this was required.

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b. How did you ensure clear lines of accountability on each ward during the COVID19 Pandemic?

Clear lines of accountability on each ward did exist before the pandemic and these arrangements have continued throughout the pandemic and are still in place. They consist of a ward nurse manager and a deputy ward nurse manager on each ward. If these staff were not present on the ward a nurse in charge would have been identified on all shifts ensuring 24/7 accountability. The ward nurse and deputy ward nurse are accountable to and can directly escalate to the Lead Nurse. Each ward is allocated to a Lead Nurse. The Lead Nurse is professionally accountable to the Chief Nurse and can escalate to her directly. Out-of-hours arrangements are in place and include on-site clinical coordinators and on-call senior manager support.

Did the number of staff per patient fall below that number at any point during the pandemic on these or any other wards? If yes, how long for.

At the start of all shifts the wards are required to input their patient acuity data into the SafeCare
System which produces a RAG status (red, amber, green) . If a ward declares a red status, an immediate escalation is triggered. The situation is reviewed by the senior nursing team and additional support as required is put in place to maintain patient safety.

a. If yes, how did you work to prevent this from repeating?

Not applicable, as safe staffing levels were continually monitored.

4. Were you aware of either the wards caring for COVID-19 patients or the ICU being critically under-staffed at any point during the pandemic?

At no time were the wards or ICU critically under-staffed during the Covid-pandemic. All areas were staffed according to patient acuity. Additional bank and agency nurses were rostered on shift, i.e. brought in to support correct levels of staffing.

a. If you were, how were you made aware of this and how did you respond to it?

As above, at no time were the wards or ICU critically under-staffed during the Covid-pandemic. The correct staff establishment was maintained for ICU and the wards based on acuity.

5. Were all the nurses working on the ICU fully trained for the roles that they were undertaking at that time?

All substantive nursing staff working in ICU are trained for the role of working within an ICU. During the pandemic staff with complementary skills were redeployed from other areas to supplement and support the ICU nursing staff as required, this included staff with previous

ICU skills and theatre/anaesthetic staff. Not all patients required mechanically ventilated support.

a. What training opportunities were provided to incoming staff assigned to the ICU during the COVID-19 Pandemic, and how frequently was training provided?

The ICU has a dedicated practice development nurse who supported the delivery of training and the competency assessment of clinicians supplementing the ICU workforce.

In addition to this surge and simulation training was provided as detailed in answer to question 1.

All clinicians who were not substantively working in the ICU during the pandemic were buddied up with a substantive member of ICU nursing staff.

6. How many fully trained ICU nurses were on shift rotation during the month of December 2021?

There were 39 registered ICU nurses substantively employed on shift rotation in ICU during the month of December. In addition, 5 ICU trained agency nurses were employed in December 2021.

7. How many fully trained nurses were on shift rotation for wards caring for COVID-19 patients during the month of December 2021?

This information is currently being collated and will follow separately.

8. Please provide the number of shifts covered by bank staff and the number of bank staff used to cover shifts.

This information is currently being collated and will follow separately.

a. Did you revise recruitment and deployment strategies for bank staff in Jersey to improve your department's response to COVID-19?

Recruitment for bank Healthcare Assistants (HCAs) was increased to support the department. A recruitment and communication campaign went out to the public to support the department in providing care to patients and to help with the Nightingale Wing.

A fast-track process was put in place for the applicants which included:

- shortened application form
- telephone interview
- fast track clearances with risk assessments to support
- classroom based training after completion of on-line training.

Bank HCAs were used across a variety of different areas and were instrumental in supporting new services such as the Urgent Treatment Centre, the COVID swabbing stations, but also to

support existing services in the Jersey General Hospital, in Mental Health and the Learning Disability Service.

In addition, HCS also redeployed nursing staff who normally worked in other roles in HCS to support the clinical response. HCS also reached out to retired clinical professionals, medical students and students on nursing, midwifery and allied health professional programmes to support a larger Covid response if required.

9. How did you ensure that the ICU and other wards with patients who had been diagnosed with COVID-19, were adequately equipped to respond to emergency situations, such as the sudden requirement of additional staff to respond to severe breathing difficulties or sudden loss of consciousness?

All staff are required to hold the Basic Life Support Certificate. Permanent registered nursing staff
working in Critical Care areas, are required to hold the Intermediate Care Certificate or Advanced Life Support Certificate.

To increase critical care and nursing capability and capacity, specific training was provided, please see details provided in answer to question 1.

Critically unwell patients are escalated immediately and a bleep system across the hospital is in place to enable quick escalation. A bleep system is a secure and real-time communication solution. It enables doctors, nurses and the wider team to communicate and collaborate across the hospital.
Patients who are assessed as deteriorating (non-critical) are escalated and discussed at the clinical operations meetings held every morning to ensure early intervention.

a. How did you work to encourage healthcare staff to report and review incidents during the COVID-19 Pandemic to identify lessons for future crises?

