PLC

SCIENTIFIC AND TECHNICAL ADVISORY CELL

(91st Meeting)

(Business conducted via Microsoft Teams)

1st March 2022

PART A (Non-Exempt)

All members were present.

Professor P. Bradley, Director of Public Health (Chair)
Dr. I. Muscat, MBE, Consultant in Communicable Disease Control
Dr. G. Root, Independent Advisor, Epidemiology and Public Health
S. Petrie, Environmental Health Consultant
A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department
Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department
E. Baker, Head of Vaccination Programme, Strategic Policy, Planning and Performance Department
Dr. M. Doyle, Clinical Lead, Primary Care (items A5 and A6 only)
M. Clarke, Head of Public Health Intelligence, Strategic Policy, Planning and Performance Department

In attendance -

J. Mason, General Manager, Health and Community Services
Dr. E. Klaber, General Practitioner, Primary Care Body representative
R. Barnes, Head of Non Clinical Support Services, Health and Community Services
J. Lynch, Policy Principal, Strategic Policy, Planning and Performance
L. Jones, Justice and Home Affairs
M. Knight, Head of Public Health Strategic Policy, Strategic Policy, Planning and Performance Department (item A7 only)
P. Le Conte, Secretariat Officer, States Greffe

Note: The Minutes of this meeting comprise Part A only.

Minutes.

A1. The Scientific and Technical Advisory Cell ('the Cell'), received and noted the Minutes from its meeting of 14th February 2022, which had previously been circulated. The Minutes were approved by the Cell. The Cell also received and noted the Minutes of a meeting of a sub-group of the Cell dated 17th February 2022.

Intelligence overview, including Analytical Cell update and HCS activity.

A2. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of its meeting of 14th February 2022, received a PowerPoint presentation, entitled 'STAC Monitoring Update', dated 1st March 2022, and heard from M. Clarke, Head of Public Health Intelligence, Strategic Policy, Planning and Performance Department in connexion therewith.

The Cell was apprised of the current situation with regards to public health monitoring, noting that as at 28th February 2022, there were 1,661 active cases of COVID-19 recorded in the Island. The majority of cases were in adults aged 40 to 49 years, followed by those aged 30 to 39 years and 50 to 59 years.

Seeking healthcare was the most common reason for testing, accounting for 870 cases; 713 had been identified following positive Lateral Flow Tests ('LFTs'); and the remainder through various screening programmes. The age ranges, gender and vaccination status of the active cases were shown, with a further breakdown by age for active cases in those aged 18 and under.

Subsequent to changes in the testing approach, the number of daily tests being undertaken had continued to decrease and now stood at fewer than 500. An average of 220 cases per day had been identified over the previous 2 weeks down from 300 per day throughout January. The overall test positivity rate (measured as a 7-day rolling average) had increased to 40 per cent. It was recalled that the relatively high-test positivity rate was due in part to people coming forward for testing following a positive LFT result.

The 7-day case rate per 100,000 population had fallen significantly for those aged under 18 years, and the 7-day case rates for all age groups were now aligned at a similar level, though a slight increase was noted in the rate for those aged over 60 years.

The Cell reviewed the clinical status of cases in hospital since 28th June 2021 and noted that as at 28th February 2022, there were 23 patients in the Hospital, with a proportion having clinical COVID-19. A decrease in the number of cases in care homes was noted.

Details were provided of the positive cases linked to schools, which had seen a gradual decrease over the course of February 2022. It was noted that 100,000 LFT results had been submitted since September 2021 as part of the schools LFT programme with 3,512 identified as positive. A total of 344 students and 59 staff had been reported with Covid in the last 10 days.

A further 6 deaths had been recorded, bringing the total to 112, with 34 registered since the start of the 4th wave on 1st October 2021. It was noted that a further death had been recorded on the day of the extant meeting.

During the week ending 6th February 2022, Jersey's testing rate, per 100,000 population, had been 4,000, compared to the United Kingdom ('UK') rate of 8,450, which included LFTs. The test positivity rate locally was 31 per cent compared to 5 per cent in the UK.

The Cell noted that 381 patients were currently recorded in the EMIS clinical IT system as suffering from 'Long Covid'. Women aged 40 to 49 years continued to be most affected. 15 patients had attended the newly established Long COVID clinic at the Hospital, and a further 55 patients had been referred.

