JERSEY INDEPENDENT

COVID-19 REVIEW

GOVERNMENT OF JERSEY DEPARTMENTS' SELF-ASSESSMENT QUESTIONNAIRES SUBMITTED TO THE INDEPENDENT COVID-19 REVIEW PANEL

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Contents

INTRODUCTION

Alongside the meetings and in-person sessions undertaken by the Independent Covid-19 Review panel, the Chief Executive of the Government was asked to commission and administer self-assessments in a form they felt would be most useful. It was determined that thirteen self-assessments would be produced. The Government produced their own template, and, in the majority of cases, departments followed this unless there was a good reason not to, i.e. similar information had recently been provided for another purpose such as the submission by SPPP to the Public Accounts Committee.

These self-assessments were then 'challenged' by the Panel in a series of two-hour online hearings informed by the earlier meetings held with organisations and written submissions. These sessions aimed to test whether the lessons learned for the future were appropriate in the light of other material and views we had heard and whether these were ambitious enough. The thirteen self-assessments are published in this compendium.

Sir Derek Myers
Chair, the Jersey Independent Covid-19 Review panel

OFFICE OF THE CHIEF EXECUTIVE

The Office of the Chief Executive (OCE) operates across all of the departments. It provides strategic and operational support to the Council of Ministers in the design and delivery of Jersey's long-term strategic framework.

The department brings together a number of corporate functions, coordinates cross-governmental work and enables the Chief Executive to have close oversight of principal risks to our island.

Chief of Staff, Government business and Ministerial support

The Chief of Staff supports the Council of Ministers by providing advanced, detailed, high-quality and impartial briefing information for Ministers to support their decisions, and provide challenge where appropriate.

External Relations

External Relations protect and promote Jersey's interests internationally. This includes managing Jersey's response to Brexit, building and maintaining Jersey's relationship with the UK Government and with the EU. The department also works to increase access to and improve trade links with Global Markets.

Communications Directorate

The Communications Directorate ensures the Government effectively communicates with Islanders, stakeholders and employees, providing information about services, informing them about their legal obligations, notifying them about deadlines, publicising Government performance, encouraging them to take action, and alerting them to changes that affect them.

OFFICE OF THE CHIEF EXECUTIVE SELF-ASSSESSMENT

Questions for all stakeholders

Governance
Please respond as appropriate: What governance arrangements did you establish to support decision making for the Covid-19 response? And/Or How did you/your department/organisation plug into governance arrangements for the Covid-19

Office of the Chief Executive / Chief of Staff

The requirement to make quick decisions and act in a very fast moving and fluid environment, with potentially significant implications for the public health and economy of Jersey, was a characteristic of the pandemic response, particularly in the initial stages.

The Office of the Chief Executive (OCE) provided oversight and management of the public service and ministerial governance arrangements for the Government of Jersey -

- to manage the work on a day-to-day basis and enable the machinery of government to continue operate effectively.
- ensure the right accountability, levels of authority and delegations were in place across all departments in relation to COVID.

A command-and-control structure was implemented to manage policy and operational decisions. The operational response was led by the former Director General for Justice and Home Affairs, reporting directly into the Chief Executive and the Office of the Chief Executive.

All ministers and senior officers were briefed of the authority and governance arrangements. The Executive Leadership Team (ELT) were informed of the shift toward such an arrangement on 10 March 2020 – coinciding with the first confirmed cases of Covid-19 on-island. This included the establishment of a Strategic and Tactical Command Group.

A One Gov Covid Team was established on 12 March 2020, that enabled coordination of a number of cross-organisational and departmental workstreams. These workstreams were established to identify and provide the resource to complete the activity working across organisational boundaries.

The capacity to deliver the pandemic response and business as usual activities was not available, so the CEO and OCE were instrumental in prioritising activity as part of the halt, defer, reduce initiative.

An extended ELT group, comprising Directors General, representatives of non-ministerial departments, States of Jersey Police and Emergency Planning colleagues met daily on a morning call, to discuss operational challenges and policy developments with respect to the Covid-19 response, with an additional ELT meeting weekly. As the pandemic progressed, and schemes/mitigations were put in place, the frequency of these meetings was decreased/increased as appropriate.

An Operating Committee of Tiers 2 and 3 officers was established to manage the operation of the public service, outside of the immediate Covid-19 response. This created the capacity within ELT to focus on the Covid-19 response.

Management information including a daily risk management update, health statistics, staff data, and operational updates/challenges was displayed on the wall of the Chief Executive's office and regularly updated, so that the CEO was kept fully abreast of developments

The Chief of Staff led the coordination of the overall governance arrangements and collation of information provided to decision makers and records of key decisions.

The Ministerial Office

The Ministerial Office supported the political governance arrangements around the formation and conduct of the Competent Authority Meetings, as well as Emergencies Council's and Council of Ministers' ongoing work in relation to the pandemic response. This included close engagement with individual Ministers, as well as ensure ongoing engagement with States Members and the wider public, as well as a range of practical arrangements to support physical distancing and business resilience and continuity.

Individual Private Secretaries within the Ministerial Office assigned to Ministers also aided Ministers in the discharge of their duties, mainly relating to obtaining information; supporting and reviewing communications and other materials provided to the public and politicians; providing advice as needed (mainly on procedural matters); and supporting practical arrangements around briefings

These processes were integrated into the wider operational and organisational pandemic management structures, including STAC, and the work of the senior officials, notably, those led by the Director Generals of Justice and Home Affairs, Strategic Policy, Planning and Performance, and Health and Community Services, as well as other Director Generals and Departments as required (Treasury and Exchequer, Children, Education, Young People and Skills, etc.).

Communications Directorate

The Communications Directorate is responsible for the internal and external communication of Government policies and initiatives, including those relating to the health, care and economic measures enacted in response to the pandemic.

Each department in the Government has its own Head of Communications who supports their Ministers and Director General with communication priorities, and these are supported by a central press office, internal communications team, and specialists in marketing, digital and design.

At the outset of the pandemic, with business-as-usual activity being re-prioritised, the directorate came together to provide reactive crisis communications and proactive behavioural change support. Utilising the OneGov structure and approach, the hierarchy within the team was flattened and groups of people were assigned to work on the various policy priorities.

These groups were responsible for supporting policy officials devise, promote and implement their initiatives; crafting and disseminating messages to all colleagues, stakeholders and Islanders; and advising Ministers and senior officials on public announcements.

Each team member was responsible for a different aspect of this work and so, on any given day, could be drafting press notices, organising media opportunities, editing content for social media, working with a graphic designer, liaising with Parish officials or coordinating internal briefings with stakeholders.

The Director of Communications was part of the Strategic Coordination Group (SCG) and the Scientific and Technical Advisory Cell (STAC) and the Head of Media was part of the Tactical Coordination Group (TCG). The Head of Internal Comms sat on the Travel Cell and the Head of Communications for Health and Community Services (HCS) sat on gold and silver command (a comms officer seconded to that department sat on bronze).

The directorate enacted a collaborative approach to decision making during the pandemic, but final accountability for the communications advice to these forums was always held by the Director of Communications, or the Head of Internal Comms during the Director's parental leave absence (in spring 2021).

At the beginning of each day, the team undertook media monitoring and public sentiment tracking – sending it out to a wide list of internal stakeholders. Following this, an all-directorate 'comms huddle' was hosted on Microsoft Teams to look at the policy announcements that needed to be made, the notices that needed cascading to colleagues, the opportunities proposed for Ministers to be interviewed, and the briefings that needed to be hosted. The proposals would be agreed and then shared with the Ministerial Support Unit, the Director Generals, and the previous Chief Executive for their sign-off and shared with the Strategic Co-ordination Group.

Proposals that were signed-off would then be worked on, with 'grip&go' meetings throughout the day to align their messaging, timings and proposed evaluation metrics. These meetings were no more than 15 minutes long, with the invite list limited to those directly involved in the planning and production, and were a quick way of coming together, driving through issues, and resolving any conflicts.

There was a weekly Practice Heads meeting composing the Head of Media, the Head of Internal and Change Communications, and the Head of Marketing, Digital and Design and the Director of Communications to make sure the team's wellbeing was looked after (many were working from home and some were isolating), the resources were appropriate (financial and people), and the overall strategy was being adhered to and was producing the anticipated results (in contact, awareness, understanding sentiment, behaviour change, advocacy).

External Relations

External Relations did not establish cross-government governance arrangements for the Covid-19 response.

However, External Relations was represented on the Strategic (Gold) and Tactical (Silver) command groups. External Relations participated in the Travel & Borders Working Group, the Safer Travel Cell and the Covid Status Certification Working Group. Where required, External Relations contributed to meetings of the Emergencies Council and the STAC. External Relations supported other departments in their engagement with UK Government on issues ranging from PPE to

vaccines. These meetings were generally chaired by the UK and attended by representatives from across the Crown Dependencies.

In terms of work priorities linked to the above arrangements:

- External Relations was instrumental in helping to develop and establish the Essential Traveller arrangements. We worked closely with colleagues in Economy, SPPP, HCS, JCIS and Ports of Jersey to ensure 'lifeline' air connectivity with the UK was established and maintained, enabling patients to travel to/from UK hospitals, essential workers to travel to/from the Island, and allowing Jersey residents the ability to travel to and from the UK in a strictly limited number of circumstances.
- External Relations took a lead role in developing the new travel arrangements and worked closely with SPPP and Public Health colleagues to evolve the regime over time to best reflect prevailing health advice. External Relations managed the booking system for public sector colleagues needing to travel.
- External Relations led engagement with relevant UK departments to ensure effective alignment between the UK's developing travel regime and Jersey's own travel classification system, and to ensure that movement between Jersey and the UK under the Common Travel Area was safeguarded.
- External Relations also played a key role in the development of a pilot COVID-19 testing regime for arriving passengers at Jersey Ports. The pilot proved a success and informed the subsequent rollout of a comprehensive arrivals testing regime.
- External Relations led the programme of repatriation for Jersey residents stranded overseas, the demand for which became particularly acute as international travel reduced and borders closed.
- We also supported GoJ departments in engagement with the EU and Governments further afield in discussions covering a wide range of policy issues related to the Covid-19 response.

Please provide an appraisal of how suitable these governance arrangements were:

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Office of the Chief Executive / Chief of Staff

Overall, the governance structures allowed for clear accountability and decision-making. The Chief Executive was responsible for the overall strategic pandemic response on behalf of the public service, with the operational lead being delegated to the Director General of Justice and Home Affairs. The Chief of Staff was also a key conduit into the decision-making groups, such as ELT and SCG. A detailed appraisal of the governance arrangements is included in the self-assessment of Justice and Home Affairs.

The Ministerial Office

The Competent Authorities was an effective focused group of ministers with relevant portfolios, so was easy to convene, and appropriate in terms of attendees. The "teams" and related technology also make for effective administrative arrangements, albeit it took some time for Ministers to get

use the new technology, and some of the distancing requirements created challenges for any in-person attendees.

The challenges relate to some duplication with Council of Ministers and Emergencies Council, in that these wider groups needed to be informed, and in the case of CoM, as the government of the Island, needed to provide direction. In addition, meetings could be lengthy, in large part because of the range of ministerial questions and views. As the work progressed, the delineation between the different ministerial groups became easier to manage – with Council of Ministers focused on the most material whole of government decisions, and Emergencies Council maintaining a watching and consultive brief, over public engagement.

The responsibilities of the Competent Authorities Minister were based substantially on the relevant ministerial portfolios and responsibilities held by attendees, and their coordination, but in hindsight, a more expansive term of reference would have helped with public understanding of the role of CAM (rather than delivering any material operational benefits internally).

Communications Directorate

The directorate liaised closely with The Competent Authority Ministers, the Executive Leadership Team, the Strategic Coordination Group and the various Gold and Silver Commands within departments. This allowed them to have oversight across the political and operational and plug gaps where the governance arrangements were not yet fully matured.

Having a comms professional in each forum was a really useful way to quickly share insights and manage emerging issues. It would have also been helpful to have the experience and insights of a private secretary in such forums from the start. At the beginning of the response, in some cases, it took too long for a political steer to crystalise following briefings from various forum members.

In the future, a greater rigour around submissions and read-outs may be beneficial, so Ministers would be better informed during the policy development stage. This could save time in getting key issues understood and decisions made by Ministers

External Relations

The governance arrangements worked well from an External Relations perspective, providing a constructive set of fora to discuss key issues and to provide effective cohesion, oversight and direction across the huge breadth of Covid work.

What implications did the introduction of new legislation have on these governance arrangements?

Office of the Chief Executive / Chief of Staff and Ministerial Office

The above arrangements reviewed and supported the legislative arrangements, which in turn enabled them to make decision in a legally sound manner.

Communications Directorate

There were no implications following introduction of new legislation.

External Relations

There were no implications following introduction of new legislation.

How did the communications directorate support you/your department/organisation operation during the Covid-19 response?

Were appropriate systems in place to support your department?
What communication was required?
What worked well?
What didn't work so well?
What have you learnt and what would you do differently?

Office of the Chief Executive / Chief of Staff

The Communications Directorate supported all areas of the Covid-19 response, including the Community Task Force and ConnectMe initiative, which were led from the Chief of Staff area.

The Ministerial Office

Communications Directorate representatives attended all Ministerial briefings and meetings and worked closely with the Private Secretaries on the development and approval of materials.

Communications Directorate

The Director of Communications (DOC) for the Government of Jersey has oversight and leadership of the corporate communications within, and from, all ministerial departments. They are the line manager for the Head of Communications in each department (overseeing their wellbeing, their My Conversation My Goals objectives, and their learning and development needs).

The DOC hosted regular meetings (at least weekly) with each Head of Communications to manage their welfare, monitor their work and guide them on objectives, challenges and opportunities.

There is a daily 'diary' of communications activity across the departments, a weekly 'grid' of communications outputs, and a 'forward look' for the months ahead. These products sit alongside communication strategies for each department and, during the pandemic, each workstream (e.g. PPE, the Nightingale Ward, vaccinations, ConnectMe, co-funding payroll etc.)

Separate responses, giving the detail of comms procedures have been submitted by departments. These should be read in conjunction with the DOC response to the Public Accounts Committee COVID-19 Response Review.

External Relations

External Relations worked closely with other departments (JHA, SPPP, Economy) on the development and delivery of relevant areas of the Covid response and the communications support for the Office of the Chief Executive (within which External Relations sat) and the other departments was effective and joined-up. My team had effective support from our Head of Communications.

Logistical and operational decision making

What Emergency Planning processes did you/your department/organisation have in place prior to the initial pandemic response?

What worked well?
What didn't work so well?

What have you learnt and what would you do differently?

Office of the Chief Executive / Chief of Staff

The GoJ put in place the standard emergency planning process supported by the Emergency Planning Team within Justice & Home Affairs, plans for which were in place before the initial pandemic in preparedness of any crisis situation. These arrangements were stepped up and down as appropriate.

As the pandemic continued, local business continuity plans were put in place in order to split teams and reduce the risk that all team members contract Covid and are unable to work. The quick rollout of Office 365 to team members facilitated this working arrangement.

Despite arrangements put in place to establish and Operating Committee, the work demands on senior officers was significant and there was a high risk that their resilience could be compromised, affecting their health and wellbeing. All senior officers were offered support and coaching during this time.

The Ministerial Office

While arrangements around Emergency Planning and the Emergencies Council were in place prior to the pandemic, the Ministerial Office did not provide support the Emergencies Council prior to the pandemic, and was not involved in emergency planning, other than our own internal business continuity arrangements, and by way of administrative support to individual Ministers with Emergency Planning responsibilities, notably, the Minister for Home Affairs and Chief Minister.

Communications Directorate

The Directorate has its own business continuity processes that were stepped up during the pandemic response.

During each wave of the pandemic, the team offered a service seven days a week, twenty-four hours a day.

A rota was developed to make sure team members were available and working during weekday evenings and at weekends, but also getting their rest. This was aligned to the Team A / Team B structure and so there was always a back-up available.

This rota meant the team could publish information on the Government's owned-channels as it could be updated and respond to media queries promptly. Providing a round-the-clock service enabled Islanders to receive accurate and timely information as soon as it was ready to be published.

Various team members attended Council of Ministers and Emergencies Council, working after these meetings to prepare and publish announcements according to the timeline agreed by Ministers.

External Relations

The Directorate had its own business continuity processes that were stepped up during the pandemic response. Our Business Continuity Plan worked well, supported by the fact the team was already well-versed in working flexibility, including from home and overseas locations.

I chaired weekly (and at one point daily) virtual meetings of my Senior Management Team to track progress and delivery of External Relations involvement in the Covid-19 response, as well as overseeing and reprioritising as appropriate, non-Covid related work.

Regular virtual team meetings were also undertaken with the full Directorate (including the overseas offices) to ensure oversight, understanding and communication of the full External Relations work programme, the wider GoJ response to Covid-19, and to monitor the effectiveness of Business Continuity arrangements. The overseas offices also had their own BC arrangements which were picked-up in these team discussions.

How have you/your department/organisation Emergency Planning processes evolved during the pandemic response?

What worked well?
What didn't work so well?
What have you learnt and what would you do differently?

Office of the Chief Executive / Chief of Staff

The levels of activity with respect to individual workstreams and frequency of meetings of key governance groups were dialled up/down as appropriate. became more relevant as current state Residual functions are now in Government Departments as BAU but will be stood back up if required.

The Ministerial Office

Our business continuity arrangements were enhanced in terms of resilience in response to the pandemic, e.g., split teams (A&B, and home and office working); electronic working and meetings; and we also enhancement arrangements around ministerial cover in the event of ministerial illness, including additional delegations to Assistant Ministers and additional Assistant Minister appointments. The Ministerial Office was also part of wider organisational business continuity arrangements and teams.

These arrangements have evolved and been enhanced over the course of the pandemic, benefiting business as usual processes, notably, through the increased use of technology for communicating (reducing costs, increasing ability to call and host meetings and briefings) and for end to end cross departmental processes (Assembly business scrutiny business, and internal information sharing and file management); flexible in-office/home working arrangements.

The above clearly was a journey, and while new arrangements were put in place quickly, and in some cases immediately, familiarity and ease have improved considerably as the officer team (and Ministers) have become more used to the tools and more technology-enabled approach to business.

Communications Directorate

The Director of Communications arrived in role on 02 March 2020. At that time, there was no designated room or facility to host press conferences or briefings.

For the first series of televised briefings with medical officers, the team had to use a break-out room and kitchenette inside Broad Street. This meant bringing journalists into the building via a separate entrance and bringing their equipment up three flights of stairs in order to make sure the right distancing could be kept from colleagues who were working on the emergency response.

This was found to be unsatisfactory and so the team worked to find Government owned space that could accommodate more frequent briefings. Initially, a room was found that could host Ministers and journalists at 1 metre distancing. The team undertook several press conferences there. Finally, they asked the journalists to dial in via Microsoft Teams and projected them on a big screen in front of Ministers.

To complement these conferences, and in line with the worldwide trend of watching more video content and listening to podcasts, the team set up an in-house Government owned studio in the Parade. The studio enabled the team to increasing video production for use on our various channels and giving them full control over the scripting, directing, and producing of Jersey-centric content

External Relations

The processes worked well during the pandemic response and there was no need to amend them.

Describe the implications on you/your department/organisation on procurement and the continuity of supply chains during the pandemic response?

Were appropriate systems in place to support your department?
What procurement was required?
What worked well?
What didn't work so well?
What have you learnt and what would you do differently?

Office of the Chief Executive / Chief of Staff

There were no direct implications for OCE, apart from ensuring that consistent corporate guidance was issued and monitoring that departments met corporate expectations. This was assessed by live audits undertaken internally.

The Ministerial Office

There were no implications.

Communications Directorate

There were no implications.

External Relations

There were no implications in the provision of goods or services to External Relations.

However, the Directorate did support other teams e.g., HCS, Commercial, in discussions with the UK Government and other jurisdictions in respect of procurement and supply issues. This cooperation worked well.

Describe the implications on you/your department/organisation of strategies and systems put in place for testing, outbreak management (including in schools, care homes, etc) and self-isolation on your department

What worked well?
What didn't work so well?
What have you learnt and what would you do differently?

Office of the Chief Executive / Chief of Staff

There were no direct implications for OCE; however, the CEO chaired the ELT group, which would consider the cross-departmental implications of the pandemic response and key initiatives, to provide timely advice to decision makers.

The Ministerial Office

No further information to add.

Communications Directorate

The Directorate followed the general Government guidance for working from home unless essential. For those who had to remain in the office, they followed the specific guidance for each building. This worked well and there were no major outbreaks affecting the work of the Directorate.

During periods of physical distancing, the team provided a dial-in facility for journalists so they could safely attend press conferences remotely. They set up a large screen so the journalists could appear virtually in the room with Ministers and ask their questions in vision.

External Relations

The External Relations directorate followed the general Government guidance for working from home unless essential. For those who had to remain in the office, they followed the relevant Broad Street guidance. The overseas offices followed local direction and guidance as relevant to their locations. External Relations is by its very nature a mobile team and thus we were prepared and well able to continue to assist in the Covid response, as well as continue with BAU, while working flexibly and outside of the core office space.

Describe the implications on you/your department/organisation of restrictions on:

Physical distancing
Mask wearing
Self-isolation
Connectivity and border control

Office of the Chief Executive / Chief of Staff

The key implications of the above were in relation to managing the office environment – physical distancing, flow of persons throughout the building, etc

The CEO chaired the ELT group, which would consider the cross-departmental implications of the pandemic response and key initiatives, to provide timely advice to decision makers.

In some instances, colleagues were based off-island or unable to travel due to restrictions/personal circumstances, which created challenges in progressing activity. However, the ability to use video-conferencing facilities meant that this risk was significantly reduced.

The Ministerial Office

Limited – we moved quickly to remote workings, and the tools for that have improved not impeded the conduct of ministerial business in terms of economy, flexibility, and information management. In the initial stages, some challenges did exist around identifying suitable venues for physical distanced working, but this was quickly superseded by an increased use of technology to conduct business.

Communications Directorate

The Directorate followed the specific guidance for the building in which the team were working (Jersey General Hospital, Broad Street etc.) There were no implications on following this guidance – and all business continuity procedures were followed.

External Relations

As above, External Relations is a very mobile Directorate. Flexible working is embedded across the team, and we have the IT in place to support effective working away from the office. Mask-wearing and self-isolation did not therefore unduly affect the productivity of the team.

The pandemic impacted the foreign affairs functions of many jurisdictions, given the halt to international travel, connectivity and border control, and the need for Governments around the world to reprioritise diplomatic engagement to Covid-focused activities. This also affected the pace of External Relations' own work programme, particularly in respect of our Global Relations strategy. This provided some initial resource capacity to support GoJ's Covid-19 response, specifically in relation to the development and establishment of the Essential Traveller Regime, the repatriation of Jersey residents stranded overseas, the Island's reconnection planning and in supporting GoJ's engagement with other Governments on Covid-19 matters.

While face-to-face engagement is always preferable in building and consolidating relationships with other jurisdictions, our external relationships were maintained successfully via virtual means when travel was not possible, including in the development of a series of high-impact webinars with a range of priority partners. Where it was possible to host in person engagement, the team maximised opportunities e.g., the inbound visit of the US Ambassador in 2020.

The balance of public health and harm with regard to wider societal impacts

Describe impacts felt on you/your department/organisation

- What community groups/sectors of the population have been impacted?

Office of the Chief Executive / Chief of Staff

The OCE does not deliver front line services so there was no direct impact.

However, the Chief of Staff led the Community Task Force initiative, which was established to provide:

- advice to the Voluntary and Community sector
- identify support service accessible through charitable organisations and provide signposting for Islanders to access those services
- a route for those needing support or wishing to volunteer
- support activity to islanders who most needed it as a result of COVID-19
- proactive targeting to ensure Islanders are getting support.
- coordination of funding mechanisms for charitable/voluntary services stood up during the pandemic response.

The Community Task Force worked with the Parishes, voluntary and community sector, businesses and government, to support all islanders

A demand and capacity exercise was undertaken to understand and balance the needs and the ability to provide resource to provide support

Vulnerable groups were prioritised, particularly those who were subject to a 'stay at home' order

Support was developed to provide services such as emergency accommodation, medicinal products delivery, food deliveries, personal care, debt management and dog walking.

Financially vulnerable islanders were supported through immediate financial assistance, and longer-term financial management support, for example:

- People who were in financial need prior to COVID
- On zero hours contracts; Reliant on overtime in order to cope financially; cash only
- Furloughed; recently unemployed due to COVID
- Unable to work due to being 'extremely medically vulnerable'
- Recently moved for seasonal work; or <6 months and can't return home
- On higher incomes but with high, fixed financial commitments
- The Community Task Force left a legacy of even better joint working, Parish and VCS partnerships, with established workstreams and processes in place and clearer, co-ordinated, streamlined VCS funding decisions

The Ministerial Office

None specific to the Ministerial Office – we contributed to the wider political management of the pandemic, which had consequential impacts on securing an appropriate balance of harms (which is an crucial element – as a good environment for decision-making, based on the procurement of good quality advice and information, is essential).

Communications Directorate

The media worked throughout the pandemic response and so they were not affected by public health measures.

As communications was aimed at the entire Island, whenever a major policy announcement was made, the team offered a Microsoft Teams pre-briefing for journalists with subject experts. This enabled journalists to ask questions, so they could fully understand the issues before the live press conference.

This gave them more time to prepare their stories, which helped them to report the information accurately, thus providing a better service for Islanders. The team also provided the media with the infographics created by the design team, to help them illustrate their coverage. This complemented the advertising that the team commissioned across a wide spread of media.

Communications activity was planned to span multiple channels in a fully integrated approach. This made sure that the critical campaign messages reached the greatest possible number of Islanders in the most cost-effective way.

One of the core objectives of the campaign was to make sure important messages about keeping safe from Covid-19 were accessible, clear, and widely understood. This meant material had to be translated into languages other than English, repeated in different tones, and broadcast through multiple channels and at different times of the day.

We monitored the effectiveness of these outputs through feedback directly on the channels (social media interactions, press conference questions, conversations with journalists) and through real-time assessments from the call centre, customer feedback, and policy officers in the OneGov Tactical Coordination Group (1TCG).

The below points set out how each form of media was used utilised to communicate messaging to Islanders and how it was monitored and evaluated:

Live press conferences

We hosted 47 live press conferences throughout the pandemic phases. These were broadcast on our social media channels, YouTube, and streamed live on Channel 103 and BBC Jersey. The team tracked the questions answered, the comments on social media and the feedback via the radio stations.

ITV Hub and Airtime

Four adverts were created for airtime (live television) and Digital Hub (playback) to communicate key messages to Islanders. It was important to utilise mainstream media from the offset of the campaign, particularly when trying to change Islanders' behaviour around social distancing, the Stay-at-Home order, and directing them to ConnectMe for support. The team received feedback from 1TCG on the behaviour change of Islanders, questions to the call centre and Ministerial correspondence.

Print advertising

To make sure the team were reaching all Islanders, particularly Jersey's older demographic, advertising within the Jersey Evening Post and the community magazines continued to be an

important form of communication. A total of 48 adverts have been placed in the JEP to date – the first on 6 March 2020. Our Island – a publication distributed to every house in Jersey – featured Covid-19 messaging throughout the pandemic. The team received feedback from the letter section of the newspaper and Ministerial correspondence.

Radio

In addition to English, all radio adverts were translated and produced in Polish, Portuguese and Romanian to make sure key messages about prevention, symptoms, the Stay-at-Home order, Connect Me and wellbeing were accessible to all our major non-native-English speaking communities. 46 adverts have been produced and aired to date. The team received feedback from calls to the radio, 1TCG on the behaviour change of Islanders, questions to the call centre and Ministerial correspondence.

Out-of-Home marketing

Roadside banners, posters, pull up banners and vinyl stickers were produced and placed at key high-traffic and commuter points throughout the Island, including parks, roadsides, parish halls, stores, King Street, restaurants, retailers and car parks.

In partnership with the Parish of St Helier, bins throughout town were used as signage, providing clear messaging about social distancing in English, Portuguese, Polish and Romanian. The windows of empty shop fronts were wrapped in their entirety and utilised for high-impact messaging about social distancing, coronavirus symptoms and prevention.

The team have also used Government-owned buildings, including the General Hospital, Jubilee Wharf and Broad St, to fully wrap doors and windows with prevention messages. The building wrapping has been undertaken by the IHE signs team to ensure costs were kept to a minimum.

PDFs of all printed material, including translated leaflets and posters, are available on gov.je so that they were accessible for businesses to print their own.

Island-wide leaflet drops

A series of Island-wide information leaflets (seven leaflets) were distributed by Jersey Post, making that key public health information made its way into 41,000 homes in Jersey – this was particularly important for targeting the non-digital population who are not traditionally active users of social media, and might not have access to the internet. The team monitored the impact of this through the radio stations and the letters section in the JEP where the team could judge how well the information had been seen, understood, acted-up and advocated for.

Digital marketing and social media

With lots of misinformation (and in my opinion a high level of disinformation) circulating online, but particularly on social media, the Government social media platforms were positioned from the outset as the source of fact for Covid-19 updates and particular advice for Jersey. The team advised Ministers to avoid giving opinions and focused, instead, on our efforts on positioning the Medical Officers for Health.

During the pandemic, the team managed a rise in organic Facebook followers, growing from 41,289 follows in February 2020 to 81,778 follows in December 2021. A larger cohort allowed us to see what Islanders from many different communities were commenting on and engaging with, and this

was fed back through the Heads of Communications to their departments or to their particular working groups.

As part of Putting Children First, the team designed content for parents, including how to discuss coronavirus with a child, and shared these on social media and Parent Mail. We worked with the Youth Service to engage with young adults through their social media channels and the youth digital radio station. Direct feedback was monitored from these channels.

A gov.je site wide banner was used when required. The banner is front and centre when users visit any page of the Government website, and the team used this to drive Islanders to find out more information. The team monitored the click-rate on these banners and made sure they were providing a smooth user-journey for people trying to get to the information they needed.

Working in partnership with the Co-op and Jersey Post, the team displayed coronavirus communication digital screens in store and in post offices. Paid-for digital advertising was placed on Liberty Bus Station screens, on the St Helier's clock tower, in the Bailiwick news site, on JEP digital, and at the airport. Direct feedback is not possible in these channels, but they formed a core part of our saturation-of-message strategy (which I deemed appropriate during a global pandemic).

To engage with our business stakeholders, emailers were sent out to our businesses database, including our registered Supply Jersey suppliers and Arm's Length Organisations, to inform them of business-specific updates. The team received direct feedback from these emails.

Telecommunication

A memorandum of understanding was signed between Government and all of the local telecommunication providers to enable the mass communication of Government messages in relation to the public health emergency caused by the coronavirus pandemic. The Island-wide SMS messaging function has been particularly effective in alerting Islanders to significant updates and announcements, and changes to advice. The team have monitored feedback on social media to these messages.

Also of note was the dedicated work a team member (Head of Communication for the Department for Customer and Local Services) did with ConnectMe. This included direct links with States Members, the Parishes (including the secretaries) and the churches. This supported getting messages out (often in languages other than English) over Whatsapp, Facebook and email. Having direct engagement meant that some localised issues could be dealt with discretely and to the benefit of those communities.

External Relations

The general public and business were impacted by travel restrictions and border controls.

Describe how the work undertaken by you/your department/organisation impacted on different population groups

Office of the Chief Executive / Chief of Staff

With respect to the Community Task Force Steering Group included States Members of Portuguese and Polish backgrounds, which provided a communications and engagement channel into communities which are often harder to reach.

For example, those individuals were able to ensure that public health and restrictions messages were able to better penetrate Portuguese and Polish communities, which, at times, provided a solution that could be deployed to avoid more draconian activity, such as enforcement activity.

The Ministerial Office

We supported overall end-to-end political decision-making, which in turn impacted materially on the overall population by way of best possible decision-making (see previous answers)

Communications Directorate

The advice the DOC gave in order to impact Islanders in the most positive way evolved over the course of the pandemic and was briefed to each session of the Emergencies Council during the 'contain, delay, shield' stage of the pandemic in March 2021.

The core approach the DOC repeated was to provide Islanders with messages and advice that were timely, clear and consistent. The DOC advocated the segmentation Island audiences into sub-groups and the delivering of specific messages to them, focusing on factually accurate messages that could support behaviour change.

By the end of April 2021, when the situation was improving dramatically in the Island, the DOC briefed a Scrutiny Liaison Committee on the team's communications approach to date and highlighted the following:

- "be as transparent as possible with Islanders so there is single version of the truth.
- "give clear advice in simple language that does not need to be nuanced.
- "The simplicity of message is key to adherence.
- "make specific messages in Portuguese, Polish and Romanian. Targeting [with bespoke messages] these communities with action-based messages."

To make sure the team were being as inclusive as possible, all key messages shared on social media were translated into Portuguese, Polish and Romanian, and British Sign Language videos were also shared on the Government social media channels.

There are a limited number of BSL signers, and none accredited to the required level to communicate key messages. To ensure the team did not exclude this audience group, The team added subtitles to all our videos, including our live press conferences. The team did translate some key messages with RAD (Royal Association for Deaf people UK), and would then share the videos on social media and add to YouTube.

The turn-around would take a few days, which unfortunately created some delay in delivery of the messages.

The team's aim was always to provide clear, easily understandable information to Islanders. This could be a challenge when communicating technical topics like the unpredictable behaviour of a new virus.

Communications colleagues worked to translate technical information into clearly worded material for the media, social channels and press conferences. The team offered interviews with Ministers and subject matter experts so the media could access the people who were making the decisions and providing the technical advice.

The team arranged online 'Ask the Expert' and 'Ask the Ministers' sessions so Islanders could ask their own questions directly and also encourage Ministers to host Twitter Q&As, attend Radio Jersey interviews and respond to Ministerial correspondence and letters in the Jersey Evening Post.

The team took advice from behavioural scientists when considering how to develop communications that could be better understood by, and resonate with, Islanders.

From all these opportunities, the team would monitor feedback closely and try to amend products and messages to make them more easily understood.

Notwithstanding the breadth of communication outputs, and their success in supporting public health and economic objectives, the team identified a few major learnings and actioned them during the pandemic response:

1. Communicating a nuanced policy position, that balanced Islanders' freedoms, their wider mental and physical health, and their household economy, against the health effects of Covid-19, was a challenging task. Sometimes the team did not challenge enough the language of policy officials, or the diverse opinions of Ministers in making sure than one single, and plain English explanation was given to Islanders as the lead message;
2. At the beginning of the pandemic, communication officers were not engaged early enough in planning Ministers' diaries for set-piece press conferences;
3. The views and opinions of young people, while being collated, were not weighted individually away from those of the family-unit. While practical policy deliberations always included the implications for children as a lead priority, due to the need to brief all Islanders in a rapid manner the communications effort did not prioritise them over any other group;

How will these be integrated going forward:

4. Plainer language began to be used, and Ministers were encouraged to adopt social media where shorter, less formal messages could be conveyed directly from the decision makers. This complemented, not replaced, the strategy of using radio and television interviews and placing adverts in the Jersey Evening Post.
5. The Ministerial Support Unit and communications officer worked more closely than ever before, with daily calls and 'grip&go' meetings throughout the day to plan diaries.

The department for Children, Young People, Education and Skills brought funds to the Directorate to provide increased communication and engagement support for children and young people. This continues to include a dedicated digital communications officer who is providing regular reports back to the department on the views of young people

External Relations

Delivery of repatriation advice and support impacted individuals and families stranded overseas or assisted those in Jersey with loved ones stranded overseas. External Relations provided dedicated 7 day per week helpline in the initial stages of the pandemic, to offer travel advice and close liaison with the Foreign, Commonwealth and Development Office. The team assisted over 650 individuals from 49 countries return home.

Jersey residents, businesspeople, public sector workers, students and those requiring health treatment in the UK were impacted by the operation of the Essential Traveller (lifeline) flights to and from the UK. Without these arrangements in place, critically important travel would not have been possible. These groups were also impacted by ongoing work to ensure alignment between the travel regimes of Jersey and the UK, and the development of the pilot for arrivals testing (which in due course allowed jersey's border to reopen).

External Relations' work with other GoJ departments and the UK Government to unblock issues and achieve cooperation across a range of policy areas had the potential to affect all population groups.

Questions for particular stakeholders (see question header)

Public Health and other relevant stakeholders
Provide a self-assessment of the effectiveness of public health interventions – both restrictions and guidance such as: lockdowns, physical distancing, shielding – in protecting Islanders
Office of the Chief Executive / Chief of Staff Whilst public health policy was led by SPPP, the Chief Executive provided the overall lead for the pandemic response. Also led from within OCE, the Community Task Force provided an avenue for issuing guidance and providing support to individuals' health and wellbeing. **The Ministerial Office** As noted in previous answers, the Ministerial Office contributed toward the overall pandemic response, focused on political decision making and structures, which in turn has important consequential impacts. **Communications Directorate** For each intervention there were specific comms metrics attached to what outtakes (clicks, engagements etc.) the team defined as success. This was particularly important when looking at the cost per item or engagements. When the did not meet these success measures, they looked fist at their own graphics, messages, and overall design and then at the product placement, timing, and relevance to that channel. For overall success in each campaign burst, the team looked for feedback from the 1TCG and from the Public Health teams who were monitoring Islanders understanding and compliance of the measures. To measure sentiment, and to advise Ministers on how their decisions were being received, the team looked at public comments on social media, callers to the radio station, letters in the Jersey Evening Post, and Ministerial correspondence.

The team identified tactical lessons learned if an announcement or a new measure was not quickly understood or acted upon. This would usually be done within two days, with new messages or artwork created and run alongside to see which was better engaged with and understood.

Sentiment and long-term behaviours were assessed before each Emergencies Council and were then shared with the participants for their feedback and steer.

External Relations

No further information to add

Please provide a high-level evaluation of the efficacy of decision making and how it was informed by learning from evidence and actions of other jurisdictions

Office of the Chief Executive / Chief of Staff

The Office of the Chief Executive led the overall governance arrangements within the public service. Daily calls and regularly updated risk and management information provided senior officers information upon which to take appropriate operational decisions.

The ministerial office supported political governance arrangements and further commentary can be found below.

The Ministerial Office

Nothing further to add.

Communications Directorate

Each Head of Communications briefed their Minister in their weekly ministerial meeting, though many Ministers were in daily contact with the Director of Communications, and some Ministers were in greater contact than this. The former Chief Executive was briefed every morning and several times during the day.

Feedback from communication campaigns from other jurisdictions (Scrutiny asked the team to look at Guernsey, Scotland and New Zealand – and the team added Japan and France) was fed into the planning grid. Nevertheless, it was always central government UK messages (and restrictions in England) that affected the news cycle most in Jersey.

External Relations

Nothing further to add

Health and Community Services, relevant external/commissioned/voluntary sector stakeholders

Outline the operational impacts on the delivery of healthcare and social care services during the pandemic response

Office of the Chief Executive / Chief of Staff

There was no direct impact on the department. However, the Chief Executive led the ELT, SCG and TCG discussions, which covered cross-operational implications, which enabled OCE to provide high-quality, timely decision-making information to support decision makers.

The Ministerial Office

Nothing further to add

Communications Directorate

Nothing further to add

External Relations

Nothing further to add

Children, Young People, Education and Skills and other relevant stakeholders

Outline the operational impacts on the delivery of education during the pandemic response

Office of the Chief Executive / Chief of Staff

There was no direct impact on the department. However, the Chief Executive led the ELT, SCG and TCG discussions, which covered cross-operational implications, which enabled OCE to provide high-quality, timely decision-making information to support decision makers.

The Ministerial Office

Nothing further to add

Communications Directorate

Nothing further to add

External Relations

Public Health; Health and Community Services; Children, Young People, Education and Skills; other relevant stakeholders

Provide a self-assessment of the effectiveness of strategies and systems put in place of testing, outbreak management (including in schools, care homes, etc) and self-isolation

- What worked well?
- What didn't work so well
- What have you learnt and what would you do differently?

Office of the Chief Executive / Chief of Staff

There was no direct impact on the department. However, the Chief Executive led the ELT, SCG and TCG discussions, which covered cross-operational implications, which enabled OCE to provide high-quality, timely decision-making information to support decision makers.

The Ministerial Office

N/A

Communications Directorate

Nothing further to add

External Relations

Nothing further to add

Provide a self-assessment of the effectiveness of strategies and systems for vaccination

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Office of the Chief Executive / Chief of Staff

There was no direct impact on the department. However, the Chief Executive led the ELT, SCG and TCG discussions, which covered cross-operational implications, which enabled OCE to provide high-quality, timely decision-making information to support decision makers.

The Ministerial Office

Nothing further to add

Communications Directorate

Nothing further to add

External Relations

Nothing further to add

Economy; Treasury and Exchequer; Customer and Local Services; other relevant stakeholders

Provide a self-assessment of the impact and effectiveness of mitigations such as support to individuals, businesses, and other organisations

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Office of the Chief Executive / Chief of Staff

From the initial stages of the pandemic response, it was clear that support to individuals and businesses would be required. The CEO was involved in many discussions about initiating and developing support schemes, alongside Economy, Treasury and Exchequer and Customer and Local Services colleagues.

Although not part of the monetary support schemes, the Community Task Force provided a number of areas of support to islanders as outlined above**.**

The Ministerial Office

Nothing further to add

Communications Directorate

Nothing further to add

External Relations

Nothing further to add

CHIEF OPERATING OFFICE

The Chief Operating Office (COO) brings together a number of internal services that support and enable the effective functioning of our public services

The Chief Operating Office is made up of two core functions:

People Services
People Services leads our culture change and people practices across the Government of Jersey that are central to delivering our strategic outcomes. The function enables change through new and different ways to bring high quality public services to Jersey.

People Services includes:

- Organisational Development
- Employee Relations
- Industrial Relations and Reward
- Resourcing

Modernisation and Digital
Modernisation and Digital develops innovative technology to help simplify internal processes and speed up how customers access our services. It supports the One Gov vision of a joined up modern and efficient public service for islanders.

The function includes:

- Information Services
- Corporate Portfolio Office
- Significant programme teams

SELF-ASSESSMENT TEMPLATE

Questions for all stakeholders

NB During the bulk of the COVID response, the department of the Chief Operating Officer (COO) consisted of three core directorates:

- **Commercial Services – responsible for procurement, supply chain management and commercial relationships**
- **Modernisation & Digital – responsible for the governments IT estate and oversight of all corporate change**
- **People & Corporate Services – responsible for HR and, in this context, business continuity planning**

As a result of the very close ties to Treasury and Exchequer (T&E) that were established during the COVID response, in November 2021 Commercial Services transferred from COO to T&E and, therefore, their response is included in the response from T&E.

The impact of and response to COVID was quite different for each directorate within COO, therefore, in answering the panel's questions we have provided responses under three sub-headings:

- **COO Corporate – which represents the central governance parts of COO and the senior leadership team (SLT) which coordinated cross COO activities and ensured that the other directorates were able to fulfil their primary roles**
- **Modernisation & Digital - which was focused on maintaining existing IT and the critical pre pandemic change programmes as wells as on providing new IT to meet the COVID response**
- **People & Corporate Servies – whose primary role was on ensuring the welfare of staff and on ensuring that there were sufficient human resources in place to support both critical services and the COVID specific activities**

Governance
Please respond as appropriate: What governance arrangements did you establish to support decision making for the Covid-19 response? And/Or How did you/your department/organisation plug into governance arrangements for the Covid-19 response?

COO Corporate

- We setup a daily Chief Operating Office Senior Leadership Team (COO SLT) call as soon as Covid governance was starting to form across government. First meeting was held 20/3/2020
- Status update, actions and decisions were taken at each meeting
- These were in addition to regular COO SLT meetings and minutes of these and the daily meeting were also submitted to the Office of the Chief Executive
- Gold and silver groups were setup in Directorates within COO and any significant items escalated to the daily call.
- An agency report was all produced in line with government wide Strategic Coordinating Group (SCG) requirements and submitted bi-weekly then weekly which documented the status across COO. Any issues were raised in the daily COO SLT calls and the COO would then escalate into daily Executive Leadership Team (ELT) calls as required. We also had representation on SCG from COO SLT so that link enabled escalation.
- Business Continuity was invoked formally, and bi-weekly then weekly BC meetings were held with leads across COO.
- We completed risk assessments for our departments overall, risk assessments for lone working and Display Screen Equipment risk assessments. Again, any issues were raised through Gold/Silver groups or Business Continuity (BC) meetings and fed into the COO SLT daily call.
- A daily workforce dashboard was established to monitor staffing levels.
- The COO provided the route to the SCG calls and ELT Daily calls for any points of escalation or exchange of information from/to the COO management team.

Modernisation & Digital (M&D)

Gold, Silver, and Bronze command teams were set up internally across M&D to manage the requirements of the Covid-19 response. Internal resources were redirected to create a business continuity office which operated in a similar way to a project support office. This ensured that documentation was maintained while acting as a central resource for M&D to coordinate and track actions emerging from Gold, Silver, and Bronze commands.

Requests from across GoJ were managed through a specific pandemic response Demand Management process, to ensure that M&D teams were not overwhelmed and that the right things were being progressed in the right order, (i.e., finite resources, both people and equipment, were allocated to the most important things).

An IT prioritisation scoring matrix was developed and approved by STAC. Covid response requests were channelled into the Demand Management process through our department Business Enablement Managers (BEM) and scored using this matrix.

A daily Demand Management meeting as part of the Bronze command was held to review all new requests, agree the scoring, and allocate to the right group or team to action, with stakeholder involvement to ensure business ownership and prioritisation of all requests. It also managed progress against all the items.

To handle other technology prioritisation contentions, a weekly IT Prioritisation Board reviewed all requests and approved submissions that required a decision from the Demand Management Board. It also reviewed progress on high priority items and managed escalations. In total 324 individual requests were managed through this process which varied from a requirement for new or additional laptops, to requirements for bespoke system design and production.

M&D were tasked with developing technology solutions to support the Public Health response to COVID-19, including PCR testing, Lateral Flow Testing, and vaccinations. We acted as a technology workstream to each of the major programmes of Test & Trace and COVID Vaccinations feeding into their governance processes, such as programme boards.

People & Corporate Services (PCS)

There was a broad spectrum of actions our HR team took to ensure we could continue to serve Jersey, from major shifts in resourcing and deployment, to organising childcare for Essential Workers.

Regular calls between these 'cells' and Bronze/Silver coordination within PCS took place.

We organised ourselves in the following areas:

- Silver Meeting – SLT (for escalation to COO SLT)
- Bronze Group

Bronze group was established to identify, manage, and deliver all task required of P&CS. Any issues requiring any authorisation were escalated to Silver team. This team initially met twice daily in order to effectively provide the organisation with the support required.

P&CS split into key areas to provide support at the start of the pandemic:

- Emergency Resourcing Team: Providing support to the SCG/TCG requests for resources from across the Government
- Business Continuity: Embedded within the TCG/OneGov response to provide daily coordination across governmental departments
- Communications/Online Resources/Wellbeing: supporting employees and managers and enabling key issues identified on daily call (though SCG and Business Continuity) to be channelled as appropriate
- FAQs/Policy: Moved policies and guidance to public facing domains to ensure all managers and employees had access to the latest advice and guidance. Typically, we would be notified 24 hours before a public decision or escalation /public health advice / de-escalation, so this allowed us to provide clarity across the organisation as Ministerial announcements were mad.
- Childcare: Identifying providers of childcare for essential Workers
- Coaching Support: to provide resilience for senior leaders
- Data – Workforce Oversight: to model and monitor capacity across services.
- Accommodation team: to ensure those with covid-19 contacts in the course of their duties, and those required for work but with shielding children and adults within the home were able to continue to work.

Most colleagues were redeployed within P&CS to support the critical team's set-up to support the ongoing pandemic

A lot of the work undertaken by P&CS in the early days held fast throughout the pandemic meaning we could adapt depending on the different stages.

The P&CS Group Director, who has corporate responsibility for Business Continuity, was included in the relevant Competent Authority, SCG/TCG and ELT Meetings concerning the response to ensure consistency of the response.

The Business-as-usual activities remained transactional and were separated off into an operations team to ensure they did not become adversely affected by the Covid response resources. Most of the demand for services came from Covid response requirements.

P&CS had members on COO SLT calls to allow linkage into wider COO.

Please provide an appraisal of how suitable these governance arrangements were:

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

COO Corporate

What went well:

The daily calls held with COO SLT; this ensured transparent and real time communications with any risks or issues raised. The team ethic, customer focus and integrity were also identified as key strengths.

What didn't go well:

COO not being brought in by other parts of government early enough. The pressure put on our resources was significantly higher because we were held, at times, at arm's length for too long.

Modernisation & Digital

What went well:

The pandemic response demand management process referred to above was key in ensuring that teams within M&D were not overwhelmed, and that the right things were being progressed in the right order. Stakeholders were involved in the daily demand process which ensured business engagement. This combined with the STAC approval of the prioritisation scoring matrix was key in ensuring an understanding of the pandemic related demands. 'Other' BAU technology requirements were handled at a weekly IT Prioritisation Board where all requests were reviewed and approved if required. This board also reviewed progress on high priority items and managed escalations.

The team ethic, customer focus and integrity were also identified as key strengths.

The governance within M&D worked well and we were able to adapt as the as the pandemic progressed, standing up additional bronze teams and standing them down or reducing frequency as required. The link to the central BC Team was particularly successful with the placement of a senior manager on to that team who was not responsible for running Gold, Silver or Bronze in M&D but could report back in.

Although engaged very late, the delivery of technology solutions was managed through a specially convened rapid response tiger team of senior level people. The team got very close to the customer experience and the end-to-end process which enabled rapid design and specification of requirements to the development teams. Development was managed through sprint cycles which maintained a high pace of delivery and regular roll out of features. All requirements were documented with the Azure Dev Ops ("ADO") application to maintain governance and quality.

The technology selected was successful in being flexible and adaptable to meet frequently changing demands and requirements. Collectively, the technology team always delivered on Public Health and Minister requirements throughout the emergency response stage of the pandemic.

What didn't go well:

We had an inability to understand, assess and mitigate the impact on programmes not part of the Covid-19 response solutions.

M&D were involved extremely late in the solution provision for Test and Trace.

What have we learnt and what would we do differently:

It is key to involve services within M&D early. The pressure put on our resources was significantly higher because we were held, at times, at arm's length by the assigned project manager for Test

and Trace for too long, almost certainly due to incorrect assumptions about delivery capability, and a lack of understanding of the importance of execution within the response process. Moreover, refusing to use the technology skills of M&D meant that a not fit-for-purpose solution was pursued by the Test and Trace Team, ultimately resulting in unnecessary and excessive stress on M&D staff who were required to stand up a solution in a significantly compressed timescale. This caused a higher public health risk to the island and reputational risk to Government. Reducing our time to respond resulted in a very high-risk scenario with no time to field test the system before it went live.

People & Corporate Services

What went well:

- The team ethic, customer focus and integrity were identified as key strengths during the pandemic
- The rapid development of data strategy, workforce models and managing demand across the organisation.
- The inclusion of the Group Director at Gold/Silver levels to ensure people matters were considered and planned effectively.

- P&CS managed the development of the emergency resourcing team and organised health & safety guidance for the organisation. There was a structured and co-ordinated response to the emerging crisis and its effect on employees right across the organisation. In a 5-month period we redeployed, recruited, and placed more people than we usually place in a year.
- The Case Management team provided a 7day/week service processing requests for emergency accommodation. In total 3703 queries were answered with 418 staff provided with emergency accommodation.
- We implemented early on a dashboard to monitor the workforce as a whole and anticipate key gaps and critical areas. This allowed us to model different workforce scenarios.

What didn't go well:

Resourcing requests were at time overwhelming with little resource in the team meaning we had minimal resilience.

Data and reporting remained a constant challenge.

What would you do differently:

People and Corporate Services were included in the early response and planning for the response, in part due to our responsibility for Government-wide business continuity. However, the lack of resources early for planning purposes meant we were in a plan and respond phase at the same time, reliant on similar resources.

What implications did the introduction of new legislation have on these governance arrangements?
COO Corporate No significant impact on COO Corporate governance arrangements. **Modernisation & Digital** A large number of policy and legislative changes resulted a system requirement that was poorly defined and required M&D team members to become subject matter experts in legislation in order to interpret requirements for a solution. There was also a lack of understanding from the operational teams as to the optimal processes, which also required the M&D team to be subject matter experts in the operational processes in order to specify requirements. The pace of implementation required the adoption of a highly agile and customised method of working, had that not be adopted then the solutions would not have met policy requirements or delivered on time. **People & Corporate Services** No significant impact on COO Corporate governance arrangements
How did the communications directorate support you/your department/organisation operation during the Covid-19 response? • Were appropriate systems in place to support your department? • What communication was required? • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
COO Corporate There were no issues with the systems in place to support communications. The comms team supported us as required and we managed internal communications within our department. Comms team would attend meetings as required and we had no issue with capacity of the team to support us. We used corporate comms messaged wherever possible and frequently linked in with the team for all BC comms. **Modernisation & Digital** There were no issues with the systems in place to support communications Remote working: M&D worked closely with the communications directorate to pass information through My States to as many staff as possible. The responsiveness of the directorate was highly collaborative. Test and Trace: There was a separate T&T communications channel in place to manage the test and trace response. This was also highly collaborative. **People & Corporate Services** Dedicated communications support. Attending daily bronze meeting and linking in with colleagues in P&CS who worked in the newly defined areas to ensure comms updates were cascaded appropriately and in a timely manner to GOJ employees. Regular updates were supported by comms.
Logistical and operational decision making

What Emergency Planning processes did you/your department/organisation have in place prior to the initial pandemic response?