A Datix incident reporting system is in place and fully embedded throughout the organisation. All staff are encouraged to embed a safety culture of reporting of incidents, irrespective of a pandemic. Staff are encouraged to report any adverse incident which has the potential to produce unexpected or unwanted effects, or any incident which has a consequence or a learning point.
By reporting an incident on Datix we are creating an official 'record of the event', and the details can be recalled and referred to in the future. The analysing of incidents
enables us to learn from events, supports the development and improvement of services, and identifies training needs.

Additionally, the SafeCare tool system allows for the reporting of red flags and professional judgements, which are then discussed daily at the operations meeting and reviewed by the lead nurse for the area.

b. What efforts were made to gain feedback and insight from patients regarding their experiences within the General Hospital during the COVID-19 Pandemic, either through exit surveys or post-discharge communications?

Patients are provided a MyExperience Survey on discharge and are encouraged to complete it. In addition, the hospital operates a patient/user/relative feedback system for both compliments
and complaints which is well publicised. The central Government feedback system can also be used.

10. What practical steps were taken by you and by ward managers to alleviate the pressure on staff at this time? As part of this review, the Panel would like to understand how staffing levels were being addressed rather than the support offered to staff through wellbeing programmes.

Staffing needs were continuously monitored and assessed on a shift-by-shift basis as described above based on the acuity of the patients and in line with the safer staffing guidance from NICE.

Additional registered agency and bank nurses were employed, and staff re-deployed from areas
where services were reduced or stopped to support staff working in areas with higher need.

Daily staff debriefs were given in The Halliwell Lecture Theatre, to provide updated information on PPE requirements, number of Covid-19 patients, 'Hot' and Cold' wards. Staff receive a regular COVID update in writing to keep them informed of activity and changes.

Staff were given support with temporary accommodation in the first wave to support any anxiety they had about working in the hospital and returning home to their family after a shift.

A wide range of wellbeing services were deployed and further details can be provided if PAC wishes to consider these as part of the response. The following has been an important part in alleviating the pressures of the working environment:

- Meditation sessions were provided by the Wellbeing team each morning.
- Wellbeing services were deployed to wards and departments to give support, this included specific trauma risk management (TRiM) sessions for specific cases. TRiM is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic, event.
- The chapel was identified as a quiet space for staff to take breaks including provision of food/drink. The place of worship was relocated to an alternative setting to maintain service.

The analysis of the BeHeard Survey results and the subsequent development of action plans in each care group after the first phases of the pandemic was an important learning journey and action plans have picked up specific issues and opportunities in each area.

11. Please give details of the business continuity plans in place for General Hospital wards, including the Intensive Care Unit and their use during the pandemic?

All areas are required to have a full business continuity plan.

A bronze cell debrief took place following phase one of the pandemic to facilitate learning in preparation for phase 2. Subsequently a specific Covid-19 response plan and action cards were developed in conjunction with the emergency planning officer to support this response. Three tabletop exercises took place to test the preparedness and suitability of these plans.

a. Who was responsible for making decisions over which wards to use for COVID-19 patients?

In phase one the decision over which wards to use for Covid-19 patients was made by the bronze cell. Wards were subsequently divided into Hot (Covid-19 positive) and Cold (Covid-19 negative) wards. A diagrammatic representation of this was created and shared with all staff on a daily basis, both at bronze, and at the daily hospital Covid-19 update meetings held in The Halliwell Lecture Theatre.

12. What decisions were made about the resources required to ensure adequate levels of staffing and how much of the funding diverted to Health and Community Services to assist with the pandemic was used for staffing?

As described above, a number of initiatives were implemented to increase available staffing to support with the Covid healthcare response.
Staffing was a large proportion of the 2020 expenditure. This included key worker accommodation for those needing to isolate, additional staffing costs for the Urgent Treatment Centre and ICU.

13. Please could you detail the total funding provided to Health and Community Services to adapt to and support the COVID-19 response and provide a breakdown of how those funds were applied.

Total Expenditure on Covid-19 staffing at the General Hospital by year.

2020	£4,520,170
2021	£2,579,865

2020 and 2021 HCS Covid Expenditure by Initiative:

Initiative	HCS Immediate Covid Response Including Winter	Nightingale Wing	GP Redeployment and Primary Care Response	Test & Trace	Covid Vaccine	PPE Supply (including Warehousing &	Covid Operations Business Case (Response to Operational Pressures)	Covid Service Recovery	Total Expenditure by Year
2020 (£)	12,316,024	1,202,708	6,015,236	541,092	192,304	4,044,170	0	0	24,311,534
2021 (£)	661	638,890	-273,702	0	5,003,110	662,169	3,967,399	1,716,253	11,714,780

Please also note that the 'GP Redeployment and Primary Care Response' shows a negative expenditure in 2021, this is because elements of the 2020 costs were estimated at year end 2020, and the actual costs varied from the amounts estimated.

14. Would it be possible to share with the PAC, on a confidential basis, the serious incident log for the ICU and for wards caring for patients with COVID-19 between 15 December 2021 and 15 January 2022.

There were no serious incidents logged between 15 December 2021 and 15 January 2022.