It was noted that footfall in St. Helier had not returned to pre-pandemic levels, but was higher at present than it had been in January 2021. Traffic levels and bus usage had begun to increase from mid-January 2022.

The Cell was apprised of the results of social media sentiment analysis, noting that social media activity had decreased following the announcement of the COVID-19 de-escalation strategy, although there had been a mostly negative reaction in

response to the vaccine offer for 5 to 11 year olds. Engagement levels in relation to COVID-19 statistics were noted to be declining.

Details regarding the COVID-19 vaccine programme were shared and it was noted that as at 24th February 2022, 221,940 doses had been administered, of which 60,533 were third 'booster' doses, with high rates of coverage in older age groups and a slowing down in uptake rates across younger eligible populations. It was estimated that 79 per cent of care home residents, 82 per cent of carers working in care homes and 84 per cent of front-line health and social workers had received a booster vaccination, though it was noted that these assessments were coded Red or Amber due to questionable or moderate data quality.

The Cell was informed that 9 episodes of flu-like illness had been reported in primary care during the week ending 27th February 2022. Overall, levels of flu-like illness were similar to those seen during the 2020/21 Winter season and significantly lower than in previous Winter seasons.

The Cell was apprised of the situation in UK, noting that over the 7 days to 25th February 2022 (21st February 2022 for hospitalisation figures), cases had decreased by 20 per cent, hospitalisations by 9 per cent and deaths by 18 per cent.

A graphical comparison of 14-day case rates per 100,000 population showed that Jersey's rate had decreased to 2,730, however remained higher than that of Northern Ireland (1,930), Scotland (1,580), England (860) and Wales (450), though it was noted that this may be explained in part by Jersey's relatively high testing rate compared to those jurisdictions. The Cell was informed that 14-day case rates remained high across Europe.

The Cell was provided with an update on Hospital capacity, which confirmed that green status was being maintained with safe levels of staffing and care. Case numbers had increased in the previous 48 to 72 hours. It was reported that the public perception of the COVID-19 de-escalation was producing challenges within healthcare settings with a failure by visitors to adhere to the continued requirement for the wearing of Personal Protective Equipment ('PPE'). Individuals had also been visiting when symptomatic and testing positive later the same day. Screening and questions were being asked at the Hospital entrance where there had been occasional incidents of violence and aggression when members of the public were challenged. There had been 2 cases among those in the hospital who had come from care homes while it was noted that there were a number of inpatients deemed medically fit for discharge due to a reluctance among care homes to follow Public Health guidance for those still testing positive for COVID-19. Work was being undertaken by the Infection Prevention and Control ('IPAC') team to try and alleviate those concerns.

A Cell member commented that, in their view, the rate of de-escalation should be adjusted for different strands of the community. For those in the vulnerable categories, the de-escalation should be slower than the general population. The Cell was informed that the communications team was working on messaging to reinforce the need for members of the public to act differently in places where vulnerable people were present.

It was noted that daily reporting was due to cease at the end of March 2022 and the question was asked whether this could be brought forward given the resources involved. The Cell was informed that this would be possible after the data had been examined at the end of the week. If cases were to rise due to the February 2022 half-term holiday, the move could be delayed for another week.

A member of the Cell requested information on the breakdown of clinical compared to non-clinical cases in care homes and was informed that a check would be made with the IPAC team to establish what information was available. It was also asked whether it would be possible to calculate the mortality rate by finding the denominator between the number of measured cases since 1st October 2021 (28,000) compared to the 34 deaths recorded to the date of the extant meeting. The number of deaths was similar to the first (32) and second (37) waves, but the data was not comparable, with 3,000 cases identified in the first wave and 4,000 in the second. Factors such as the number of cases being detected at the time and the severity of the variant would also need to be taken into consideration. It was felt that this would be a useful exercise and if the overall mortality rate was put alongside that of other jurisdictions it was suggested that Jersey's figure would compare favourably.

In response to a question in relation to the compliance with the COVID-19 testing in schools, colleges and nurseries now it was no longer a requirement to post results of Lateral Flow Tests, for example by noting the demand for test kits among school-aged people, it was confirmed that consultation was ongoing with colleagues in the Children, Young People, Education and Skills Department in connexion with compliance from a parent and child perspective, unions and headteachers with a view to settle future policies for schools in the forthcoming weeks.