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

COO Corporate

What worked well:

We had a clear BC Plan in place with defined membership of an Incident Response Team which meant there were clear lines for decision making and escalation. We also had clear lines of communication within our teams to disseminate messages and guidance as required.

What didn't work so well:

No significant items to note.

What have you learnt and what would you do differently:

Having clear decision-making lines of authority and our corporate governance framework helped us respond in a well-managed way. We need to continue to keep these documents up to date and continue to ensure we have clear delegated authorities in place.

Modernisation & Digital

As an IT department, we have business continuity, incident response and disaster recovery processes in place.

What worked well:

Prior to the requirement for the Covid-19 Pandemic response, Governance existed but was further matured in the light of the need for rapid decision making. The processes established worked well in the initial activities and were scaled back over time as the emergency steps were put in place.

The upward and downward communication worked well.

What didn't work so well:

None of our response processes were pandemic proof. They were not based on everyone being able to work, but everyone requiring an alternative location for work, they were also short-term measures, and not designed to continue for months and years on end. For example, there were logistics issues with different buildings, as we needed to split teams and there were multiple teams with claim on the same space e.g., the Hub at Highlands.

Most incidents prepared for would have been over a matter of hours or days, the pandemic was over many months/years. The reliance on key people meant there was very little resilience at senior levels.

What have you learnt and what would you do differently:

Communications once established became repetitive, and as such were scaled back

We have established improved reciprocal arrangements with other directorates to ensure that we can split teams when needed.

The pandemic response has completely changed our sense of scale of an incident. The pandemic, although treated as an incident was in fact a crisis

People & Corporate Services

Business Continuity process across COO, including mapped 'time critical' services (although reversed engineered)

How have you/your department/organisation Emergency Planning processes evolved during the pandemic response?

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

COO Corporate

What worked well:

The stakeholder involvement in demand management and prioritisation worked well during the pandemic. COO remained flexible in its approach which meant we could adapt and change to evolving needs. BC cascade processes worked really well and there was a strong core team who managed cascades and arrangements well.

What didn't work so well:

Nothing specific for COO Corporate; see specific examples given at directorate level below.

What have you learnt and what would you do differently:

We have gained confidence and the ability as to how to work flexibly and adapt as a COO SLT. We have identified one of our strengths is crisis management and we are into a strong rhythm as to how to manage BC incidents. We have communication lines setup and a clear hierarchy for decision making.

Modernisation & Digital

What worked well:

The M&D principle of 'build for re-use' through an architectural approach to solutions, has proven its worth even in a crisis. As detailed earlier in the response, BATS is a perfect example of this, and the same mentality has been applied to all M&D responses. Nothing should be a point solution to be thrown away.

The redesign of two existing and in-flight Government Plan programmes, Microsoft Foundations (MSF) and Replacement Assets allowed for a significant proportion of the Covid-19 response by M&D. These programmes already had the intention to deliver what was needed, and so we used the focus of responding to the pandemic to restructure our plans and use the same programme resources to significantly accelerate the required deliverables. This included the rollout of Office 365 (allowing for teams to be used across the board in place of face-to-face meetings), the reengineering of our remote management capability (allowing for users to access systems remotely and facilitated large scale home working) and the mitigation of our inability to failover across data centres.

What didn't work so well:

The treatment of the Covid-19 response as a continual 'emergency response' resulting in 3-to-6-month business cases and funding agreements limit the value for money options when procuring products and services, it has also harmed the ability to properly plan resource allocation and management. This needs to be moved to a longer term, funded element of the organisation to enable ongoing support and development of technical solutions.

What have you learnt and what would you do differently:

Work specifically for Covid-19 was reported through the Test & Trace Programme with this managed as an ongoing 'emergency response', involving temporary funding through ongoing submission of 3-to-6-month business cases. However, the implementation of frequently changing public health measures has meant that we have an ongoing funding requirement. Since implementation of the Book and Trace System (BATS) we have made over 650 individual changes to support policy and operational changes. This continual short-term allocation of resources has harmed the ability to properly plan resource allocation and management. Given that the impact of the pandemic is continuing, and the potential to move into other Public Health initiatives, we have identified a requirement for a longer-term organisation is funded to enable ongoing support and development of the technical solutions

People & Corporate Services

What worked well:

- The accelerated development of an e-rostering system allowing us to quickly onboard and pay people using online rostering and time sheets has now been rolled out across government to replace paper based and disparate systems for shift rostering and payment of flexible contracted staff.
- New processes and systems were built in days to ensure the rapid onboarding of new staff. Between April to July 2020 over 450 staff were sourced to respond to requests from all government departments.

What didn't work so well:

- Given the longevity of the response, we must do more to anticipate supporting those in the response teams, as considerable pressure and time requirements were placed on them, particularly those in key roles.

What have you learnt and what would you do differently:

- We have established a flex-positive project which looks to introduce flexible working practices across Government, building on our learning during the pandemic.
- Prioritising wellbeing is important as we rebuild, we have redirected time to support senior leaders to rebuild teams and created new development opportunities to embed a more compassionate leadership style.
- We have seen the value of coaching being provided in a tailored fashion reflecting the needs of the individuals and their environments. Ensuring a focus between practical and psychological assistance. The sessions held during the pandemic have shown a clear need and desire for this to maintain and build managers capabilities going forwards.

Describe the implications on you/your department/organisation on procurement and the continuity of supply chains during the pandemic response?

- Were appropriate systems in place to support your department?
- What procurement was required?
- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

COO Corporate

Were appropriate systems in place to support your department:
Standard procurement approaches in line with the Public Finances Manual (PFM) were adopted, this included framework relationships, catalogue items, multiple quotes, and formal exemptions where time did not allow for adherence to PFM.

What procurement was required:
Please see examples below in directorate breakdown.

What worked well:
Please see examples below in directorate breakdown.

What didn't work so well:
Please see examples below in directorate breakdown.

Modernisation & Digital

Were appropriate systems in place to support your department:
Standard procurement approaches in line with the Public Finances Manual (PFM) were adopted, this included framework relationships, catalogue items, multiple quotes, and formal exemptions where time did not allow for adherence to PFM

What procurement was required:
A service from Microsoft was procured to configure solutions to develop the test and trace platform.

Additionally there were numerous hardware purchases from laptops to servers.

What worked well:
Microsoft were able to stand up a team of experts rapidly, and due to their global presence were able to employ a "follow the sun" approach to the configuration which meant that development could take place 24 hours a day to meet the initial deadlines.

The relationship we developed with Microsoft through the crisis was critical to our response, and moreover has had long lasting benefits of significant value to the government.

What didn't work so well:
Continued requirement to obtain exemptions for Microsoft to continue to configure the platform, despite favourable commercial terms and the use of a local supplier.

Initially when we first went into lockdown there were issues with the supply of hardware due to a sudden global increase in demand.

What have you learnt and what would you do differently:
Longer term contracts to eliminate the need for regular review.

People & Corporate Services

What procurement was required and what worked well

A contract was put in place for a 4 -month period with an external company to provide peer to peer support and counselling during Covid.

It is worth noting that P&CS also undertook a contract change with Team Jersey In order that they could provide coaching for frontline leaders – over 60 took up the coaching support so was well received (This represented a change to current contract, so **not** a procurement process).

What didn't work so well/what would you do differently
No significant items to note.

Describe the implications on you/your department/organisation of strategies and systems put in place for testing, outbreak management (including in schools, care homes, etc) and self-isolation on your department

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

COO Corporate

What worked well:

We implemented clear safety plans and control measures across COO, which involved adhering to the work from home order most of the time. Workplace safety plans (WPSP) were introduced with measures such as distancing, single flows around buildings and splitting teams to manage resilience. This ensured low levels of infection and enabled the continued and uninterrupted delivery of key services. This WPSP was updated and re-circulated in line with changes to legislation, advice, and guidance.

What didn't work so well:

Sometimes the communications from the BC team as to specific measures we needed to put into place were confusing, such as displaying certificates, which is expected during a fast-moving pandemic. However, this did lead to increased work to sometimes identify exactly what we had to put into place.

What have we learnt and what would we do differently:

Nothing significant to report

Modernisation & Digital

What worked well:

The covid workplace safety plan (WPSP) was introduced with split teams which did not mix. This ensured low levels of infection and enabled the continued and uninterrupted delivery of key services. This WPSP was updated and re-circulated in line with changes to legislation, advice, and guidance.

What didn't work so well:

Nothing significant to report

What have we learnt and what would we do differently:

Nothing significant to report

People & Corporate Services

What worked well:

The P&CS developed the health and safety response for different workplaces, in consultation with public health colleagues. The team focused on workplace safety plans – ensuring workplaces undertook assessments and put measures in place to ensure physical distancing, enhance cleaning protocols, source extra hygiene products to protect colleagues still attending work. This was supplemented by measures to support those staff working from home such as ensuring regular contact being made for wellness checks as well as all team meetings having wellbeing as part of the agenda.

What didn't work so well:

Nothing significant to report

What have we learnt and what would we do differently:

Nothing significant to report

Describe the implications on you/your department/organisation of restrictions on:

- Physical distancing
- Mask wearing
- Self-isolation
- Connectivity and border control

COO Corporate

Physical distancing

We ensured anyone working from the office had a valid reason to do so and the majority of the workforce worked from home. We segregated teams into A/B/C to ensure resilience as best we could. We also introduced a desk booking system for our two main buildings to ensure offices were not overcrowded and physical distancing remained.

Mask wearing

This was recommended at certain stages of the pandemic, and we followed guidelines within our office space.

Self-isolation

Staff were allowed to self-isolate at home and in a lot of cases were still able to work remotely if they did not feel unwell.

Connectivity and border control

Remote working was rolled out rapidly through M&D and the acceleration of the O365 programme. Connectivity problems existed at one stage and people were asked to only connect if required at certain times, but this did not last for a long time.

Modernisation & Digital

Physical distancing

Ensuring adherence to requirements around physical distancing was achieved primarily through home working where possible, continuation of a,b and c teams, the introduction and use of a desk booking systems and one-way systems within the building.

Mask wearing

For those individuals within M&D who carried out roles where they were required to be physically present, PPE was provided. In the early days of the pandemic, there was a lot of nervousness around individuals who were required to work in healthcare settings particularly given the shortage of PPE.

Self-isolation

The majority of individuals within M&D are able to carry out some elements of their roles remotely. In the event that they were required to self-isolate, where individuals were well enough to work, 'normal,' or alternative duties were carried out.

Connectivity and border control

Hired Services contributed to, and continue to contribute to a significant element of the service delivery within M&D. These hired services are based both on and off island. The majority of individuals were able to continue to carry out their duties remotely, without the need to travel on island. The small number of individuals who were required to carry out their duties in a face-to-face capacity, remained on island for the duration of the lock down. It is important to highlight the level of commitment these individuals made and the impact this had on their personal lives

People & Corporate Services

Physical distancing:

We ensured only those who were classed as essential workers/had a valid reason worked from the office. The vast majority of the workforce worked from home. We segregated teams into A/B/C to ensure resilience as best we could. We also introduced a desk booking system for our two main buildings to ensure offices were not overcrowded and physical distancing remained.

As restrictions have eased, workplace safety plans were updated to provide guidance to colleagues on physical distancing, testing requirements, cleaning of workstations and office space, and general safety measures.

Mask wearing
For those individuals within P&CS who carried out roles where they were required to be physically present, PPE was provided.

Self-isolation
The majority of individuals within P&CS are able to carry out some elements of their roles remotely. In the event that they were required to self-isolate, where individuals were well enough to work, 'normal,' or alternative duties were carried out.

Connectivity and border control
Contractors based in the UK remained under the relevant lockdown guidance for the area they lived in. They were unable to travel during lockdown periods and continued to work from home

The balance of public health and harm with regard to wider societal impacts
Describe impacts felt on you/your department/organisation • What community groups/sectors of the population have been impacted?
COO Corporate The most significant impact felt by the COO colleagues was the effect of the pandemic on wellbeing. Absence levels have not been significantly higher, but staff do share the adverse impact working at such a pace and for such a length of time has had. **Modernisation & Digital** See response above. **People & Corporate Services** Generally front-line services were prioritised for advice and policy guidance, particularly schools and health workers. Most BAU activity and resources were stopped and redeployed to response efforts.
Describe how the work undertaken by you/your department/organisation impacted on different population groups
COO Corporate The majority of the work completed by COO is for internal GoJ users and not the general public so no significant items to record in this section. **Modernisation & Digital** See response above. **People & Corporate Services** See response above.

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HEALTH AND COMMUNITY SERVICES

We aim to enable Islanders to live longer, healthier and productive lives. We provide safe, sustainable, affordable and integrated services in partnership with others.

These include the provision of a wide array of hospital services, social care and support in the community, such as:

- providing hospital care including emergency care, intensive care and maternity services and in the UK when needed
- providing social care services, and services in the community
- monitoring and improvement of the quality of all services
- the education and development of medical professionals
- the provision of a coordinated approach to mental health care
- offering free, private and confidential counselling services
- influencing and creating conditions that allow people to improve their health

SELF-ASSESSMENT TEMPLATE

Questions for all stakeholders

Governance
Please respond as appropriate: What governance arrangements did you establish to support decision making for the Covid-19 response? And/Or How did you/your department/organisation plug into governance arrangements for the Covid-19 response?

Governance Arrangements:

Governance arrangements initiated within HCS comprised the following structure. This structure is aligned to the recommended incident command and control structures as recommended by the Emergency Planning College. The Structure enables effective communication and shared situational awareness. In addition to this the structure supports the principle of subsidiarity enabling effective and dynamic decision making:

HCS_Governance_Structure.docx

- HCS response was clinically led with local decision making which enabled an agile response to a rapidly changing situation supported by an adaptive workforce.
- The structure operated in collaboration with the central government incident response. Open channels of communication across senior clinical and management teams enabled safe service planning
- The governance arrangements were flexible and responsive to the changing nature of the pandemic to support agility of response, adhering to the principle of dynamic decision making.

Scientific Technical Advisory Committee (STAC)

- Health and Community Services commenced a daily STAC in March 2020, it was chaired by the Medical Director for Health and Community Services (HCS) until August 2021
- The purpose of STAC as identified in the Terms of Reference:

STAC_Terms_Of_Reference_V1.0.pdf

- Provided a common source of health, scientific and technical advice to GOJ and **GOLD** Commanders during emergencies.
- Provides a safe space to debate live issues and ensures that advice is provided in a timely and co-ordinated way, based on best available information. This helps ensure that policy/operational advice and decisions made during emergencies are informed by health, scientific and technical expertise.
- Enable decision makers to assess a range of advice and evidence presented to them, including that from STAC, combined with their own experience and judgement to make decisions during emergencies.

STAC_Terms_Of_Refe
rence_V2.0.pdf

HCS Operational Command Response Structure

A summary of the roles of the HCS command & control structure is outlined below which is closely aligned to the Joint Emergency Service Interoperability Principles (JESIP) Joint Doctrine:

Bronze (Operational)

- The **BRONZE cell** was responsible for the management of the operational resources to manage the response to the incident, this included daily service delivery management of both business-as-usual activity and COVID-19 activity. The cell worked closely with the operational response for both primary and community response. The Bronze commander was responsible for making decisions at an operational level such as staff resource deployment, patient placement, consumable deployment.

Silver (Tactical)

- The **SILVER cell** developed and adapted the response framework for the incident as well as representing HCS at the government Tactical Coordinating Group (TCG). The **SILVER cell** responded to the needs of **BRONZE** with the escalation of issues via the communication lines established between the two cells. The principles of subsidiarity were implemented throughout the response. The **SILVER** commander was responsible for making tactical decisions examples of these included capacity management protocol, surge plans, procurement of additional resources/equipment.

Gold (Strategic)

- The **GOLD cell** included executive members and set the overall strategy and aim of the response to the incident. The **GOLD** commander also represented HCS at the government Strategic Coordinating Group (SCG). External communications were issued from the **GOLD** commander. Principles of subsidiarity were supported and response to escalations from **SILVER** were managed in a timely manner. Strategic decision making was undertaken by this group including policy decisions and mobilisation.

We have continued with the **Community Bronze Cell** through the pandemic and the cell continues to meet to support continuity of response.

- During the second wave an additional group was initiated. **The Community Support group** which reports into the Community Bronze cell and directly to the Chief nurse. This group is open to all Homecare and Care Home providers. The purpose is to provide up-to-date information and support to the sector. The group would escalate any issues to the **Community Bronze cell** to resolve and provide rapid response when required. The group is supported by the Chief Nurse's department, Infection Prevention and Control (IPAC) and Peer to Peer Swabbing team.
- The second wave was supported by an Emergency Planning Officer (EPO). This enabled further training & exercising to be implemented as part of the emergency preparedness cycle. Table-top exercises were undertaken to validate the plan including the lessons learnt from wave one response.

Recommendations:

- Revisit Covid-19 guidelines and ensure these are generic for a health-related pandemic
- Revisit those aspects of changes in care delivery that benefited outcomes to see if they can be embedded into business as usual.
- Implement a high consequence infection disease policy with tertiary transfer arrangements to be developed in collaboration with Public Health

- Implement further command & control training sessions for commanders as part of their continued professional development

Please provide an appraisal of how suitable these governance arrangements were:

- What worked well?
- What didn't work so well?
- What didn't work so well?
- What have you learnt and what would you do differently?

What worked well?

- Early recognition of the threat presented by a new emerging infectious disease.
- Implementation of the generic principles included within the pandemic influenza plan to manage the response to an emerging infectious disease.
- Effective coordination of urgent action and the responsiveness of staff across HCS and other GOJ departments to collaborate and coordinate and move into a Command-and-Control structure.
- The daily organisational wide **BRONZE** updates were effective, co-ordinated, and supported the flow of information providing shared situational awareness with the wider organisation. This flow included the daily reporting to the **SILVER Cell** for decisions which required tactical decision making and **GOLD Cell** for strategic decision making
- Dedicated loggists/administrative support producing immediate minutes from response meeting supported action and delivery.
- Formalised communication and trust-based relationships within and between cells.
- Robust governance enabled accurate and timely information to be shared with both the **Tactical and Strategic Coordinating Groups (TCG, SCG)** enabling government and legislative processes and decision making to be informed by Health and Community Services.
- As part of lessons learnt the command & control structure was adapted for wave two to meet the requirements of the Joint Emergency Services Interoperability Principles (JESIP). The adjustment to this structure enabled the continued information flow from the wider services and departments however provided improved clarity on the decision-making process.
- As the pandemic progressed the governance arrangements flexed and adapted accordingly from lessons learned and was able to adapt a more proactive approach as compared to the initial reactive approach as the organisation became accustomed to operating within emergency response mode.
- Health & Community Services participated in the UK's Health Security Agencies Crown Dependency & Overseas Territories weekly sessions which enabled sharing of learning between jurisdictions.
- Nightingale governance informed by the UK Nightingale Network. This included a full simulation exercise

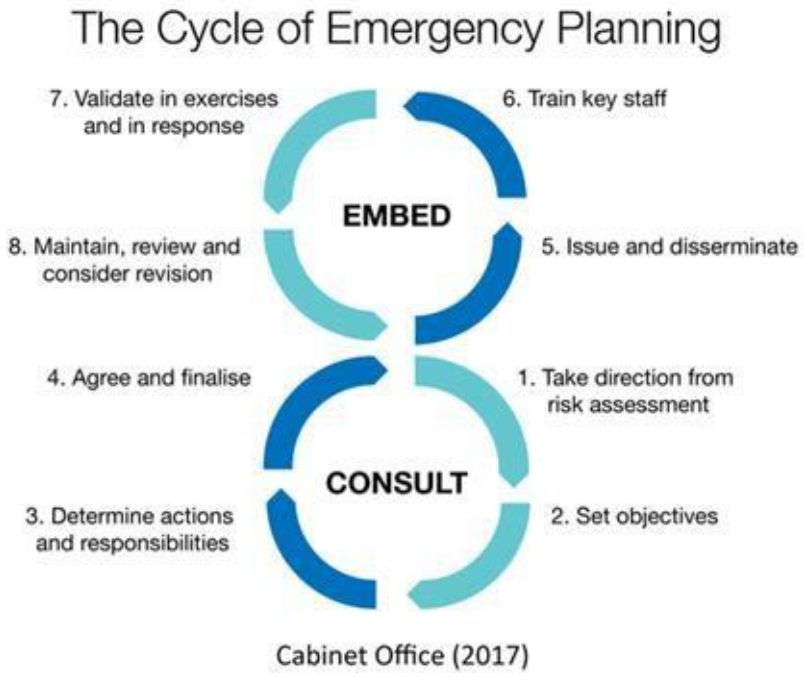
What didn't work so well?

- Initially the response was reactive to set up the governance arrangements the previous business continuity plans were not as robust as required for a pandemic of this nature and lessons were learned as the arrangements were enacted.
- There was not a dedicated Emergency Planning Officer (EPO) role within the department, this role was needed to be sourced from within the wider organisation. Once in place this supported a more proactive, structured response.
- Some roles had not exercised skills since initial training e.g., the loggists, skills were unpractised. Some roles were not prepared for some of the more sensitive issues, such as numbers of possible deaths, and initially required support.

- The membership of cells changed rapidly in the early stages to ensure robustness of governance, this was disruptive at times and required new members to be rapidly inducted into the cell taking capacity from other members.
- The cells were made up of operational managers from HCS and external partners, this moved employees from their operational roles resulting in colleagues trying to cover both governance and operational functions simultaneously.
- Non-Clinical Support Services (NCSS) were not initially included in the governance structure; however, this was swiftly rectified as porters, catering and housekeeping were essential in the HCS response to Covid-19.
- There was a large volume of new information and guidelines to be disseminated on an almost daily basis in wave one which was challenging to manage, the increased use of digital improved information sharing improved this process.

What have you learnt and what would you do differently?

- It is recognised and highlighted throughout our Covid-19 response that robust governance structures that work together are essential. This is not only in relation to HCS but across the whole system including all of Government and the external partners.
- For the future, we must ensure the emergency planning, business continuity plans, and specific skills are maintained, are regularly refreshed and readily available. This will require dedicated roles to ensure a proactive approach to our emergency response can be taken. HCS is adapting all its emergency response plans to align with the emergency preparedness cycle to ensure that plans are tested and validated but also that suitable training and development opportunities are offered to the members of staff who may utilise these.



- Significant learning has been from cross government working. As our colleagues within the Public Health (PH) team have been appointed we have been able to develop assurance processes together rather than in isolation.
- A separate team of staff has been required to concentrate on looking at policy development, people management and operating frameworks, that capture and support the new ways of working as they are created to make sure that these remain in place.

Recommendations:

- Continue with engagement with Health and Care partners to ensure robust, standardised community wide Emergency response
- Ensure that there is resource with competent skills to enact our emergency response and Business Continuity Plans (BCP)
- Regular training and regular involvement for trained loggists and other specialist response roles
- Consideration of funding for a dedicated specialist team for emergency preparedness resilience and response within HCS

What implications did the introduction of new legislation have on these governance arrangements?

- A significant amount of legislation has been passed during the pandemic especially when Covid-19 related legislation was first introduced in March 2020. Officers from the Legislative Drafting Office, Law Officers' Department, Strategic, Planning and Performance and HCS (Infection Prevention and Control IPAC) have worked together to translate policy into legislation and support the legislative process through the States Assembly.
- Many of these have impacted on HCS and the wider Health and Care sector. It has been a rapidly changing legal environment and the governance structure has at time been tested in communicating and implementing the new laws. However, as time has progressed, and a more proactive approach has been introduced the governance structure has flexed to meet needs and this has become easier.
- It is essential that a full review of the changes is carried out as some of the new laws would continue to benefit the system but ended on a certain date.
  An example being:

The temporary legislation to allow the certification of death by one medical office only supported the certification of death within the hospital and the development of the community team. This was very efficient and should be considered within the legislative structure of the future.

- Operationally resources were invested to support legislative intent e.g., porters provided perimeter security, PPE provided to support legislative requirement which diverted the resource from their business as usual.
- Social distancing and isolation had a huge impact on working within HCS reducing capacity and impacting on delivery of care, but without the legislation this could have had a more serious impact.

How did the communications directorate support you/your department/organisation operation during the Covid-19 response?

- Were appropriate systems in place to support your department?
- What communication was required?
- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

- There is a Head of Communications allocated from the central GOJ team to provision Communications support to HCS, this post reports into the centre. At the beginning of the pandemic response, a further Communications Officer was redeployed from a non-Ministerial department. The HCS Head of Communications attended **SILVER** and **GOLD** meetings to report back on communications issues and act on relevant actions. The Communications Officer attended daily **BRONZE** meetings and disseminated information

via daily bulletins to staff. The department worked closely with the central comms directorate throughout the pandemic.

Were appropriate systems in place to support your department?

- Yes. We were well supported by the central team and our own Head of Communications.
- The Head of Communications, who was a member of **SILVER** had full use of the central communications function.
- There were daily communication huddles, media monitoring and public sentiment tracking.
- External HCS communications were always approved by a **GOLD** commander

What communication was required?

- Communication required was both internal and external. The external was taken from HCS **SILVER** to the central team; however, an executive/gold commander would undertake approval processes.
- Internal communications included announcements to all colleagues, across all locations, on how to keep themselves safe, how to operate services, and how to triage patients.

What worked well?

- Staff who attended the daily face-to-face updates in the Halliwell particularly appreciated this in person form of communication as it was an opportunity for them to ask questions during a time of both Island-wide and global uncertainty.
- External communication through the central team provided a government wide consistent approach
- Increased use of virtual communication i.e., Microsoft TEAMs which facilitated continuing team meetings and discussions

What didn't work so well?

- At the beginning of the pandemic, due to the volume of staff joining Starleaf, it started to be used as a medium for other communications – this diluted some of the important all-staff messages. Once the volume slowed, the messages aligned and were more strategic.
- Not all staff were able to attend, the daily briefings in the Halliwell, therefore communications could be sporadic or limited for those staff, especially those working within the 'HOT' (infectious) wards. Other comms channels were well utilised to plug this gap, but the face to face was so well received that it was unfortunate that not all staff could attend each day.
- In the early stages external communications to external providers was often provided at times that did not suit their needs e.g., late on Fridays and sometimes were missed, which added to some confusion with partners. This was rectified and improved over time.

What have you learnt and what would you do differently?

- Planned, efficient, clear, and thorough communication via several different channels is key for departments to operate safely, knowledgeably and efficiently.
- It is essential that information is consistent and timely.
- Having the face-to-face sessions was extremely positive and well received, however this is not possible for all. At the time with member of staff supporting COVID19 excluded from the sessions, it is now evident that this would have been permissible for these to attend. It is important to have a cascade system so information can reach as many as possible, a formal process for this may have improved communication.
- HCS would have benefitted from its own dedicated HCS Communications Team made up of more than two communications professionals. Ideally, we required two allocated to internal communications to allow for both reactive and proactive communications. This

has been implemented post-pandemic and there are now four members of the Communications Directorate working solely in HCS.

- There is still a need to find the best way to communicate with external providers when in a crisis, although the general communication with providers has improved significantly during this period and needs to remain in place.
- Training for commanders in communicating in a crisis should be delivered to all HCS commanders as part of their continued professional development.

Logistical and operational decision making

What Emergency Planning processes did you/your department/organisation have in place prior to the initial pandemic response?

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

What Emergency Planning processes did you/your department/organisation have in place prior to the initial pandemic response?

- HCS had a Major Incident Plan (2018) the aim being:

"To provide a timely, efficient, and effective response to any Major Incident involving the States of Jersey Health and Community Services (HCS)."

- The plan includes a series of action cards to effectively implement the procedures required.
- HCS also had a Management of Flu Pandemic Policy in place and in November 2019 a tabletop exercise for the management of a Flu Pandemic was held with representatives across government and from Primary and Secondary care (including key services from the 3rd sector).
- HCS did not have an Emergency Planning Officer (EPO) in post at the start of the pandemic but key staff had received major incident training at various levels. A major incident for the pandemic was never declared.
- Each HCS department had their own Business Continuity Plans, these were of differing quality and levels of preparedness, however all were reviewed as part of the response to the pandemic with a focus on the relevance to the incident type.

What worked well?

- As the pandemic was not declared a major incident the flexible approach to its management, led by clinical decision makers was very positive. This gave us the agility to work differently and to quickly implement change, for example the setting up of the cells, the rapid development of the Urgent Treatment Centre (UTC) and supporting our GP colleagues to work differently.
- An Ethical Framework was developed with the guiding principle that patients who are most likely to benefit from clinical care interventions do so. Decisions on which patients are provided with access to critical care, or continue to receive such care, would be made by a Central Triage Committee, using threshold criteria.

COVID-19 Ethical framework.pdf

- The cross-government emergency exercise the previous autumn facilitated a more practised response to the pandemic. People were aware of their responsibilities, the scheme of subsidiarity for the response, the process of cells and cross government working etc.

- Having the ability to work across sectors from both within and external to government in a very short timeframe enabled a robust response to the unfolding emergency.
- Having a temporary EPO assigned at the latter end of wave one of the pandemic until the end of Phase 2 proved beneficial in setting out a structured approach to the pandemic. Updated action cards that related to the specific issues relating to COVID-19 were helpful in guiding staff on how to manage patient flow, infection control procedures etc.
- There were productive relationships between Estates and Non-Clinical Support Services (NCSS). They worked together to deliver rapid building work, adjusted working practices within housekeeping, stores, laundry to ensure safe service delivery for our patients and our staff.
- During wave one COVID-19 was an emerging infectious disease and was classified as a high consequence infectious disease, to align with the emerging guidance as more was learnt about the virus a risk adverse approach was undertaken, this ultimately led to the very positive results in Jersey, including a reduction in anticipated deaths and no staff deaths.

What didn't work so well?

- Due to the initial unknown nature of the virus, it was unclear at the start re the required management. This sometimes resulted in a risk adverse approach, however during the second wave clinicians were better educated re disease presentation and the corresponding response due to greater scientific understanding of the virus.
- It was also recognised that the initial response working across government left some departments short on resource, an example of this being HR support, the two HR business partners were pulled into the cell structure leaving a gap in the ability to support the recruitment and on-boarding of staff.

What have you learnt and what would you do differently?

- There were in place both emergency plans and cross government exercises which were excellent preparation for any incident, the ability to be agile, utilise existing plans for the response and have a resource that has the skills to meet an unknown emergency is essential. In this circumstance the pandemic flu plan provided some principles that were used to support the initial pandemic response.
- HCS requires a dedicated emergency planning provision for Emergency Preparedness, Resilience and Response (EPRR) activities, HCS would have greatly benefited from having a dedicated EPO post to support the implementation of the emergency planning cycle and business continuity management cycle.
- Additional business support officers would have been beneficial in dealing with recruitment, finance etc to support HCS with the immediate needs presented by the pandemic.
- Some Emergency law changes enacted as a response to the pandemic eg certification of deaths would be beneficial to maintain.

Recommendation:

- For HCS to employ a full time Emergency Planning Officer/team
- Review of Business Support Officers provision
- To review and embed new practices or law changes as 'business as usual'.

How have you/your department/organisation Emergency Planning processes evolved during the pandemic response?

- What worked well?
- What didn't work so well?

- What have you learnt and what would you do differently?

How have you/your department/organisation Emergency Planning processes evolved during the pandemic response?

What worked well?

- The most effective emergency planning has been through the relationships developed through multi-disciplinary team working across government departments and external partners.
- The assigning of an EPO, supported by the EPO from the Ambulance Service to help prepare for the second phase of Covid-19 was helpful in pulling together a structured approach to manging a pandemic. In addition, managers were given training on the principles of JESIP:
    - Co-locate.
    - Communicate.
    - Co-ordinate.
    - Jointly understand risk.
    - Shared Situational Awareness.
- Resilience Direct, an online storage platform for emergency planning documentation and response management was implemented. These tools are used to help personnel to respond to an emergency and collectively support the process.
- A defined structure of work cells was developed, which included: Infection Prevention & Control, Bed Management, Clinical Management, Workforce, HR, Nightingale Hospital Wing, Digital & Communications, Mental Health & Social Care and Community Resilience, PPE. Each workforce cell had its own Terms of Reference, action cards, risk register and delivery plan for Covid.
- The incident structure met the standards of command and control as recommended by the Emergency Planning College and JESIP principles
- To ensure decision making was effective all commanders applied the principle of subsidiarity to ensure timely decision making
- Tools were utilised to improve effectiveness of incident control meetings such as IIMARCH, METHANE briefing methods
- Action cards were utilised to support the response for the incident these were adapted throughout the incident as emerging guidance was released or following implementation of lessons learnt.
- All commanders were aware that action cards were there to support the response however dynamic decision making and dynamic risk assessments should be undertaken to formulate the required decision.
- Dynamic risk assessment and decision making was particularly important during outbreak situations whereby patient placement and was adjusted to minimise exposure and transmission risks
- As the further scientific evidence into the virus emerged staff risk assessments were adapted which enabled more staff to resume normal working within a safe environment. The staff risk assessment was adapted throughout the pandemic as further evidence emerged.

An operational plan for managing Covid was written, this included the following elements:

- Activation of the COVID-19 plan
- Roles of Responsibilities for each of the nine work cells
- HCS Command and Control Framework for Gold, Silver and Bronze
- Key operational tasks

- Communications
- Management of COVID-19
- Action cards

All information was held on Resilience Direct as well as the intranet. From a business continuity perspective hard copies held within the incident control room.

- Overall, the preparation for phase two supported by an EPO was very effective, it allowed thinking time for the development of a structured COVID-19 preparedness plan that could be flexed according to the needs of HCS. Staff liked the action cards, and the proforma for these have been adopted in other areas. All information was stored on Resilience Direct. A hard copy of the policy and action cards was made available.
- Both the Covid-19 preparedness plan and the action cards were tested through two tabletop exercises which enabled the validation of the plan, application of the learning from phase one and for commanders to receive feedback.
- Structured debriefs were undertaken at the end of the exercises which enabled participants to reflect their thoughts to the emergency planning officer.
- As a result of the exercises plans and action cards were further adapted to incorporate participant feedback.
- Working across government through both the Tactical (TCG) and Strategic groups (SCG) developed a sense of cohesion and departmental support. This enabled joined up planning, supporting cross government decision making and collaboration.
- As part of exercise and training participation with Jersey Ambulance Service was undertaken, this ensured that responders and commanders had a joint understanding of risk and how each organisation's plan would impact.
- In 2021 strategic and tactical commanders from HCS joined a leadership in crisis training jointly with Jersey Ambulance Service at both a strategic and tactical level, this session was delivered by off-island expert trainers via South West Ambulance Service NHS Trust.

What didn't work so well?

- Initially digital support and infrastructure was challenging, there was a need for equipment to work remotely and in different ways. HCS staff had to learn how to use new technologies. This made the applications such as Resilience Direct difficult to access.

What have you learnt and what would you do differently?

- To recruit an emergency planning officer to be responsible for the delivery of the Emergency Preparedness Resilience & Response principles.
- Continued joint emergency preparedness, resilience & response training across government.

Describe the implications on you/your department/organisation on procurement and the continuity of supply chains during the pandemic response?

- Were appropriate systems in place to support your department?
- What procurement was required?
- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Were appropriate systems in place to support your department?

- At the onset of the pandemic there were concerns about the supply chain, particularly for health equipment and Personal Protective Equipment (PPE) as there was a well reported international shortage. Very quickly the HCS Non-Clinical Support Services (NCSS) worked

with the government commercial team to protect the supply chain. Initially the stores of PPE and all supplies were delivered and coordinated from HCS Five Oaks stores.

- The government had appropriate systems in place, but these systems quickly needed to join up to provide items specific to Covid-19
- Commercial service linked with NCSS to procure additional PPE
- Commercial Services, HCS estates and Infrastructure, Housing and Environment (IHE) linked around the procurement of the Nightingale Wing

What procurement was required?

- HCS needed to continue 24hr care which required continued procurement of all BAU requirements, e.g., food, pharmacy supplies, toiletries etc

Additionally, there were specific procurement requirements in relation to Covid 19 these included items such as:

- Medical equipment e.g., ventilators, respiratory equipment etc
- Health Apps to monitor Long Term care conditions remotely
- Digital equipment to enable remote/home working
- PPE, much higher volumes of both specialist PPE and regular use PPE. HCS initially provided PPE to other government departments and external partners prior to the development of the PPE cell
- Nightingale Wing plus all equipment including additional oxygen and staff amenities.
- Additional care beds
- Increased primary care counselling service
- Spot beds within care homes
- Additional advocacy services

As new treatments have developed, procurement of vaccine supplies and medicines has been required

What worked well?

- Working jointly across GOJ departments
- NCSS Service Leads able to respond at pace and with agility
- Improved dialogue and negotiation with NHS supplies to ensure supply chains
- Working with the UK Nightingale network

What didn't work so well?

- Increased cost of equipment in short supply.
- Initial concerns re global shortages.

What have you learnt and what would you do differently?

- Joined up approach to procurement is essential.
- Need skilled resource in HCS with knowledge of health and care procurement. An increase in commissioning capability for external partnerships working jointly across all GoJ departments
- Pandemic preparation is essential for the future, this includes having up-to-date, resilient pandemic stock available locally.

Describe the implications on you/your department/organisation of strategies and systems put in place for testing, outbreak management (including in schools, care homes, etc) and self-isolation on your department.

- What worked well?

- What didn't work so well?
- What have you learnt and what would you do differently

Covid 19 Testing

What worked well?

- Jersey responded quickly to the need to Test and Trace and rapidly put testing regimes and centres in place.
- HCS already had good relationships with two testing centres in the UK and secured a further centre to process samples.
- Digital systems to receive the results were rapidly initiated with UK centres and integrated through to Jersey utilising the NPEX system.
- Initial island wide Covid-19 testing involved ambulance crew and nursing staff going out to Islanders with symptoms, including care homes, to test. It rapidly became clear that this was not sustainable as the numbers increased. This impacted on resources that were vitally required to deliver other essential care.
- HCS were able to test within the hospital initially using Cepheid rapid PCR testing this commenced on 9/4/2020 – and provided a 24/7 service providing a TOTAL Cephid tests of 38, 530.
- Rapidly links were enhanced with Public Health England to increase testing capacity. In April 2020 the Test and Trace programme was developed within Justice and Home Affairs (JHA). During August 2020 the microbiology open cell functionality was developed with the live launch Sept 2020. This increased the on-island capacity 2000 PCR tests per day.
- Diasorin Antigen testing commenced on 02/12/2020 providing a 24/7 service with a TOTAL 122,097 tests
- Jersey went live with Reverse Transcription RT-PCR 5/11/2021 - TOTAL 95,590 at 13/2/22
- Total tested by Infection Sciences was 256,317 at end Feb 22, and continues to increase daily
- A drive through testing centre outside of the hospital supplies department at Five Oaks was quickly set up. The location of the car park at Hospital Supplies Five Oaks worked effectively, the ring road layout enabled safe flow of cars in and out. Members of the public were given time slots, and this supported the smooth flow of traffic in and out of the centre. A mobile unit was set up for the care home sector and home visit swabbing for those who were unable to get to a swabbing centre.
- As the infection rate of Covid-19 intensified, the demand for testing increased and a dedicated team was developed from a range of clinical and bank staff. This in combination with the need to test at the borders quickly demonstrated that the Five Oaks centre was no longer fit for purpose. This led to the development of both the drive through testing centres at the harbour and at the airport and the service transitioned from HCS to a central GoJ team.
- IPAC initiated 24/7 rota to support Island resilience
- Further development of the testing programme saw the establishment of an on-site swab station at Jersey General Hospital, this enabled hospital staff to access workforce screening with ease on arrival to work.
- In addition to the testing programme, HCS adapted testing requirements to increase screening & testing requirements of both patients and staff during periods of increase incidences or outbreaks.
- An external provider was contracted to operate a laboratory (OpenCell) at the Airport staffed by agency biomedical staff which enabled on-island testing for community screening rather than referring the samples to off-island laboratories. This provided improved turnaround time. This service has transitioned back to a government operated

laboratory by Health & Community Services in a dedicated covid-19 laboratory temporarily located on Rozel ward pending its relocation to the former kitchens.

- The utilisation of support staff within Pathology to help with the packaging samples to be posted daily to the UK for processing has resulted in some support staff with a science degree taking up a position of trainee Biomedical Scientists. This has come at a time when the recruitment of off Island fully trained biomedical Scientists was already proving difficult and demonstrated an opportunity for the Island to grow its own scientific workforce on-island.

What didn't work so well?

- Initially there was limited lab capacity, and most tests were sent off-island. The time to process results meant delays, especially over the weekend.
- The results also needed to be inputted manually by the microbiology staff onto an excel spreadsheet until the NPEX integration was established. With over 1000 samples being processed a day, consequently some results were inputted incorrectly due to human error.
- Sometimes the process changes were quicker than communications which caused some difficulty in aligning messaging.
- The Microbiology team needed to be more heavily involved in the testing decisions thus impacting on resource.
- Mechanisms around the ordering and payment of testing kits were initially unclear, this resulted in some orders being blocked and Pathology initially bearing the financial burden.
- Recruitment of swabbing staff for all the sites was difficult. Redeployed staff often did not have the skills required. Time restraints meant the preparation of the antibody testing centres including IPAC arrangements was undertaken at short notice.

What have you learnt and what would you do differently?

- HCS had good systems to deliver the initial testing regime and was able to develop and hand over the service to the government central Covid-19 team.
- The Pathology manger should be part of Hospital Bronze and be based within the **BRONZE** cell. This has been addressed as part of the Covid-19 preparedness policy.
- The importance of maintaining good off island links for resilience purposes is balanced with the ability to build local capability.

Helpline

As part of the Health and Community Services response to the Covid Pandemic in March 2020 we worked with our Government of Jersey Colleagues to support islanders due to the uncertainty that the Pandemic brought to all of us. Our first step was to have a dedicated mobile number held by the Infection, Prevention and Control Team. However, as things developed it was identified that we needed to expand this to a dedicated Helpline to support islanders. Initially this was based within the hospital in the Education Centre but it soon became necessary to expand the service further and it was transferred to 28 The Parade.

What worked well?

From reviewing the services and looking at lessons learnt the following has been identified as positives:

- HCS responded quickly to an unexpected and fast developing pandemic.
- Clinical staff were initially redeployed to support the helpline

- The service clinical leadership undertook the management of the testing centres staff. While HJA undertook the operational management.
- The population of Jersey was able to have a dedicated helpline to support them with questions and the latest public health advice to the pandemic. Islanders who had developed symptoms were quickly booked in for PCR tests both through the drive through centres and home visits if required.
- In the first 3 months the team expanded from 1 person on call via mobile phone to a team of 6 and then to 30 staff. This required expansion of services, 2 moves of location and training staff.
- Flow charts were developed and updated initially several times a day though this reduced as more knowledge was learnt about Covid 19.
- A minimum of a daily huddle was held with staff to ensure that they were kept up to date with changes and developments in Covid services and treatment.
- During the first 6 months of the helpline being set up 2 Myocardial Infarctions and 1 Stroke victim was identified as people sought help and these were triaged to 999 calls for the ambulance service by clinicians manning the helpline.
- During the first 6 months of the pandemic the service opened Five Oaks, The Airport Drive through, Airport Arrivals, Harbour Drive Through and Arriving passengers for routine PCR swabbing. In addition, support for passengers arriving via Private Aircraft and Boats were accommodated.

What didn't work so well?

While many positives have been identified we did learn some lessons to help with any future pandemic or similar situation that may require a rapid response.

- There was an initial lack of IT equipment available on island to support the development of services though this was resolved within a couple of weeks. In the meantime, pen and paper was reverted to and staff at quieter moments were able to upload information on to the computer system to keep track of all referrals and, bookings and advise. In future it would be beneficial to have a stock of IT equipment including printers available.
- At the start of the pandemic information flow from the Government did not always reach the staff on the helpline prior to public announcements. The management of the Team had daily meetings with Infection Prevention and Control to try to keep up to date with developments. In the future it would be beneficial for the media to be informed after staff.
- The Government made the decision that some helpline staff were employed only on short term contracts which made retaining staff difficult, and the need to continually go back out to recruitment. In hindsight we should have acknowledged that this was a pandemic and history informs us this is not a short-term problem and staff could have potentially had longer contracts provided.
- Issues arose whenever new testing sites were set up (Five Oaks, airport, private plane arrivals, harbour, private boat arrivals, pre-assessment, mobile unit), especially with label printers, the BATs system developed frequent malfunctions and needed many IT patches initially when launched to get it to work effectively. It is felt the BATs app was launched very quickly which resulted in some IT glitches which caused additional operational work for staff.
- Five Oaks testing centre was found to be inappropriate due to the lack of facilities and this centre was quickly relocated to the Airport Drive through.
- As border restrictions were relaxed new swabbing centres needed to be opened and recruited to sometimes with as little as 3 days' notice.

What have you learnt and what would you do differently?

- Assigning a project management team to support the development of helpline for Covid 19, this would have assisted with improved structure, follow through and logging of issues
- Rolling contracts for staff who were specifically employed for the Helpline and Swabbing centre rather than short term
- A stock of IT equipment on island to support future urgent responses.
- Improved communication on changes and advise to the public including ensuring media is not informed before staff.

While not directly linked to the Covid 19 response, the Jersey Care Model has identified a need to support islanders with Health and Social Care needs through a Teleguidance Service that will be launched this summer. Learning and experience form the Covid 19 Helpline has helped informed the expectations of this service and in the future if a similar urgent response was required HCS would be in a better position to support islanders.

What worked well?

- Within the General Hospital capacity was separated into 'hot' and 'cold' areas with staff aligned to each area to minimise transmission, outbreaks and protect patients and our teams.
- Outbreaks were well managed by dedicated staff and resulted in safe ward closures where it was the safest course of action
- Hospital based outbreaks were managed by the Bronze Commander and Infection Prevention & Control Lead Nurse in collaboration with the clinical team.
- Epidemiology assessments were undertaken as part of any outbreak in within HCS to identify lessons learnt and reduce the risk of further transmission
- Staffing managed in relay teams which worked opposite each other so if one team was impacted the other team could work
- Housekeeping teams changed the way they worked to continue to provide excellent service ensuring the hospitals were cleaned with new cleaning regimes put in place. They worked around the clock ensuring HCS continued to provide safe health care.
- The portering team were an essential part of managing outbreaks: They manned entrances ensuring the right people entered the hospital with the correct PPE. They also managed the safe flow of patients around the hospital, within a challenging environment.
- Covid-19 PPE packs were assembled and stored within the Obeya room at the Hospital ready to be delivered to care and residential homes as needed. These were delivered out swiftly as and when required.
- PPE Cell opened on 9th April providing PPE to a very wide range of agencies to help manage outbreaks.
- The Care sector were quickly provided free PPE as costs were escalating and there was an initial shortage in supply and an increased usage. Initially emergency drop off were made to homes where there were outbreaks, but the PPE cell quickly took on this responsibility
- The IPAC team increased in size to offer both hospital and community response. This has been praised by many care home and home care partners.
- If an outbreak in a care home was identified and there were issues e.g. staff sickness, inability to get supplies, a rapid emergency response was implemented led by the Chief Nurse.

What didn't work so well?

- Unavoidable short notice changes around PPE both within and external to HCS caused initial challenges which required repeat fit mask testing, learning from this was

implemented which required staff to be fit mask tested on two masks to enable a seamless change in the event of supply disruption. Communication channels were set up to resolve.

- Some public behaviour re not adhering to PPE structures presented some challenges and was linked to some of the outbreaks within the hospital triggered by members of the public not adhering to policy and visiting relatives whilst having symptoms of COVID19 and without wearing PPE.

What have you learnt and what would you do differently?

- Good clear, accurate and timely advice to the care sector is essential and can always be improved.
- Continued reminders about Infection control are essential, it is evident that as Public Health interventions have reduced there is a greater need for robust measures in provider services
- Staff outbreaks have an impact on staff deployments and in some occasions required re-deployments to take place. In the early stages staff with Covid-19 were accommodated in hotels to minimise the outbreak, which helped minimise the spread.

Self-Isolation

What worked well?

- Staff identified as Covid-19 positive went into immediate self-isolation. In phase 1, staff who were unable to self-isolate at home were offered accommodation at one of the Island hotels until they were COVID negative. This was coordinated and managed by the Chief Nurse.
- An HCS Wellbeing services was initiated which provided a holistic wellbeing approach including psychological, physical, spiritual, nutritional support
- HCS were able to offer staff:
    - 1848 physical and psychological wellbeing checks
    - 279 Follow up checks and low intensity support
    - 1150 Personalised wellbeing emails sent
    - 44.7% Of people contacted reported concerns affecting their mental wellbeing
    - 35.7% Of people contacted reported physical complaints affecting their physical health
    - Wellbeing Wednesday
    - Regular HCS mindful movement and mindfulness sessions
    - HCS Intranet Wellbeing site – Wellbeing pack
    - 24/7 spiritual support
    - 24/7 employee assistance line
- There was almost universal willingness and engagement from staff of all disciplines across HCS to step into the breach to support nursing staff to deliver care on the wards.
- HCS where possible supported external partners such as domiciliary care market and care homes to continue to provide care through utilisation of the HCS staff bank.
- The swift response from the digital teams to set up IT access and provide laptops to staff to enable them to work from home was beneficial, especially for staff who were deemed vulnerable.

Other initiatives set up by HCS to help islanders isolate safely included:

- Prescription deliveries in Partnership with Call & Check and Jersey Post
- Infection control information disseminated Island wide and managed by HCS IPAC team

- Spot Purchase beds for patients with Covid that did not require hospitalisation
- Support to the Integrated food bank
- Other initiatives that supported the HCS response included:
- 'Connect Me' an IT platform located on gov.je that provides sign posting for Islanders on getting help and support around wellbeing and accessing information in relation to housing, finance etc.

What didn't work so well?

- HCS staffing was impacted significantly by staff isolating because of testing positive, HCS was also impacted by provisioning staff to cover the testing centres, all of this challenged delivery of BAU.

What have you learnt and what would you do differently?

- Within the confines of Jersey, maintaining a full complement of staff during a pandemic will always be a concern, as we are unable to draw in staff from other hospitals, as happens in other jurisdictions. This adds a further layer of pressure on the Island health and care workforce with staff having to work long hours at times to cover shifts within all care settings.
- This demonstrates the need for healthy staffing numbers within the health care sectors in Jersey. Within an Island setting staffing will also be difficult, we can only draw on our own clinical and non-clinical staff, bank staff and agency to staff to fill gaps.
- The ability to work together with external providers and support them as well as supporting hospital services is truly commendable.

Describe the implications on you/your department/organisation of restrictions on:

- Physical distancing
- Mask wearing
- Self-Isolation
- Connectivity and border control

Physical distancing

- The Jersey General Hospital does not lend itself to physical distancing.
- The wards were divided into HOT (Covid-19 positive) and COLD (Covid-19 negative) areas which enabled a proactive management of our covid patients, with appropriately trained staff assigned to these areas. Taking personal risk assessments into account, staff were allocated to either a hot or cold ward to reduce the risk of transmission of infection.
- A ward structure comprising 6 bedded bays (which do not meet modern HTM standards) and only 2-4 cubicles per ward made physical distancing difficult. In the early phase alterative beds within bays were closed to allow a minimum of 2 metre distancing between patients. This was achievable by ceasing routine surgery. This in turn was to impact on waiting times but much work has been undertaken to reverse this and most waiting list are now shorter than pre the pandemic.
- In addition, the difficult decision to stop and then reduce visiting had to be taken to both prevent spread but also to enable distancing in very cramped areas.
- In non-clinical areas people worked in teams with only half of a department in at a time. Desks were moved to be at least 2 meters apart, and shielding partitions were installed to provide separation between people. Mask wearing remains compulsory when moving around the HCS buildings.
- As we have eased back into business as usual, the ability to keep beds closed has not been an option with the current configuration of the hospital. The physical layout of the wards does not lend itself to this approach. This also required strict observation of visiting rules.

- All measures were documented within workplace safety plans.
- In clinical areas UV/HEPA air filtration devices had been installed to reduce viral loads within clinical areas. This was particularly important within wards admitting COVID-19 positive patients.
- We are a teaching hospital and had to deliver education & training differently during the pandemic to meet our university and Deanery requirements
- Initiated IPAC protected breaks for staff as had to maintain social distancing on clinical areas to ensure staff wellbeing and to protect patients and our staff.

Mask Wearing

- Initially there were high levels of anxiety amongst frontline and community staff around the type of PPE they should be wearing. This was due to rapidly changing guidelines and media accounts. HCS quickly developed protocols, drafted posters and discussed with staff what masks were required in what situation. Donning and Doffing guidelines were produced, disseminated and training given.
- All staff across HCS and many in the community have been FIT Mask tested. Some staff have been given additional training to provide FIT mask training in their own workplace for new staff.
- Mask wearing as an obligatory requirement by all staff working within healthcare settings has not been an issue, staff understand the importance of it, as do patients and most visitors to the hospital and care homes.
- There have unfortunately been some instances of visitors to the hospital being abusive to staff when asked to wear a mask.
- It needs to be noted that some staff continue to have to wear full PPE whilst working.
- Throughout covid 19 there have been PPE audits undertaken by IPAC team

The balance of public health and harm with regard to wider societal impacts

Describe impacts felt on you/your department/organisation

- What community groups/sectors of the population have been impacted?

