Management of the Healthcare Response to the COVID-19 pandemic

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Contents

Summary

Introduction

1. In late 2019 a novel coronavirus emerged in China. Since then it has spread rapidly around the world. This novel coronavirus is called SARS-CoV-2 and the disease that it causes is called COVID-19. The World Health Organisation (WHO) declared COVID-19 a global pandemic on 11 March 2020.

2. The novel nature of both the virus and the disease are important because it can be argued that the clinical dimensions of existing flu pandemic strategies and therefore key parts of countries' response plans would not have been designed for this specific scenario.

3. The rapidly evolving nature of the COVID-19 pandemic has called for an extraordinary response from the Government of Jersey as it has sought to save lives and protect health and livelihoods on the Island. In doing so, it sought to pursue a 'suppress, contain and shield' strategy with the aim of ensuring the continued control and suppression of the virus in a safe and sustainable way that protects Islanders by causing least overall harm.

4. Exhibit 1 is taken from the Government of Jersey's COVID-19 strategy published in June 2020 and maps the key measures in Jersey's COVID-19 strategy to five essential elements of an elimination strategy, sourced from Baker et al (2020), and key WHO advice.

Exhibit 1: Government of Jersey COVID-19 Strategy

Jersey's Framework for a Safe Exit from COVID-19	Baker et al (2020)[1] Essential elements of an elimination strategy	World Health Organisation[2]
Suppress & interrupt the spread Level 3 measures to enable staged, careful, easing of some restrictions – and whilst promoting hygiene and physical distancing throughout School closures	Intensive **hygiene** promotion Intensive **physical distancing**	**Personal measures**: frequent hand hygiene, physical distancing, respiratory etiquette **Physical and social distancing measures** such as: physical distancing (of at least one metre), cancelled mass gatherings, school closures, working from home, avoiding crowds in other settings
Contain and interrupt the spread Household isolation for confirmed cases Self-isolation (quarantine) for people who've been in contact with confirmed cases In-bound travellers must isolate for 14 days Testing and contact tracing – both now at scale enabling widespread testing and rapid contact tracing	**Border controls** with high quality quarantine of incoming travellers. Rapid **case detection** identified by widespread **testing**, followed by rapid case **isolation**, with swift **contact tracing** and quarantine	**Movement measures** such as: limiting movement of persons, offering guidance regarding travel, arranging travel in advance to avoid congestion at travel hubs (bus terminals, airports) and considering a *cordon sanitaire* or other selected measures
Shield the most vulnerable Severely vulnerable (high risk medical conditions) and vulnerable (underlying medical conditions, noting overall vulnerability increases with older age): advised to be extra vigilant, and may seek medical advice about balancing risks	[Not explicitly listed]	**Special protection measures** to protect special populations and vulnerable groups for: those at risk of more serious illness from COVID-19, groups with social vulnerabilities, those living in closed settings, and groups with higher occupational risks
The largest public awareness and engagement strategy ever undertaken in Jersey	A well-co-ordinated **communication** strategy	The need to "communicate effectively, engage communities" identified as top success factor for implementation of other public health and social measures

[1] Baker, M. et al. (2020). 'New Zealand's elimination strategy for the COVID-19 pandemic and what is required to make it work' in The New Zealand Medical Journal. Vol. 133. No. 1512. Pp. 10-14.
[2] WHO (2020). 'Overview of Public Health and Social Measures in the Context of COVID-19 (Interim Guidance, 18 May Update)

5. This report evaluates the Government's management of the healthcare response to the COVID-19 pandemic during 2020. It considers:

- how public health risks were identified and managed
- arrangements for the healthcare response for patients with COVID-19
- arrangements for the continuation of the healthcare response for non-COVID-19 patients
- the deployment of and support for frontline workers; and
- co-ordination with third party organisations to ensure an effective 'whole system' health and care response to COVID-19.

6. The review I report here is one in a series I am undertaking to evaluate the Government's response to the COVID-19 pandemic. Other reviews planned will consider overall governance and decision making, communications and the strategies for test, trace and vaccine roll out.

Key findings

7. The key findings from my review are as follows:

- action was commenced early in 2020 to start to understand and monitor COVID-19 and its potential impact on Jersey. Senior Health and Community Services (HCS) staff were aware of the key risks from COVID-19 from an early stage. Whilst business continuity plans (BCPs) were in place in January 2020, a lot of work went into improving them between mid-February and the end of April 2020

- at the outset, the specialist public health function was operating at limited capacity. The Government took action in March 2020 to re-deploy internal resources to the public health function. The fast moving pace of COVID-19 resulted in an absence of formal record keeping in the early stages in respect of how public health advice given to Ministers was determined

- from late April 2020 there is a better audit trail, through the Scientific and Technical Advisory Cell (STAC), of the public health advice given. However, this record of advice given is not always comprehensive, nor are there detailed records of the discussions around how this advice was created (including alternative options considered)

- during March 2020 HCS significantly reduced the non-COVID-19 elective and non-urgent physical and mental health services it provided. The suspension of these services during the first wave lockdown and the need to introduce COVID-19 compliant clinical pathways, resulted in a growth in healthcare waiting lists

- additional proactive community care plans were put in place and were targeted at and delivered to vulnerable patient groups in the community, such as the elderly. These plans sought to ensure continuity of services during the period when a different model of primary and community care operated due to the pandemic

- the hospital and community system did not experience significant gaps in staff deployment during the first wave despite high levels of staff absence. The reasons for this were that the number of COVID-19 patients never reached a level where the shortage of staff became an issue and that the suspension of elective and non-urgent services created staff availability. At the time the decision was made to build the 180 bed Nightingale Hospital however, it was not clear where the extra staff to support the facility would come from should the facility have been required in practice

- the decision to employ the General Practitioners (GPs) was based in part on ensuring the resilience and sustainability of GP services and also on providing GP capacity to support an integrated primary and secondary care service. The services provided by GPs resulted in benefits to patients

- the Government worked with third party organisations to fill the gaps and overcome weaknesses that existed in the wider health and care system during the COVID-19 pandemic. When HCS steps in and fills a gap in another organisation's services, there is a risk of a lack of clarity, as to roles and responsibilities of the organisations and individuals involved; and

- despite 44 COVID-19 deaths in 2020, overall mortality (including COVID-19) was 14% lower than 2018 and 10% lower than 2019.

Conclusions

8. Jersey has not experienced the significant rates of COVID-19 infections that other countries have. As at 31 December 2020 the total of number of confirmed COVID-19 cases in Jersey was 2,760 and the total number of COVID-19 deaths was 44, which represents 1.6% of all confirmed cases. The public health advice given has been effective when assessed against a strategy of least overall harm.