In summary, the Chair stated that decreasing case numbers were noted, but there were still some areas of vulnerability and some deaths were being reported. The challenge for the hospital included the need for visitors to act responsibly and for some care homes to implement current public health guidance when inpatients were medically fit to be discharged. A review of testing in schools would be part of ongoing work and a discussion around mortality rate and how it could be compared and presented with a suitable denominator was required.

The Cell noted the position and expressed its appreciation for the update.

Personal Protective Equipment.

A3. The Scientific and Technical Advisory Cell ('the Cell'), received a presentation from Mr. R. Barnes, Head of Non-Clinical Support Services, Health and Community Services and Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department in connexion with the supply of Personal Protective Equipment ('PPE').

The Cell was informed that as Jersey began to de-escalate its emergency pandemic responses, phased withdrawal of Government-provided free-of-charge PPE should be considered. PPE was now readily available at a reasonable price on the local and international market, negating the requirement for a Government-provided service. Public health benefits of continued provision of free PPE needed to be balanced against the risks and continued impact on local suppliers, such as COVID-19 cost pressures and stock holding including the potential for large-scale write-off, as had been revealed in February with £8.7 billion written off by the UK Government which was unusable and/or expired.

The report recommended:

1. Continued holding of a reasonable 45-day emergency pandemic stock of PPE. This could be used to re-establish supply in an emergency (for example for a new aggressive variant).

2. Continued supply of free of charge PPE to all public organisations until such time that departments could safely return to pre-pandemic PPE

requirements: Public care homes; schools, uniformed services, Health and Community Services; Government of Jersey delivered public services.

3. Extension of free of charge PPE to all private health organisations which were primarily residential/domiciliary based to 30th June 2022 with an option for further extension: Private care homes; domiciliary care providers.

4. Continued cessation of free of charge PPE to all other private organisations from 31st March 2022 with an option for extension on a case-by-case basis: Dentists; early years staff; GPs; optometrists; supermarkets; pharmacies; airlines; private health clinics; funeral directors; and private utility businesses.

The post-emergency public health priorities had been identified as reduced disruption, the maintenance of vaccination levels, protection of the vulnerable and response to risk. When considering the provision of PPE for different sectors, it was important to consider these strategic commitments, with a particular focus on the protection of vulnerable Islanders and the requirement to minimise disruption in critical organisations.

The Cell was informed that from a public health perspective the main purpose was aligning decisions around the post-emergency strategy. The emphasis had moved away from mitigation, however the Island was committed to protecting those more vulnerable or compromised and that was the reason free PPE to care homes and domiciliary care providers had been extended while negotiating the exit of the pandemic phase and to allow time to monitor the situation in the spring and summer of 2022.

A Cell member suggested that to delay the cessation of free PPE in the independent care sector would offer the opportunity to carefully consider the possible impact and future infection control policies. Concern was expressed about the likely response from the independent care sector to that change. The requirement for PPE for the purposes of COVID-19 was in the guidance so an understanding through consultation of what was likely to happen post-2022 was very important. Should residential or domestic care providers be required to provide PPE out of their own pockets, cessation could mean a decline in standards at some level given the exceptional infectiousness of Omicron and the Winter wave of infection. Some assurance would need to be provided before free PPE was removed. It was not the concern of the Cell who paid for the PPE as long as the right precautions were being taken in those places housing cohorts of the population at the greatest risk. The paper was praised, but the need for close consultation with the care sector about what would happen in practice when free PPE ceased was highlighted.

With reference to Minute No. A2 of the extant meeting, it was noted that access to PPE in order to follow the essential guidance was a factor in accepting and taking back patients who were clinically fit to be discharged from Hospital, but were still testing positive for COVID-19. The cessation of free PPE could provide an additional challenge and concern to organisations that were expected to comply with guidelines when accepting positive patients back.

An observer questioned whether GP surgeries and pharmacies which were in the front line in terms of seeing COVID-19 patients and potentially keeping them out of secondary care should continue to receive free PPE. This was an environment where those who were or were not COVID-19 positive from vulnerable groups could be mixing and they should be treated the same as the private care home and domiciliary care providers.

Another Cell member, who also supported the continued provision of free PPE to the independent care sector, suggested that it would be beneficial for clear guidance on the most effective measures to prevent infection in terms of face coverings, ventilation and whether other types of PPE were less important. If a choice had to be made, it would be helpful for care homes to know what had the greatest impact on infection protection.

