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Public Accounts Committee

Public Hearing

Witness: Director General of Health and Community Services

Thursday, 10th March 2022

Panel:

Deputy I. Gardiner of St. Helier (Chair)

Connétable K. Shenton-Stone of St. Martin (Vice-Chair)

Connétable A. Jehan of St. John

Senator T.A. Vallois

Mr. A. Lane

Ms. H. Miles

Mr. G. Phipps

Mr. P. van Bodegom

Ms. L. Pamment, Comptroller and Auditor General

Witnesses:

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

Dr. I. Muscat, Deputy Medical Officer of Health

Mr. P. Armstrong, Medical Director, Health and Community Services

Ms. M. Roach, Head of Finance, Health and Community Services

Ms. A. Muller, Director, Improvements and Innovation

Ms. J. Poynter, Associate Director, Improvements and Innovation

Ms. R. Naylor, Chief Nurse

Mr. A. Noon, Medical Director, Primary Care

Ms. C. Power, Director, Culture, Engagement and Well-Being

Ms. C. Thompson, Deputy Chief Nurse

Mr. S. Chapman, Associate Medical Director of the Surgical Services Care Group

[14:05]

Connétable K. Shenton-Stone of St. Martin (Vice-Chair):

Thank you very much for coming this afternoon. Welcome to this public hearing with the Director General of Health and Community Services for our review of the COVID-19 response. We will be asking questions about the management of Health and Community Services during the pandemic and not about the specific public health measures introduced at that time. I will just go around the table so that we can introduce ourselves. I am Karen Shenton-Stone, Constable of St. Martin, and Vice-Chair of the P.A.C. (Public Accounts Committee).

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

Deputy Inna Gardiner, St. Helier, Chair of the Public Accounts Committee.

Senator T.A. Vallois:

Senator Tracey Vallois, member of the Public Accounts Committee.

Comptroller and Auditor General:

Lynn Pamment, Comptroller and Auditor General.

Connétable A. Jehan of St. John:

Andy Jehan, Constable of St. John and member of the committee.

Ms. H. Miles:

Helen Miles, independent member of the P.A.C.

Mr. P. van Bodegom:

Paul van Bodegom, independent member of the P.A.C.

Mr. A. Lane:

Andrew Lane, independent member of the P.A.C.

Director General, Health and Community Services:

Caroline Landon, Director General, Health and Community Services.

Deputy Medical Officer of Health:

Ivan Muscat, Deputy M.O.H. (Medical Officer of Health) and D.I.P.C. (Director of Infection Prevention and Control).

Chief Nurse:
Rose Naylor, Chief Nurse.

Medical Director, Health and Community Services:
Patrick Armstrong, Medical Director.

Associate Medical Director of the Surgical Services Care Group:
Simon Chapman, I am an A. & E. (Accident and Emergency) consultant and also the Associate Medical Director of the Surgical Services Care Group.

The Connétable of St. Martin:
Thank you. We will start with departmental responsibilities. Sorry, could you all introduce yourselves online, please?

Director, Improvements and Innovation:
Anuschka Muller, Director of Improvements and Innovation. Can I just say before we go around the table, we have great difficulties here at this end to hear people who are not close to the mic. For those who are close to the mic if they could refrain from paper ruffling, it is very difficult to hear the Chair and the outside of table. Thank you.

Director, Culture, Engagement and Well-Being:
Cheryl Power, Director of Culture, Engagement and Well-Being.

Medical Director, Primary Care:
Adrian Noon, Medical Director for Primary Care.

Associate Director, Improvement and Innovation:
Jo Poynter, Associate Director for Improvement and Innovation.

Deputy Chief Nurse:
Claire Thompson, Deputy Chief Nurse at the time of the pandemic and Interim Director, Children's Services.

Head of Finance, Health and Community Services:
Michelle Roach, Head of Finance for Health and Community Services.

Director General, Health and Community Services:

And that is all from our side, thank you.

The Connétable of St. Martin:

Thank you very much. I will start with the first question, which is about departmental responsibilities. Please could you provide an overview of your work and responsibilities as Director General of Health and Community Services during the COVID-19 pandemic?

Director General, Health and Community Services:

So though the pandemic I was a member of the One Government COVID-19 Response Team and that was a team made up across government of Director Generals and various associated professionals. My role was to represent Health and to be involved in the decision-making around recommendations and advice that we would provision across government to other services around our response to the pandemic. I also had my role within Health and Community Services, which was to lead our response across Health, supported by clinical colleagues.

The Connétable of St. Martin:

Has your remit changed as D.G. (Director General) since the start of the pandemic?

Director General, Health and Community Services:

I think all of our roles have changed significantly since the start of the pandemic. We have all had to work in slightly different ways. As a Health Director General, I have worked much more closely with colleagues in departments that I would not necessarily always have worked as closely with in order to have a joint response to the pandemic. That has continued. I remain still part of the Senior Officers Group and I attend C.A.M. (Competent Authority Ministers).

The Connétable of St. Martin:

Were there any other new roles and responsibilities that you had to take on?

Director General, Health and Community Services:

No.

The Connétable of St. Martin:

How did you and other Director Generals assign responsibilities of workstream in response to the pandemic?

Director General, Health and Community Services:

That was done through the One Government COVID Response Team. We met on a weekly, sometimes twice-weekly, sometimes more than that, basis right at the beginning of the pandemic in

2020. There was a whole framework around the response, which was the T.C.G. (Tactical Command Group) then the S.R.G. (Strategic Response Group). Decision-making recommendations came up through that group to senior officers and senior officers collaboratively made the decisions around advice and recommendations that would be given to Ministers and duties that needed to be undertaken by officers.

Deputy I. Gardiner:
Just a quick question. Were the heads of the emergency services part of these meetings, did they join in some capacity or at some point?

Director General, Health and Community Services:
They were part of the meetings. So they were T.C.G., the tactical group had the heads of fire, police, and ambulance.

Deputy I. Gardiner:
How often did they meet?

Director General, Health and Community Services:
I think they met fortnightly. But you would need to clarify that with J.H.A. (Justice and Home Affairs) because it sat underneath that umbrella. So I did not attend that because I was not on that group. I was on the Strategic Command Group.

Deputy I. Gardiner:
So how is the Strategic Command Group connected to that group?

Director General, Health and Community Services:
There is the tactical group, which is the group that is doing the day-to-day work around identifying issues that are happening across the services. That feeds into the Strategic Command Group and you had one officer who led that, who was Kate Briden, who at the time was the Deputy Director General for J.H.A. The Strategic Command Group was the group that was led by Julian Blazeby and that was the group that made strategic recommendations around decisions that the operational group were wanting to make.

Deputy I. Gardiner:
Why were the heads of the emergency services not included in the strategic group?

Director General, Health and Community Services:

That is a question you probably need to take up with J.H.A. I am not responsible for setting up the groups. I was a member of those groups, so I cannot answer that question.

The Connétable of St. John:
Who represented Health on the tactical group?

Director General, Health and Community Services:
The tactical group was represented by I think Rob Sainsbury.

The Connétable of St. Martin:
You have said that you interacted with other departments over the course of the COVID-19 pandemic in ways that you probably would not have if there had not been the pandemic. So how did you assign and manage workstreams and policy enactments, was that just all through the groups that were set up?

Director General, Health and Community Services:
Yes.

The Connétable of St. Martin:
How were the responsibilities of each department being tracked and recorded?

Director General, Health and Community Services:
Within our own department, we had very clear lines of sight around our escalation and decision-making within that department. Across government it was a similar government structure where there was minutes-taking in each of the groups and decisions were tracked in that way through those minutes. I will pass on to Helen, thank you.

Ms. H. Miles:
We are keen to understand how you worked to minimise the siloing across your departments and with other non-governmental organisations.

Director General, Health and Community Services:
There was a multiagency response, which required cross-departmental working because various skillsets were across various different departments. The reduction in silo working was facilitated through S.C.G. and T.C.G. where that cross-departmental working took place. Where you had officers from all over government coming together. Then S.T.A.C. (Scientific and Technical Advisory Cell) further facilitated integrated working because again you had people from across government. Then there were lots of different sub-working streams, so for example the Nightingale, the test and

trace, there were sub-working schemes set up around all of that. So there were multiple opportunities for you to work with different colleagues from across government in order to impact upon decision-making.

Ms. H. Miles:
Did you have anybody from any non-governmental organisation sitting on T.C.G.?

Director General, Health and Community Services:
I am not the ideal person to ask on this and I did not sit on T.C.G. I think they may have done.

Ms. H. Miles:
How did you request and track secondments of staff to H.C.S. (Health and Community Services) and other departments during the pandemic?

[14:15]

Director General, Health and Community Services:
That was done through the central H.R. (Human Resources) team. The H.R.D. (Human Resources Department) for the Government of Jersey, everyone moved to slightly different roles and Mark co-ordinated a lot of the resilience, the day-to-day resilience response, Mark Grimley. So the tracking around the movement of staff happened at a local level because of course we needed to know where our staff were, but it was co-ordinated through a cell at the centre, which was led by Mark Grimley.

Ms. H. Miles:
Was that also the same for recruitment of temps from agencies or was that just for the internal movement of government staff?

Chief Nurse:
I can answer that. Within Health's operational response to what was happening, we had a bronze team that ran the day-to-day operational activity, which Simon was the lead clinician. But supporting that team we had a P.P.E. (personal protective equipment) cell, a workforce cell, an infection control cell. It was the workforce cell that managed the appointment of agency staff to Health posts. Whether that was within H.C.S. or whether that was to support the wider community as well.

Ms. H. Miles:
But you led that through Health and then pushed them out to Mark Grimley as was necessary to spread it out.

Chief Nurse:

Yes, there was a clear connectivity with Mark Grimley because there were support staff that we pulled in from other services. But we also had to manage a lot of that ourselves because we had retired nurses offer themselves to come back to work. We had, as you probably recall, a big recruitment of staff to come and support the Nightingale. So we managed that very much from a Health point of view because they were very specific clinical roles we were looking for.

Ms. H. Miles:

Thank you. Can you tell us your relationship with Public Health and the Public Health Policy Team within S.P.P.P. (Strategic Policy, Performance and Population)?

Director General, Health and Community Services:

We work very closely. Ivan straddles both of our teams. He is our D.I.P.C. Sorry, Director of Infection of Prevention and Control and he is also the Medical Officer of Health. So he straddles both of our teams, thankfully for us. So we worked hand in glove with Public Health. I do not know, Patrick, if you want to elaborate on your role as Chair of S.T.A.C.?

