States of Jersey
States Assembly

États de Jersey
Assemblée des États

Public Accounts Committee

Public Hearing

Witness: Director General of Health and Community Services

Monday, 28th June 2021

Panel:

Deputy I. Gardiner of St. Helier (Chair)

Connétable K. Shenton-Stone of St. Martin

Connétable R. Vibert of St. Peter

Connétable J.E. Le Maistre of Grouville

Senator T.A. Vallois

Mr. A. Lane

Dr. H. Miles

Mr. P. van Bodegom

Mr. G. Phipps

Ms. L. Pamment, Comptroller and Auditor General

Witnesses:

Ms. C. Landon, Director General, Health and Community Services

Mr. R. Sainsbury, Group Managing Director, Health and Community Services

Ms. A. Muller, Director of Improvement and Innovation, Health and Community Services

[14:31]

Deputy I. Gardiner of St. Helier (Chair):

Good afternoon and welcome to the public hearing. I am Deputy Inna Gardiner, Chair of the Public Accounts Committee. I would like the Committee to introduce themselves.

Mr. A. Lane:

Adrian Lane, independent member.

Ms. H. Miles:

Helen Miles, independent member.

Mr. P. van Bodegom:

Paul van Bodegom, independent member.

Connétable R. Vibert of St. Peter:

Constable Richard Vibert, member of the P.A.C. (Public Accounts Committee).

Connétable K. Shenton-Stone of St. Martin:

Constable Karen Shenton-Stone, member of the P.A.C. and vice-chair of the P.A.C.

Connétable J.E. Le Maistre of Grouville:

Constable John Le Maistre, member of the P.A.C.

Senator T.A. Vallois:

Senator Tracey Vallois, member of the P.A.C.

Deputy I. Gardiner:

In attendance ...?

Comptroller and Auditor General:

Lynn Pamment, Comptroller and Auditor General.

Deputy I. Gardiner:

Would you like to ... and Graeme Phipps is online on the hybrid. This is the small screen that we have.

Mr. G. Phipps:

Independent member of the Committee.

Deputy I. Gardiner:

Would you please introduce yourself and your team?

Director General, Health and Community Services:

Caroline Landon, Director General, Health and Community Services.

Group Managing Director, Health and Community Services:
Robert Sainsbury. I am the Group Managing Director, Health and Community Services.

Director of Improvement and Innovation, Health and Community Services:
Anuschka Muller, Director of Improvement and Innovation.

Deputy I. Gardiner:
Thank you. I really appreciate that you found the time to come to P.A.C. and speak with us. We all recognise that 2020 and up until now it was a very challenging year for all of us and specifically for your department with COVID and the hospital and the Jersey Care model and it still continues, so we do recognise that you face several challenges and unexpected ones through the year. Would you give us an indication what do you feel are the key challenges that your department are facing?

Director General, Health and Community Services:
So, I think currently it is around our staff regaining some of their resilience, some of their well-being. It has been a very difficult year and I think our staff have been significantly impacted upon. They have been fantastic but they have been impacted by the pandemic. It is completely unprecedented, even if you have worked in health a long time, and presented us with challenges that, despite planning, we had not predicted or planned for. So we have had to really mobilise quickly and that has been difficult for staff. I think regaining our elective activity. In our first wave we stopped all elective activity. In our second we learnt that we could continue doing it and we continued our elective activity in the second wave, despite it being far more impactful in terms of volume and in terms of mortality. I think we came out of the second wave much quicker because of that learned resilience that we had got around elective care, but it is still a challenge to be able to get back to where we need to be for our patients, to get them seen in a timely fashion. Of course, we have the financial challenges coming out of COVID. We had to spend a considerable amount of money in order to be able to ensure that we were resilient, that we had our continuity plans in place in order to continue to deliver care, and that costs money. So, there is a lot of work to be done in order to be able to recoup that position.

Deputy I. Gardiner:
Thank you very much. You mentioned 3 challenges: staff, elective activities and financial. What are the plans to deal with, for example, these 3 challenges?

Director General, Health and Community Services:

So, around staff and their well-being, I think particularly in the second wave we absolutely recognised the pressures that staff had been under and put in place a well-being programme. That was a fairly significant programme of support for staff. We have continued that and we have our lead A.H.P. (allied health professional), Cheryl, who is leading that piece of work with us, who feeds into our chief nurse. That is a whole programme of work to support our staff, to give them opportunity, time and space to leave their workplace and have opportunities to regrow their resilience. Not all staff want to access it. In Jersey, we are not used to people coming into the hospital and dying, we are really fortunate, and a lot of staff have been really affected by that. All they want is they want some time away from the workforce and they want a chance to re-baseline the way they care. So we are trying to do that. It is an iterative programme of support. We are talking to our staff. We had our Be Heard survey. It was not a great time to do it, in the middle of a pandemic, and correspondingly the results were not what we would want. So we have reacted to that by recruiting an O.D. (organisation development) expert to come in and work with our teams around how we can adjust some of the messages that have come through that Be Heard survey. You can say it is a difficult time, but there is stuff in that survey we need to listen to and react to, and that is what we are doing. Around elective work, we have been very fortunate in Jersey. Because we learnt from the first wave that ... so we went into the first wave, we stopped all elective work apart from emergencies and cancers, and that was a decision that our clinicians made, because our response was clinically led by our associate medical directors, but what we learnt in that wave is that we did not want to be storing up a position where we had people waiting for secondary care, already compromised in their health presentation, being further compromised by not having their elective procedures. Therefore, if we do get a third wave or a fourth wave, you have people who are already clinically compromised who are going to be vulnerable. So we worked really hard, and Rob led his teams in order to be able to ensure that we delivered our elective caseload. However, our G.P. (general practitioner) colleagues have been really challenged and patients have not been wanting to go to their G.P.s. There is still a lot of fear out there, which we are still seeing and feeling now, so we have had a backlog of people going to their G.P.s, then being referred to outpatients, and then ... I have forgotten the word, transferring into the ... converting into an inpatient procedure. So we still have a lot of catching up to do. We have a lot of catching up to do around screening, so we have plans in place. We have put in a bid for a COVID recovery business case. We are optimistic that we will have that money in order to be able to bring in some additional support, particularly a mobile unit around some bowel screening.

Deputy I. Gardiner:

What is the bid? What is the funding that you really need?

Group Managing Director, Health and Community Services:

We have various different bids. So we have some screening programme initiatives that we need to undertake. We have a particular need in endoscopy and there are around 1,000 people that we need to undertake a scope, an investigation procedure. That is around half a million pounds that we have had to outlay costs for, for that initiative. Across all the specialties we have seen that kind of investment required, in all honesty.

Deputy I. Gardiner:

So, if we are thinking about the funding, that is the funding that you require to catch up on a global scale what we are thinking that you are missing, inadequate funding to meet the requirements and expectations from you?

Director General, Health and Community Services:

I think if the pandemic had come a few years hence ... the request for money is because of the impact that the pandemic has had ...

Deputy I. Gardiner:

No, no, I understand, I recognise it.

Director General, Health and Community Services:

But what I am trying to say is, because I am trying to be really open, is bear in mind we have been transforming the way we deliver health and community services since 2018 and we are still not as efficient as what we could be. So I think that if this had happened a few years down the line and we had been a bit tighter on our processes, a bit more effective on our delivery model, then perhaps we would not have needed as much money, but we still would have needed it. So, it is a kind of iterative process of us moving through our model of care and how we deliver, particularly within secondary care within the general ...

Deputy I. Gardiner:

So would you recognise the Jersey Care Model as another challenge that you are facing?

Director General, Health and Community Services:

A challenge around ...? In what way?

Deputy I. Gardiner:

You said if we would be further with our model delivery, if our model will be different compared to what we have now, we would be in a different place, which I absolutely agree.

Director General, Health and Community Services:

Yes, yes, yes.

Deputy I. Gardiner:

Basically, on the key challenges, staff, electives and financial, would you describe the delivery of the Jersey Care Model as another challenge that you are facing as a department?

Director General, Health and Community Services:

I think we have a lot on our plate to do, but I think the Jersey Care Model will help to address some of those challenges, particularly around resilience across the system. One of the biggest challenges we had with the pandemic is that a lot of organisations just were unable to continue delivering their business and stopped doing their business. Therefore, the requirement to deliver that fell upon H.C.S. (Health and Community Services). We provisioned staff across the whole of the health economy in Jersey. Again, that was a challenge for our staff to have to go and work in different environments. So, I think that the care model would help that because there would be less silo working. Again, there has been great benefits come out of it, but it was very challenging having to go into different organisations and provide nursing staff, provide care to patients that were not our patients, having to have very difficult conversations with families, who did not want their care being provisioned by secondary care staff no matter how fabulous they are. If you have been used to having your regular carer and they are no longer there, it is really difficult, particularly if you are a dementia patient or if you are a family living with a dementia patient. So it has been tough and I think the care model will ... the care model is not the panacea to all ills, but what it will do, I think, is encourage less silo working. I think we thought we were getting there and the pandemic brought into stark relief that perhaps we were not.

Deputy I. Gardiner:

We all know about the shortages in nursing and carers. What is the situation with shortages now?

Director General, Health and Community Services:

Do we have the exact figures?

Group Managing Director, Health and Community Services:

There are key areas of pressure and they are probably mirrored in terms of the position that the U.K. (United Kingdom) is in at the moment. So, for us in terms of the areas that have the biggest workforce challenges, they include our theatre at the moment that has some nursing vacancies that we are recruiting to. Within our radiology department we have some radiographer vacancies. That is another workforce that globally is quite difficult to recruit to. In mental health we had historical, longstanding vacancies across nursing and medical staffing, but we have actually done really well in that area. So we were running at around 50 per cent of our workforce in mental health was locum

or agency. We are down to just 3 agency nurses now within that area. In radiography, about 40 per cent of the staff are temporary and in theatres we have about 7 agency nurses. The key area in terms of the Island pressure relates more to carers and finding people in the wider care sector to provide domiciliary care or care home support. That is a difficult to recruit to area in Jersey and, again, that mirrors the U.K. position.

Deputy I. Gardiner:

Thank you. I will pass to Dr. Helen Miles.

Dr. H. Miles:

Thank you. I just have some questions about the Target Operating Model for your department. There was a big restructure in 2018 and you have already told us that the T.O.M. (Target Operating Model) has been implemented to include tier 4. Can you just tell us really what are the top 3 most significant challenges that have been brought about by the Target Operating Model?

Director General, Health and Community Services:

So I think the first one is that we are a clinically led organisation. We were not and we are now. So we have a clinically led structure. So the hand that touches the patient is steering the ship, guiding the organisation, making the decisions. That is cascaded all through the organisation. We are new. We are only a year and a bit into that and, of course, we have the pandemic but ... or 2 years into it. We have an executive tri now. So the director general does not lead the whole of Health. Instead there is the chief nurse, the medical director and the group managing director, who sit at the top of the organisation and make collegiate decisions with their replica tris within the organisation about what best services our patients.

Dr. H. Miles:

Sorry, did you say tri, replica?

Director General, Health and Community Services:

Tri, a triumvirate, sorry, a triumvirate. So we have a triumvirate leadership team in every single service and we have an executive triumvirate, which is the chief nurse, the medical director and the group managing director, at the top of the organisation so that decision-making is not just invested in one role, because that is not safe. So I think that has been really, really valuable and really valuable for our clinical leadership model.

[14:45]

I think the ... I am just trying to think what I was trying to ... because I wrote down some thoughts about this ... and the governance structure. So what we have done is we have put in a ... so we have changed the leadership structure, we have changed the executive structure, and we have put in place a completely refreshed governance structure. So we have governance from ward to board. Again, it is new but what we are trying to do is have a golden thread. So we are 2 years into that. We have a committee structure. We have a quality and risk committee, we have a finance and performance committee, and we have a people and organisational development committee. That feeds into the Health and Community Services board. So we are trying to get that golden thread around clinical leadership and clinical decision-making with governance running all the way through the organisation.