The Chair summarised that there was a lot of support in general for the report but that several areas needed to be followed up. Firstly, to cover the private care sector to ensure that implementation of cessation would not cause further problems, and, secondly, that guidance should be issued to ensure risks were mitigated. He added that consideration needed to be given to GP surgeries and pharmacies to ensure public health guidance was being followed and implemented.

It was confirmed that a consultation would be started with GPs and pharmacies to establish what the impact of a phased cessation of free PPE would involve and a paper would then be presented with the final position for those services and care homes and domiciliary services, the latter for whom an extension had already been applied and this could continue to be reviewed to decide how long it should last. Health and Community Services and the Jersey Care Commission would undertake a long-term impact report to try and establish a middle ground. This could include identifying what the PPE guideline were pre-COVID-19 and then noting anything additional to combat the pandemic specifically and establishing the difference between those 2 figures. That could be a way of working out where the costs would lie in future. The extension to GP surgeries and pharmacies, in line with the care home and domiciliary services, would be considered following consultation.

Another Cell member suggested that a public health overview was required to establish what would work best in the context of infection control in care homes and GP surgeries and it could go beyond PPE and into ventilation and include the types of masks and PPE utilised, based on the latest thinking and evidence.

The Chair noted that a consistent point was being made about considering infection control more broadly and there were 2 areas that needed to be progressed. The public health team needed to keep an overview of infection control more generally and look at the guidance in terms of the health of Islanders in vulnerable settings.

The Cell noted the position and thanked Mr. Barnes and Dr. Newman for the update.

PCR laboratory.

A4. The Scientific and Technical Advisory Cell (‘the Cell’), heard from Dr. I. Muscat, MBE, Consultant in Communicable Disease Control, and Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department, in connexion with the proposal to maintain a Polymerase Chain Reaction (‘PCR’) Lab at the Jersey General Hospital.

Dr. Newman provided the Cell with the historical background to the proposed construction of a PCR laboratory in the General Hospital.

In March 2020 there was no capacity for PCR testing in the Island and all PCR testing had to be sent to Public Health England in the UK, which limited the capacity for testing and had an extended turnaround time. From April 2020 a small amount of PCR testing was available in the Health and Community Services Laboratory but this could not be scaled up. In order to rapidly achieve the significant increase in testing required, an agreement was first reached with an off-Island private provider

of testing, followed by a collaboration with an external provider to bring in a Covid-specific PCR processing lab located at the Jersey Aero Club. This provided secure, rapid PCR testing for the Island which had been a mainstay of the management of Covid-19 throughout the pandemic.

The development of a Government of Jersey owned and managed PCR laboratory facility was approved by the Competent Authority Ministers as a key part of the Future Testing Strategy agreed in March 2021. It represented a substantially more cost-effective approach to COVID-19 testing when compared to the costs associated with an external provider of this service, with an estimated break-even point for the capital spend at approximately the 3-month point, but potentially sooner based on current testing requirements. It also established a significant asset for the Island that could be redeployed for other health laboratory purposes once the COVID-19 testing requirement no longer remained.

To make the best use of the time and facilities available, the 2021 Future Testing Strategy outlined a two-step phased approach to the establishment of this facility, with a temporary laboratory being constructed initially on Rozel Ward at the Jersey General Hospital (which was not in use at the time) whilst preparations were made for a move to the permanent location in the old hospital kitchens situated under the current HCS pathology laboratory. These kitchens had not been used for a considerable period of time. This temporary laboratory had now been successfully established on Rozel Ward for a number of months and plans were now needed to make the move to the permanent location.