Medical Director, Health and Community Services:

I reported to Director General for S.P.P.P., Tom Walker, in that role. I would also mention that at the beginning of the pandemic the Public Health team was a very small team and it has been built up through that time. So the Public Health team we have now is far-removed from the Public Health team we had at the time.

Ms. H. Miles:

We had a really helpful hearing with the Public Health team, Professor Bradley joined us for that a couple of weeks ago. Has COVID-19 changed any of the interactions that you had? Has it built on them and made them more positive or are some of those relationships going to fall away now?

Medical Director, Health and Community Services:

No, they have definitely not fallen away. The appointment of Professor Peter Bradley has been a really positive move. We are having more conversations and collaborative working than we ever have before, particularly around things like the Jersey Care Model. There is very regular contact with their team.

Ms. H. Miles:

In terms of the delegation then, Professor Bradley has now taken over the Chair of S.T.A.C. from an S.P.P.P. perspective and that has fallen away from your responsibility as in H.C.S.?

Medical Director, Health and Community Services:
Yes.

Ms. H. Miles:
Again a question for the Director General, can you tell us how your relationship with healthcare providers, such as G.P.s (general practitioners) developed over the pandemic?

Director General, Health and Community Services:
Since I have been in post, we have had monthly meetings with our G.P. colleagues, which is monthly meetings that I attended. I no longer attend them, they are led by our Medical Director, and I know that our Medical Director has other interactions with G.P. colleagues. We have Adrian on the line, who is our Medical Director for Primary Care currently. We worked really well with G.P.s and I think the G.P. response was integral to the overall Health response to the pandemic on the Island.

Ms. H. Miles:
Can you just talk to us about how G.P.s were drawn into the COVID-19 response? Because of course they were private businesses, if that is the right word?

Director General, Health and Community Services:
I would like to ask Adrian to answer that because he was the person who led on that. Adrian, are you able to hear us and respond, please?

Medical Director, Primary Care:
There was 2 factors really, one was there was an impending need for a different model of healthcare during the pandemic to protect our patients. Then there was the financial side where, as private contractors, they were getting paid for the people who walked through their front door predominantly. Clearly, when people were staying at home and isolating, there was a significant risk to their income. So there were 2 reasons, but from my point of view it was really the ability to remodel the clinical care that we gave to patients during the pandemic that was the biggest driver.

Ms. H. Miles:
Thank you. Has the recruitment of G.P.s impacted your services in H.C.S.?

Medical Director, Primary Care:
We have 116 G.P.s on my performance list at the moment, which is pretty well the same number. What has changed is the number of hours that they work. So in the next few years there will be a significant challenge to recruit further G.P.s and also to look at using other health professionals in the surgery to support the clinical decision-making, particularly nurses.

Ms. H. Miles:

Thank you. A question back now for the Director General. Thank you, Adrian. What actions are being taken to return to normal, if it will ever be normal again, for operational services?

Director General, Health and Community Services:

That has been predominantly based upon our business continuity plans and withdrawing from incident response mode. Although we are still responding to the incident but not on the same level of continuity. We started really enacting those plans in summer 2020 when we had a brief hiatus. Our main focus has been, as you would expect, on returning to business as usual around reducing our waiting lists. So identifying clinical need and ensuring that we impact on those lists accordingly. So that is the work that has been ongoing. But there has also been a lot of work happening around holistic work around our staff. Our staff have been deeply wounded by this experience because it has been fairly brutal for staff within the hospital who have had to run towards the fire every day, but particularly in that first year when there was no expectations of what to expect or how to treat it or what the impact was going to be on patients and families. So we have done a lot of work around trying to holistically support staff to get back to normal. I think it takes a long time for staff to forget what they have seen and what they have had to endure. I do not know, Simon, if you wanted to elaborate on that? I brought Simon along today because Simon led our clinical response, particularly within the first and second wave.

Ms. H. Miles:

We are particularly interested in knowing what your focus is to reduce the backlogs.

Director General, Health and Community Services:

All right. Sorry, Simon. So we have been doing a lot of work around our waiting lists. Our inpatient waiting list is back down to pre-pandemic levels, in fact it has reduced slightly. We have done some great work around cardiology and around orthopaedics. Our outpatient wait is still not where we need it to be; it has increased. A lot of that is to do with the fact that we did not have front line G.P. services for a long time in the pandemic, therefore we have a backlog in referrals coming through. So we are having to catch up with those referrals. So the work that we have ongoing is putting on additional clinics, maximising our utilisation rate in theatres, and ensuring that we are constantly reviewing our conversion rates, which is the work that Simon leads in surgery.

Ms. H. Miles:

Have you any idea of a timeframe that you will be able to get back to normal?

Director General, Health and Community Services:

Yes, we have a trajectory around improvement. Our trajectory around improvement, which, can I please point out, can be impacted by another wave. We are challenged on a daily basis; we have 62 staff off today with COVID. But taking all of that into account, we are looking to significantly reduce our waiting lists across our main surgeries by September in inpatients and that is some of the work that Simon is leading. Outpatient wait is a bit trickier. Our outpatient wait, we do not think we will get back on top of and where we need to be probably until the end of this year, beginning of next year.

Mr. A. Lane:
You mention you do work on theatre utilisation. I guess that is one of the key constructive pinch-points if you like. What has happened in that? Where are you at and what would a good standard look like internationally?

Director General, Health and Community Services:
I will answer that but I am conscious that we have the Chief of Surgery here. We have been doing a lot of work around theatres, changing the way that we manage our patients, changing the way we schedule our lists. Utilisation currently sits at around 68 per cent, 70 per cent. That is very good in a pandemic. We are probably one of the few jurisdictions that has maintained elective activity throughout the pandemic and have managed to maintain our inpatient waiting position there or about. We would like to get to about 80 per cent.

Mr. A. Lane:
What do we expect the N.H.S. (National Health Service) in the U.K. (United Kingdom) to be at?

Director General, Health and Community Services:
It depends upon your presentation and on your volume and the acuity of work you do. For a hospital like us, with the acuity of work we do, probably looking at about 85 per cent.

Mr. A. Lane:
So some way to go.

Director General, Health and Community Services:
We have got a way to go. But we are not aspiring for 85 per cent; we are aspiring probably for around 80 per cent because we need to have some flexibility. Because in the U.K., if I have a road traffic accident, I have a multiplicity of organisations to go to. We need to keep our tables empty so that we always have emergency capacity available. Similarly, we need to have empty beds so that we always have capacity available. I do not know, Simon, if you wanted to add anything. I am conscious I am talking of your area.

Associate Medical Director of the Surgical Services Care Group:

What you have alluded to is quite correct. So we can exploit our Day Surgical Unit, because by definition it is day surgery, and we are looking to extend the hours of operation that we can manage patients through that. But that is a specific cohort of patient presentations that you can manage. There are inpatient surgical procedures that are restricted to our bed availability. We are talking about it is all about pandemic, we are still in the pandemic, we are still responding to waves. We have to isolate our COVID patients away from our main patients. We have to treat certain emergency patients differently to elective patients. Unfortunately the estate that we work in is very restrictive in regards to that. It is not a modern facility that can ebb and flow to those different needs. So there are certain operations that unfortunately we cannot just magically increase our turnaround and our turnover. But there are other areas that we can. So the performance rate of 85 per cent, there are some areas where we are matching that. There are other areas where we do not, just because the nature of the facility does not allow us to do that at the moment. But we continually look at our waiting lists, look at our patient needs, and try to align the current resources to that.

Mr. P. van Bodegom:

I have some questions on management of public finances, procurement and supply chain management. What was the impact of the pandemic on the Health Department expenditure during 2020 and 2021?

Head of Finance, Health and Community Services:

The impact initially for COVID expenditure, 2020 was £23.6 million, in 2021 it was £11.9 million. However, if we are looking at the impact on the departments across Health, this was fully mitigated as a result of the funding that is held centrally in the Treasury COVID Reserve, which was accessed via business cases.

Mr. P. van Bodegom:

Director General, how did you assess the stock of ventilators and P.P.E. that you already had?

Associate Medical Director of the Surgical Services Care Group:

Initially, from a hospital perspective, when we talk about ventilators, it is the ability to be able to provide invasive ventilation. That is key to intensive care. But also we have the facility to provide back-up machines that we utilise in theatres. So any hospital will benchmark what they are able to provide from a ventilation perspective in terms of the number of I.T.U. (Intensive Therapy Unit) beds and the number of I.T.U. staff and the facilities there. When the pandemic presented itself, and it was felt at the time that invasive ventilation was the way forward to manage these patients, we took a step back to rationalise what could we do in terms of the machinery that we have and what can

we do with the staffing. The landscape has changed dramatically in regard to that. Not only in terms of resources that we can bring in from off-Island, but also the nature of what we treat. So COVID is treated massively differently now compared to how it was. So as soon as we were in the pandemic, in the early days of it, we were doing constant evaluations of what our treatment options were, what we could facilitate, and how we would need to bend ourselves to the needs of those patients. It was not just ventilation; it was also oxygen demand as well. So it is difficult to say: "We could do this on day one, this on day 5," because it was continually changing. We were working on projections. When we were looking at what was happening in northern Italy, I think one projection was that we might have to ventilate in excess of 80 people, which for a small Island jurisdiction is way beyond anything that we would think we could do.

[14:30]

In terms of asking for outside assistance and equipment. I am sure you may be aware that we recommissioned previous invasive ventilation equipment. So there was an ability, if we needed it, to be able to put equipment in. I do not think at any stage we did not have the equipment to provide to the patients that we needed to at the time.

Mr. P. van Bodegom:
So you believed you had at the time the full capacity?

Associate Medical Director of the Surgical Services Care Group:
We had capacity to match what we needed to and we had plans in place, if there was a surge of activity, to match that. Luckily that did not occur. But also at the time it became apparent that non-invasive ventilation was an effective treatment modality and high-flow oxygen was also an effective treatment modality. When that awareness was coming on fortunately we were in the process of doing the Nightingale. The Nightingale plan was to have its own oxygen provision. So at the end of the day we were in a remarkably better position than all of the hospitals in the United Kingdom because we had that oxygen facility to provide that support if we needed to.

Mr. P. van Bodegom:
At that point we were believing that the requirement to ventilate was disappearing, reducing?