9. A full reflective and evaluative 'lessons learned' exercise on the COVID-19 healthcare response should be undertaken across the whole health and care system on the Island. This should include Government and third party organisations. In addition, the proposed expansion of the public health function as part of the Jersey Care Model should be reviewed to ensure that the function is properly equipped to address future health protection emergencies.

Objectives and scope of the review

10. This review has evaluated the effectiveness of the Government of Jersey's management of the healthcare response to the COVID-19 pandemic.

11. The review is part of a series of reviews I am undertaking looking at the Government's response to the COVID-19 pandemic as shown in Exhibit 2.

Exhibit 2: Comptroller and Auditor General reviews of the Government response to the COVID-19 pandemic

Overall Governance and Decision Making Processes						
Commun-ications	Procure-ment processes and supply chain manage-ment	Manage-ment of the healthcare response	Test, trace and vaccine roll out	Risk manage-ment	Schemes to support businesses and individuals	Manage-ment of public finances

12. In evaluating the effectiveness of the healthcare response, the novel nature of both the virus and the disease are important, because it can be argued that the clinical dimensions of existing flu pandemic strategies and therefore key parts of countries' response plans would not have been designed specifically for this scenario. Formal risk management tools like BCPs are ideally suited to managing events with higher levels of certainty. However, responding to a novel global pandemic, with such a high number of direct and indirect unknown unknowns, creates different challenges.

13. In a world of 'known unknowns' or even 'unknown unknowns', it is difficult to follow best practice, because there is unlikely to be any identified. Therefore, significant levels of uncertainty will inevitably impact on how people respond and the decisions they make. My review has sought to take account of and understand the context within which the Government of Jersey was operating throughout the COVID-19 pandemic.

14. My review has evaluated the following aspects of the healthcare response to the COVID-19 pandemic:

- how public health risks were identified and managed
- arrangements for the healthcare response for patients with COVID-19
- arrangements for the continuation of the healthcare response for non-COVID-19 patients
- the deployment of and support for frontline workers; and
- co-ordination with third party organisations to ensure an effective 'whole system' health and care response to COVID-19.

15. My review has not looked specifically at the testing programmes, contact tracing procedures and vaccine programmes introduced during the COVID-19 pandemic. A further review planned for 2021 will consider these aspects of the healthcare response.

16. The review approach is explained in detail in Appendix One.

Detailed findings

Identification and management of public health risks

17. Exhibit 3 summarises some of the key dates in the Government's healthcare response to COVID-19.

Exhibit 3: Timeline of key dates in the healthcare response

Date	Activity
24 January 2020	Initial Review Group (IRG) established
2 February 2020	HCS meeting held to "monitor the spread of COVID-19 globally". No records retained of this meeting
6 February 2020	Informal HCS Group established to discuss emergent issues and co-ordinate actions
7 February 2020	Letter received from the NHS in England titled "*Novel Coronavirus: Advice for the NHS in England*" Tactical Co-ordination Group met for the first time
11 February 2020	Strategic Co-ordination Group met for the first time COVID-19 situation discussed at the Jersey Resilience Forum
19 February 2020	Coronavirus helpline set up
20 February 2020	Meeting between Dr Ivan Muscat and the Minister to discuss legislation
26 February 2020	The Informal HCS Group (now re-named COVID-19 working group) meeting records its advice to extend the coverage of the Jersey 14 day isolation requirement for people returning from high risk countries. There is no record as to whom this advice was given
3 March 2020	Dr Ivan Muscat informs the COVID-19 working group that "it is getting closer and we need to manage day trippers with advanced monitoring, barriers and posters"
4 March 2020	Council of Ministers briefed and agree overall objectives for the response to COVID-19
10 March 2020	First detected COVID-19 case confirmed in Jersey Formal Jersey COVID-19 Command and Control structure is established

Date	Activity
11 March 2020	WHO declared COVID-19 a pandemic
12 March 2020	Emergency Council met for the first time
14 March 2020	First public advice issued including social distancing measures for over 65s, essential travel and self-isolation for those suffering symptoms
18 March 2020	Announcement of strategy to 'contain, delay and shield'
20 March 2020	Initial meeting of Competent Authorities Ministers Detailed briefing to Health and Social Security Scrutiny Panel
27 March 2020	COVID-19 legislation debated at the States Assembly
30 March 2020	Lockdown commences
28 April 2020	Formal STAC met for the first time
1 May 2020	Publication of Safe Exit Framework
3 June 2020	COVID-19 Strategy published
26 June 2020	Publication of Safer Travel Policy
2 November 2020	COVID-19 Winter Strategy published

18. Action was commenced early in 2020 to start to understand and monitor COVID-19 and its potential impact on Jersey. Public health risks were identified and reviewed continually from early February to late April 2020. However, before the formal STAC was established towards the end of April 2020 it is difficult to see a clear audit trail that records how public health advice to Ministers was being determined.

19. At the beginning of February 2020, the public health function in Jersey was operating at limited capacity. The Medical Officer of Health was not available due to a period of planned sickness absence and Dr Ivan Muscat had been designated as one of two Deputy Medical Officers of Health. The Government took action in March 2020 to re-deploy internal resources to the public health function. The workload for Dr Muscat, was considerable. Dr Muscat is a Microbiologist and a consultant in communicable disease control. He splits his time between HCS where he has an extensive clinical workload and the Government public health function.

20. Throughout the period of the pandemic, Dr Muscat has drawn his professional public health advice from his own experience, plus a range of reliable public health specialist sources. The fast-moving pace of COVID-19 resulted in an absence of formal record keeping in the early stages in respect of how public health advice given to Ministers was determined.

21. Prior to the establishment of the formal STAC, a broad range of specialist public health advice was given to Ministers (including from Dr Muscat). There is however a limited audit trail of how this advice was determined. This lack of record keeping means there is very little evidence of why specific public health advice was given, as opposed to alternative advice. For example, there is no clear audit trail of how the public health function considered advice from the following sources:

- Public Health England (PHE) – there were regular pandemic meetings between PHE and the Crown Dependencies of Jersey, Guernsey and Isle of Man
- WHO
- European Centre for Disease Prevention and Control
- American Centers for Disease Control and Prevention ; and
- other relevant world-wide sources.

22. In certain instances the advice is summarised in PowerPoint presentations. The decisions taken by Ministers in respect of the advice received are recorded in the minutes of the meetings of the Competent Authorities Group and the Council of Ministers.

23. Dr Muscat's dual expertise, both as a microbiologist and an experienced public health specialist, has been relevant and vital to the particular public health challenges caused by COVID-19. His specific combination of experiences has facilitated the technical implementation of on-Island COVID-19 virus testing, as well as advice on the wider pandemic from a population perspective. However, the overall resilience of the public health function is limited. The Government has recognised this, and the Jersey Care Model includes plans to expand the public health function.