Dr. H. Miles:
There are a lot of committees there, there is a lot of boards, there is a lot of structure that clearly did not exist before, but how is all that benefiting Islanders?

Director General, Health and Community Services:
So I think that we now are able to ... we have the mechanism to be able to demonstrate that our decision-making is both clinically and fiscally sound. Before we did not have the ability to do that. So what we are endeavouring to do is to deliver a transparent leadership model whereby all decision-making passes through our assurance process and is ratified at board level.

Dr. H. Miles:
I can see that from a governance perspective, but from a patient perspective, how are patients getting a better service as a result of the Target Operating Model?

Director General, Health and Community Services:
Do you want to ...?

Group Managing Director, Health and Community Services:
I can answer that. Because we have needed all of that governance to be able to drive how we work differently. The thing that we wanted to strive in establishing the T.O.M. was to have care groups across the breadth of our organisation that work together. So one of the big objectives that we had is how do we get continuity of care for people? Because if we look at Islanders, they were bouncing around our own health and care system, so the same patients were accessing mental health, social care, the hospital, and if you look at the top 10 attendees we have to hospital, they were literally going around and around and around the system. So the model looked to create integration and to drive closer working between physical health, mental health, adult social care particularly, which were very separate entities within what was H.S.S.D. (Health and Social Services Department). I

think we have had some success in that area, I would say, particularly between the physical and mental health element. The pandemic has in some way accelerated integration, but in some ways it has slowed it as well, really. So we are rejoining that journey around that original intention. But for people it should mean that you have consistency of contact. You should know who your person who has ultimate responsibility for your care and delivery is, and it should be more seamless for you to understand how you access and how you get information across the system.

Dr. H. Miles:

You are saying ... there are a lot of "shoulds" there, but is it actually happening? Is there that consistency of care?

Group Managing Director, Health and Community Services:

So we are seeing some good results. Again, it is difficult to look at the performance because comparing how your organisation is working now to pre-pandemic is quite difficult. So one of the biggest indicators we would look at is are people attending to accident and emergency and reattending and constantly being readmitted. We have not seen that because we have had about a 17 per cent drop in people coming to accident and emergency anyway. So the normality of how you measure your performance around is this structure stopping people falling through those siloes is more challenging for us because we have had such a huge disruption to the service. There are examples in mental health where some of the service changes we have driven around out of hospital care has clearly stopped people coming into hospital, so we are seeing less demand and pressure for the beds, but in physical health that has really been quite difficult for us to extract at the moment.

Director General, Health and Community Services:

I think that if I was a patient I would want to go to an organisation that was clinically led and professionally managed, not management led, which is what we were. I would want to go to an organisation where there was a qualitative performance report, which we did not have, which demonstrated patient outcomes and which was scrutinised by multiple eyes across the organisation and there was a clinician leading my care who was held to account around that. We had none of that. We had none of that assurance that we could say to you: "When you come to us, this is what will happen and this is what we aspire for the outcome to be for you and this is how we are going to measure it to ensure that that happens to the best of our ability. If it does not happen, this is how we are going to take it back through our committee structure so we can learn from it." So it sounds onerous but what it does is it gives a real framework of safety around the care that we are trying to deliver.

Dr. H. Miles:

So you have described a very robust governance structure, there is no doubt about that, and I think you say that you receive information from your monthly care group performance review meetings. What services are you prioritising for review out of that care group?

Director General, Health and Community Services:

So at the moment we have a few services that we are supporting. We have women's and children's, and we have done a lot of work with maternity because we were not where we needed to be. I think we are all really clear about that. Now we are focusing on paeds because as you shine the spotlight in it starts to peel away the different layers. There is a big, huge piece of work going on around theatres, around scheduling and particularly feeding into the recovery work that we are trying to do around our waiting lists. We have work happening around dental. We have a lot of challenges in dental on the Island. It is probably our toughest challenge, I would say, dental, and radiology, a lot of work happening around radiology. But the other thing the T.O.M. did is we did not have Anuschka's team so we were hugely reliant upon consultants and consultancy firms. Despite assertions to the contrary in the press, I am not in favour of consultative firms. They borrow your watch, tell you the time. But we needed that expertise because it is really difficult to get health expertise on Island. But with Anuschka's team, at the moment we have 3 consultants in helping us with a big piece of improvement work, significant health experience. Every single one of them has one of Anuschka's team attached to them because we do not want to have that person back in again in a year or 2 years. We want to harness that learning. We still have them in there, not as many, and we are going to have them in for the rest of the year, but it is a real iterative journey around improvement. It has come from the T.O.M.

Dr. H. Miles:

Thank you for that. Can you tell us how you are integrating the Jersey Care Model into your Target Operating Model?

Director General, Health and Community Services:

I think we have been very clear that it was about integration and that we started that with the T.O.M. and that the Jersey Care Model is a further iteration of that. So it is about ...

Dr. H. Miles:

So the Jersey Care Model is coming out of your Target Operating Model?

Director General, Health and Community Services:

I do not think it is coming out of it but it is very much aligned to it. It is very much aligned to that process of integration and as ... well, I am not going to repeat what Rob says around shared services.

Director of Improvement and Innovation, Health and Community Services:
It is very much you are almost ... and Rob would explain it better, but with the care groups, they already almost provide the foundations for providing the input and the changes required for the Jersey Care Model. What we have in addition to that is my team as a more supporting function so that we develop new pathways with external partners internally. Somebody from a supportive function needs, of course, to make sure that processes are in place, that the programme is managed and so on. So in that sense the T.O.M. provides the framework already to make the changes for the Jersey Care Model.

Dr. H. Miles:
So at what stage are we with for the Jersey Care Model? Is there an implementation plan?

Director General, Health and Community Services:
I will ask Anuschka to do that.

Director of Improvement and Innovation, Health and Community Services:
It is the first year of a 5-year programme, as you probably know, and at this stage we have created the governance for the Jersey Care Model programme as requested by scrutiny, including an independent oversight board. So this is happening at the moment. The governance has been agreed, which is aligned to the internal governance as well but particularly focusing on how are we doing on the Jersey Care Model, which integrates a lot of the external partners. Whereas H.C.S. governance is, of course, internally focused, the Jersey Care Model needs to take into account all partners.

Dr. H. Miles:
The funding then for the Jersey Care Model comes from Customer and Local Services?

Director of Improvement and Innovation, Health and Community Services:
Well, it comes from the Health Insurance Fund.

Dr. H. Miles:
Okay, so are you at the stage now where you have put in your bids and your request for next year's money from the Health Insurance Fund?

Director of Improvement and Innovation, Health and Community Services:
What it is is the implementation plan has been designed and it is year by year, so it is a developing programme. So at the moment we have a detailed finance tracker for this year, what has been paid

from the Jersey Care Model funding, and we are planning ahead for next year what will be the areas where the funding will be required.

Dr. H. Miles:

So when will we know how much the Jersey Care Model is going to cost next year?

Director of Improvement and Innovation, Health and Community Services:

So the initial funding has been provided as part of the Government Plan for 2021-2023, so it is all lined in the Government Plan so you have the detail there. Of course, underneath what we are developing is the detail of what is then ... where is that funding going, and, of course, that may change. It might be less in certain areas, so we want to make it as efficient as possible. But that work is being done at the moment, also work in, for example, in primary care. A lot is dependent. It is not something we as a team can say this is the way the Jersey Care Model is going to go, it is a partnership working requirement.

Dr. H. Miles:

So what responsibility does the Health and Community Services board have then around performance management across H.C.S.?

Director General, Health and Community Services:

They have oversight of performance management. So, operational accountability for delivery sits at care group level and is ... the A.M.D.s (associate medical directors), the tris are held to account around that at the executive care group reviews, which are cascaded further down the organisation. That then goes through the committee structure and the committee provides assurance to the board, so the board receives assurance around delivery and has oversight of that whole process. Ultimately, I am the accountable officer so I sit on the board alongside the Minister for Health and Social Services. The board acts really well as a place of escalation.

Dr. H. Miles:

Okay. So does the responsibility of the Health and Community Services board relate to services provided only by H.C.S. or does it extend to all of the Jersey healthcare system?

Director General, Health and Community Services:

So at the moment it is H.C.S.'s services we contract. The intention with the care model is that we would eventually, through the partnership board, move towards a different style of governance, although we will still always need our own internal structure but that will report slightly differently as the health economy starts to change.

Dr. H. Miles:

Okay. So at the moment then, for example, it is Justice and Home Affairs that are responsible for delivering the Ambulance Service. Does the director general of Justice and Home Affairs sit on that Health and Community Services board?

Director General, Health and Community Services:

No.

Dr. H. Miles:

No. So if you have issues over ambulance provision, and obviously ambulances I would think are kind of a key area for Health and Community Services, how does that relationship work?

Director General, Health and Community Services:

We have a really good relationship. I think you meet with the chief ambulance officer every month and I meet regularly with Julian. We have had conversations. You have touched on conversations we have had around inviting the Ambulance Service to be part of the board, because we do have other partners on there. We have the sector partners, we have primary care, and it has been an ongoing conversation really about should that happen. I think it is something that we will continue to look at.

Dr. H. Miles:

Because I guess it is not just about ambulances. If you think with the separation about C.A.M.H.S. (Child and Adolescent Mental Health Service), you think about children's social care, we have talked about the Target Operating Model delivering an integrated service, and actually C.A.M.H.S. and children's social care are the responsibility of C.Y.P.E.S. (Children, Young People, Education and Skills). Does the director of C.Y.P.E.S. sit on the Health and Community Services board?

Director General, Health and Community Services:

No.

Director of Improvement and Innovation, Health and Community Services:

Can I just say the Health and Community Services board is not in the sense of Island-wide health and community services. It is really about the department, how the department, the services that sit within the department, whether they are delivered efficiently, effectively, the right performance. So none of the other departments have such a governance structure in place as our department, so I can absolutely understand where you are coming from. We are trying to have a wider conversation about the wider health system that comes with the Jersey Care Model governance, where we have all of these players.

Director General, Health and Community Services:

But I completely see where you are coming from. We have had 2 years of the governance structure. COVID came and we stopped for a couple of months. Retrospectively now we think that is a learning for us. We probably should not. We have started up again and these are the conversations we are having. But Anuschka is right, is it appropriate for us to have those within a governance structure which is solely around provision of services that we have control over, either fiscally or managerially? We have neither with the Ambulance Service or with C.Y.P.E.S., although we do have greater interaction with C.Y.P.E.S. because of the contracting. But do we instead start having those conversations through the partnership board which will be up and running in September? It is kind of an ongoing conversation. I think it is about timing. I completely see where you are coming from.

Dr. H. Miles:

This seems to be quite critical because obviously we have OneGov. We are all supposed to be sharing resources across the Island and that was the idea, yet we talk about moving away from siloes.

[15:00]

Yet the Health and Community Services board seems to be a particular silo that has very little influence from key partners in terms of children's social care, C.A.M.H.S. and the Ambulance Service. So it is just trying to work through that. I guess, moving on then, how do your departmental governance arrangements, which seem to be very strong, align with and feed into the corporate governance arrangements, in particular the risk and audit committee?

Director General, Health and Community Services:

I think you have to acknowledge, and it is a constant rub, I suppose, that we are a healthcare service sat within government and we have to have very strong governance accordingly because of what we deliver and because of the trust that people put in us around that delivery. So our governance structures by necessity are going to be very different to what is elsewhere in government. But risk and audit we work very closely with. I think we do very well around our risk management and we feed into the corporate risk register and we attend the monthly risk and audit committee meetings. We present there. We maintain our escalation through to the corporate risk register. All of our risks are ... 5 risks that are 20 and above are listed as extreme on the corporate risk register as well. So we interact well through risk.