Associate Medical Director of the Surgical Services Care Group:
It was … realistically, until the vaccination came into play, people were still finding their way. If you look at the response globally, say you were in the United Kingdom, in terms of how they were commissioning Nightingale hospitals to provide ventilatory support to people, until the vaccination came along and dulled down that clinical response and deterioration, I think everybody was …

Director General, Health and Community Services:

Then as regards P.P.E., In April 2020 the P.P.E. cell was set up because we recognised that the demand was going to be huge and that we needed to be able to control that. Because we were not only servicing the health providers within government, we were servicing health provision Island-wide. But both the provision of P.P.E. and ventilation was managed through our bronze cell. So while there was a government-wide escalation process, which was the T.C.G. and S.C.G., through senior officers and through to Ministers, there was also bronze, silver and gold, within the hospital. Our bronze and silver cells were led by our clinicians, Simon headed that response, and on a daily basis we were assessing the availability of equipment, availability of P.P.E., availability of staff, and how we could allocate that appropriately. Because, as Simon says, particularly in the first couple of months, we did not know what we were facing.

Associate Medical Director of the Surgical Services Care Group:

Can I just add to that? In addition, we also had a clinical group, who were evaluating the knowledge that was coming out of other areas in regard to treatment profiles. So how we treated COVID was being updated similar to how we were updating our clinical response. So, as guidelines were changing, nationally and internationally, we had a group that was looking at how that could be implemented on the ground for our patients as well.

Director General, Health and Community Services:

What needs to be perhaps recognised in all of this is that in those early days, and again Simon and Patrick can speak better than me about this, we had very, very sick patients coming in, very sick. There was no means of treating those patients. So we were having to make decisions, clinicians were having to make decisions based upon those presentations, which were challenging.

Associate Medical Director of the Surgical Services Care Group:

Ultimately, you like to look at a major incident or a pandemic and you have a start point and you have an end point. There was no start point, this was something that gradually came in, gradually started to take effect. The knock-on effect of staff being in contact with people who we did not know had COVID at the time, and then they had to isolate. So, not only were we dealing with the patients, we were also dealing with the impact on the staff. Patients are humans and staff are humans and we were seeing what was happening around the world and this thing just swept through and nobody was prepared for it. Then suddenly you realise we are a small Island and, although we have very close links to the United Kingdom, the United Kingdom was facing the same situation. In those early days it was a case of this is a different playbook to what we have been involved with before. I am an emergency medicine consultant, I have worked on air ambulances, I have been to major incidents, I have dealt with big things and I have learned from people who have done similar. None

of us, none of our peers, and none of our peers' peers, had dealt with a pandemic in a modern age. We were looking at stuff from S.A.R.S. (severe acute respiratory syndrome) and the Middle East and how they were managing things. Even those were relatively contained within different hospitals where they would contract things. This was suddenly sweeping across the globe and we were looking at what is that going to do to us. We were going to work and the Island was going into lockdown. We were leaving loved ones at home. Some of my colleagues were isolating themselves from their families and yet still doing their job. So all those interplays were going on at the same time that we were trying to find our way through a clinical disease that even now it is providing different quirks in terms of how it affects people with long COVID, doing the M.R.I. (magnetic resonance imaging) and showing it has an effect on brains as well. So all those things, people are going to write P.h.D.s (Doctor of Philosophy) on this for a long, long time, and lessons learned, there are going to be things that are going to come out for a very long time. I think it is just worth appreciating that, in the early stages, was where we were at.

Director General, Health and Community Services:
We were tracking everything in effect through those cells because basically we were ensuring that we had every piece of equipment that you could possibly need really. Because of not knowing how to respond to a disease.

Mr. P. van Bodegom:
Just with the P.P.E., where were you sourcing the P.P.E. from?

Director General, Health and Community Services:
We had a significant stockpile of P.P.E. because of course we have flu pandemic preparedness happening. But we sourced it from multiple places. The majority of our stock came from the N.H.S., did it not?

Deputy Medical Officer of Health:
Through the N.H.S. But it was initially managed by Health, but then it became such a big job in its own right and requiring to provide P.P.E., not just for H.C.S. but outside H.C.S., that it was centralised.

The Connétable of St. John:
What kind of stock levels did we have?

Deputy Medical Officer of Health:
Three months, and maintain that 3 months was the original plan.

Mr. P. van Bodegom:

The C. & A.G. (Comptroller and Auditor General) found that there appeared to be a confusion as to the number of ventilators, invasive and non-invasive, that the department had. Why was there confusion?

Director General, Health and Community Services:

I am going to ask Simon to answer that because that question is quite a difficult question.

Associate Medical Director of the Surgical Services Care Group:

So I guess you have to try to understand what you are trying to achieve. So an anaesthetic machine in surgery provides invasive ventilation and it is based in theatres. It is not the same machine that you would use to provide invasive ventilation to somebody in an intensive care unit. But it can do the same job. Then non-invasive ventilation is where you are providing a degree of ventilation but you do not have a tube down into the lungs. So it is form of ventilation but it is non-invasive. Your invasive machines can provide non-invasive ventilation and with some adaptation potentially your non-invasive ventilators could be changed to provide invasive ventilation. Then there is another thing called C.P.A.P. (continual positive airway pressure) that comes under the heading of non-invasive ventilation but is not. So it depends on what you are trying to achieve in terms of which machines you can utilise and where you can provide it. So it is quite a complex answer. If somebody asks a question of how many machines can you use to support an individual's breathing requirement that is in addition or in an escalation to a mask and oxygen, that is one number. How many machines can you use on intensive care to provide invasive ventilation, that is another answer. That is where the confusion comes I guess.

Deputy I. Gardiner:

But confusion, at least in the C. & A.G. report, came from different numbers. On 30th April 2020 we had 70, for example, non-invasive ventilators and 30th June we have 39 plus 40, so we have different numbers for invasive, not-invasive, in about 3 months. So we are asking why there was confusion in counting between the numbers that were supplied.

Associate Medical Director of the Surgical Services Care Group:

I do not have an answer to that unless people were compartmentalising the machine differently. As I said, you can use a non-invasive ventilation machine for doing your C.P.A.P. but you would not use your C.P.A.P. to do non-invasive ventilation. Then if you are delivering high-flow oxygen ...

Deputy I. Gardiner:

No, no, no, it was on the basis of information provided, the action taken provided a total capacity of 31 invasive and 70 non-invasive ventilators by 30th April. These volumes however are not

consistent with the result reported by the Minister for Health and Social Services on 30th June 2020 of 36 invasive, 39 non-invasive and 40 C.P.A.P. non-invasive units. These volumes are not consistent with the figures of 26 invasive ventilators and 39 non-invasive ventilators confirmed by the Director General for H.C.S. in February 2021. This is extract from the C. & A.G. report. So as a committee ...

Director General, Health and Community Services:

We spent a lot of time answering this question, which was asked of us repeatedly throughout the pandemic, and the position changes. The position changes regularly even now because we have ventilators that are working and not in service, we have ventilators that are in service, ventilators that have stopped working and we have the whole issue that Simon has around people badging ventilators as invasive and non-invasive, or classing C.P.A.P. machines as ventilators when they are not. So I think it is to do with terminology and confusion about how we answered the question. There is no attempt to try to be obtuse around that. We had significant ventilation capacity. I am not a clinician but I am looking at the Medical Director, I think that S.T.A.C. believed we had sufficient capacity to be able to meet demand once we understood that demand was not going to be 200 patients.

Deputy I. Gardiner:

No, it is not about the demand, it is about how we count. We are the Public Accounts Committee, we want to know about the counting, the procedure to count, and I can understand some of them were in a box, but do we count working units or do we not, or do we count all units including ones that need repair. So it is about the consistency and counting.

Medical Director, Health and Community Services:

Simon's answer probably beautifully illustrates the confusion about what people would count as a ventilator and what they would not. For people who are giving the answer to that question, they are coming up to clinicians in the middle of a pandemic and saying: "How many of these machines have we got?" and quite frankly that was not our focus at that point as clinicians of going around and counting things and giving a clear answer. I suspect people who wanted to give absolute clarity around it were not getting clear answers from people such as Simon and myself because we were otherwise distracted.

Director General, Health and Community Services:

But it is a good point and the C. & A.G. has made a good point that we need a really effective equipment inventory and that is something that we have taken on board going forward. We have asked our new Head of Non-Clinical Services to make that a priority over the next year. Because,

although we do have an inventory, it was not up to date around all of the equipment that we had available to us. So that is a piece of work that we are continuing to do.

Mr. P. van Bodegom:
How have you tracked spending related to the response to COVID-19 within your department under the Public Finances Law?

Head of Finance, Health and Community Services:
Throughout the pandemic, and ongoing, with the ongoing spending there has been no deviation from the Public Finance Manual. We record expenditure separately for COVID under separate heads of expenditure. The costs are there. There is deviation from the scale of delegation that remains in place and the Health team in general have a very good understanding of the requirements of the Public Finance Law and the Public Finance Manual through regular training and communication. There has not been any deviation, I am quite assured.

Mr. P. van Bodegom:
Have you undertaken work to identify and separate business as usual for the Health Department as opposed to business under the COVID-19 response?

Director General, Health and Community Services:
Financially. Michelle, did you hear that?

Head of Finance, Health and Community Services:
No, I am sorry.

Director General, Health and Community Services:
So what work we have done, Michelle, to manage our finances, our B.A.U. (business as usual), so our standard money, and our monies that we have spent around COVID.

[14:45]

Head of Finance, Health and Community Services:
If I start with business as usual, ongoing from 2020 onwards, as per the Government Plan, we introduced a zero-based budget and methodology, which gives us very clear, granular detail on the B.A.U. budgets that are required for Health. That is down to every member of staff, 2,600 permanent staff, and every item of expenditure to be matched to activity where possible. Similar with the COVID expenditure throughout, any funding supplied for COVID expenditure was via a business case, a very detailed business case. We looked at the qualitative and quantitative need of those business

cases. That would be reviewed by myself and it would also be reviewed by the central Treasury team separately. So you know there is clear delegation throughout and then funding would be made available following that review.

Mr. P. van Bodegom:
So you can clearly identify the difference between the 2 scenarios?

Head of Finance, Health and Community Services:
Yes, we can.

Director General, Health and Community Services:
Yes. We have been really clear about that because we have to use business cases for all of the monies that we have spent on COVID and we also have to demonstrate any extraneous impact there may have been on B.A.U. that would not be suitable for a business case. So we are really clear about that across the whole of our response. Because, as you can imagine, we have had to have significant expenditure for healthcare provision.

Mr. P. van Bodegom:
So, if there was one item that you could clearly identify, you could track that pre-pandemic, during pandemic and then exiting pandemic?

Director General, Health and Community Services:
I am fairly confident we could. Michelle, if there was one item that we needed to track pre-pandemic, pandemic, and where we are now, still in the pandemic, we can track that, can we not, because we can track that through our lines?