24. There were times in the early stages of the pandemic when the 'key man' risk of having a single point of expertise was apparent. For example, at the Gold Group meeting on 26 March 2020 there was no update on infection control as Dr Muscat was not present at the meeting. The Medical Officer of Health returned to work in late April 2020.

25. As noted in Exhibit 3, a formal STAC was established and met for the first time on 28 April 2020. This was over three months after the need for a STAC had been identified by the IRG. Prior to 28 April 2020, other groups within the emergency response structure had performed roles similar to STAC.

26. The role of STAC is not the same as the UK Government Scientific Advisory Group for Emergencies (SAGE) which had met 28 times by 28 April 2020. Both SAGE and STAC provide scientific and technical advice to support government decision makers during emergencies. SAGE provides scientific and technical advice based on primary research and is focussed solely on the health domain. STAC however considers emerging knowledge from primary research and secondary analysis and uses the expertise of its members to interpret that into a Jersey context, within the strategic aim of least overall harm. STAC is not just providing advice on a single specialist scientific and technical health domain, but on the domains of other harms as well.

27. The membership of STAC as set out in the June 2020 COVID-19 Strategy is shown in Exhibit 4.

Exhibit 4: Membership of STAC

- Medical Director (Chair)
- Medical Officer of Health (Vice Chair), attends Emergencies Council
- Consultant in Communicable Disease Control
- Dr Graham Root, Independent Advisor -Epidemiology and Public Health
- Managing Director, Jersey General Hospital
- Chief Nurse
- Associate Medical Director for Primary Prevention and Intervention
- Associate Medical Director for Unscheduled Secondary Care
- Associate Medical Director for Women and Children
- Associate Medical Director for Mental Health
- Environmental Health Consultant
- Group Director for Policy
- Director of Strategic Policy, Planning and Performance
- Director of Strategy & Innovation
- Chief Economic Advisor

28. In support of STAC, the following are standing invitees:

    - Head of Public Health Policy

- Head of Health and Social Care Informatics; and
- Senior Statistician.

29. The membership of the COVID-19 STAC brings more than purely scientific and technical expertise. While nearly all members of STAC are Government employees or employees of organisations mainly or directly funded by the Government, Dr Graham Root offered his services to the Government and became an independent advisor to STAC. Dr Root is an epidemiologist who is the Chair and Founding Director of Montrose (which is a specialist public health consultancy, based in Jersey).

30. STAC has been formed as part of the specific response to COVID-19. However, there could be a need to form other STACs in the future to provide advice to Government to inform decision making. From a perspective of good governance there would be value in adopting a consistent code of practice for the establishment and operation of STACs in Jersey. A code of practice should encompass principles and procedures to be followed in determining membership, relationship with the sponsor department within Government, independence and objectivity, working practices and communication and transparency.

31. From late April to early June 2020 there is a better audit trail through STAC of the determination of the public health advice given to Ministers. However, the record of final advice given is not comprehensive, nor are there detailed records of the discussions around how this advice was created (including alternative options considered). There is evidence that the advice given was not one dimensional and that it attempted to balance the "*least overall harm*" concept across three domains of evidence:

- epidemiological
- system capacity; and
- harmful impacts of COVID-19, including wider health impacts, social and cultural, economic and environmental.

32. During the period of my review, STAC relied on a range of external primary scientific and technical research to formulate its advice. However, the sources that underpin the advice are not openly and transparently recorded. Also, the resulting discussions, to put this external information and advice in a Jersey context, have not been recorded clearly. The minutes of the STAC meetings do not always include details of the advice STAC uses, the advice it rejects and the advice it amends and why. In addition, the minutes do not contain useful action plans or an audit trail of follow through of actions taken.

33. Scientific and technical advice intended to support the health and well-being of a population is usually accompanied by an impact assessment aimed at assessing how this advice affects vulnerable groups, to ensure it does not widen health inequalities. These groups could include people covered by protected characteristics such as age, race and disability as well as those experiencing poor physical or mental health or economic deprivation. From the documentation provided, it is not possible to see whether formal assessments had been undertaken on the effect of public health advice on vulnerable segments of the Island's population. I accept that the fast moving pace of COVID-19 and the need, in certain instances, to make quick decisions mean it can be challenging to undertake and document such impact assessments fully. However, best practice would require a minimum standard of documentation.

34. Between late April and early June 2020 a strategic framework to assess risks and to advise on decisions was being developed. This framework was issued in early June 2020, when the Jersey COVID-19 Strategy was published.

35. Since early June 2020 the STAC meetings and the information STAC receives, have evolved to enable reporting against this framework. This has provided the pathway that has guided Jersey out of wave one lockdown and then, as risks increased, into wave two lockdown. From reviewing the documents available, the role of STAC in advising on key COVID-19 decisions, has not been consistent. For example, during May and June 2020 STAC was heavily involved in advising on the COVID-19 reopening of the Island and the establishment of border controls. This included specific advice on:

- the wider impacts on Jersey (physical and mental health and well-being) of continuing with a policy of border closure
- scalable testing and contact tracing arrangements for people arriving on the Island
- a plan to respond to any surge in new cases; and
- a plan that balances the return of economic and social activities on the Island in a way that mitigates future potential health harms.

36. However, STAC was not asked to provide advice on the final set of restrictions imposed over the 2020 Christmas period. STAC subsequently considered the Christmas gatherings guidance when its advice was sought by Ministers regarding possible exemptions.

Recommendations

R1 In light of the COVID-19 experience, review the expansion of the public health function proposed as part of the Jersey Care Model to ensure that it is properly equipped to address future health protection emergencies.

R2 Introduce formal procedures to improve the documentation of specialist public health advice to make it clear what advice was given, and why that advice was given, as opposed to alternative advice that was not given.

R3 Ensure that all future material pieces of public health advice that are provided to Government contain appropriate impact assessments, that take into account the impact of that advice on vulnerable communities.

R4 Develop and implement a Code of Practice for future STACs to encompass principles and procedures to be followed in determining membership, relationship with the sponsor department within Government, independence and objectivity, working practices and communication and transparency.

R5 Improve the records and minutes of future STAC meetings to provide a more complete audit trail as to:

- how advice given has been determined
- the action plans arising from the meetings (including timescales and responsibilities for actions); and
- the follow through of matters arising and actions taken.

Arrangements for the healthcare response for patients with COVID-19

37. COVID-19 is a rare example of a disease where the key health interventions (until such time as a vaccine is available) are public health (such as physical distancing, face masks, hand washing and isolation) rather than clinical (such as surgical or drug based treatments). Not all patients who become infected with the virus show symptoms and not all require hospitalisation as not all become severely or critically ill with COVID-19. The novel nature of both the virus and the disease mean that the clinical dimensions of existing flu pandemic strategies would not have been designed specifically for the COVID-19 scenario.