Dr. I. Muscat, MBE, Consultant in Communicable Disease Control, suggested that the reasons the move had come up for discussion rather than follow the original plan to relocate the laboratory from Rozel Ward to the former kitchen were twofold. Firstly the de-escalation climate had been interpreted in different ways by different people. As stated earlier in the extant meeting, it was the Cell's responsibility to ensure de-escalation was orchestrated and the different strands managed appropriately, for example the timing of the Spring booster, the cessation of provision of free PPE to care homes and other sectors and ensuring that anti-virals for the vulnerable were made available with appropriate implementation and solidity. Returning to the PCR laboratory discussion, he suggested that some people would argue that it was not needed. And, secondly, that it would cost too much to convert the former kitchen and therefore it required careful consideration. Dr. Muscat, MBE, argued that the PCR laboratory needed to be kept to scale because it was important to be able to monitor what was happening during de-escalation. It was necessary to continue to screen the population as a whole and not just small sections in various ways to diagnose people and in part identify those who would benefit from anti-virals which were not available previously, when testing was just used to isolate people. It was important to retain resilience given the effort involved in setting up the system which initially took so much time and it was necessary to outsource until it was completed. The estimated cost of converting the former kitchens into a laboratory would pay for itself within a month compared to sending that volume of tests away. If the number of tests dropped then it would take a little longer. The laboratory would continue to provide a valuable function and could be rescaled in the event of a new variant in Autumn/Winter which always produced an acceleration of respiratory viruses. The question for the Cell was did it feel it was reasonable to proceed with the original plan to continue to sustain PCR testing within the Island in order to monitor and deliver the service required to patients in the community and have the resilience to deal with resurgence if it happened.

The Chair suggested that Cell could need more information, and potentially a written paper, at the next meeting in order to deliberate fully prior to making a decision.

One of the Cell members commented that it was inconceivable to allow the Island to return to a position where it did not have PCR laboratory capacity. It was likely to be needed for at least the next year. How and where it was procured, built or supplied was not a discussion for the Cell, unless it involved a scientific or technical element it was competent to talk about. The member's personal view was that they strongly supported the project to develop a permanent laboratory with value for money considerations alongside general preparedness in this pandemic and capacity for whatever the next disease emergency might be.

Dr. Muscat, MBE, pondered how the general public would perceive it if the PCR laboratory capability was dismantled within the umbrella of the pandemic and when it could not be guaranteed that there would not be a resurgent variant going into the Autumn, particularly if the alternative was to put together another PCR laboratory in a vacuum. He added that there was some urgency in the situation**.** Rozel Ward needed to be vacated by the end of June which gave a 14-week lead-in time if the move to the former kitchen was to go ahead. That did not leave much time for the evacuation of Rozel Ward as the transition would require a period of outsourced testing until the validity of tests in the new location was verified. For that reason it was important to hold the discussion and make a quick decision. Another member offered their full support to the plan.

In response to a suggestion from a member that the Cell was fully supportive, but for the caveat it would appreciate more information, Dr. Muscat, MBE, agreed it was reasonable for the Cell to consider the matter in principle, but leave the questions in relation to financing to others within their business cases. He was also asked whether the laboratory could have uses beyond PCR testing, with other respiratory illnesses or other research purposes.

He responded that in the short term it would pay for itself in a month within the COVID-19 pandemic. If tests weren't being sent away, the capital cost of setting up the PCR laboratory would have been the same as a month's revenue if the tests had to be sent off-Island. If COVID-19 receded to become a flu-like illness PCR tests would be the way forward at that point as much more of a Health and Community Services diagnostic facility.

The Chair noted the position and thanked Dr. Muscat for the update. He summarised that the consensus was that the PCR laboratory was required and an urgent decision was necessary due to the lead-in time before Rozel Ward had to be vacated. The Cell was only required to agree in principle that the service was needed and that questions of implementation and finances would be transferred to another group. The final point to note was the further application to PCR testing elsewhere in HCS and other applications, such as veterinary which could be part of another group looking at long-term sustainability. The Cell gave its full endorsement to the project and asked for the message to be given to the body concerned with the transfer of the laboratory service from Rozel Ward to the former kitchen.

STAC questionnaire.

A5. The Scientific and Technical Advisory Cell ('the Cell'), heard from Mr. A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department in connexion with the independent review of the Government of Jersey's response to the coronavirus pandemic.

Mr. Khaldi explained that the independent review was based on a States Assembly proposition and that the members of the panel and the terms of reference had yet to be announced, but this was likely within the next 2 weeks. The review would welcome the views of all those involved in policy making and the delivery of the

Island's COVID-19 response, including members of the Cell. Mr. T. Walker, Director General, Strategic Policy, Planning and Performance, the officer responsible for the review, intended to issue a questionnaire to all Cell members, past and present, immediately after the review was formally announced. It was expected that the review would initially take evidence from key parties and all stakeholders including members of the general public, these would be transparent and could be submitted on a dedicated website.