Head of Finance, Health and Community Services:
Yes, we can track it obviously from the audit of the initial business where all the detail was provided, the core description, which is very detailed, on the financial ledgers, so we could go down to an amount, a person, and a date of expenditure. If funding was not available post-expenditure, we drew down the funding following the expenditure being incurred, and again there was another element of scrutiny there to ensure that it was COVID expenditure.

Mr. P. van Bodegom:
Thank you. What tools and resources do you use to help your department interact with commercial services?

Director General, Health and Community Services:

We have a commercial services lead who works closely with us to provision any support that we need, particularly around large contracts … well, all our contracts really but we need particular support around some of our bigger contracts. So all of that is done through that process, through our procurement department. It is a bit of a hub-and-spoke model.

Senator T.A. Vallois:
Just in terms of the procurement side of things, what was the volume and value of procurement breaches and exemptions recorded by Health and Community Services in 2020 and 2021 that relate directly to the COVID-19 pandemic, if any?

Director General, Health and Community Services:
Michelle, do you have that information around the procurement and the expenditure?

Head of Finance, Health and Community Services:
I do not have the number of breaches or exemptions so would have to gather that data. What I can say is that at the beginning of the pandemic there was a ministerial decision sent for the value of up to £5 million for P.P.E. and then linked in with commercial procurement of stock was made … I think what we have to remember is we had to source stock very quickly due to the shortages, so there would be retrospective exemptions in some cases. We kept them to a minimum. But I can get the figure if required for the next ...

Senator T.A. Vallois:
We would appreciate that. Thank you very much. So how have you monitored the use of business cases during COVID-19? I mean we are going through a pandemic and you are having to write these business cases to ensure that all the decisions made by your department that required those additional funds were adequately and formally recorded.

Director General, Health and Community Services:
All of that is managed through our governance structure. So it is done at care group level and then it is done through our Finance and Performance Committee. So in 2020 £23.6 million of business cases were submitted and approved and in 2021 COVID business cases to the value of £6 million, with a remaining £10 million approved by the Government Plan for 2021 to 2024. All of those come with business cases, which then go through our Finance Committee. Then it has to go through the whole loop, because that is our internal process, of the central teams.

Senator T.A. Vallois:
In terms of the working practices, what does your department use to maintain a consistent audit trail for the decision-making related to the use of public funds?

Director General, Health and Community Services:

Again that is through our governance structure. So it goes to our Finance Committee. If it is expenditure that is going to impact upon patient care, which most of it is, it will be sighted by our Chief Nurse and our Medical Director, so there can be a quality impact assessment done, so we can ensure that the money that is being spent is going to benefit patients and the outcomes that we need. But sign off is still our Governance Committee.

Head of Finance, Health and Community Services:

To add to that, Caroline, there is a central repository where all of the business cases are tracked and it goes through a ministerial decision. So there is full tracking of the initial business cases, the review, the final business case and the final sign-off. So that is held centrally within Treasury.

Director General, Health and Community Services:

Our Finance Committee is chaired by our Assistant Minister and so it is just about ensuring that we have, not just the oversight of the Chief Nurse and the Medical Director but also the oversight of the Assistant Minister, who is then able to report into the Minister, so that we have a real clear track around what that spend is. So when it goes to the centre we can show that trail of governance.

Senator T.A. Vallois:

The C. & A.G. recommended that all future supplies of P.P.E. should be reviewed for quality on receipt, prior to the approval of payment. Could you please provide an update of the current practices?

Director General, Health and Community Services:

I might have to come back to you on that. My understanding is that we are doing that.

Senator T.A. Vallois:

So, from an extract from the C. & A.G. report, around 1.8 million of P.P.E. supplies that had been purchased from 4 suppliers were referred for further investigation following quality concerns on inspection. While volumes were validated on delivery, quality tests were not performed promptly prior to full payment being made. So understanding those practices are really important, whether they have changed or not, from what date though has the U.K. Department of Health been charging Jersey for P.P.E. supplies, if at all?

Director General, Health and Community Services:

So the management of P.P.E. in the pandemic, very early on, moved from Health. So around the volume of supplies that came that were not fit for purpose I will need to find out about that from the central team. I will also need to find out around when we started being charged.

Senator T.A. Vallois:
Who was formally in charge or had management of P.P.E.? Was it a separate Director General?

Director General, Health and Community Services:
Yes, it was managed by the Director General for J.H.A.

Senator T.A. Vallois:
Justice and Home Affairs?

Director General, Health and Community Services:
Yes.

Senator T.A. Vallois:
Okay. That would have been discussed through all the other groups that you mentioned before?

Director General, Health and Community Services:
Yes. So not necessarily the individual purchases but there was a regular presentation around the volume of stock that was held, the run-rate around the stock, and what stock was on order.

Director General, Health and Community Services:
So, if it was the Director General for Justice and Home Affairs that was managing that - you all have lots on your plate so you have another person managing that - the accountability for the money and the provision of the P.P.E., did that still lie with yourself as Director General or did it lie with the Director General for Justice and Home Affairs?

Director General, Health and Community Services:
It lay with the Director General for Justice and Home Affairs.

Deputy I. Gardiner:
Now? I mean since the beginning of the pandemic until now the purchase of P.P.E. is with the Director General for Justice and Home Affairs or it has moved back to yourself?

Director General, Health and Community Services:

The purchase of it since … and I will need to come back to you with the date, but I think it is since the beginning of the year it has moved back to me.

Deputy I. Gardiner:

Since U.K. started to charge us for P.P.E., how have you ensured that this is the best value for money of purchases for P.P.E. or is this going through the corporate services?

Director General, Health and Community Services:

At the moment it is being managed through our Five Oaks and we have also got additional storage around our P.P.E. because of the volume of P.P.E. we have. My understanding is that those conversations happen there and with our central procurement team, who are supporting us around the procurement and volumes of P.P.E.

Senator T.A. Vallois:

So, if P.P.E. has moved back to you from the beginning of this year, has the governance structure therefore changed in terms of managing the pandemic? As was mentioned before, it has not gone, has it, so what does that now look like? I am assuming the P.P.E. cell is gone?

Director General, Health and Community Services:

The P.P.E. cell does not exist anymore, that has stopped. Monitoring of P.P.E. is done through our Non-Clinical Services Manager.

Senator T.A. Vallois:

When it was transferred back to yourself, did you do any kind of updating or looking at the framework to make sure you were satisfied with how it was being managed?

Director General, Health and Community Services:

Before the Director General … because part of the impetus for moving it was that we had a change in Director General and so there was going to be a slight gap around that. We needed to understand where those responsibilities were going to sit and so as part of the handover process with the Director General there was conversations around what the process had been, what it was going to be going forward and how we could monitor that. But there was a very good job done by J.H.A. around understanding P.P.E. requirements and particularly around date management, because P.P.E. can run out of date. So I am quite sure that it is well managed and well governed.

Deputy Medical Officer of Health:

Remembering the context of now and 2 years ago, so 2 years ago the world went from baseline production of P.P.E., provision of P.P.E., to suddenly everyone wanting masses of it. In order to try

to ensure that we did not run dry, a 3-month buffer of P.P.E. was guaranteed and that was kept at 3 months depending on the burn rate of P.P.E. at the time. So that there would be sufficient warning that we needed to escalate our purchase of P.P.E. if we could not maintain that 3 months. Now, there is a huge provision of P.P.E. relatively speaking. The concerns about running out of P.P.E. are nowhere near what they were then. The concerns about being given sub-quality P.P.E. no longer exists. We are in a completely different position because the world has caught up with COVID. But in the beginning it was a complete novelty.

Senator T.A. Vallois:

I understand that. It was mentioned before about P.P.E. being provided Island-wide, so charities, care homes, things like that. Is that still the case and, if that is still the case, are they being charged?

Director General, Health and Community Services:

Not currently, is my understanding.

Senator T.A. Vallois:

They are not currently being charged but they are still receiving P.P.E.?

Director General, Health and Community Services:

Yes. I just went through my notes, so quality checks are conducted by H.C.S. health and safety prior to purchase and again on receipt of stock. So there is a process in place for that and the contracts are maintained by H.C.S. suppliers but topped up by commercial services. That is B.A.U. commercial services having oversight of our stock levels. So it in effect has moved back to H.C.S. because we have returned to a mode of B.A.U. around P.P.E. supply. We realised very quickly in the beginning of the pandemic that we would not be able to manage it within H.C.S. because the hospital response was so consuming. Again, it was one of the benefits of being able to use another department and say: "Can you help us and can you please take over the management and distribution of this because it is so huge?"

Senator T.A. Vallois:

Just in terms of the 3-month supply that you did have, that was purely for hospital use? That was for Island-wide, so at the beginning you had enough for 3 months Island-wide?

Deputy Medical Officer of Health:

It was a community-wide pandemic.

Medical Director, Health and Community Services:

I think at the beginning our expectation on flu stocks were for Health and Community Services. So at the very beginning that was one of the pressures on the system that suddenly the government was having to provide P.P.E. to other organisations.

Senator T.A. Vallois:
The P.A.C. notes an F.O.I. (Freedom of Information) published on 13th September 2021 regarding the Nightingale Hospital's furniture and equipment that indicated that all furniture and equipment is now catalogued and stored. Are any of the items listed now being used either by the General Hospital or elsewhere within the Health estate?

Chief Nurse:
I do not have the specific detail. We can provide that afterwards in terms of how it has been recycled back into practice. Again it goes back to what we said about previous items and expiry dates and using equipment. So some it has gone back into practice, some of it has gone back into a pandemic store and some of it has been distributed around.

[15:00]

Senator T.A. Vallois:
Has any of it been sold at all?

Chief Nurse:
I do not think so, but I would need to check.

Director General, Health and Community Services:
I am not aware of any that has been sold. Michelle, are you aware of any of the Nightingale equipment being sold?

Head of Finance, Health and Community Services:
No, there has not been anything sold at the moment. As Rose said, a lot is still in storage. There is initiatives underway to explore disposal of that stock, which means some may be sold, some may be gifted, there is no detail as yet, it is being worked on.

Director General, Health and Community Services:
We tend to avoid selling our stock. We tend to either gift our stock across the community or to utilise our stock in response to various emergency situations that have arisen elsewhere, if the Minister has indicated that he wishes for that to happen. Then of course we look at that. We have been

looking at that currently around Ukraine and what stock we have and what stock is available to offer to the emergency response. We are just compiling that for the Minister.

Senator T.A. Vallois:
It might be best for us, on the basis of that answer, to maybe write to you with the finer questions around values and usable/unusable items. Is there any intention to publish a final waste decommissioning report on the Nightingale Hospital, do you know?