38. In November 2019 a flu pandemic table-top planning exercise had been held. The report that followed (dated 20 November 2019), included 18 recommendations. Despite the COVID-19 pandemic being different to a flu pandemic, a number of the recommendations from the report (such as the need to develop business continuity plans and provide training to key people) are relevant to any health related emergency. The Government had not implemented these recommendations before COVID-19 emerged in early 2020.

39. By February 2020 HCS was planning for COVID-19. The planning activities focussed mainly on HCS rather than a whole of Government approach. Daily meetings were being held within HCS with input from the Infection Prevention and Control Team (IPAC) and the Environmental Health Department HCS referred to this series of meetings as 'pre STAC'. The first set - 'Corona meetings' – ran from 6 February 2020 to 2 March 2020 and was succeeded by the 'COVID-19 Working Group' from 2 to 12 March 2020. These meetings had no standard agendas however, and risk assessments were not considered specifically at these meetings. The documentation from these meetings did not record the clear assignment of actions. In addition, the follow up of actions and escalation processes were not clear.

40. At a practical level face mask testing and training started during February and the HCS Readiness and Delivery Plan was scheduled to be reviewed twice a week. Tight-fitting respirators (such as disposable FFP3 masks and reusable half masks) rely on having a good seal with the wearer's face. To ensure that respiratory protective equipment (RPE) will protect the wearer a 'face fit' test should be carried out the first time a worker uses a particular type of respirator. The wearer should carry out a pre-use seal check or fit check, which they should repeat every time they put a respirator on. All frontline staff needed to undergo mask 'fit' testing and training, and use of specific masks and equipment. There were however weaknesses in the administration and monitoring of compliance with this testing and training. For example, a list of doctors who had been mask tested was not maintained by the medical staffing department and some staff failed 'fit' testing.

41. The meeting of 6 February 2020 set out a suggested healthcare pathway for symptomatic people and agreed to test the pathway. A live scenario however happened on the evening of 6 February 2020. A person who had been in Kuala Lumpur had presented at the Emergency Department (ED) with symptoms. As Kuala Lumpur was not considered a risk, the patient was initially returned to their hotel but was subsequently admitted to hospital when, on the same day, travel advice changed to include Malaysia as high risk.

42. At the meeting on 25 February 2020 self-isolation rules were considered. The meeting decided that asymptomatic travellers from Mainland China, Republic / South Korea, Iran and Northern Italy should self-isolate for 14 days. Whilst the

notes of the meeting refer to a list of high risk countries in use in the UK, the Jersey list did not include Vietnam, Cambodia, Laos and Myanmar. There is no record of why these countries were not included in Jersey's list.

43. The Council of Ministers received a verbal briefing from the Director General of HCS and the Emergency Planning Strategic Lead at its meeting on 4 March 2020. The Council of Ministers agreed that the Government's objectives should be to:

- minimise risk and harm to the public
- maximise the safety of emergency responders
- maintain public awareness and confidence
- ensure business continuity across all sectors; and
- provide an effective and coherent response.

44. The first confirmed Jersey COVID-19 case was on 10 March 2020. On the same day the formal command and control structure was established, including for HCS Gold, Silver, Hospital Bronze Group and Community and Primary Care Bronze Group.

45. During the second half of March 2020 the majority of non-COVID-19 elective and non-urgent care (physical and mental health) was suspended. These services subsequently restarted during June 2020. The first confirmed COVID-19 death on the Island was on 25 March 2020. The decisions on which services were suspended in March 2020 and which face to face services would continue were not supported by consistent documentation against a clear set of risk based criteria.

46. Also during the second half of March 2020, a decision was made to transfer a number of patients from Samares ward at Overdale to the Sandybrook nursing home at St Peter. The patients transferred were not screened for COVID-19 and staff at Sandybrook were not advised to wear Personal Protective Equipment (PPE), although PPE was available to all staff. Subsequently, staff from Sandybrook had to self-isolate.

47. Senior HCS staff were aware of the key risks of COVID-19 from an early stage. These risks included how potential COVID-19 patients could present at the hospital, the availability of PPE (including face masks), guidelines of what PPE to wear and who should wear it, vulnerable 'at risk' patients, virus testing of patients and staff, staff shortages caused by self-isolation/sickness/off-Island travel, hospital bed capacity needed in a reasonable worst case scenario, oxygen supplies and workforce shortages in general. However, decisions on testing of patients and PPE guidance were not supported consistently by documented risk assessments.

48. Whilst business continuity plans were in place in January 2020, a lot of work went into improving them between mid-February and the end of April 2020. By 28 May 2020, HCS was using version 14 of the COVID-19 Readiness and Delivery Plan which was a comprehensive risk based service continuity plan.

49. A decision was taken in April 2020 to build a Nightingale Hospital. The assessment of bed capacity in the Jersey General Hospital and the community that supported the decision showed a total bed capacity of 352, with the potential for a further 68 beds in the system. The HCS COVID-19 Readiness and Delivery Plan initially estimated bed requirement to manage a COVID-19 pandemic as 600. This was based on the PHE Model produced on 16 March 2020 showing 'reasonable worst case scenarios' for UK Crown Dependencies. The potential 248 bed gap was the driving force behind the decision to build a 180 bed Nightingale Hospital which opened on 11 May 2020. The Nightingale Hospital did not, in the end, admit any patients. I have considered the decisions regarding the Nightingale Hospital further in my review of *Procurement and Supply Chain Management during the COVID-19 pandemic*.

50. Governance of clinical quality during the period from March to May 2020 was through the major incident Command and Control arrangements, rather than through the existing HCS Quality, Performance and Assurance Committee. The HCS Quality, Performance and Assurance Committee stood down in March 2020 and did not restart until May 2020.

51. When the HCS Quality, Performance and Assurance Committee restarted in May 2020 the Assistant Minister for Health and Social Services stood down from his Ministerial role and his role as Chairman of the Committee. This left a period where a replacement Assistant Minister had not been appointed. During this interim period, the Chief Nurse (who is the HCS Director of Nursing) undertook the role as Chair to enable the Quality, Performance and Assurance Committee to continue to discharge its duties in line with its terms of reference. It is not recommended practice for a Director of Nursing to Chair a Committee which has the main purpose of giving assurance regarding the quality of care given by the service. Recommended practice would be for an independent lay person with an appropriate background to chair the Committee.

52. Not all patients who become infected with COVID-19 require hospitalisation as not all become severely or critically ill. As a point of comparison, the American Centers for Disease Control and Prevention reported on 8 December 2020 that the largest cohort, including more than 44,000 people with COVID-19 from China, showed the illness severity can range from mild to critical as follows:

- mild to moderate 81%

- severe 14%; and
- critical 5%.

Further that 'Among US COVID-19 cases reported 22 January to 30 May 2020, overall the number of people who were hospitalised was 14% [and] 5% of patients died'.