Dr. H. Miles:

Just going back to ... you said you are a health service, you are delivering health, yet just going back to the previous point, you have 2 elements there over which you appear to have very little control, i.e. the ambulance and the children's social care. With the benefit of hindsight, if you were redesigning the Target Operating Model, would you draw those functions back into your area of jurisdiction?

Director General, Health and Community Services:
I think it is difficult for us to with hindsight look back on decision-making of colleagues at a time when we were not responsible for the delivery of healthcare in Jersey. I think we work closely with colleagues in C.Y.P.E.S. and in J.H.A. (Justice and Home Affairs) to ensure that the services delivered are the services we would want for our patients. I think it is an ongoing dialogue that we need to have with colleagues about where those services best sit. I do not know, colleagues, if you wish to add any more.

Group Managing Director, Health and Community Services:
Yes, I agree. Today we have a joint operational meeting with colleagues in C.Y.P.E.S. about C.A.M.H.S. and children's services generally, and we have our unscheduled care group meets with the Ambulance Service regularly. So operationally you can have that dialogue. I am not sure it is about where they sit, it is about how do we make sure that we are working together in partnership and we have mutual goals and mutual objectives. That is the bit that I think we recognise we need to do more work on with those areas.

Dr. H. Miles:
I just want to move on because I am conscious of time, and thank you for being open in discussing that. Again, it comes to the role of H.C.S. and the board corporate. My next area is about complaints and feedback. So, what percentage of complaints to your department are made through C.L.S (Customer and Local Services), which is either the corporate complaints ...?

Director General, Health and Community Services:
So, 50.6 per cent in 2021 and 31.6 per cent in 2020.

Dr. H. Miles:
Okay. Do you have the same kind of process for handling complaints, the same target times for responding?

Director of Improvement and Innovation, Health and Community Services:
Can I just add to that just to give you some clarity around it? So the complaints are not coming through C.L.S., they are not through the department, it is the corporate customer feedback

management system and they are logged. So anyone can access that system. It is being designed and implemented by C.L.S. but it is actually a corporate customer feedback management system. So if I receive a feedback or complaint, a customer contacts me and says: “I was really unhappy with a contact in a different department” I would log that for that department, even though I am not part of that department. But that is the purpose of it, that we can all log feedback regardless of whether it is for our department or not. So what we have here is what has been logged on the corporate system, which may have come from an internal person or from somebody else, and then in addition to that we also have, of course, our own in H.C.S., quite a sophisticated feedback and risk system called Datex. In that corporate system about 50 per cent are also logged, which is good because there are 2 ways of logging.

Director General, Health and Community Services:
We were concerned about that when it was first proposed because healthcare is really intimate, regardless of your presentation, and we are bound by confidentiality, which we are really ... you know, we are anal about because we have to be. So we were very clear that we wanted to maintain our own process as well so that if you want to, of course you can complain via the corporate complaints process, but if you want to complain into the hospital, to us, you can also do that. It gives patients a choice.

Director of Improvement and Innovation, Health and Community Services:
But it is the same timeframe, the same kind of process, it is aligned.

Dr. H. Miles:
It is the same, so the corporate one and the H.C.S. one is the same?

Director of Improvement and Innovation, Health and Community Services:
Yes.

Dr. H. Miles:
There is no difference in the days between response time ...?

Director of Improvement and Innovation, Health and Community Services:
No.

Dr. H. Miles:
Okay. How do you track the outcomes of the complaints?

Director General, Health and Community Services:

We do that through various forums. We do it through the care group performance reviews. Executive colleagues have information every month around which complaints are open, which complaints are closed. Then through quality and safety we do the themes because we have quite common themes around complaints, predominantly around access and also to do with experience. So that is the work that takes place in quality and safety around getting assurance.

Director of Improvement and Innovation, Health and Community Services:
Just in addition to that, we capture each complaint providing a lot of detail. So our own feedback team is logging the information and then also logging all the additional information. Usually, the feedback goes back ... or complaint goes back to the relevant service, to the relevant people. It is being discussed in their groups and it is usually part of a professional clinical discussion if a patient has fed back that something was not right. They take that as a learning exercise, so as a group they learn from it. This is also then being logged, plus, of course, the answer being fed back. So it is quite a long audit trail. Then what is really good is when they are generic or making it anonymous but key learning areas are then being shared across wider professional groups so that other care groups can learn from that as well. Some of the patient stories are being then shared in committee meetings so that there is wider learning. Quite often ...

Dr. H. Miles:
Lessons learnt type ...

Director of Improvement and Innovation, Health and Community Services:
Lessons learnt, yes, and it is really that this is the feedback, that was the comment, this is what we did to deal with it and this is what we learned and that is what we have changed accordingly.

Director General, Health and Community Services:
Patient stories at board, they have been really ... they are quite common in the U.K. but we have not done it here, and they are really powerful. The next step we want to start doing is, with patients' consent, start recording some of those patient stories so that we can put them on our intranet because ... yes.

Dr. H. Miles:
Are you satisfied with your responses to complaints and are you on top of your complaint times?

Director General, Health and Community Services:
No, we are not satisfied and we certainly are not on top. Anuschka's team is leading the review of our P.A.L.S. (Patient Advisory and Liaison Services) service.

Dr. H. Miles:

Sorry, P.A.L.S. service?

Director General, Health and Community Services:

Patient Advisory and Liaison Services, so around our response rates in particular but also in the way that we tackle letters and also that ... there is a whole culture that we should try to stop it getting to a complaint, so encouraging patients to feed back in the moment and making it safe for them to do so, even if it is negative feedback, so that we can try and stop a complaint, not because we do not want the patient to complain but because there is so much bureaucracy around it. If there is some learning we can get in the moment, then that is really valuable, but we are at the beginning of that journey.

Director of Improvement and Innovation, Health and Community Services:

But at least we have done quite a massive review. We had a lot of outstanding complaints so ...

Dr. H. Miles:

So you are satisfied you know where the issues are and ...?

Director General, Health and Community Services:

Yes.

Director of Improvement and Innovation, Health and Community Services:

Yes, so they have massively reduced, so we are on top of what is currently being done.

Dr. H. Miles:

Okay. I am going to stop now and hand you over to the next questioner. Thank you.

Senator T.A. Vallois:

Thank you very much. So, mine is on to probably one of your biggest and most important assets, your staff, and, of course, being the biggest department with your employees of the States. My Conversation, My Goals, just to understand, is that effective and do you utilise that for all of your staff within Health and Community Services?

Director General, Health and Community Services:

Can I ask Anuschka to answer that because she is our executive lead for that?

Director of Improvement and Innovation, Health and Community Services:

Yes, of course. So, My Conversation, My Goals, as you are probably aware, there were several iterations of the I.T. (information technology) system on how to capture that. It is generally difficult to use an I.T. system for appraisal capturing when the staff are not on an I.T. system, so all of the manual workers, of course, cannot access that. So, in that respect it has not been successful to roll out across the organisation. It had part success, I would say, where people were able to access it that really make the effort to access it and to capture information. We had a lot of feedback to the central organisation and development team on things that are not working, what could be improved, and they have taken that on board. I would say a key difference here is that we always have the professional appraisals as well that are being taken, which is a different matter. So in order to have the professional accreditation done, professional revisions appraisals need to be done regularly and that is really being followed through. So the My Conversation, My Goals is running almost in parallel. However, where we want to go to and where it becomes a really important part is using My Conversation, My Goals even if it is in a different way, which would be great having it as a paper template or something where people can capture their objectives and it is clear how they align back to the departmental business plan so they can see that golden thread. So that is still a work in progress, yes.

Senator T.A. Vallois:
So is that the professional appraisal that is carried out right across the board with clinicians, nurses, everybody who works within Health and Community Services on a regular basis, like every 3 months, every 6 months? How often does it ...?

Director of Improvement and Innovation, Health and Community Services:
From a clinical perspective, Rob is probably better to ...

Group Managing Director, Health and Community Services:
We try to do it annually because we need accreditation obviously for revalidation for our nurses, midwives and allied health professionals. It is a bit clunky in all honesty because you are submitting professional evidence to reregister if you are a nurse to the N.M.C. (Nursing and Midwifery Council). You have to do the statement then to upload it to My Conversation, My Goals and they are somewhat a bit different. So I think, given we have over 150 different professionals working in health, it is hard to use a single document when you have such breadth of professional roles that work in very different ways.

Senator T.A. Vallois:
I can imagine; that is why I asked the question. It is quite easy to set a corporate standard, but it does not necessarily roll out as easy at the department.

Director General, Health and Community Services:
Absolutely.

Senator T.A. Vallois:
How do you capture what would be the intentions of My Conversation, My Goals in terms of staff performance and that feedback from your staff to ensure that you are performing on that business plan level and delivery in terms of Health and Community Services?

Director General, Health and Community Services:
We have been very clear as part of our management restructure and the work that we are doing with teams around the basics of management that perhaps have not been in place, like one to ones every month with your staff, down to the level of having to micromanage some of that around having to see the schedule, making sure it is happening and making sure that there is at least some conversation going on in there that is fruitful for both parties. I think through our people and organisational development work that our H.R.D. (human resources director) is leading we are starting to do much more support for staff around how you have conversations within that hour every month that feed into your quarterly and your annual appraisal, My Conversation, My Goals. But I think you hit really aptly on some of the struggles we have in health in that it is very difficult to fit a one size fits all upon a business that is delivering care. I think that sometimes we need to be more mindful of that. These interactions, if they are going to be meaningful, have to relate to what people are actually doing day to day.

Senator T.A. Vallois:
So it is understanding ... from my point of view, what you are saying there, it is a very different animal, is it not, the States of Jersey, put it that way, but how then does the corporate align with what you are expected to carry out in terms of going through the performance framework and your staff, I suppose, being overseen by that corporate structure? Because the States Employment Board are their employer, as an example. It is just understanding how it does or does not fit and if there is an expectation in terms of online performance management and how that ... you are accountable to the principal accountable officer for spending money and for making sure you deliver health and community services, so from your point of view that feeding in to the centre so they can see the bigger picture.

Director General, Health and Community Services:
We do that through our policy performance report. That is about 100-odd, 200 different indices of performance, both quality, operational and fiscal. We submit that every month to the centre. They have access to it and they are able to see what we are doing against our key indicators as we feed into the risk and audit committee around our key risks.

[15:15]

You start to see those risks coming through our Q.P.R. (quality performance and risk) anyway. Then we cascade that through our own organisation. Through our governance structure I am assured because I hold my executive directors to account, particularly the executive tri, around the care group performance meetings. I get assurance via the committees which I attend. I do not oversee them. Then I feed into the chief executive around performance within the organisation from the data that comes through that structure. Again, we are 2 years in so there are lots of gaps still in the structure and it is not where we need it to be, but it is a damn sight better than what we had.

Director of Improvement and Innovation, Health and Community Services:
Can I just add to that? I think it is important to see there are 2 different strands. On the one hand we have, of course, the corporate setting, political priorities, which are then reflected in the Government Plan, and these are then reflected in our departmental plan and how to ensure that these are being delivered. So for that aspect we have then also now a level downwards care group performance business plans, which is more relevant for each care group, which is more detailed. Within each, the Government Plan initiatives are featuring, so you have that golden thread from common strategic policy priorities down to care group business plan objectives, plus there are also items in there, of course, like C. and A.G. (Comptroller and Auditor General) recommendations or other priorities from a corporate perspective that are relevant for each care group. We are overseeing the delivery of these business plans for the care group in that monthly performance review. So that is one aspect I think more from a corporate golden thread perspective. The other aspect, of course, as an operational front-line service are the operational objectives, and the indicators are there showing that care is being delivered on time at the right quality, so providing that assurance, and that is being done through that quality performance review and that report, which is very much based on performance, which then also links back into the corporate performance framework as how it contributes to the outcomes and the indicators. So I think it is important to see the 2 strands, delivering the priorities but at the same time providing assurance that services are operationally delivered at the right point.