It is evident that all groups and sectors of society have been impacted by the effects of covid 19. These impacts have arisen from many factors including:

  - Regular testing
  - Vaccinations
  - Emotional/mental health
  - Physical health
  - Self-isolation
  - Mask wearing
  - Physical distancing
  - Inability to leave the island

- Staff were impacted significantly in the pandemic situation support for all members of the workforce was facilitated through implementation of appropriate education and well-being solutions which were vital in sustaining resilience.
- The staff were supported by the public in many ways including, following rules, clapping and cheering, and providing significant acts of kindness which all resulted in maintaining staff morale.
- These impacts have required HCS to change how it delivers its services. The skilled staff within HCS have been required to set up, develop and often provide the practical services such as test and trace, vaccinations, providing PPE. This has resulted in staff undertaking

additional work or moving out of the hospital environment to provide these reducing the pool to provide care.

- In addition, we have had to find new ways of working to manage the care of patients with covid 19 and more latterly with long covid, whilst continuing to provide all other Health Care services.
- We have had to increase and change the Mental Health offer and work closely with partners to support the increased emotional needs of Islanders.
- Our social care department has found new ways to work to ensure care continues within the community.
- HCS had to prepare for the impact at its worst-case scenario and planned, designed and worked in partnership to rapidly develop the Nightingale Wing whilst continuing to provide care.
- HCS had to work with new technologies, working with partners to develop a self-help app for long term conditions whilst simultaneously enabling home working and remote engagement with UK hospitals.
- This was at a time when staff working in HCS were also directly personally impacted by the factors in the list above.
- Staff have frequently gone above and beyond their duties to provide safe patient care. The resilience of staff throughout the pandemic is to be noted. All clinical and non-clinical teams have worked tirelessly to support colleagues, patients and Islanders.

Describe how the work undertaken by you/your department/organisation impacted on different population groups

Primary Care:

- Initial stages saw new contractual arrangement with the General Practitioners- who worked with HCS to deliver telephone and video appointments to ensure continuity of access to primary care and an Urgent Treatment Centre.
- The urgent treatment centre was set up in the out-patients department of the Hospital during the first wave of COVID (April to August 2020. General Practitioners had entered into a contract with the Government of Jersey to provide medical services and health in general was undergoing rapid transformation.
- There was justified concern that the health system would become “overrun” rapidly with large numbers of critically unwell patients. The existing Emergency Department was therefore converted to treat just severely ill COVID patients and less serious emergency presentations would need to be seen elsewhere.
- HCS converted the out-patients department to see less acute and non-COVID patients. Staffing presented a challenge as our existing ED staff would be required in the Emergency Department. We therefore requested and received support from GP colleagues (especially those who had previous emergency medicine experience). They staffed the unit from 8am to 11pm every day and then based the GP out of hours service in the treatment centre out of these hours. We supported them with experienced ED nursing staff and colleagues from orthopaedics, paediatrics, and ENT.
- In addition, in wave two primary care clinicians worked within the Emergency Department

- This enabled rapid second opinions and clinical support to decision making which helped reduce that risk and apprehension that some GPs had that they had not got up to date skills in this area.

What worked well?

- There was effective collaborative work between primary and secondary care.
- GPs were able to relearn skills they had not used for some time.
- Prompt care at a single point of access with excellent patient feedback.

What didn't work well?

- It was disappointing that it could not continue after the first wave as GPs contract ended and they did not have capacity to restart this again in the further waves of COVID.
- Needed much clearer engagement from secondary care with a broader group of clinicians. During the time that the UTC operated the secondary involvement was predominantly with doctors from ENT and orthopaedics.
- In addition to this there was a Pharmacy delivery service developed in partnership with Jersey Post, Call & Check and pharmacies to ensure that individuals had their prescriptions delivered to their doors

Children

- An inpatient Child and Adolescent Mental Health (CAMHS) unit was opened for 3 months during the first wave. In addition, appointments offered virtually for all other CAMHS patients who required care.
- Staffing in the community CAMHS was increased to manage the caseloads with phone calls to all families and Young People.
- A Covid response plan dedicated to paediatrics was developed and implemented.
- Lessons learnt demonstrated the adaptation of the plan across the waves. Initially children with Covid19 were managed on an adult ward. In later stages the needs of both negative and positive patients were delivered within the paediatric environment.
- Multi agency safeguarding measures were stepped up to maintain oversight and support for Children and Families.

People with Long Term Conditions:

- In addition to continuation of GP services a new digital app was introduced to enable people with long term conditions to manage their care at home with the ability to link to specialists as required
- New working arrangements were put in place with care homes and home care providers to ensure continuity of care.
- In response to the Covid-19 pandemic, HCS therapy services were reconfigured to support revised ways of working, both within the hospital and more widely across community and specialist services.
- Occupational and Physiotherapy teams were combined under shared team leadership into the following therapy teams:
  - In-Hospital Response team
  - Out of Hospital Response team
  - Specialist Support team
- The Out of Hospital Response team was reconfigured to support individuals within the community to access therapy services during this pandemic.

- Physiotherapy & occupational therapy staff were re deployed from H&CS to provide an increased capacity within the existing RRRT service. This was done in anticipation of greater demand for access visits and discharge home visit assessments from JGH, which can no longer be undertaken by the in-hospital therapy team.
- The Rehabilitation at Home pathway has been developed to expedite discharge for those who have ongoing rehabilitation needs, but who could be managed in the community with rehabilitation provision. This provision supported the reduced in-patient rehabilitation provision at the general hospital.
- The Community Therapy Team pathway supports all other referrals for community therapy, such as those with long-term neurological conditions, frailty and falls. Referrals to this pathway are triaged and allocated based on their clinical need to a team of therapists who will support them either remotely or face-to-face in their homes.

Mental Health

- To continue to support people with long term mental health conditions new structures were put in place. This included:
    - A Home Treatment model in the community to meet the need of people with enduring mental health needs and avoid admission to hospital where clinically possible. This has continued.
    - Community crisis / triage team, working with colleagues from JHA to prevent the need to attend ED where appropriate. This has also continued and is currently being reviewed.
    - Redesign of inpatient care to safely nurse people with mental health needs who also developed Covid, and ensure infection prevention
    - Introduction of a new caseload prioritisation and risk assessment process to ensure ongoing contact with those most in need
    - Introduction of a daily operational oversight meeting to ensure responsiveness to emerging challenges / pressures and effective deployment of staff
- New working arrangements were commissioned to meet the need of Islanders emotional health in partnership with external partners. This resulted in significant increased capacity for low level mental health interventions.
- Relocation and reorganisation of Alcohol and Drug Service so that they could continue to provide service throughout the pandemic.

Social Care

- At the onset of the pandemic the social work department were required to quickly transform practice to adhere to public health guidelines—such as the use of personal protective equipment (PPE), adhering to physical distancing requirements, social isolation and closure of non-essential in-person workplaces—whilst still maintaining connections with their clients. This saw the increased use of virtual consultations.
- Social workers have had to quickly integrate digital care in practice to maintain continuity of client care despite having little training and access to technologies specifically developed for social work practice.
- Introduced 24hour social work on call service
- HCS in partnership with community providers developed an emergency equipment service
- Introduced multi agency Community Adult Support Panel CASP to step up safeguarding of vulnerable adults
- Reallocated HCS property to Shelter Trust to support vulnerable adults

Questions for particular stakeholders (see question header)

Public Health and other relevant stakeholders
Provide a self-assessment of the effectiveness of public health interventions – both restrictions and guidance such as: lockdowns, physical distancing, shielding – in protecting Islanders
Please provide a high-level evaluation of the efficacy of decision making and how it was informed by learning from evidence and actions of other jurisdictions

Health and Community Services, relevant external/commissioned/voluntary sector stakeholders
Outline the operational impacts on the delivery of healthcare and social care services during the pandemic response
The onset of the pandemic impacted the operational delivery of healthcare and social care services in many ways. **Waiting Lists - Inpatient and Outpatient** • At the point the pandemic was declared, routine outpatients, routine surgery and routine diagnostics was stopped to enable full mobilisation, training of staff and to realise bed capacity. Emergency surgery continued, as did chemotherapy treatments for cancer patients. Where possible, face to face outpatient appointments were delivered via telephone clinics or delivered via 'StarLeaf ', a video platform if this could be accommodated. Those patients with a suspected cancer were reviewed and followed up via a telephone consultation. • GPs also embraced telephone and video conferencing for their patient consultations. • The overall reduction in outpatient consultations resulted in a marked rise in the waiting list for some specialities, more specifically orthopaedics, general surgery and ophthalmology. • As HCS returned to business-as-usual, Covid recovery clinics were provided in surgery and orthopaedics and in medicine specialities to address the long waiting list. **Staffing** • BAU operational staffing level procedures have continued throughout the pandemic. These include daily operational and staffing meetings facilitated by the lead nurses and ward nurse managers to ensure safe staffing levels are maintained throughout. At these meetings sickness, vacancies and other absences are considered in conjunction with the SafeCare tool (an IT system) which determines staffing demand based on patient acuity. • During the pandemic, other aspects of staffing were considered as well, for example, outcomes from individual staff risk assessments. Individual staff risk assessments were undertaken to ensure staff safety to continue to work. This resulted in some staff having to shield as per public health guidance at the initial phase of the pandemic. Risk assessments were also undertaken in relation to working on a ward with 'Covid' patients (Hot Wards). Staff assessed as high risk were moved to work on wards with no 'Covid' patients (Cold Wards).

- To provide further support in relation to staffing, a **workforce cell** was set up during the first phase of the pandemic. In addition, a **staff wellbeing team** was developed to provide emotional support.
- Recording of sickness absence amended for COVID related illness to ensure staff were encouraged to report COVID related illness and isolate accordingly whilst supported by the organisation.
- As outpatient services and elective surgical lists were reduced and/or halted early in the pandemic, staff were redeployed from these departments to the wards and to the Urgent Treatment Centre to provide further resilience.

To increase critical care and nursing capability and capacity, specific training was provided, including:

- Critical care surge training - 200+ staff
- Simulation training continued throughout the pandemic to support those working in critical care
- Simulation exercise for Nightingale wing
- Physiotherapists and Occupational Therapists were provided with training in basic nursing skills which allowed them to work alongside and support the ward nurses to deliver care, as appropriate.
- FIT mask test training

Recruitment for bank Healthcare Assistants (HCAs) was increased to support the department. A recruitment and communication campaign went out to the public to support the department in providing care to patients and to help with the Nightingale Wing and as a result 200 staff were recruited. A fast-track process was put in place for the applicants which included:

- shortened application form
- telephone interview
- fast track clearances with risk assessments to support
- classroom-based training after completion of on-line training.

Bank HCAs were used across a variety of different areas and were instrumental in supporting new services such as the Urgent Treatment Centre, the COVID swabbing stations, Test and Trace helpline but also to Health & Community Services support existing services in the Jersey General Hospital, in Mental Health and the Learning Disability Service.

In addition, HCS also redeployed nursing staff who usually worked non clinically in other roles in HCS to support the clinical response. HCS also reached out to retired clinical professionals, medical students and students on nursing, midwifery and allied health professional programme.

Relevant external/commissioned/voluntary sector stakeholders

- Commissioned and external partners have been critical to the HCS response.
- There were initial concerns that the early focus of response was solely with HCS but it was quickly recognised that external partners were essential to a coordinated response which led to the initiation of the bronze cell.
- New covid laws impacted directly on the wider provision of care, particularly the need for increased PPE. Through the joint working an emergency response was set up to the provision of PPE prior to the PPE cell going live on the 9th April 2020.
- There was initial confusion about care providers admitting or re-admitting patients with COVID and the requirement for negative results for discharge from Hospital, resulting in patients who had a COVID-19 positive test but were medically fit for discharge having to remain in hospital unnecessarily to complete their isolation period and on occasions await a negative PCR test. Jointly a solution was found for one provider to admit to empty home

capacity people who tested positive. The provision of all necessary equipment to the home by HCS enabled this to happen.

- HCS & Public Health produced a join policy statement to mitigate this so medically fit pts could return home whilst positive to complete their isolation period.
- The sector also experienced negative responses when entering residential areas to provide care and having to wear full PPE as some neighbours believed that COVID was either being carried by the carer or within the neighbourhood. This resulted in a communications campaign to support the sector.
- Care providers have been impacted significantly by reduction in staffing due to COVID 19, HCS has supported where possible, and the Chief Nurse department has stepped in where critical. This led to the **Community Support Group** being developed, frequency ranging from daily to weekly depending on need. This enables all care home and home care providers to come together to support each other, receive early information and raise issues which are resolved or escalated.
- The care sector has been instrumental in the delivery of some excellent practise during covid, including the development of the vaccination programme for people with learning disabilities over the weekend in an environment and with staff that they feel safe with. This programme was highly successful ensuring a very high uptake of vaccinations in this population group. A further example would be the community FIT mask testing programme where providers offered space and identified potential trainers to trained to support the wider sector

Other operational issue raised by the sector have included:

- Parking
- Clinical waste collection
- Vaccinations
- Insurance
- Fit mask testing
- Access to therapy teams,
- Care homes with parent companies in the UK with differing policies

The wider sector has shown great resilience and we hope to continue to work as closely in the future.

Children, Young People, Education and Skills and other relevant stakeholders
Outline the operational impacts on the delivery of education during the pandemic response

Public Health; Health and Community Services; Children, Young People, Education and Skills; other relevant stakeholders
Provide a self-assessment of the effectiveness of strategies and systems put in place of testing, outbreak management (including in schools, care homes, etc) and self-isolation What worked well? What didn't work so well? What have you learnt and what would you do differently?
Care Homes

What worked well?

- Vaccination programme in care homes with mobile team
- The test and trace programme
- Joint working across Island with IPAC to manage outbreaks
- Emergency response when required
- Coordinated Supply of PPE
- Use of the HCS bank when in crisis has been helpful, although at times challenging to source staff.
- The law changes around regulation with the Jersey care Commission JCC has helped significantly
- JCC webpage as a portal for all care providers has been an excellent resource.

What didn't work so well?

Care homes would suggest that:

- There was a delay in providing PPE
- The changing guidance was difficult for them to follow
- They often felt alone when their home was impacted
- Messaging was often late on a Friday so did not see until late, which impacted on their ability to adjust
- They felt pressure to take people who tested positive when they were unable to keep others safe

What have you learnt and what would you do differently?

The ability to be flexible, work in partnership and good clear communications is critical. The pandemic improved collaboration and has been very positive as the best outcomes are delivered collaboratively.

Provide a self-assessment of the effectiveness of strategies and systems for vaccination

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

What worked well?

- Governance structure and direct link to other national vaccination programmes as well as JCVI. Single venue for vaccination allowed easy operational control, performance monitoring and efficient use of resources.
- Establishment of scalable mobile teams to reach isolated individuals and groups including all care homes across the island.
- The learning disability vaccination events.

What didn't work so well?

- Competing demand for clinical staff. HCS clinical staff were redeployed to cover GOJ vaccine centre, GOJ Test and Trace Service and the Care Home sector, this impacted initially on HCS resilience
- Data collection across the care home sector and repetition has caused concern

What have you learnt and what would you do differently?

- The single venue with a joined-up approach, with the flexibility and agility to respond to specific areas is essential.

• Engaging the primary care sector and utilising their skills could improve the vaccination programme in the future. • Need to quickly move to a Jersey care Record to prevent many of the digital challenges.

Economy; Treasury and Exchequer; Customer and Local Services; other relevant stakeholders
Provide a self-assessment of the impact and effectiveness of mitigations such as support to individuals, businesses, and other organisations • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?

STRATEGIC POLICY, PLANNING AND PERFORMANCE

Leading strategic policy, planning and performance to achieve the ambitions of Islanders for the future

What we do

We work across government and with our communities to:

- ensure integrated policy development across government, working with ministers, departments and the community to improve outcomes for Islanders
- provide strategic performance management and insight, benchmarking government impact, and supporting senior and departmental teams to ensure continuous improvement in public services
- ensure strategic and long-term planning is delivered to a high standard, working in close partnership with Treasury and Exchequer to align longer-term objectives with resources and investment
- provide an effective foresight function, including horizon scanning and scenario modelling, to identify future risks, opportunities and solutions
- ensure effective governance and outcomes from its associated Arms Length Functions

Strategic Policy,
Planning and Performance

19-21 Broad Street | St Helier
Jersey | JE2 3RR

Deputy Inna Gardiner
Chair
Public Accounts Committee
By email

03 December 2021

Dear Deputy Gardiner,

PAC Covid-19 Response Review

Thank you for your letter of 5 November regarding the Public Accounts Committee's review into the Government's response to the Covid-19 pandemic. I have sought to answer your questions below.

1. How did your responsibilities as Director General change during the COVID-19 Pandemic? What new responsibilities did you take on and what responsibilities did you hand over to other officers?
a. How was this tracked?
b. What new responsibilities did your department take on and what responsibilities did you hand over to other departments? How were these tracked?
c. How did you work with other departments and key stakeholders to identify new areas of work to mitigate the impact of the pandemic?

The Department for Strategic Policy, Planning and Performance (SPPP) is responsible for the development of public health policy and strategy. This responsibility was not handed over to any other department. My formal responsibilities as Director General were unchanged throughout 2020 and most of 2021, although the primary focus of the department's work was pivoted to focus on responding to the Covid-19 pandemic and this has been the priority for much of 2020 and 2021.

More recently, following the departure of the former Director General for Justice and Home Affairs, formal responsibility for test, trace and Covid safe operations transferred to my department on 15th October 2021. In addition, the Director of Public Health now Chairs the vaccination programme board and so oversees the deployment of Covid-19 and Flu vaccination. The Interim Director of Public Health Policy and Strategy now Chairs the Covid Safe Certification programme board. These recent changes have added to the responsibilities of my department.

Other departments have played a significant role in responding to the pandemic. In particular Justice and Home Affairs has overseen Covid-19 operations during 2020 and most of 2021, including test, trace and Covid safe, Customer and Local Services has managed the Covid Helpline and Connect Me activity, and of course Health and Community Services has played a significant role in the healthcare response, alongside primary care and the wider residential and home care sector. It should also be recognised that central departments have played a vital role in supporting the response to the pandemic. For example, colleagues from Treasury & Exchequer and the Chief Operating Office have provided essential support in financial and people resourcing, commercial services and digital solutions. External Relations has played an important role in relation to the safer travel policy and in supporting global procurement, sometimes in quite challenging

circumstances. Departments such as the Office of the Chief Executive, States Greffe and Law Officers' Department have also been vital to the response, supporting communications, democratic decision making and the preparation of emergency legislation.

In addition to working with these departments and organisations to mitigate the health risks of Covid-19, we have worked with other departments and stakeholders to support the delivery of a Covid-19 strategy based upon achieving outcomes which cause the least overall harm. This has included, for example, colleagues and stakeholders from education and childcare, business and industry, travel and transport, law enforcement and border controls.

2. We know there has been a huge impact of COVID-19 response measures on departmental business as usual activities, including the secondment of Government staff to other departments to aid the response effort. Do you have a 'back-to-normal' recovery plan for your department?
a. In respect of the secondment of Government staff to other departments to aid the response effort, how did you ensure disruptions to certain workstreams were prioritised in an objective and consistent way?
b. What would you do differently next time?

This was explained in the CEO's response provided on 11th October 2021, as below.

> **Departmental Impacts**
>
> **SPPP:**
>
> At the outset of the emergency response to the pandemic in Jersey, the strategic focus of the whole department was pivoted to focus on the provision of public health advice, legislation and intelligence in order to protect Islanders. At the peak points of the pandemic, more than half of the department's capacity was fully deployed on COVID-19 work, often with the addition of many valuable secondments from elsewhere in the public service and also supplemented by interim specialist support as needed.
>
> In addition, some mainstream work was identified at the outset as needing to continue throughout the pandemic due to statutory, Assembly or external timelines (examples include the Island Plan, Government Plan, Brexit, Climate Emergency, Redress Scheme and Census) and these projects were kept going by a small number of dedicated colleagues, often working alone, to ensure that these workstreams would still be able to deliver as Jersey emerged from the peaks of the emergency.
>
> This approach was supported by Ministers and explained in the Annual Report and Accounts 2020 (see pages 86-87). The status of each work-steam was published in the SPPP Departmental Annual Report 2020 and the Mid-Year Review 2021, which also illustrate the evolution and how items that were deferred initially have started to come back on track as capacity has been gradually released back onto mainstream activities during 2021.
>
> There were a number of positive aspects to highlight from this experience, not least the huge commitment of our public servants to protecting their community, and the commendable flexibility and agility demonstrated by the public service. SPPP conducted a professionally facilitated emergency response debrief with all staff, which highlighted not only the sense of achievement amongst all involved, but also many of the challenges of having the civil service on the front line of an emergency response for a sustained period of time, given that previous civil service working practices were not necessarily set-up to support a sustained 24/7 emergency response in the same way as the blue light services. These lessons can be taken forward as part of updating contingency

planning arrangements for the department and the development of a strengthened public health protection function for the future.

In relation to secondments, it should be noted that my department was generally a beneficiary of secondees from elsewhere in government, which had a very positive impact in supporting the Covid-19 response.

3. How have you monitored the effects of the COVID-19 Pandemic on departmental business as usual activities and the disruptions to it?
a. What tools were developed by your departments to monitor this?
b. How do you minimise the impact on services and key deliveries?
c. What decision making tools/approach did you use to decide on who should be seconded, and to where?
d. How did you compensate for staff seconded to other departments to aid the response effort?

The effects on other work were managed using normal methods, such as the reprioritisation and rescheduling of policy and legislative projects in consultation with relevant ministers. As noted above, some mainstream work was identified at the outset as needing to continue throughout the pandemic. This included the Island Plan, Government Plan, Brexit, Climate Emergency, Redress Scheme and Census. These projects were kept going throughout the peaks of the Covid-19 response by a small number of dedicated staff.

As noted above and in the CEO's response of 11th October 2021, the impacts were then reported in Mid-Year Reviews, Annual Report and Accounts, and Departmental Annual Reports.

Also as noted above, my department was generally a beneficiary of secondments from elsewhere and so this had a positive impact.

4. Was any departmental authority changed during the Pandemic, including as a result of crisis management efforts, and if so, were they consistent with existing laws and regulations?

Formal authorities were unchanged and so remained consistent with existing legislation. This question was addressed in the CEO's response of 11th October 2021, as below.

SPPP:
There were no changes made to departmental authority during the pandemic, however, additional resilience was introduced. For example, in response to the situation emerging at the start of 2020, a need was identified to ensure that the statutory function of the Medical Officer of Health (MOH) could always be sustained, in order to provide appropriate public health authorisations and statutory advice. As a result, at all times during the pandemic, there have been three appropriately qualified people designated by the Minister as MOHs - starting with Dr Turnbull, Dr Muscat and Dr McInerny, and now being Professor Bradley, Dr Muscat and Mr Armstrong. This was consistent with the existing legislation, which allows for the designation of alternate MOHs.

5. Who is responsible for monitoring the performance of services established in response to the COVID-19 Pandemic within your department?
a. What and how have you documented lessons learnt?
b. How do you intend to incorporate lessons learned from the performance of these services into the wider performance of your department?

The arrangements for monitoring the performance of the department were unchanged, and so the outputs of public health policy work were monitored in the usual way by means of management and ministerial oversight. As ever with policy work, the outputs are highly visible and subject to scrutiny through the democratic system and by the wider public. This process has been heightened and accelerated during the Covid-19 pandemic, with policy and legislation developed rapidly, and with real time feedback loops throughout all the phases of the pandemic.

More recently, the department has been more involved with Covid operations and the deployment of the vaccination programme. These emergency response operations are managed closely by the relevant managers, who have needed to respond to continuous changes in operational requirements arising from developments in the global pandemic and policy changes necessary to deal with ever changing circumstances. Some operational dimensions have been critical at different points in time and so have been subject to close management, such as testing turnaround times, test centre throughput, contact tracing capacity and vaccination centre throughput and progress through key population groups.

Programme and project boards have been used to oversee test and trace, Covid safe certification and vaccinations. These have been chaired by the relevant senior officer and comprised representatives from partner departments, including People Services and Treasury. Programme boards have met regularly to review delivery requirements, make improvements and manage risks. Significant issues have generally been reported to Competent Authority Ministers as they arise.

We have benefited from the Covid-19 reviews undertaken by the Comptroller & Auditor General (C&AG) and by Scrutiny, which have captured and documented a number of useful lessons from the pandemic response to date. The improvements identified through these reviews have either been incorporated or are in hand, as per the formal responses provided to these recommendations, which are then reported subsequently through the tracker process.

6. How were self-assessment frameworks and Key Performance Indicators used to ensure that key services continued to operate?
a. What worked well?
b. What would you do differently?

As explained in the CEO's response of 11th October 2021, departmental performance systems have been maintained, including service performance measures, programme and project performance, and financial management and monitoring. This has all worked well.

As noted above, there are lessons that can be drawn from having the civil service on the front-line of an emergency response for an extended length of time. The work we have done to gather the views of our staff on this experience has surfaced many useful points and will help us focus more on the wellbeing of our people during these particularly demanding periods.

7. What role did your respective Ministers play in deciding on resource and staff reallocations? What level of consultation was provided to them?
a. What level of responsibility as the head of your department did you have on how staff should be reallocated and what resources could be taken from your departments and applied to the COVID-19 responses? How was this decision making formalised?

Ministers were involved where a reallocation of resources may have had an impact on their policy, legal or administrative responsibilities. Such matters were generally discussed with ministers as part of emergency decision making, which throughout the pandemic has often had significant resource implications, and formalised as part of that overall decision making process. As the head of my department and Accountable Officer, I am fully responsible for the deployment of resources

provided to my department to support the Covid-19 response, including any necessary reallocation of those resources.

8. Can you update us on how your department has responded to the recommendations made by the C&AG on the response to the COVID-19 Pandemic? Have any recommendations been implemented?
a. Have any changes made to the operations or working practices?

There are six such recommendations assigned to my department, all of which are in hand. The recommendations are being addressed through the development of a code of practice for STAC, the development of a new public health law, and through expanding the public health function to ensure it is properly equipped to address future health protection emergencies.

9. What thought has been given to 'future proofing' services?

As noted above, there is a need to 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. This includes the need to strengthen the public health protection function and the public health intelligence function, which has been critical to inform decision making and the wider public during the pandemic. This will also allow us to monitor the indirect impact of the pandemic on health and recommend action to address health need.

The pandemic has identified to governments worldwide (including Jersey) the importance of data in making decisions in the light of uncertainty. For example, the UK report on *Improving health and social care statistics: lessons learned from the COVID-19 pandemic*[1] concluded that "Sharing and linking data can have life-saving impacts. This must be prioritised by governments beyond the pandemic." There is, therefore, a need to join-up more administrative data across the wider public service for both operational and statistical purposes (with appropriate data protection and privacy controls) and to do this ahead of any future public health emergencies. These improvements have been initiated and will be taken forward during 2022

10. How did you work with Commercial Services to understand your department's procurement needs during the pandemic?

Commercial Services have been an invaluable partner during the pandemic, supporting the procurement needs that have arisen through test and trace and the vaccination programme. These needs have often arisen at short notice and in the context of very challenging global supply chains. Commercial Services have participated in programme boards, where such needs are generally identified and discussed. Colleagues from Commercial Services have responded promptly and effectively on each occasion, sometimes with the able support of External Relations. We are grateful for the excellent support they have provided and continue to provide.

11. How have you measured, monitored, and reported on your performance, financial management (including value for money and cost benefit analyses) and impact on work programmes during the Covid-19 pandemic? What 3 things could be improved?

As noted above, departmental performance systems have been maintained, including service performance measures, programme and project performance, financial management and

[1] Improving health and social care statistics: lessons learned from the COVID-19 pandemic – Office for Statistics Regulation (statisticsauthority.gov.uk)

monitoring, along with mid-year and annual reporting, which includes the impact on wider work programmes.

Considering the lessons from the Covid-19 response more broadly, our ability to monitor and report upon the direct and indirect impacts of the pandemic could be improved considerably through better research and more joined-up administrative data sets across public services. This is an area that the Director of Public Health, Chief Statistician and Head of Public Health Intelligence intend to take forward in 2022.

12. What would you do to improve how your department communicated with the rest of the Government of Jersey and external stakeholders?

My department has been central to providing Covid-19 briefings for ministers, States Members, the media, other government departments, key stakeholders such as business associations, and the wider public. These briefings have routinely covered updates on public health intelligence and analysis, public health policy changes, operational delivery of testing, tracing, Covid safe and vaccination. At times, this has stretched the capacity of the public health function and added to the need to work 7 days a week and late into the evenings. To help improve the position going forwards, investment in a public health communications capability, and in more senior public health capacity, will form part of the overall strengthening of public health.

My department has been supported throughout by the Communications Directorate and so the CEO's response of 11th October 2021 includes a number of relevant points. Highlighted in that response is an opportunity to consider at the outset how a policy might be communicated, particularly where the policy has nuances or complexities. The introduction of behavioural science into policy development has been particularly helpful and has improved aspects of public health policy design to help support better communications.

In closing, I would like to pay tribute to all the public servants and health care workers who have worked tirelessly over the last two years to keep our Island safe. Jersey is fortunate to be served by such dedicated and indefatigable teams of people and I continue to be humbled by what they can achieve.

I hope this response is of assistance to the Committee and am content for this to be published.

Yours sincerely,

T. Walker

Tom Walker
Director General
E t.walker@gov.je

cc: Chief Executive

PUBLIC HEALTH (as part of SPPP)

We aim to understand the local health needs and health inequalities amongst the population of Jersey. Using this information, we work to protect and improve the wellbeing, physical and mental health of Islanders

• works to improve health outcomes, reducing the incidence of disease, injury and death in the population;
• encourages and promotes good health in Jersey and works towards making healthy lifestyle choices easier;
• develops an understanding of health inequalities and ways to reduce them.

Public Health

Written Submission to the Covid-19 Independent Review

1. Introduction

Public Health welcomes the opportunity to respond to the Independent Review of Jersey's response to the Covid-19 pandemic. We have prepared this submission to support the Independent Review in considering the public health policy response to the pandemic from March 2020 to January 2022. In the submission, we provide:

(a) An epidemiological narrative, setting out data on infections and health outcomes.
(b) A policy narrative, describing the use of public health data and evidence in decisions.
(c) Observations on relevant aspects of the Terms of Reference from a public health perspective.

The Covid-19 pandemic is a matter of significant public concern. It has had, and continues to have, a heavy impact on the lives and livelihoods of all Islanders. It is, therefore, essential that the questions people have about the public health response to the pandemic are addressed. We must also identify lessons from the Independent Review and act on its recommendations. This will help to ensure that we are as prepared as possible for any future pandemic or comparable disruptive event.

2. Structure

The main element of the Public Health submission is an epidemiological chronology. The chronology provides data on infections and health outcomes during the pandemic, and key policy decisions and events. The chronology is based on:

- Public Health Intelligence data
- minutes from the Scientific and Technical Advisory Cell (**STAC**)
- minutes from Competent Authority Ministers (**CAM**)
- speeches and statements given by Ministers
- press notices published during the pandemic

The submission is divided into four sections. Each section reflects a semi-distinct period of the public health policy response and corresponds to one of the four waves of Covid-19 infection in Jersey.

Chronological section	Period
Initial response	March to August 2020
Autumn/Winter 2020-2021	September 2020 to March 2021
Spring/Summer 2021	April to August 2021
Autumn/Winter 2021-2022	September 2021 to January 2022

Further sections of the submission address key aspects of the public health response:

- the development of legislation
- governance and decision-making arrangements
- the impact of Covid-19 on population health outcomes
- the interaction between policy and service delivery, including Test and Trace and the Vaccination Programme
- public health communication and engagement

Two addendums are also included with the submission, which provide responses on the delivery of Test and Trace Programme and the roll out of the Vaccination Programme.

The submission concludes with observations about the Public Health response to the pandemic and lessons that can be drawn from the experience to date. Reference is made, where possible, to work that has commenced, or is planned, to put in place arrangements to respond to future public health emergencies.

The submission also includes the findings of a survey of STAC members[1]. The aim of the survey was to give members the opportunity to reflect on their contribution to the pandemic response, and to assess the effectiveness of STAC. The survey is intended to enable the Independent Review to gain an understanding of how STAC members, having had the experience of providing advice in a public health emergency, would improve arrangements for the future.

3. Epidemiological chronology

3.1. Initial response: March – August 2020

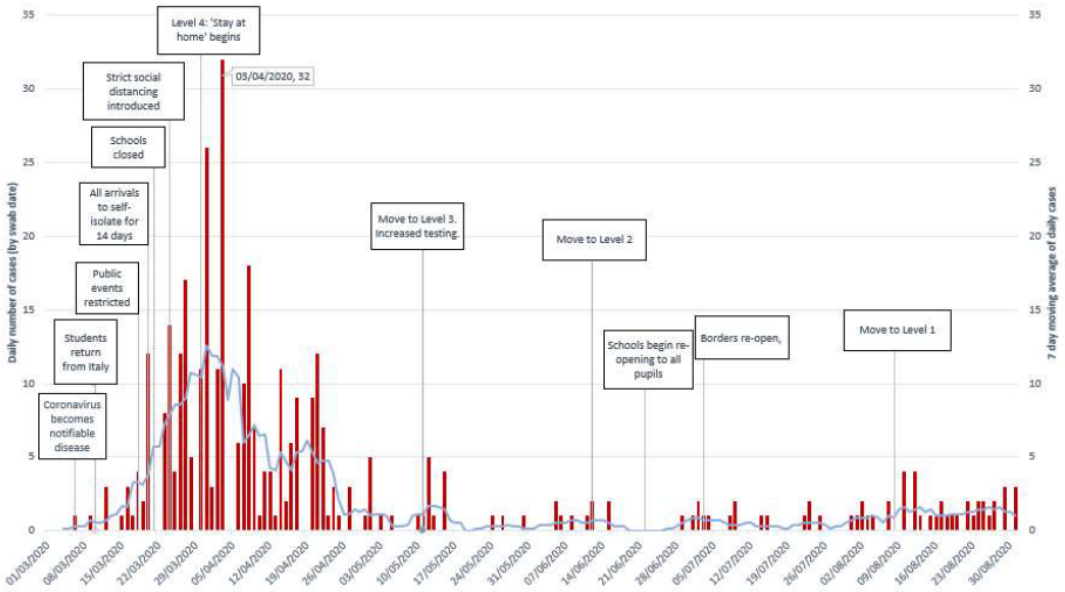


Figure 1: Covid-19 daily case numbers, 01 March – 30 August 2020

The first wave of the pandemic saw 373 cases identified through PCR tests through March to August 2020, although this represents an underestimate of the true number of cases in the Island due to the limited availability of tests at the beginning of the pandemic. Most cases were in working age adults, with 119 adults aged over 60 tested positive during this time and 11 under 18s. Of the total number of cases over this period, 130 were individuals with underlying medical conditions. The first positive swab was conducted on the 6 March, with daily cases increasing to the highest point in the wave of 31 cases on 3 April (based on swab date) before beginning to decline through April. Hospital occupancy peaked in April with 23 cases in hospital before reducing and reaching zero in June. Over the period, there were 32 deaths where Covid-19 was recorded on the death certificate; 16 were laboratory confirmed whilst the remainder were determined as probable Covid-19 by the certifying medical practitioner based on symptoms. Of these deaths, 13 occurred in a care home and 13 in Jersey General Hospital.

3.1.1. Account of key events and policy decisions

The public health response between March and August 2020 focused on:

[1] The survey of STAC members was undertaken in March 2022. It included past and present members from March 2020 to January 2022.

- measures to respond to the Covid-19 pandemic – 'suppress, contain and shield' strategy
- the standing up of various governance structures and programmes to respond to the pandemic
- significant support from Strategic Policy, Planning and Performance in policy and operational roles
- the safe exit from the initial response to the pandemic from May to August

The epidemiological chronology in this submission begins in March 2020, but the first public health advice about Covid-19 was issued at the end of January 2020. Further updates followed and Health and Community Services (**HCS**) convened a daily STAC to monitor the Covid-19 situation and formulate contingency plans. The first case of Covid-19 was reported in Jersey on 10 March.

In the initial response to Covid-19, the Government of Jersey (**GOJ**) adopted a 'suppress, contain and shield' strategy. The strategy deployed recognised public health measures to control, supress and/or eliminate outbreaks of infectious diseases, which were consistent with measures being used in other jurisdictions at the beginning of the pandemic. The objective of the strategy was to delay and flatten the curve in Covid-19 cases and, in doing this, protect Islanders' health and reducing the pressure on healthcare services.

From 12 March onwards, a series of escalating restrictions were implemented, which became known collectively as 'lockdown'. The restrictions were established in legislation and supported in guidance, including:

- travel restrictions – *minor travel restrictions for arrivals from a limited number of jurisdictions were in place from February 2020 under the direction of the Medical Officer of Health*
- physical distancing
- shielding of vulnerable persons
- school closures
- 'stay at home' orders (commenced 30 March)
- business closures

The restrictions were implemented based on public health advice and modelling. They were used to prevent a large and rapid increase in Covid-19 cases, which would cause harm to population health, lead to deaths, and place pressure on healthcare services, schools, and other critical infrastructure. The GOJ was clear from the beginning of the pandemic that the restrictions would be in place for no longer than necessary and would be removed when safe to do so in recognition of the wider impact on Islanders.

It is important to emphasise that, alongside restrictions, measures were also introduced to facilitate the provision of essential services in a way that minimised in-person contact between Islanders, and which sought to reduce disruption to the community. Regulations were, for example, passed by the Assembly to enable the States Assembly and the Courts to operate remotely; to allow signatures on documents to be witnessed remotely; to enable care homes to function properly with reduced staff numbers; and to facilitate efficient civil administration procedures such as the registration of births, marriages, and deaths.

Testing, isolation and contact tracing measures were also an important element of the public health response from the beginning the pandemic. Appendix A shows the evolution of these arrangements, including the formation of the Test and Trace Delivery Programme and the development of a series of Testing Strategies to monitor and contain Covid-19 infection[2]. The measures initially included both a PCR and an antibody testing programme consisting of:

[2] Initial 'Contain' strategy outlined in the published June 2020 COVID-19 Strategy

- diagnostic PCR testing for all islanders with symptoms and direct contacts of positive cases
- diagnostic PCR testing of those with symptoms, direct contacts of positive cases, and asymptomatic staff and residents to manage infection in the hospital, care homes and other priority institutions
- diagnostic testing to identify asymptomatic essential workers
- three rounds of a community antibody survey (May – June 2020) to help estimate the potential previous exposure to COVID-19 in Jersey (as mass PCR testing was not initially available)
- an Essential Worker Antibody Survey to offer extra insight into the potential exposure across those groups who are working during the stay home period

A contact tracing team was set up under Environmental Health and then absorbed into the Test and Trace Programme under Justice and Home Affairs. The team was responsible for identifying persons who had been in contact with a positive case of Covid-19, and for ensuring that testing and isolation requirements were being complied with to contain transmission.

On 1 May, one month after lockdown had been implemented, the Covid-19 Safe Exit Framework was published, setting out how the Island would exit safely from the initial pandemic. The GOJ's aim with the Safe Exit Framework was to move sequentially from Level 3 down to Level 1, at each level easing restrictions safely. The framework enabled more activity to take place and businesses to reopen in a way that balanced an increase in social contact, avoided unnecessary risks, and reduce transmission.

By June, there were fewer reported cases of, and hospitalisations from, Covid-19. The GOJ published the Covid-19 strategy update on 3 June, which described how it planned to control the virus in a safe and sustainable way, whilst removing the more harmful restrictions as it became safe in line with the Safe Exit Framework.

Cases of Covid-19 became more sporadic at this time with no new known cases in the seven days up to 30 June. There was, however, an increased risk of Covid-19 transmission as the restrictions eased. The public health response from June to August thus focused on reducing the risk of transmission. It included measures such as:

- Good infection control practices and environmental hygiene in health and care settings; proactive screening of staff and residents; and isolation and screening of symptomatic patients and/or staff.

- Enhanced testing and tracing capabilities so that, if new cases were identified, transmission could be quickly contained, and people cared for. Details of the Contain Strategy from June 2020 are set out in Appendix A.

- Continuing to minimise the risk of bringing new cases of Covid-19 into Jersey through controls at the border.

Jersey's border remained open throughout the pandemic, but the introduction in March 2020 of a 14-day isolation period for all arriving passengers reduced the Island's connectivity almost entirely. All commercial air services were suspended, with air travel limited to a single daily GOJ-subsidised flight.

In April/May 2020, a policy was developed to introduce arrangements for the safe reopening of the Island's borders. This began with the introduction of a trial testing programme in June 2020 and the Safer Travel Policy on 3 July. The Policy – based on a RAG system – facilitated relatively unrestricted movement to and from the Island during the summer, with some restrictions such as a requirement to provide travel information, undertake testing on arrival, and a period of isolation until receiving a negative test result. Increasing case rates in the UK/internationally from late August led to countries and regions being reclassified under the RAG system, which led to a reduction in travel volumes.

Overall, Jersey continued to progress through the various levels of the Safe Exit Framework between June and August. Decisions were based on public health advice and made in consultation with STAC,

following the epidemiological situation and information on the effectiveness of control measures in Jersey and in other jurisdictions, balanced against the need to minimise the wider harm to Islanders' wellbeing.

The Island entered Level 2 of the Framework on 12 June and Level 1 on 8 August, which focused on living safely with the virus and ensuring Islanders and businesses followed public health guidelines.

3.1.2. Learning points

At the beginning of the Covid-19 pandemic, the GOJ's Public Health function, drawing extensively on officers from Strategic Policy, Planning and Performance, provided advice, guidance, legislation, and health intelligence. A number of SPPP Officers also took on key operational roles during this time. The rapid expansion and flexibility of the public health response, as well as the level of commitment shown by officers, is one of the positive aspects from this experience. It highlights, nevertheless, the need for a robust Public Health function to be established within the GOJ to ensure that appropriate capacity and resources exist to address future health emergencies.

Moreover, new governance structures were developed in response to Covid-19. For example, when the virus was identified in January 2020, HCS convened a STAC to monitor the Covid-19 situation and prepare contingency plans to manage its impact. The Emergencies Council was also convened and coordinated the response to Covid-19. These bodies worked as well as they could in the early phase of the pandemic, but it is felt that Public Health did not feature as strongly as it might have done – in terms of representation and participation in giving advice and decision-making – given the public health nature and impact of the pandemic.

The departmental responsibility and oversight of STAC was transferred from Health and Community Services to Strategic Policy, Planning and Performance in April 2020. This decision was taken so that STAC would be linked with the public health policy response and cross government decision-making. The structure, terms of reference, and membership were also revised to ensure that the committee reflected the pandemic situation and included appropriate health, scientific and technical expertise.

An Analytical Cell was formed at the end of May 2020, as a sub-group of STAC, which allowed regular information sharing and case discussions between the Deputy Medical Officer of Health, IPaC, Public Health, contact tracing team and health informatics. This helped inform testing priorities and highlight policies requiring further development, as well as provide information and analysis to STAC via the chair (Deputy Medical of Health).

This highlights the importance of having appropriate and flexible governance structures to respond to public health emergencies, and a robust Public Health function so that it can inform, engage, and contribute towards decision-making relating to public health matters.

3.2. Autumn/Winter 2020-2021: September 2020 – March 2021

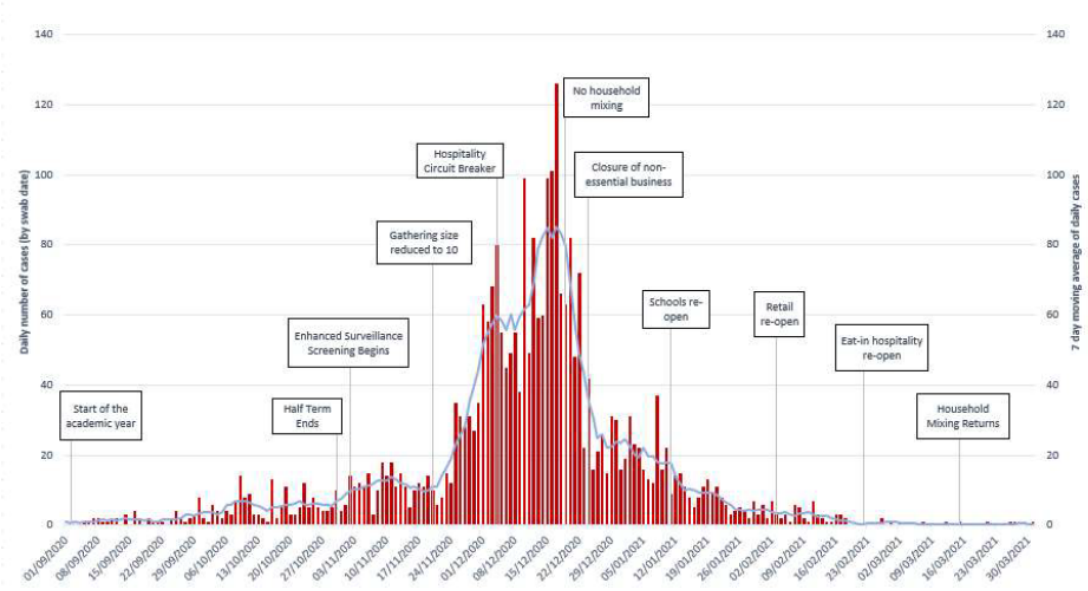


Figure 2: Covid-19 daily case numbers, 01 September 2020 – 30 March 2021

Over this period, a total of 2,855 cases were identified in Jersey. This includes a small number that were later deemed to be old infections or treated in another jurisdiction. Around one in three – 990 cases, 35% – were asymptomatic cases. The first hospitalisation occurred in early October, but it was not until early December when the cases in hospital began to rise (the hospital occupancy was 10 on 3 December), peaking at 33 Covid-19 positive cases on 18 December. Hospital occupancy remained at relatively high levels until early January, declining through the month, with less than 5 cases in hospital at any time over February and March. Cases in care homes over this period also saw a peak around mid-December (with 79 active cases in care homes on 23 December), declining over January. In total, 37 Covid-19 registered deaths sadly occurred over this period, ranging in age from those in their 50's to those in their 90's. 25 of those deaths occurred in hospital and 12 in care homes.

3.2.1. Account of key events and policy decisions

The public health response in autumn/winter 2020-2021 was characterised by the following events and policy decisions:

- The second wave of Covid-19 from late September through to a peak at the end of December
- The Covid-19 Winter Strategy Update
- The introduction of new restrictions and a 'circuit break'
- The implementation of the Covid-19 Vaccination Programme
- The Reconnection Roadmap and gradual release of Covid-19 restrictions

Whereas the Island had reported low numbers of Covid-19 cases at the end of the summer period, the number of cases and new clusters of transmission began to increase in mid- to late-September. This was not an unexpected development, and it was anticipated that transmission would increase during the winter. The situation continued to deteriorate through October and November as other jurisdictions such as England and France introduced lockdown measures. It was in this context that the GOJ published a Covid-19 Strategy Update, which set out plans to continue the suppression of Covid-19 but reflected the changing context of the pandemic. The Strategy included the following priorities:

- Increasing on-Island testing
- Continually updating travel classifications
- Introducing mask policies for indoor public spaces

- Adopting shielding programmes to keep people at high risk safe but connected
- Vaccinating for flu and when possible, for Covid-19
- Ensuring that the GOJ is prepared, especially to support care, health, and economic interventions
- Being ready to escalate if needed, but using the 'least overall harm' principle
- Communicating about sensible behaviour, backed with enforcement

The testing and tracing capability was increased to reduce the risk of Covid-19 transmission and an enhanced workforce testing programme introduced, with Covid-19 testing offered to employees in higher risk public facing industries. At the same time, the role of analytics adapted beyond tracking the epidemiology of the pandemic to include analysis of individual cases and clusters to inform and direct testing and environmental controls to contain the spread of the virus. The chair of the Analytical Cell moved to Public Health and continued to have regular contact with senior officers regarding the pandemic situation to inform policy and decision-making.

The Safer Travel Policy continued during this period, but more countries and region were classified as *amber* and *red* for arriving travellers, resulting in significant isolation periods for most travellers. The whole of the UK was classified as *red* on 21 December.

Restrictions were reintroduced in November, including a requirement to wear face masks in indoor public spaces and advice to work from home wherever possible. On 4 December, a 'circuit breaker' was introduced following the continued increase in Covid-19 cases and more hospitalisations. The circuit breaker required all hospitality venues, and indoor gyms/sports facilities to close. Ahead of the Christmas period, a 2-metre physical distancing law came back into force, and the 'rule of ten' introduced to reduce the scope of household mixing. On 24 December, non-essential retail, close contact services and indoor recreation centres were required to close.

Plans for Jersey's Vaccination Programme were being prepared during this period in anticipation of the arrival of the Covid-19 vaccine. This included the establishment of the Vaccination Governance Board. The roll out of the vaccine commenced on 13 December, with at-risk Islanders offered their first dose of the vaccine, including nursing and care home residents and staff. The prioritisation of these groups for the vaccine ensured that the elderly and vulnerable persons were protected, and individuals caring for them could do so safely. The vaccination centre opened for appointments on 19 December, enabling first and second doses of the vaccine to be administered to priority groups, in age order, in accordance with the recommendations of the Joint Committee for Vaccination and Immunisation (**JCVI**).

Between January and March 2021, a staged approach for relaxing Covid-19 restrictions was adopted. The focus was on supressing Covid-19 transmission and giving the Vaccination Programme sufficient time to deliver the vaccine to the most vulnerable groups. With a reduction in the number of Covid-19 cases and in the number of hospital patients with Covid-19, restrictions were gradually removed, including the reopening of non-essential retail on 3 February and hospitality venues on 22 February.

A staged process for relaxing Covid-19 measures was announced by CAM in January 2021. The first stage included the return of school pupils on 11 January, one week later than planned, and further measures were relaxed over the weeks that followed based on the epidemiological situation. CAM published a Reconnection Roadmap in March. The Roadmap provided a detailed plan for removing restrictions and returning to normal life. It described a series of stages, from Stage 4 in March 2020 to Stage 7 in June, where, at each stage, further measures would be relaxed depending on positive cases remaining low and public health advice that it was safe and appropriate to do so. The risk of Covid-19 transmission remained high at this point, and there was no change to travel policy based on the high rates of Covid-19 in the UK and other jurisdictions.

3.2.2. Learning points

At this stage of Covid-19 pandemic, the GOJ had the difficult task of mitigating the risk of Covid-19 infection whilst responding to broader pressures such as the impact of the pandemic on children's education, routine health services, the economy, and people's wellbeing. The GOJ had to consider and weigh up many different factors in its response to ensure the least overall harm. For example, there were frequent amendments to the Safer Travel Policy in response to escalating case rates in the UK and to retain connectivity. This included changes to the geographic assessment process to reflect regional variations in infection rates and changes to the arrivals testing regime. In general, Jersey was some two weeks behind the UK in terms of the epidemic curve in terms of the progression of the virus. This provided time to monitor the situation and understand the likely trajectory on-Island, which could then allow time for action to be taken.

There was also a desire to avoid blanket restrictions as had been seen during the first wave of the pandemic. Nonetheless, despite the introduction of a range of non-pharmaceutical interventions, such as the requirement to wear a face mask in public indoor settings, it did become necessary to introduce a circuit breaker in December 2020 to prevent widespread severe illness and disruption. Whilst these measures were stark, they were effective in reducing infection rates and established the foundation for the safe roll out of the Vaccination Programme. Moreover, the upscaling of on-island testing helped to identify and isolate positive Covid-19 cases more quickly and speed up the contact tracing process, which gradually helped to reduce the impact on the community.

Similarly, the Reconnection Roadmap was successful in reducing the Island's Covid-19 restrictions. The phased approach supported an appropriate balance between the relaxation of restrictions so that Islanders could begin to resume normal activities, with appropriate safeguards and guidance put in place so that it could be done so safely. As part of this reconnection approach, there was a focus on keeping schools, colleges and nurseries open, and minimising disruption to children and young people's education. The first stage of the Reconnection Roadmap saw the return of school students on 11 January (one week later than planned) with all necessary precautions and contact tracing in place. Throughout the pandemic, Children, Young People, Education and Skills (**CYPES**), working with Public health, has sought to balance the benefits of managing Covid-19 in education and early years settings against the educational drawbacks, ensuring the continuation of in-school learning; minimising disruption; and protecting students and staff.

Covid-19 had touched almost all aspects of the community by this point, and it became clear that pandemic fatigue had begun to emerge in response to a prolonged public health emergency. This was an expected and natural response since the severity and scale of the pandemic had called for the implementation of restrictions on people's day-to-day lives and livelihoods and their personal freedoms. The fatigue resulted in a need to invest considerable time and resources in maintaining and reinvigorating public support to reduce Covid-19 infection. This included communication and engagement activities to ensure support for the measures.

It was also noticeable that staff in Public Health and Strategic Policy, Performance and Population were experiencing fatigue, having worked under continuous pressure for a sustained period, with the resulting impact on their personal lives. Policy officials were required, at pace, to undertake a range of activities – e.g., media queries, States questions, engagement with Scrutiny, public correspondence, Freedom of Information requests – in addition to the Covid-19 policy response. Were there be a need to respond to a future pandemic or comparable disruptive event, it would be important to recognise the potential impact on officers early and take steps to ensure appropriate capacity and working arrangements. A professional de-brief was held in June 2021, which reflected on officers' experiences of the pandemic and sought to capture the learning so that the response could be improved if similar challenges were to arise again.