53. As at 31 December 2020 the total of number of confirmed COVID-19 cases in Jersey was 2,760 and the total number of COVID-19 deaths was 44, which represents 1.6% of all confirmed cases.

Recommendations

R6 Ensure risk assessments are documented to support decisions made on guidance issued to staff.

R7 Undertake a formal reflective evaluation of the lessons learnt on business continuity planning during 2020.

R8 Introduce formal arrangements to review the effectiveness of Business Continuity Plans on an annual basis and report the findings of these reviews to the Risk and Audit Committee.

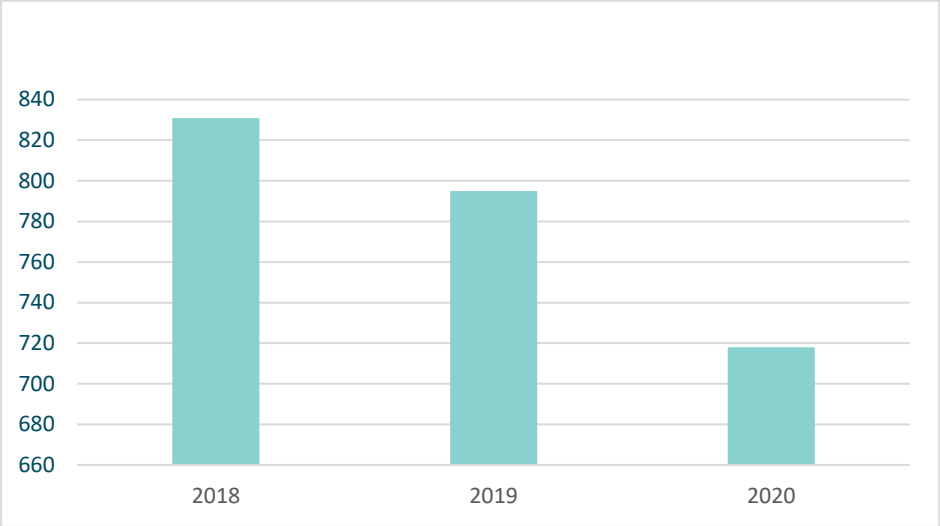
R9 Review the COVID-19 experience and develop future emergency pandemic preparedness to deal with the risk from high consequence infectious diseases such as flu and COVID-19. There should be a formal public report produced to summarise the outcome of this review.

Arrangements for non-COVID-19 patients

54. During March 2020 as HCS prepared for COVID-19, it significantly reduced the non-COVID-19 elective and non-urgent services provided. During the first lockdown, the negative impact that lockdown was having on the wider health and well-being of patients and the public was noted on a number of occasions at STAC (in particular at the STAC meeting on 6 May 2020). The re-opening of non-COVID-19 health services was one of the key drivers to exit lockdown.

55. Despite 44 COVID-19 deaths in 2020, overall mortality (including COVID-19) was 14% lower than 2018 and 10% lower than 2019, as Exhibit 5 shows.

Exhibit 5: Overall Mortality 2018-2020



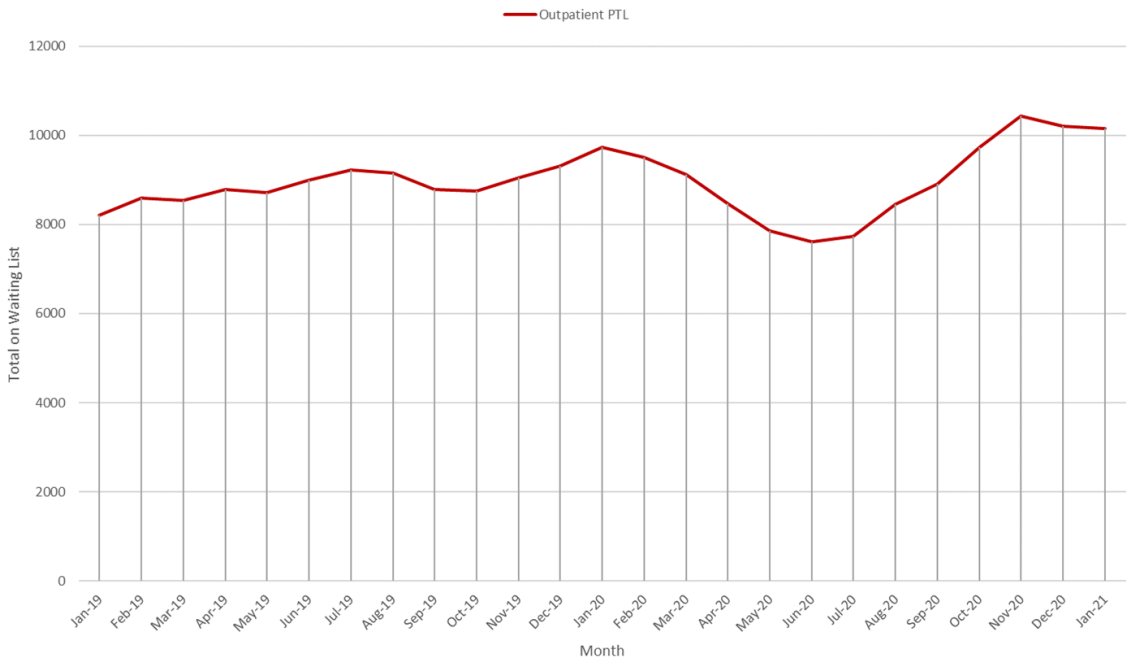
Source: Government of Jersey data

56. During the COVID-19 pandemic in 2020 additional proactive community care plans were put in place and were targeted at and delivered to vulnerable patient groups in the community, such as the elderly. These plans sought to ensure continuity of services during the period when a different model of primary and community care operated due to the pandemic.

57. At the start of the COVID-19 pandemic HCS had recently introduced Patient Tracking Lists (PTLs) to monitor all patients through their patient journey from attendance to discharge. When services resumed the PTLs helped with the clinical prioritisation of which patients to treat first. The clinical prioritisation that took place at this time highlighted a concern that the historic practice of combining privately funded patients on the same operating theatre list as publicly funded patients, could lead to lower risk patients being treated before higher risk patients. The solution put in place was to separate the publicly and privately funded patient lists.

58. The suspension of services during the first wave lockdown and the need to introduce COVID-19 compliant clinical pathways have resulted in waiting lists for other treatments growing. Exhibit 6 shows the outpatients PTL from January 2019 to January 2021. It shows that the number of patients waiting for an outpatient appointment grew from just above 8,000 in January 2019 to over 10,000 by the end of November 2020. As at 26 February 2021, the number of patients waiting for an outpatient appointment was 9,289.