Senator T.A. Vallois:
That is really helpful.

Director General, Health and Community Services:
The corporate performance report has ... I agree, that is really eloquently ... the corporate performance report has a sample of our indicators, so it is not our full performance report. Our full performance report is also naked, and we have conversations about that report because in other

jurisdictions that report is public. We have conversations about that because the whole aspiration of our governance structure is that we are transparent. I think some of the challenges for us within Jersey is that it is a very different jurisdiction and that the information can be used in ways that would inhibit patients from accessing care because it can be presented in a way that is sensationalised. That is difficult. So that is the ongoing conversation we have about showing that report publicly but it is us. It is us, it is H.C.S., and I think, Lynn, you have seen it and it is everything that we deliver across the board.

Senator T.A. Vallois:

Okay, so you mentioned risks, if you could give an indication of the top 5 risks? If you are looking at your risk register and you said: "Right, right now, here is my top 5" what would they be?

Director General, Health and Community Services:

Health and safety. We do not have an appropriate health and safety system. Boilers. Boilers are the bane of our lives. The estate, we have significant issues with the estate, as you can imagine. We have a reprieve in summer but then winters are really, really difficult. We have issues around uninsured claims, so claims coming forward and significant financial risk there. There is one more that is in my top 5. So it is health and safety, boilers, estate ... sorry? Insurance and pandemic planning. Pandemic planning because I think that ... although I think colleagues have been amazing, we have a lot to learn still, a lot of learning.

Senator T.A. Vallois:

It is good that you are learning and being open about it.

Director General, Health and Community Services:

Yes. I have done pandemic planning for 30 years and there is nothing like living in a pandemic to realise that your pandemic planning was ... optimistic.

Senator T.A. Vallois:

Well, if you have not lived it you would not know, would you? So, those risks, managing those risks from your point of view, we have been talking about the hospital for a very long time so I would imagine that under your estates thing is the fingers crossed that it will go through. But other areas like your boilers, like your pandemic planning, how are you managing that or mitigating those risks as you are delivering?

Director General, Health and Community Services:

So I will have to go to my ... because I do not have that at my fingertips, but we review our risk register. So the risk registers are reviewed monthly in the care group meetings and then reviewed

in quality and risk and the top 5 risks go to board every month. Generally, you would not have the same top 5 risks because you are mitigating them effectively, but because ours are so significant they have been more or less the top 5 risks for the last 12 months and the estate one for the last 2 years. But around the effective health and safety management system we have recently appointed a new health and safety manager and he has put in place some risk assessment templates around the estate and around how we are working. He has updated our training manuals and our training opportunities in fire and safety, violence and aggression, and safe handling. He has developed a health and safety dashboard with key performance measures that come through to the assurance committees each month, and he also reports to the States Employment Board. So we have ongoing monitoring of the situation, but it is a 25. It is the highest risk on our risk register. We review it every month and it is ... we need a robust health and safety management system in order to be able to mitigate that risk.

Senator T.A. Vallois:

So in terms of incident reporting or managing those incidents, how do you carry that particular ...?

Director General, Health and Community Services:

We have incident reporting that comes through. So for risks that happen within our clinical areas we have Datex and we have health and safety risks that come through on our Datex system as well, and that incident reporting then goes through the appropriate escalation structures.

Senator T.A. Vallois:

So that will feed into the corporate risk register then?

Director General, Health and Community Services:

Yes. All of these risks are on the corporate risk register as extreme. Boiler replacement, I can go into all of it. There are 2 boilers in situ, one operational and one contingency. They are both serviced annually and have had upgrades, but they are old. They are really old boilers. The estate infrastructure I can go into but I think you are all fully aware of that.

Senator T.A. Vallois:

Well, we have been around a long time. **[Laughter]**

Director General, Health and Community Services:

Pandemic again is around us working differently for that, and the uninsured claims is the claims where we do not have insurance, particularly around some malpractice, and where we can have significant financial liability. Again, we work really closely with our insurers, and Mike Thomas has worked really hard to build those relationships, but it is still a real challenge for us. There are key

risks. Of course, we have many other risks on our risk register, but the risks that we consider are key risks are the 20 and 25s. Every risk that is 16 and above gets looked at at committee.

Senator T.A. Vallois:

Just finally from me you will be glad to know, you note in recommendation 6 - this is about the pandemic planning - that lessons learnt from the early days of the pandemic have been incorporated into operational decision-making and that risk assessments have been improved. Would you be able to give us 3 examples, specific examples, of those lessons learnt?

Director General, Health and Community Services:

So, the weekly interface with the care sector has been fantastic. When you think about it now, it probably should have been something we always did. That has been really good for just enhancing lines of communication. We have maintained that and we have that every week, and that has been really good. The operational hub, we now have one hub for operations, which Rob has led on, and all decision-making takes place there or at management of activity. All care that is delivered across our estate 24/7 is managed in this one operational hub. It has been really great for having really strong, safe, collegiate decision-making. It can be quite a challenging environment sometimes at 8.00 a.m. of a morning when the surgeons want one thing and the medics want another, but really good for having that joint decision-making, breaking up our own internal siloes. P.P.E. (personal protective equipment) management. We are an Island jurisdiction. I say that; it would have been the same in every other trust I have worked. We had a P.P.E. store and we issued P.P.E. but were we super organised and super efficient? No, because it was quite an organic process. You went to the P.P.E. department and you got your masks, you got your gloves, you got your aprons. We maintained it, of course, as part of our B.C.P. (business continuity management) but we did not maintain it with the rigour with which the pandemic forced us to do and we have absolutely held on to that. It has been fantastic. So our P.P.E. now is super professional.

Senator T.A. Vallois:

This is going to sound like a silly question when I ask you. How have they improved your departmental performance?

Director General, Health and Community Services:

I think the hub has improved it because it has enabled us to manage our elective and emergency pathways much more collaboratively, so not so much at the expense of each other. The weekly care meeting has helped us because it has helped us to join up patient pathways more and has almost been baby steps towards the care model. So we are much more interlinked now around patients' onward journey or predictors around patients that may come in. Before you would appear

at our front door and you would be a bit of a surprise. Now we kind of know you are coming. Not all the time, but we have an eye on you, where you are.

Senator T.A. Vallois:
That is pretty scary.

Director General, Health and Community Services:
It just enables us to link up that care better. That has really helped. So it is the operational hub and what was my other one I said? P.P.E. and ... and I think the biggest learning we took was around elective care. We absolutely needed to maintain our elective activity. In the first wave we did not and the impact of that I think ... I think you have to weigh up harm and at the end of the first wave we had a whole workshop around our elective waiting lists and looking at the risk and doing harm reviews across that waiting list and recognising that even if the second wave came and was really truly dreadful, the balance of risk and harm around stopping all elective activity was higher than the risk would be of the pandemic. We will know that for the next time. That was a piece of learning from the first wave.

Senator T.A. Vallois:
I will pass over to ...

Deputy I. Gardiner:
No, just a minute, a follow-up.

Senator T.A. Vallois:
Oh, sorry.

Mr. A. Lane:
I would just like to follow up on something you said about your local H.C.S. performance report. You said in other jurisdictions that would be a public document but in Jersey that might not work. What would need to change to make you feel confident about putting that in the public ...?

Group Managing Director, Health and Community Services:
Can I answer part of that? I think that would be really challenging in Jersey because there is a real sensitivity because it is small. Admissions, say, into the mental health unit, suicides, these are reported in a very sensational way in the media here and the way that they are interpreted can really impact on people in terms of how you want to promote your services. So if you hear about a negative impact continuously for your service and then that stops somebody seeking help and seeking support, that can be really counterproductive. So in terms of just putting everything out there, it feels

that that information is not always appropriately and proportionately then interpreted. It becomes a front-line headline that you just would not see in other jurisdictions. Blood contamination headlines, I probably have a long list over the last 3 years of things that you just would not see elsewhere. It would be handled in a different way.

Director General, Health and Community Services:
Not just our patients, our staff. So we have a long way to go in where we need to be and we have significant workstreams happening around the services that we have talked about, but our staff are working hard. A lot of our staff have not worked in other places so they have not had the opportunity to see different ways of working. We are trying to support our staff to deliver a service and it is not helpful when there are headlines around ... this is not us trying to hide our performance but this is us trying to support our staff to deliver better performance for our patients. Sometimes in Jersey that is difficult because it is sensationalised. I understand that in other ...

Mr. A. Lane:
So the things you cannot change ...

Director General, Health and Community Services:
I understand it for other service providers but we provide health. We are different to I.H.E. (Infrastructure, Housing and Environment). I am not trying to say that we are special, but we are not delivering roads, we are delivering care. It is sometimes difficult for us to be in that arena of being a bit of a football.

Director of Improvement and Innovation, Health and Community Services:
Also if you have very small numbers it is identifiable.

Group Managing Director, Health and Community Services:
Identifiable cases, yes.

Director General, Health and Community Services:
You cannot go down the road. You cannot say: "Well, Jersey Hospital is rubbish but that is okay, I am going to go up the road to the other one." It is about just ensuring our patients feel safe, and it is not rubbish, really safe good care.

Dr. H. Miles:
Sorry, just a really quick one just to clarify. Did you say you do not have any insurance against malpractice?

Director General, Health and Community Services:
No, we do have insurance.

Group Managing Director, Health and Community Services:
No, we do.

[15:30]

Director General, Health and Community Services:
We do have but we have some uninsured claims. So we have some claims that have come through that we just do not have the appropriate insurance cover for because that is ... it could be a claim that is just not part of what we are insured. Insurance here is very difficult. It is very different to the U.K.

Dr. H. Miles:
Can you give an example of what an incident might be for that?

Director General, Health and Community Services:
Can you think of an insurance claim that we have had?

Director of Improvement and Innovation, Health and Community Services:
Might need to follow up.

Group Managing Director, Health and Community Services:
I guess it is the ... so our arrangement for medical indemnity for our clinicians is a bit different to the U.K. So you have a proportion of personal responsibility from the clinician here, which is a bit different to the N.H.S. (National Health Service). Where the Government indemnity ends and the clinician's takes over is sometimes challenging. We see it particularly in obstetrics and gynaecology, do we not?

Director General, Health and Community Services:
Yes, and ophthalmology.

Group Managing Director, Health and Community Services:
And ophthalmology.

Director General, Health and Community Services:
Yes. We can provision you with individual anonymised ones if you ... because it is quite interesting.

Dr. H. Miles:
It would just be helpful to know what liability that is putting to the States of Jersey, really, and what steps are being taken to kind of plug that gap.

Director General, Health and Community Services:
Yes, absolutely, we can do that.

Deputy I. Gardiner:
Another very quick one: if I remember correctly, the Government target to respond to complaints is 25 days and you are working within 28 days. Is it correct and, if yes, would you aim to come to the Government target?

Group Managing Director, Health and Community Services:
I think that is quite challenging for us ...

Deputy I. Gardiner:
It is only 3 days and even then it is 30 per cent not respondent with this.

Group Managing Director, Health and Community Services:
In both our experiences, when you have … a high proportion of our complaints can result in litigation, and they do, so that always extends the complaint process. We definitely need to be quicker but it is sometimes quite difficult for us to respond within that framework, particularly also because of the indemnity element. Clinicians, if they are providing statements, they have to consult their indemnifier, their legal representative and that complicates the system and makes it quite difficult to align it.