3.3. Spring/Summer 2021: April – August 2021

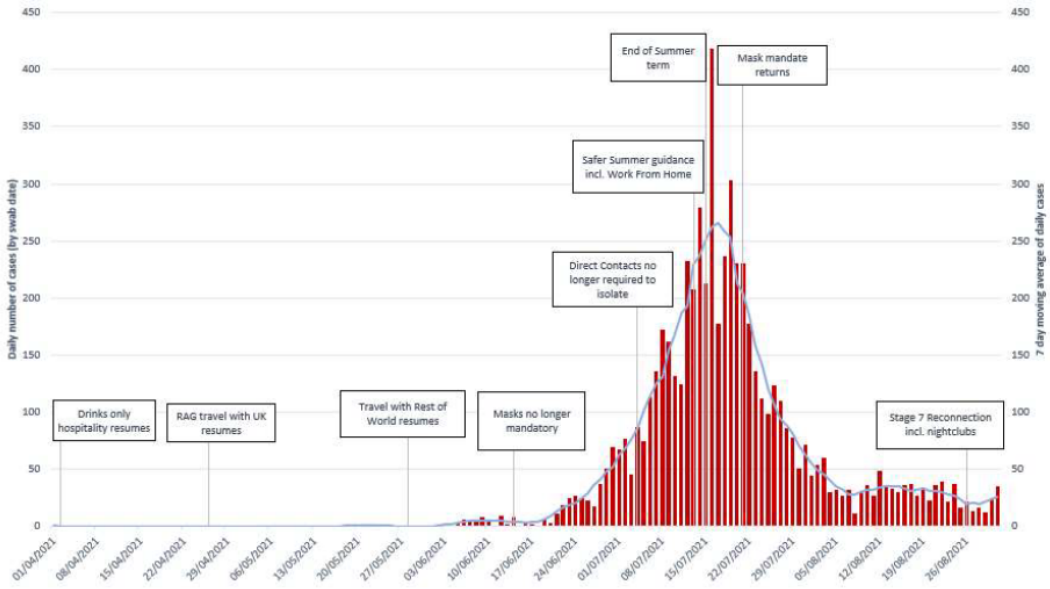


Figure 3: Covid-19 daily case numbers, 01 April – 31 August 2021

Jersey's third wave occurred in June and July 2021, with 6,121 cases being identified; of these, 1,602 were asymptomatic (26%). Over 400 cases were identified on 16 July before cases steadily declined, helped by a six-day heatwave, the end of the school term, and the end of the European Football Championship. Minimal cases were reported in care homes, with occupancy reaching 13 in late July and hospitalisations were also considerably lower than the previous wave (reaching a high of 21 Covid-19 positive cases on 29 July). In total, there were 9 Covid-19 registered deaths over this period (5 in the hospital, 3 in care homes and 1 in the community).

3.3.1. Account of key events and policy decisions

The public health policy response between April and August 2021 focused on three areas:

- the continuation of the Vaccination Programme delivery to eligible groups of Islanders
- the gradual removal of restrictions through the stages of the Reconnection Roadmap
- the shift from a 'suppression' towards a 'mitigation' strategy
- the response to the emergence of the Delta variant of Covid-19
- integration of vaccination status into the Safer Travel Policy
- the introduction of the Covid Status Certification scheme to provide evidence of vaccination to Islanders for use elsewhere and to facilitate the changes to the Safer Travel Policy

During the period, the Vaccination Programme continued to deliver first and second doses to eligible groups based on the recommendations of the JCVI. At the end of April, 60% of Islanders aged 18 and over had received their first dose of the Covid-19 vaccine; 35% were fully vaccinated with two doses of the vaccine. By mid-August, 86% of Islanders aged 18 and over had received their first dose of the vaccine; 80% were fully vaccinated with two doses of the vaccine. Moreover, further groups became eligible for the vaccine, including all young people aged 16-17 and those aged 12-15 at high risk from Covid-19, either because of an underlying health condition or because they lived in a household with someone who was immunosuppressed.

As the Vaccination Programme made progress, it enabled the resumption of normal activities, as the most vulnerable Islanders were protected, and the risk of severe illness and hospitalisation reduced. This allowed the Island to move through the various stages of the Reconnection Roadmap, including

Stage 5 on 12 April and Stage 6 on 10 May, with further restrictions removed at each stage – such as gathering limits; working from home guidance; and physical distancing.

The high level of protection afforded by the vaccine enabled a shift in the Island's approach towards managing Covid-19, moving from a suppression strategy – which it had adopted since the beginning of the pandemic – towards 'active mitigation'. This approach aimed to negate the wider detrimental effects of restrictions on Islanders' health and wellbeing and restore their freedoms, whilst ensuring that the removal of restrictions was done safely and in combination with less intrusive public health measures such as regular testing.

A key aspect of this approach was the maintaining of robust test, trace, and isolate arrangements to limit and control Covid-19 infection. A new testing strategy was announced on 30 April. This covered four areas of testing (see Appendix A for more information):

1. Active Case Control to identify and isolate positive cases, stop clusters, and control outbreaks.
2. Safe Places to protect vulnerable and enclosed populations, preserving vital services (screening for people in frontline services and enclosed communities such as care homes).
3. Community Testing in people's workplaces to minimise disruption to businesses and livelihoods, and in education settings (both using Lateral Flow Testing)
4. Travel to safely manage the Island's borders.

At the end of May 2021, the Safer Travel Policy was revised to include lower testing and isolation requirements for those who could show that they were fully vaccinated (defined at the time as a complete primary course of an MHRA approved vaccine). The was followed in early June with the successful bulk mailout of secure paper certificates under the Covid Status Certification (CSC) Scheme, providing evidence for all islanders who had completed their primary vaccination course (two doses in Jersey). The CSC team, led jointly by Public Health and M&D officers, worked closely with External Affairs colleagues and the UK Foreign, Commonwealth and Development Office to ensure that these certificates would be accepted as evidence of vaccination internationally. Over the next two months the scope of the CSC scheme expanded to offer single dose letters, certification of doses administered elsewhere, and the production of QR codes for use in the French Pass Sanitaire system (launched on 14 August 2021).

Nevertheless, in the context of rising cases of the Delta variant in June and July, the move to Stage 7 was delayed from its original date on 14 June and throughout July. The decision was taken based on the prevalence of Covid-19 among young people who were largely unvaccinated. As such, the delay in proceeding to Stage 7 was intended to provide time for Islanders to receive their first and second doses of the vaccine, and to help reduce Covid-19 transmission in schools so that they could remain open until the end of the summer term. The move to Stage 7 took place on 26 August 2021.

3.3.2. Learning points

The gradual removal of restrictions through the Reconnection Roadmap was not a smooth process, and it was subject to competing pressures. From a public health perspective, it was imperative that restrictions were relaxed based on the epidemiological situation and the need to manage Covid-19 cases. The greater infectiousness of the Delta variant, for example, necessitated the postponement of moving to Stage 7 of the Roadmap until August 2021. Nevertheless, public health advice needed to be considered by CAM in the round, having regard for the broader social and economic harm of restrictions. Some of the decisions were not, however, necessarily consistent with what the stages agreed in the Roadmap, and there was a tendency to look at measures introduced in the UK/other jurisdictions despite different epidemiological situations.

The Vaccination Programme has been one of the successes of the GOJ's Covid-19 response, and it continues to afford Islanders protection from the virus. The roll out of the vaccine to more eligible groups during this period, however, made it more difficult to explain that vaccination progress did not

equate to full protection, and it still required adherence to non-pharmaceutical interventions, particularly as the vaccine was yet to be delivered to younger age groups.

Finally, the greater infectiousness of the Delta variant led to a significant increase in Covid-19 cases between June and August 2020. This created operational pressures as the coronavirus helpline and Contact Tracing did not have the capacity to deal with the increasing number of cases. The services responded as effectively as they could, but the pressure required Public Health to change policy to suit operational and political requirements, such as removing the policy for direct contacts to self-isolate, rather than adopt the optimal public health policy response based on the epidemiological situation.

3.4. Autumn/Winter 2021-2022: September 2021 – January 2022

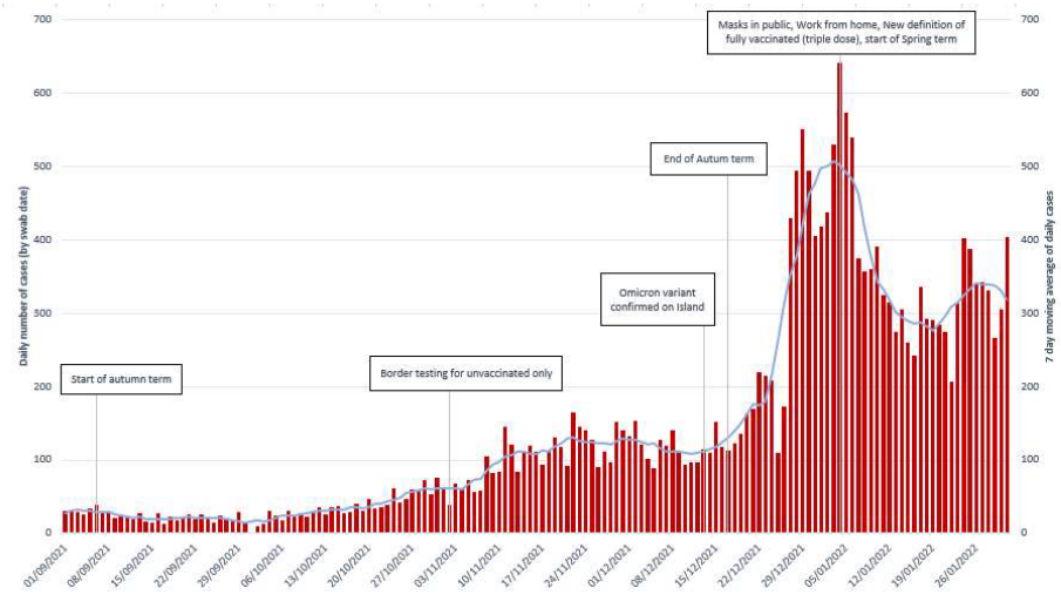


Figure 4: Covid-19 daily case numbers, 01 September 2021 – 31 January 2022

At the start of this period, cases were averaging about 30 per day, increasing to over 100 per day by mid-November. In total, 21.833 cases were identified between September 2021 and January 2022. The peak of cases was seen in early January, with 663 cases identified on 6 January. Surges in cases were linked to Christmas parties, with rates increasing throughout December in the 18-39 age group, as cases began to fall in the under 18s with the closure of schools for the Christmas Holidays. As cases started to decline in young adults, cases in children and those aged 40 and over began to climb with cases linked to Christmas and New Year gatherings – like the inter-generational mixing seen during the summer European Football Championships. Cases in hospital were present throughout this wave, with a peak of 30 being seen in January 2022, higher than the peaks in previous waves. Meanwhile, care home cases reached 50 over this wave. A total of 36 deaths were recorded as having occurred by the end of January 2022.

3.4.1. Account of key events and policy decisions

The public health policy response in autumn/winter 2021-2022 is set in the context of the continued delivery of the Vaccination Programme, and evidence of the effectiveness of the vaccine in reducing severe illness. Following the move to Stage 7 of the Reconnection Roadmap in August, the intention was to build on this progress and remove restrictions further as the Island learned to live with Covid.

The public health policy response focused on enabling day-to-day life and work to return to as near as normal as possible. The Covid-19 Winter Strategy 2021-2022 set out how the GOJ would manage Covid-19 over the autumn/winter period, as follows:

- Maximising the uptake of Covid vaccinations, including for younger people, and Islanders eligible for booster doses.
- Putting control of risk in the hands of Islanders by making Lateral Flow Tests available to everyone.
- Maintaining test, trace, and isolate capabilities.
- Making it easier for people to travel by removing the need for fully vaccinated passengers arriving in Jersey to test and isolate on arrival and implementing digital Covid Status Certification.
- Expansion of digital Covid Status Certification to provide QR codes for all first, second and booster vaccine doses, accepted throughout the EU DCC scheme[3] and anywhere with FCDO agreements.
- Preparing for rises in infection with resilience plans, particularly for health services and schools.
- Supporting those suffering with Long Covid with a pathway of advice and services.

The focus of the strategy on continuing the roll out of the Vaccination Programme reflected the high levels of protection afforded by the vaccine and its effectiveness in reducing the impact of Covid-19. CAM announced the extension of the vaccine to further eligible groups during the autumn based on guidance from the JCVI. The roll out focused on extending the booster programme to improve levels of immunity and increasing uptake of the vaccine among young people where coverage was lowest. This included, for example, offering the vaccine to students in secondary schools and colleges.

Maximising the uptake of the vaccine took on further importance in December with the emergence of the Omicron variant. Additional measures were introduced to increase vaccine uptake, including the reduction of the interval for Islanders to receive the booster vaccine (from six to three months) and administering a fourth booster dose to all severely immunosuppressed individuals.

The autumn/winter period also saw the rationalisation of testing arrangements, with the expanded deployment of Lateral Flow Testing. This included:

- The schools testing programme for secondary school students and education staff
- The home testing programme for Islanders aged 12 and over
- The continuation of the community testing programme for eligible businesses with specific public-facing activities.
- Direct contacts of a person identified as a positive case of Covid-19 were encouraged to take 10-days of Lateral Flow Tests.

The deployment of on demand, self-administered Lateral Flow Tests reflected the policy intention of allowing Islanders to take responsibility for their own testing needs and making risk-based decisions. At the same time, rapid on-demand PCR tests remained available for Islanders who were displaying symptoms of Covid-19.

The policy decision to adjust border testing arrangements under the Safer Travel Policy was made in response to changes in risk both on-island and internationally. The gradual step down of testing and isolation requirements for fully vaccinated and recently recovered travellers was based on knowledge of the virus and the protection afforded by vaccination or previous infection. The policy intent was to balance protection for Islanders, whilst supporting the Island's connectivity needs. The rationalisation of the Island's border arrangements was accompanied, however, by the ability to react quickly to changes in epidemiological risk, as happened when the Omicron variant of Covid-19 emerged at the end of November, when testing and isolation was reintroduced for all arrivals from outside the CTA, regardless of vaccination status or previous infection.

[3] EU Digital COVID Certificate Scheme

The epidemiological evidence in mid-October began to show a rise in the number of Covid-19 cases and in the rate of growth of cases, especially among young people. This led CAM to implement new measures on 5 November, following public health advice and based on consultation with STAC. The measures included requests for Islanders to:

- Get vaccinated against Covid-19 and flu as soon as possible.
- Know their Covid-19 status by increasing the frequency of Lateral Flow Testing.
- Wear a face mask in indoor public settings whenever it was practical.

This approach reflected Step 1 of the contingency measures in the Winter Strategy. At this step, the GOJ would introduce voluntary guidance and request that Islanders adopt self-mitigation behaviour, reflecting circumstances where there was a risk to business continuity, but the risk of hospitalisation was lower.

With the emergence of the Omicron variant of Covid-19 at the end of November, CAM introduced a series of temporary restrictions in response to the risk posed by the variant. The restrictions were:

- The requirement for passengers arriving in Jersey, who had travelled outside the Common Travel Area in the 10 days before their arrival, to perform a PCR test on arrival and isolate until receiving a negative result regardless of vaccination or recovery status (from 3 December).

- A mandatory requirement for Islanders to wear a face mask in specified public indoor spaces, and a strong recommendation for employees to work from home where practical (from 4 January).

The measures were based on evidence indicating that the Omicron variant was more transmissible than other strains of the virus. At the time, cases had been doubling every two to three days in the UK, which, if repeated in Jersey, would have led to a much higher peak than the Island experienced during Winter 2020-2021. The measures thus aimed to reduce transmission of the Omicron variant so that people could stay well and receive their booster vaccination.

By January 2022, scientific evidence was beginning to indicate that the Omicron variant, whilst being more transmissible, posed a significantly reduced risk of severe illness. The vaccination also afforded a high level of protection against the variant, and this was reflected in more manageable numbers of cases; a reduction in severe illness; and less disruption to public services. The evidence of the impact of the Omicron variant led CAM to announce the de-escalation of Covid-19 measures on 28 January. The measures included:

- The removal of mask legislation and working from guidance (1 February).
- All requirements under the Safer Travel Policy removed (7 February).
- Contact tracing in the community, businesses and schools ended (7 February).
- Mandatory isolation requirement for people who test positive removed and replaced with guidance (31 March)[4].
- All Covid-19 legislation reviewed, removed, or renewed as required.

Alongside the measures, Ministers published a Post-Emergency Covid-19 Strategy on 24 February. The strategy sets out a plan for how Jersey intends to live with and manage the virus as the public health emergency ends. The strategy focuses on investment in Covid-related recovery projects to begin tackling the harms caused by the pandemic. It also identifies the importance of responding quickly and proportionately, if necessary, should the virus evolve.

3.4.2. Learning points

[4] Following advice from Public Health and in consultation with STAC, CAM took the decision on 18 March 2022 to extend the mandatory isolation requirement by a further month, until the end of April 2022. https://www.gov.je/News/2022/Pages/IsolationRequirementExtended.aspx

The public health policy response in autumn/winter 2021-2022 was characterised by the balance between, on one hand, continuing to remove Covid-19 restrictions but recognising, on the other, that the pandemic was not over and there remained a high level of risk and unpredictability. The Winter Strategy attempted to balance these requirements. It aimed to build on and preserve the gains that had been made through the Vaccination Programme, and began to embed a transition from enforceable, restrictions towards a reliance on guidance and personal judgement. However, the strategy included contingency measures, which could be used if necessary to prevent greater harm to Islanders, health services, infrastructure, and businesses.

Nevertheless, from a Public Health perspective, it became challenging to implement measures set out and agreed in the strategy when Covid-19 cases began to increase during October. The Step 1 contingency measures outlined in the strategy, such as the recommendation to work from home, were, for example, not taken forward even though public health advice identified the need to act early and implement measures to reduce Covid-19 transmission and prevent disruption. It is vital that a range of factors/sources of advice are considered when determining whether to introduce restrictions. This ensures that decisions are proportionate and reflect the overall balance of risks. This led, however, to the deferment of decisions and an inconsistent approach when introducing measures – for example, where Step 2 contingency measures, including legal restrictions such as mask wearing, were implemented before voluntary measures such as advice to work from home.

4. Survey of STAC members

As part of the Public Health response, a survey of STAC members has been undertaken to reflect their contribution to the pandemic response and to assess the effectiveness of STAC. The survey findings are provided at Appendix B. The themes identified from the survey comments are:

<u>STAC formation, Terms of Reference, and role definition</u>

- There was consensus that the general purpose of STAC and terms of reference were well-defined and available.
- Some members questioned whether the scope of STAC was adequately defined. This included, for example, whether the purpose of the group was to look only at technical and scientific analysis or more broadly at economic and social considerations.
- More than one comment stated that the link between STAC advice and Ministerial decision making was not clear.

<u>Cross Discipline Challenge</u>

- In general, there was strong confidence from members in asserting opinion and challenging the views of others.
- One member indicated that a lack of diversity of the group impacted their individual comfort in challenging others.
- More than one member suggested that at times their individual views were dismissed.
- There were a number of responses expressing confidence in the chair.

<u>Meeting Preparation</u>

- There were a number of responses that more time needed to be allocated to preparation and analysis of materials.
- Most members dedicated considerable time outside normal working hours to STAC in addition to heavy normal workloads in pandemic response roles.
- There was strong consensus about the need for future training or mentoring to support members of STAC.

Scientific and technical expertise diversity of membership

- A member indicated that GoJ employees were overrepresented in the membership.
- One comment suggested the membership was overly weighted towards medical/clinical expertise.
- A member felt that some attendees/contributors (not members) lacked the technical credentials for STAC and simply provided subjective opinion.

Diversity in general

- There was general consensus from those who commented that STAC was not representative of the local community in terms of age, ethnicity, socio-economic status, or gender.

Focus of STAC

- There was general agreement that STAC was focused on the correct topics/considerations.
- More than one member highlighted that there was a lack of focus on the economic impacts of the pandemic with another member reflecting that economic considerations lacked area specific data or analysis.

General Points

- A number of members commented that changes in membership over the course of the pandemic affected the dynamic of group – in most cases positively.
- One member suggested that the group may have been improved by members being tasked with specific work or research rather than being provided with analysis and data.
- More than one comment indicated that the STAC focus was reactive rather than looking ahead and planning strategically.
- One member commented that STAC may have benefitted from access to specific case data rather than being provided high level population level information.
- One member indicated that, at specific points during the pandemic, STAC had been provided with inadequate or incorrect analysis resulting in poor decision making.

Future Improvements

- There was strong consensus as to the need for training for members.
- More than one member suggested the production of pre-approved and agreed terms of reference and role definitions.
- One member suggested the use of off-island experts when no suitably qualified local members were available.
- One comment suggested tapping into non-Government on-island expertise rather than relying on Government employees.

The survey findings and comments will be used to inform decisions about the future operation of a scientific committee, or equivalent, in a pandemic or any comparable disruptive event.

5. Legislation

5.1. Brief account of issues considered in the initial phase of the handling of the pandemic, February and March 2020.

By February 2020, the GOJ was exploring potential steps that could be taken under existing legislation in anticipation that people with Covid-19 might arrive in Jersey in the following weeks. Discussions at this stage involved the Joint CI Emergency Planning Officer, officers from Health and Justice and Home Affairs Departments and the Law Officers' Department.

A Strategic Co-ordination Group had been established to plan the response to screening and treating people who are suspected of having Covid-19. The SCG recognised that the most important thing at that point was for HCS to plan their approach to screening and treating patients who might have the Covid-19. It was anticipated that there would be less emphasis at that point on compulsorily detaining people, and more on encouraging people to come forward, seek treatment and self-isolate.

The strategy planned by HCS was, in summary, to isolate and screen possible cases, including screening people arriving in Jersey and in the community, and keep confirmed cases in isolation. Operational guidelines describing the system to be followed were being developed.

By 14 February, the GOJ had received the UK Health Protection (Coronavirus) Regulations 2020, which included a very extensive set of powers to impose restrictions in individuals, including powers to compulsorily screen, isolate and impose other restrictions on individuals where the Secretary of State or a registered public health consultant have reasonable grounds to suspect that an individual is, or may be, contaminated with the Coronavirus. Consideration was given to the extent to which Jersey already had similar powers. The powers available at that time could be summarised as follows.

Travellers

In relation to persons travelling to or from Jersey (whether or not they are resident in Jersey), Jersey had the Public Health (Vessels and Aircraft)(Jersey) Law 1950 (the "**1950 Law**"), which contains Order making powers so that the Minister for Health and Social Services may make provision to manage public health risks arising from travel to and from Jersey.

In exercise of the powers in the 1950 Law, provision had already been made about the carrying out of checks and imposition of controls on incoming passengers on planes or ships to prevent the spread of infectious diseases. The Public Health (Aircraft) (Jersey) Order 1971 and the Public Health (Ships) (Jersey) Order 1971 contained similar provisions to one another. In relation to an aircraft or ship, amongst other things, the Medical Officer of Health or a qualified medical practitioner acting under his or her instructions could:

a) at the request of the commander of the plane or master of the ship, examine and detain any person on board; and

b) cause any person leaving a plane or ship who the medical officer suspects to be suffering from an infectious disease to be isolated or sent to hospital, or sent to some other suitable place.

These powers were backed with criminal offences for non-compliance.

In the community

In relation to cases of coronavirus in the community, the only compulsory powers to confine a person or examine them, were found in the *Loi 1934 sur la Santé Publique* (the "**1934 Law"**) (A translation of the 1934 Law can be found here). The principal relevant powers and restrictions in the 1934 Law are found in Articles 13, 16 to 19 and 21 of the 1934 Law.

It was noted that it may be appropriate to amend the Notifiable Diseases (Jersey) Order 1988 (the "**1988 Order**"). Where a disease is prescribed in the 1988 Order, this triggers the application of Article 23 of the 1934 Law, which obliges any doctor who attends on a person with a notifiable disease, or any person who has the care of or the nursing of a person with such a disease, to notify the Medical Officer for Health. Article 23 also placed a restriction on moving a person with such a disease from their home without the permission of the Medical Officer for Health. Breach of these requirements was and remains a criminal offence.

It was noted that if it was necessary to supplement these powers, then there was some ability to do so by Order in the 1950 Law and by Regulations under the 1934 Law (see Article 30), or also by triennial Regulations, or by invoking the order making powers in the Emergency Planning (Jersey) Law 1990. However, it was noted that the powers of individual Ministers as 'competent authorities' under the 1990 Law were limited to addressing risks to the delivery of certain essential services and that the more extensive Order making powers provided to the Emergencies Council could only be used in the event of a declaration of a state of emergency by the Lieutenant Governor.

As policies developed, it became clear that there were gaps in the existing powers compared with those being taken in the UK. For example, the 1971 Orders were limited in respect of the diseases covered and did not necessarily permit the detention of a person on arrival in Jersey who had been exposed to coronavirus, but who had no symptoms. Also, in relation to people in the community, the provisions of the 1934 Law did not provide equivalent powers to those in place or being taken in the UK to impose screening requirements and other restrictions on a person's conduct in the community, with a view to detecting cases of Covid-19 and reducing the risk of the virus being spread. This was not surprising as the 1934 Law had been designed to address the implications of cholera epidemics which occurred in Jersey in the early part of the twentieth century and had not been substantially reviewed or amended subsequently.

In view of the centrality of the role of the Medical Officer of Health in the operation of the 1937 Law, and the then Medical Officer for Health being away from the office for an extended period, it was considered that it might be best to appoint both Dr I. Muscat and Dr J. McInerney, then the Deputy Medical Officers of Health, each as the Medical Officer of Health. Fresh appointments were also made to appoint a number of Health Inspectors to assist the Medical Officer for the purposes of the 1934 Law at the same time, this included members of the Jersey Ambulance Service. For the purposes of the 1934 Law, it was also considered appropriate to designate the General Hospital as place to which a person may be taken for treatment pursuant to the powers in the 1934 Law. It was also proposed that the Notifiable Diseases (Jersey) Order 1988 should be updated to include coronavirus.

A decision was made at this stage to begin developing the policy around powers to require people to submit to compulsory screening and isolation and to restrict travel. It was recognised that there were powers in Article 30 of the 1934 Law and by triennial regulations to put such provision in place, but these powers had limits that would restrict their utility. It was acknowledged that it might be necessary to bring forward a new Law to support the on-going response to the pandemic.

By 24 February, the Minister for Health and Social Services had been briefed and had agreed to make the appointments and designations under the 1934 Law mentioned above. This included updating the Notifiable Diseases Order to include Covid-19. Political agreement was also given to develop policy in respect of screening and isolation regulations. It was also acknowledged that it was important that additional policy officer resource was assigned to working on these matters.

In the period up to the first Emergency Council meeting on March 12, it was recognised that the UK's measures in relation to Covid-19 were designed not just to contain Covid-19, but also to prepare to respond to an epidemic, including by enabling normal transactions and public services to be delivered remotely. Officers and Law Officers spoke with officials in the UK Government to discuss the strategies that they were pursuing in support of their projected "delay, contain and manage" phases for Covid-19. These discussions covered measures focussed on the following themes:

1. Enhanced capacity and flexibility in deploying staff such as: emergency registration of health care staff.
2. Easing legislative and regulation to enable schools, hospitals, and the justice system to continue to operate.
3. Introducing via legislation schemes that allowed key industries to continue to operate such as the constructive industry and provided for the closure or restriction of non-essential work or economic activities.

4. Measures to contain spread and flatten such as: social distancing - school closures – quarantine
5. Support measures such as the provision of sick pay – contract tracing and gathering information to support decision making

Jersey progressed the development of policy and legislation reflecting similar themes before and after 12 March. The Covid-19 (Screening, Assessment and Isolation) Regulations 2020 were designed and passed by the Assembly to provide new powers, subject to appropriate safeguards, to screen people arriving in Jersey and in the community and to require people to isolate where there were grounds to consider they may be infectious. The Covid-19 (Enabling Provisions) (Jersey) Law 2020 was developed and passed by the Assembly at the same time, which enabled the Assembly to legislate on a range of other implications of the pandemic through subsequent regulations and orders without the need for the legislation to receive sanction by the Privy Council.

5.2. Learning points

The GOJ has had to make decisions at pace throughout the Covid-19 pandemic. This is evident with the continuous development, renewal and passing of legislation since March 2020 in support of the relevant pandemic strategy. The legislation that has been passed is included at Appendix C.

The focus of legislation has changed as the pandemic has evolved. Depending on the epidemiological situation and the level of the public health risks faced, legislative provisions have been amended, re-enacted, and repealed over the period.

A significant amount of legislation has been passed during the pandemic (147 items, with two items due for debate on 29 March 2022), especially when Covid-19 related legislation was first introduced in March 2020. Officers from the Legislative Drafting Office, Law Officers' Department and Strategic, Planning and Performance have worked intensively and with commitment throughout the pandemic to translate policy into legislation and support the legislative process through the States Assembly. It is, however, important to reflect upon the pace and manner by which legislation was developed and passed, and the effectiveness and implications of this approach. The main issues identified are:

Adequacy of existing legislation	The pandemic has highlighted weaknesses in the legal framework for dealing with public health emergencies. The main public health legislation available at the beginning of the pandemic – Loi (1934) sur la Santé Publique – was outdated, written close to 90 years ago in French – and did not provide the powers or oversight necessary to respond effectively to modern public health emergencies. In the absence of an appropriate legal framework, numerous standalone pieces of legislation were developed at pace to mitigate the impact of the pandemic on Islanders. The 1971 Orders for ships and aircraft were also mainly limited to the diseases in the World Health Organization International Health Regulations from 1969 1973. The powers mentioned previously – the power to examine or detain a person on board – are the few that apply to infectious diseases generally instead of the WHO list. This raises various questions about the adequacy of the legislative response, not least whether the laws introduced at the time were effective in underpinning Covid-19 measures; the extent to which the new legislation provided a sufficient suite of powers to manage the pandemic; and whether there were gaps in the legislation.

Opportunity for review by Ministers, Scrutiny, and the States Assembly	The potential risks associated with the pandemic and the urgency of the public health response meant that a large number of Laws and Regulations needed be debated and passed by the Assembly in a short period of time. Therefore, detailed scrutiny of legislation was not practical, and it was also not possible to observe standard parliamentary process (e.g., lodging periods with associated time for amendments). However, scrutiny – by Ministers, Scrutiny and the States Assembly – is an important feature of the democratic process. The ability for politicians to properly review legislation provides it with legitimacy, especially in an emergency where extensive powers are introduced imposing controls on people's freedoms. It can also improve the quality and effectiveness of legislation by giving stakeholders the opportunity to identify problems, review the scope and nature of powers, and the potential human rights implications, and amend the legislation where necessary. Officers have been mindful throughout the pandemic of the need to ensure that politicians have a meaningful opportunity to review legislation, which was vital when seeking to introduce restrictions on people's civil liberties, but which had to be balanced against the urgency of introducing legislation in a public health emergency and the size and scale of the task to bring forward the legislation.
Enforceability of legislation	The Covid-19 legislation, in most instances, included enforcement powers such as the requirement to desist from an action that was in breach of a public health restriction with associated offences and penalties (such as a fine or imprisonment). The introduction of these enforcement powers reflected a genuine need to ensure compliance with public health measures given the risk of Covid-19 infection. However, it is questionable whether all legal restrictions were enforceable from a practical policing perspective (e.g., the difficulties associated with enforcing social distancing) and, where there were breaches, the extent to which proscecutory action could be taken. Furthermore, some consideration was given to whether certain restrictions might have been enforced by the police issuing fixed penalty notices, as opposed to gathering evidence before a prosecution is initiated in a more conventional way. The issuing and subsequent enforcement of fixed penalty notices might, in some cases, have been viewed as a proportionate means of enforcement, particularly for less serious breaches of Covid-19 restrictions. However, fixed penalties are not a mechanism which is frequently used in Jersey and there were some understandable reservations with extending their use to new contexts. It may be that the enforceability of legislation was a moot issue if the introduction of legal restrictions drove compliance, i.e., people complied because they did not wish to break the law, and they responded well to the clarity of a legal approach, even though the law was difficult to enforce.

	It would be helpful to understand whether similarly high levels of compliance with restrictions could have been met using guidance rather than law for any future pandemic or comparable disruptive event. Or whether legal restrictions were required to deal sections of the public who would, otherwise, has chosen not to comply with guidance.
Relationship between legislation and guidance	The GOJ has not solely used legislation but also guidance to direct public behaviour during the pandemic. Guidance has been used for different purposes. Guidance has been used to: (a) Provide the public with information to adopt behaviours and practices to mitigate the risk of Covid-19 transmission – e.g., good hygiene practice. (b) Provide information on how to comply with legal measures – e.g., if you are a business, these are the distances you should use to separate tables, which must be of X specification. (c) Advise people what to do when something was not in law – e.g., wearing a face mask. Moreover, not all the matters that could reasonably be established in public health guidance could be legislated for properly. This was because voluntary approaches were preferable in some instances based on the level of public health risk – that is, to make voluntary requests of the public to adopt or change their behaviour. Some of the public health measures would also be difficult to enforce, and it would not have been practical or proportionate for enforcement officers to stop a person from behaving in a particular way. Furthermore, throughout the pandemic, when taking the decision whether to adopt a legislative approach, there has been a need to consider whether the same level of compliance could be achieved by publishing guidance. For example, before the legal requirement to wear a face mask in public indoor settings was mandated, it was introduced as guidance but levels of adherence were inconsistent. It would be helpful to understand whether guidance worked in all circumstances, and the risks of expressing guidance as mandatory when it might not have had legislative backing.
Gap between legislation and practice	The rapid pace of developing and implementing legislation created the risk that the powers and processes followed by officers could be misinterpreted, overlooked, or contradicted in practice. Whilst there was a good working relationship between officers at a policy and operational level, and frequent communication on policy and legislative issues, the standing up of new teams (such as Track and Trace) quickly in an emergency situation suggests that it is possible that tools and powers may have been interpreted in ways in which it was not initially intended, or in ways that were outside the scope of the legislation. Moreover, given the significant number of cases at times, operational teams were placed under significant pressure and were required to prioritise work. Some processes provided for under law might not have been followed as a result – for example, the requirement to keep under review instructions to isolate when imposed.

Review of legislation	As a result of the limited time that Ministers, the States Assembly and Scrutiny had to review Covid-19 legislation at the beginning of the pandemic, expiry provisions in legislation have been provided an important way to review legislation and ensure that it remains necessary, proportionate and effective as the context of pandemic evolved. The Covid-19 (Enabling Provisions) (Jersey) Law 2020 has, for example, been extended twice since commencing in April 2020, and various pieces of subordinate legislation have been amended, repealed or extended since March 2020 to support the pandemic response, e.g. the Covid-19 (Amendments – Extension, Suspension and Repeal) Regulations 2020; and the Covid-19 (Amendments – Extensions to September 2022) Regulations. These restrictive timeframes were important for ensuring proper democratic oversight and accountability for emergency legislation, but it was a resource intensive task. It raises the question whether the systems and processes were in place to review and amend the legislation, and whether there was a commitment from Ministers and stakeholders to review legislation at such regular timeframes. The Covid-19 Workplace Restrictions Order, for example, required the Minister for Health and Social Services to approve an extension of the requirements each month – to enable contact tracing; mask wearing; Covid Safe Team powers. In reviewing the legislation, it is valuable to consider whether the sign-off process became routine and if it was subject to appropriate scrutiny or challenge. To overcome this concern, most legislation included a provision to ensure that any legislation was proportionate and necessary to the level of public health risk. For example, before making a Ministerial Order, the Minister for Health and Social Services was required to consult with the Medical Officer of Health, and other Ministers, to ensure they were satisfied that the risk to public health caused by Covid-19 has reached the level at which it was proportionate and necessary to make the Order.

The pandemic has highlighted significant gaps in Jersey's legislative powers for responding to major public health risks and emergencies. The legislation available at the beginning the pandemic (the Loi (1934) sur la Santé Publique) provided limited powers to manage and control Covid-19 infection. In the absence of an appropriate legislative framework, numerous pieces of legislation were developed at pace, which raises questions regarding the adequacy of the process by which Covid-19 policy was translated into legislation, and the risks associated with that; the arrangements for Ministers and the States Assembly to consider that legislation; and the robustness and enforceability of the legislation. This is not a preferred approach to the management of public health emergencies.

To this end, the development of a new Public Health Law and Civil Contingencies Law[3] provides an opportunity to incorporate learning from Covid-19. The draft laws will be developed in 2020/2023. If approved, the laws will:

- Introduce a legal requirement for the relevant Minister/s or the Director of Public Health to develop and maintain preparedness plans for public health emergencies.
- Provide a broad range of powers for use in response to public emergency situations.
- Establish an appropriate threshold and clear accountability for use of those powers.
- Provide appropriate safeguards to protect people who are subject to those powers.

Ministers and officials will work together to ensure that the new legislation addresses the challenges experienced whilst legislating for the Covid-19 pandemic response and improve Jersey's preparedness for future public health emergencies.

Alongside the bespoke Covid-19 legislation that has been introduced during the pandemic, it is also important to highlight the measures introduced to facilitate the provision of essential services. This encompasses legislation to mitigate indirect impacts of public health measures, including provision to:

- allow wills to be signed/witnessed via audio or video link rather than face-to-face so that people can continue to manage their personal affairs;
- enable care services to operate with reduced staff due to Covid-19 under the regulatory oversight of the Jersey Care Commission;
- allow the Courts to operate remotely;
- support efficient civil administration procedures such as the registration of births, marriages, and deaths.

These items of legislation have helped to mitigate potential risks to services and enable appropriate contingencies to be put in place and reduce disruption. Notwithstanding the operational challenges that these services have faced, the legislation has facilitated, as far as practical, services to function as close to normal as possible. For example, in comparison to the UK, Jersey has managed to avoid having a large backlog of cases in its criminal or civil courts, in large part because arrangements for courts to hear cases remotely were quickly made in a number of cases.

6. Governance and decision-making

The GOJ has mobilised an extensive response to the Covid-19 pandemic and moved forward fast to deliver this. Figure 5 illustrates the range of governance and decision-making structures involved in the public health response. The diagram below is simplified, but it sets out the core processes from evidence through to action that were in place for most of the pandemic.

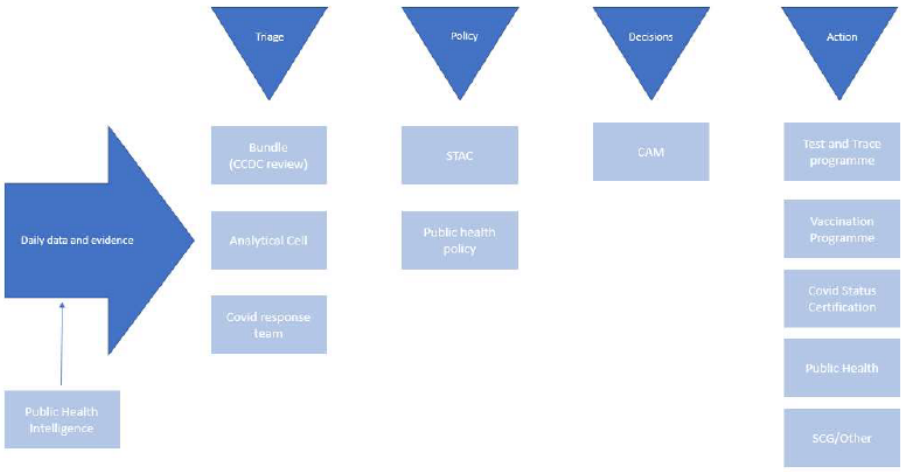


Figure 5: Government of Jersey Covid-19 governance and decision-making arrangements

- In the first stage of the process, Public Health Intelligence data and evidence was rationalised using triage. There was a regular review of data and evidence through the Analytical Cell, the Covid response team, and Bundle, a process through which evidence and policy options were discussed with the Medical Officer of Health. These early processes were instrumental in the public health response because they allowed officers to come together, direct resources and consider action, and communicate data to relevant senior officers based on the pandemic situation.

- In the second stage, Public Health developed policy options and proposals based on the data and evidence, and the outcomes of the triage process. STAC also provided advice to ensure that policy decisions were informed by health, scientific and technical advice, combined with STAC members' own experience and judgement.

- In the third stage, policy proposals and recommendations were provided to Competent Authority Ministers for review and decision. Significant matters discussed by CAM were also considered by the Council of Ministers, in line with the Ministerial Code.

- At the final stage, decisions were implemented through a variety of operational mechanisms such as through legislation, guidance, communications, and operational bodies such as the Testing and Tracing and the Vaccination Programme.

A strength of the governance and decision-making arrangements throughout the pandemic has been the ability to bring together an accessible and wide-ranging network of officials from across the GOJ. This enabled policy to be developed and approved quickly, and for decisions implemented in a short period of time. It was also possible to bring stakeholders such as Ports of Jersey and Visit Jersey into discussions quickly for advice and to understand the operational impacts of proposals and decisions. However, from a public health perspective, the challenge with this approach was that, from time-to-time, these interests became too close to decision-making. This led to concerns that decisions might not have always been based on the public health evidence and data presented, but on the interests and objectives of particular groups where there were less rigorous sources of data and information.

Whilst Competent Authority Ministers was established under the Emergency Powers and Planning (Jersey) Law 1990, those Ministers can only act in their areas of competency. Outside of their areas of competency, Ministers act in their ministerial capacity, not as a competent authority. CAM could not, therefore, make collective decisions because their statutory powers were individual and narrow – for example, powers to make Orders or propose Regulation pursuant to the Covid-19 legislation. The CAM process provided the opportunity for timely consideration of data, and of evidence and policy options, which supported individual Ministers to make decisions. The difficulty is that CAM was not a decision-making body, and Ministers, particularly the Minister for Health and Social Services, were responsible for making decisions. In practice, these lines of responsibility were blurred at times, with CAM treated as if it could decide policy and direct other Ministers to implement decisions – such as to make certain Orders. This had the potential to lead to disagreement and delay in decisions and actions. There were few instances of such disagreement and, whilst this governance arrangement was not ideal, it had the effect of achieving consensus and moderating Jersey's strategy.

A learning point is, therefore, to understand the effectiveness of CAM as a structure for coordinating the public health response to the pandemic, and in supporting fast and streamlined decision-making. It is also important to determine whether the adaptation of executive structures in this way provided robust governance and oversight arrangements for coordinating the response. This includes how CAM interacted with other legal decision-making bodies such as Council of Ministers and the Emergencies Council; how CAM supplemented these bodies and how its respective role was different to them. The new Civil Contingencies Law will make some improvements in this area.

Regular meetings have also been held between the Minister for Health and Social Services and Public Health throughout the pandemic. There has been a weekly meeting with the Minister where matters concerning all aspects of the Covid-19 public health response have been discussed. In addition, there have briefings each month jointly with the Health and Social Security Scrutiny Panel and the Scrutiny Liaison Committee, and briefings held with all States Members on major policy announcements. The opportunity for regular dialogue between Public Health and politicians has supported openness and transparency in the public health response to the pandemic; ensured political oversight of decisions and actions; and helped to inform policy development.

Moreover, throughout the pandemic, STAC has provided a forum for discussion on issues relating to the pandemic and has provided timely scientific and technical advice to Public Health and Ministers, which has helped to inform decisions. STAC was instrumental in the cross-government response to the pandemic, but it appeared that it did not always act as an objective reviewer of science. Instead, there were occasions when non-members attended, and advice was based on opinion/non-scientific judgment. There have been efforts to reorientate STAC towards an evidence-based committee and a code of practice has been introduced. However, the future operation of a scientific committee during a pandemic or comparable disruptive event should have a stricter role, and there should be effort to ensure that the advice provided to decision-makers is made on the best available health, scientific and technical advice.

For future emergencies, paid expertise from outside Jersey should be considered in the membership. In practice, the introduction of a behavioural scientist as an attendee (not as a member) of STAC was progress in this direction, but reliance on local expertise under most circumstances is not likely to be sufficient.

In the early stages of the pandemic, decisions were made through the Strategic Coordination Group and Tactical Coordination Group. One of the issues to this approach was that these group functions were modelled on emergency responses aligned to short-lived emergencies as opposed to a pandemic situation. The initial response included a cross-section of departments focusing on emergency service preparation. Only the Medical Officer of Health was represented in these groups from a public health perspective. There was limited public health engagement in early stages of planning for the pandemic, which would have been important to prevent the spread of infection. Public Health was only engaged in late February 2020 to support the development of legislation to mirror preparations across the UK and other jurisdictions. This quickly escalated to drawing on wider policy capability to support public health functions and decision-making.

Whilst the role of Public Health within the Strategic Coordination Group was not understood during the early stage of the pandemic, it was better articulated as the pandemic evolved, as the Strategic Coordination Group took responsibility for the management and resilience of critical Island services. Nonetheless, it underlines the need for a stronger health protection function within Public Health and the GOJ, and a clear understanding of its role and responsibilities in an emergency, including activities to protect the population from infectious disease outbreaks. A review of Jersey's health protection function is underway, which will support the development of a health protection capability. This will include revisions to infectious disease surveillance and notification processes; the development of a governance framework; and putting in place appropriate knowledge and skills.

7. Public health impact

Public Health Intelligence has produced a range of data on the direct and indirect impacts of the Covid-19 in Jersey. The following data is provided in this section of the submission:

- Direct impacts of Covid-19 on the population

- levels of infection
- reinfections
- hospitalisations
- care homes
- long Covid

- Indirect impacts of Covid-19 on the population

- mental health
- Jersey Opinion and Lifestyle Survey (JOLS) 2020 data
- GP consultations and prescriptions data

- Routine vaccine programmes
- Learning loss
- Economy – loss of work and earnings
- Reported domestic crime
- Inequalities

7.1 Direct impacts of Covid-19 on the population of Jersey

Indicator	Wave 1 Before 1st Sept 2020	Wave 2 1st Sept 2020 to 31st Mar 2021	Wave 3 1st Apr 2021 to 31st Aug 2021	Wave 4 1st Sept 2021 to 31 Jan 2022*	*Total to end January 2022*
Number of cases	373	2,854	6,111	21,833	*31,171*
- Under 18 years	11	365	1,599	6,274	*8.249*
- 18-39 years	108	971	2,378	6,786	*10,243*
- 40-59 years	135	988	1,613	6,419	*9,155*
- 60+ years	119	530	521	2,354	*3,524*
Number of re-infections	<5	<5	41	986	
Total Cases per 100,000 population	296	2,702	6,314	19,603	
Peak number of Active Cases in Hospital	23	33	21	30	
*Peak number of Active Cases in Care Home Residents***	N/A	79	13	50	
Total deaths where COVID recorded on death certificate	32	37	9	36	

Table 1: Summary table for key metrics across

**Note wave 4 continuing, but for the purposes of this submission, data is up to end of January 2022.*
*** Care Home data available from 1st July 2020.*

Figure 6 (below) summarises the four waves of Covid-19 infection in Jersey since March 2020 (in blue). Key mitigations and milestones during the pandemic are shown in black; and the roll out of vaccines is shown in green. Covid-19 related deaths are indicated in red. They show that despite cases having been much greater in the current fourth wave of infection compared to the second wave last winter, fatal outcomes are much less likely in the most recent wave.

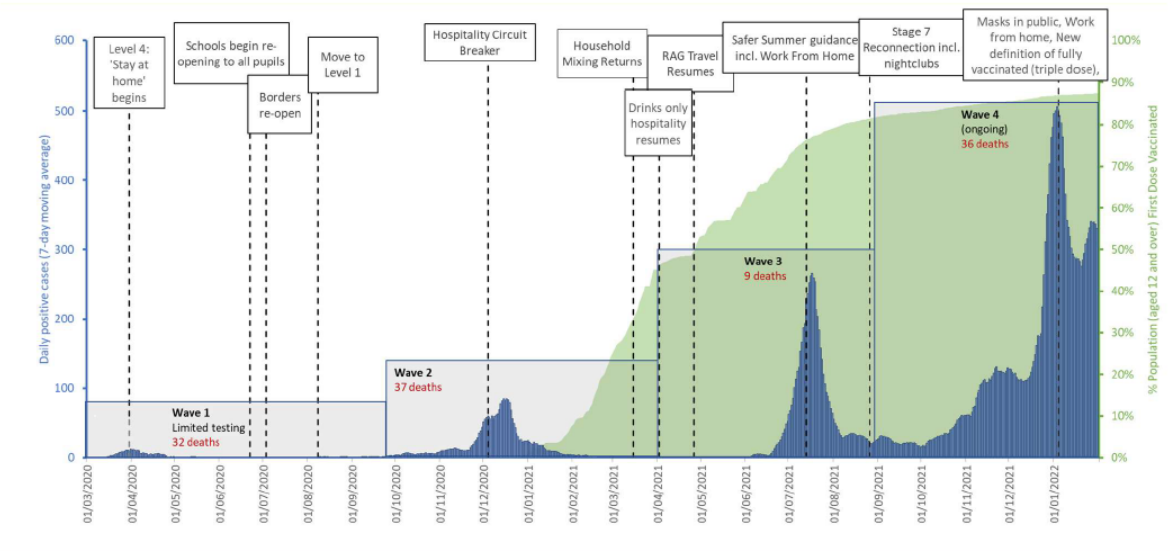


Figure 6: Summary of waves and key mitigations and milestones

7.2.1. Levels of infection

Jersey has seen four distinct waves of infection since the start of the coronavirus pandemic, driven by different variants and with increasing numbers of people being infected each time.

The case numbers in the first wave are known to be a significant underestimate of the level infection in the Island at that time due to the limited testing capability. Three rounds of household antibody surveys[5] were conducted in the summer of 2020, estimating that some 3,300 islanders were likely to have been infected by May 2020, rising to 4,300 cases by late June. This means that case numbers represented roughly one-tenth of the true level of infection in the Island during the first wave. An essential workers antibody survey[6] was also conducted in May and June, but the self-selected survey design meant that results were not statistically representative of the different sectors but showed that of those tested between 3-4% returned a positive result.

The PCR testing offer increased over the course of 2020, with inbound travel tests available from July 2020 and in November 2020, with the roll out of PCR workforce screening and a greater number of tests being conducted for the purposes of contact tracing. As such, it is likely that the case numbers for Jersey represent around one-third to half of the true level of infection on the Island. However, as no further antibody surveys were conducted, it is not possible to give a precise figure. The testing rate per 100,000 was significantly higher than that in the UK and other jurisdictions at that time.

Age groups

During the first wave of infection in Spring 2020, as testing was limited, it was difficult to assess the age group spread of true infection on-Island. Testing was targeted to those who were suffering with symptoms or severely ill, who are more likely to be elderly.

In the second wave during winter 2020-21 case rates rose across all age groups reaching a 7-Day case rate peak of between 400 and 650 cases per 100,000 population.

During early 2021, vaccination began to be rolled out, and by early summer very high coverage had been achieved amongst adults aged 40 years and above. Vaccine immunity is likely to have contributed

[5] Statistics Jersey, Reports for May, June and July 2020
[6] Public Health Intelligence, report for June 2020

to older age groups experiencing lower case rates than younger adults and children during the third wave in summer 2022.

In October 2021, the fourth wave of infection began in the Island, primarily in children and those aged between 40 and 59 years (an age group that many parents fall into) in the first instance. As the highly transmissible Omicron variant displaced the Delta variant in December 2021, a shift in the age mix of cases was seen, with rocketing infection rates in young adults (aged 18-39 years), reaching a peak of over 5,500 per 100,000 population. Case rate rises followed amongst older adults, but again, vaccine coverage amongst older people is likely to have helped keep case rates lower. Case rates for children aged under 18 reached a peak early in the Spring 2022 school term, at around 5,200 per 100,000 population.

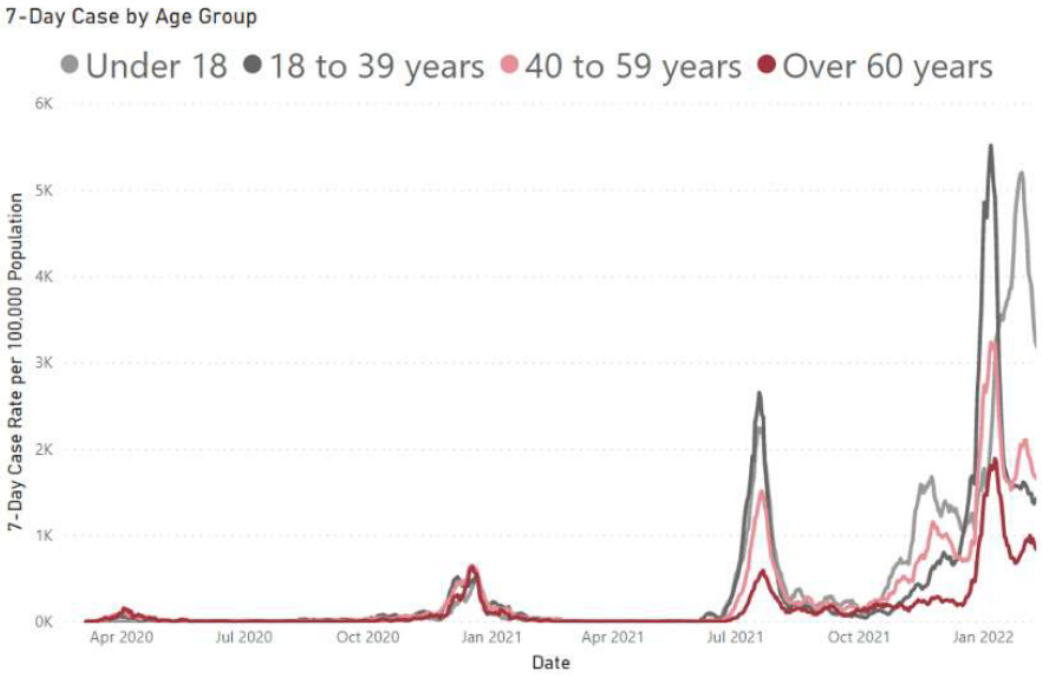


Figure 7: 7-day case notification rate per 100,000 population by age group

Comparison of 14-day case notification rates to other jurisdictions

Figure 8 compares 14-day case rate for Jersey with that for the devolved nations of the UK. Whilst it is helpful to compare population normalised case rates across the jurisdictions, it is important to remember that there were differences in testing regime between them, sometimes substantial. For example, extensive border testing through much of 2020 and 2021 meant per capita PCR testing rates were often higher in Jersey.

