Centralised COVID Governance Minutes

Meeting Name: STAC
Date & Time: 28/04/2020 1200-1500hrs
Room: Boardroom 4th Floor PCH

Attendees: Refer to STAC Terms of Reference for membership
Actions and minutes: Rebecca Young

Apologies:
None

1. Introduction and status update

Minute	-Welcome -Introduction from attendees -Meeting had been given 1 week notice, then given 24 hrs notice to meet today and not tomorrow. Information has been requested in preparation for the ministers at 3pm today. -STAC must maintain input at a high level to guide the road map to the ministers on the exit strategy. Global, local and national evidence with be used to advise ministers, government, HCS gold and SCG gold. The evidence used must be strong and reliable. The information and advice we [STAC] give, must be clear and explicit. We need to work on a 'risk of harm' theory, in terms of health, economy and education. -Basic principle is to prevent the health system being overwhelmed with an attempt to pass the virus through the community as safely as possible. Acknowledging that some may die and we must manage the consequences of this. -ToR were introduced and it was agreed that the participation of other external public health colleagues was not needed at every meeting. But instead acknowledge that advisors will be invited from other jurisdictions, including other island jurisdictions, as and when appropriate Action: ToR amend to show advisors from all islands to be invited as needed[1] -It is important to agree steps by the end of each meeting to allow for timely decision and actions	Owner

2. Intelligence overview and recent changes

Minute	Public health intelligence presentation -There is evidence that children are not 'super spreaders' as expected. -Primary care are not mentioned on these slides should we be using this intelligence. -Reference to an app that people can register symptoms. This should be discussed with Tony Moretta as to feasibility.	

[1] Corrected on 18 August 2020. Minutes had erroneously implied some members were removed.

	-Switzerland have revised guidance that grandparents can see grandchildren as children are not carriers. -How many people are asymptomatic carriers? The accepted number is 30%. We must have a clear evidence link for this information -Need to look at maintaining community care to reduce admissions to JGH. We need to keep control of this. -The 7 day modelling needs to be clear for presentation to the ministers to guide exit strategy. -At point of school closure there was a reduction in case/symptoms. Then an up lift after lock down? This could be due to people returning to island from travelling, work, university. There is thought this is because school closure had appeared to have an effect. Jersey is individual in that families here really close down due to limited extended care networks. -What is the harm in keeping children out of school? This effects their social development and mental health by staying home. There have been minimal pre term deliveries since lock down. This could be linked to less stress/exhaustion in pregnancy. There has been a drop in child admissions. This may be as children are not becoming symptomatic with illness from school. They are also not playing outside and less physical activity risk. Less reporting of sexual and physical and mental abuse. This is concerning. There is an increase of 30% in reporting of domestic violence. The numbers of child abuse are down. This is a concerning trigger Action: MM to provide numbers on drop in reporting of child abuse -In terms of the modelling, does that not rely on knowing on who many people have had it? We assume that for every 1 person that has been +ve then 10 more will be +ve. Pre requisite for giving good advice is to know where we are now. Safe exit roadmap presentation Decision: Group agreement to guidance principles on page 3. -This needs to come with a caveat that with the limited time to prepare this information. This is a high level principle. -We must highlight that Covid is still active and we need to be able to lock back down quickly if and when needed. -Are we looking at peak or a ripple? The aim is to be below bed capacity. A slow delivery of phased exit so we can move 1 step back if cases peak/increase. -We need to understand the impact of what BAU we can maintain. We may need to increase mitigation if things are moving too fast. It does seem an obvious risk to step down too quickly. -In reference to moving between levels 3 and 2 we will need to demonstrate how and when we can move between these levels. The trajectory over 4 weeks could identify this movement. -Have separate vulnerable groups been looked at in the phases? No not in this case, this applies to the population as a whole. If you bring in shielding this allows for reacting to lifting outcomes and measures. Shielding in PH are in place for vulnerable groups. Questions are around the over 65s who are classified as vulnerable but are not severely vulnerable. We are being very paternalistic in our approach, should we be? Should we be doing this? How long do we tell them they are going to be in lockdown? There are 4-5,000 severely vulnerable people on island with concerns that these groups are	