Director General, Health and Community Services:
I think it would be valuable for us to have a decommissioning report. We have done lots of lessons learned from the Nightingale and from both setting it up and the decommissioning of it. I know that our Estates Department that was very involved in that, with external partners, has been very keen to learn around the decommissioning. So that is something that we are very keen to embrace.

Deputy I. Gardiner:
I imagine there were lessons learned from Nightingale, could you advise us of several of them here?

Director General, Health and Community Services:
Can I ask Simon and Rose, who set up the Nightingale for us?

Deputy I. Gardiner:
About lessons learned.

Associate Medical Director of the Surgical Services Care Group:
From do it to opening it was 25, 26 days. We opened it and ran a 30-hour live simulation with patient actors and staffed 2 of the wards so we knew that if we were going to put patients in there it was a viable facility. I do not think any Nightingale in the U.K. was able to do that. The thing that we learned, which was a massive thing, and I think we alluded to when we talked about the business partners, was that the team environment. It was a team approach, it was not one person, it was not one area, it was a hospital-wide response from the cleaners all the way up to the consultants. It showed when you have a single purpose and it is well-defined what you can achieve. We had a very simple purpose that we committed that we would open on 11th May and managed to do that. Red tape sort of evaporated, the building departments were there, the architects were there, the clinicians were there, the clinical modelling in terms of how we were going to treat and what we were going to treat was there. We had a timeframe, 11th May was chosen because it was the peak projection early on. So that was incredibly valuable. Further lessons I guess were in terms of a response to a clinical pandemic, the Nightingale was one aspect of a health response, and we are here as the hospital, but it was an Island health response to a pandemic. We could not have done

what we had done with the Nightingale without the support of all those other agencies playing their role at the same time. So the fact that we had that cross-department, cross-jurisdiction, so G.P.s, private business, communication and interaction was massive. That is why the Island did an extraordinary thing, which was to have an operational Nightingale within 25 days.

Chief Nurse:

If I could just add just a couple of other things from that. One was around speed of trust, and that was right across the whole industry, so it was not just in relation to us, in relation to how the build went up. There was a lessons learned piece of work done around the construction of the building as well, which I think is in the public domain. The other is around the fact that the clinical voice was really strong in the build of the Nightingale. We felt very much heard as clinicians and that people did respond to that really well. The other we learned around: "Do not do it on your own." So we connected very well with the Nightingale network in the U.K. and the people who were leading those, not just on the building but also on how we were going to staff it. Because, again, we are small Island, everybody else was struggling with the same thing, we only have the people we have. So that was really fundamental to us about how we started to develop the workforce plan should we need to use the Nightingale. Finally, it was a fantastic project to be involved in.

Director General, Health and Community Services:

So I think we learnt about harnessing different skills as well, and learning about those skills that we had across the organisation that perhaps we would not have known about, and the staff that we had who wanted to do something different and this was an opportunity for them to do that and for them to learn from it and to be able to educate all the staff on it. I think the staff really enjoyed that, so for us what it has really done, and it is part of the whole trying to make H.C.S. an organisation where you can move between roles much more flexibly, has really shown us the opportunities that can be afforded by getting staff to go off and just do something completely different. It was a really difficult time, a really big ask, I mean, Rose went pale and Simon did when I asked them, but staff I think found a great deal of happiness in doing it.

Chief Nurse:

Yes, they did.

Associate Medical Director of the Surgical Services Care Group:

I think it also demonstrates that there is resilience within the community and within the staffing and within the population of a very small Island because it galvanised an awful lot of people.

Deputy I. Gardiner:

What would you do differently in hindsight from the lessons learned?

Associate Medical Director of the Surgical Services Care Group:
Have more notice.

Deputy I. Gardiner:
Yes, what would you do differently if it comes next time?

Associate Medical Director of the Surgical Services Care Group:
Are you talking about the need for a Nightingale or a pandemic?

Deputy I. Gardiner:
No, around the Nightingale. I am not talking about to build or not to build. I am not talking about the decision because we have been over that; I am just saying where we are standing now we have experience of 2 years looking back, and if another pandemic comes is there anything that we would do differently or not?

Director General, Health and Community Services:
I do not think we would do anything different around the Nightingale. I am sure there are always ways that you can improve the way that you deliver a facility, but I think it demonstrated that if we worked across government, across the community, how we could really deliver at pace. I did not even expect the ask that I put to Rose and to Simon to manifest itself, even though we knew the need was potentially great, and the fact that it did I think was a celebration of cross-community, cross-organisational working and cross-government working. I think it was a feat, the Nightingale.

Associate Medical Director of the Surgical Services Care Group:
There were small things. So having run the simulation with a ward fully operational for that amount of time, there were little things and lessons learnt there, but in terms of being able to provide a facility that could manage and treat a significant number of patients that would overwhelm the health economy as it was prior to that. It was definitely one of the solutions that we put forward as a potential. The fact that we were able to have it online so quickly, I do not think there is anything that we could have changed to do that any quicker than it was done. We had the flexibility while we were doing it, so even as the treatment options were changing for COVID we had already built in the capacity to flex the different areas of the Nightingale to provide different levels of care. So I think we did a pretty good job and there is nothing major that I would change in terms of how we got it built, what it looked like, what it was going to be able to achieve.

Mr. P. van Bodegom:
If it was full of patients how many staff would you have needed?

Associate Medical Director of the Surgical Services Care Group:

It is called a Nightingale because the setup of it is very different to a functioning hospital. So if you think about the hospital that we are planning to build at Overdale, 75 per cent of patient accommodation is going to be single cubicle rooms. So the staffing that you need to do that is very different to a Nightingale ward when you can visually see 30 beds, so the staffing ratios change. But also, as we alluded to before about acuity, you staff to the acuity of your patients. The acuity of the patients that were going to go to the Nightingale were very different to the acuity of the patients that were going to be in the hospital. So in our modelling we were looking at ... you were going to have a significant proportion of people who are going to have a high oxygen requirement and a form of ventilation, and the premise was that those were going to be housed within the hospital. Then those patients that were either stepped down or relatively stable who needed a degree of oxygen but less acuity care were going to be in the Nightingale in an estate that allowed you to have a higher ratio of nurse to number of patients. But also how you play that is ... we talked about the number of H.C.A.s (healthcare assistant) that were trained up and recruited, so a nurse with a couple of H.C.A.s can manage a greater number of low acuity patients than you would expect to have on the hospital side. So it was looking at that application, but it was very much a “we are going to choose the patients that are going to go to the Nightingale” rather than “the Nightingale is part of the hospital” and that is why I think we called it the Nightingale wing because it was not a standalone hospital.

Mr. P. van Bodegom:

So the numbers of staffing could fluctuate, or would fluctuate?

Associate Medical Director of the Surgical Services Care Group:

If we had been full we would not have maintained the ratio of staff to patients that we would do in the main hospital but that was always the intent because the acuity of the patient demographic in the Nightingale was going to be different.

Director General, Health and Community Services:

We were prepared for that. The Chief Nurse - and I do not want to speak for you, Rose - worked through ratio management about how we would manage that because of course our staff were impacted by the pandemic as well around our numbers, so we had that in the planning around what those potentially worst case scenarios around ratios could look like and how you would manage that.

Chief Nurse:

Yes, and it was designed deliberately so we would only open ... it was designed in a compartmental way, so you would literally fill up the beds from one end so you would only staff for what you needed.

Again, if you take an average staffing ratio in the hospital it would be one registered nurse to 6 patients on average depending on how sick people are. Over there we were looking at 1:50 but if it was stretched even further we could stretch it further by having a slightly different model. So if it had been full we would have lots of conversations with our partner organisations because in that position we would have been in quite a surge position as an Island, and how we started to prioritise the care delivery we did across services. So conversations with Family Nursing and Home Care, Hospice, all those other providers who said: "We want to help if we get into that position." So all of that was factored into our workforce plans, but the fundamental bit was the design of the building. It was deliberately designed in that way around the staffing model as well as the clinical need.

The Connétable of St. John:

I am going to ask about the management of the healthcare response. How did you work with your department to develop your department's business continuity plan?

Director General, Health and Community Services:

We already had business continuity plans in place within the organisation and particularly around preparedness, which is very valuable around the pandemic. Those business continuity plans were of course dusted off the minute the pandemic arose. We were already really clear around the structure we would have around our emergency response; it was a standard acute response which is bronze, silver and gold. There was a daily bronze meeting with feedback to silver twice a day. There was a bronze cell which sat within the organisation and worked across both the hospital and across the wider community, and those B.C.P.s (business continuity plan) were managed through there and decision making around allocation of staff, response, movement of services, were made within that cell. So you had one co-ordinated voice as opposed to different departments responding differently, and the business continuity planning was held there ... or the response as a result of the plans was held within that cell.

The Connétable of St. John:

How does that differ to the thing you mentioned earlier, the incident response mode?

Director General, Health and Community Services:

Incident response, continuity response within the organisation is the same response. There was a separate structure which sat outside of health which was the T.C.G. and S.C.G. and of course I sat on S.C.G. Rob sat on T.C.G. so we were able to feed our own decision making that was made at bronze, silver and gold through to there.

The Connétable of St. John:

So what are the key changes to the plan that were needed based on the experience of the pandemic?

Director General, Health and Community Services:
I am 30 years in health and have done flu-preparedness and pandemic planning year in, year out, but this is the first pandemic that I have been exposed to and I think our plans had to be very agile. I think we did not ... I do not think anybody knew what to expect or the many unknowns that were going to be around the presentation.

[15:15]

I think we had our plans well around how to divide the hospital into hot and cold sites, how to manage our beds, how to split off staff, how to have our A teams and our B teams. But I think that it was still a great shock. I think no matter how much you plan the realities of a pandemic within an acute hospital where you have no known treatment - because with a flu we have treatment so that was always part of the planning - was very difficult and think we took a lot of learning from that really.

The Connétable of St. John:
So the key changes?

Director General, Health and Community Services:
The key changes around our planning going forward; I think we are still learning those and still gathering those through. I think one of the key lessons we learnt is that you can never communicate enough, so we need to make sure our communication channels are much clearer. Although we had communication in the Halliwell every day and although we gave communication to staff via our StarLeaf communication, you can never communicate enough and we just need to have really clear work streams around that in our pandemic response. I do not know, Simon, if you can think of anything that we would change significantly?

The Connétable of St. John:
The key lessons you are talking about, are they in your continuity plans now going forward?