As mentioned, case detection in the first wave was minimal in Jersey and across the devolved nations. In Autumn 2020, case rates began to rise across the UK, as the more transmissible Alpha variant rose to dominance. Jersey maintained very low case numbers until winter, when case rates in Jersey then rose to peak in late December at a 14-Day case rate of around 950 cases per 100,000 population. Cases began rapidly declining in Jersey several weeks before the devolved nations saw corresponding drops, with England reaching a peak case rate of 1,250 in the second week of January.

The Delta variant, much more transmissible than previous strains, began its climb to dominance in the UK during June 2021. Jersey case rates began to rise soon after and reached a peak in 14-Day case rate of 2,900 per 100,000 populations during July 2021. This peak was almost three times greater than

corresponding rates in the devolved nations, although it should be noted that rates across the UK are averaged across many different towns and cities, each with slightly differently timed waves. Some localities in the UK at this time had comparable rates to Jersey, but this was balanced by other localities reporting lower case rates. Through much of Autumn 2021 Jersey maintained lower case rates than the devolved nations. The arrival of the Omicron variant in winter 2021 sent case rates increasing to their highest levels to date across Jersey and all the devolved nations.

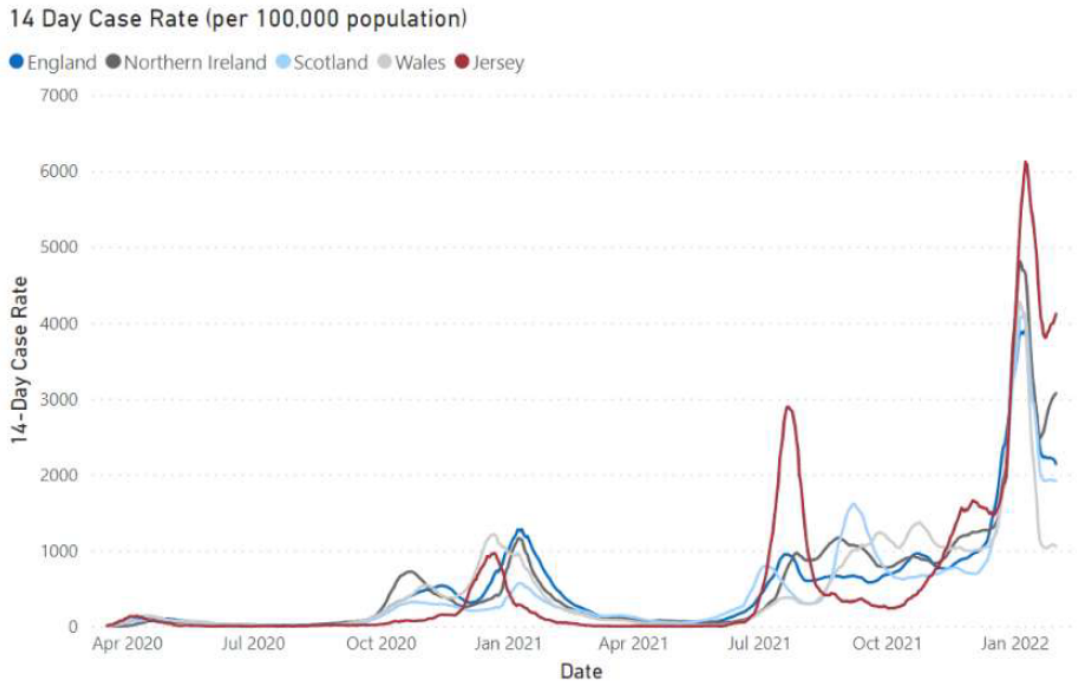


Figure 8: 14-day case notification rate per 100,000 population for the devolved nations of the UK and Jersey

7.2.2. Reinfections

Not all cases identified by PCR test have been sequenced locally, and the PCR test used by the hospital lab did not allow for monitoring of the S-gene drop-out used by the UK and other jurisdictions to distinguish between variants. However, a small number of tests were sent to Public Health England/UK Health Security Agency and a private lab for sequencing. As such, Alpha, Delta and Omicron have all been confirmed in Jersey in line with the emergence of these variants in the UK (with whom most of our travel is via).

As reported by the UKHSA[7], the Omicron variant has a greater level of immune escape and the levels of reinfections in Jersey have risen since the variant arrived on Island (Figure 9).

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1060337/Technical-Briefing-38-11March2022.pdf

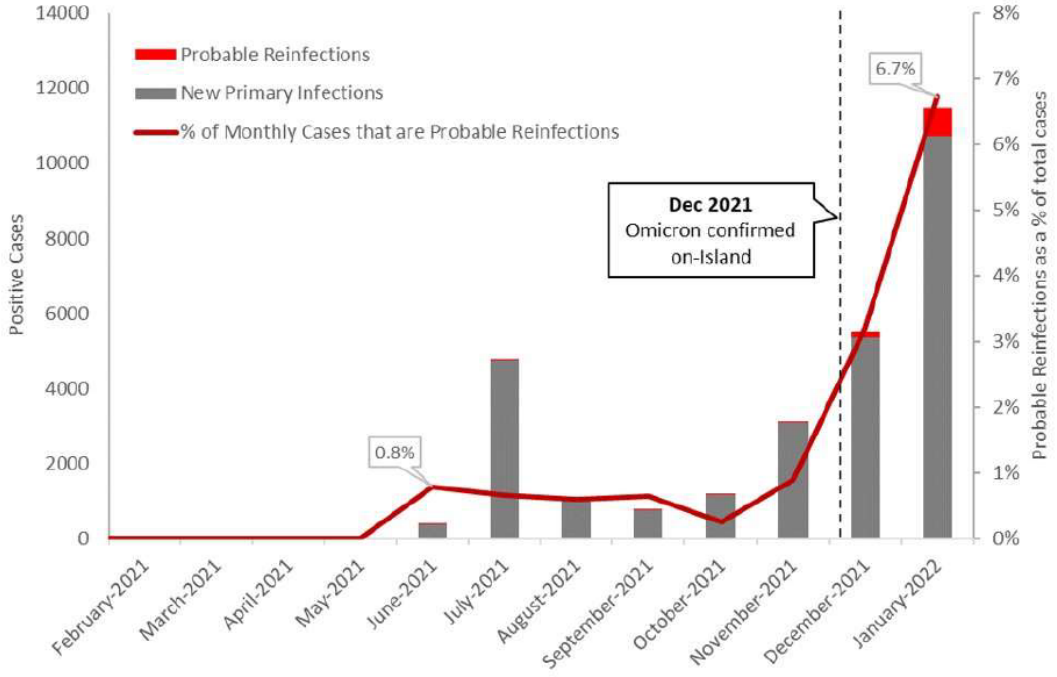


Figure 9: Probable reinfections

The numbers of reinfections in 2020 were small (less than 5) but became more common in 2021. Just under 1% of cases were reinfection during summer 2021 and this rose to 6.7% in January 2022, when the Omicron variant was well-established as the dominant variant on-island.

7.2.3. Hospitalisations

Quantifying the burden of the disease on the Island has presented a challenge, with the most reliable metric of the severity being hospitalisations. Recognised as a lag indicator, as in other jurisdictions, hospitalisations begin to rise some 10- or more days after cases begin to rise and present the most severe cases. The true burden of severe illness caused by the virus on the Island, where individuals did not require hospitalisation, is not fully known.

The table below shows admissions to the General Hospital with a positive test result two weeks before admission or at any point after admission but before discharge, or where clinical coding on discharge includes a Covid ICD-10 code in the primary position. Due to the small numbers involved, it is not possible to provide a monthly breakdown to avoid breaching the privacy of individuals involved.

Year	No swab - Coded as Primary Diagnosis COVID	Positive swab - No coding information	Positive swab - Coded as Primary Diagnosis COVID	Positive swab - Coded Primary Diagnosis not COVID
2020 From February	5	16	58	50
2021 to July	5	43	25	9

Table 2: Admissions to the General Hospital with a positive test result

Note that clinical coding is performed at or soon after the point of discharge so patients still in hospital or recently discharged from hospital may not yet have been coded.

For hospital cases from July 2021 to December 2021, HCS Informatics performed additional episode level analysis to validate cases (ahead of clinical coding being conducted for this period). Details of this analysis can be found here.

The number of active cases in hospital for the first wave is shown in Figure 10. It is likely that this is an underestimate due to the limited amount of testing available in early 2020.

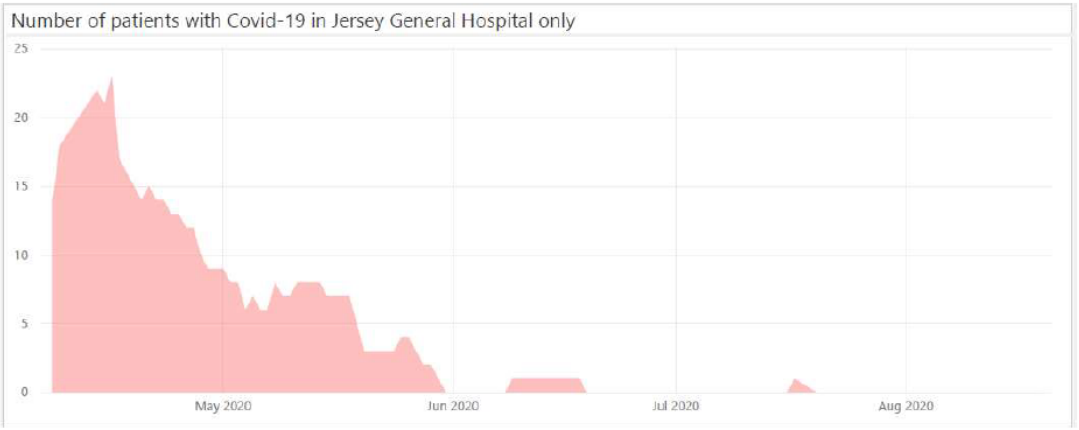


Figure 10: Number of patients with Covid-19 in Jersey General Hospital

In order to provide the public with an indication of the burden that COVID was having on the health system, the number of active cases in hospital became part of the routine published Covid data from July 2020 onwards and this dataset is shown in Figure 11. These figures include both clinical and non-clinical[8] COVID patients across both the Jersey General Hospital and St Saviours Hospital.

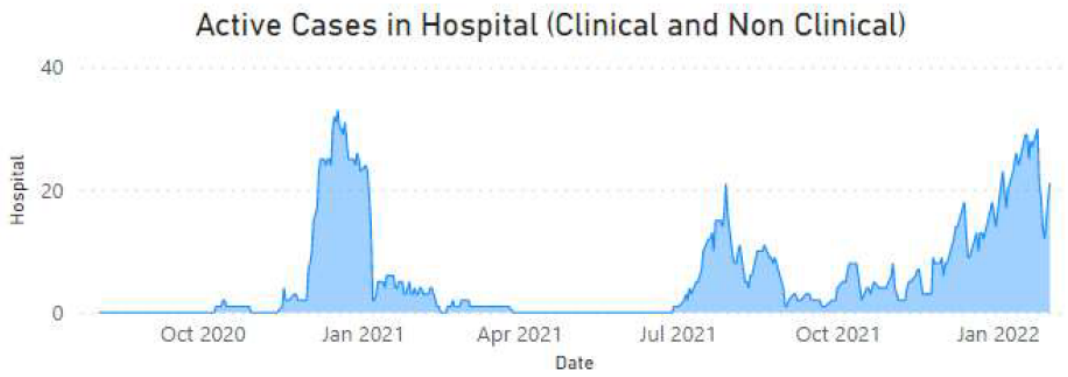


Figure 11: Active Cases in hospital (clinical and non-clinical)

Due to the differences in admission policies in Jersey, caution is required when trying to compare the level of hospitalisations locally to other jurisdictions.

7.2.4. Care homes

Active Cases in Care Homes have risen and fallen in line with general infection levels in the community. Figure 12 shows high numbers of cases identified amongst residents in the second wave (December 2020), which was largely before vaccines were available. Smaller peaks in Care Home cases followed during the third wave in summer 2021, when the majority of this group had been double vaccinated. Most recently in the fourth wave (January 2022), which was driven by the Omicron variant and has a

[8] Clinical = those patients with Covid as their primary diagnosis for admission; Non-Clinical = patients admitted for reasons other than Covid

high propensity to infect those with existing immunity from vaccination, cases in Care Homes peaked again at 50.

Cases amongst Care Home Staff were also tracked for operational purposes and saw similar rises and falls along with the infection levels in the wider community.

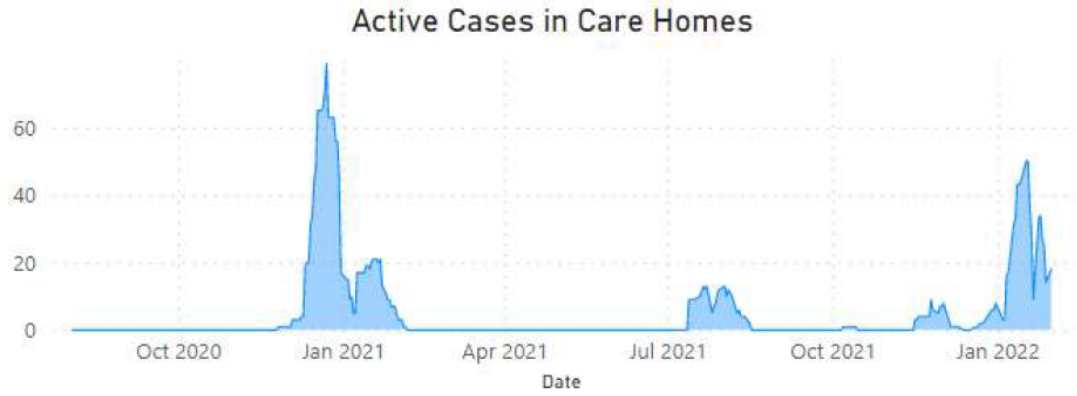


Figure 12: Active cases in care homes

7.2.5. Mortality

Throughout the pandemic Jersey has reported on the number of Covid-19 related deaths as and when deaths are registered with the superintendent registrar. These Covid-19 deaths are defined as deaths where Covid-19 is mentioned on the death certificate, which indicates that the doctor reporting the death judges Covid-19 to have wholly or partially caused the death. See Table 3 below for a summary of Covid-19 deaths reporting and definitions. Slightly different measures of Covid-19 deaths are used in the UK and elsewhere, for example, with deaths within 28 days of a positive test being counted, even where Covid-19 infection may not have been judged to have contributed to the cause of death.

	Covid-19 Positive at time of death (or shortly before)	
Covid-19 Mentioned on death certificate	Yes	No
Yes	Individuals where Covid-19 wholly or partially caused the death of the individual. Covid-19 is rarely the only cause recorded on the death certificate as, on the whole, people accumulate morbidities as they age which often contribute to death.	A number of 'probable deaths' were identified early on in the pandemic due to limited availability of testing at that time but where the doctor recording the fact and cause of death felt that Covid-19 may have contributed to the death.

No	Those individuals who happened to be positive at the time of death, but Covid-19 did not cause (or contribute) to the death. Also used as an indicator of deaths more generally (Died within 28 days of testing positive for instance, or within 60 days) as a proxy for the impact of Covid-19 on mortality. Not reported routinely in Jersey, but is reported widely in the UK	Not known to be a Covid-19 related death. Deaths of this kind may be indirectly related to the Covid-19 pandemic due to the overall crisis situation.

Table 3: Covid-19 Death Reporting Definition Summary

**Pink background indicates deaths which are publicly reported in Jersey as Covid-19 related deaths by the superintendent registrar.*
***Blue background indicates deaths that are not routinely reported as Covid-19 related deaths in Jersey but may be included in definitions elsewhere in the world. Grey background indicates deaths which are not Covid-19 related by any definition but may be picked up in analyses that look at excess all-cause mortality.*

The underlying cause of death is coded by the Office for National Statistics using the International Classification of Diseases, Version 10 (ICD-10), which enables statistical analysis of deaths data locally. Analysis of Covid-19 deaths in 2020 was set out within the 2020 Mortality Report[9]. This report presents various definitions of Covid-19 deaths, including a metric considering deaths within 60 days of a COVID positive test. The age-standardised mortality rate (ASMR) in 2020 was 49.1 deaths per 100,000 people, which compares to a rate of 126.9 in England and Wales (using an equivalent methodology). Fully coded deaths data for 2021 is not yet available from the ONS and will be published in due course later this year.

Another way of measuring the impact of the pandemic on mortality is by using a measure of excess mortality. This looks at the differences between expected deaths from all causes (in a normal year, if the pandemic were not to have occurred) and the actual deaths from all causes. This measure captures direct impacts of Covid-19 on mortality (i.e. Covid-19 deaths) as well as indirect impacts. The "P-score" describes the difference between expected (based on an average over the previous 5 years) and actual total deaths. A positive score indicates higher than expected deaths, whilst a negative score indicates lower than expected deaths.

Whilst Jersey saw higher than expected deaths in April and December 2020 (coincident with Waves 1 and 2 of Covid-19 infections), 2020 overall saw negative excess death overall (-6.9%). Preliminary data from deaths in 2021 indicates that annual deaths were within the expected range, and that over the 2020-21 period Jersey saw around 47 *fewer* deaths per 100,000 population than expected. This figure contrasts with most other jurisdictions internationally, which saw substantial excess deaths over the 2020-2021 period[10]. In the UK, for example, there were estimated to be between 100 and 165 excess deaths per 100,000 population across the devolved nations, and in France an estimated 124 excess deaths per 100,000 population. Some jurisdictions are estimated to have seen negative excess deaths like Jersey such as Australia, New Zealand, and Singapore. These jurisdictions implemented Covid-19 strategies that were towards the "elimination" side of the spectrum.

[9] https://www.gov.je Jersey Mortality Statistics 2020
[10] www.thelancet.com Estimating excess mortality due to the Covid-19 pandemic: a systematic analysis of Covid-19-related mortality, 2020–21

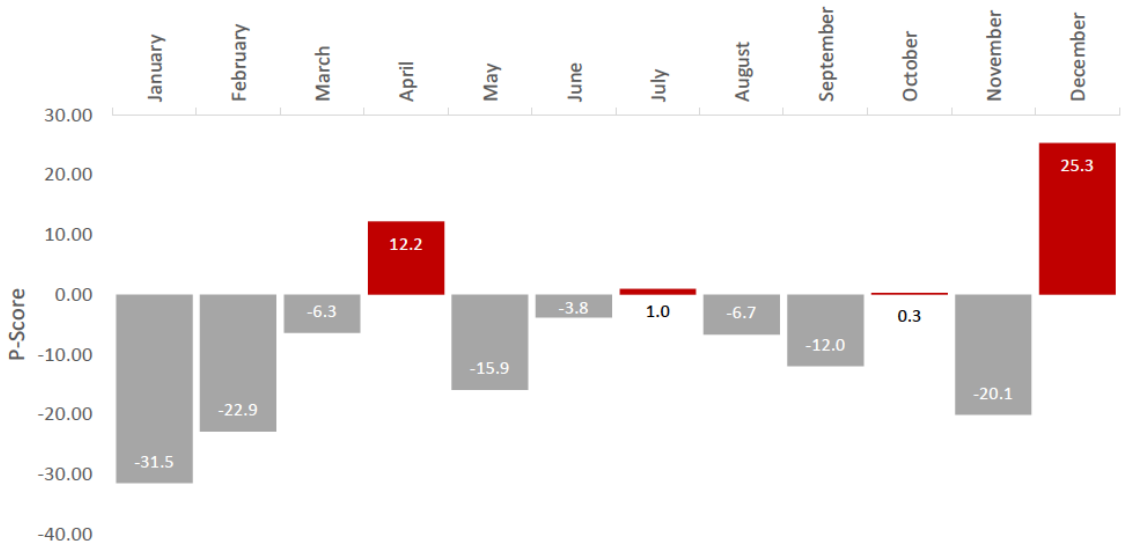


Figure 13: Excess Mortality by month in Jersey, All Persons (2020) (Source: Public Health Intelligence, Further Mortality Report 2020)

For information on the causes of death recorded on death certificate, the Superintendent Registrar has answered a number of FOIs which detail these[11].

7.2.6. Long Covid

In March 2021, SNOMED codes became available in EMIS (the primary care computer system) to allow GPs to record patients with ongoing Covid symptoms (after 4 weeks) or Post-Covid-19 Syndrome (after 12 weeks). Due to the timings of the codes becoming available and reporting practices across the 14 GP surgeries, this data is likely to represent an underestimate of those impacted by Long COVID since the start of the pandemic.

By the end of January 2022, around 370 patients had been recorded as having one or more of the available codes, associated with around 550 GP episodes. On a monthly basis, the highest numbers of patients being reported by GPs was in August 2021 (71 patients, 39 with ongoing symptoms and 32 with post-Covid-19 syndrome), and January 2022 (94 patients, 33 with ongoing symptoms and 61 with post-Covid-19 syndrome). Figure 14 shows the age and gender distribution of these patients, with females and those in the middle age brackets constituting the larger proportion.

[11] https://www.gov.ie/government/freedomofinformation/pages/foi.aspx?ReportID=5392

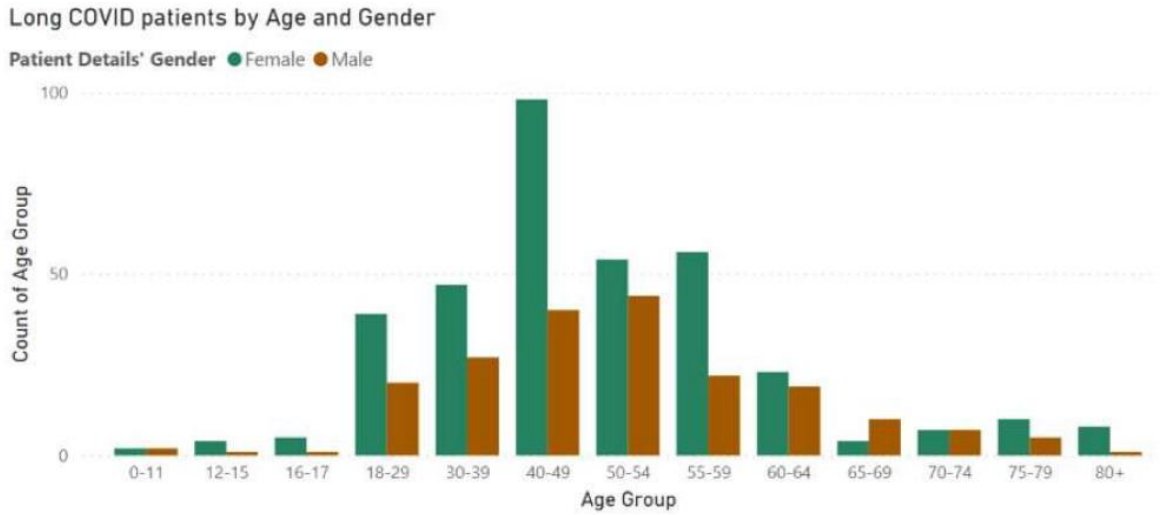


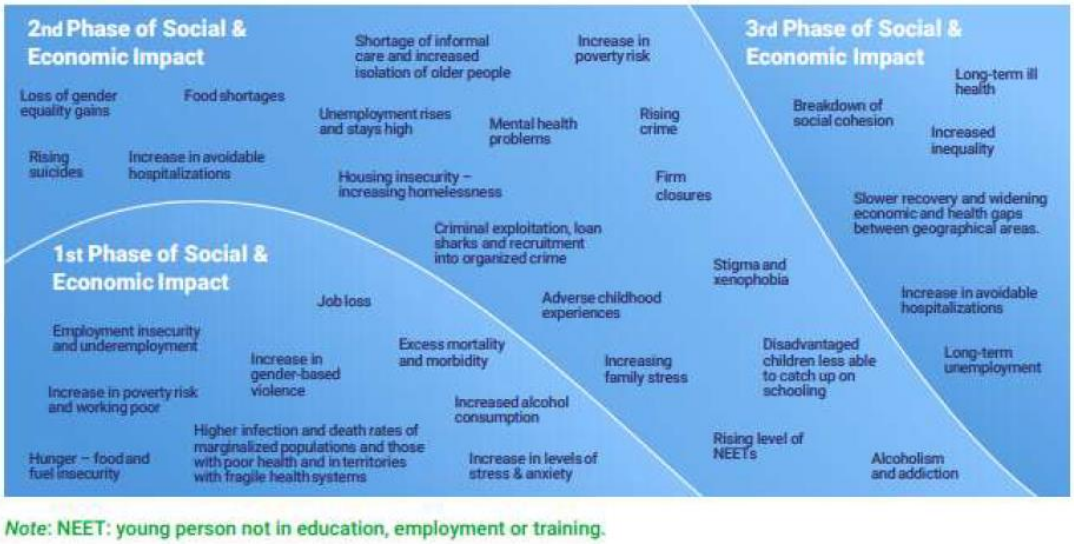
Figure 14: Long Covid patients by age and gender

A Long COVID Clinic was established in February 2022 to provide a multi-disciplinary route to assess and support patients.

Due to the challenges in obtaining data on those suffering from Long COVID locally, it is difficult to assess whether the burden of disease in Jersey is different to that being observed in other jurisdictions.

7.2 Indirect impacts of Covid-19

The indirect impacts of Covid-19 are likely to be far reaching and appear in the short-, medium- and long-term, as evidenced by the World Health Organisation (Figure 15). As such, evidence is emerging of the impacts of the pandemic on Islanders and further evidence, understanding and insights will be gathered as part of the COVID Recovery Understanding and Insights Project.



Note: NEET: young person not in education, employment or training.

Figure 15: World health Organisation, phases of socioeconomic impact from Covid-19[12]

[12] https://apps.who.int/iris/bitstream/handle/10665/338199/WHO-EURO-2020-1744-41495-56594-eng.pdf

Detailed below are some early evidence of the indirect impacts on Islanders being seen within administrative and survey data.

7.3.1. Mental health

The Jersey Children and Young Peoples Survey runs every two years, with the latest round conducted in October 2021. One important finding is the increase in anxiety across all year groups, especially in females (Figure 16).

Figure 3.6 ONS4: Overall how ANXIOUS did you feel yesterday?

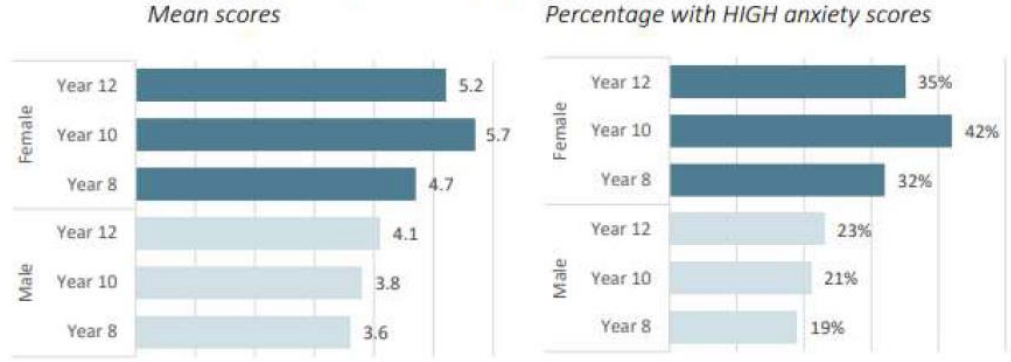
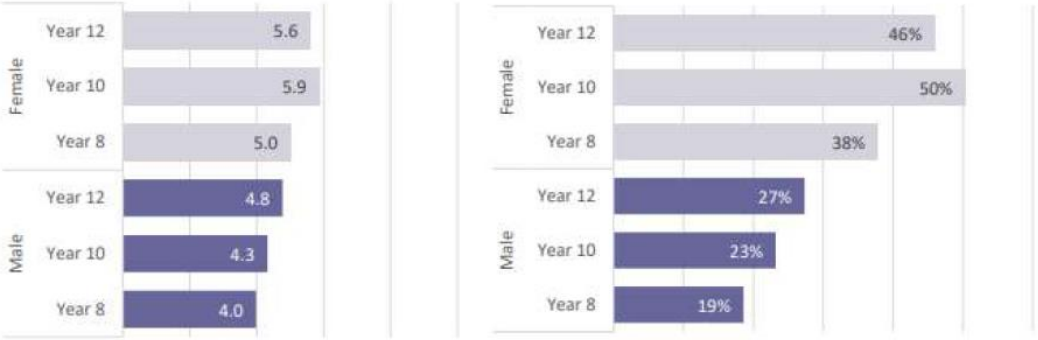


Figure 5.6 ONS4: Overall how ANXIOUS did you feel yesterday?



- anxiety has increased in all year groups since 2018, but particularly in Year 12 females

Figure 16: ONS4 anxiety question results from 2019 (top) and 2021 (bottom) from the Jersey Children and Young Peoples Survey

The Jersey Opinions and Lifestyle Survey 2020 (JOLS) found similar levels of anxiety, life satisfaction and feelings of worthwhile to results for 2019 but significantly different to 2018 (Figure 16).

Table 2.1 Percentages scoring very high or high in satisfied, worthwhile and happy wellbeing measures, and very low or low in anxiety measure, 2018 – 2020

	very high and high satisfaction, worthwhile, happy		
	2018	2019	2020
Overall, how satisfied are you with your life nowadays?	82%	66%	64%
Overall, to what extent do you feel the things you do in your life are worthwhile?	82%	67%	69%
Overall, how happy did you feel yesterday?	81%	66%	68%
	very low and low anxiety		
	2018	2019	2020
Overall, how anxious did you feel yesterday?	65%	58%	60%

- the percentages of adults with high or very high scores for satisfaction, worthwhile or happy wellbeing measures, and very low or low scores for anxiety measures, were similar to those in 2019, but significantly lower than in 2018

Figure 17: JOLS 2020, mental health indicators comparison to 2018 and 2019

It should be noted that JOLS is a random sample online and postal survey in English only, which may miss Islanders with lower levels of literacy and English language skills.

Data from the 2021 Health, Activity and Wellbeing Survey is being analysed and will be published later in 2022.

Details of mental health service activity are provided by HCS in their performance reports[13].

7.3.2. Jersey Opinion and Lifestyle Survey (JOLS) 2020 data

In the Summer of 2020, Statistics Jersey ran a shorter version of their annual social survey to enable a greater understanding of the impact of the pandemic on Islanders. The full report can be found here: Jersey Opinions and Lifestyle Survey 2020. The survey results were presented to STAC on 7 September 2020 and CAM to further understanding of the impact on Islanders.

Key highlights from a public health perspective:

- A quarter of households (25%) reported that someone in their household had delayed seeking medical treatment or advice due to the Covid-19 outbreak. This was higher in socially rented accommodation (34%).

- Wellbeing measures (Life satisfaction, feeling worthwhile and happiness, and anxiety) were similar to the results for 2019 but lower than in 2018.

- Differences were seen across age groups – for example, a greater proportion of 16–34-year-olds reported that their life was better than before the Covid-19 outbreak (24%), than those over 65 years (5%). Changes to finance also showed a difference across age groups, with 29% of younger adults expecting their finances to improve compared to 10% of older adults and conversely a greater proportion of older adults (30%) expected their finances to worsen over the next year than 16–34-year-olds (22%).

- Respondents were asked about changes in their health-related behaviours. The response received was mixed, with some suggesting they had increased their smoking, drinking or physical activity,

[13] https://www.gov.je/government/pages/statesreports.aspx?reportid=5518

whilst others indicated that these had lessened, likely widening already existing inequalities across the population.

- More than half (62%) of the population were somewhat or very worried about their family being infected by Covid-19, and 59% were somewhat or very worried about the effect of Covid-19 on their life right now.

- Around one in five (22%) indicated that they were always or often lonely.

- Changes to working patterns were reported, with over half 54% of workers indicating they were working from home, whilst 27% reported an increase in hours worked and 18% reported a decrease in hours worked; 13% reported a decrease in pay or being asked to take leave.

7.3.3. GP consultations and prescriptions data

Changes in prescribing patterns were seen in March 2020 due to free health checks for Islanders aged over 80 provided by GPs and HCS and medication packs for 3 months being provided to patients. A significant uptick of around 50% in prescriptions is shown in Figure 17, which shows the total items dispensed by community pharmacies under the health insurance fund (HIF).

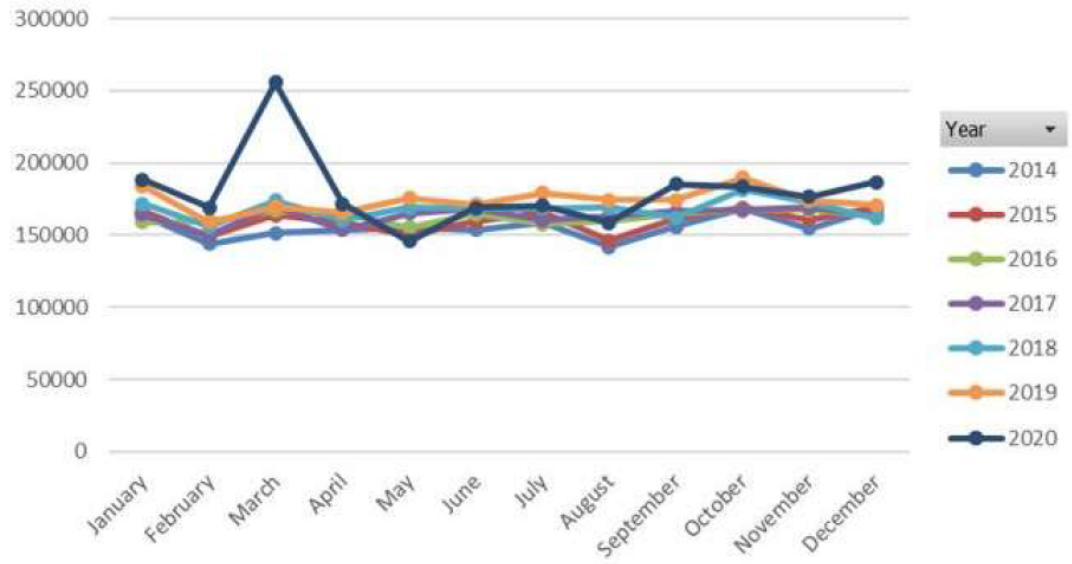


Figure 18: Total items dispensed by community pharmacies (under HIF)

The changes to health seeking behaviours as a result of the pandemic and the reduction in face-to-face consultations has impacted to some extent on observational monitoring of patients. For example, in 2020, the number of patients meeting the criteria for the Jersey Quality and Improvement Framework (JQIF) Obesity disease register fell from 11,081 at the end of 2019, to 8,709 at the end of 2020. Conversely, there was an increase of more than 1,300 patients on the asthma register (Figure 18).

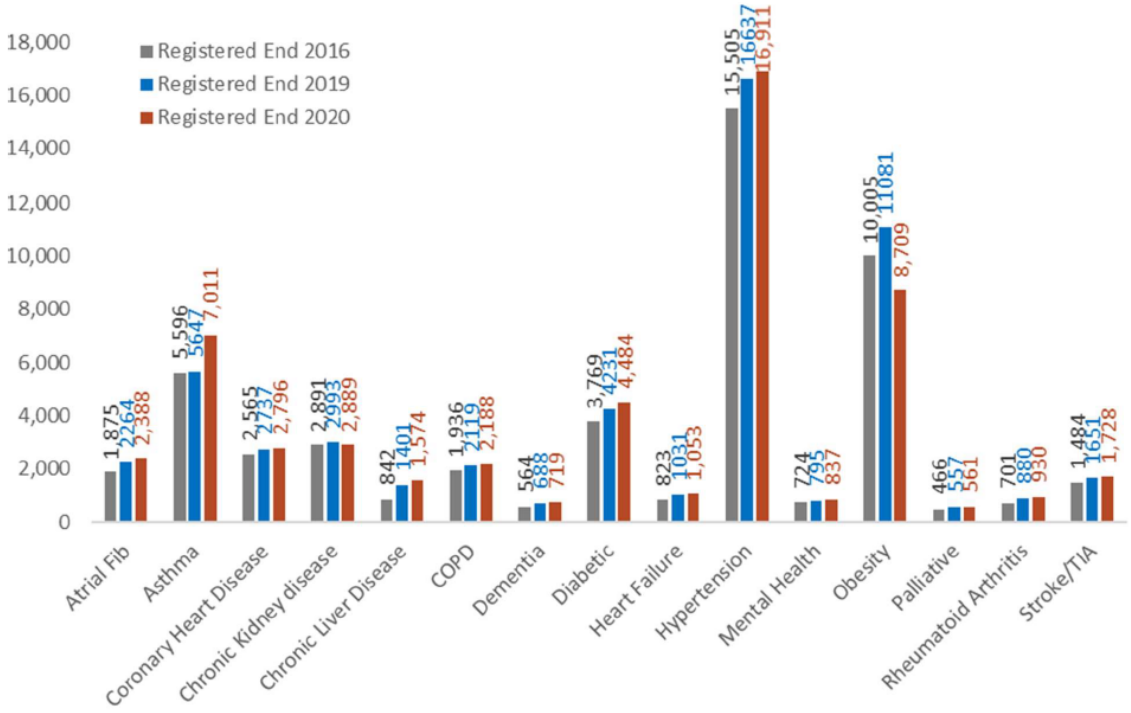


Figure 19: Number of patients registered on JQIF disease registers at end of year

7.3.4. Routine vaccine programmes

The Covid-19 Vaccination Programme has, like other jurisdictions, been the biggest vaccination programme in history. With over 200,000 doses having been administered in Jersey by the end of January 2022, it has bought vaccination to the forefront of Islanders minds. There has been some hesitancy witnessed as part of the vaccine roll out[14], and along with disruption to services, this has impacted on other vaccine programmes in some jurisdictions. However, that isn't the case locally in the data available to date:

- In winter 2020/2021 and winter 2021/2022, the extended influenza vaccine programme saw high rates of uptake in all priority groups.
- The data for 2020 routine childhood immunisations showed a small increase in vaccine uptake rates compared to 2019. Jersey met the WHO aspirational target of 95% uptake across all 13 childhood vaccine coverage measures.
- In terms of adult routine vaccines, the Pneumococcal Polysaccharide Vaccine (PPV) and Pertussis for pregnant women saw similar uptake levels in 2020 to previous years, although there was a slight decrease in the uptake for shingles vaccine in 2020

7.3.5. Learning loss

Jersey schools were closed to the majority of pupils between 21 March 2020 and 22 June 2020: a total of ten school weeks. From mid-June 2020 a gradual return to partial or full school attendance was implemented. Further details of the school closures and their impacts is available here.

[14] The Vaccination Programme, supported by Behavioural Science Consultants, commissioned a local company to conduct a series of focus groups with Islanders to understand which groups of the population were likely to take up the offer of the Covid-19 vaccine, and to understand any reluctance to take up the offer of the vaccine. The findings were used to adapt the Vaccination Programme to achieve better uptake rates.

Jersey schools closed at a similar time to UK schools, with the return to gradual opening in June also occurring at a similar time period. Individual schools will have managed the return to school according to the risks in their school population.

An additional week of closures occurred in January 2021 amid the winter wave of cases, this was a shorter amount of time than some devolved nations (for example schools in Scotland did not open for face-to-face lessons until 1 February).

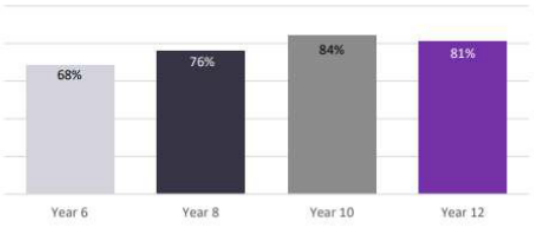
The Department for Children, Young People, Education and Skills can provide further information of the impact of learning loss in the school population as a result of the pandemic.

As shown in Figure 7 (figure of 7-day case rate by age group), those aged under 18 saw a relatively high rate of infection in the third wave of the pandemic, coinciding with the end of the school summer term. Case rates were also relatively high again in January 2022 following the start of the spring term (relative to other age groups).

The Jersey Children and Young Peoples Opinion and Lifestyle Survey 2021 (JYPOLS) included a question about whether those answering the survey had had to isolate due to Covid-19 and the reason for this. The survey found that the majority of those in secondary school year groups (over three-quarters) had had to isolate at any point (as of October 2021) and over half of pupils in year 6.

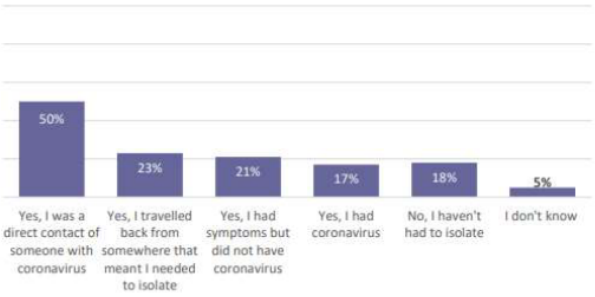
Coronavirus

Figure 3.14 Proportion who have had to self-isolate at any point since the coronavirus pandemic began[13] *(Years 6, 8, 10 & 12)*



- Year 10 and Year 12 were more likely to have had to self-isolate than Year 6

Figure 3.15 Did you have to self-isolate at any point since the coronavirus pandemic began[14]?



- overall, 77% of Years 6, 8, 10 and 12 have had to self-isolate at some point since the coronavirus pandemic began
- the most common reason for self-isolation was due to being a direct contact
- one in six (17%) young people had tested positive for coronavirus by the end of October 2021 – pupils in fee paying schools were more likely to have tested positive

Figure 20: JYPOLS COVID questions

Additional analysis considering the impact of isolation on pupils from the survey has been requested.

7.3.6. Economy – loss of work and earnings

The disruption caused by the virus to the livelihoods of many islanders will be felt for many years to come. During the first wave of the pandemic and the resulting lockdown, there was a significant rise in the number of people actively seeking work (ASW) and claiming income support. Further details can be found here.

Figure 21: Statistics Jersey weekly economic indicators - unemployment

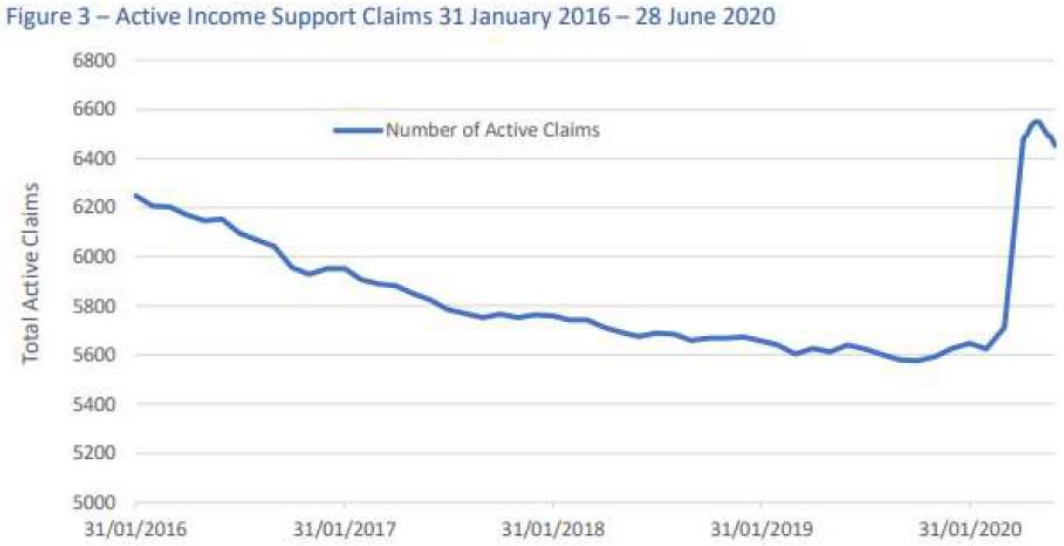


Figure 22: Statistics Jersey weekly economic indicators – income support claimants

The stress, pressure on families and likely changes to financial situations will have had an impact on the mental and physical health of Islanders, similarly to other jurisdictions and widened existing health inequalities.

JOLS 2020 showed, for instance, that workers in hospitality were more likely to report a decrease in pay due to coronavirus, than say those working in finance and the public sector.

Figure 1.5 Proportion of adults who experienced a decrease in pay due to coronavirus (COVID-19): by industry

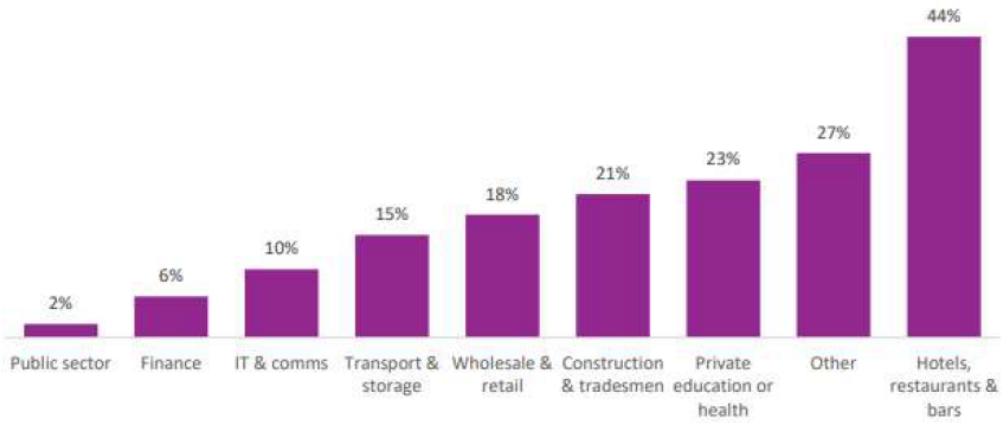


Figure 23: JOLS 2020, proportion of adults who experienced a decrease in pay due to Covid-19, by industry

Further details about the impact that the pandemic has had on Islanders, and their health needs, will be investigated as part of the COVID Recovery Understanding and Insights Project in 2022.

7.3.7. Reported domestic crime

"Domestic crime" is defined as any crime between parties who are related (including step-relations), spouses, partners or ex-partners. The Jersey Police Annual report for 2020[12] noted that domestic crime in 2020 was 2% down on the 2017-19 average. Two thirds of domestic crime in 2020 involved common and grave & criminal assault; the same proportion as in 2019.

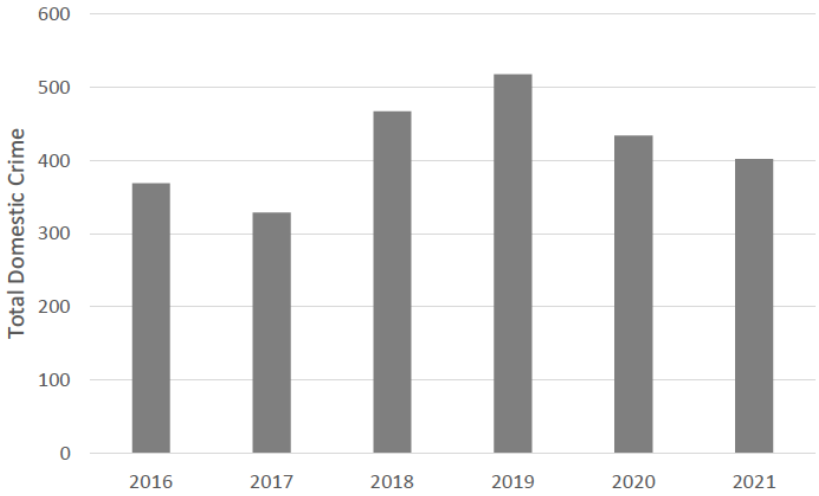


Figure 23 Reported domestic crime (Source: Jersey Police)

7.3.8. Inequalities

The full impact of the Covid-19 pandemic across the socio-economic spectrum is not fully understood in Jersey. There is no Index of Multiple Deprivation available to analyse outcomes against. In addition, ethnicity data has historically been poorly collected in the administrative systems so is not of a high enough quality to be able to analyse and draw any conclusions. For example, in December 2020 the Public Health Team conducted analysis of the testing data to establish whether there were any differences in infection by different ethnicities, however, ethnicities were only available for 49% of those who tested positive (as at 17/12/2020). This lack of ethnicity data also hampered analysis of

vaccine uptake across different groups – to counter this, focus groups were conducted to explore vaccine hesitancy with limited success at engaging minority ethnic groups locally.

A business case was written in February 2021 for a research project to try and gather further data on how the pandemic impacted on Islanders, using a range of quantitative and qualitative techniques. The project was endorsed by STAC (22 February 2021), but it was not supported when presented to CAM as more assurances that it was needed were required. This project, strengthened through work with Statistics Jersey and the Modernisation and Digital Department, became part of the bids to the COVID Recovery Fund, being successfully awarded the funding by the Political Oversight Group in February 2022.

8. The delivery of public health policy

Other departments, and operational services created in response to specific elements of the Covid-19 response, have played a significant role in responding to the pandemic. They have ensured that public health policies and decisions, as approved by Competent Authority Ministers, are translated quickly and effectively into delivery. The types of service and their functions have evolved with the pandemic, including Testing and Tracing; Covid Safe; Covid Status Certification and the Vaccination Programme.

The Testing and Tracing Programme and the Vaccination Programme have provided responses on the operational delivery of these initiatives, which are included as addendums to this submission.

What has been achieved by the policy and operational responses to the pandemic, working together, has been extraordinary. In a short amount of time, the GOJ was able to set up and delivered large and complex projects such as Test and Trace and the Vaccination Programme. This was only made possible by the strength of backgrounds, perspectives and interests that were brought together from across the GOJ, drawing on the skills, knowledge, and networks necessary to deliver these projects at pace, including public health, medical, operational and logistics, finance, procurement, HR, and IT expertise. No single department would have been able to respond on its own and establish large-scale projects and services without diverted resources from other departments. It is important to maintain and build on these networks to ensure that the same capacity and capabilities exist to respond to any future pandemic or comparable disruptive event.

From a public health perspective, the challenge with the implementation of policy during the Covid-19 pandemic has been the delineation between policy and operational matters. Figure 5 explains the governance and decision-making process through which public health policy was developed, agreed, and delivered in response to the pandemic. However, at times, the boundaries between policy and operations became blurred, and policy responses had to adapt to the operational requirements or challenges that were posed, which may not have delivered an optimal policy decision. This raises concern about the level of public health influence and oversight on the implementation of policy, including the timing and room for divergence from agreed policy.

There was during the pandemic a significant flow of policy advice, decisions and legislation coming from Public Health. This created challenges for operational services, particularly as there may not have been the capacity, time, resources or infrastructure to implement those policy decisions. The creation of bodies such as the Vaccination Governance Board, the Covid Status Certification Board and the Test and Trace Programme Board, the Daily Analytical Cell, the ITPB-IT Prioritisation Board, and informal day-to-day contact between officers ensured that there was an appropriate interface to ensure a working relationship between policy and operational responses.

Given the high impact of the policy decisions, it would be difficult to separate policy and operations. A learning point from the pandemic is the importance of ensuring that processes and opportunities exist for operational considerations to be taken into account when formulating policy. Likewise, it is essential that operational services understand the rationale and implication of policy decisions, and

that there is, ultimately, Public Health oversight of the implementation with clear accountability for delivery.

9. Public health communication and engagement

Public Health received a dedicated communications lead in September 2020 to make sure there was single, senior, point of contact for all communication outputs from the public health team. This was especially important ahead of the rollout of the Vaccination Programme in December 2020. The communications lead was embedded within the public health team to ensure close and joined up working with policy officers and the Behavioural Science Design Group.

Whenever a major public health announcement was made, where possible, we offered a Microsoft Teams pre-briefing for Scrutiny panels, States Members and journalists with the subject experts. This enabled stakeholders to ask questions, so they could fully understand the issues before the announcement or press conference. For Scrutiny and States Members, it was an opportunity to be briefed in advance of a public announcement and to ask questions. It also gave journalists more time to prepare their stories, which helped them to report the information accurately, thus providing a better service for Islanders.

Our communications activity was planned to span multiple channels in a fully integrated approach. This made sure that the critical campaign messages reached the greatest possible number of Islanders in the most cost-effective way.

Throughout the last two years, multiple Island-wide information leaflets have been distributed by Jersey Post, making sure that key public health information made its way into 41,000 homes in Jersey – this was particularly important for targeting the non-digital population who are not traditionally active users of social media, and might not have access to the internet. All leaflets were translated into the most widely spoken non-English languages in Jersey (Portuguese, Polish, Romanian, Bulgarian). We monitored the impact of this through the radio station call-ins and the letters section in the Jersey Evening Post where we could judge how well the information had been seen, understood, acted-upon and advocated for.