Exhibit 6: Outpatients PTL January 2019 to January 2021

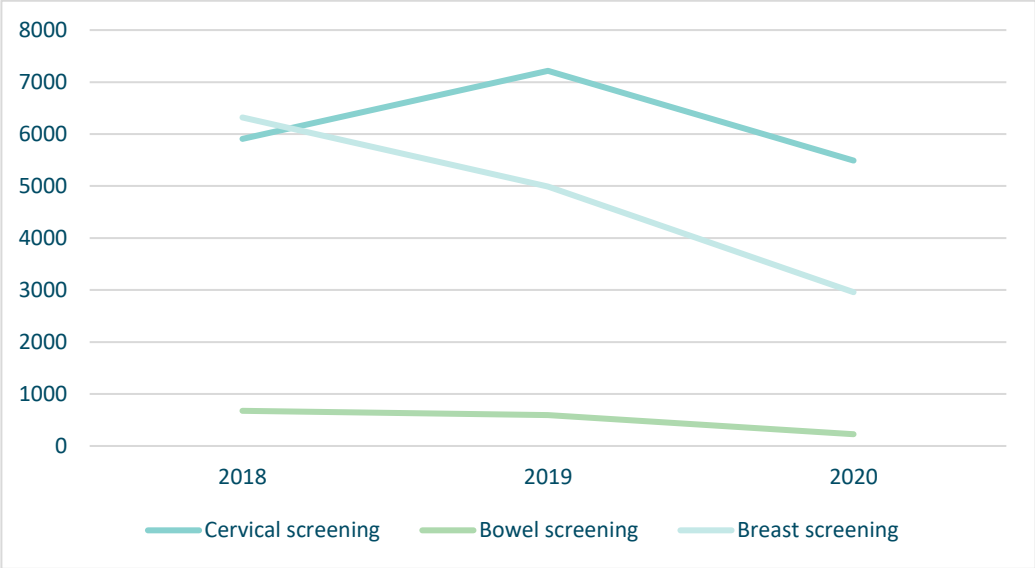


Source: HCS presentation 11 January 2021

59. HCS has learnt from the first wave lockdown in terms of impact on other services. For example, HCS has created new separate clinical pathways for COVID-19 and non-COVID-19 patients, which has ensured that non-COVID-19 patients could continue to be treated during the second wave. There is also a greater appreciation, both within HCS and STAC of the harms that can be caused by suspending services, including the impact on mental health.

60. Healthcare screening services also saw significant reductions in services during the COVID-19 pandemic. Exhibit 7 illustrates the impact on cancer screening services.

Exhibit 7: Cancer screening services



Source: HCS presentation 11 January 2021

61. HCS is aware of the risks around the growing waiting lists (particularly cancer screening) going into 2021 and is putting in place plans to reduce these during 2021.

Recommendation

R10 Ensure that the Operational Plan for 2021 prioritises reducing waiting lists and catching up on the cancer screening backlog.

The deployment of and support for frontline workers

Staff deployment

62. During the COVID-19 pandemic, operational and tactical workforce decisions were made at the HCS Bronze Groups and also at care group levels. If required, issues were escalated up to the Silver Command for decision.

63. These operational/tactical workforce decisions, in services directly run by HCS, were supported by the HCS workforce information systems that were operating at that time. These included workforce electronic rostering (e-rostering) and sickness and absence monitoring. These workforce systems enabled HCS to report on the levels of staff absence and vacancies on a day to day basis, skill gaps for key clinical services and staff redeployed to cover service gaps. For certain services

not directly provided by HCS, such as contracted out cleaning services, HCS did not hold workforce information.

64. The HCS workforce information systems meant that HCS leaders knew how many clinical and medical staff they had at any one time. During March and April 2020 there was a high level of HCS staff absence. However, as a mitigation non-urgent and elective work had been suspended and, in practice, the number of COVID-19 patients was relatively low compared to other international healthcare systems.

65. Despite high levels of staff absence, the hospital and community system did not experience significant gaps in staff deployment during the first wave. The key reasons were that the number of COVID-19 patients did not reach a level where the shortage of staff became an issue and that the suspension of elective and non-urgent services created staff availability.

66. The need for an additional hospital surge facility (the Nightingale Hospital) to manage the potential volume of COVID-19 patients requiring hospital care, was identified based on modelling dated 16 March 2020. This model used public health data and the reasonable worst case scenario from the PHE Model referred to earlier. The 180 bed Nightingale Hospital was completed by 11 May 2020.

67. The business case estimated running costs of £4.3 million for a four-month period, including £3.3 million for staffing. At the time of the business case however, the operational plan had not been finalised and the risk of staff availability was not quantified. It was therefore not clear where the extra staff to support those 180 beds would come from should the facility be required in practice. The business case to extend the period of the Nightingale Hospital from January to March 2021 did include a limited risk assessment in respect of staffing. The Nightingale Hospital has not been used for patient care and so the issue of how to staff the facility did not arise in practice.

68. During the second wave (autumn/winter 2020/21) some nursing and residential care homes experienced staff shortages as a result of sickness and the need for some staff to self-isolate (due to contact tracing requirements or COVID-19 infection). This risk was managed through the Community Bronze Group meetings.

69. An area of good practice is the Community Bronze Group, which has continued after June 2020. In this daily meeting independent organisations, such as nursing and residential care homes, provide reports on risks and issues, which include workforce information. Based on this workforce information, HCS has shared agency and bank support and has even redeployed HCS staff into nursing or residential care homes in times of significant shortage. HCS also has a daily situation report which includes activity on staffing and IPAC issues.

The employment and deployment of GPs

70. The Competent Authorities Meeting on 25 March 2020 considered the need to expand medical staffing and estate whilst providing an integrated primary and secondary care model. Experience at the time was that primary care activity was reduced by around 25% which provided the opportunity to use GPs in secondary care settings where pressures were anticipated. The continuity of primary and community care on the Island was also considered to be at risk due to weaknesses in resilience planning.

71. A business case was subsequently prepared drawing on some of the principles previously underpinning the developing Jersey Care Model. These included service design based on need, efficient working arrangements, smooth interaction and communication between care settings as well as risk assessment.

72. The business case proposed that an integrated solution would protect both primary and secondary sectors. GP capacity would be used to support an integrated primary and secondary service including:

- establishing a consolidated GP infrastructure around three of the 13 surgeries
- providing primary care support remotely
- support to the ambulance service
- support in the urgent treatment centre
- support in community settings
- adding resilience to HCS services
- support to Government services such as the prison; and
- certification of patients who succumb to COVID-19 and die in the community.

73. The integrated arrangement was proposed for four months with an option to extend to six months. The contract provided for each GP to undertake 10 sessions of activity per week in one or more of the areas specified above. Private work was permitted with approval from the Group Medical Director with income accruing to the Government unless it was agreed that the disruption to the contract with HCS was minimal.