Director of Improvement and Innovation, Health and Community Services:
Just to clarify, an acknowledgement of the complaint, that has always been done in that timeframe, it is the question of the whole response to the complaint and solution being provided in that period, that would be difficult in some cases.

Deputy I. Gardiner:
My question is around Government's central guidelines is only 3 days but it is a difference and this is how we are creating the …

Director of Improvement and Innovation, Health and Community Services:

No, and I think the acknowledgement … that is what I think the definition of a response there is, that we could kind of align that, I think, but we will take that back.

Deputy I. Gardiner:

Yes, thank you. We will move now to the recommendations of the C. and A.G.

The Connétable of Grouville:

Referring to the C. and A.G. report on healthcare management, in November 2019 a flu pandemic exercise had been undertaken and a report produced which contained a number of recommendations, including for business contingency plans and training of key staff. Why had these recommendations not been implemented by March 2020?

Director General, Health and Community Services:

Those recommendations … the flu pandemic exercise was a public health exercise that we participated in as a provider. The findings of that report that were shared across government were around system-wide resilience, Island-wide resilience and the response for that is being co-ordinated by J.H.A. and the Office of the Chief Executive because that is where Island resilience sits.

The Connétable of Grouville:

Do you know if all the recommendations have been implemented now?

Director General, Health and Community Services:

I know there is the Jersey resilience framework that meet every month and there is work ongoing to ensure that all of the recommendations are responded to.

The Connétable of Grouville:

Presumably you had a lot of input into that process though?

Director General, Health and Community Services:

I do around business continuity plans for H.C.S. but I am assured around business continuity planning for H.C.S. I think as a healthcare provider we have to be robust around our continuity but I know that some of the recommendations around Island-wide resilience we just play a part in.

The Connétable of Grouville:

Recommendation 9 you have only partially accepted. It indicates you do not want to review a published report on future pandemic preparedness. Why is that?

Director of Improvement and Innovation, Health and Community Services:

Yes, I can answer that one. Just for clarity this is not correct. The recommendation says review the experience and develop future preparedness and then publish the review. I think the wording was a bit unclear. If it says publish the review, it was review the experience, not a report on future preparedness. We made it quite clear in our response that for H.C.S. future preparedness is very important and that we have plans in place to provide that. It may need a bit of discussion, what this review the experience and publish a report actually means. That was a bit unclear to us so that is why we partially accepted it because we can only act for the H.C.S. part and for that part it is absolutely important to do the emergency planning, to be prepared for that. That is in place but if we look at … if you reviewed the experience as an Island-wide experience that is a government-wide more public health task, which would not sit with us so hence the partial …

The Connétable of Grouville:

So will you publish your preparedness, will you make it an official document?

Director of Improvement and Innovation, Health and Community Services:

For H.C.S. we can publish that, yes.

The Connétable of Grouville:

Thank you.

Deputy I. Gardiner:

But this response was the Government response. I am looking at the beginning of the response, the chief executive and director general of health, would it be expected that the report or the recommendation was aimed to the whole Island Government OneGov corporates or … I understand that you as a department cannot publish for the whole Government, but what was surprising was that this report cannot be published on behalf of the Government with you as a participant.

Director General, Health and Community Services:

I think it would be published by public health. The Island has really been challenged by the fact that we had no public health functionality. It is one of the biggest surprises when I came into post, looked around, where is public health. We now have a director of public health that we have appointed but pandemic planning sits with public health. I am a provider service. With respect, you should not want me to be responsible for pandemic planning, that is a public health functionality. I could be conflicted in my provision of that. Absolutely we will feed into that report but the actual pulling together of an Island-wide response around experience sits within public health and sits centrally. We will be part of that but what we have said is - and I think we listened very hard, Lynn, to what

you have said - we push back against that to say that is not just an H.C.S. response, that is a whole Government response as you have indicated.

Deputy I. Gardiner:

So maybe it is better to take this response back to the Government and say: "As we discussed with Public Accounts Committee", we absolutely agree with you, it is not H.C.S.'s response, it should be the Government response. So who is responsible for this report should not be you as a director general, it should be …

Director of Improvement and Innovation, Health and Community Services:

I think it would be worth having …

Deputy I. Gardiner:

So this recommendation can be accepted and can be implemented and a report can be published but not under your responsibility, it is under the Government. This is something I would encourage them to review.

Director of Improvement and Innovation, Health and Community Services:

I think it probably needs a conversation outside of this review. The wording of the review to the COVID experience is also not clear from the findings from the report so it is difficult to link it back to what is actually meant, so it might be useful to clarify that and then both sides are clear what is expected, rather than trying to interpret this.

Director General, Health and Community Services:

But it is a really important point and it is one of the things … one of the conversations around public health when there was a recognition about we needed public health, which is blindly obvious, is that should it sit with me as director general for H.C.S.? If I am responsible for bowel screening and I have a problem with my wait list in endoscopy, then of course there is a potential conflict there. Public health should sit outside of me, screening programmes should sit outside of me, so that I do not look at them or influence them or impact upon and I do the provision part, which is the response to that. I think it is about us getting used to that as an Island. Now, of course, even if it did sit with me I would not be able to do that now but that is because of the governance we had in place. Two years ago when the director general was all powerful, even more so you would not want public health to sit with me. You have to have that cleanliness for safety around provision and around an educative, supportive public health function.

Deputy I. Gardiner:

But when I see the public health law coming in December 2022 it feels very … we are talking about a public health law which is important and what steps we are taking to ensure we get it in another couple of years.

Director General, Health and Community Services:
We have appointed a fantastic director of public health, which is an amazing thing for the Island. I think he has started.

Group Managing Director, Health and Community Services:
Yes, he started today.

Deputy I. Gardiner:
Thank you very much, I appreciate the open conversation.

The Connétable of Grouville:
The C. and A.G. report notes that a lot of work went into improving the business continuity plans between February 2020 and April 2020. What is your assessment of the current effectiveness of the H.C.S. business continuity plan?

Director General, Health and Community Services:
I think they are robust, I think there is still work to be done. We are fortunate in that we appointed a general manager who is an emergency planning officer, who was emergency planning lead for a large trust in London, so it is useful having those other eyes within the organisation to help us as well. Business continuity is constantly evolving because as we change our services we have to change our response. But, yes, my current assessment of them is that they are robust.

The Connétable of Grouville:
What are the top 3 lessons you have learnt in respect of the use of the implementation of business continuity plans during the COVID pandemic?

Director General, Health and Community Services:
Around the plan specifically or around our readiness?

The Connétable of Grouville:
Your readiness, particularly with the COVID-19 pandemic.

Director General, Health and Community Services:

What I have learnt is that we need to have clearer expectations and understanding of what partners can provision and the resilience that partners have. It was - and I am reiterating - incredibly difficult for us to have to provision services that we do not routinely provision and to support with staff. I think that is because we had made assumptions around other organisations' resilience, if we had even thought about them, to be frank. We just assumed that people would have business continuity plans that they would stand up and work to and we were proved quite wrong around that and that added to our challenges. Going forward what we are doing is we are working closely with other organisations around joining up our business continuity. Because a lot of the pressures were because other organisations, through no fault of their own, third sector organisations … we should have thought about it and I think that has been the big learning for us. I think the care model will help to break down some of that silo working. We have great emergency planning capabilities and we need to share that.

Deputy I. Gardiner:

Thank you, and we will go to the estate management.

The Connétable of St. Peter:

Yes, estate management. How do you expect the property footprint of H.C.S. to change over the coming years, providing the future hospital is delivered within the current model? What are your contingency plans if this is not the case?

Director General, Health and Community Services:

I am going to ask Rob to lead on the estate management because he is our executive lead for that.

Group Managing Director, Health and Community Services:

In terms of the concept of the new hospital, obviously it is more encompassing than the current general hospital so it is a campus approach, so it would incorporate physical health, mental health, educational services. So rather than having what is effectively 3 hospital sites at the moment between St. Saviour, the general hospital and Overdale you would have all of those hospital facilities within one. That makes things operationally much easier for us and give us better breadth of staffing oversight and practical benefits. There are then other smaller services that we have within wider estate that also need to be modernised, so within the learning disabilities area we have some clear plans that we want to modernise that estate, that will be independent of the new hospital. Then, of course, there are other facilities that we have that we would not necessarily want within the hospital footprint. In terms of contingency, if we do not have the new hospital then that presents a significant challenge for us because our interim measures of what we are doing within the whole of the estate … so St. Saviour is an example, we are upgrading Clinique Pinel so that we can transfer Orchard House to that facility. We need to close Orchard House in the next 6 months. Clinique Pinel will

provide mental health services for a 5 to 8 year window probably, but it is not a long-term mental health facility. It was not designed as that. We are, I guess, making good with what we have. That would be the same in our general hospital as well, we would just be on a continuous backlog of maintenance, which is cyclical, going around and around and around in terms of reactive estates management, which is where I feel we are at the moment.

The Connétable of St. Peter:
It would be a challenge with the old hospital building. That would be part of a contingency but it is tired and just hanging on in there.

Group Managing Director, Health and Community Services:
Yes.

The Connétable of St. Peter:
So I would think you probably have some concerns if the new hospital is not delivered.

[15:45]

Group Managing Director, Health and Community Services:
We would have significant concerns if we do not have the new estate, across the whole of our physical and mental health inpatient services.

Director General, Health and Community Services:
Also about what we can deliver. We are so hampered about what we can deliver, about how we can do care differently it we had the estate in order to be able to support us to do that and we just do not.

Group Managing Director, Health and Community Services:
The pandemic has strengthened that case for change. The need to be able to have very clear physical separation between hot, cold pathways, adequate side rooms to isolate patients who could be infectious, reverse air pressure, all of those elements were incredibly challenging within an estate like ours.

The Connétable of St. Peter:
How is H.C.S. represented on the Corporate Asset Management Board and what direct involvement do you have in the development of decisions and plans regarding the department's property needs and future property portfolio?

Group Managing Director, Health and Community Services:

We are part of the Corporate Asset Management Board. I attend it with my head of estates, Mr. John Carter, so we feed in all of our estates position, our estates requirement from backlog maintenance from a short, medium and long-term perspective. All of our major capital programmes are fed through to that board, so the Five Oaks refurbishment, Aviemore, the Clinique Pinel, all of that is part of our timeline, as well as the digital programme as well, because that has infrastructure consequence. We have good involvement, we contribute to the decision-making, then the C.A.M (Corporate Asset Management) Board then looks at the whole estate needs for the Government of Jersey and then obviously feeds that through to E.L.T. (Executive Leadership Team) and the Council of Ministers.

The Connétable of St. Peter:

Were you involved in the decision to locate the new hospital at Overdale? Were you asked about that?

Group Managing Director, Health and Community Services:

Yes.

The Connétable of St. Peter:

Yes, okay. Which group within your department is primarily involved in the management of H.C.S. property and what is their relationship to the Corporate Asset Management Board, Jersey Property Holdings, I.H.E. and other organisations beyond the department?

Group Managing Director, Health and Community Services:

Sorry, I did not catch the beginning of the question.

The Connétable of St. Peter:

Right, okay. Which group within your department is primarily involved in the management of H.C.S. property?

Group Managing Director, Health and Community Services:

We have our own estates and facilities service and it is part of our non-clinical support services care group. So head of estates and head of facilities report directly through to me and they are the direct interface with I.H.E. and Jersey Property Holdings as we are the client and in nearly all cases we are the tenant effectively. So we feed into both I.H.E. and J.P.H. (Jersey Property Holdings) in terms of our requirements. We provide our own reactive support for our estate with that team but when it comes to planning and changes required within the estate we feed through as the customer - as I would describe - through to those 2 other bodies.

The Connétable of St. Peter:

Why is Jersey Property Holdings not responsible for maintenance and management of your buildings? Is there a reason for that, that you are not within that central organisation?