Director General, Health and Community Services:
We are going through a whole process of refreshing our business continuity plans. The government has appointed a business continuity lead, which is going to be really helpful, around supporting all departments to do that. But, yes, that is the work that we are doing at the moment, lessons learnt from the pandemic.

The Connétable of St. John:

In March 2020 your department significantly reduced the non-COVID elective and non-urgent physical and mental health services it provided. What responsibility have you had regarding the maintenance, closure and suspension of key services during the pandemic?

Director General, Health and Community Services:

Sorry, what responsibility? I am not sure what you mean.

The Connétable of St. John:

What was your responsibility in terms of the maintaining, closure or suspension of key services?

Director General, Health and Community Services:

So decision-making around key services happened through that response organisation. We were really clear once we understood that this was a respiratory disease which was highly transmissible, and for which there was no known treatment, that we were going to have to halt exposure for our patients. A hospital, by dint of being a hospital, is generally fully of vulnerable people and I think we saw from where the pandemic was hitting that vulnerable people were particularly being impacted, particularly elderly people. So it was a clinical decision that we would need to suspend elective activity, that we would need to stop as much face to face activity as what we could, while we still tried to maintain some responses, particularly for our acutely unwell mental health patients. But we did have to stop a lot of activity. That was a clinical decision that was made through the cells and a decision that in effect I ratified, being advised by the Medical Director and the Chief Nurse. I do not know if you want to add anything else.

Medical Director, Health and Community Services:

It has been different at every phase of the pandemic and, as we keep saying, for us it is not over so we continue to learn and have to respond on a daily basis. At the very beginning we required time for our staff to prepare themselves on training and I think we got that right because some of the feedback has been: "That was very valuable, people getting prepared." But I do not think any of us (1) expected to be in a pandemic and (2) expected to be in the pandemic for this length of time, going on now for 2 years. It seems to have almost become normal. It is having to respond to the peaks and troughs and then all the challenges around staff and beds, which we are still doing today. It is about trying to look at the clinical priority, who most needs the resources that we are able to provide. We have not done this in isolation, we have looked at what has been done in other jurisdictions. We have taken advice obviously from Ivan through the infection prevention and control, because that does impact on some of the services that we can provide. It is different every day really, but we have looked at how other jurisdictions across the world - but obviously particularly the U.K. - have approached it and then learned from them.

Director General, Health and Community Services:
I think my responsibility was to support the clinical decision-making. It was a clinically led response.

The Connétable of St. John:
How do you intend to resolve the impact that the removal of services has had on Islanders with the reopening of services?

Director General, Health and Community Services:
I think we are able to monitor through our Q.P.R. (Quarterly Performance Review) which has our indicators on it around the services that we provision, and through our waiting list data. We are managing that on a week by week basis. We are looking across our capacity, our outpatients and our inpatients capacity, seen where our need is greatest and allocating resource accordingly. We always manage our patients according to clinical priority anyway, and that is managed by our clinicians. So it is putting in the framework and the support to enable our clinicians to do that.

Medical Director, Health and Community Services:
You have got to remember over the last 2 years the amount of information that we have had through the development of our patient tracking lists, et cetera, we have far more data now than we did at the beginning of the pandemic in terms of how we manage that.

The Connétable of St. John:
We note that recommendation 6 of the C. & A.G.'s report on the management of the healthcare response was only partially accepted due to the need for certain decisions to be taken in the emergency command and control structure, and to consider the limited availability of staff to support documentation administration. How do you intend to formalise the acknowledgement and documentation of associated risks as part of the decision-making process?

Director General, Health and Community Services:
What was the recommendation, please?

The Connétable of St. John:
It was around documented risks and assessments prior to the issuing of guidance to staff.

Director General, Health and Community Services:
I think we have quite a robust risk management process compared to what we had previously. We have up to date risk registers that are evaluated on a monthly basis through our Quality and Risk Committee which is managed by the Chief Nurse, and we have our Risk Management Department.

We have governance representatives in all of our care groups who escalate risk through to our corporate risk register if required, or manage those risks locally, and ...

The Connétable of St. John:

I think it was to do with, for example, facemasks and P.P.E. to be worn and when by H.C.S. staff. There was an issue around risk assessments and guidance being issued to staff.

Director General, Health and Community Services:

Are you able to comment on that, Ivan?

Associate Medical Director of the Surgical Services Care Group:

I can comment on it. At the beginning of the pandemic there was no specific guidance, so even Public Health England - which we aligned to, I think, after a few weeks because they did not have anything - it was changing almost constantly. So Ivan and I would meet first thing in the morning every day to look at how we would try and highlight the potential at-risk people who were coming into the hospital, but then also which areas ... what their P.P.E. response should be so we could proportionate it. Once Public Health England had established their guidelines I think we just aligned straight away to theirs, but there was a bit of a lag between the pandemic really being present and Public Health England coming on, so we were literally doing it on a daily basis.

Deputy Medical Officer of Health:

The P.P.E. guidance has simplified and become much, much easier to implement as we have gone along over these last 2 years. So we have learnt how to best utilise P.P.E. in the same way as we have learnt how to best respond to COVID. Tomorrow we will have something better as well, and so on; we are still very much on a learning curve but much better off than we were 2 years ago.

The Connétable of St. John:

Is that documented now, for example, the use of the P.P.E.?

Deputy Medical Officer of Health:

Yes, yes, there is guidance because of course we need to have a singular guide that is disseminated to the healthcare providers.

The Connétable of St. John:

Recommendation 11 of the C. & A.G.'s report regarding the future business cases for new facilities to include an explicit assessment of the staffing risks and plan mitigations was agreed to be implemented by December 2022. Is this on track?

Director General, Health and Community Services:

Yes, that is the work that we are doing around the workforce planning which is looking at how we staff any additional activity that we need to do in any other area, so if we did need to rebadge a ward to provision a different service, or a different part of our estate, then how would we staff that. Would we necessarily staff that with nurses and doctors or would it be a therapy-led ward that would be supported by healthcare assistants. That is the work that the Chief Nurse is leading on with the H.R.D. from the centre around workforce planning.

The Connétable of St. John:

Is it on track for 2022?

Chief Nurse:

Yes.

The Connétable of St. John:

Is the independent internal audit review of the G.P. surgery contract payments part of the H.C.S.'s activity?

Director General, Health and Community Services:

Michelle, I think that is part of the Treasury, is it not?

Head of Finance, Health and Community Services:

Yes, it is, it is Treasury. We do have the balance ... obviously we have the balance sheet but, yes, it is a Treasury function.

The Connétable of St. John:

Are you involved in the review or not?

Head of Finance, Health and Community Services:

At what level? In terms of the review do you mean the outstanding debt?

Director General, Health and Community Services:

I think it is about the finance, Michelle, so you know the review that has been done by Internal Audit around the G.P. contract?

Head of Finance, Health and Community Services:

No, I am not part of that, Caroline.

The Connétable of St. John:

Has the review of the States-wide occupational health service been completed within the timeframe suggested, December 2021?

Director General, Health and Community Services:

The review of occupational health does not sit with H.C.S. Occupational health sits with the centre.

The Connétable of St. John:

How frequently do the Health and Community Services board and the committees underneath it review and discuss improvements to services as a result of the pandemic?

Director General, Health and Community Services:

Did you want to talk, Rose, about your committee and about quality and safety? I think that is the most pertinent committee around that.

Chief Nurse:

All of the care groups meet with the executives on a monthly basis and go through not only their operational activity and their updates but also in relation to their business plans moving forward and the work that they are doing. Because COVID is part of what we do at the moment separating COVID from business as usual in the way that you probably want as an answer is not that straightforward, because it is part of what we do every single day. Those care group reports feed into our Quality and Risk Committee, which is an assurance committee that informs the board, so that committee is chaired by Deputy Pointon at the moment. That committee is joined by clinicians, we go through the risk register, particularly focusing on the high risks, we talk about those in detail and then we have various reports from lots of parts of our services.

The Connétable of St. John:

Are those written reports?

Chief Nurse:

Written reports. Sometimes there will be a verbal update as well, but in the main they are all written reports. This is the Quality and Risk Assurance Committee. We also have other committees, one around people and organisational development and one around finance performance and operations. We would receive a quality and risk, a regular report from infection prevention and control, around COVID activity as well as our broader infection control activity and also includes information about audit data, lessons that we need to learn and what needs to be disseminated back through to the care groups. Is that a broad enough answer?

The Connétable of St. John:

Yes, I think that is what we are looking for, to see if it features on your H.C.S. board's monthly board meetings as a separate item or is it just business as usual?

Chief Nurse:

It is a bit of both. It definitely features within our I.P.A.C. (Infection Prevention and Control) report, which you would expect it to, and if there is anything specific with it happening within a care group that will feature in its own right, but generally it is part of what we do at the moment.

Director General, Health and Community Services:

Those reports get signed off by the committee chairs, which is the Assistant Ministers, so the Assistant Ministers are briefed in advance of the committee, they work with their executive lead around what they want to see at committee, in effect, because the Executive Director can do a report and the Assistant Minister may say: "I have looked at the Q.P.R. (Quarterly Performance Review) and I want to see a focus around this next month" so they will have that impact upon the report, and then the report will go to the board. It will be presented by the Assistant Minister to the board, which is chaired by the Minister, and the Minister may there at the board, or indeed any member of the board, say that he wants to have a deep dive on a particular issue. He will not necessarily come back to the board; he will task one of his Assistant Ministers to do it through one of the subcommittees of the board.

The Connétable of St. John:

If this goes into a deep dive, is that in writing?

Director General, Health and Community Services:

If there is a deep dive then there will be a report through to the relevant committee and it generally will be in writing because the committees are quite strict about having written reports. We have been on a journey with our governance for the last 3 years so we have been aided by the C. & A.G. around advice about how we should manage our reports.

[15:30]

Deputy I. Gardiner:

Going back to the previous questions from the Constable of St. John about the occupational health service. I understand it is not under your management but I think I will connect this to our previous conversations around health management Island-wide and I am aware of the new occupational health tender for the government going forward because we do need to address occupational therapy. If I understand it correctly your department is not currently involved. Have you been

consulted and can you give your views because at the end of the day you are Health and Community Services and I would think if we are looking into health Island-wide, this type of tender, you should have some say in? What are your views on it?

Director General, Health and Community Services:
My understanding is that we have been asked for our opinion around the provision of occupational health services. I am looking at Rose and Ivan.

Chief Nurse:
We have definitely had some initial conversations pre-COVID. COVID then happened and then we are just picking up those conversations at the moment.