The intention was to publish findings by the end of July for the new Council of Ministers following the General Election in June, with constructive proposals for the management of future emergencies. Therefore, whilst the review would look back on how the pandemic had been handled to date, it had a future-focused mandate to look constructively at how a small island like Jersey should manage future emergencies in an improved way.

Questions in the survey would focus on how the Cell worked over the period and from an individual perspective how the skills and expertise of members were utilised. Collectively it would examine how the Cell looked at evidence and data and whether it was allowed to fulfil its role. It would be looking at whether a scientific committee of this type could be improved given the small island context and the lack of direct access to academic institutions in the United Kingdom which formed part of the SAGE architecture.

The survey would include a mixture of free text, closed questions and some 4- or 5-point scales. As the Minutes were now unattributable, any representative excerpts taken from free text responses would be summarised and included in a report of the Cell survey responses compiled by Mr. Walker. This would not prevent any individual Cell member from making their own representation to the review panel. There had been 25 members of the body since it had been in existence.

The Chair stated that it was positive to know that the opportunity was being taken to learn from the experience of the last 20 months and he encouraged all members to participate The Cell noted the position and thanked Mr. Khaldi for the update.

Vaccine update.

A6. The Scientific and Technical Advisory Cell ('the Cell') with reference to Minute No. A4 of its meeting of 14th February 2022, received a presentation, dated 24th February 2022, entitled 'Vaccination coverage by priority groups', which had been prepared by Ms. E. Baker, Head of Vaccination Programme, Strategic Policy, Planning and Performance Department and heard from her in connexion therewith.

As at 20th February 2022, 60,533 third (booster) doses had been administered, with 90 per cent of those aged over 50 having received a third dose. This meant that 90 per cent of the resident population aged 18 years and over had been administered a first dose, 88 per cent had been double vaccinated and 69 per cent had received a booster dose. Among the school aged, 65 per cent of 16 to 17 years olds and 51 per cent of those aged 12 to 15 had received a first dose. The working group was expected to produce a debrief following the completion of the schools programme. Take up among the eligible at risk 5 to 11 year olds was around 30 per cent, which was similar to other jurisdictions. Implementation of the universal vaccination on this age group, approved by the Cell sub-group on 17th February 2022 following the JCVI recommendation, was dependent on the supply of the vaccine and operational planning. Concern had been expressed in relation to misinformation circulating in regard to the vaccination of children. This was being monitored and reviewed in consultation with the Children, Young People, Education and Skills Department, the States of Jersey Police and the UK and with support from the behavioural psychology team. Vaccination rates among healthcare staff in care homes (82 per

cent) and frontline health and social workers (84 per cent) had been reassuringly high and although the clinics at the General Hospital had now been paused, healthcare workers could still attend at the Fort Regent Vaccination Centre. An additional spring booster for the over-75s and immunosuppressed was in operational planning.

The Cell noted the progress and the Chair stated that the minutes of the sub-group meeting were available to members.

COVID recovery projects.

A7. The Scientific and Technical Advisory Cell ('the Cell'), received a presentation, dated March 2022, entitled 'COVID-19 Health and Social Recovery', which had been prepared by Mr. M. Knight, Head of Public Health Strategic Policy, Strategic Policy, Planning and Performance Department and heard from him in connexion therewith.

Mr. Knight provided an overview and update of the Covid recovery process. This included the early recognition of the Covid harms caused by the measures to protect against infection, including worsened health outcomes and social issues which had deepened inequality. These discrete harms had magnified pre-Covid challenges but from a positive perspective social connectivity and resilience had improved.

The 5 proposed criteria for the Recovery projects were that they should be: **Covid harms-related:** Related to direct or indirect harms caused by Covid over 2020/2021. These could relate to exacerbation of pre-Covid issues. **Evidence-based:** Evidence of harm in local data or testimony. Aligned to evidence of harms in academic literature. **Citizen-centred:** Where relevant, levering community and citizen capacity – engaged and reconnected most impacted groups / communities. **Targeted and impactful:** Positive cost-benefit and delivering targeted outcomes for Islanders. **Temporary and timely:** Pump prime investment over 2022/23 with longer term impact. Projects to be designed accordingly and with sustainability in mind.