Group Managing Director, Health and Community Services:

I would say we work closely with that organisation, so we do work jointly with them. Our estates team work with them every single day. My understanding is that within I.H.E. and J.P.H. there are Target Operating Model changes and considerations being reviewed at this moment.

Deputy I. Gardiner:

Just a minute, the question was why you are not part of it?

Group Managing Director, Health and Community Services:

I would say we are part of that.

Deputy I. Gardiner:

Have you transferred your assets to Jersey Property Holdings?

Group Managing Director, Health and Community Services:

Jersey Property Holdings have the assets.

Deputy I. Gardiner:

No, I mean are they in their maintenance list? Why are they not on their maintenance list?

Group Managing Director, Health and Community Services:

So they are but we provide what I would describe as stepping in where we are able to to support.

The Connétable of St. Peter:

Yes, but you have your own maintenance area, do you not?

Group Managing Director, Health and Community Services:

Yes.

The Connétable of St. Peter:

Outside of Jersey Property Holdings?

Group Managing Director, Health and Community Services:

Yes, we do.

The Connétable of St. Peter:

Yes. I suppose that is the question: why is that? Why is the hospital model different to the majority of other properties?

Group Managing Director, Health and Community Services:

I think it has been historically set up in that way and obviously we are reviewing that in light of the new hospital. What I would say is that the reactiveness and the ability to deploy quick change in an emergency situation within the Health estate is very different to the wider government estate. So the roof coming off the hospital, the leaks that we have, require onsite maintenance and they require health expertise. That, at the moment, has been held within Health for a long period of time. There are options to integrate that into a one government approach but at the moment that expertise does not sit within that other portfolio, it sits with H.C.S. and that is what is under review with our colleagues.

Deputy I. Gardiner:

Just to confirm, there are currently no plans in place to integrate into the OneGov estate management?

Group Managing Director, Health and Community Services:

We are exploring plans about how we …

Deputy I. Gardiner:

You are exploring, okay.

Group Managing Director, Health and Community Services:

Yes. So we are working with partners to understand do we require the bespoke health element, things that we would retain, or could this all be undertaken in a different way.

Director General, Health and Community Services:

I was at a meeting this morning about this with Andy Scate and there was a list of the various properties, and what we agreed out of that meeting was that we would now start working towards which estate could be transferred safely, but the hospital was not part of that. I am not sure the hospital ever will be for all of the reasons Rob said, because of that responsiveness and because of that specific expertise that is needed to service the technology and the machinery within the hospital. All that could change within the next 5 years but currently that is what is being mooted.

The Connétable of St. Peter:

What progress has there been regarding the Liberate disability access surveys within H.C.S.? What changes have been identified and have bids to fund areas of improvement been prepared?

Group Managing Director, Health and Community Services:

That is quite challenging for us, I would say, particularly within the general hospital. We are actively looking at the Gwyneth Huelin area, particularly for disability access to be improved. We are also looking at the Peter Crill side of the building to see whether or not we could do something different there as well. To be able to support people with disability needs in terms of access at the hospital, we have had to physically put in place a worker who is able to direct people to be able to get into a close entrance area in order to drop off people conveniently. That is the nature of how manual it is for us to show that support, those challenges in a very old estate.

The Connétable of St. Martin:

I just wanted to ask one more question relating to estate management. Richard mentioned Overdale and I have a very specific question which is about Samarès Ward. Is that going to be mirrored in the new hospital for stroke patients? I know that there is much consternation about the closing of that ward for healthcare workers and patients and about the new way it is handled because it was such a fantastic service. I know because unfortunately I had relatives there but they did recover very well. It is not working so well now and people's recovery rates are so much slower. I just want to know if the Samarès Ward is going to be mirrored in the hospital?

Group Managing Director, Health and Community Services:

There will be inpatient stroke rehabilitation within … and general rehabilitation at a specialist level within the new facility. That has much better facilities because it will have better access to gyms and obviously have the core of all the professional team on site, so yes that model will be there.

Senator T.A. Vallois:

Can I just ask, from the maintenance point of view, you have this team in place that are reactive to what happens in any emergencies, but what proportion of your budget is spent in terms of your estate or do you have to go separately for extra money from other areas? So proportionally your budget for that maintenance team.

Group Managing Director, Health and Community Services:

I do not have the … it is significant.

Deputy I. Gardiner:

We will put that as a written question. It is important, I think, to really understand what the maintenance budget is but we can follow up if you do not have it.

Group Managing Director, Health and Community Services:
It is significant. You are talking £8.6 million but in total for maintenance in 2020 £7.89 million was our expenditure so it is increasing.

Director General, Health and Community Services:
That is significantly less than what it was in previous years, predominantly because of the pandemic and the work that we were not able to do, but we still had all of the challenges. Particularly winter is very difficult around the facility because you just have significant leaks everywhere, so it is very hard for us to deliver care there.

Deputy I. Gardiner:
Just a very quick question. Jersey Property Holdings have Concerto develop the programme. Is your estate under Concerto as well or do you use this programme for maintenance? Are you planning to use this programme? Have you heard about this programme?

Group Managing Director, Health and Community Services:
No.

Deputy I. Gardiner:
Did I pronounce it correctly, Concerto? I am just checking whether you are aware of this programme and if you work with this programme for maintenance management.

Director General, Health and Community Services:
I am sorry, we are not.

Group Managing Director, Health and Community Services:
I have a feeling that my head of estates probably would have knowledge of it because I have heard that terminology.

Deputy I. Gardiner:
Okay, just checking.

Director General, Health and Community Services:
I thought it was an estates technical term.

Group Managing Director, Health and Community Services:
No, it is to do with requisition.

Director General, Health and Community Services:
Is it?

Group Managing Director, Health and Community Services:
Yes.

Mr. A. Lane:
If we can return to the topic of some of the pandemic response, you talked at the very start of this hearing about the removal of elective services as one of your key issues in response. When you make the decision what impact assessment did you make of how that would affect people generally?

Director General, Health and Community Services:
Our response was led by our associate medical directors, so the response from the beginning of the first wave was led by clinicians and those decisions were made by the clinical leaders within each care group. Those risk assessments … I am not sure we did impact assessments but we did risk assessments around measuring the risk. They were done as part of the individual care group leads, taken through the hub which was led by the associate medical directors and fed through to the executive team, which was the medical director, chief nurse and group managing director, with a recommendation through then to Gold which was chaired by me. As I say, we have learnt. We came out of the second wave quicker and faster, even though it was harder for us, and we learnt in the first wave that we had to continue elective activity in the second wave. Perhaps not strong enough impact assessments but I think it hit us quick and we learnt.

Mr. A. Lane:
Did you set any tolerances or red lines in terms of how waiting lists would be impacted?

Director General, Health and Community Services:
Emergencies had to be seen, cancers had to be seen and we still maintained our weekly and monthly overview of our waiting list so that we could see hot spots, so that we could do harm assessments around patients who may look like they may be a potential issue.

Mr. A. Lane:
Did you set the parameters as to what drives those hot spot reviews or were they just judgmental?

Director General, Health and Community Services:

Clinically led. All of our waiting list review management is clinically led. So what we do is we try to understand … you can be badged as urgent or emergency, routine, soon and we do regular reviews and ask our clinicians to review those categories because people can move between those. You could be routine and suddenly become urgent, so it is about having an ongoing dialogue with clinicians around the clinical priority.

Mr. A. Lane:

Okay, and you now have said the second time round you have continued with more elective services because that felt like it was the right thing to do. How did you make the assessment it was the right thing to continue this time around?

Director General, Health and Community Services:

I think it was our learning from the first time, from understanding the growth in our waiting list, recognising the reduction in presentations and how perhaps by us not offering elective service we were not encouraging that but contributing to people not presenting at G.P. services, not presenting at our front door, because if nothing is going to happen you are going to think: "Why would I present?" I think that we also learnt about … it is all part of the round around supporting our staff. I think one of the things we did in the first wave, if you were in secondary care you just respond and you make an assumption around the professionals around you that they respond. In the second wave I think we had recognised we needed to wrap a lot more support around our staff to enable them to do even more. I do not know if you wanted to add that, I think the whole waiting list management process has been very much wrapped around not just the outcomes for our patients but the outcomes for our staff and the well-being of our staff.

[16:00]

Group Managing Director, Health and Community Services:

We could see very clearly from wave 1 the lag effect of people not accessing healthcare, presenting then when they are in a worse condition. The lag we had in referrals then led to a big balloon of waiting list activity, which proved really problematic for us. We could just see that if we continued with that in wave 2 it would be similar to what the U.K. is and our waiting list would have doubled. We would really have difficulty to recover. We are confident, when we looked at the activity, that on the balance of harm the impact of not progressing some of these life-limiting conditions potentially and not treating people could be much more harmful than the impact of COVID. We made the decision across specialities that we would need to continue. In mental health particularly we realised that we had to … it was inconceivable that we would suspend something like the Jersey Talking Therapy waiting list, which we did in the first wave, and our learning was that was really detrimental, we had to sustain that service, and that is how our planning changed.

Director General, Health and Community Services:
We learnt more about the disease and its transmission. It did come as a disease with lots of unknowns but in the first wave we learnt much more about how to utilise P.P.E., much more about transmission, so we were able to make more bold decisions around elective activity, and also we learnt how to manage our theatres differently and to do our hot and cold flows, which is challenging within the general but we managed to do it.

Mr. A. Lane:
You have used the phrase "balance of harms", is it the same, Director General, as the clinically-led assessment that you …

Director General, Health and Community Services:
It is the harm reviews, yes. Harm reviews.

Mr. A. Lane:
Okay. So as we stand today, do you have a clear view of waiting lists, both across your own state and the community-based services that you rely on? The third party prevent stuff.

Director General, Health and Community Services:
Absolutely, and I welcome you to go online and see our waiting lists which are published, and which are accurate, transparent waiting lists for our patients, which we have been doing since July 2020. So everyone can see those waiting lists. As regards community partners, services that we commission, yes, but not necessarily all services that we work with. Again, that is about us building that partnership working, it is about trust. Because not everyone would want to share that information with us. Again, without wishing to sound like I am banging on about it, that is our aspiration around the partnership board and the model so that we start to build trust in relationships and share information.

Mr. A. Lane:
So you may start to gather that information in the future?

Group Managing Director, Health and Community Services:
Yes, we do get … just to add to that, one of the benefits is that we now get a more accurate position of community capacity. So the number of residential nursing care home beds that are available, the number of hours that are available by domiciliary care or reablement services in commission partners, because of the pandemic we needed that information to understand the system resilience.

We now have that on a weekly basis and that helps massively from our system resilience and understanding operational pressure management.

Director General, Health and Community Services:
But that was an urgent response, because before that we had not had that and we would not necessarily have had that easy transfer of information. We were responsible for that. We are a big monolithic organisation and some smaller organisations would perhaps not tell us about their capacity because of fears around how we might utilise it or how we may choose to commission it competitively for our benefit rather than theirs. It is all really understandable but the pandemic erased all that and has enabled us to start building some of that trust with organisations.

Mr. A. Lane:
Can you outline for us now the action you are taking to bring waiting lists back to normality?

Group Managing Director, Health and Community Services:
Yes, so we have identified across all of our specialities a recovery plan. So we undertake waiting list assessment with a patient tracking list, which is live. So it tells us how long patients have been waiting and our main focus has been on those people who have been waiting over 90 days. For those people we have undertaken a harm review to make sure that they are scheduled to have treatment as early as possible, whatever specialty that would be, and that has formed part of our capacity plan so we are having to adjust our theatre capacity. We are still having difficulty with an outpatients perspective because at the moment we are having to adhere to continued social distancing and P.P.E. and some of those public health measures do not always optimise your productive healthcare system. But generally across all the specialties we are now enacting our COVID recovery plan. We are doing the same in mental health to get through our waiting list for Jersey Talking Therapies.