	being compelled to stay home. Suggests that some level of personal choice should be in place. We need to consider how society manages these vulnerable groups in terms of employment, sick leave, risks of returning to work. Need to consider how sustainable this is. Should go down the route of shielding. But supported with good quality evidence to empower people to make choices. This is on the understanding that it is not reasonable to expect people to stay in the current state of lockdown for a longer term. Suggest more activities that are less risky to choose between. We need to think about the longer term, there are vulnerable people now who will still be vulnerable in 18mths time. Decision: Shielding will be encouraged but with supportive guidance. Decision: Extremely vulnerable should be in discussion with their doctor to manage their health Decision: Vulnerable given information to make a risk assessed decision -Stay at home April has brought 1) management of cases to allow for preparation 2) 'buy time' to lift mitigation -Asks that section 4 be extended to include children Action: MP to do this and send to MM ~~And agree that key indicator will be doubling rate ~~MM what is the collective on how to refer to this virus? Agreed that Covid-19 should be used as this is specific. Document 2 -Announce a small changes to lockdown measures -Agreement that we want people to be enjoying outdoor activities. Stress social distancing whilst doing these activities. Emphasis on the importance of hygiene for hands, surfaces and bathrooms. Must still remember to wash hands regularly. -Advice on wearing masks in the community along with what can be done in 4 hours advisable. Why does it need to be limited to 4 hrs? 4 hrs is arbitrary, conclusion with police that this wouldn't be enforced. The benefit of suggesting a time limit it will encourage people to not be out for the whole day. Decision: We are suggesting an extended time to 4 hours as we are not sure of the impact this will have on transmission rate. It does give some evidence to enforce if people are being witnessed to be out for longer periods. Decision: outdoor recreation; no limits on type of activity as long as social distancing ~~agreed the principle of level 3 is sensible and guidance can be developed -Cloth masks if used should be indoor public areas not when going on outdoor activities Decision: Group agreement to the 3 stage approach -MP what about the return to school for children and vulnerable children? Schools and colleges to stay closed until half term. This will be extended to reopen to essential worker and to children with additional support needs. The staging needs to be focussed around the harm not being done by not being re opened. This then creates the bigger picture of grandparents [vulnerable groups] delivering child care.	

	-Schools reopening and not business needs work and time that cannot be dedicated to it today. Decision: Message from STAC is that we have accepted the document. There is not enough time at this meeting to come back with educated guidance. Decision: We are happy with the narrative, documents with more detail will be available in 1 week to the ministers. IM inform that knowing that the detail we have today may change in relation to monitoring. MM this caveat is in the narrative. -If we rapidly test contain and shield we can effectively contain. -Aim to test: hospitals admissions, all symptomatic HCW, care home referrals, GP helpline referrals, admissions to care homes. -This is in relation to availability of swabs. -Do we want a recurrent back stop? Rule for symptomatic care home, 1 +ve leads to all residents being tested. Or are all home residents and staff tested monthly -Suggestion all tested monthly and then reactively as +ve cases occur -There was 1 index case in a home it was difficult to come to conclusion as to how to isolate the home ie the floor or the whole home. At this point due to the limitation of swabs the first symptomatic is tested, then anyone with symptoms is treated as +ve (without testing). The protocol will change depending on the facility ie lakeside have 3 buildings. Isolate +ve building. Lavender villa 1 building therefore close whole building -Test pts for admission ie pts that are staying overnight. If we are returning to BAU should we need to look at screening? Healthcare settings due to greatest number of Covid pts, most vulnerable people and spread within an environment. -In terms of wider social workers ie police, if they are symptomatic they will be tested Decision: Symptomatic community staff will be tested -The dentists capacity is limited due to PPE. Is there a way testing can assist in return to some of their work. There may become a ceiling to off island testing. In May we are hoping to get platform based testing which is more reliable. At this time dentists may have already been exposed. Aerosol in the environment will limit pts. -Proactive testing frequency may need to be reviewed from 1 month to 2 weeks. What are we aiming to achieve by this testing? To find those asymptomatic +ve patients, find institutional baseline, societal control. IM the people/staff who are likely to get Covid and are those working with patients with Covid ie ICU and care homes. Action: Frequency and priority will be discussed by IM and SS Decision: Broadly in agreement, happy with the columns (for testing priority) but some mobility will need to be for certain people/groups. -A cross sectional testing would be done for 500 families this weekend as a pilot. -Discussion about using biochemistry samples from GPs, could be used for an unlinked anonymous Covid testing. This will go through Ethics and primary care body. Unlinked anonymous survey. ST has experience of this in the context of HIV. Stress that it is a testing of the population and not people.	

	-In terms of exit strategy what happens to symptomatic patients? They will be advised to self isolate and be tested. -If we have swabs delivery and access to Colindale. Do we extend swabs to care homes? There are 1100 staff. Do they take priority in the coming week? IM this needs further discussion Decision: Yes to test staff in homes with a +ve patient	

3. Issues for discussion

Minute	None	

4. AOB and questions

Minute	None	