Deputy Medical Officer of Health:
That is absolutely where we are and there are some immediate areas that we need to address in terms of immunisation and so on, outside of those areas that are already managed by occupational health infection control, but we do see it as a potential stepping-stone to the creation of a more robust system. Occupational health is outside of my remit. The infection control aspects of it of course are of interest to me and I do need to cater for them.

Deputy I. Gardiner:
I am raising it here and I am sure the next person will continue, but it is completely in my head connected to our previous conversation about a framework Island-wide for our Health and Community Services.

Director General, Health and Community Services:
I have been used to occupational health being hand in glove with the provision of services, because of course a healthy workforce delivers great care and occupational health and provision health working side-by-side really around policy development and about how you manage your wider workforce. We are really supportive around having a robust occupational health service. I think we all agree with that.

Deputy I. Gardiner:
I think input from your department would be important into this, and not just the government going in one direction when you have the expertise and can contribute. I will go into a couple of questions around intensive care if I may. Could you please identify how Bartlett Ward was managed in relation to the Intensive Care Unit during the COVID-19 pandemic and what additional resources were provided to allow it to operate and synchronise with the unit?

Director General, Health and Community Services:
Sorry, what was the first bit?

Deputy I. Gardiner:
So the Bartlett Ward and the Intensive Care Unit, how did it operate together, how this synchronisation between the 2 places worked.

Chief Nurse:
Just so I understand the question, so you have asked how Bartlett and I.C.U. (Intensive Care Unit) worked together?

Deputy I. Gardiner:
Yes.

Chief Nurse:
What was the second part?

Deputy I. Gardiner:
During the pandemic and what additional resources were provided to allow synchronisation?

Chief Nurse:
Okay, so if we just start with some context around staffing levels. We have agreed staffing levels across all of our ward areas based on U.K. best practice guidance, which basically sets out how you calculate staffing levels and come to an agreed approach in terms of what your registered nurse to patient ratio is going to be and what your healthcare assistant skill mix is going to be in relation to that, and then there is some specialist guidance for critical care units that we also follow. Our basic starting point at the beginning of COVID was that we have quite a rich ratio in terms of our staffing, so we have a 1:6 registered nurse ratio and our skill mix is quite rich as well, which means that we have a good proportion of registered staff to healthcare assistants to support them on those wards. We have always gone that way because we recognise we are an Island. When we are thinking about staffing critical care we have to also take into context that we are an Island. That is just a backdrop to the answer, in that staffing is quite complex, so again when you calculate your staffing you take professional judgment into account, you take patient acuity, which is how ill patients are, and you take activity into account, and that is how you start to calculate your staffing levels. So we go into a pandemic at the same time as the rest of the world is in a pandemic, recognise that we are an Island, and recognise we have the set-up that we have got. In terms of those particular 2 areas what we needed to do quite quickly was to start to upskill staff right from the get-go, so we talked about some training that we did when we stepped down some of our activity to enable staff to be

freed up from elective work so that they could support the surge training that we were doing, and that was particularly around the care of critically unwell patients. Over the course of the last 2 years Bartlett has remained our hot ward, in effect, our nominated COVID ward and I.C.U. have had COVID patients and non-COVID patients flexing in and out of that over the period of time. More latterly Bartlett and I.C.U. have worked really closely together to develop the skills, so we have had intensive care nurses working alongside nurses on Bartlett Ward and we have had Bartlett Ward staff go up to intensive care. That does not make them intensive care nurses, but gives them some additional skills and some additional competence. We have got better at joined-up working across some of our specialties. The other area that played really well into the intensive care response was our theatre staff, so again as Simon described our theatre staff are used to using the type of machinery that they would use on intensive care, but they use it in a different way. They were a group of staff that came together right at the beginning of COVID and worked very closely with intensive care. This again fitted with the British Association of Critical Care Nurses' guidance which was revised several times throughout COVID which stipulated and recognised that hospitals were really affected by activity and therefore the challenges around the workforce, whether that was around vacancies or whether that was around sickness and absence, would mean that staffing levels that were set in these national documents possibly could not be met. The British Association of Critical Care Nurses revised their ratios and temporarily suspended their guidance for a period of time and gave additional guidance that had we needed it we could have reduced our critical care nurse ratio to patients and supported those by registered nurses from theatres who had been trained. I know that is quite a complicated answer.

Deputy I. Gardiner:

It is not complicated. Thank you.

Associate Medical Director of the Surgical Services Care Group:

May I add a little bit to that? So the relationship between intensive care and Bartlett has changed over the course of the pandemic, so early on any critically ill patient who needed ventilatory support other than normal levels of oxygenation was managed in intensive care, because the premise was that these people are going to be intubated and ventilated. There was no stance of ever having ventilated patients in Bartlett, i.e., making Bartlett an Intensive Care Unit. The idea was to decant it to theatres because of the equipment and the skillset. As we learned that we could manage patients with lower saturations and not require intubation then the relationship between those patients in Bartlett and intensive care changed, and now it has got to the point where non-invasive ventilation, so providing pressure support ventilation, not in intensive care but in Bartlett, can be achieved because it is the same clinical model so the relationship has sort of changed. In the first instance Bartlett was just managing patients who did not need additional support. Now it can manage patients who need additional support but do not need intensive care. We are very fortunate. We talk to our

clinicians on a first name basis, patients get reviewed or discussed in the round in the morning, so if we have got critically unwell patients or patients who are likely to become unwell they are discussed in the morning, so they are highlighting any additional resources that may need to follow that patient, so we try to avoid any surprises, and that is something that has evolved from the pandemic. It is a snapshot, but it has been a thing that has evolved over time in relation to how we manage those patients.

Deputy I. Gardiner:
How did you ensure that staff responsible for operating equipment used to support and treat patients with COVID-19 such as assisted breathing were properly trained and qualified to use them?

Chief Nurse:
That was through some of the training that we did, particularly at the outset with critical care, but also with registrants it is engrained in you that you do not use equipment unless you have been qualified and competent to do so. So within critical care we have a practice development nurse that has supported an ongoing training programme with other nurses at the hospital, we have regular simulation days throughout the course of the year in terms of simulation training, so that training that they started at the beginning has continued and we do have a workforce that are very flexible and responsive to support their colleagues in other areas. Again, it is about making sure we maintain those skills.

Deputy I. Gardiner:
Is training going through the day or also in the evening time or the night-time?

Chief Nurse:
Training happens in a whole heap of ways when you work in healthcare. There is the bedside training, which you will do alongside your clinical colleagues, so that will be a training opportunity while caring for somebody in practice. There is more formal training that you can have, so I could be on the night shift, we could have less patients than we thought we would have and I could do a training session with another member of staff while they are on duty, whether that is around a piece of equipment or around a procedure. I do not know if Simon wants to add to training, as he is in clinical practice frequently.

Associate Medical Director of the Surgical Services Care Group:
We had a specific training programme for the Nightingale, because that was going to be putting people into a very different environment and so there were various …

Deputy I. Gardiner:

Let us concentrate on our General Hospital.

Associate Medical Director of the Surgical Services Care Group:

We have a COVID training passport, so we have a standard level of training across the board that if people are going to be utilising different bits of equipment they have familiarisation training. We have the ability to rotate staff so putting I.C.U. staff into departments and also bringing Bartlett staff into intensive care when people are being managed on ventilation. There was informal training and competency alignment going on as standard. Also when you are recruiting, and we had agency nurses coming in, they will come in with a certain skillset and it is making sure you align people's skillset to where they are going to be deployed.

Deputy I. Gardiner:

How did you account for and respond to concerns raised by patients and staff within the General Hospital where they gave you feedback raising concerns to show they are dissatisfied with your department's response? That is around COVID patients.

Director General, Health and Community Services:

We had 2 ways for patients to feed back to us. They could either do it through the central team or they could do it through our H.C.S. team. We also have a P.A.L.S. (Patient Advice and Liaison Service) function but of course we did not have that functionality throughout the pandemic but we do have that now, and that is a facility that sits within the Chief Nurse's Office and is an opportunity for patients to be able to feed back on their experience, whether that be negative or positive, and we try to harness lessons learned through there. We have work to do around building our P.A.L.S. because it needs to be better-resourced and we need to increase the responsiveness of that service, but that is work that our Chief Nurse is leading on.

Chief Nurse:

Also to add to that, again for anybody who is in our service, whether they have got COVID or not, there is regular visibility from our senior nurses so they can talk to somebody and we encourage people to raise any issues that they have got at the time so that we can do something about it as much as possible. In relation to our staff, again it was the feedback that we had from staff and we did have regular touch points and certainly it was very moving when you met with groups of staff, particularly those who had worked in the hot areas, about some of the pressures that they felt and the lessons that they had learned and how they wanted to take those forward. Some of those teams have presented to us as an executive team and some of them have met with us on an individual basis. Really what people wanted was a lot of visibility, so again through our senior nurses they are very visible around their areas. This is about making sure we are on top of any issues that our staff are having. As Simon said we know staff on a first name basis and when staff get into difficulty they

do get some individual support around that. Well-being has been developed throughout the course of the pandemic and continues to be for staff.

Deputy I. Gardiner:
We as a committee receive different communications and while asking you about the feedback let us go to practical things. What feedback have you received from COVID patients? What concerns were raised by the COVID patients and how were they dealt with?

Chief Nurse:
We did have some concerns particularly around communication with relatives.

Deputy I. Gardiner:
Concerns that were raised by patients with you?

Chief Nurse:
Yes, raised by patients, so these were patients who were in hospital and obviously their relatives could not visit because they were on Bartlett Ward and it was about how we supported them to communicate with their relatives.

[15:45]

That was one very clear piece of feedback from patients who had COVID who were in hospital. There were some other broader themes. Again, it was not directly raised by the patient but there were other broader themes around loss of a loved one during COVID and how we could improve our response and our support for individuals around that. We did a big piece of work in relation to that. Then there has been feedback in relation to people who have suffered with the effects of long COVID as they have started to recover from the immediate acute phase.

Deputy I. Gardiner:
Were concerns raised by the patients about their medical care that they received or the conditions?

Medical Director, Health and Community Services:
Through our normal business we get feedback from patients.

Deputy I. Gardiner:
I was asking specifically about COVID patients and any concerns regarding care or conditions that were raised by patients with you and, if yes, what type?

Medical Director, Health and Community Services:

I must be careful what I say, because there are ongoing investigations as there always are within health if patients raise issues. Normally they would be reported through our datech system and they can be fairly low level but we can also have serious incidents which are more significant. I am trying to think of anything specific, but I cannot really off the top of my head. It is the sort of feedback and the way that we manage issues within health.

The Connétable of St. John:

How long would it take to get back to someone who has raised a concern?