Mr. A. Lane:
Do you have an expectation as to when normality is achieved?

Group Managing Director, Health and Community Services:
That is quite difficult.

Director General, Health and Community Services:
In our conversations we have set ourselves trajectories and milestones. The group managing director has an objective to deliver it by the end of the year. I will be holding him to account on that. Again, we have to take into account winter, the challenges that winter may bring, particularly from what we are seeing in other jurisdictions around the flu. Because we have not had it for 18 months

it looks like it is going to be very prevalent within the community so we need to understand the impact it will have on our bed base. But our aspiration is to return to pre-pandemic waiting lists by the close of 2021.

Group Managing Director, Health and Community Services:
We are on a trajectory to do that.

Mr. A. Lane:
Does that also include things like cancer screening?

Director General, Health and Community Services:
Yes, absolutely.

Group Managing Director, Health and Community Services:
Yes.

Mr. A. Lane:
At the start of the hearing you mentioned one of your bids for funding and we asked you about the total funding. We managed to not avoid the answer but miss the answer somewhere.

Director General, Health and Community Services:
I think we can get that from Michelle. Michelle, what is the total we asked for the COVID business plan, please? I cannot remember it. Are you there, Michelle? Can we come back to you, but 3.6 does seem familiar.

Group Managing Director, Health and Community Services:
Yes, I believe it is around 3.5 million.

Mr. A. Lane:
Are there any other challenges that pertain to the continuity of provision of primary and community care services?

Director General, Health and Community Services:
So community services, I think that we are making strides around how we start talking differently in that relationship about how we deliver care. We have recently started to deliver 24-hour community nursing, night nursing in effect, and that is the first time that has happened in Jersey. That is directly out of the work that Anuschka's team has been leading around the care model. There is a lot of conversations to be had with community providers and a lot of trust, as I think I have alluded to, to

be built up. There is an ongoing challenge around that and around developing those relationships that we hope to be developed by the partnership board. There is an awful lot about money because we are the holders of all the money, so we are the holders of all the power. People have to come to us … historically have come to us as supplicants and that is not the way to deliver great care for any health economy. Our aspiration 5 years from now is to be sat around a partnership board, all the money is in the middle of the table and we have Island-wide determinants about how we spend that money. But we have to get to that and we have a lot of relationship building to do that. I include primary care in that. We are very different business models but we all want the same thing, which is right care for patients in the right place. I think we are making great strides with our primary care colleagues around talking. We have our ups and downs but I think we are moving to a position where we need to be, where we are working together. As I always say, primary care delivers the majority of care on this Island, not us, but they are quite voiceless and the power sits with us. Their voice is not perhaps as powerful as us because we sit within Government and we hold the budget, but we do not want to be in that position, we want to be in a collaborative health economy where money is allocated according to the needs of patients and their outcomes and we are a part of that. We want to be a really fantastic secondary care, mental health and social care provider.

Mr. A. Lane:
Can we turn to the Nightingale hospital? When it was decided to build that there was a lack of clarity about how it would be staffed. How was it we ended up in that position?

Director General, Health and Community Services:
Do you want to talk about the staffing model for the Nightingale?

Group Managing Director, Health and Community Services:
I can, yes. I would describe it as definitely a dynamic situation and it had a dynamic staffing model. So we undertook training and assessment of the key workforce that we would identify to go to the Nightingale. That revolved mainly around our emergency assessment unit staff, so there were key positions, key nursing staff who we trained. We developed a COVID passport for the Nightingale so that everybody knew what they would need to do in the facility and we had to train people to support non-invasive ventilation patients effectively. We had that training in place but I think we recognised, given the impact that we had from contract tracing alone, staffing would become challenging and the U.K. experienced the same thing. Supporting the Nightingale from a module perspective, so for 30 beds, maybe 60 beds or maybe 90 beds, would be something that we could quite easily plan for; supporting the Nightingale for 180 beds would require the whole system workforce to be used in a different way. We had looked at that but our approach is very modular in that had we built … and for the initial capacity that might be required, we had planned for that, so

we trained staff, we developed a shadow workforce, shadow rota, we had plans if we needed to use the facility.

Mr. A. Lane:
The initial capacity was? You mentioned a number of bed numbers?

Group Managing Director, Health and Community Services:
So up to 28 initially was what we would assume we might need to go to. Obviously, the modelling changed because as the treatment of COVID changed, with dexamethasone, with patients who did or did not require non-invasive ventilation for it, that meant that the use of a Nightingale changed. Even in wave 2 where we had more patients with COVID in hospital, their primary health need was not necessarily COVID so they would not have been suitable for the Nightingale facility. I think it is similar to what the UK did.

Director General, Health and Community Services:
I also think … and I would ask esteemed colleagues to just reflect on the environment that we were in. We were basing our assumptions upon the imperial modelling, which was being used internationally, which was a worst-case scenario.

Mr. A. Lane:
This is the reasonable worst case?

Director General, Health and Community Services:
Yes, and we were in an environment where primary care was saying to us we are going to go out of business, we need you to help us or else we are not in a position to deliver primary care. Other providers around us were shutting and we were on the Island … our own staff were really scared, a lot of our staff went off work because they were scared, understandably, for their families and we do not have a hospital down the road to support us, and we wanted to still do emergency and cancer work, so we made the decision around the Nightingale and if push had come to shove and we had to staff those 180 beds, Rob, who is a nurse, would have had to put his uniform on and staff those beds, as would all our nurses in management positions. We would have asked them to do that. We would have staffed those beds but did we have a concrete plan for staffing all 180? No, we did not but I absolutely do not regret the decision-making around the Nightingale because if the modelling had been right, if we had not had those early interventions, particularly around medication and how we treated patients in I.T.U. (Intensive Treatment Unit) then we would have needed those beds.

Mr. A. Lane:

From the answer it is almost as much about creating a separation from the general hospital as there was about creating additional bed capacity?

Director General, Health and Community Services:
Absolutely, it was around infection control but a bit like the elective work, we learnt as the disease progressed around infection control and how we could work simultaneously with dirty and clean. We learnt how we could do that differently, but at the beginning of the pandemic we were in a situation of very little knowledge and a significant amount of public panic and other provider concern.

Mr. A. Lane:
Given those massive uncertainties upfront - I am not sure how you would do this - what have you learnt about how to manage the assessment of needs for that sort of decision and the timing with which you commit to things?

Director General, Health and Community Services:
It was not just that we had to build the Nightingale, we looked at accessing 600 … was it 600 beds that we identified across the Island? We identified 600 beds across the Island that we could move patients to. But then the reality of that when we started looking at it was a lot of patients in those beds, that was their home, they had lived there for years and years, it was not as simple as … there were a few patients that had only been there short term but most of those beds were people's homes and we were just going to move them and put patients in there. It was also going to present us with a real staffing issue around multiple sites to staff. So the conclusion was that we had one site. Going forward, I do not think I can answer you. I think I need to go away and think of that as a team, about how we could have thought differently within that environment presented with a disease that we had little knowledge of.

[16:15]

But we have definitely learnt about the Nightingale, we have learnt about thinking differently about what we would build in future and how we would perhaps start more modular in our aspiration, but at the time it felt like we were going to have significant mortality in Jersey looking at the modelling so we needed to provision care.

Director of Improvement and Innovation, Health and Community Services:
Just in addition to that, at the beginning there was no test and tracing programme, which was really the mitigation to making sure the cases were not going up. Then the different restrictions were put in place. If we had another disease which would act completely differently, would not act like COVID but would also be very transmittable, we would probably be in the same position as going through

all the different models, going through the options, what is possible and how to mitigate any severe impact. The pictures people had in front of them were from Italy, nobody wanted to have that here, that people were dying in front of the hospital or in the corridor. We just need to remember at that time we did not know anything and we went through the models 100 times looking at if we reduce it by half a per cent or put it up by half a per cent we have the worst case, best case. However you looked at it, it was clear under the current circumstances there would be a demand for additional beds. The political decision was either afterwards you will be in the fire: "You have not needed the Nightingale, why did you spend that money?" or if you had not built it, you would have needed it and: "Why did you not build it?" whatever decision was made. So I think we need to see that in that context.

Director General, Health and Community Services:
But we do need to tabletop the whole of this pandemic and we have talked about that. Because I have done pandemic planning for 30 years and 50 per cent of it was useful in this situation. It has been an awful tragedy but it has also been a phenomenal learning for health economies, I think.

Group Managing Director, Health and Community Services:
Definitely.

Mr. P. van Bodegom:
The C. & A.G. found that the Government worked with third party organisations to fill gaps and overcome weaknesses in the wider healthcare system during the pandemic. What were the key gaps and weaknesses that had to be overcome?

Director General, Health and Community Services:
So it was predominantly around P.P.E. was a significant challenge, which we had to respond to quickly. I have already alluded to we were used to managing P.P.E. but not at the level that we were suddenly required to do that. Thankfully for us, J.H.A. colleagues stepped in and so did military colleagues and absolutely sorted that for us. Business continuity planning was not where we expected it to be within other organisations, and resilience. Resilience around continued service delivery and how that could look was a challenge. We had multiple organisations just stopping delivering care. We had the G.P.s come to us and ask for help and say they could no longer continue because primary care was going to come to an end because they were not going to be able to service their surgeries. They were going to be fiscally traumatised because of the reduction in footfall. So I think we had made some assumptions that did not take that into account.

Mr. P. van Bodegom:

Thank you. So what plans are you putting in place to mitigate these risks for the future, if crisis arises again?

Director General, Health and Community Services:
So again I think it is about the continued conversations that we are having with the care sector weekly. It is about the continued monthly conversations that we have with the primary care body. It is about us moving towards a different way of delivering care, a more integrated health economy. We are a small Island; we should be really fantastic at this. We should be sharing our government resource across the whole of the community in order to deliver care. That is what we want the care model to do. Call it by whatever name you wish, it is an integrated model, which involves utilising resource to improve outcomes. That is what we would like to do going forward. I hope that when we start the first partnership board meeting in September that will be at the top of the agenda. A bit of a show and tell: "This is what we have in our toolbox. What is it that you need to help us to get to where we need to get to?"

Mr. P. van Bodegom:
What is the one thing that you would do differently next time to balance or address COVID risk with other lack-of-service risks?

Director General, Health and Community Services:
We have learned around the elective work, so next time I would not be as quick to stop elective work. I think we made the right decision because we did not understand the disease. But we have learned so much around P.P.E. utilisation, around infection control procedures, around how we can split our activity and work differently, that I would perhaps not make that decision as quickly. I do not know.

Group Managing Director, Health and Community Services:
Yes, I agree. I think it would be the judgment about what you stop doing to prepare for something that you might have, when you know you have an element of risk. In health you always have people who are unwell who need treatment and care. I agree with you, I think if we were in that position we would really have to scrutinise any kind of cease in that kind of activity.

Director General, Health and Community Services:
Because we have had people coming in who were really unwell and have really suffered. They are self-medicating and just holding it in.

Director of Improvement and Innovation, Health and Community Services:

That is basically what you did after the first wave, everything was stopped and that line was already applied in December when the second wave, we have not stopped that much.

Mr. P. van Bodegom:

We have mentioned G.P.s already. What were the challenges to the resilience and sustainability of the G.P. services that came to light during the COVID-19 pandemic and resulted in the decision to employ G.P.s for a period of time?