A core objective of all the public health campaigns was to make sure important messages about keeping safe from Covid-19 were accessible, clear, and widely understood. This meant material had to be translated into languages other than English, repeated in different tones, and broadcast through multiple channels and at different times of the day.

For major public health measures such as stay home, symptoms, pre-emptive measures, mask wearing, physical distancing and re-connection, roadside banners, posters, pull up banners and vinyl stickers were produced and placed at key high-traffic and commuter points throughout the Island, including parks, roadsides, parish halls, shops, King Street, restaurants, retailers and car parks.

In partnership with the Parish of St Helier, bins throughout town were used as signage, providing clear messaging in English, Portuguese, Polish and Romanian. The windows of empty shop fronts were wrapped in their entirety and utilised for high-impact messaging.

PDFs of all printed material, including translated leaflets and posters, were available on gov.je so that they were accessible for businesses to print their own.

The Government of Jersey hosted 47 live press conferences throughout the pandemic phases. These were broadcast on our social media channels, YouTube, and often streamed live on Channel 103 and BBC Jersey.

A memorandum of understanding was signed between Government and local telecommunication providers to enable the mass communication of Government messages in relation to the public health

emergency caused by the pandemic. The Island-wide SMS messaging function has been particularly effective in alerting Islanders to significant updates and announcements, and changes to advice.

We monitored the effectiveness of these outputs through feedback directly on the channels (social media analytics, press conference questions, conversations with journalists) and through real-time assessments from the Coronavirus helpline, customer feedback and social media sentiment, and policy officers.

To make sure we were being as inclusive as possible in our communications, key messages have been translated into Portuguese, Polish, Romanian, Bulgarian and other languages upon request (for example, Hungarian, Filipino and Nepalese for seasonal workers) throughout the pandemic response. When the vaccine was offered to seasonal workers, these translated leaflets were provided through the Jersey Farmers' Union and translators were on site at the vaccination centre.

British Sign Language (BSL) videos were also shared on the Government social media channels. There are a limited number of BSL signers in Jersey, and none are accredited to the required level to communicate key messages, so to make sure we did not exclude this audience group, we added subtitles to all our videos, including our live press conferences.

A lot of work was undertaken with key stakeholders from the Parishes and voluntary and community sector with support of the ConnectMe service, particularly to support the rollout of the Vaccination Programme. This was to ensure the communications were meeting the needs of Islanders in the most effective way. During the initial offer of the Vaccine Programme, communications were coordinated though care homes, Age Concern, Call and Check, Good Companions Club and Jersey Alzheimer's Association.

Easy Read Information Leaflets were provided at key points during the response, particularly for the rollout of the Vaccination Programme (for example, these leaflets were sent to 10,000 Islanders who were in the at-risk vaccination groups). More recently, expert support to produce these publications has not been available, and work on ongoing to find a solution to this.

Certain key announcements have been translated into video format with Royal Association for Deaf people UK (RAD), which were shared on social media and add to YouTube, where the translate function could be used to generate subtitles in different languages. The turn-around for RAD / BSL videos often took several days – sometimes rolling into the following week – which meant the message was then late or out of date.

Notwithstanding the breadth of communication outputs, and their success in supporting public health objectives, we identified a few major learnings and have actioned them following a review by the Directorate.

1. Communicating a nuanced policy position, that balanced Islanders' freedoms, their wider mental and physical health, and their household economy, against the health effects of Covid-19, was a challenging task. Sometimes the language of policy officials, or the diverse opinions of Ministers, were too precisely reflected and this meant that simple and plain-English messages were not in our leading communications.

2. Communication officers were not engaged early enough in planning Ministers' diaries. Steps should be taken to ensure timely access and coordination of diaries to ensure Ministers are available for immediate announcements.

3. The views and opinions of young people, while being collated, were not weighted during the response and so whilst practical policy deliberations always included the issue of children, due to the need to brief all Islanders in a rapid manner the communications effort did not prioritise them.

4. While lots of work was undertaken to engage minority groups, we faced gaps in our data to support this in the most effective way.

From a public health perspective, we also lacked a means of detailed understanding around the sentiment and experience of all Islanders (particularly those in non-English speaking communities and lower-income households). This has been problematic because it felt, at times, that some individuals or groups had a greater say or involvement in different components of the pandemic response and influenced decisions disproportionately. In effect, these individuals and groups became a proxy for the views and experiences of the broader population, but there was little way of knowing whether that was the case.

In responding to a future pandemic or comparable disruptive event, it would be valuable to engage with broader public experience and sentiment on the response, which might include regular polling or focus groups, and more specific work to understand the perspectives of low-income households and different ethno-linguistic groups.

10. Concluding remarks

The Covid-19 pandemic has presented an unprecedented challenge for Jersey, and it remains ongoing. Over the past two years, through four distinct waves of infection, the virus has impacted on all aspects of Island life. This has resulted in the introduction of various extraordinary public health measures, to varying degrees and in different combinations, to mitigate the risks of Covid-19. These measures were necessary, but they have come at a cost to people's wellbeing, children and young people's education, routine healthcare and the economy. It has been imperative, as part of the public health response, to balance these various factors, applying data and evidence to ensure that actions and decisions taken are proportionate and necessary based on the level of risk, and in place for the shortest time possible.

As the pandemic has progressed, our understanding of the virus – how it behaves, its impact, and how to treat it – have transformed and greatly improved, as have the tools available to tackle the virus. The epidemiological situation has been dynamic, with new Variants of Concern identified at different phases of the pandemic, but these advances have enabled the public health response to shift from the deployment of universal legal restrictions at the beginning of the pandemic towards less intensive, targeted measures, focusing on personal responsibility, as part of the de-escalation approach.

The Vaccination Programme has underpinned this approach, with the roll out of vaccines in late 2020 supporting a gradual return to normal as greater protection has been afforded by the vaccine. The roll out of the vaccine has been performed in combination with a series of other measures such as a large-scale testing and tracing capability, measures to protect the most vulnerable, guidance to encourage safe behaviours, and Non-Pharmaceutical Interventions to mitigate the risks of Covid-19 and support Islanders to get vaccinated in a safe and timely way. Antivirals also became available in February 2022 and use of them is maturing.

Maintaining resilience in critical services such as in education settings and the hospital, contingency plans, and continuing surveillance through Public Health Intelligence have also ensured that the GOJ has been able to respond quickly and flexibly to changes in the Covid-19 situation.

The Covid-19 pandemic has highlighted the strengths and weaknesses in the public health approach to managing a pandemic or any comparable disruptive event. The principal role of Public Health has been to manage the risk of severe disease and mortality as a result of the pandemic, and this has been largely achieved. The pandemic has not ended though, and it is important to draw out the key learning points to inform preparation for another pandemic or comparable disruptive event. They include:

1. The GOJ has mobilised an extensive response to the Covid-19 pandemic and moved forward fast to deliver this, with emergency plans put in place, and governance and decision-making structures set up, to manage the public health response. Understanding the effectiveness of these arrangements,

including their functions and mandate, how they enable fast and evidence-based decision-making; governance and oversight arrangements, and ensuring they have appropriate public health content and representation will help to prepare the Island for an equivalent event in the future.

2. Cross-departmental cooperation has been a key feature of the pandemic response. It is important to build on these relationships and ensure that the learning is sustained in other areas of the GOJ's activities and for future emergencies. Within this, there is a need for strong Public Health leadership (insofar as it relates to public health matters), which has the capacity and capabilities to drive policy development, and which can inform and engage in decision-making.

3. The public health response to Covid-19 has been subject to other competing policy pressures. This has been important in balancing other economic and social concerns and ensuring that the public health response is proportionate to the level of risk. However, in the event of a future pandemic or comparable disruptive event, public health data and evidence and advice should be supported by equivalent data and evidence from other policy areas to inform decision-making.

4. STAC has provided valuable evidence to inform decision-making throughout the pandemic. The pandemic put the GOJ in a challenging situation it has had to ensure clear, trusted, and legitimate decision-making, informed by the best available evidence. STAC has helped to fulfil this function. The future operation of a scientific committee during a pandemic or comparable disruptive event should have a stricter role, with more varied sources of expertise, and there should be effort to ensure that the advice made to decision-makers is made on the best available health, scientific and technical advice.

5. The pandemic has highlighted significant gaps in Jersey's legislative powers for responding to major public health risks. The legislation available at the beginning the pandemic provided limited powers to manage Covid-19 infection and, in the absence of an appropriate legal framework, numerous pieces of legislation had to be developed at pace with little opportunity for review. This is not an optimal way to manage a public health emergency. The development of a new Public Health Law and Civil Contingencies Law provide an opportunity to learn from Covid-19.

6. Public Health Intelligence has had integral role during the pandemic. It has provided and presented data and information to inform public health policy and decisions in response to the emerging and ongoing risks of Covid-19. It has also ensured the public are informed about the pandemic situation and can make informed choices to protect their own health and the health of others. The pandemic has, however, highlighted gaps in some areas of data (for example, the impact of Covid-19 on care settings such as care homes, GPs and the hospital). There have also been issues with the quality of data – the process for data cleansing is not always rapid; coding practice can often be variable; and achieving data agreement time-consuming. Increasing the capacity of the Public Health Intelligence team, including a reporting schedule to ensure we have an overview of health trends, is one of the immediate actions that has been taken in this area.

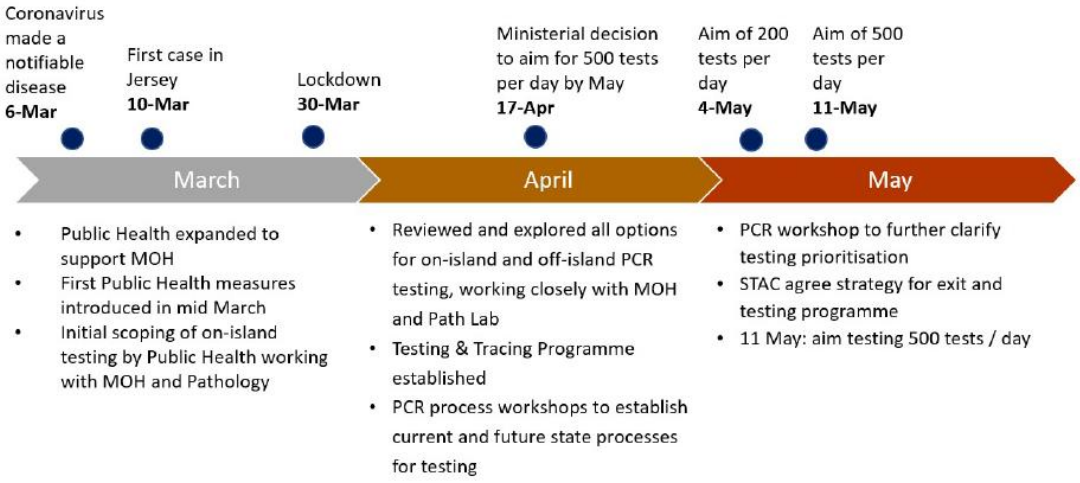
7. There has been an unprecedented use of communication and engagement channels throughout the pandemic across all areas of policy, including about the spread of Covid-19 and the policies undertaken to control infection, and to share instructions on how to comply. It is important to build on the effectiveness of these measures in the response to Covid-19 and other public health matters.

8. The differential impact of the Covid-19 pandemic on different communities is not well-understood, and there was limited capacity to produce intelligence about the indirect impact of the pandemic on health. This is not unique to Public Health, with limited data on how inequalities work in Jersey. Work to understand Jersey's communities and their health needs, and to join up administrative data sets across the GOJ, will be gathered as part of the Covid Recovery Understanding and Insights Project. The preparation of a Public Health Strategy will also define priorities for improving and protecting health.

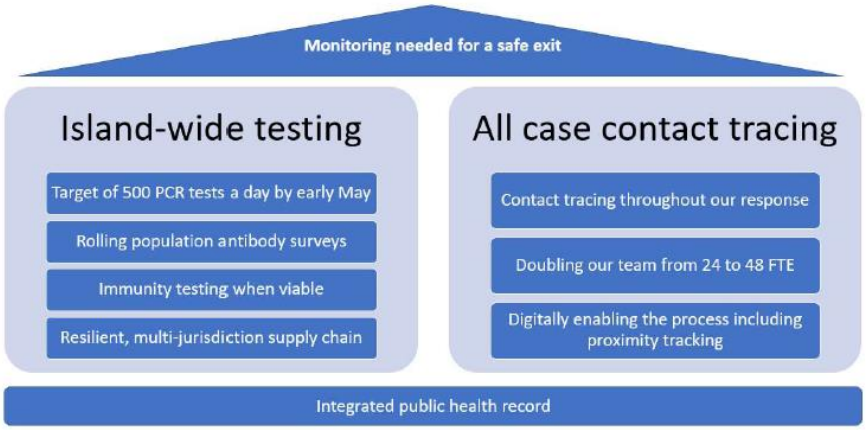
Appendix A – Testing Strategy Evolution and Chronology[15]

Initial response (March to August 2020)

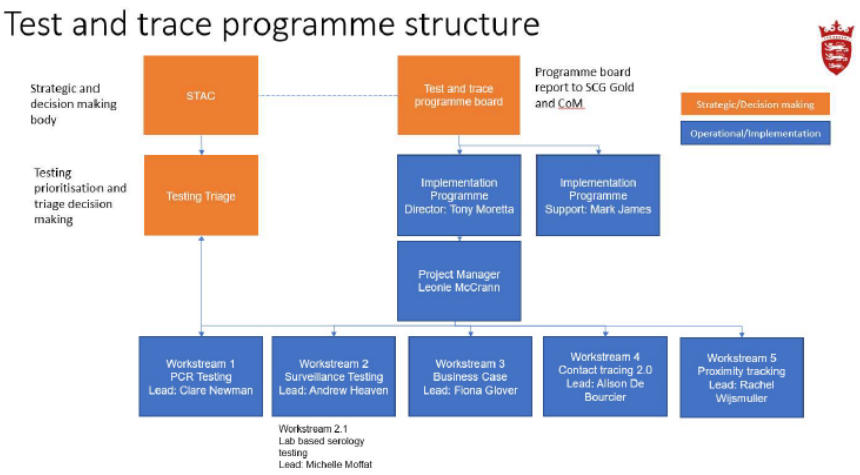
Rapid transition from limited capacity for testing within HCS (initially only via PHE, then small testing capacity within the pathology lab from 9 April 2020) and small team of contact tracers within EH, to a government wide Test and Trace Programme.



April 2020 – Establishment of the Test and Trace Programme within Justice and Home Affairs (JHA).



[15] All slides included in this Appendix are contemporaneous and were presented in a variety of settings.



The rapid creation of the team was facilitated by the bringing together of skills and resource from both the private and public sector, with a number of SPPP officers taking on key operational roles.

Increased testing capacity to 500 PCR tests per day was achieved by early June, although the majority of tests were still processed off-island, with a turnaround time of 36-72 hours.

June 2020 – Establishment of the Contain Strategy

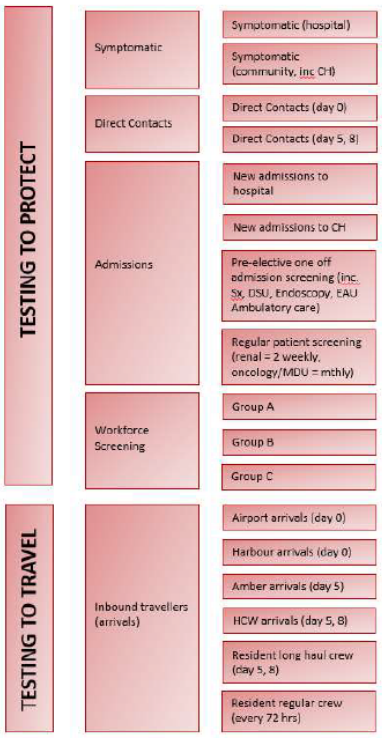
Testing to protect	Testing to travel	Testing to understand	All case contact tracing	Ensuring isolation
1. Seeking healthcare with symptoms 2. Planned Screening a) Contact b) Admissions c) Workforce	3. Arrival screening 4. Departure testing	5. Individuals 6. Population level 7. Combined studies	8. Conventional contact tracing 9. Digital contact tracing	10. Monitoring and enforcement 11. Quarantine

July 2020 – Development of a streamlined process for off-island testing with a private provider, leading to increased testing capacity up to 2000 PCR tests per day, with a turnaround time of 36-48 hours.

August 2020 – Delivery of the on-island testing facility (Open Cell) – live launch on 15 Sept 2020
On-island capacity increased to 2000 PCR tests per day with a turnaround time of less than 12 hours.

Autumn/Winter 2020-2021 (September 2020 to March 2021)

Evolution of the Contain Strategy with expansion of the 'Testing to Protect' and 'Testing to Travel' programmes; 'Testing to Understand' was not further developed due to changing priorities and a decreased focus on antibody testing based on emerging evidence.



November 2020 – Expansion of the 'Testing to Protect' programme to offer PCR screening to a wide range of workforce groups (Group A+, Group A, Group B, Group C).

Group A+ – ALL HCS staff, peer swabbing, DiaSorin		**Group A - every 4 weeks, peer swabbing**		**Group B – every 6 weeks, Harbour**	
Patient-facing **WEEKLY: 2,133**	Non-patient facing: **EVERY 2 WEEKS: 1,067**	General Practice: **290**	Domiciliary Care and agency workers, including FNHC : **1,820**	*Estimated headcount:*	
Group A+ TOTAL: 3,200		Dental Practice: **230**	Emergency services: Ambulance Service: **96** Police: **316** FRS: **102**	Early Years and Childcare Services: **658**	Schools and Colleges (all staff, CYPES data): **2,371**
		Residential and Care Home – inc. Hospice: **1,740**	Prison Service: **149**	Veterinary Practice: c.100	**Group B TOTAL: 3,129+**
			Group A TOTAL: 4,743		

Group C – every 8 weeks	
Estimated headcount (as December 2019, Statistics Jersey: Labour Market Survey, unless stated otherwise):	
• Legal and finance **13,450**	• Agriculture and fishing: **1,100**
• Island Utilities and infrastructure Services: **710**	• Leisure and Recreation Services: **339**
• Building and Construction (& quarrying): **5,970**	• Retail (& wholesale) Services: **6,940**
• Security and Facilities Management Services: **680**	• Public Services (other): **2,745**
• Domestic and Commercial Cleaning Services: **1,000**	• Public Transport: **443**
• Other healthcare: **500**	• Wellbeing, cosmetic and beauty services: **590**
• Freight, Post and Delivery Services (transport & storage): **2,020**	• Voluntary and Community Sector: **500 est.**
• Hospitality Services (hotels, restaurants and bars): **4,730**	• Worship, funerals and marriages sector: **170**
Group C: 41,887	**COMBINED EST. TOTAL: 52,959**

November also saw the introduction of regular Cohort Screening (hospital inpatients, care home residents and visitors, years 11-13 students).

December 2020 – launch of the DiaSorin (antigen) testing platform within the HCS pathology laboratory to further increase testing capacity for screening of high-risk workforces.

January 2021 – launch of Schools' Lateral Flow Testing (LFT) Programme for years 11-13 and all secondary school staff.

Spring/Summer 2021 (April to August 2021)

April 2021 – launch of the Future Testing Strategy (developed in February / March 2021)

CURRENT		
Testing programme	**Category**	**Details**
Testing to protect	Seeking Healthcare (symptomatic)	Hospital
		Community
	Contact Tracing	Direct contacts
		Indirect contacts
	Admissions Screening	Admissions to hospital
		Admissions to care homes
		Pre-elective admissions
		Regular high-risk patient screening
	Workforce Screening	Group A+
		Group A
		Group B
		Group C
	Cohort Screening	Hospital inpatients
		Care home residents
		Care home visitors
		Years 11-13 students
Testing to travel	Inbound Travel	Passengers arriving to Jersey (+ occasional pre-departure testing)

FUTURE	
Testing programme	**Details**
Active Case Control	Symptomatic (hospital and community)
	Contact tracing
	Outbreak management inc. workforce
Safe Places *(individuals entering, living and working in enclosed communities; or delivering health and emergency services)* **(previously a mix of admissions, workforce groups A+ & A, and cohort)**	Hospitals
	Care Homes
	Domiciliary Care
	Emergency services
	GP and Dental Practices
	Prisons
Community Testing **(previously a mix of workforce B & C, and cohort)**	Years 11-13 students
	Schools and colleges
	Remainder of workforce groups B & C
Travel	Inbound travel
	Pre-departure testing

The Future Testing Strategy outlined a transition from the Contain Strategy to four new testing programmes:

The aim of the new strategy was to make the best use of available testing technologies in order to offer more frequent testing for a greater number of people, in the most cost-effective way. It also approved the development of GoJ delivered PCR service to replace the external provider (Open Cell).

Programme	Key principles
1. Active Case Control *(those with symptoms, active cases and their direct contacts)*	**Overview:** much greater emphasis on identifying all symptomatic cases quickly; the use robust testing and tracing processes to rapidly respond to all active cases and clusters **Technology:** PCR testing **Frequency:** as per current and future public health and contact tracing policies **Delivery:** continued use current arrangements including hospital/GP, drive through/walk in facilities/home visits, with mobile teams as needed for outbreak management
2. Safe Places *(anyone entering, living and working in enclosed communities; those delivering health and emergency services)*	**Overview:** to offer greater frequency of screening and protection, in a way that is cost effective and sustainable **Technology:** a move to primarily **DiaSorin Antigen testing (previously PCR)** for this group; PCR testing to remain for new admissions to enclosed communities and care home visitors **Frequency:** staff testing at a **minimum of 1-2 weekly (previously 4 weekly for most groups)**; current frequency retained for patients, residents and visitors **Delivery:** DiaSorin using **peer to peer swabbing (previously a mix of peer-to-peer and drive through etc)** for all workforces; PCR swabbing as per current arrangements for all patients, residents and visitors
3. Community Testing *(targeted at the other groups within the population)*	**Overview:** to offer greater frequency of testing and engage with a much wider range of the population in a way that is cost effective and sustainable **Technology:** a move to **Lateral Flow Devices** + other new technology as available **(previously PCR)** +/- PCR on entry into the programme and throughout **Frequency:** **weekly** LFDs and PCR at regularly agreed intervals as per best evidence available **(previously 6-8 weekly)** **Delivery:** Community testing programmes using **supervised self-swabbing and reporting (previously drive through etc)** ; PCR swabbing as per current arrangements
4. Travel *(arrivals and departures from the island)*	**Overview:** remains as per current programme, fully informed by the Safer Travel Policy **Technology:** **PCR testing** **Frequency:** as per the Safer Travel Policy **Delivery:** swabbing as per current arrangements

Implementation of the Future Testing Strategy continued throughout the spring and summer of 2021.

Autumn/Winter 2021-2022 (September 2021 to January 2022)

September 2021 – Approval of a testing strategy update that provided a proposed framework to simplify and rationalise testing, in the context of significant vaccination population protection and the move to an 'Active Mitigation' approach. The principles of proportionate simplification, reduction and removal of testing were used throughout.

Alongside this simplification was the launch of a universal offer of LFT home testing for Islanders aged 12 and over, to support the 'Winter Strategy 2021' ambition of increased self-management.

Anticipating a reduction in data as a result of the rationalisation of testing, a fifth testing programme was provisionally introduced to consider the ongoing Epidemiological Surveillance of COVID-19.

		CURRENT Simplify, reduce, remove – based on continued progress FUTURE		
		Current Testing Regimes	**Autumn / Winter (Not before 19 Oct)**	**Spring (Not before 1 Mar)**
Active Case Control	Symptomatic	1 x PCR, isolate if positive	Continue with current testing	
	Direct Contacts	1 x PCR + optional 10 daily LFT	Continue with current testing	Consider reducing definition of DC to Household Contacts only
Safe Places		Combination of PCR, DiaSorin and LFT testing	Simplify testing	Consider removal of testing
Community Testing		Combination of PCR and LFT testing	Simplify testing	Consider removal of testing
Safer Travel		1 x PCR + isolate based on vaccination status	Covid Status Certification (CSC) system	Consider removal of testing
Epidemiological Surveillance		Not currently deployed	Options to be developed	

January 2022 – as part of the de-escalation process and 'Post-Emergency Strategy' the testing strategy underwent further review, again applying the principles of proportionate simplification, reduction and removal of testing.

Underpinning the principles of de-escalation was a further move to personal responsibility. To support this, the home testing LFT programme was expanded to the whole population, with a recommended increase in frequency of testing for higher risk sectors.

Continue the ambition as outlined in Winter Strategy

		CURRENT Simplify, reduce, remove – based on continued progress FUTURE	
		Feb – Mar 2022	**April 2022 onwards**
Active Case Control	Symptomatic	PCR; mandatory isolation if positive result	PCR; guidance to isolate if positive result
	Positive LFT	PCR; mandatory isolation if positive result	PCR; guidance to isolate if positive result
	Direct Contacts	10x daily LFT (3y and under – 5x LFT in 10 days) End centralised contact tracing processes	Review advice to direct contacts
Safe Places [staff, visitors, residents inc. new admissions]		Regular LFT home testing at population level • Standard community risk: twice weekly LFTs • Higher risk sectors: daily LFTs (work / school day only)	Consider if ongoing testing of asymptomatic population remains proportionate as case rates decrease
Community Testing		Remove the need to report negative LFT results (except to release from isolation) Retain the use of PCR and Diasorin as screening tools in only the highest risk settings	
Safer Travel		No testing or isolation requirement Any new significant risk – consider the use of CSC (vaccine/PDT) or mandatory isolation (based on the level of risk)	
Epidemiological Surveillance		Continue to develop and assess the need for surveillance	

The above process continues to be applied, with changes based on prevailing cases rates and ongoing advice from Public Health, in consultation with STAC.

More details on all the above, including the development of the testing and isolation requirements underpinning the Safer Travel Policy, can be provided as required.

Appendix B – Findings of the Survey of STAC Members (March 2022)

1. Please indicate which time periods your membership on STAC covered (tick all that apply to reflect the majority of your time on the committee):

	Answer Choices	Response Percent	Response Total
1	Wave 1 (March – August 2020)	57.14%	8
2	Wave 2 (September 2020 – March 2021)	78.57%	11
3	Wave 3 (April – September 2021)	78.57%	11
4	Wave 4 (October 2021 – January 2022)	57.14%	8
		answered	14
		skipped	0

2. Why were you invited to STAC? (tick all that apply)

	Answer Choices	Response Percent	Response Total
1	Because of my profession	85.71%	12
2	Because of my experience	78.57%	11
3	Because I can bring a different viewpoint to discussions	42.86%	6
		answered	14
		skipped	0

3. How well was the role of STAC defined to you before you started? (tick one only)

	Answer Choices	Response Percent	Response Total
1	Very well defined	0.00%	0
2	Well defined	71.43%	10
3	Not well defined	14.29%	2
4	Not at all well defined	14.29%	2
		answered	14
		skipped	0

4. Were you aware of the Terms of Reference for STAC? (tick one only)

	Answer Choices	Response Percent	Response Total
1	Yes	85.71%	12
2	No	14.29%	2
3	Not sure	0.00%	0
		answered	14
		skipped	0

5. How well did you understand your role as part of the cell? (tick one only)

	Answer Choices	Response Percent	Response Total
1	Very well defined	14.29%	2
2	Well defined	71.43%	10
3	Not well defined	14.29%	2
4	Not at all well defined	0.00%	0
		answered	14
		skipped	0

7. Were you able to allocate sufficient time to attend STAC? (tick all that apply)

	Answer Choices	Response Percent	Response Total
1	Yes – within working hours	71.43%	10
2	Yes – outside of working hours	64.29%	9
3	No	7.14%	1
		answered	14
		skipped	0

8. Were you able to allocate sufficient time to preparation before each STAC meeting? (tick all that apply)

	Answer Choices	Response Percent	Response Total
1	Yes – within working hours	42.86%	6
2	Yes – outside of working hours	100.00%	14
3	No	14.29%	2

9. For future use of expert/scientific committees, what improvements to the support offered to members would you recommend? (tick two that are most applicable)

	Answer Choices	Response Percent	Response Total
1	Allocated more time to prepare	57.14%	8
2	Training/pre-briefing	57.14%	8
3	Access to resources to perform additional research	28.57%	4
4	More time between the distribution of papers and the meeting	35.71%	5
5	Other (please specify):	57.14%	8
		answered	14
		skipped	0

10. Overall, to what extent did STAC membership represent the diversity of the island in its membership? e.g. gender, age, ethnicity, socio-economic backgrounds

Item	Average	Min	Max	Std. Deviation	Total Responses
On a scale of 0 to 10: where ten is 'completely' and zero is 'not at all', pick one number	3.79	2.00	7.00	1.52	14
				answered	14
				skipped	0

11. To what extent did STAC membership represent a diversity of relevant scientific and professional expertise from relevant disciplines?

Item	Average	Min	Max	Std. Deviation	Total Responses
On a scale of 0 to 10: where ten is 'completely' and zero is 'not at all', pick one number	6.14	3.00	9.00	1.55	14

12. Did STAC address the correct COVID questions/matters? (tick any statements below that you support)

	Answer Choices	Response Percent	Response Total
1	STAC's scope and remit was broadly right for the circumstances	57.14%	8
2	More attention could have been given to the indirect impacts of COVID such as mental health	35.71%	5
3	A greater focus was needed on the welfare of government and other staff in responding to the pandemic	28.57%	4

12. Did STAC address the correct COVID questions/matters? (tick any statements below that you support)				
4	More emphasis should have been made regarding the health of vulnerable islanders and/or inequalities		42.86%	6
5	Economic impacts should have been better researched and analysed		50.00%	7
6	Other (please specify):		35.71%	5
			answered	14
			skipped	0

13. How much do you agree or disagree with the following statements about STAC?						
Answer Choices	**Strongly agree**	**Tend to agree**	**Tend to disagree**	**Strongly disagree**	**Don't know**	**Response Total**
The support provided by Public Health to STAC (data, evidence and analysis) was effective	57.14% 8	35.71% 5	0.00% 0	7.14% 1	0.00% 0	14
The discussions held by STAC to reach consensus on the data and evidence were effective	7.14% 1	57.14% 8	21.43% 3	14.29% 2	0.00% 0	14
STAC discussions were respectful	35.71% 5	50.00% 7	7.14% 1	7.14% 1	0.00% 0	14
STAC felt like a safe space for me to be able to express my views	14.29% 2	28.57% 4	57.14% 8	0.00% 0	0.00% 0	14
STAC advice reflected the range of views expressed in the discussion	28.57% 4	42.86% 6	21.43% 3	7.14% 1	0.00% 0	14
					answered	14
					skipped	0

14. How much do you agree or disagree with the following statements about STAC?						
Answer Choices	**Strongly agree**	**Tend to agree**	**Tend to disagree**	**Strongly disagree**	**Don't know**	**Response Total**
STAC was effective in assessing short term issues (ie emergence of new variants) that required rapid decision making	26.67% 4	53.33% 8	6.67% 1	0.00% 0	13.33% 2	15
STAC was effective in assessing medium to longer term issues (i.e. strategies, future plans)	0.00% 0	40.00% 6	33.33% 5	6.67% 1	20.00% 3	15
					answered	14

Appendix C – Covid-19 Legislation *(LDO best estimate as at 03/03/2022)*

147 items, with 2 items due for debate on 29 March 2022. The list does not include items drafted but then never made for various reasons.

Title	Made
Notifiable Diseases (Amendment No. 2) (Jersey) Order 2020	06/03/2020
Cremation (Suspension and Modification of Regulations – Covid-19) (Jersey) Regulations 2020	24/03/2020
Marriage and Civil Status (Amendment of Law) (Covid-19 – Temporary Amendment) (Jersey) Regulations 2020	24/03/2020
Statutory Nuisances (Amendment) (Jersey) Regulations 2020	24/03/2020
Regulation of Care (Amendment of Law) (Covid-19 – Temporary Amendment) (Jersey) Regulations 2020	24/03/2020
Regulation of Care (Standards and Requirements) (Covid-19 – Temporary Amendments) (Jersey) Regulations 2020	24/03/2020
Medical Practitioners (Registration) (General Provisions) (Covid-19 – Temporary Amendments) (Jersey) Order 2020	25/03/2020
Covid-19 (Schools and Day Care of Children) (Jersey) Regulations 2020	27/03/2020
Covid-19 (Screening, Assessment and Isolation) (Jersey) Regulations 2020	27/03/2020
Covid-19 (Enabling Provisions) (Jersey) Law 2020	27/03/2020 (registered 07/04/2020)
Covid-19 (Restricted Movement) (Jersey) Order 2020	29/03/2020
Covid-19 (Screening, Assessment and Isolation) (Amendment) (Jersey) Regulations 2020	02/04/2020
Marriage and Civil Status (Amendment of Law No. 2) (Covid-19 – Temporary Amendment) (Jersey) Regulations 2020	02/04/2020
Social Security (Contributions) (Covid-19) (Jersey) Order 2020	03/04/2020
Covid-19 (Residential Tenancy) (Temporary Amendment of Law) (Jersey) Regulations 2020	09/04/2020
Covid-19 (Restricted Movement) (Amendment – Extension) (Jersey) Order 2020	09/04/2020
Planning and Building (General Development) (Amendment No. 5 – Covid-19) (Jersey) Order 2020	09/04/2020
Regulation of Care (Amendment of Law) (Covid-19 – Temporary Amendment No. 2) (Jersey) Regulations 2020	09/04/2020
Control of Housing and Work (Exemptions) (Covid-19 – Temporary Amendment) (Jersey) Order 2020	17/04/2020
Prison (Temporary Amendment – Covid-19) (Jersey) Rules 2020	21/04/2020
Covid-19 (Construction Work) (Jersey) Regulations 2020	22/04/2020
Covid-19 (Construction Work) (Jersey) Order 2020	22/04/2020
Covid-19 (Emergency Provisions – Courts) (Jersey) Regulations 2020	22/04/2020
Covid-19 (Health Insurance Fund) (Jersey) Regulations 2020	22/04/2020
Covid-19 (Mental Health) (Jersey) Regulations 2020	22/04/2020
Covid-19 (Restricted Trading) (Jersey) Regulations 2020	22/04/2020
Covid-19 (Signing of Instruments) (Jersey) Regulations 2020	22/04/2020
Covid-19 (Restricted Movement) (Amendment – Second Extension) (Jersey) Order 2020	24/04/2020
Covid-19 (Restricted Movement) (Amendment – Exceptions) (Jersey) Order 2020	01/05/2020
Covid-19 (Restricted Trading) (Jersey) Order 2020	01/05/2020
Covid-19 (Construction Work) (Amendment – Extension) (Jersey) Order 2020	10/05/2020
Covid-19 (Restricted Movement) (Amendment – Exceptions, Public Places and Third Extension) (Jersey) Order 2020	10/05/2020
Covid-19 (Restricted Trading) (Amendment) (Jersey) Order 2020	10/05/2020

Covid-19 (Capacity and Self-Determination) (Jersey) Regulations 2020	13/05/2020
Covid-19 (Restricted Trading) (Amendment No. 2) (Jersey) Order 2020	15/05/2020
Covid-19 (Civil Partnership and Marriage) (Jersey) Regulations 2020	19/05/2020
Covid-19 (Workplace Restrictions) (Jersey) Regulations 2020	19/05/2020
Covid-19 (Restricted Movement) (Amendment – Workplaces and Fourth Extension) (Jersey) Order 2020	20/05/2020
Covid-19 (Workplace Restrictions) (Jersey) Order 2020	20/05/2020
Covid-19 (Construction Work) (Amendment – Exemptions and Second Extension) (Jersey) Order 2020	22/05/2020
Cremation (Suspension and Modification of Regulations – Covid-19) (No. 2) (Jersey) Regulations 2020	27/05/2020
Covid-19 (Safe Distancing) (Jersey) Regulations 2020	28/05/2020
Covid 19 (Construction Work – Third Extension and Workplace Restrictions – First Extension) (Jersey) Order 2020	03/06/2020
Covid-19 (Construction and Workplace -Amendments and Further Extensions) (Jersey) Order 2020	11/06/2020
Covid-19 (Civil Partnership and Marriage No. 2) (Jersey) Regulations 2020	16/06/2020
Covid-19 (Safe Distancing – Suspension) (Jersey) Order 2020	25/06/2020
Covid-19 (Workplace Restrictions – Third Extension) (Jersey) Order 2020	25/06/2020
Covid-19 (Workplace Restrictions) (Amendment No. 2) (Jersey) Order 2020	30/06/2020
Covid-19 (Workplace Fourth Extension and Construction Repeal) (Jersey) Order 2020	09/07/2020
Covid-19 (Control of Testing) (Jersey) Regulations 2020	14/07/2020
Covid-19 (Rates) (Jersey) Regulations 2020	14/07/2020
Covid-19 (Workplace - Fifth Extension) (Jersey) Order 2020	23/07/2020
Covid-19 (Workplace - Sixth Extension) (Jersey) Order 2020	06/08/2020
Covid-19 (Workplace – Seventh Extension) (Jersey) Order 2020	20/08/2020
Covid-19 (Workplace – Eighth Extension) (Jersey) Order 2020	02/09/2020
Planning and Building (General Development) (Amendment No.6 - Covid-19) (Jersey) Order 2020	08/09/2020
Covid-19 (Amendments – Extension, Suspension and Repeal) (Jersey) Regulations 2020	09/09/2020
Covid-19 (Social Security – Reduction of Contribution Rates) (Jersey) Regulations 2020	09/09/2020
Covid-19 (Enabling Provisions) (Amendment) (Jersey) Law 2020	09/09/2020 (registered 18/12/2020)
Covid-19 (Workplace – Ninth Extension) (Jersey) Order 2020	16/09/2020
Covid-19 (Workplace – Tenth Extension) (Jersey) Order 2020	30/09/2020
Social Security (Contributions) (Covid-19) (Amendment) (Jersey) Order 2020	30/09/2020
Covid-19 (Workplace – Eleventh Extension) (Jersey) Order 2020	15/10/2020
Covid-19 (Workplace – Twelfth Extension) (Jersey) Order 2020	29/10/2020
Covid-19 (Workplace – Thirteenth Extension) (Jersey) Order 2020	12/11/2020
Covid-19 (Workplace Restrictions) (Amendment No. 3) (Jersey) Order 2020	19/11/2020
Covid-19 (Gatherings) (Jersey) Regulations 2020	24/11/2020
Covid-19 (Workplace Restrictions) (Amendment) (Jersey) Regulations 2020	24/11/2020
Covid-19 (Regulation of Care – Standards and Requirements) (Jersey) Regulations 2020	25/11/2020
Covid-19 (Workplace – Fourteenth Extension) (Jersey) Order 2020	26/11/2020
Covid-19 (Workplace Restrictions) (Amendment No. 4) (Jersey) Order 2020	30/11/2020
Covid-19 (Safe Distancing – Exception and Revocation of Suspension) (Jersey) Order 2020	03/12/2020
Covid-19 (Workplace Restrictions) (Amendment No. 5) (Jersey) Order 2020	03/12/2020

Emergency Powers and Planning (Medicines and Vaccines – Covid-19 and Influenza) (Jersey) Order 2020	04/12/2020
Covid-19 (Workplace – Fifteenth Extension) (Jersey) Order 2020	09/12/2020
Covid-19 (Gathering Control) (Jersey) Order 2020	11/12/2020
Covid-19 (Workplace Restrictions) (Amendment No. 6) (Jersey) Order 2020	18/12/2020
Covid-19 (Gathering Control) (Amendment) (Jersey) Order 2020	22/12/2020
Covid-19 (Workplace – Sixteenth Extension) (Jersey) Order 2020	22/12/2020
Covid-19 (Workplace Restrictions) (Amendment No. 7) (Jersey) Order 2020	23/12/2020
Covid-19 (Gathering Control – Extension) (Jersey) Order 2021	04/01/2021
Covid-19 (Workplace – Seventeenth Extension) (Jersey) Order 2021	04/01/2021
Social Security (Contributions) (Covid 19) (Amendment No. 2) (Jersey) Order 2021	07/01/2021
Covid-19 (Gatherings and Workplace Restrictions – Miscellaneous Amendments) (Jersey) Order 2021	15/01/2021
Covid-19 (Gathering Control – Second Extension) (Jersey) Order 2021	19/01/2021
Covid-19 (Workplace – Eighteenth Extension) (Jersey) Order 2021	19/01/2021
Covid-19 (Gathering Control – Third Extension) (Jersey) Order 2021	28/01/2021
Covid-19 (Workplace – Nineteenth Extension) (Jersey) Order 2021	28/01/2021
Covid-19 (Workplace Restrictions) (Amendment No. 8) (Jersey) Order 2021	29/01/2021
Covid-19 (Workplace Restrictions and Gathering Control) (Amendment) (Jersey) Order 2021	01/02/2021
Covid-19 (Workplace Restrictions) (Amendment No. 9) (Jersey) Order 2021	09/02/2021
Covid-19 (Island Plan) (Jersey) Regulations 2021	10/02/2021
Covid-19 (Gathering Control) (Amendment No. 2) (Jersey) Order 2021	15/02/2021
Covid-19 (Gathering Control) (Amendment No. 3) (Jersey) Order 2021	16/02/2021
Covid-19 (Workplace Restrictions and Gathering Control) (Amendment No. 2) (Jersey) Order 2021	19/02/2021
Covid-19 (Gathering Control – Fourth Extension) (Jersey) Order 2021	25/02/2021
Covid-19 (Workplace – Twentieth Extension) (Jersey) Order 2021	25/02/2021
Covid-19 (Gathering Control) (Amendment No. 4) (Jersey) Order 2021	04/03/2021
Emergency Powers and Planning (Medicines and Vaccines – Covid-19) (Jersey) Order 2021	04/03/2021
Covid-19 (Workplace Restrictions and Gathering Control) (Amendment No. 3) (Jersey) Order 2021	12/03/2021
Planning and Building (Covid-19 Bridging Island Plan) (Jersey) Order 2021	22/03/2021
Covid-19 (Workplace Restrictions and Gathering Control) (Amendment No. 4) (Jersey) Order 2021	25/03/2021
Social Security (Contributions) (Covid 19) (Amendment No. 3) (Jersey) Order 2021	26/03/2021
Covid-19 (Gathering Control – Fifth Extension) (Jersey) Order 2021	31/03/2021
Covid-19 (Workplace – Twenty-First Extension) (Jersey) Order 2021	31/03/2021
Covid-19 (Workplace Restrictions) (Amendment No. 10) (Jersey) Order 2021	31/03/2021
Covid-19 (Safe Distancing – Suspension No. 2) (Jersey) Order 2021	09/04/2021
Covid-19 (Workplace Restrictions and Gathering Control) (Amendment No. 5) (Jersey) Order 2021	09/04/2021
Covid-19 (Amendments – Extension and Suspension) (Jersey) Regulations 2021	23/04/2021
Covid-19 (Enabling Provisions) (Amendment No. 2) (Jersey) Law 2021	23/04/2021 (registered 23/07/2021)
Covid-19 (Gathering Control – Sixth Extension) (Jersey) Order 2021	28/04/2021
Covid-19 (Workplace – Twenty-Second Extension) (Jersey) Order 2021	28/04/2021
Covid-19 (Workplace Restrictions) (Amendment No. 11) (Jersey) Order 2021	28/04/2021
Covid-19 (Screening, Assessment and Isolation – Authorised Officers) (Jersey) Order 2021	30/04/2021
Covid-19 (Workplace Restrictions) (Amendment – Enforcement Officers) (Jersey)	30/04/2021

Order 2021	
Planning and Building (General Development) (Amendment No. 7 – Covid-19) (Jersey) Order 2021	04/05/2021
Covid-19 (Workplace Restrictions and Gathering Control (Amendment No. 6) (Jersey) Order 2021	07/05/2021
Covid-19 (Workplace Restrictions) (Amendment No. 12) (Jersey) Order 2021	17/05/2021
Covid-19 (Gathering Control – Seventh Extension) (Jersey) Order 2021	25/05/2021
Covid-19 (Workplace – Twenty-Third Extension) (Jersey) Order 2021	25/05/2021
Emergency Powers and Planning (Medicines and Vaccines – Covid-19) (Third Period) (Jersey) Order 2021	02/06/2021
Covid-19 (Workplace Restrictions and Gathering Control) (Amendment No. 7) (Jersey) Order 2021	11/06/2021
Covid-19 (Election of Jurats) (Jersey) Regulations 2021	30/06/2021
Covid-19 (Gathering Control – Eighth Extension) (Jersey) Order 2021	30/06/2021
Covid-19 (Workplace – Twenty-Fourth Extension) (Jersey) Order 2021	30/06/2021
Covid-19 (Workplace Restrictions) (Amendment No. 13) (Jersey) Order 2021	20/07/2021
Covid-19 (Gathering Control – Ninth Extension) (Jersey) Order 2021	30/07/2021
Covid-19 (Workplace – Twenty-Fifth Extension) (Jersey) Order 2021	30/07/2021
Covid-19 (Workplace Restrictions and Gathering Control) (Amendment No. 8) (Jersey) Order 2021	04/08/2021
Covid-19 (Gathering Control Repeal and Workplace Restrictions Amendment) (Jersey) Order 2021	24/08/2021
Covid-19 (Workplace - Twenty-Sixth Extension) (Jersey) Order 2021	24/08/2021
Emergency Powers and Planning (Medicines and Vaccines - Covid-19 and Influenza) (Fourth Period) (Jersey) Order 2021	24/08/2021
Covid-19 (Workplace – Twenty-Seventh Extension) (Jersey) Order 2021	28/09/2021
Covid-19 (Amendments – Further Extensions) (Jersey) Regulations 2021	08/10/2021
Covid-19 (Employment-Minimum Wage) (Jersey) Regulations 2021	08/10/2021
Covid-19 (Workplace – Twenty-Eighth Extension) (Jersey) Order 2021	27/10/2021
Covid-19 (Enabling Provisions) (Amendment No. 3) (Jersey) Law 202-	23/11/2021 (not yet registered)
Covid-19 (Workplace – Twenty-Ninth Extension) (Jersey) Order 2021	25/11/2021
Covid-19 (Workplace Restrictions) (Amendment No. 14) (Jersey) Order 2021	25/11/2021
Emergency Powers and Planning (Medicines and Vaccines – Covid-19 and Influenza) (Fifth Period) (Jersey) Order 2021	25/11/2021
Regulation of Care (Standards and Requirements) (Reinstatement of Covid-19 Modifications) (Jersey) Order 2021	13/12/2021
Social Security (Contributions) (Covid-19) (Amendment No. 4) (Jersey) Order 2021	20/12/2021
Covid-19 (Workplace – Thirtieth Extension) (Jersey) Order 2021	21/12/2021
Covid-19 (Workplace Restrictions) (Amendment No. 15) (Jersey) Order 2021	23/12/2021
Covid 19 (Workplace Restrictions - Repeal) (Jersey) Order 2022	28/01/2022
Covid-19 (Screening, Assessment and Isolation – Partial Suspension) (Jersey) Order 2022	03/02/2022
Emergency Powers and Planning (Medicines and Vaccines – Covid-19) (Sixth Period) (Jersey) Order 2022	28/02/2022

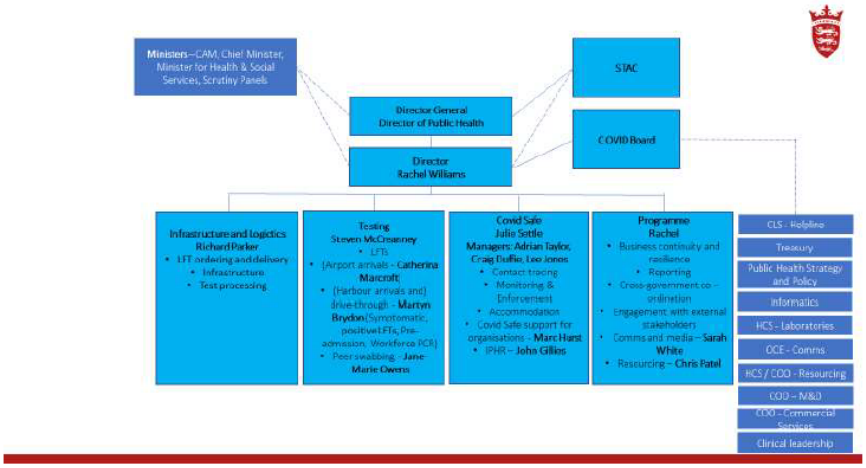
Drafted and lodged, for debate on 29/03/2022 –

Covid-19 (Enabling Provisions) (Amendment No. 4) (Jersey) Law 202- (P.27/2022)	*29/03/2022*
Covid-19 (Amendments – Extensions to September 2022) (Jersey) Regulations 202- (P.28/2022)	*29/03/2022*

Addendum 1 – Testing and Tracing

Self-Assessment Template

Questions for all stakeholders

Governance
Please respond as appropriate: What governance arrangements did you establish to support decision making for the Covid-19 response? And/Or How did you/your department/organisation plug into governance arrangements for the Covid-19 response?
Testing and Tracing governance was implemented at programme inception. As at March 2022 key roles and services are:    Policy direction is determined by CAM, advised by STAC and with the proposals being developed by Public Health Policy colleagues. Covid Board currently meets every 3 weeks. During the earlier part of the pandemic, it met weekly. Team leaders from across the service (including other Government Departments e.g. Coronavirus helpline) currently meet twice per week – Tuesday for Public Health policy updates, general updates from team and requests for information / assistance; Friday for risks, achievements and any other matters. Frequency of meetings has changed through the pandemic – in the early part, and when in crisis / emergency response mode, meetings were as often as twice per day (7 days a week). This then reduced to daily, then 3 times per week, and now twice per week. The Director meets Head/ Lead at least weekly, with more frequent communications by Teams / phone / in person as required. The Director meets Director of Public Health weekly (was Director General Justice and Home Affairs up to October 2021, after which the Team moved Departments to SPPP), and communicates any significant changes to risk or activities of note by phone / email / Teams in between meetings, as necessary. The Director attends and reports to Competent Authority Ministers, Scrutiny Panels, and attends STAC to provide input and insight from an operational perspective. A backbrief meeting is held for the team after each CAM where a significant decision has been made which impacts the team.

The Testing Leads meet formally weekly and have communication via phone and email daily. Covid Safe operational meetings are 3 times a week, with daily operational calls to prioritise work.

Core team members attend other cross-Government or pan-Island meetings, including:

- Strategic Co-ordination Group (SCG) – senior leadership group (Chaired by Director General Justice & Home Affairs) to co-ordinate the emergency response. Meets during a 'wave', then is paused in between
- Safer Jersey group – stakeholders across business (Chaired by Environmental Health); aims to share developments and listen to challenges and issues within key business sectors, including retail and hospitality
- GoJPoJ – Government and Ports of Jersey leads, Chaired by Head of Testing, to ensure co-ordination and a partnership approach e.g. for the arrivals testing centres
- Analytical Cell – Chaired by Public Health Policy Principal - reviews case numbers and clusters

The frequency of each of these meetings has changed in the past 2 years, with frequent meetings during periods of significant change and/or increased risk / positive case numbers.

A Tactical Co-ordination Group (TCG) is called when a significant pan-island risk is identified e.g. the first significant infection within a care home, schools, food distribution etc. TCG is Chaired by the Director of Testing and Tracing, and comprises a small number of senior leaders from Public Health and the relevant sector. TCG meets daily to identify and quickly progress actions which aim to reduce risk and manage the outbreak.

Please provide an appraisal of how suitable these governance arrangements were:

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

What worked well

- Very much a partnership approach
- Flexible and agile – arrangement remained under review and were amended quickly, as required
- Board meetings comprised colleagues from across Government, ensuring broad representation. Key decisions were taken at Board and recorded
- Terms of Reference were clear, Board notes were clear
- Input was encouraged – for risk mitigation and to identify solutions
- Attendance was consistent – participants were committed
- Weekly written Board update was circulated, ensuring key partners were informed of progress and risk regularly
- Team meetings (on Teams) provided opportunity for sharing of progress, risks and issues, and for joint working on solutions and/or requests for information, support or input from others in the team. Meetings were kept positive and solution-focused
- Reporting to CAM and ELT, through the OneGov Covid Team initially and then directly – this ensured Ministers and Executive were up to date, and that there was appropriate oversight and decision making
- Meeting frequency was reviewed regularly and adjusted
- Programme was robustly managed, but without excessive paperwork
- Director is an experienced leader of large multi-site programmes, with a background in health; Service Leads were recruited for their skills, experience and solution-focused approach
- Dedicated Commercial Services input

What didn't work so well

- On occasion, the operational team were somewhat unsighted on forthcoming changes in policy. Short timescales to develop policy, and then to implement changes following CAM then placed pressure on both the policy and operational teams. This was discussed with Policy colleagues and changes made, to help ensure greater visibility of policy direction whilst policy was in development, and therefore increase the lead-in time to possible policy changes
- Limited dedicated support initially for information governance and HR – posts were not included in the original team structure. To mitigate, Information Governance for Covid Safe was secured from IHE, and a Covid Resourcing Team was recruited in order to address capacity gaps
- Initially, Treasury colleagues were overstretched, which placed pressure on individuals (who delivered their inputs in addition to their substantive roles). Latterly a dedicated Finance Lead was appointed to address this capacity gap

What have you learnt, what would you do differently

Learnt / confirmed that:

- Very close working with Policy colleagues is essential to ensure visibility of changes, in order to make operational changes in a managed and timely way
- Flexibility and agility is paramount, to respond quickly to a fast-changing emergency situation and rapidly unfolding events which had different global responses
- Programme management doesn't have to be onerous
- Adjust the frequency of meetings, and the frequency of reporting, to match the risk at the time
- Also review attendees – there's a risk of attendee-creep, where 1 person from each team increases to 2 or 3, which isn't time effective
- Having dedicated specialists is essential for a large, new team (finance, HR, information governance)

What implications did the introduction of new legislation have on these governance arrangements?