The Health and Recovery Milestones were identified as follows:

- April 2021: Executive Leadership Team support for investment in a Health and Social Recovery Programme
- May-June 2021: Department engagement identified greatest challenges across their services. Project options to bring recovery benefit and value to those most impacted.
- July 2021: Development of business cases for supported solution options within Departments. Agreement for an allocation and Political Oversight Group to support development of recovery projects.
- September 2021: Proposed Government Plan included Health and Social Recovery Allocation £5million 2022, £3million in 2022.
- December 2021 / Jan 2022: Project business case refinement and reprofiling to allocation limit (Government Plan approved).
- February 2022: Political Oversight Group approved 2022/23 projects.

Supported Recovery Projects

- Understanding and Insight: Ensuring impacts could be best understood by improved use of unlinked, anonymous service data across departments as

well as research to listen to and understand the experiences of Islanders.

- Early Years: Targeting 0–5-year-olds whose normal development had been negatively affected by the pandemic. Support would be provided for improvement in communication, learning, and social and emotional development.

- Children and Young People's Education, Health and Wellbeing: Reducing pandemic impact of disrupted learning – continuation of Jersey Tutoring Programmes and Summer Schools and introduction of universal wellbeing programme.

- Children's Dental Health: Provide access to preventative dental health check-ups and treatments for primary school age children who had dental care delayed while these services were closed.

- Further Education: Targeted adult learning to those most impacted by isolation, disconnection, and employment disruption.

- Long COVID: A multi-disciplinary team to assess and treat Long COVID in the community through primary care, and where necessary through secondary care referral.

- Countryside Access: Engaging with those most impacted by poor access to the protective benefits of green space and the natural environment during lockdown to volunteer into schemes that improve access and infrastructure.

- Arts, Physical Activity and Social Prescribing: Under review.

Mr. Knight commented that Mr. I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance, had taken the lead on the project to look at existing data and bring it together, anonymised, from across departments so its usage could be evidence-based. The Cell had previously expressed an interest in such a qualitative research development. Income, census and service data could be aligned with learning from the supported project which would become available in the Autumn of 2023 when reports on the outcomes could be shared with other projects in order to help identify priorities and make more sustainable.

A Cell member commented that it would be important to examine what other countries were doing in order to support post-Covid recovery in a health and social context and look at the evidence and practice. From a Jersey perspective he added that there should be a focus on occupational health due to the experiences of negative impact within workplaces and the radical change to where and how work was conducted. There was also anxiety caused by businesses closed and livelihoods under threat. He suggested that how the workforce could be restimulated would contribute to the recovery and not just begin and end with a series of projects. The effects of the pandemic experience would be felt for many years and some would only become visible in future years. It was also important to strive for a better understanding of the important area of the impact of the pandemic on mental health.

In response to a suggestion from another member that there appeared to be a number of projects funded by a relatively modest budget and whether much thought had been given to identifying who would benefit the most, Mr. Knight admitted that it had been a challenge as there had been numerous approaches, but that the focus had been on understanding the impact on customers identified by departments. He explained that the early years project had been identified through service level data and the

experience of professionals that revealed families were struggling more and development milestones were not being met. The CYPES programme had been identified in a similar manner. The Insight and Understanding project was considered an essential step in identifying and understanding from internal evidence of some of the impacts that were expected to happen but there was a need to understand the experience at a local level. He added that reference work would be required from the project leads over and above the performance and business cases to feed back to the Political Oversight Group on the learning in order to challenge what appeared to be working and anything that was not delivering benefits in order to take into account any reallocation of the budget before any further data from the Insight and Understanding project became available.

The Chair commented that the Cell welcomed the initiative, but stressed the plans needed to take into account Islanders' sentiment and that the implementation had sufficient resources. Further opportunities in occupational health had been mentioned and there could be others which needed to be considered. It was important to target those in the greatest need or most impacted and it would be important to review and evaluate the impact on the more vulnerable communities.

Matters for information.

A8. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A3 of its meeting of 7th February 2022, noted the 'UK Health Security Agency Risk Assessment', dated 23rd February 2022, and the 'UK Health Security Agency Technical Briefing 37', dated 25th February 2022. They also considered the following:

- a weekly epidemiological report, dated 24th February 2022, which had been prepared by the Strategic Policy, Planning and Performance Department;
- statistics relating to deaths registered in Jersey, dated 24th February 2022, which had been compiled by the Office of the Superintendent Registrar; and
- a report on PH Intelligence: Covid-19 Monitoring Metrics An Overview of the last 12 Months, dated 25th February 2022, which had been produced by the Health and Community Services Informatics Team.

End.