74. The contract was reviewed at the agreed break period in month three and it was announced on 2 July 2020 that the arrangement was no longer required. The contract ceased on 9 August 2020.

75. Having identified the potential pressure and need for additional bed capacity based on the reasonable worst case scenario, five options to co-ordinate GP practice resources into an integrated, sustainable and flexible arrangement were considered. The first option of doing nothing was not considered to be a viable as this did not meet the immediate clinical need already identified and the mitigation listed above.

76. The preferred option was a GP employment contract with separate surgery agreements which placed the GPs in temporary employment of the States. The business case included a detailed assessment of the financial costs of the preferred option and the risks. The other options were dismissed for reasons including cost and being unacceptable to GPs. However detailed evaluation of the costs and benefits of the alternative options was not part of the business case.

77. The cost of the agreement was based on the cost elements shown in Exhibit 8. To meet this cost, a total of £4.4 million was agreed as a withdrawal from the Health Insurance Fund (HIF) to fund the GP and surgeries contracts.

Exhibit 8: Cost basis of GP contracts

Cost element
GP salaries and employment costs
GP support and infrastructure costs
Less - Medical Benefit payments and other fees payable to GPs expected in period
= Net additional cost to Government

78. The GP employment costs were based on actual salaries for commensurate positions in HCS. The infrastructure costs were based on an assessment of 'reasonable' running costs of each GP practice which were independently verified. The contracts provided that GP fees from non-COVID-19 patients would still be payable along with the associated Medical Benefit payments. This was not initially factored into the business case due to estimating difficulties and the fact that it was unlikely to impact on the decision. However, the final business case dated 8 April 2020 reflected this benefit accruing to the States on the basis of 70% of normal activity. The lower patient volumes anticipated resulted in a forecast net reduction in Medical Benefit payments of £0.7m in the period.

79. GP fees from patients in the initial business case were proposed at a consistent level based on the average at the time, which was around £42 per consultation. The business case does not include a rationale for the fee rates proposed. A decision was subsequently taken to subsidise adult consultation and home visits by a reduction to around 50%. The figures reflected in the final business case are shown in Exhibit 9.

Exhibit 9: GP Fees proposed and actual

Category	Proposed fee £	Actual fee £
Child under 4	0	0
Child 4 – 17	10	10
Adult	40	20
Home visit	80	40
Pregnancy bundle	120	120
COVID-19 related	0	0

80. The contracts for GPs and practices were drafted and agreed in early April 2020 for four months with a requirement that each practice would provide key data on costs and GP fees each month, one month after the end of the period. There was an inherent control risk associated with the expenditure and income recording in each practice and an ongoing audit process was agreed. This would allow the Government an opportunity to audit expenditure and income and make adjustments as necessary to the monthly payments. However, the monthly returns required under the contract were not received from all practices during the contract period. The final returns due one month after 9 August 2020 were not all received by HCS until the week commencing 2 November 2020.

81. The amount paid by the Government during the period was 90% of estimated 'reasonable costs' which were independently verified at the start of the process, with the balance payable following the final validation. The total claims show that expenses exceeded the expected sum by £205,000. Two practices submitted overall claims below the 90% advance and four practices submitted claims at a level between 18% and 50% above that expected. As at 5 February 2021, four cases were still under discussion and one potential overpayment is being considered for reimbursement. The remainder have been finalised. Income collected in the period and due to the States was very close to the forecast. As at 5 February 2021, over £2 million of the income received by surgeries between 9 April and 8 August 2020 was still unpaid and being recovered.

82. The decision to employ the GPs was based in part on ensuring the resilience and sustainability of GP services. At the time the decision was made, the continuity of primary and community care on the Island was considered to be at risk due to weaknesses in resilience planning. HCS set up a group to determine how to deploy the GP workforce effectively. Work undertaken by GPs in practice included telephone triage and proactive case reviews of vulnerable patients. The services provided by GPs resulted in benefits to patients.

Staff training

83. Throughout the pandemic the training needs of staff were appropriately identified. This is the case both 'bottom up' within care groups and functional departments as part of the HCS Readiness and Delivery plan and departmental BCPs and 'top down' particularly through Silver and Bronze Command meetings. Examples of this include Intensive Therapy Unit patient ventilation training.

84. Mask training however was rolled out inconsistently to staff, particularly early on in March 2020. There was poor formal documentation of who had received training, variable compliance with the requirement to undertake training, a lack of equipment to test with, changing PPE guidance and a loss of a laptop containing evidence of who had passed and failed the training. In addition, a HCS Bronze Group meeting in late March 2020 queried whether the higher than expected training failure rate was to do with the quality of training – but there was insufficient data to cross check who had trained whom.

Infection control and testing of staff

85. Infection control was managed through the normal HCS infection control structures and procedures. These procedures were revised, in line with COVID-19 guidance, to address the new risks emerging. PPE and other infection control advice has evolved during the pandemic.

86. Decisions regarding testing were part of the Test and Trace Programme Board, overseen by the Director General for Justice and Home Affairs. A COVID-19 testing strategy for Jersey care staff was adopted. This included the routine testing of HCS staff. If staff test positive (or a contact of theirs tests positive) they must self-isolate and can only return to work when they deliver a negative Polymerase Chain Reaction (PCR) test at the end of their self-isolation period.

Support for frontline workers

87. During the first wave of the COVID-19 pandemic, a team of 15 staff was seconded into an expanded HCS health and well-being team and a HCS staff well-being committee was established. The creation of this team of 15 staff was possible

because non-urgent and elective care had been suspended and staff were redeployed. This team provided a wide range of support, including seeking to ensure staff had break out areas and safe spaces to discuss anxieties. At the end of the first wave as HCS moved back to 'business as usual' this team was disbanded as staff went back to their normal roles. However the HCS staff well-being committee has continued to meet.

88. A procedure was established for risk assessments for vulnerable staff. However, there were weaknesses in the procedures that were established. The risk assessment methodology was not formally signed off by an appropriate command and control group and it was not clear as to whether all HCS staff had completed one, or just those who felt at risk. It is not clear who held the HCS records to evidence all risk assessments had been completed, including nil returns. There were also significant problems in practice in getting risk assessments signed off.

89. Concerns were expressed in a number of interviews undertaken as part of my review as to the quality of the Occupational Health service. The current service was described as being focussed on getting staff back to work, rather than a more proactive offer that supports staff health and well-being in a more rounded way. The Government is currently taking forward a new Occupational Health tender, however at the time of my fieldwork there had been no direct involvement in this new tender process from HCS staff.

Recommendations

R11 Ensure future business cases for new facilities include an explicit assessment of the staffing risks and planned mitigations.

R12 Complete the final, independent internal audit review of the GP surgery contract payments and ensure the outstanding income due is recovered promptly.