Director General, Health and Community Services:

So the G.P.s came to us and asked for help. They said that they were fiscally challenged, that G.P. practices were going to close. Their demographic was going to be particularly challenged. We have G.P.s who are elderly on the Island and who were in that vulnerable group. They felt that there was going to be a significant challenge to the continued delivery of primary care on the Island. So they asked the Government to help with that and that is how we came to have the G.P. contracts. Again, it was a great opportunity for us to work together with primary care in situ within our estate. Again, it was not all roses, but we learned a lot from each other and I think it has contributed to our greater relationship going forward. They probably would not want to do it again, because doing it in a pandemic is not the greatest way to do it. We would probably do it differently next time. But together we delivered a lot. That tent on that front of the hospital, which I know looked shabby, but that tent, what we delivered through there and the volume of patients that we saw was significant. We did that because the G.P.s worked alongside us and they know their patients and they will take bolder decisions than perhaps we will because they know the people that they are serving.

Deputy I. Gardiner:

Thank you very much for your answers because, as you are probably aware, we will have a COVID review based on all signature reports later on this year and we will welcome you again to reflect. Because I am sure there will be other reflections through the year. We are still going. So what I would like to do now, I would like to check with the Committee if, around performance or estate management, if any follow-up questions that were raised or have not been asked. Because these are reviews that we are going forward and finalising now. If there are any more follow-up questions?

Mr. P. van Bodegom:

Rob, you mentioned that the current maintenance is £7.8 million per annum?

Group Managing Director, Health and Community Services:

No, that was the 2020 figure. It is £7.89 million. So pre-pandemic it was £12 million and I think that 2021 is a similar figure to 2020. Obviously, we are not at the end of the year yet, but we have had again significant disruption to the capital programme, again because of COVID, effectively.

Mr. P. van Bodegom:

The range of work, it is not just your roof that is leaking that is costing that amount of money, it is everything, is it not, your M. & E. (mechanical and electrical) throughout the building?

Group Managing Director, Health and Community Services:

It is huge. So we always have ward-based refurbishment as required. We have day surgery that required ventilation change. We obviously have the huge capital programme, including Pinel and Orchard House. La Chasse has been opened. We have had to move our drug and alcohol services to Maison Le Pape. There are too many to mention. It is continuous estate change.

The Connétable of St. Martin:

I was just going to go on about Samarès Ward again and just ask: are the clinicians involved in the decision to move their work to the community as it is at the moment?

Group Managing Director, Health and Community Services:

Yes, they have been involved and I think it is really important to note that the hospital part of the rehabilitation requirement in Samarès is still taking place. If somebody needs in-patient physiotherapy or occupational therapy and hospital-based rehabilitation support, that is now happening within the general hospital. I do accept that Samarès was a particularly good facility. In terms of the clinician support around the pathway, that has had to be adjusted. So our physios, for example, are now having to work across the community and the in-patient services and our O.T.s (occupational therapists). We are having to adjust that way of working. We want to continue to focus on that model to really understand the outcomes because it is quite early and it is pandemic impacted still because we are still seeing low numbers of people presenting with stroke. So that work, I would say, is very much ongoing. In terms of the new hospital, we would still have an element of in-patient rehab. But we would expect much more community out-of-hospital rehabilitation to be in place as well. That is really good for stroke pathway.

Director General, Health and Community Services:

Samarès is a beautiful facility. When I arrived on Island and saw Samarès I thought: "Wow, an ostensibly beautiful facility." But when we started to look at Samarès, because there is no Machiavellian plan around rehabilitation and it was as part of the care model work, and we started to look at the outcomes of the patients, it was not necessarily the right place for all patients to be. We had patients in there that were there up to a year. When we started to look at the outcomes, what it started to demonstrate was that, instead of you walking up and down the stairs outside Samarès, it would be better to have someone walking you up and down the stairs in your own house or you putting the kettle on in your own kitchen, not doing it on Samarès Ward. Absolutely there is

a need for rehabilitation and what we are trying to do is bring that rehabilitation closer to home. But, as the Deputy challenged me in scrutiny, it seems like for some patients that is incurring cost that they would not have had when Samarès was open. So that is the work that we are doing because that is not our intention and we do not want people not to have rehabilitation because it costs too much. Because the whole point of the care model is what you get now for free you will get for free but just within a different setting. But if you have a stroke or if you have a neurological presentation, there are beds in the general to address your presentation. But rehab, we are trying to move it into people's homes and into the community. But we are absolutely not stuck on that. If Jersey rises up and says: "That is not the care that we want on this Island", of course we will hear that, of course we will. But we are not anti-Samarès, we are just trying to look at how we can be more personal in how we deliver care.

Deputy I. Gardiner:

As long as we really put right the funding because currently, as it is revealed in the community, and we are getting now some evidences that the cost to the patient or to the patient family increased.

Director General, Health and Community Services:

We need to know that. This is never going to be perfect in its delivery and we need to know that. We have a case that we are dealing with at the moment.

Group Managing Director, Health and Community Services:

Yes, we have a number of cases and in the model we are looking at how we ensure that you continue to have that in-between hospital support, which is free at the point of access. But that cannot be free at the point of access for ever in that hospital environment. There has to be a pathway that goes to another position. If we find that people are now incurring costs because they are not going to that end destination of a placement in the same way as previously, then we would look to redress that. But that is the work that we are undertaking at the moment.

[16:30]

Senator T.A. Vallois:

Just lastly, in terms of commissioning, your department does a great deal of commissioning. We have had D.G. (director general) of C.Y.P.E.S. in who talked a lot about commissioning. In terms of performance, service performance and delivery of services, how do you manage that commissioning and ensuring it is the right provider? But also how do you work that across the likes of C.Y.P.E.S., your expertise, your knowledge, and of course they provide C.A.M.H.S., children's services, it used to be in health, but similar I would imagine type of commissioning treatment. So just to understand from that point of view how that is managed?

Director of Improvement and Innovation, Health and Community Services:

So just to update, it is a very good point, we are aware that the commissioning process is not ideal at the moment and it is probably not a proper commissioning process. It is more probably a contracting process. So as part of the Jersey Care Model a commissioning strategy has been developed. So that is currently under way and has been started internally across departments, C.L.S., C.Y.P.E.S. particularly, and H.C.S., to understand how do we commission for outcomes? What are the key strategies and the key objectives for that? It is now in a phase where also external providers are being part of it, so we want to hear their voice, what do they see as the key advantages of having a commissioning strategy. Everyone is quite keen to get to that place because then we commission for outcomes that we then measure with a certain set of performance metrics. It is clear that it is not just: "Here is some money and you deliver services." It is just a bit of how we know that, but it is for outcomes for people. Service providers can join up together so we can do that together but we are evidencing that with the right outcomes. So that commissioning strategy is the first step to have that joined-up approach. There is a commissioning working group, which is cross-departmental.

Director General, Health and Community Services:

But I think around the children I remember being in a meeting with you where you said children do not understand contracts. That is so around how we are trying to get to a point, it is about where we have got to mental health, such a good place for advocacy, and the advocacy services, and it is about getting to that whole concept with children about children know what they need in order to be able to deliver. It is about us supporting that more than us being very mandatory around we are going to do this, we are going to do that, we are going to set these parameters. That is the ongoing conversations that we need to have with C.Y.P.E.S. around it just being much more therapeutic.

Deputy I. Gardiner:

Two questions from me there to tidy up, the first one because we are doing the estate management review and the Corporate Asset Management Board has an expectation that each department will submit their requirements for the property, for the estate that they will need in the next 5, 10 years. As we are developing Jersey Care Model, have you had time to submit your requirements for the property, for the estate that you will require in the next 5, 10 years for the Jersey Care Model? Have you had a chance to submit? If yes, well, perhaps you will get a list of your requirements. If not, when will the detailed requirements be submitted to the Corporate Asset Management Board?

Director General, Health and Community Services:

Excuse me, I am just looking at what our estates manager has said. We are working with I.H.E. and the hospital delivery team to cover proposals around the current estate issues. The 5 to 10-year

plan has been developed around what estate will be required, or not, due to the changes in the model of care and the impending hospital. So I think we recognise that when we move to the hospital ...

Deputy I. Gardiner:
No, the question was simple: have you submitted the list of your requirements to the Corporate Asset Management Board?

Director General, Health and Community Services:
I do not know the answer to that.

Group Managing Director, Health and Community Services:
We have for H.C.S. but your question was have you done it for the Jersey Care Model and ...

Deputy I. Gardiner:
In mind, I mean on top of it. Obviously the Jersey Care Model will require some infrastructure within communities, some sort of infrastructure.

Group Managing Director, Health and Community Services:
So that has not been identified at this point but we have submitted our requirements from an H.C.S. perspective to C.A.M.

Deputy I. Gardiner:
When do you think you will be able to submit requirements, which will regard Jersey Care Model infrastructure, to the Corporate Asset Management Board? I mean approximately, I am not ... just when do you think the plans for infrastructure requirements will come across to the Corporate Asset Management Board?

Director of Improvement and Innovation, Health and Community Services:
We would need to check that.

Deputy I. Gardiner:
Okay, no problem. Yes, absolutely. I really appreciate that you told us ...

Director General, Health and Community Services:
I think it is more about infrastructure investment in other partners. It is a bit like we talked the other day. So we are not having hubs definitely. Some of the conversations we are having with primary

care is around how we would pump prime infrastructure within primary care or within other partners. But you are right, we do need to think through additional estate or repurposing our estate.

Deputy I. Gardiner:

Or even with the primary, for example, the G.P. practices, I agree that they can be the right type of the centre. But again would the G.P. practice that exists have enough infrastructure or would need another bigger premises for G.P. practices to be able to do blood tests, for example, to be blood centres? So I do not know. But the only thing that I am ... because we are looking ... the Corporate Asset Management Board came back to us and say: "If departments did not submit their requirements, we cannot accommodate what they need and we cannot plan." So to work together we need the submissions and this is what I am asking, when. It is absolutely fine if you will get back to us.

Director General, Health and Community Services:

Yes, can we? Can we go away and have a conversation about ...?

Deputy I. Gardiner:

Yes, absolutely.

Director of Improvement and Innovation, Health and Community Services:

We are currently developing the pathway so that comes as the first bit. So what are the clinical pathways; for example, long-term conditions. Then based on that it is clearer what goes into the community, how the partners are contributing, what are our contributions. So it is almost, yes, it is difficult to say that now, some work needs to be done to then say this is what is there and what is required in addition.

Deputy I. Gardiner:

Absolutely. The last quick question: we talked about risk and we talked about the challenges that you are having. If you are looking at the estate of health, what are 3, 5 ... if you said the urgent attention for the public ... if I would go to the public and say these are the areas, I think that you mentioned dental. What are other areas, 3, 5 top areas that need urgent attention and maybe extra funding for the health, health-related?

Director General, Health and Community Services:

I think it is our estates. I think our biggest challenge is around our estate and our ...

Deputy I. Gardiner:

No, I mean the delivery, the services to the ...

Director General, Health and Community Services:
Oh, sorry, services. I think it is our task-and-finish areas that we are doing, which is women's and children's, theatres, dental and radiology.

Deputy I. Gardiner:
Women's and children's, theatres, dental and radiology, these are the areas that require urgent attention?

Director General, Health and Community Services:
Yes.

Group Managing Director, Health and Community Services:
Child and adolescent mental health as well, joint work with C.Y.P.E.S. around child and adolescent mental health, that is a pandemic issue.

Director General, Health and Community Services:
I am not sure urgent attention is the right word but just thinking about for the public, because we have clearly defined task-and-finish plans that we could share with you around the actions that we are taking, all led by an executive director - I am leading the theatres one - around the improvement plan we have in place in order to be able to deliver what we need to deliver. But what we do need is support. We need absolute support and recognition that we are trying to deliver health and that we need time and space to do that. The care model and the hospital are really important, but we are trying to deliver care every day for Islanders.

Deputy I. Gardiner:
But you need to deliver care every day, this is what is important, exactly. Okay. Thank you very much for your time. The public hearing is closed.

[16:38]