None

How did the communications directorate support you/your department/organisation operation during the Covid-19 response?

- Were appropriate systems in place to support your department?
- What communication was required?
- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Regular communications were essential internally and with the public / media. The Comms department worked closely with the Testing and Tracing Team.

This worked best when there was a dedicated Comms Lead; unfortunately, there were some staffing changes and periods where there wasn't a dedicated person (due to staff turnover) which meant that, for example, there were duplicated requests e.g. responses to media enquiries.

Logistical and operational decision making

What Emergency Planning processes did you/your department/organisation have in place prior to the initial pandemic response?

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Government Emergency Planning systems and processes. This included an Emergency Planning Lead and a flu pandemic plan.

What worked well / not so well

The current Director and Leads were not involved in Emergency Planning prior to the initial pandemic response, and therefore can't comment on the period before the pandemic. Director took up post in June 2020, Operational Leads in August 2020.

The flu pandemic strategy is useful, but it is not an operational toolkit.

Of note, the Director was involved in the OneGov Covid Team (1GCT) from the beginning of the pandemic, and was responsible for leading the Community Taskforce, which was set up to co-ordinate services and support for Islanders who were shielding or isolating. A separate submission can be produced for this work, should that be required / requested.

What have you learnt and what would you do differently

Learning will continue to be consolidated, incorporating learning from the UK (noting that this was one of the subjects of the Local Government Association conference on 23 /24 March 2022). Systems, structures and processes in Jersey will be reviewed in the coming months, including consideration of Emergency preparedness resilience and response (EPRR), local resilience partnerships (or similar for Jersey), and health protection (review is in development). As part of this, an operational toolkit is needed, which can be 'plug and play' for future pandemics, along with a list of those who were integral to this pandemic response, who can be seconded to lead a future response.

Skills, experience and mindset are all important – solution-focused, creative, clear-thinking, calm and resilient people who are highly organised, brave, bold, robust and able to work in partnership are required to lead pandemic response services.

The future health protection / public health delivery function should seek to retain key individuals, to ensure organisational memory, skills and experience are not lost.

How have you/your department/organisation Emergency Planning processes evolved during the pandemic response?

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

What worked well

- ***Commitment*** – across Government and from partners such as Ports of Jersey, Police and JCIS (Jersey Customs and Immigration Service). This enabled the testing service to be implemented quickly and at scale. Resource was drawn quickly from across the organisations, with individuals seconded to both testing and tracing.

- ***Enthusiasm*** – a real sense of 'we're in it together' helped with extremely long hours and 7-day working. The crisis nature of the issue helped both individuals and organisations coalesce for a common purpose. The pandemic response, especially when the level of commitment required became clear, differentiated those individuals who put themselves forward, and continued to do so, for many months.

- ***Community effort*** - communications around the seriousness of the situation worked well in rallying the community. Managers were willing to release staff to be seconded to the Covid response in the early days. Calls for volunteers went out via media and volunteer.je to an unprecedented response, which was coordinated by the Community Taskforce.

- ***Agility and resilience*** – teams involved in the response were highly creative, resilient and flexible to changing circumstances. Staff up-skilled quickly and cross-skilled as roles expanded throughout the course of the response. The team was brave in the face of many

unknowns and flexed their approach during surge periods. Dedicated leads emerged in different areas, such as Comms, M&D etc., providing a consistent approach. The team delivered its own IT systems (IPHR and BaTS) to support operations.

- ***On-island lab*** - bringing the testing lab on-island greatly improved turnaround times and scope of control.

- ***Media/public response*** – the overall media response was felt to be positive and the public comms worked well. The public response made the team felt like their hard work was recognised.

- ***Repurposing*** - some systems, processes and teams who worked in similar roles / areas were repurposes e.g. Environmental Health team introduced the Contact Tracing service, based on their contact tracing principles for other transmissible diseases / situations such as a food poisoning outbreak

- ***Responsiveness to change*** - Speed of response in developing services, which was helped by a relaxation of restrictions e.g. enabling individuals to work on a risk assessment pending DBS checks being completed, exemptions to full tendering in order to build testing centres. Services were responsive, with successive (often short notice) changes to policy and/or demand. Managers were creative and resilient, solution-focused and committed.

What didn't work so well

- ***Scalability*** – services weren't scalable at the beginning of the pandemic, as the scale required was far greater than previous flu outbreaks. Initial service locations were selected based on immediate availability (out of necessity to respond very quickly); services were introduced e.g. at FiveOaks, whilst alternative, larger locations were sought (Airport drive-through).

- ***Skills*** – there was no list of key people with the right skills, knowledge and experience who could be repurposed for the pandemic response. It took time, and external recruitment in some cases, to find the right people (most of whom are still with the team now).

- ***Whole Government resilience*** – Prioritisation of the pandemic response required IHE staff to be seconded to Contact Tracing for the first few months. This impacted Environmental Health's ability to deliver BAU functions. When it became clear that the pandemic was ongoing, fixed term and zero hours colleagues were recruited and a new Operational Lead selected. Skills were transferred from IHE staff, and one senior IHE leader remained in the Contact Tracing Team, which provided continuity and professional oversight.

- ***Recruitment*** - recruiting before the Emergency Resourcing arrangements were agreed was bureaucratic and time-consuming. Emergency Resourcing enabled new joiners to commence more quickly e.g. with a risk assessment and supervision pending DBS clearance. However, resourcing capacity within People Services and the HCS Bank remained a challenge e.g. having enough people to undertake interviews or identify and roster team members. The OneGov Covid Team introduced a dedicated Resourcing Team, which reduced pressure on People Services and provided recruitment and repurposing.

- ***Reconnection plan*** - was well received but operationally difficult and complex. At times it felt like 'looking into a crystal ball' and was hard to align with public comms. As time went on, the pressure to implement significant changes quickly continued. On occasion, the frequency and pace of change was unrealistic (especially when IT changes were required), and at times the operational teams had not been fully sighted on the possible direction of

change or probable required speed of response. This reduced the ability of the operational team to contribute to realistic requirements (although the Director General did represent the team at meetings, and did explain the impact on the service), and it placed pressure on a small number of leaders in the operational teams to deliver successive changes quickly (requiring excessive hours to be worked over many weeks).

- ***Lead-in times*** – the pace of change meant that time for testing of operational systems was not possible. This meant that, for example, IT system changes had to be implemented without full comprehensive, robust testing. On occasion, this led to issues being identified once the changes had been implemented, and workaround solutions then introduced e.g. an issue with test result notification which required manual review and manual notification until the IT 'gate' was fixed.

Learning/what could have been done differently

The timescales of the pandemic were always uncertain, and the necessary emergency / crisis approach in the initial stages of the pandemic meant that decisions had to be taken very quickly. As the initial pandemic developed and it became clear that services needed to be more scalable and sustainable, a dual track was implemented – with services being operated at the same time as sustainable services were being developed (larger premises, more staff (fixed term, to release secondees), new IT systems, reviewed processes).

During a lengthy pandemic where the global situation is changing and local risks emerging almost daily, change is inevitably constant and the pace of change is unrelenting. The demands feel at times unachievable, and everyone has to draw deep from reserves of resilience that we didn't know we had. The importance of rest / recuperation time is well understood, but with a small team and an emergency situation, in a 7-day service where the risk is changing daily, the ability to take a break was very limited.

The support from colleagues was critically important, and helped build excellent, trusted relationships – some people are at their best in a crisis, but we do need to be mindful of 'burnout' and ensure some breaks (even if just an exercise break daily) are built into working patterns.

Humour is important, along with a focus on solutions and a positive, optimistic outlook – and an ability to identify what is possible (at stretch) and aim to achieve this, rather than aiming for perfection. The ability to negotiate and compromise is also required on occasion – where expectations are unrealistic and unachievable, discussions were needed to help craft a solution which was more deliverable, but still able to achieve the desired outcomes.

Personal networks to secure help, support and input quickly is critical.

The team learnt that they are more resilient than they think they are. The team also got better at preparing for each surge, reflecting on and implementing learning from previous surges.

What we would do differently

- develop closer relationships to policy colleagues earlier in the pandemic (and outside of formal structures if necessary)
- anticipate that IT solutions can create issues - assume risk with any IT change
- secure longer term contracts for staff - the unpredictable nature of the pandemic meant that contracts were often renewed for 3 months. This led to some staff leaving for more secure employment
- improve the onboarding process
- ensure emergency data sharing approvals are in place, to support departments working together
- assume the emergency will be in place for many months / years, and:

- devise sustainable working patters / shift patterns and managerial cover to share the responsibility for long days over 7-day working
- focus on wellbeing, work/life balance etc

Describe the implications on you/your department/organisation on procurement and the continuity of supply chains during the pandemic response?

- Were appropriate systems in place to support your department?
- What procurement was required?
- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Procurement involved: testing centres (scaffolding, portacabins, testing booths, sheds, shelving / storage); PPE and consumables; IT systems; transportation (car / van plus off-island transport for swabs); office space and supplies; cleaning; waste management; laundered scrubs; IT and phone hardware; licenses for phones and software; zero hour staff; test processing contracts; LFTs.

What worked well

- ***Bringing in expertise*** – the team identified early on that they didn't have resource around infrastructure and logistics, so an Infrastructure and Logistics Manager was recruited. Dedicated expertise from Commercial Services was available, which was essential in securing LFTs. The Director had almost 10 years experience in Government, so was able to provide guidance based on knowledge.

- ***Stakeholder relationships*** – excellent relationships with external partners e.g. Ports of Jersey were instrumental in enabling the Airport drive-through, on-island testing and the testing centres at Airport and Harbour. Their leads worked in very close partnership with Testing, devising systems and processes and overcoming operational challenges in real time e.g. when 2 large ferries arrived in July 2020 and needed to be processed and cleared very quickly, before the tide turned and passengers would have been stranded in Jersey. Weekly meetings, and with key operational leads being based in the Port locations was critical, as was the relationships which were built by all parties contributing positively and supportively, which created a truly 'one team' ethos.

What didn't work well

- **Somewhat inflexible requirements/systems** – the existing systems/governance processes are appropriate for BAU Government but are not sufficiently responsive for an emergency situation (e.g. exemption processes required for renewing small contracts with suppliers).

- ***Lack of training*** – there needs to be easily accessible (online) training for key governance requirements e.g. Supply Jersey, Public Finance Manual, Commercial Services requirements.

Learning/what we would do differently

Better recording of processes/documentation to ensure a smooth handover of responsibilities.

Dedicated staff to support governance.

Describe the implications on you/your department/organisation of strategies and systems put in place for testing, outbreak management (including in schools, care homes, etc) and self-isolation on your department

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Testing

The scope of testing has included: inbound travel (Airport and Harbour); private planes and boats staff; leisure boats; community peer-to-peer - health (including GPs and dentists), emergency services, prison, care homes (staff and residents), domiciliary care agencies; Airport drive-through and Harbour, pus the home visit team for symptomatic individuals, direct contacts and follow ups, follow up travel tests at day 5, 8, 10 etc., pre-admissions some pre-departure travel testing (e.g. for patients having procedures in the UK); workforce PCRs; education settings. LFTs for education, businesses and latterly all islanders at home.

Testing services include the staff, facilities, IT, systems and processes for making appointments, registering individuals, checking identity and contact details, taking the swabs, packing, batching and sending for processing (originally to the UK, then to the on-island lab (from September 2020) and since November 2021 to the hospital lab). Sending swabs off-island for sequencing.

Covid Safe (previously called Contact Tracing, Monitoring and Enforcement)
Scope includes – contacting positive individuals to provide advice and guidance, and to identify and contact direct contacts; booking tests for direct contacts; monitoring and enforcing isolation; processing critical worker and compassionate exemptions; processing pre-departure certificates; welfare calls (at points in the pandemic, sometimes as often as daily); welfare / isolation compliance visits to individuals' homes; attending the daily analytical cell, gathering evidence and legal documentation for enforcing regulation; monitoring email inboxes and responding to individuals queries; contacting LFT positive individuals; issuing Recovery Letters; providing advice on individual isolation requirements.

What worked well
In addition to points already raised e.g. partnership working:

- ***Adaptability*** – the team were consistently flexible and adapted to change – in terms of response to policy changes and changes in demand

- ***Continually improving*** - through service review and improvements to systems, processes, staffing, training in order to improve flow, speed and customer experience – and also to improve the working lives of colleagues where possible.

- ***Customer / community focus*** - the approach was adapted based on how the situation was impacting the community/individuals – they considered welfare (e.g. possible domestic abuse and/or safeguarding risks) and how the measures would affect people.

- ***Pragmatism*** – a solution-focused approach, with deliverable, pragmatic solutions – including workaround solutions where necessary.

What didn't work well

- ***Consistency of communication*** - when teams handed over, and sometimes the IT systems did not integrate in order for one version of the truth to be held e.g. about an individual's contact details.

- ***Policy changes*** – some policies had beneficial impacts but also had unintended consequences e.g. removing the requirement for Direct Contacts to isolate meant schoolchildren were able to continue their education in the classrooms rather than experiencing multiple periods of isolation as a Direct Contact, and also improved the mental health and wellbeing of Islanders; but it may have also contributed to increased demand, as asymptomatic Direct Contacts were in the community (albeit mask wearing, hand hygiene and social distancing should have help reduce the risk of transmission).

- ***Airline cooperation*** – for overseas travel, airlines in the UK check Covid forms and compliance prior to boarding. For travel to Jersey, there was no such check. This resulted

in passengers arriving having not filled in the required forms or being unaware of Jersey's Safer Travel Policy – some of whom were 'red' or 'amber', meaning they had to isolate on arrival. One of the four airlines was unable to provide the flight manifest quickly, which delayed contact tracing. (to note: airlines were dealing with a huge amount of pressure as well at this time).

Learning/what we would do differently
Learning has been covered in previous answers.

A key recommendation is for an operational toolkit to be available to support a future pandemic / whole-island public health emergency, along with a list of individuals involved in leading the pandemic response, who could be repurposed in future if required.

Describe the implications on you/your department/organisation of restrictions on:

- Physical distancing
- Mask wearing
- Self-isolation
- Connectivity and border control

- ***Physical distancing:***
  - the number of staff that could be in one office was restricted; office space needed to be larger than normal to accommodate distancing
  - it was often challenging to find accommodation for people who needed to isolate
  - new office procedures e.g. one in one out, one person in the lift, team segregation
  - online meetings.

- ***Mask wearing*** – monitoring compliance in businesses was one of the functions of the Covid Safe team. The teams themselves were highly compliant with enhanced internal team policies, as remaining safe and Covid-free was critically important for service continuity.

- ***Self-isolation*** – monitoring isolation was a core function of the Monitoring & Enforcement, and latterly the Covid Safe team. Through doing welfare checks, the team experienced welfare concerns first hand, which impacted some of the staff personally. Isolation itself created staffing availability issues in some services across the island. The effect of isolation on children and disruption to schools was also significant.

- ***Connectivity and border control*** - at peak, there were 36 inbound flights per day, which required arrivals testing. Significant issues were experienced by the arrivals testing teams in:
  - frustration of passengers due to frequently changing rules
  - airlines cancelling flights
  - regionalised RAG status which many passengers struggled to understand
  - passengers not checking requirements before travelling, and arriving to be told they must isolate or return home
  - many passengers also didn't have contingency plans for if they tested positive, so accommodation would have to be arranged
  - private pilots and commercial private pilots.

The balance of public health and harm with regard to wider societal impacts

Describe impacts felt on you/your department/organisation

- What community groups/sectors of the population have been impacted?

What community groups/sectors of the population have been impacted?

Testing and tracing has impacted every Islander, and every visitor to the Island. Key groups have included:

- Health and care services, including care homes, Ambulance service, GP surgeries, domiciliary care agencies, dental practices
- Education (teaching staff, nurseries, support staff, children, parents)
- Emergency Services, including SOJP, FRS, JCIS
- Prison service
- Critical National Infrastructure
- Freight, post & delivery services
- Hospitality sector
- Retail sector
- Building and construction
- Cleaning services
- Leisure and recreation
- Public transport
- Public sector
- Security and facilities management
- Voluntary sector
- Wellbeing, cosmetic and beauty
- Worship, funeral and marriage

Describe how the work undertaken by you/your department/organisation impacted on different population groups

Testing and tracing impacted on different groups differently, depending on the relative risk to the group (caused by vulnerability, frequency of infection or criticality of the service).

The team helped keep the island safe by providing free and fast testing, ready access and keeping the public informed of their positive/direct contact status. An acknowledged downside of this is that some people, for example children and teachers, had to test and isolate very frequently which negatively impacted their wellbeing.

Children: the service worked closely with CYPES colleagues, in order to work with education settings. Testing and tracing policies, along with the spread of infection amongst under-18s, led to significant numbers of children isolating due to being positive or Direct Contacts, whole classes being designated as 'Indirect Contacts' (and needing testing), and long lists of school children who needed to be contacted and appointments booked. The number of school staff testing positive or isolating led to classes and, in some cases whole schools, being temporarily closed.

Over Christmas 2020, the team worked closely with headteachers to identify and implement process changes, and to proactively offer support e.g. through visits to individual schools to help them be 'covid-safe'. Testing was brought into schools (initially for staff and year 11, 12 and 13 students). Latterly, the school LFT programme provided boxes of kits and encouragement to test frequently prior to attending school.

Care homes: Initially, testing was provided within care homes by the testing team. This was supported by a mobile unit which had been provided by FRS. As it became clear that the pandemic was going to continue for months, a peer-to-peer support service was offered. This provided competency training and ongoing support for staff in care homes, to enable them to test staff and residents regularly, at a time which best suited their operational needs (rather than at a fixed time for testing services being brought in to the home). Latterly, when LFTs had been approved for wider use, LFTs were provided to care homes as part of the workplace screening programme.

Jersey has been a high-testing, low prevalence community throughout the pandemic – the Jersey public were responsible and utilised the testing resource available, which helped keep the death rate low. In terms of the population as a whole, policy changes have determined the testing and tracing services that were provided – in type and volume. Service changes have improved accessibility and speed for Islanders e.g. people can now book their own test appointment.

Addendum 2 – Vaccination Programme

The roll out of the Vaccination Programme followed the advice of the Joint Committee for Vaccinations and Immunisations (**JCVI**), identifying a range of priority groups, including clinically vulnerable Islanders and those working in front-line health and social settings.

Jerseys' vaccine programme was World Leading and achieved the fastest deployment, with high levels of uptake.

- The objective of achieving an 80% take up for both primary doses in adults was achieved in just 7 months.

  - 88% of population over 18 years old received 2 doses of COVID vaccination
  - 62% of all islanders over 18 years old received 2 primary doses and a booster
  - Collaborative working – awarded with 'Team of the year' award in 2021!

The 2021 winter influenza (flu) vaccine programme was co-administered at the vaccination centre, with over 13,000 doses being administered at the same time as the COVID booster vaccine. This led to a doubling of the uptake of the flu vaccine in the 50-65 age group compared to previous years.

- Primary care and acute care were not overwhelmed, and the high levels of response needed for islanders in a pandemic were maintained throughout the year.
- Public Health measures relating to educational, economic and social welfare were formulated with full visibility of the vaccination levels in the community.

Overall Lessons Learned	
Centralised model (Fast, Safe and Efficient use of varied vaccine quantities)	▪ Equitable distribution of vaccine ▪ Designated roles in a centralised team, allowed safe and efficient service. Clinical side and project team ▪ Vaccine dose management to minimise wastage ▪ Agile and Flexible model to deploy which mirrored variable vaccine deliveries
Fort Regent as Vaccine Centre	▪ Great central location with supporting infrastructure ▪ Safe deployment, social distancing, flow, easy access for all Islanders (inc more traditional hard to reach groups)
Part of UK pg	▪ Being a member of the JCVI Committee, allowed expert policy thoughts were fed to our pg, in advance of publication of guidelines which occurred each week ▪ Being a member of the PHE vaccine governance supported the fast deployment of the vaccine
Comms	▪ Regular comms and updates – created an Island wide momentum which resulted in high levels of confidence in service and therefore high uptake rates
Celebratory Comms	▪ 'Celebratory' comms: Milestones, workforce etc. Again, created engagement with the Island

<50 Strategy	▪ Focussing on age/demographic and the comms for that group were designed differently – rather than generic, again created a sense of ownership and excitement about the programme
Minority Group Engagement	▪ Consideration/engagement with minority and hard to reach groups, was important and there was good feedback (e.g., shelter trust, Agricultural workers) that this individualised prg's supported uptake
Early Media	▪ Working with the media early on created a sense of openness and trust. We did however underestimate the requirement of information – which became very quickly overwhelming
▪ Effective, targeted comms are vitally important to the success of the project; working with behavioural scientists, assisted inform the comms. ▪ Media management and their expectations require significant support. ▪ Scrutiny and spotlight of the pg. was incredibly high and so resilience.	

Digital	
Training Lead Essential	▪ Communication channels between stakeholder groups/share of decisions ▪ Instalment of digital systems requires training of use of digital at vaccination centre
▪ Digital certification – took longer and was far more challenging than was anticipated. ▪ The booking system was adopted from the Swabbing booking system. This was a challenging system to use and created additional work at the beginning of the programme.	
Pharmacy	
Centralised model	▪ A centralised model with single point of storage and management, ensured that good governance was easy to maintain ▪ Purchasing of equipment, even without the budget in place, ensured that essential equipment was on island, on time
Project	
Reporting	▪ Centralised model, ensured that data and reporting lines were quickly available to the Chief Minister and CEO
▪ Negotiation on Business case (lines of accountability) took time and were could have created unnecessary delay to the project to have time and population criteria. ▪ There was no set policy or funding in place to allow the Vaccination Programme to go ahead with administering a medicine that was approved on a temporary authorisation for use. This entailed a significant amount of policy work and discussion. It would be useful to have agreed and a position in place in the event that this should this occur again.	
People	
Hotline collaboration	▪ Having a close working relationship with an already established contact centre, was valuable
Op's lead, workforce lead, project lead and Head of Pg.	▪ Having a small senior team, led to quick decision-making and lines of accountability clear

	▪ Having an experienced logistics person on the team, rather than from health was one of the key successes
Booking & Ops team	▪ Having back-office function, should have been planned for at an earlier point ▪ Was a valuable function to support the high number of queries and booking questions
▪ Policy and governance – due to the vaccine availability there became a high number of requests to receive the vaccine outside of the JCVI priority groups. This was a challenge to manage, which required a vaccination prioritisation panel, to review the applications. The governance and panel set up, wasn't anticipated, but once set up, provided support to this challenge.	

ECONOMY

We provide advice, policy, and legislative support to every economic sector, and through relationships with arm's length organisations that support economic development, regulation and conformance to recognised international standards

What we do
We help create the environment for Jersey to have a sustainable, vibrant economy, and a skilled workforce, for the future. Our main responsibilities include:

- working closely with partners to support the development and diversification of Jersey's economy, including the retail, hospitality, rural digital, aircraft and marine sectors
- protecting and developing the reputation and opportunities for financial services industry, and ensuring that it meeting international standards for combatting crime
- overseeing Jersey Business to support new and established businesses
- developing growth and trade and, through Locate Jersey, encouraging inward investment, the relocation of appropriate business to Jersey, and the relocation of high net worth individuals who will contribute economically and socially
- liaising with organisations to support and promote sport, arts, heritage and culture
- providing impartial analysis and advice on the economy, competition, and intellectual property to the States Assembly and Government

SELF-ASSESSMENT TEMPLATE

Questions for all stakeholders

Governance
Please respond as appropriate: What governance arrangements did you establish to support decision making for the Covid-19 response? And/Or How did you/your department/organisation plug into governance arrangements for the Covid-19 response?
Functional reporting lines for all economic matters had transferred (to the now Director General, Economy) shortly before the onset of COVID-19. This was a long-standing – rather than prescient – move however the consolidation of financial and headcount resources undoubtedly supported our response, governance and oversight. The enlarged team remained within Office of the Chief Executive ("OCE") throughout 2020 / 21 and adopted OCE governance models together with our compliance to GoJ-wide governance e.g. Public Finances Manual. For ease of reference throughout this response and consistent with current organisational structure, I will refer to my team as Department for the Economy ("Department" or DfE") throughout this response Actions and initiatives were submitted to the relevant forum for update and / or approval, including Competent Authority Ministers, Emergencies Council and the Council Of Ministers. The Chief Economic Advisor was appointed to the Scientific & Technical Advisory Cell ("STAC") to provide an economic view in the context of the 'balance of harms' strategy adopted by Ministers.
Please provide an appraisal of how suitable these governance arrangements were: • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
The governance arrangements broadly worked and certainly provided robust challenge across key areas of the pandemic response. Having been structured under the emergency planning framework, we may have benefited from transition to something more akin to a business as usual ("BAU") footing, particularly after the 2nd wave of infection and with the vaccination phase effectively moving us to a point of living with COVID-19 in the community. The emergency planning framework is better designed for a significant 'blue light' emergency scenario with more immediate risks to life, infrastructure etc rather than to consider and address collateral harm issues of a pandemic such as increased mental health and domestic violence issues arising from lockdown periods. The same can be applied to economic harm from episodes of business and economic disruption that cause harm on each occasion and cumulative harm over time. The governance arrangements did not adequately address these longer term, cumulative issues in a manner consistent with balance of harms.

What implications did the introduction of new legislation have on these governance arrangements?
There were no implications following introduction of new legislation.
How did the communications directorate support you/your department/organisation operation during the Covid-19 response? • Were appropriate systems in place to support your department? • What communication was required? • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
My Department worked closely the Communications Directorate throughout the pandemic. Key touch points were: • Development and approval of press releases on economic support measures • Development and approval of press releases and supporting collateral (leaflets, posters, signage) regarding the various public health measures implemented) • Web and social media content to explain the actions taken by the Department and reach our target audience of individuals and businesses needing access to economic support • Staging of media conferences, webinars etc to convey key messages throughout the pandemic. Overall, this worked very effectively, particularly so when one considers the novel content and pace required. A key issue was the absence of discipline around the communications grid, something that could be cynically viewed from outside and in my opinion, unduly so. An effective communications grid supports clarity and co-ordination of messages and channels in order that there is the best possible opportunity to those messages being received and understood by the intended audience. This can also prevent messages being trailed or test ed ahead of formal announcement in a way that may confuse or bring pressure upon others.
Logistical and operational decision making
What Emergency Planning processes did you/your department/organisation have in place prior to the initial pandemic response? • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?

The Department and its staff were familiar with emergency planning protocols and our own business continuity planning. The latter already took account of remote working and staff all held GoJ-issued laptops that supported remote working. One additional benefit was the early rollout of Office 365 functionality as this facilitated collaborative working far more readily than would be possible, including the highly valuable use of Teams.

Staff were encouraged to take annual leave throughout the year, regular day time breaks etc.

Assistance was given to set-up a comfortable work environment at home with risers, headsets etc.

How have you/your department/organisation Emergency Planning processes evolved during the pandemic response?

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

For our purposes, the processes worked well during the pandemic response and there was no need to amend them.

Describe the implications on you/your department/organisation on procurement and the continuity of supply chains during the pandemic response?

- Were appropriate systems in place to support your department?
- What procurement was required?
- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

The Department holds responsibility for economic matters and the island supply chain is a key factor in sustaining trade. Work previously undertaken on Brexit planning served us well as sound relationships had been developed, notably within the logistics chain and essential retail (supermarket and pharmaceutical) providers. This enabled:

- stand-up contingency arrangements with Condor Ferries
- planning for safe conduct of essential retail e.g. limited footfall at any one time, store signage and floor markings to respect social distancing, rapid re-design of till and counter areas to create physical barriers that mitigate aerosol spread
- assurance over supplies into the island and onward capacity to reassure the public in efforts to dissuade panic buying

I wish to commend the logistics chain and essential retailers for their ready and constructive engagement during this period.

Describe the implications on you/your department/organisation of strategies and systems put in place for testing, outbreak management (including in schools, care homes, etc) and self-isolation on your department

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

The approach evolved throughout the pandemic as initial concerns subsided, public health requirements reduced etc and the Department followed these throughout.

A rapid move to home-working (for all other than critical staff), physical distancing within the office environment, increased personal hygiene and cleaning measures within the office etc all assisted in maintaining business continuity and resilience.

A corporate 'steer' from People & Corporate Services kept line managers abreast of the prevailing strategies that we, as an employer, wished to adopt for the workforce whilst generally leaving some room to interpret for setting or circumstances of the individual departments within GoJ.

Describe the implications on you/your department/organisation of restrictions on:

- Physical distancing
- Mask wearing
- Self-isolation
- Connectivity and border control

The Department was no more impacted than similar large office settings from the restrictive measures introduced by Public Health.

We held financial and governance responsibility for the lifeline Blue Islands Southampton connectivity that supported essential travel during the early part of the pandemic. This played a valuable role in transporting islanders for essential health treatment in the United Kingdom as well as being a vital link for critical family / life events and essential business travel.

The balance of public health and harm with regard to wider societal impacts

Describe impacts felt on you/your department/organisation

- What community groups/sectors of the population have been impacted?

Overall, the balance of harms strategy was pulled around significantly by a combination of political and public pressures. Examples include comparisons to Guernsey, Sweden, Australia, New Zealand, Ireland and others. A look back over the last 2 years would suggest that no single strategy or playbook has been universally effective and instead, jurisdictional approaches had to be designed and modified as circumstances presented.

Nevertheless, these external political and public pressures at times led to an imbalance in favour of positive COVID-19 related health factors to the detriment of real-time consideration of economic, social and non-COVID-19 health harms. Overall deaths reported by official figures were lower in 2020 than in 2019 and I say this not to be dismissive of the risk to life and long-term health that COVID-19 presented, but simply that a significant range of other harms would require active consideration within a genuine balance of harms approach, for example:

- Loss of learning and companionship in educational settings
- Loss of livelihoods of business owners and employees
- Reduction in early stage self-reporting and / or identification of symptoms that signal long-term, serious health issues
- Consequential mental health pressures from those fearing the health, economic and social impacts of the pandemic
- Increased prevalence of domestic abuse during forced lockdown periods and from increased anxieties about future outlook

There has been a tendency also to look at these in the moment so to speak i.e. against current caseloads, rather than to see cumulative deterioration or acceleration in other harms and assess current or near-term actions against that accumulated harm.

The Department worked effectively with colleagues across Government to design and deliver an unprecedented package of economic support measures that evolved throughout the pandemic, indeed, some are just expiring in March 2022. This significantly mitigated loss of livelihoods, business infrastructure and the consequential pressures on individual's mental health although at a very considerable financial cost. It is important to consider this in the way that the best form of business support was always through businesses being able to enjoy unfettered trade.

Describe how the work undertaken by you/your department/organisation impacted on different population groups

The Department's work supported a broad range of groups:

1. Individuals: through design and delivery of the **Co-Funded Payroll Scheme ("CFPS")** with colleagues across GoJ we supported 16,000 individual employees at the height of the pandemic. CFPS evolved throughout the pandemic to provide an appropriate level of ongoing support to preserve employment and livelihoods.

2. Businesses: whilst businesses secured indirect financial benefit from CFPS supporting an element of their employee payroll, that scheme was designed principally with the individual in mind.

   A **Business Disruption Loan Guarantee Scheme ("BDLGS")** was conceived, designed and delivered by GoJ and the template rolled out in parallel to Guernsey, Isle of Man and Gibraltar. BDLGS provided a GoJ guarantee to banks in favour of individual borrowers for up to 80% of new credit facilities by way of overdraft or loan. This supported working capital and ongoing viability of businesses.

   Recognising additional support for seasonal businesses across hospitality and events, the **Visitor Accommodation Support Scheme ("VASS")** and **Visitor Attraction and Events Scheme ("VAES")** were conceived, designed and delivered. VASS delivered support to hotels and self-catering units based around their fixed costs whilst VAES delivered support to attractions and events-related businesses, also bsed upon fixed costs.

   The **Fixed Costs Support Scheme ("FCSS")** recognised a gap in provision for smaller businesses, typically with lower turnover and made fixed payments based upon size of the business and whether they were fully or partially restricted in their trade as a consequence of Public Health restrictive measures.

3. Charities and voluntary groups: the Department holds responsibility for the Jersey Reclaim Fund, receiver of proceeds from dormant bank account legislative obligations. Funding was released from the Fund to support local charities and organisations with increased resources during the pandemic.

TREASURY AND EXCHEQUER

Treasury and Exchequer looks after the island's finances and assets, ensuring the protection and good use of public funds

What we do

We aim to ensure long-term financial sustainability for the island by making sure ever Jersey pound of taxpayer's money is spent wisely and all financial implications or decisions are understood.

Our responsibilities include:

- long-term financial planning, prioritisation of investment decisions and ensuring the financial stability of the Government
- financial management, accounting reporting and compliance
- administration of the financial assets and holdings of the Government, and undertaking the Government's role as a shareholder to partner organisations
- evaluating and improving the effectiveness of risk management, controls and governance processes
- collection of Government revenues and ensuring compliance

Commercial Services

Commercial Services leads on developing the market for supplying goods and services using best practice commercial models and collaborating with our supply chain to ensure value for money and innovation across commissioning and procurement. It also advises and supports in areas such as commercial negotiations and total cost of ownership modelling. It supports the One Gov vision of a Commercial organisation that is more business-like.

The function includes:

- Procurement
- Strategic supplier relationship management
- Other commercial activities

SELF-ASSESSMENT TEMPLATE

Please note: As a result of the very close ties to Treasury and Exchequer (T&E) that were established during the COVID response, in November 2021 Commercial Services transferred from COO to T&E and, therefore, their response is included in the response from T&E.

Questions for all stakeholders

Governance
Please respond as appropriate: What governance arrangements did you establish to support decision making for the Covid-19 response? And/Or How did you/your department/organisation plug into governance arrangements for the Covid-19 response?

Treasury and Revenue Jersey Senior Leadership Teams held regular meetings since the start of the pandemic to discuss and address any Governance and Business Continuity issues. All meetings were formally minuted. This fed into the corporate Business Continuity calls which were initially held on a daily basis and we were required to provide a RAG status. We continue to monitor our status weekly and feed into central activity. This includes a forward look to address any challenges or issues we become aware of.

The Treasurer, and his Senior Leadership Team, met formally with the Minister weekly throughout the pandemic (as they did before the pandemic and will continue to do). The Minister was advised and consulted as appropriate as the response developed.

The department did maintain (and continues to do so) a full schedule of all Covid-related decisions taken by the Minister, or the Director General under delegated or statutory authority.

Operationally T&E did not take on any new responsibilities, but increased priority was placed on certain financial operations to support departments and the island. Our focus changed to the most relevant matters: paying individuals and suppliers promptly, deferral of debt, closer monitoring of investment portfolio, closer cash flow monitoring and forecasting, working on support schemes e.g. BDLGS, CFPS, Blue Islands lending and the related funding, financing, tax and debt management changes and financial strategy reworking required. A small number of T&E staff were seconded to other areas of Government during the pandemic.

At the start of the pandemic, T&E Senior Leadership Team and other key officers reviewed Business Continuity Plans to include essential activity and conducted stop, start, continue analysis of all projects to determine what needed to be reprioritised. Projects and BAU activities such as the Government Plan, Independent Taxation and the Annual Report and Accounts were therefore sometimes covered by other colleagues and reprioritising of resourcing.

The corporate matrix was used to assess staff who were business critical to T&E and those that could be released. We were playing a key role in assessing CV19 response, implications, funding and then monitoring programmes of work.

Commercial services set up a response structure, including an online triage system, agreeing priorities for the directorate with the CEO and COO. No changes were made to the delegated authority framework in COO to respond to the Covid pandemic COO SLT met daily initially to manage the response, feeding into the emergency response structure in place across the Government. Support was requested from Commercial Services from Departments through a centralised inbox. The inbox is an improved service and is still in existence so is now part of our business operations.

Commercial Services acted as a supporting service enabling the Health and Community Services project team through provision of support for procurement strategy development. This included supply chain surveillance and key strategic commercial and procurement negotiations. The team led on the commercial negotiations within a number of strategic forums co-ordinated by the UK Department for Health & Social Care (DHSC) including the Devolved Administrations, Crown Dependencies and Overseas Territories (DACDOT) Forum and the UK NHS Supply Chain Forum. Participation in these forums assured continuity of supply both in terms of the volumes and type of products and consumables required.

Please provide an appraisal of how suitable these governance arrangements were: • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
The following are examples of where improvements have been made, but we are always seeking continuous improvement and so further changes are likely in time as we learn from experience: - Reporting processes were developed and enhanced through the pandemic period. For example, in the first instance calculating the financial impact of different scenarios lacked sufficient specificity in the guidance and hence was open to varying interpretation. Once identified from the review and feedback this was amended. - Trackers were reviewed regularly and challenged. We still maintain the trackers and have expanded their use. - A new format of Business case writing and review was being developed and enhanced as we went through the pandemic. Improvements were made through dialogue and collaboration across teams and departments Commercial Services are constantly learning, adapting, and enhancing our working practices and all our learnings are part of our strategy for 2022. It is key to involve Commercial Services earlier in the process. The pressure put on our resources was significantly impacted due to incorrect assumptions about our delivery capability, and a lack of understanding of the importance of execution within the response process. This has since been picked up working with the Corporate Programme Management Office on reviewed Public Finance Manual processes and with Strategic Finance in respect to the new Business Case template development. To make requests more efficient and improved auditable trails around the exemption and breaches process, we implemented an online form and have subsequently implemented docu-sign as a further secure electronic signature route to deliver a secure and consistent solution and enhance efficiency by removing manual processes. Working with HCS and IHE, improvements have been made around the goods receipting of equipment and goods into the stores, ensuring a consistent approach. In addition, we have implemented new contractual framework agreements which include both on and off island suppliers to mitigate potential surges in demand of critical goods in the future e.g., the PPE framework
What implications did the introduction of new legislation have on these governance arrangements?

Additional arrangements were put in place either to improve resilience against Covid-related risks of absence or to recognise additional demands on the time of the Minister and Treasurer. All additional arrangements were consistent with existing laws and regulations. The additional arrangements were:

- T&E worked with SPPP to bring forward Regulations P28/2020 to enable the Minister for Treasury and Resources to make available sufficient funds to support Islanders and businesses on a timely basis. The regulations amend Article 24 of the Public Finances (Jersey) Law 2019, to provide the Minister with powers to withdraw amounts from the Consolidated Fund and other States funds, under Article 24 of the Law, because a state of emergency has been declared or there exists an immediate threat to the health and safety of Islanders, or to the stability of Jersey's economy or to the environment and to increase the limit on financing in one year from £3 million to £100 million and total outstanding financing from £20 million to £500 million.
- The Minister appointed an additional Assistant Minister on 20th March 2020 (MD-TR-2020-0028).
- The Minister approved (in MD-TR-2020-0027) an additional delegation to the Treasurer to approve allocations from the General Reserve. This delegation was not used and has now been removed.
- The Treasurer approved a number of delegations:
    - To the Director, Strategic Finance, of all functions in the event of the Treasurer's incapacity.
    - To the Director of Treasury and Investment Management to complete documentation relating to the appointment of investment managers, and to trade within the CIF to rebalance participating Funds back within their Strategic ranges
    - To the Director, Strategic Finance to make recommendations for approval to the Minister where the Treasurer considers that he has a conflict of interest; and/or where the amount recommended for approval is less than £500,000.
    - To the Director, Strategic Finance, of all functions in the event of the Treasurer's annual leave or illness.
    - To the Director of Treasury and Investment Management to approve the closure of bank accounts.
    - To the Director of Treasury and Investment Management to conduct trades within the Public Employee Pension Fund ('PEPF') to rebalance the Fund back within its strategic ranges.

How did the communications directorate support you/your department/organisation operation during the Covid-19 response?

- Were appropriate systems in place to support your department?
- What communication was required?
- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

The department focussed on communication, both formally and informally, during the pandemic, utilising the help of the communications directorate, particularly our Head of Communications. Examples include:

- Provision of regular financial information to ELT and CoM
- Provision of regular financial information to Departmental Senior Leadership Teams by Business Partnering
- Publication of the half-yearly report to the States Assembly

- A letter from the Treasurer setting out the level of financial control expected
- Media releases on tax measures and the Co-funded Payroll Scheme
- Use of virtual meetings for whole department briefings and events to keep in touch, provide training and provide induction videos to new starters, and keep operations running smoothly.
- OurGov newsfeed articles to share departmental information both across government and within specific departments.

In terms of potential improvement we could provide updates or briefings to the key internal senior stakeholder groups – the Senior Leadership Team and the Senior Manager Groups – at their monthly and quarterly meetings. Members of the T&E SLT could also attend other departmental SLTs to provide information as required to provide additional information over and above that provided by Finance Business Partnering teams. Updates, briefings and Q&A documents could be provided regularly for the key external stakeholder groups.

Logistical and operational decision making

What Emergency Planning processes did you/your department/organisation have in place prior to the initial pandemic response?

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

What worked well:
We had a clear Business Continuity Plan in place with defined membership which meant there were clear lines for decision making and escalation. We also had clear lines of communication within our teams to disseminate messages and guidance as required.

What didn't work so well:
No significant items to note.

What have you learnt and what would you do differently:
Having clear decision-making lines of authority and our corporate governance framework helped us respond in a well-managed way. We need to continue to keep these documents up to date and continue to ensure we have clear delegated authorities in place.

How have you/your department/organisation Emergency Planning processes evolved during the pandemic response?

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Business Continuity lessons have been captured throughout by Business Continuity leads and have been fed back to the central Business Continuity team. We continually improved our approach to the response as the pandemic progressed, implementing lessons learned throughout. Project closure reports may also include lessons learnt with recommendations.

At the start of the pandemic, T&E Senior Leadership Team and other key officers reviewed Business Continuity Plans to include essential activity and conducted stop, start, continue analysis of all projects to determine what needed to be reprioritised.

Home working was established during the pandemic in the majority of teams and we supported this with the provision of home office equipment where appropriate. Any required move to home

working as a result of a future emergency would be a lot easier to implement following the pandemic.

During the pandemic we used Office 365 and Teams application to meet virtually and keep operations running smoothly. This has changed the way we now work across Government and enabled us to work more flexibly.

Describe the implications on you/your department/organisation on procurement and the continuity of supply chains during the pandemic response?

- Were appropriate systems in place to support your department?
- What procurement was required?
- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

During this period the procurement requirements of the T&E department itself were limited in comparison to other Departments.

Commercial Services support for the organisation:
Support was provided via the Command Cell Structure outside of Commercial Services – to assure a holistic island response, however in terms of PPE and Covid related consumables, a Pandemic Stock Level was set by the PPE cell. PPE, Commercial and Distribution Cells were established and determine the volume and type of products required, monitor, and procure the required goods and then distribute to key locations, respectively. HCS held responsibility for the PPE and Distribution Cell, Commercial Services the Commercial Cell.

The PPE Cell and Commercial Cell met daily to ensure consistent oversight of demand and supply requirements. Goods were procured on an ongoing basis against the agreed pandemic levels. The Commercial Cell used multiple procurement channels to ensure no single point of failure and continuity of supply. Members of the team were assigned key suppliers to manage relationships and ensure clarity of communication and were particularly proactive chasing delivery timescales.

Daily calls were held with COO SLT, this ensured transparent and real time communications with any risks or issues raised.

It is key to involve Commercial Services earlier in the process. The pressure put on our resources was significantly impacted due to incorrect assumptions about our delivery capability, and a lack of understanding of the importance of execution within the response process.

The Commercial Services leadership team are constantly learning, adapting, and enhancing our working practices. All our learnings are part of our strategy moving into 2022. The business continuity team are undertaking lessons learned through the business continuity network. We continually improved our approach to the response as the pandemic progressed, implementing lessons learned throughout. Project closure reports may also include lessons learnt with recommendations. Referring to the above response to what didn't work so well regarding the resourcing impact due to incorrect assumptions about our delivery capability, and a lack of understanding of the importance of execution within the response process this has since been picked up working with the CPMO on reviewed PFM processes and with Strategic Finance in respect to the new Business Case template development. To make requests more efficient and improved auditable trails around the exemption and breaches process, we implemented an online form and have subsequently implemented docu-sign as a further secure electronic signature route

to deliver a secure and consistent solution and enhance efficiency by removing manual processes. Working with HCS and IHE, improvements have been made around the goods receipting of equipment and goods into the stores, ensuring a consistent approach. In addition, we have implemented new contractual framework agreements which include both on and off island suppliers to mitigate potential surges in demand of critical goods in the future e.g., the PPE framework.

Describe the implications on you/your department/organisation of strategies and systems put in place for testing, outbreak management (including in schools, care homes, etc) and self-isolation on your department

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

We implemented clear safety plans and control measures across T&E, which involved adhering to the work from home order most of the time for finance and commercial services colleagues.

For Revenue Jersey colleagues and essential employees, who worked from the office, measures such as distancing, single flows around buildings and splitting teams to manage resilience were introduced (including a weekly rota, with seating plan). This ensured low levels of infection and enabled the continued and uninterrupted delivery of key services. These measures were updated and re-circulated in line with changes to legislation, advice, and guidance. All staff were encouraged to sign up to the work force lateral flow testing programme and, when introduced, encouraged to sign up to the free home lateral flow testing programme.

Throughout the Stay At Home period the T&E Payments Team were in the office processing invoices to ensure the prompt payment for goods and services required the island's covid-19 response. A shadow Payments Team was also established comprising of employees from across Government who had previously worked in the T&E Payments Team and who could be called upon in the event of staff sickness. Priority was given to the making of payment to suppliers and individuals. The Public Employees Pension Team resources prioritised the payment of pensions over routine administration.

We held a Ways of working survey during 2020 to capture colleague and line manager views of home working to ensure we had a view of what people were feeling about the new ways we were working during the pandemic. During 2021 we held a flexible working pilot in Business Partnering and Shared Services teams and in 2022 we rolled out the flexible working framework to the rest of finance and commercial services. This built on our learning during the pandemic about managing teams remotely and the needs and desire for colleagues to sometimes work from home and has enabled us to consider and increase the number of roles and tasks that can be done effectively from home. This will enable us work differently and more flexibly into the future.

In addition, we have created a People and Culture working group and a Wellbeing group to help prioritise wellbeing in the department following the pandemic.

Describe the implications on you/your department/organisation of restrictions on:

- Physical distancing
- Mask wearing
- Self-isolation
- Connectivity and border control

Physical distancing

We ensured anyone working from the office had a valid reason to do so and the majority of the workforce worked from home. We segregated teams into A/B/C to ensure resilience as best we could.
During the pandemic Revenue Jersey operated on basis of teams split between office locations and WFH to ensure resilience as best we could. 50% of our colleagues were working from home, 50% from the office. We also introduced a desk rota system for our two main buildings to ensure offices were not overcrowded and physical distancing remained. Meetings were carried out via Teams and restrictions on number of people in meeting rooms was set to the minimum. Mixing between buildings was not allowed. No Hot-Desking on any one day.

Mask wearing
This was recommended at certain stages of the pandemic, and we followed guidelines within our office space.

Self-isolation
Staff were allowed to self-isolate at home and in a lot of cases were still able to work remotely if they did not feel well.

Connectivity and border control
Remote working was rolled out rapidly through M&D and the acceleration of the O365 programme. Connectivity problems existed at one stage and people were asked to only connect if required at certain times, but this did not last for a long time.

The balance of public health and harm with regard to wider societal impacts

Describe impacts felt on you/your department/organisation
- What community groups/sectors of the population have been impacted?

N/A

Describe how the work undertaken by you/your department/organisation impacted on different population groups

T&E played a pivotal role supporting colleagues across Government, including:
- devising and appraising business cases for new schemes and projects in response
- contributed to the development of financial measures to assist businesses and the community (such as the Co-Funded Payroll Scheme)

Whilst T&E assisted with the development of various services established in response to the pandemic, the operation of these services sits with other departments, for example the business support schemes which sit operationally in Customer & Local Services.

Questions for particular stakeholders (see question header)

Economy; Treasury and Exchequer; Customer and Local Services; other relevant stakeholders

Provide a self-assessment of the impact and effectiveness of mitigations such as support to individuals, businesses, and other organisations
- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

T&E played a pivotal role supporting colleagues across Government, including:
- providing continued services to Islanders

- devising new schemes and projects in response
- contributed to the development of financial measures to assist businesses and the community (such as the Co-Funded Payroll Scheme),
- made swift changes to financial legislation
- ensured our health services in particular had access to the funds they needed
- provided real-time business partnering input to a number of areas.

Finance and Commercial services teams worked collaboratively on a number of key deliverables which supported and benefited the organisation as a whole and other external organisations / islanders, for example:

- new grant and business support schemes
- support for Blue Islands
- the purchase of essential supplies such as PPE

This work was often undertaken at extreme speed in order to deliver an essential response, but existing approaches and controls were maintained.

Whilst T&E assisted with the development of various services established in response to the pandemic, the operation of these services sits with other departments, for example the business support schemes which sit operationally in Customer & Local Services.

Business Support Schemes

Scope of intervention

Officials from T&E, CLS and Economy worked collaboratively to establish the following initiatives:

- Co-Funded Payroll Scheme
- Business Disruption Loan Guarantee Scheme
- Fiscal Stimulus initiatives
    - Spend Local
    - Fiscal Stimulus Fund
    - Reductions in Social Security contribution rates
- Fixed Cost Support Scheme
- Visitor Events and Attractions Scheme
- Visitor Accommodation Support Scheme
- Fisheries Support Scheme
- Social Security and GST deferrals

These Schemes represented a comprehensive package of support to protect businesses and livelihoods from the economic consequences of Covid-19.

Effectiveness of intervention

We consider that the scale and breadth of support provided rose to the occasion in terms of meeting the impact of Covid-19 on the economy. From the outset, it was acknowledged that Government could not fully compensate for the impact of the pandemic on the economy. The objectives of support measures varied between Schemes depending on the needs they were designed to address, but they were framed around the following aims:

- Protect employment as far as possible
- Protect livelihoods as far as possible
- Avoid business failures as far as possible

- Position the economy for a robust recovery

Each of those aims have been met or are on track to be met. The number of businesses in the economy grew overall. While some businesses ceased trading, the absolute number of business failures was low. While there was an initial impact on employment the labour market has rebounded strongly. Wage rates for sectors in scope of the Co-Funded Payroll Scheme were in line forecasts based on the income distribution within supported sectors indicating that sectors in scope of the Scheme did not experience substantial wage deflation and livelihoods were consequently protected. The economy has proved resilient and the Fiscal Policy Panel forecasts economic growth that is in line with expectations when key business support measures were agreed.

Speed of response and cross-departmental collaboration

In every instance, economic support schemes were developed at extreme pace. Initiatives that would ordinarily take months or years to develop were implemented in a matter of weeks. This was made possible by seamless cross-departmental collaboration that showed the potential effectiveness of a true 'One Government' working philosophy.

Schemes were administered by either CLS, the Economy Team, or IHE (Fisheries Support Scheme) and policy was led by T&E and/or the Economy Team.

Management Teams in each department re-prioritised key staff to focus on the development and implementation of business support schemes.

In line with recommendations from international institutions like the World Bank, IMF and OECD, Government amended its conventional operating model for economic support schemes and moved to post-hoc control processes based on audits in order to quick liquidity into the economy quickly. This decision to abandon orthodoxy shows the extent to which the Government grasped the gravity of the economic context and responded accordingly.

Lessons learned

There were severe limitations on the degree to which public health scenarios could be forecast and this led to a need to make fast-paced adaptations to business support measures. Close engagement between Government and industry representatives allowed officials to appreciate the likely impact of the changing public health measures on the economy. However, the way in which measures manifested in terms of business consequences changed over time meaning that amendments to Schemes were regularly necessary. While stakeholder engagement was strong from the outset, more proactive engagement, together with stronger relationships, and more data based on actual claim rates allowed the Government to make adaptions to business support schemes more quickly as time went on. The conscious need to iterate quickly following business feedback was something that grew stronger over time and has allowed for a more effective response.

CHILDREN, YOUNG PEOPLE, EDUCATION, AND SKILLS

The Children, Young People, Education and Skills Department provides learning opportunities that begin at nursery and continue through statutory, further and higher education to adulthood

What we do

Our aim is to provide education that ensures opportunity and is equal for all. We provide learning opportunities beginning from nursery and continuing through statutory, further and higher education to adulthood.

We are responsible for children's services and education, including higher and further education policy, apprenticeships and wider skills in Jersey. This includes:

- providing and monitoring an effective curriculum and teaching and learning for 3 to 19 year olds
- professional development and training of all teaching staff
- supporting and providing advice to head teachers
- making educational provisions for the special needs of all children
- providing careers advice
- providing financial assistance for higher education courses
- delivery of the Jersey's youth service
- registration of childcare settings
- delivery of library services across Jersey
- liaison with the trusts and voluntary organisations for the promotion of childcare

Education partnership is a social partnership agreement between the States of Jersey and the The National Association of Schoolmasters Union of Women Teachers (NASUWT).

SELF-ASSESSMENT TEMPLATE

Questions for all stakeholders

Governance
Please respond as appropriate: What governance arrangements did you establish to support decision making for the Covid-19 response? And/Or How did you/your department/organisation plug into governance arrangements for the Covid-19 response?