Medical Director, Health and Community Services:

It depends. We will get back to people straight away and let them know what is going to happen, but that may require an investigation, and I am speaking very generally here. If it is a more significant event, a serious incident, we may often look to have that investigated by someone from outside our organisation, so it varies a lot depending on the incident. Obviously through COVID if you are trying to get someone from outside the organisation to do an investigation they are all very busy as well.

The Connétable of St. John:

If something does not require an investigation but is an observation by a family member how long would it take to get some kind of feedback?

Director General, Health and Community Services:

Again, it depends on the response. So if a complaint or not necessarily a complaint but an observation comes through into an individual executive director that should automatically go to feedback anyway, so that it is centrally logged, not sitting in an individual executive's email inbox. Then there is an agreed time limit around how we answer that. I cannot remember the exact detail of that, but we can share it with you, which is a government-wide standard. We endeavour to get back to patients as quickly as we can. It is logged through feedback but I am in correspondence with patients quite regularly and I will try to get back to them as soon as I see the email, because I think that is good practice and it is what I am here to do. What we have learned from our staff, and I think it applies to patients as well, is that in H.C.S. our staff have not told their story because they have been head down, head to foot P.P.E. dealing with patients in the wards, some of those patients dying, and that is a piece of work that we are doing to harness the story of H.C.S. and our experience of the pandemic, both for our staff but also for posterity and for some learning. I think that patients who have experienced COVID whether that has been COVID where they have just had sniffles or COVID where they have been in hospital and have come out of hospital and have been not necessarily physically impacted but certainly psychologically impacted, I do not think we have had a forum for patients to tell their story of COVID. This is a once in a lifetime experience for all of us

and I think that is something that we really need to think about across departments, about how we do that. The long COVID clinics are offering patients an opportunity to come in, see a clinician and talk about symptoms that they are having as a result of COVID but I think there is something around giving people a forum to express their experience of it.

The Connétable of St. John:
If someone raised a concern with the department in December would you have expected them to have had a response by 10th March?

Director General, Health and Community Services:
If they raised it when, sorry?

The Connétable of St. John:
In December.

Director General, Health and Community Services:
Yes, I would have expected them to have had a response by then and if they have not I apologise wholeheartedly for that and if you bring that to my attention I can ensure that is rectified.

Mr. A. Lane:
You talked a little bit about what happens when a concern or complaint is raised. What are you doing to ensure there is a culture where concerns and complaints can be raised and patients or staff feel able to raise those? There has obviously been some press recently in certain cases and I am just interested at what is happening to allow that speak up to happen.

Director General, Health and Community Services:
There are multiple ways for staff to speak up and we are currently looking to put in place through our culture and well-being a freedom to speak up guardian-type post as they have in the N.H.S., which is a dedicated member of staff or members of staff that staff are able to go to in complete confidence and to raise any issues that they may have, which they feel unable to share through any other forum. Staff are able to raise complaints or issues that they wish to talk about in confidence through our central team in government. There is the ability to do it through our H.R. team. There is a multiplicity of ways for staff to be able to speak up.

Mr. A. Lane:
You are adding to those now based on best practice. Are there any other best practices that you have not followed that you are going to consider bringing in the future?

Director General, Health and Community Services:

Yes, we have been looking at "Happier", which is an app that is used in a lot of N.H.S. trusts whereby we purchase the app and it goes on to staff members' phones and they are able to input into that. It starts to give us a feel across the organisation of how people are feeling and what issues they may have and if there are any themes around that. Our investment in a Director of Culture and Well-being is indicative of our intent to ensure that we make H.C.S. the best possible place for staff to work, so that we can continue to attract staff to come and join us.

Deputy I. Gardiner:

How did you look to develop strategies with non-government organisations such as Hope Jersey or a primary care body to ensure that they were aware of your department's work and to create spaces to ensure that the wider health community felt that they could be involved and briefed in response to COVID-19?

Director General, Health and Community Services:

There was a bronze cell that happened every day. That was across the community and that was the forum by which we were able to disseminate both resilience information around the track of the pandemic and the response to it, both locally within Jersey and nationally and internationally and I think that worked quite successfully. I know that we had senior representation on that call and representation from all partner organisations across the Island and indeed so successful was that call that we have continued it but not on a daily basis.

Deputy I. Gardiner:

How did you include nursing homes within this work?

Director General, Health and Community Services:

We had the Care Federation on that call every day, who represent nursing homes.

Chief Nurse:

To add to that, we set up regular contacts with them, so myself and Patrick. I remember at the very beginning again when it was all unfolding I think we had 74 nursing care home sector members on the call as they had all worked out their technology. As Caroline said, that has continued throughout so we have to have SITREP (Situation Report) meetings with those homes and we also have regular community-wide meetings with those areas as well. In Ivan's team, in the infection prevention and control team we have a nurse specialist who is dedicated to support the nursing home and community home sectors as well, so they feel much better supported in relation to how they have been managing throughout COVID.

The Connétable of St. Martin:

With time going on, how would you have changed Jersey's approach to COVID-19 and what lessons should be learned?

Director General, Health and Community Services:

I think that the approach has been comprehensive and I think that is evident within the morality rate and with the outcomes for I would say the great majority of our patients who have presented at our doors. I speak from the health perspective of the services that we provision. What I would change is I think we need a new hospital to provision a pandemic response. The building we have which occupies probably half of my time is very challenging and the challenge for me every day is asking our staff to come in and deliver within that building. To ask them to deliver in a building that has few single rooms, that has corridors that you are not able to provision hot and cold services in, is incredibly challenging. I would do it differently in a new hospital.

The Connétable of St. Martin:

I appreciate that and I also appreciate the fact that all the doors in there do not open automatically.

Director General, Health and Community Services:

We have many things that are challenging.

The Connétable of St. Martin:

What would you say are your 3 key successes and 3 key problems that your department has encountered during the pandemic, apart from having a crumbling hospital?

Director General, Health and Community Services:

I think for me the key success has been working across departments. There is of course always the ability to do that and we do that regularly, but I think the pandemic absolutely dissolved boundaries between departments and between organisations. As Simon has so eloquently said it enabled us to get so much done so quickly and to have a system-wide health response. I think that system-wide response from primary care, nursing homes, care homes, charities, hospital is such an incredible credit to Jersey. I am going to ask Ivan to talk about those statistics but I think that eloquently sums up what I think we did well in our response.

Deputy Medical Officer of Health:

I think context is really important here. I do not know whether it is a farfetched analogy, but in World War 2 the death rate among U.K. citizens, that is soldiers, civilians, people in the colonies and so on, was about 75,000 a year for each of the 6 years and the mortality of the U.K. during the 2 years of COVID is about 162,000, which is about 75,000 a year. I know the population sizes were different

in 1945 than 2020, but we are talking about that scale, if you see what I mean, so I accept that Neville Chamberlain gave us a year or so to arm ourselves, whereas we did not have a year to arm ourselves since Wuhan emerged. Despite that, people have done really well and in Jersey our mortality to date is about 108 per 100,000. It is 115 but we have got more than 100,000 population. The comparable mortality in the U.K. is 268, so we have sharp edges and blunt edges and we have got our problems but we have responded reasonably well if you look at it within that context, within the context of no warning and competing with the rest of the world for resources, technology, diagnosis, P.P.E., the whole lot, really. For a small Island with a single crumbling hospital that is not bad.

Director General, Health and Community Services:
One thing that we have done brilliantly is our staff. I think they have been COVID heroes. What they do is unseen in those rooms and theatres and I think that it feels like things are easing up for everybody else but for our staff they are still head to foot P.P.E., they are still masked 24/7 and they are still dealing with sick patients coming in through our door. One of the things that health staff across the Island but absolutely within J.G.H. (Jersey General Hospital) have done is I think they have brought their best selves to work every day and as we move into normality I think we have to remember that they are exhausted and that we have to continue supporting them, because the pandemic is still happening today within Jersey General.

The Connétable of St. Martin:
On behalf of the panel we would like to thank your staff very much.

Director General, Health and Community Services:
We really appreciate that, so thank you.

The Connétable of St. Martin:
Just before we close, has anyone got any follow-up questions from the panel?

Deputy I. Gardiner:
First of all I would like to really recognise the hard work that has been done by the staff and the whole department, because of what we have all gone through in the last few years. Now you still have 16 members of staff with COVID and you still have high numbers, so it is not over and you are still dealing with it. We thank you for the response and the work that you have done through the pandemic. I have 2 quick questions around the timelines, one connected to COVID, one not. First, you mentioned the business continuity lead that works now across the department looking into the business continuity. When do you think we will see anything from that work? What is the timescale?

[16:00]

Director General, Health and Community Services:
That is a government-wide post and I might add that has only recently been appointed to, so I am not able to give you an accurate answer around that.

Deputy I. Gardiner:
In your department when do you think?

Director General, Health and Community Services:
With my department with the business continuity plans they are an ongoing feast, in effect, around updating what we are doing. Again, they are something that gets reviewed through the care group structure and then escalated accordingly if there is a need for executive or ministerial support. It is an ongoing process for us around keeping those up to date.

Deputy I. Gardiner:
Back in June you mentioned about public engagement around care models, the questions that we have been posing. When do you plan to start public engagement around care models?

Director General, Health and Community Services:
Those dates have been scheduled now and should be finalised … by the end of March at the latest we should be able to share those dates and that is the plan to go back around to the parishes as we did back in 2019, 2020, a long time ago, and the intent, as I said then, was to go back out but I was inhibited from going back out because of the pandemic. I know there have been questions back to me about us having done it remotely and retrospectively I think perhaps maybe we could have done that, but we have been very busy dealing with the pandemic. Now that restrictions are much looser, and the teams are all back within the environment, we are going to fulfil that commitment to come out to the parish halls. We greatly enjoyed it last time. We want to talk about the care model. It is not our model. It is a model for the people of Jersey so we want to hear that feedback.

Deputy I. Gardiner:
So by the end of March we will have dates when it will happen?

Director General, Health and Community Services:
Yes, it is being managed … Anuschka, are you able to confirm for the panel, because I know those dates have been scheduled. When will we be able to publicise them, please?

Director, Improvements and Innovation:

We are going to release the dates in due course. It is part of the newsletter that will be sent out.

Director General, Health and Community Services:

When will that be? Will that be by the end of the month that we will be able to release the dates?

Director, Improvements and Innovation:

Yes, absolutely.

The Connétable of St. Martin:

Thank you very much. If I am still in office I will look forward to welcoming you into the parishes and thank you very much. On that note I will close the hearing.

[16:03]