R13 Undertake a review, led by the Jersey Care Commission, of business continuity and resilience planning in primary and community care services.

R14 Introduce systems to ensure comprehensive records are maintained of completion of mandatory training requirements.

R15 Review the States wide Occupational Health service and ensure that any new tender meets the future needs of all HCS staff including access to confidential external counselling and support.

R16 Undertake a 'lessons learnt' exercise from COVID-19 to understand staff health and well-being needs (both physical and emotional) and build these lessons learnt into future training programmes and service designs.

R17 Maintain comprehensive health and well-being assessments for all staff including any identified risks and how these are being managed.

Co-ordination of the whole system response

90. The Government of Jersey has stepped in to fill the gaps and overcome weaknesses that existed elsewhere in the wider Jersey health and care system during the COVID-19 pandemic. This is evidenced through examples such as:

- the employment of GPs at short notice and putting procedures in place to deploy and supervise this resource
- the provision of staff to work in nursing and residential care homes at points in time; and
- providing equipment, consumables, services and advice to third parties at short notice.

91. When HCS steps in at short notice and fills a gap in another organisation's services, there is a risk of a lack of clarity, as to roles and responsibilities of the organisations and individuals involved. In some instances, there has been a lack of clarity in respect of responsibilities for services commissioned by Government. For example, Government funding to Family Nursing and Home Care (FNHC) is provided from the HCS budget and HCS commissions services from FNHC. When HCS directly then provides services or staff into an independent third party organisation from whom HCS commissions services, there is a lack of clarity as to what this means for the personal responsibilities of the HCS Accountable Officer. Similarly, there is a lack of clarity as to what this means for the managerial and professional responsibilities of the HCS Director of Nursing, who is also the Chief Nurse for the Island. The two roles (managerial and professional) are split in the case of medical leadership on the Island but are held by a single individual in respect of nursing.

Recommendations

R18 Undertake a retrospective reflection and learning exercise with key stakeholders during the Spring of 2021. This exercise should seek to identify lessons from the COVID-19 pandemic for future whole system working.

R19 Provide greater clarity as to the roles and responsibilities of the HCS Accountable Officer and the Chief Nurse/HCS Director of Nursing when HCS steps in to support services provided by third party organisations.

Appendix One
Audit Approach

The review included the following key elements:

- Review of relevant documentation provided by the States of Jersey
- Interviews with key officers.

The documentation reviewed included:

- Available Terms of Reference, minutes and papers for HCS COVID-19 related meetings constituted between 6 February 2020 and 15 May 2020 (numbering more than 100 documents). This included various HCS pre-command and control meetings (up to 10 March 2020), HCS Gold Command, HCS Silver Command, HCS Hospital Bronze Command and HCS Community Bronze Command
- Scientific and Technical Advisory Cell (STAC) papers 28 April 2020 to 7 December 2020
- Jersey's COVID-19 Strategy (June 2020)
- Table top exercise: flu pandemic – evaluation report November 2019
- HCS COVID-19 Readiness and Delivery Plan (version 14), 28 May 2020
- Nightingale Hospital bed escalation plan (COVID-19)
- Competent Authorities Meeting – Integrated Primary and Secondary Care Health Economy Response 25 March 2020
- Primary Care Physicians – Employment Contract and Surgery Contract
- Business case – Redeployment of Primary Care 7 and 8 April 2020
- Safe Exit Framework
- Safer Travel approach
- Relevant Freedom of Information requests and responses
- Health and Social Security Scrutiny Panel – approved minutes
- HCS Operational Position as at 11 January 2021
- Summary reconciliation of payments to GP practices

The following officers were interviewed:

- Director General, HCS
- Director General, Strategic Policy, Planning and Performance
- Group Managing Director, HCS
- Group Medical Director, HCS
- Chief Nurse of the Island of Jersey/Director of Nursing, HCS
- Associate Medical Director for Primary Care
- Interim Director of Health Modernisation
- Deputy Medical Officer of Health
- Associate Director of People Services – Health
- Head of Finance Business Partnering

The fieldwork was carried out by affiliates working for the Comptroller and Auditor General.

Appendix Two
Summary of Recommendations

R1 In light of the COVID-19 experience, review the expansion of the public health function proposed as part of the Jersey Care Model to ensure that it is properly equipped to address future health protection emergencies.

R2 Introduce formal procedures to improve the documentation of specialist public health advice to make it clear what advice was given, and why that advice was given, as opposed to alternative advice that was not given.

R3 Ensure that all future material pieces of public health advice that are provided to Government contain appropriate impact assessments, that take into account the impact of that advice on vulnerable communities.

R4 Develop and implement a Code of Practice for future STACs to encompass principles and procedures to be followed in determining membership, relationship with the sponsor department within Government, independence and objectivity, working practices and communication and transparency.

R5 Improve the records and minutes of future STAC meetings to provide a more complete audit trail as to:

- how advice given has been determined
- the action plans arising from the meetings (including timescales and responsibilities for actions); and
- the follow through of matters arising and actions taken.

R6 Ensure risk assessments are documented to support decisions made on guidance issued to staff.

R7 Undertake a formal reflective evaluation of the lessons learnt on business continuity planning during 2020.

R8 Introduce formal arrangements to review the effectiveness of Business Continuity Plans on an annual basis and report the findings of these reviews to the Risk and Audit Committee.

R9 Review the COVID-19 experience and develop future emergency pandemic preparedness to deal with the risk from high consequence infectious diseases such as flu and COVID-19. There should be a formal public report produced to summarise the outcome of this review.

R10 Ensure that the Operational Plan for 2021 prioritises reducing waiting lists and catching up on the cancer screening backlog.

R11 Ensure future business cases for new facilities include an explicit assessment of the staffing risks and planned mitigations.

R12 Complete the final, independent internal audit review of the GP surgery contract payments and ensure the outstanding income due is recovered promptly.

R13 Undertake a review, led by the Jersey Care Commission, of business continuity and resilience planning in primary and community care services.

R14 Introduce systems to ensure comprehensive records are maintained of completion of mandatory training requirements.

R15 Review the States wide Occupational Health service and ensure that any new tender meets the future needs of all HCS staff including access to confidential external counselling and support.

R16 Undertake a 'lessons learnt' exercise from COVID-19 to understand staff health and well-being needs (both physical and emotional) and build these lessons learnt into future training programmes and service designs.

R17 Maintain comprehensive health and well-being assessments for all staff including any identified risks and how these are being managed.

R18 Undertake a retrospective reflection and learning exercise with key stakeholders during the Spring of 2021. This exercise should seek to identify lessons from the COVID-19 pandemic for future whole system working.

R19 Provide greater clarity as to the roles and responsibilities of the HCS Accountable Officer and the Chief Nurse/HCS Director of Nursing when HCS step in to support services provided by third party organisations.

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