Decision making for COVID-19 in CYPES was built upon existing frameworks. Ultimately, the majority of decision taken at a Ministerial level were made by the Competent Authorities Ministers (CAM) or Emergencies Council. For relevant proposals requiring Ministerial Approval the following governance structure was followed:

- Officer development for proposal / policy change – CYPES Officers / Public Health Officers
- CYPES Senior Leadership (COVID-19 DLT with daily gold team meetings) – feedback and challenge
- Children's & Education Minister – endorsement of proposal
- SPPP – Guidance development
- STAC - Guidance on proposal (if required)
- CAM – Ministerial Approval

Guidance from STAC was sometimes sought earlier in the process if necessary, to inform the development of policy / initiative changes. CYPES Officers were represented at STAC when discussions centred on the impact of the pandemic on children.

In addition, regular briefings of key stakeholders were undertaken either during the development of the policy / initiative change or prior to release. Stakeholder groups included:

- Union Officials
- Headteachers of schools and colleges (or their delegates)
- Nursery owners and managers
- Office of the Children's Commissioner

Senior Officers were also represented at both the Strategic Coordination Group (SCG) and the Tactical Coordination Group (TCG). The Director General (or delegate) would attend CAM, CoM and/or Emergencies Council to support the Minister for Children and Education.

Please provide an appraisal of how suitable these governance arrangements were:

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

CYPES Officers worked extremely well with colleagues in SPPP and Public Health from the start of the Pandemic. This ensured the development of policies and initiatives to combat the pandemic were considered, appropriate and delivered in accordance with challenging timescales. Access to STAC guidance and consideration through existing Officer / Minister structures within the department ensured proposals requiring a decision by the Minister for Children & Education or by CAM were well prepared and thought through.

The timing of communications with Stakeholder groups could have been improved prior to the release of policy / initiative changes. On occasions wider policy decision made for the whole community (for example for testing / isolation) had significant impact on schools. The pace of these decisions and outward communication meant that officers in CYPES were not able to fully brief stakeholders in advance. Although rel.ationships with policy makers during COVID was extremely good there is always room for improving communications when announcements are to be made that impact across departments

A further positive to be taken was the working relationship with the Office of the Children's Commissioner and the creation of the Child Rights Impact Assessment (CRIA) for school reopening and vaccinations. Much of the information included in the CRIAs stemmed from joint working to develop a survey for children and young people and the impact of COVD in May 2020.

What implications did the introduction of new legislation have on these governance arrangements?

There were no implications following introduction of new legislation.

How did the communications directorate support you/your department/organisation operation during the Covid-19 response?

- Were appropriate systems in place to support your department?
- What communication was required?
- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

The CYPES Head of Communications and other supporting communications officers played a central role in the forming and dissemination of information about the pandemic and campaigns. The CYPES Head of Communications is a member of the Senior Leadership Team (SLT) and attends the Ministerial meetings in the department. Their link into the central communications team provided a means to ensure activities undertaken in CYPES and those government wide initiatives were reported through appropriately.

The main aim of the communications for children and young people was to:

- Explain and provide reassurance on the health measures and actions by the Government in a clear, consistence and youth friendly language
- Empower young people to act upon the public health advice
- Inform in a timely and consistent and engaging approach
- Signpost to the support measures that the Government has put in place to support children, young people and families.

Government messages and campaigns, around Safe Back to School, Lateral Flow Tests, Public Health Guidance, Covid-19 Vaccine, were directly tailored to various audiences, including children, young people, parents and carers.

At the start of the pandemic, posters, leaflets, videos and social media messages were designed for schools, nurseries and colleges.

Influencers, those who children and young people trust, such as headteachers, the Children's Commissioner, Dr Muscat and young people were filmed sharing advice and experiences as part of our safe back to school campaign.

Subtitles were added to all videos, with age specific content developed for children and young people; all key messages were translated into British Sign Language and key announcements have been translated into Portuguese, Polish and Romanian.

And to make sure advice reached those without digital technology, adverts were created for TV; newspaper and community magazines, radio adverts in English, Polish, Portuguese and Romanian, roadside banners, posters, pull up banners and vinyl stickers were produced for schools and all printed material, including translated leaflets and posters were updated on gov.je so that they are accessible for schools to print their own.

We ensured that children and young people had a voice throughout the pandemic through the Children and Young People's survey, schools, YES Project, Children and Families Hub, Kooth Jersey, Youth Service's Radio Youth FM and on Tik Tok and other social media channels.

A survey was jointly commissioned by CYPES and the Children's Commissioner's Office.
A total of 2,105 children and young people shared their thoughts and feelings on a

range of topics, from the impact coronavirus has had on their friendships to their experiences of home learning and returning to school.

We identified key influencers to join discussions and be interviewed live on Radio Youth FM with Ministers and the Children's Commissioner engaging with children and young people to ensure an ongoing, open, two-way exchange of views about what we do to help.

The radio shows were presented by young people who are both volunteers at Youth Arts Jersey.

We launched a freephone number for the Youth Enquiry Service and awareness campaign by the Government and Jersey Youth Service to promote the support available to children, young people and families.

A new See It, Hear It, Report It campaign was launched by the Departments for Children, Young People Education and Skills and Justice and Home Affairs, with support across the whole of Government and the States of Jersey Police, to encourage Islanders to work together to keep everyone at heightened risk safe and in sight.

Channels: We used the following to engage directly with children and young people

- Government of Jersey social media channels
- We created a new Government of Jersey TikTok account for young people
- Media channels
- Schools, nurseries, colleges
- Highlands College
- Parentmail through schools
- Studentmail through schools
- Sessions at Youth Clubs
- Letters to all children and young people and parents from Dr Muscat – directly addressing parents and children and young people with guidance and key messages
- Jersey Youth Parliament
- Children's Commissioner's Office
- Learning at Home – new website created on Gov.je
- Charities
- 4Insight survey groups
- Activity groups
- Jersey Sport
- Youth Service Radio
- Youth service social media – encouraged young people to create content on relevant social platforms (Snap Chat, TikTok and Instagram) with key messages and share it.

- Video content was created for school assemblies, youth services and screens in school reception areas.

Communications between the Children's Commissioner's Office worked well, particularly with the launch of a confidential survey, which was a collaborative project that gave children and young people a chance to comment on their experiences of Covid so that ongoing support can be tailored to meet their needs. The survey was also used to inform the Safe Back to School strategic policy project. Weekly meetings with the Children's Commissioner and her officers, including the OCC's press lead, certainly assisted here.

Logistical and operational decision making

What Emergency Planning processes did you/your department/organisation have in place prior to the initial pandemic response?

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

CYPES services, including schools and colleges, adopt a health and safety risk management approach in the delivery and maintenance of its services. This risk management framework meant the adoption of new COVID process / procedures to enable services to be delivered were developed from a risk-based mindset. Safety plans and risk assessments were developed by schools and service areas to enable the safe reopening of schools/colleges and ongoing delivery of services.

The department's risk management framework included:

- The development of clear guidelines
- Communication plans and channels
- Safety Plans
- Risk assessments
- Audit and review with over 150 compliances note of visit inspections completed
- Cleaning strategies
- Business continuity planning across all CYPES services
- A CYPES Hub, which provided support and advise for all service areas
- Risk leads identified to implement plans, challenge, and audit
- A learning outcomes log was developed and implemented.

Emergency Planning was already built into CYPES business continuity planning for schools and services.

How have you/your department/organisation Emergency Planning processes evolved during the pandemic response?

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Building on the above, CYPES created the CYPES Hub and CYPES Health & Safety COVID Team to support schools and services reopen following the first lockdown, and then to support with the adoption of new guidance and control measures throughout the pandemic. Officers from the central CYPES Department worked closely with schools and services to develop risk assessments, assist with the adoption of control measures (e.g., best practice hygiene, circulation, ventilation measures) and provide support during spikes in numbers of COVID cases.

Senior Advisors for Schools would work closely with Headteachers to provide ongoing support to enable the continued delivery of education within the school, including advising on staff challenges and class/ year group closures. Officers in the Early Years team did likewise with the nursery sector.

In addition, there has been a sharp COVID focus from the CYPES Informatics Team. Working with colleagues in Public Health, a sophisticated dashboard of information and indicators has meant that senior leaders in CYPES and the Minister has up-to-date information on the impact of COVID in schools and CYPES services. This has not only informed the development of future policy / initiative changes but has enabled officers to support schools in a timely way should numbers of cases begin to increase.

All the above has taken a significant effort on the part of a relatively small team in the central CYPES department. The impact of working through the pandemic is now beginning to be understood, on both a personal level for employees but also for the wider CYPES programme of work as the focus now moves from the Pandemic to the delivery of the department's business plan.

CAMHS continued to provide all services during COVID restrictions. Teams were separated into A and B functions to ensure service provision with many satellite community environments used to deliver services. A specialist Duty and assessment team was developed using agency nurses to manage increased referrals and ensure prompt response, risk assessments and initial assessments.This model worked particularly well and a permanent Duty and Assessment service is now in place with recruitment occurring to replace agency staff with permanent mental health practitioners. Due to restructions and difficulties securing specialist off island mental health treatment during the pandemic, CAMHS developed Meadowview as an inpatient environment to support a small number of young people requiring inpatient treatment for mental health. Setting this up the environment and delivering the service with required staffing was a considerable achievement, though there was learning taken about the therapeutic benefit of such a facility in Jersey.

Our Childrens' Social Care Service continued to provide services throughout based on the daily assessment of risk. We developed a vulnerable childrens list, including variables such as child protection plans, children in need plans, children looked after, care leavers, children known to early help services and school attendance. Home visiting risks assessments were put in place to balance child

protection and health protection. Our children's homes remained operational throughout and we actually experienced significant improvements in relationships between care staff and children living in homes.

In addition, Department senior officers worked corporately in delivering Emergency Planning processes across government. These projects included:

1. The delivery of a contact tracing centre at Highlands College
2. A training centre for healthcare assistants
3. Emergency transport response to and from Nightingale Hospital

Describe the implications on you/your department/organisation on procurement and the continuity of supply chains during the pandemic response? • Were appropriate systems in place to support your department? • What procurement was required? • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
There was a slight delay with the implementation of corporate strategy/process for the ordering and distribution of PPE, which resulted in us sourcing our own PPE. However, this did improve with PPE equipment and Lateral Flow Tests being obtained through the central cell and following that there were no further significant issues arose.
Describe the implications on you/your department/organisation of strategies and systems put in place for testing, outbreak management (including in schools, care homes, etc) and self-isolation on your department • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
Much of this has been described above. By utilising data to identify clusters of cases, using further intelligence directly from schools and service leads and ensuring sufficient support was provided by central department officers, we have been able react in a timely way to increases in numbers of COVID across our services. Working closely with Public Health officers, guidance and control measures have been adapted to reflect the context of the pandemic and these have been communicated to schools regularly. This was staff resource intensive to manage, ensuring policy options were fully considered, operational practices developed, guidance amended and then communication undertaken. Schools in particular were an early focus of LFTs with years 11-13 included in an onside testing programme. This was resource heavy in schools and did not achieve the high levels of testing hoped for. A move to at-home testing following the roll-out of LFT in the community provided a better model, which did not impact on the delivery of education during the school day. It would have been better to have not delivered the testing straight away from home, rather than in school; however, LFTs were new and there needed to be confidence in the validity of test results, hence the tests being carried out in schools under staff supervision. Childrens homes staff were prioritised with PPE from the outset and we introduced regular testing very early on. We stopped all cross-home working arrangements. There were incidents were children in homes had Covid. Rotas were adjusted accordingly and we minimised staff changes, and some staff actually moved into homes during the period to provide continuity in care and to prevent the spread the risk of infection.

Describe the implications on you/your department/organisation of restrictions on:

- Physical distancing
- Mask wearing
- Self-isolation
- Connectivity and border control

Physical distancing when introduced into schools during the first lockdown meant that schools could not operate at full capacity. This restricted numbers and following the introduction of the bubble system all pupils were able to return. However, this has impacted on the day-to-day operation of schooling, initially with staggered drop-offs and pickups and split breaks times.

The introduction of mask wearing from Autumn 2020, firstly on Liberty Buses for students and then more widely in secondary schools for pupils and all staff across all schools and nurseries has presented challenges, both for teaching and learning and wellbeing. The decision to retain masks in schools during phases of the pandemic has been informed by case numbers in schools and from advice from STAC and Public Health Guidance. The wearing of masks is a contentious issue, with many agreeing the need for them but others not wanting to wear them. Continued mask wearing in schools following the relaxation of guidance across the community has added further calls for the guidance to be changed.

Self-isolation (as opposed to mandatory isolation) for those staff and pupils deemed vulnerable was more apparent at the start of the pandemic. Central guidance equipped managers to enter into discussions with staff about working from home or enabling onsite working following the adoption of a risk assessment and sufficient control measures put in place. Initially this did have an impact on staffing numbers in schools, however, has become less of an operational issue following the roll-out of the vaccination programme.

Children have more prominently impacted by restrictions on travel, the requirement of mask wearing and self-isolation requirements when compared to adult groups as a result of their vaccination status.

Mask wearing during lock down was minimised in children's homes as far as possible and was subject to individual young people and staff risk assessments.

The balance of public health and harm with regard to wider societal impacts

Describe impacts felt on you/your department/organisation

- What community groups/sectors of the population have been impacted?

This section covers children, young people and their families.

For a review of the impacts of measures adopted with regard to wider societal harms please see the following CRIAs, which detail this impact for the re-opening of schools and the vaccination programme.

School Opening CRIA

School Opening CRIA Comment

Vaccination CRIA

The Department of CYPES would recommend that greater consideration and risk assessment is undertaken on the management of public health measures for children and young people when there are differential restrictions in place for adults (largely as a result of vaccination status). There is clear evidence that young people and children have faced restrictions on travel, disruption to learning and access to public services as a result of most of the group not being vaccinated. Children have also experienced self-isolation requirements that are different to the Adult population that the department of CYPES believes has had significant impact on child and adolescent mental health and wellbeing.

The children's commissioner has sighted these restrictions in liberty are unfair for children when they have been unable to obtain vaccination as a result of their low priority group status. In the event future public health measures being implemented CYPES would recommend we consider the impact on children and young people specifically, and that any variation in policy application because of age, disease risk and vaccination status has full and proper impact assessment.

The Department of CYPES would note that activity (in line with national trends) across Child and Adolescent Mental Health services has increased significantly since the pandemic. Referrals to CAMHS increased from 683 in 2020, to 855 in 2021, with an average of 100 referrals per month so far in 2022 indicating continued increase in demand. This is notable in access to services, referrals for mental health and neurodevelopmental assessments, inpatient hospital admissions and specialist areas such as Eating Disorders, self harm, anxiety and depression increasing. We would recommend continued focus on the 'balance of harms' and impact for children and young people when considering public health measures.

We are concerned about the increase of child abuse as a direct, and in direct result of the pandemic, at the time of restrictions, at present and into the future. We experienced an increase in demand for care places though this has since reduced. We have not yet seen a significant increase in referrals to the front door.

Further detail on the impact of the pandemic on children is outlined in the attached letter from the Minister for Children & Education to the Children, Education and Home Affairs Scrutiny Panel Chair (dated 18/2/22).

Describe how the work undertaken by you/your department/organisation impacted on different population groups
Please see above

Questions for particular stakeholders (see question header)

Public Health and other relevant stakeholders
Provide a self-assessment of the effectiveness of public health interventions – both restrictions and guidance such as: lockdowns, physical distancing, shielding – in protecting Islanders
Please provide a high-level evaluation of the efficacy of decision making and how it was informed by learning from evidence and actions of other jurisdictions

Health and Community Services, relevant external/commissioned/voluntary sector stakeholders
Outline the operational impacts on the delivery of healthcare and social care services during the pandemic response

Children, Young People, Education and Skills and other relevant stakeholders
Outline the operational impacts on the delivery of education during the pandemic response

Schools and other departmental services have been remarkable in keeping their doors open to children, young people and families for the overwhelming majority of the period of the pandemic. Partnership working between school leaders and government officials, coupled with a resilient staff team, pupils and parents, has meant that education has continued to be delivered in school during the most challenging period in living memory. The impact on the delivery of education is vast and it would be impossible to detail everything in this form. However, staff in schools have found a way to ensure the safeguarding of pupils and the delivery of education has continued throughout. This has endured as a challenge with the fact that the children in nursery settings and primary schools are not vaccinated.

Public Health; Health and Community Services; Children, Young People, Education and Skills; other relevant stakeholders
Provide a self-assessment of the effectiveness of strategies and systems put in place of testing, outbreak management (including in schools, care homes, etc) and self-isolation • What worked well? • What didn't work so well • What have you learnt and what would you do differently?
See questions answered in above section
Provide a self-assessment of the effectiveness of strategies and systems for vaccination • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?

The vaccination roll-out in for young people was delivered by the Vaccination Team. CYPES worked in partnership with the team and in particular the Head of the Vaccination programme to design and deliver appropriate delivery strategies for different aged children and young people and those with particular needs. Officers from the central CYPES team and representatives from schools have worked closely with the Head of Programme to continue to promote the uptake of vaccinations amongst children and young people.

An early decision to provide vaccination at the Fort rather than in schools, albeit in a dedicated age-related area, may have had a detrimental impact on early vaccination rates for 12-15 years olds, however this decision was based on the current vaccination delivery model and concerns about the impact of the anti-vax groups on schools. It is notable that Jersey has experienced lower vaccination rates for children and young people than comparative areas within the UK and when compared to Guernsey for eg.

As GOJ have adopted the JCVI model for vaccination roll out there has inevitably been a lower rate of vaccination amongst children as lower priority groups. In addition, sustaining services within an Island context can be challenging in the absence of mutual support from neighbouring public services in nearby jurisdictions. We would recommend that future vaccination prioritisation not only considers JCVI recommendation but also prioritisation ba sed on sustaining service continuity for critical infrastructure within Jersey including Education.

Economy; Treasury and Exchequer; Customer and Local Services; other relevant stakeholders
Provide a self-assessment of the impact and effectiveness of mitigations such as support to individuals, businesses, and other organisations • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?

CUSTOMER AND LOCAL SERVICES

CLS brings together a wide range of front line government services to make it easy for customers. We are also responsible for delivering more services in the community and establishing a stronger relationship with Parishes and the voluntary sector

Customer and Local Services SELF-ASSESSMENT TEMPLATE

Questions for all stakeholders

Governance
Please respond as appropriate: What governance arrangements did you establish to support decision making for the Covid-19 response? And/Or How did you/your department/organisation plug into governance arrangements for the Covid-19 response?

We initiated daily CLS Gold Business Continuity meetings from the 18th March 2020. Status updates, actions and decisions were taken at each meeting and record. The frequency of the meetings changed as the situation has developed, but are still in place weekly today. These meetings were in addition to the existing governance cycle that provides CLS leadership with oversight and assurance normally, although clearly these would also now include significant focus on the pandemic and impacts on the organisation and our service to the public.

An agency report was all produced in line with government wide Strategic Coordinating Group (SCG) requirements and submitted bi-weekly then weekly which documented the status across CLS.

CLS DG and SLT members supported/attended Competent Authority Ministers, STAC, Strategic Co-ordination Group and decisions cascaded to Department and/or decisions informed by CLS experience/advice.

Benefits areas under the remit of the Social Security Minister (isolation benefit, Covid Response Emergency Support Scheme (CRESS), Income Support), were discussed at ministerial meetings and then recorded via ministerial decisions. The CRESS scheme was also approved at a COM meeting.

Local project governance was applied to all projects, including those under the remit of other Ministers. A short form project governance check list and signoff was introduced to support the rapid implementation of changes. This included ensuring new data sharing agreements, DPIAs, risk logs etc were in place as appropriate.

New schemes launched and operated included Isolation Benefit, CRESS, Co-funded Payroll Support (CFPS), Visitor Accommodation, Fixed Costs support schemes and Spend Local. Checklist completion was audited by the CLS Governance team in the early schemes to ensure key compliance needs and risk assessments were understood and not omitted in the interest of rapid implementation.

A Covid-specific Risk Appetite Statement for CLS was agreed and reviewed periodically as the pandemic progressed.

For schemes that have closed, a closure report has been completed and lessons learnt transferred into live projects where appropriate. For the Covid Business Support schemes auditing has, and continues to, take place as schemes operate and then close.

Please provide an appraisal of how suitable these governance arrangements were:

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Worked well:

- Rapid local decision-making and responses
- Risk based decision-making processes and maintaining information logs from the outset to assist responses to follow-up audits
- Cross-departmental and Parish data sharing enabled by early Director General support

Not so well:

- It was not always possible to share/urgently release/receive resources across Government due to competing priorities.
- Given the rapidly changing picture at times, many of the schemes were changed at very short notice to respond to the emerging needs of the island. This meant operating at higher than normal risk levels (although this was accepted by Ministers).

Lessons Learned:

- Ideally, we need to put adequate data collection / databases in place at an early stage to support even modest schemes
- Multiple agencies / teams working on the same project at the same time mean that objectives can be achieved swiftly.
- The need for government departments to work together on data sharing initiatives has helped improve data sharing processes and understanding of good data practice. It has also improved the networking of the government governance officers. Relationships built up during the pandemic have been maintained and built upon .

What implications did the introduction of new legislation have on these governance arrangements?

The legal requirement to isolate provided a robust governance environment within which the risks associated with the isolation benefit were minimised.

The support schemes set up and administered through CLS did not require legislation. Ministerial directions were provided as required to cover new support schemes.

The introduction of new legislation (or ministerial agreement) meant CLS needed to implement a number of new schemes / processes in short timescales. This required very careful assessment and mitigation of risks to deliver the required services on time, with a greater risk profile being agreed in a number of cases.

How did the communications directorate support you/your department/organisation operation during the Covid-19 response?

- Were appropriate systems in place to support your department?
- What communication was required?
- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

There were very regular and consistent comms to all members of the dept by the director general, supported by the head of comms for CLS and the CLS Senior Leadership Team (SLT).

Microsoft Teams enabled messages to be shared quickly and efficiently with all members of the Covid team and colleagues were regularly kept up to date through specific & numbered Covid emails from the Director General. In addition, a CLS bi-weekly email to all colleagues was used to remind and re-enforce key Covid messages.

Weekly opportunities created for colleagues to have direct access to Directors (via Teams) to ensure that any issues were escalated.

Our Coronavirus Helpline team worked closely with Communications, Policy and the Digital team to ensure messages to the public were clear and well timed to avoid surges in customer calls that could not be answered. Given the nature of the pandemic this was sometimes unavoidable.

Teams group chat worked well for escalation of feedback and themes from the Helpline of current questions or concerns of Islanders so they could be addressed, clarified or reinforced in future comms.

Social media was a particularly effective tool for tailoring messaging for quick dissemination based on customer insight.

Key GoJ communications were shared with Parishes and Civil Society Organisations through the ConnectMe team and the Financial Impact Action Group.

Logistical and operational decision making

What Emergency Planning processes did you/your department/organisation have in place prior to the initial pandemic response?

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Worked well:

- Existing business continuity plans were in place but mainly covered existing buildings not being usable and failing IT.
- The majority of CLS people already had a laptop to enable office-based hot desking. This facilitated a rapid switch to home working.

Didn't work so well:

- GoJ's remote working IT infrastructure didn't have adequate capacity to support wide-scale home working in the early months of lockdown, although this issue was resolved by M&D colleagues as a priority.

What have we learned:

- Home working can and does work well if properly managed
- Our people have a very broad spectrum of understanding and confidence in use of various IT tools and applications available to GoJ. This ranges from people who are only just confident in use of standard office packages through to expert trouble shooters who can self serve. In terms of support for home workers with limited IT skills, this can contribute to feelings of isolation when IT problems arise.
- Teams meetings provide more efficient use of time and significant time was saved from physically walking between buildings or meeting rooms. We recognise that the face to face connection is valuable and important for some meetings, however there are many operational focussed meetings where Teams will be the permanent approach in the future.

How have you/your department/organisation Emergency Planning processes evolved during the pandemic response?

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Because many colleagues are now able to work from home, with laptops and also receiving customer calls, we have a much more robust response to any future emergency.

Worked well:

- The flexibility & adaptability of our people
- There was a very significant team effort to solve problems and rise to the challenge of delivering new and adapted services
- Regular and consistent comms to all members of the dept by the Director General & SLT

Not so well

- Sharing of former CLS experienced or general customer facing staff from across Government

Lessons Learned

- Significant experience on what can & can't be supported using home working
- Operating a much greater volume of front office services online or over the phone rather than in person

Describe the implications on you/your department/organisation on procurement and the continuity of supply chains during the pandemic response? • Were appropriate systems in place to support your department? • What procurement was required? • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
There were no significant procurement issues. Spend Local was CLS's most notable procurement activity; Commercial Services supported the set up of a new supplier contract quickly.
Describe the implications on you/your department/organisation of strategies and systems put in place for testing, outbreak management (including in schools, care homes, etc) and self-isolation on your department • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
Worked well • Our Covid-safe plan was regularly updated as were our BC plans to ensure a resilient split of workers between buildings and home working, and adequate desk spacing in offices. Teams therefore were split into 3, to limit the impact of an outbreak. • The majority of our people adapted well to home working. • New personal hygiene requirements, masks, screens, reduced office occupation & desk spacing & one-way system through the office were all introduced and maintained • Regular communications and consistent reinforcement of public heath guidance via departmental comms • Regular Lateral Flow Tests were in place for office workers Didn't work well • No issues Lessons Learned • Regular bulletin style email updates from DG were appreciated by colleagues who commented there was so much information to take in – it was useful to have in one place and know where to refer back to.
Describe the implications on you/your department/organisation of restrictions on: • Physical distancing • Mask wearing • Self-isolation • Connectivity and border control

Front office services were rapidly re-designed to reduce the frequency of in-person customer visits at Philip Le Feuvre House (La Motte St.) and to ensure on-line and telephone channels were as accessible as possible.

Public-facing services were suspended at the Library, Superintendent Registrar and Back to Work in line with public health requirements with colleagues redeployed to many other customer-facing activities.

Crematorium services were also significantly limited and adapted to fit with prevailing health requirements.

Customer satisfaction measures show that none of the above had a negative impact on the service customers received.

The majority of CLS colleagues were able, if required, to work from home, so any self-isolation requirements did not have as much as an impact as elsewhere. Those in roles which require physical presence were still able to do some activity whilst isolating, such as online development training.

The balance of public health and harm with regard to wider societal impacts

Describe impacts felt on you/your department/organisation

- What community groups/sectors of the population have been impacted?

CLS teams provided significant support to ensure that homeless and vulnerable islanders had safe accommodation to live in during the lockdown periods. We worked with a wide range of other GoJ colleagues, Civil Society and independent funders to support additional accommodation needs.

CLS also worked to support community groups through ConnectMe and the Financial Impact Action Group to reduce its impact on the wider community. While there was considerable resilience, it is clear that we have seen an increase in the need for mental health support as a result of the pandemic. Many islanders who are reliant on the day-to-day support of Civil Society Organisations were unable to access provision due to the restrictions and the need to isolate.

Describe how the work undertaken by you/your department/organisation impacted on different population groups

We ensured as wide a range as possible of CLS services continued to operate.

We operated the coronavirus helpline which provided support to all islanders providing a seven day-a-week one-stop shop for handling all public enquiries. Call volumes varied enormously and ranged between 400 and 2,500 calls a day on various topics including symptoms, travel, testing, public health measures, vaccinations and contact tracing

We set up an operated a number of new temporary financial support schemes – Isolation benefit, cofunded payroll, visitor accom & fixed costs schemes, CRESS, as well as the economic recovery spend local scheme – supporting those most financially affected by the pandemic

Significant work to support community via community task force & connect me to support individuals and organisations including access to food, emergency housing, financial support, mental health services and medical supplies, as well as supporting organisations and the parishes to access volunteers, guidance and practical support to be able to safely continue to offer support to their clients.

We also provided significant support for the emergency housing team to provide advice and emergency accommodation to people facing housing difficulties. This service provided support to more than 200 households in the Island.

ConnectMe and the Financial Impact Action Group were able to ensure GoJ, Parishes and Civil Society Organisations were able to work collectively to support islanders.
Through the work of thematic clusters we were able to provide information and advice to Civil Society Organisation which included supporting vulnerable groups to access vaccinations. These work streams linked to the GoJ Bronze Community Cell.

INFRASTRUCTURE, HOUSING, AND ENVIRONMENT

Infrastructure, Housing and Environment (IHE) provides the conditions, facilities and decisions needed for Islanders, the environment and business to flourish and prosper.

The department's focus is to provide the critical national infrastructure and decision making needed to enable Islanders, businesses and visitors to live, work and enjoy the Island. The department is a key delivery agent in protecting and enhancing Jersey's natural and built environment, and in protecting the habitats and species which make the Island special.

Our delivery team services are split across four directorates: Operations and Transport, Natural Environment, Regulation, and Property.

Operations and Transport

The Operations and Transport team is responsible for:

- collection, treatment and disposal of the Island's waste water
- recycling and disposal of refuse and other waste materials from the Island's residents and businesses
- providing a maintenance service for all parks, gardens, playing fields, woodlands, trees and open land administered by IHE
- providing an Island wide municipal cleaning and public convenience cleaning service to areas administered by IHE and other client departments and parishes, in accordance with agreed standards
- the management of the main road network for the benefit and safety of all users
- development and implementation of the Sustainable Transport Policy (including public bus service, school bus service, cycling and pedestrian facilitates, travel awareness and parking policies)
- provision and maintenance of all public car-parking services
- the vehicle procurement, maintenance, repair and fleet management of all States vehicles
- running the Government of Jersey's sporting and events facilities

Natural Environment

Natural Environment provide scientific services and practical advice to support government policy, legislation, and enforcement. The team are responsible for:

- informing the public and sectors
- safeguarding our land and marine environments and our natural and farmed flora and fauna
- operating a meteorological and climatological service for the Channel Islands

- providing a government veterinary service
- providing a fisheries protection and research service for our 800 square miles of territorial waters
- managing the Island's countryside access networks and ensuring that Jersey complies with international legal obligation

Regulation

The Regulation team protect Islanders by delivering socially-responsible regulation, preventing unfair commercial practices, and providing statutory functions including planning and building, trading standards, licensing, driver and vehicle standards, food safety, water quality, plant health and noise, waste and pollution prevention. The team is responsible for:

- ensuring motor vehicles are roadworthy and drivers are competent
- ensuring safe rental accommodation and food practices
- enforcing consumer protection laws and providing a comprehensive consumer and business advisory service
- protecting the Island's waters and wider environment from pollution
- protecting the Island from plant-based pests and diseases
- regulating border controls for plants, animals, and products of animal origin
- keeping people safe by ensuring our buildings are safe
- ensuring best use of land and development of the built environment

Property

The Property directorate provides well-maintained, safe, legislatively-compliant and financially-sustainable property which allows the Government of Jersey to meet its obligation to the public. The capital team deliver major capital projects which support the continued provision of high standards of service to the public including:

- managing the government property portfolio and ensuring it is correctly configured to match future requirements
- maintaining the assets under management to ensure they are safe and compliant with the relevant landlord obligations
- delivering major government building and infrastructure projects

SELF-ASSESSMENT TEMPLATE

Questions for all stakeholders

Governance
Please respond as appropriate: What governance arrangements did you establish to support decision making for the Covid-19 response? And/Or How did you/your department/organisation plug into governance arrangements for the Covid-19 response?
The Infrastructure, Housing and Environment department is responsible for the Islands' physical built and natural infrastructure, including government property assets, waste, highways, the natural environment, sports sites and the regulatory decision making for external sectors of the economy totalling circa 2.4Bn of GVA. The government created a 1GCT function to coordinate across departments, in addition the Strategic Coordination Group (Gold command) was called and met regularly. This was attended by the IHE Director General. IHE was represented in the 1GCT team with a departmental Head of Service representative, and the IHE HR Senior Business Partner. At a departmental level, IHE Senior Leadership (Chaired by the Director General) met on a regular basis twice a week, and this linked to the department business continuity group at silver and bronze levels. This met on a changing frequency during the various stages of the crisis, from daily, to weekly, to monthly. Information from the department was fed up through this hierarchy as appropriate for decision making at the appropriate levels. Specific directorate leadership teams across the five directorates of Property/Regulation/ Ops and Transport/Natural Environment and Office of the DG, met regularly to make service specific decisions on a tactical basis.
Please provide an appraisal of how suitable these governance arrangements were: • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?

The one team approach across government through to a coordinate 1GCT worked very well. The department felt part of this coordinated family, and departmental information, responses and issues were quickly communicated.

There was sometimes an information lag from the STAC and CAM forums back to the department, from an officer management perspective the department didn't feel as connected to those decision-making groups.

The Government's Exec Leadership team continued to meet on government business, but that agenda was not always linked to the decision making at STAC and CAM.

In addition, the crossover between IHE/SP3/Health/Stac, at times, did not allow the management of IHE oversight of the inputs that department subject matter experts were having into the decision-making forums of either STAC or CAM.

What implications did the introduction of new legislation have on these governance arrangements?

There were no implications following introduction of new legislation.

How did the communications directorate support you/your department/organisation operation during the Covid-19 response?

- Were appropriate systems in place to support your department?
- What communication was required?
- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Communications was coordinated across Government via the Comms Directorate. Each department has, and had, a dedicated Head of Comms and as a result the department felt very supported.

This ranged from service closure information, service change information, wider Island-resilience confirmations, as well as downward messaging on organisation and wider societal behaviour.

As mentioned above, quicker read out/inclusion from the STAC and CAM meetings could have been more beneficial to departmental management – though this is not a responsibility of the Comms Directorate.

Logistical and operational decision making

What Emergency Planning processes did you/your department/organisation have in place prior to the initial pandemic response?

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

The department has its business continuity processes that were initiated during the pandemic response.

This allowed the department to assess critical services, and to identify which areas could release staff. The changing nature of the economy allowed certain regulatory staff to be released into contact tracing to support the contact tracing function which commenced within Environmental Health. It was clear within weeks that the usual CT approach deployed by this team would need further support and so other regulation staff were quickly released, in addition to staff from elsewhere within IHE and across government.

Construction, food, parking and transport sectors were affected and so regulation in these areas was naturally reduced in any case. This was the same principle in other areas of the IHE business in terms of property and certain environment services. In other areas such as waste and water, critical infrastructure needed to be maintained for the safe functioning of the Island and so staff were not released from those areas.

Critical services were maintained at all times across our critical national infrastructure. This approach worked very well as the Island continued to function.

The department also led on the permitting of the construction industry to allow key construction activities to continue throughout the pandemic.

In future, the length of redeployments and the likely timescale for events to be managed, would need to be assessed. Work pressures built up in regulatory areas even though these sectors of the economy were anticipated to have slowed down. This would mean in future that fewer staff would be released for other duties, as backlogs in work are still present in the department.

How have you/your department/organisation Emergency Planning processes evolved during the pandemic response?

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

The learning from the pandemic has been the need to reassess emergency response plans linked to duration. Our business continuity plans focus on events over a 24-hour to 2-week period. They were not geared up to focus on response times and events over many months.

Therefore, such plans were dynamically used depending on pressures at the time and on specific services.

Emergency response capacity was also limited in certain key areas, and as a result certain key specialist staff were exposed to long working hours and constant delivery pressure in order to keep the response running.

Describe the implications on you/your department/organisation on procurement and the continuity of supply chains during the pandemic response?

- Were appropriate systems in place to support your department?
- What procurement was required?
- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

The department has a number of key specialist suppliers to run services. These range from specialist contractors to specialist material and chemical suppliers.

The commercial team and wider government were critical in ensuring key personnel were still able to visit and undertake critical work, and the department responded in a very positive way to ensure these key dependencies were maintained.

This support was critical in the construction of the Nightingale Hospital which took place over a 26-day period, and the development of the IPHR system, which was also supported by M&D.

Again, in hindsight, planning for longer duration events would need to take place so that materials supply and planning for such events can be added to our emergency response plans and ongoing contracts.

Describe the implications on you/your department/organisation of strategies and systems put in place for testing, outbreak management (including in schools, care homes, etc) and self-isolation on your department

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

The IHE department initiated the contact tracing service via the Environmental Health function. The team also initiated and developed phase 1 of the integrated public health record. It was therefore well placed in following the rules required and providing the necessary advice through its dedicated health and safety team.

The department followed key corporate advice on testing/isolation/circulation etc. This was an operational challenge in our "always on" services such as Energy Recovery, and Liquid Waste. Teams A and B were deployed, and this ensured critical services remained operational at all times.

Managing and delivering government services in a changing and remote environment was at first a real challenge, however staff and systems responded and adapted well to this new normal.

Difficulties arose following the first phase of response, when rules were starting to be relaxed, but differing practices still remained in certain areas. This was driven by a combination of service difference, localised views on staff wellbeing, and individual staff nervousness.

In places, individual staff are still reluctant to return to physical at work environments, with personal health and safety concerns being balanced against organisational need.

In future, greater clarity as to the step up or step down of rules and consistently following these step processes would be helpful.

Describe the implications on you/your department/organisation of restrictions on:

- Physical distancing
- Mask wearing
- Self-isolation
- Connectivity and border control

Due to the varied nature of departmental activity, there were differing pressures. Outdoor staff, indoor staff, critical infrastructure staff all had differing approaches depending on the dynamic risk assessments of their specific workplaces. It was a constant challenge to ensure service delivery continued due to changing rules and therefore there needed to be a better understanding from policy/rule makers as to the operational and delivery reality of the rules.
The balance of public health and harm with regard to wider societal impacts
Describe impacts felt on you/your department/organisation • What community groups/sectors of the population have been impacted?
All sectors of the Island and community were affected by the pandemic. All parts of the department were affected in one way or another, either by staff withdrawal, service change, or policy requirements. Work levels increased across the department and the result of this added pace/length of working day is still being seen across the workforce and their associated workloads.
Describe how the work undertaken by you/your department/organisation impacted on different population groups
The department provides critical infrastructure and services used by all Islanders. The department delivered the Nightingale Hospital which benefited Islanders as the insurance policy for the health response. It also initiated the contact tracing service and public health record which benefited and affected all Islanders. The department led on the permitting of the construction industry to allow key construction activities to continue throughout the pandemic. Departmental services continued to run to ensure waste, water, roads etc functioned, and the natural areas were available to Islanders to enjoy. Government property was used flexibly to ensure the workplace pressures were accommodated and space was found for a variety of functions, for instance the contact tracing teams

JUSTICE AND HOME AFFAIRS

The Justice and Home Affairs department integrates public protection, law enforcement, emergency services and emergency planning, to keep Jersey safe and secure

Our responsibilities
Justice and Home Affairs encompasses:

- States of Jersey Police
- Ambulance Service
- Fire and Rescue Service
- Jersey Customs and Immigration Service
- States of Jersey Prison Service
- Health and Safety Inspectorate
- States Analyst
- Jersey Field Squadron RE

Our vision is for Jersey to be a place to live, work and visit, where people are safe and feel safe, which is free from discrimination and where rights and differences are respected.

We'll achieve this by:

- developing a modern, effective, efficient and integrated criminal, civil and administrative justice system, which focuses on prevention, early intervention and collaboration
- creating a modern, effective, efficient and integrated ‘blue lights’ and emergency response service, which is collaborative and responsive to the needs of Jersey’s communities
- safeguarding the rights of people in our island, including to travel
- protecting our national security by controlling our borders against unlawful entry by people, goods and illegal trade
- developing a prison service which focuses on changing behaviour, rehabilitation into the community and reducing the risks of reoffending

SELF-ASSESSMENT TEMPLATE

Justice and Home Affairs

Questions for all stakeholders

Governance
Please respond as appropriate: What governance arrangements did you establish to support decision making for the Covid-19 response? And/Or How did you/your department/organisation plug into governance arrangements for the Covid-19 response?
As the then Director General for Justice and Home Affairs (JHA), Julian Blazeby was the lead Director General (DG) for the operational aspects of the Covid-19 response, chairing the Strategic Coordination Group, and being the Accountable Officer (AO) and Senior Responsible Officer (SRO) for Covid Operations including the Testing and Tracing Programme. The AO and SRO for the Testing and Tracing programme moved to Tom Walker, Director General for Strategic Policy Performance and Planning (SPPP), from 15 October 2021, coinciding with Kate Briden's appointment as Acting Director General for Justice and Home Affairs (JHA) on Julian's departure. Testing and Tracing is covered in the SPPP self-assessment. Due to the requirement to adopt an 'emergency planning' response to the pandemic and the need to provide central, overall coordination of the government's operational response, Mr Blazeby took on additional responsibilities as an AO of areas not normally associated with JHA as well as the role of SRO on other themes. These included the early lead on the Nightingale Hospital, before handing over to Infrastructure, Housing and Environment, and lead DG for the One Gov Covid Response Team (1GCT) which included Personal Protective Equipment (PPE) sourcing and supply, and the Community Taskforce, along with Testing and Tracing, aspects of the Vaccination programme, and Covid Status Certification. These additional responsibilities meant that there was a requirement to report to other Ministerial portfolios as well as the Minister for Home Affairs. The changes were recognised as necessary and were discussed with colleagues at Treasury and Exchequer (T&E) to ensure compliance and good governance. These responsibilities, and the associated service delivery, were tracked through regular team meetings comprising partner departments, written updates, reports to Competent Authorities Ministers and Executive Leadership Team, and regular Programme Board meetings. JHA Heads of Service and other members of their Senior Leadership Teams were members of the Strategic Coordinating Group (SCG) and the Tactical Coordinating Group (TCG). The JHA Services were involved in several ways in the Covid-19 response and each managed implementation and maintenance of their own operating structures and processes, including business continuity. This did not generally involve new responsibilities as the activities undertaken were within their normal scope of practice, but on Covid-19 activity. For example, the States of Jersey Police (SoJP) and Health and Safety Inspectorate (HSI) supported Government in 'policing'

this public health pandemic. They adopted a public & community policy of continuing to police with consent through an operational model of what was termed the 4 Es; Engage, Explain, Encourage & Enforce (as a last resort). They kept records of enforcement action including lower levels words of advice.

Please note that the SoJP have submitted a separate self-assessment response. There are occasional references to the SoJP within this JHA response due to the necessary partnership working.

Each JHA Service had their own arrangements for governance and business continuity, as well as a role in the wider response structures. There were also linkages between JHA Services and other Departments, for example Ambulance Service officers attended Health and Community Service (HCS) Operational and Tactical response meetings in order to ensure a joined-up response. Service Senior Leadership Teams met regularly to review and adapt their arrangements, with particular focus on resilience of operations, ensuring continuity and effectiveness of service, and contributing to the wider response effort.

Please provide an appraisal of how suitable these governance arrangements were:

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

What worked well?

These arrangements engaged the JHA Services in the SCG and TCG. They evolved and were adapted significantly over the months as new responses were needed as the pandemic evolved.

The 1GCT conducted a lesson learnt exercise in June 2020, to create a 'toolkit' for future use in a similar situation. It was used when the 1GCT was formed again in November 2020 and provided a valuable framework to make the set up much swifter and enabled the team to be more effective more quickly.

What didn't work so well?

The unprecedented nature of the pandemic and its emergence meant that, whilst emergency planning activity is continually undertaken, there was no exact scenario planning nor governance structure to be adopted, so it had to be created very quickly and adapted often. This sometimes had the effect of confusion when dealing with a novel issue and not being sure which approval route it should follow.

As a small, independent jurisdiction, Jersey had to manage the crisis at both a 'national' and local level. This created an inherently complex governance framework with increased hierarchy. While largely unavoidable, in some areas, this meant that the Services that make up JHA were not sighted on critical decision points or included / consulted at key moments. One example was the Nightingale Hospital. As a place providing 'treatment or care', the facility fell within the ambit of the Fire Precautions (Jersey) Law 1977, but the States of Jersey Fire and Rescue Service, who enforce the law, were not included in the early planning and this led to avoidable risk and workload both pre- and post-commissioning of the facility.

Response teams were overlooked for critical worker schooling initially which caused avoidable concern for the staff involved.

What have you learned and what would you do differently?

It is clearly not possible to maintain a fully resourced team for all eventualities of a pandemic or other emergency event, but key is the ability to flex and scale resources rapidly. Ensuring colleagues are prepared in other ways is a key objective moving forwards e.g., in emergency planning exercises, business continuity planning, cross-skilling etc. Consideration is being given to widening the training available for people who can lead emergency responses across the Government to provide greater capacity and resilience.

What implications did the introduction of new legislation have on these governance arrangements?

The change in the Public Health law affected SoJP, Customs & Immigration (JCIS) and Ambulance, in regard to inspection and enforcement:

Paramedics were categorised as Health Inspectors, with powers, which if not followed could lead to enforcement by (SoJP or JCIS) or lead to fines. These powers were not in the event used, but there were a number of times when they were close to being used, and there was significant research, planning informing and revalidation to the process, working with Law Officers, Public Health, HCS and Ministers.

- The 1934 Loi allowed the appointment of a number of Health Inspectors to support the Medical Officers of Health in the fulfilment of their functions.
- In order to provide sufficient capacity in the event of an epidemic of Covid-19, the designation of all Ambulance paramedics as Health Inspectors under the 1934 Loi was made.
- The powers allowed for entry to assess, swab and if necessary, convey to a place of safety. (The primary role of the Ambulance paramedics would be to assess the health of an individual suspected of having Covid-19 through a clinical assessment including swabbing the individual and then, if necessary, facilitating their transfer to a designated place of safety.)
- The changes in regulations had a significant impact on the Health & Safety Inspectorate (HSI). The HSI are the central government point for all workplace and gatherings, queries, complaints and the impact of the additional regulatory responsibility, on their capacity to undertake their Business-as-usual operations (number of proactive visits etc), was significant. However following the revoking of the legislation, on 26 August 2021, their capacity is now back to pre-Covid-19 levels.
- JCIS and SoJP Officers were also deployed (alongside Environmental Health Officers and Honorary Police Officers) as part of the Monitoring and Enforcement of Isolation, especially in 2020.

How did the communications directorate support you/your department/organisation operation during the Covid-19 response?

- Were appropriate systems in place to support your department?
- What communication was required?
- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Emergency response structures were all inherently part of the broader communications approach.

The communications cascade was predominantly led by Public Health colleagues, with the need for the JHA communications team to refine to best fit each service under JHA.

The advice/ guidance was well delivered through communications department meetings/email updates, but equally Heads of Service were always well-versed in what the guidance and/or legislation meant within their own working environments; naturally very different to the majority as many are frontline/ key workers.

As ever with JHA departments, there was a need for face-face briefings as service personnel often don't access email or Our Gov on a regular basis, and work in a command/ control environment. Therefore, a lot of updates and instructions were delivered through managers.

At times, there has been a particular interest in the level of personnel within services who have had Covid-19, and that has been managed between Heads of Service / Director General with the communications team providing updates to the media.

Logistical and operational decision making

What Emergency Planning processes did you/your department/organisation have in place prior to the initial pandemic response?

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

JHA oversee the Emergency Planning Team for the GOJ, and so make a distinction between Emergency Planning and Business Continuity. This question has been answered based on the business continuity approach taken in relation to the department and its services and includes specific information relevant to the Emergency Planning Team (who supported the Covid-19 response within the wider framework used by the GOJ).

JHA is a collection of services and professions, most of which have standalone statutory functions with activities defined by external professional practice and so it is neither practicable nor appropriate for there to be a single, departmental 'emergency' plan. Instead, planning and response for crises is delivered at two levels; first, maintaining business continuity while simultaneously addressing the wider community impacts of the crisis itself and, second the narrower focus of business continuity of essential functions alone.

An example of the first, 'simultaneous' approach would be in the Jersey Customs and Immigration Service where teams maintained the critical – albeit reduced – activities for border protection, revenue collection and immigration matters while also lending capacity to running the novel 'essential travel' approval and booking system in the context of the tightly restricted borders at the time. An example of the emphasis needing to be placed more centrally on 'pure' business continuity was in the States of Jersey Prison Service where, self-evidently, the main effort was on continuing to provide a safe and secure prison, including health protection measures for the prisoner population. In relation to the more focussed, business continuity approach, each service enacted and delivered its own plan

<u>What worked well</u>

A particular success, in the context of a very challenging situation, was the way the 1GCT's 'Emergency Resourcing unit', with support from other government departments as well as St. John

Ambulance and Ports of Jersey, were able to provide support to the States of Jersey Ambulance Service. The service itself, despite being comprised of health professionals, was fully engaged in business continuity both because of increased demand but also because of the stringent restrictions on the use of Personal Protective Equipment (PPE) and the isolations requirements when staff had been in contact with Covid-19 positive patients. The Service is small and so the impact on capacity was immediate and profound. A rapid response to requests, reduced administration and a responsive team working to onboard staff - the ability of the resourcing team to access and secure trained and experienced people to provide vital back up to more qualified but stretched crews was very helpful in the early stages of the pandemic. Alongside this and not part of the Resourcing Team's approach – as part of their mutual aid arrangements, St. John Ambulance Jersey and Normandy Rescue came under the command of the Chief Ambulance Officer and this too, was extremely important.

More widely, the Emergency Planning Team has a coordinating and supporting role in ensuring that the Island has a range of plans in place to deal with crises; two such plans were relevant initially.

- First, was the generic Emergency Measures Plan which sets out the Island's overarching framework for the management of a crisis or emergency.
- Second was the Channel Islands Strategic Pandemic Influenza Plan. Clearly, SARS-Cov-2 was a novel virus and so challenged and, to some extent, evaded the planning assumptions of pandemic plans globally. Nevertheless, the rapidly developed public health-based response strategy did include a notable number of mitigations and measures found in the pandemic plan and these were effective.

<u>What didn't work so well</u>

The pace and novelty of the situation meant that well intentioned plans created unintended consequences – for example, fixed term contracts were rapidly issued to student paramedics who had returned to the Island to enable them to work as Ambulance technicians and supplement the stretched resources in the Service, but unfortunately, most did not have the driving licence requirements needed to drive the category of vehicle required (as this would be part of their studies at a later stage, before full qualification as a Paramedic). Work arounds were developed in relation to the deployment of crews.

<u>What have you learnt and what would you do differently?</u>

Learning - more thorough questioning, possible template for urgent staff support that details the essential requirements of the role as a guidance for discussion.

The Emergency Measures Plan was not followed in full and a different set of decision making, and coordination arrangements were implemented, reflecting the weight of decision-making activity and control measures predominating in the ministerial, 'national' sphere, alongside the local response construct. One of the effects of this was that, while a Strategic Coordinating Group (SCG) was in place, it could be observed that it did not undertake the role in accordance with the published plan or in line with the training and experience of many of the members in that it rarely made any decisions; this may have been unavoidable given the nature of the pandemic, and has been considered to be a 'hybrid' model. The SCG did nevertheless create an important forum for the exchange of information and coordination, and cascade of function and information to the TCG and 1GCT.

How have you/your department/organisation Emergency Planning processes evolved during the pandemic response?

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Alongside the ongoing management of the COVID pandemic, Jersey has since contended with disruption and protests by French fishing fleet as well as the crisis in Ukraine; both of these, again, engaging 'national' level thinking, planning, deciding and acting and so experience is being built and refined in managing crises in this 'hybrid' mode and it feels, to the Emergency Planning Team, that this experience and practice is leading to improvements for the future.

A risk that must be managed within this context though, is that the response to a conventional 'local' emergency (such as a major accident, search and rescue situation, fire or similar) is and must be managed differently and so, with much 'live' experience for a very wide range of stakeholders having been gained in the 'hybrid' model, extra effort must be put to ensuring everyone understands that this template cannot and must not be used in all crisis situations.

Describe the implications on you/your department/organisation on procurement and the continuity of supply chains during the pandemic response?

- Were appropriate systems in place to support your department?
- What procurement was required?
- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

From March 2020, JHA coordinated the response teams. The 1GCT was led by Kate Briden to co-ordinate the response and management of all cross departmental activities to support and protect the Jersey community against the threat of the of Covid-19. We formed operational cells to manage the community response, supplies and supply chain, business continuity and emergency resourcing and worked in partnership with the Executive Leadership Team (ELT).

These included (for example):

- Extension of cleaning contracts for the Ambulance Service and other locations; enhanced cleaning across the GoJ estate
- Creation of the PPE Cell
- Resolution of issues regarding obtaining PPE

Describe the implications on you/your department/organisation of strategies and systems put in place for testing, outbreak management (including in schools, care homes, etc) and self-isolation on your department

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Fire & Rescue

<u>What worked well?</u>

Fire & Rescue's business continuity arrangements stood up well and, throughout the pandemic, core activities including critical safety messages, priority enforcement activity and emergency response continued as normal.

The Fire & Rescue service was able to split its teams into two and then three locations. Initially, before the rollout of MS Teams capability, the Service's leadership team, operational teams and specialists working in Fire Safety Protection were posted to both the Headquarters and station in St. Helier and to the Western Fire Station respectively. The purpose was to ensure that any transmission or outbreaks would be less likely to affect an entire team or roster group, the consequences of which would have been severe.

Following the rollout of MS Teams, key people were able to work from home, thus reducing pressure on workspaces with inherently lower occupancies and further reducing transmission risk across teams. This has been very effective in moving from the initial crisis phase to a more enduring risk management phase.

What didn't work so well?
Fire & Rescue's Mobile IT provision does not extend to Watch based personnel or on-call personnel and so contact and communication with these valued colleagues was much more difficult.

Some opportunities were lost to understand and more effectively manage risk regarding fire safety in the Nightingale Ward which might have been better managed with the earlier involvement of firefighters.

While willing, firefighters were unable to provide the same sort of community-based support as was seen delivered by UK colleagues because local resources are so small as to have made resilience a critical challenge.

Initially, it appeared difficult to ensure a sufficiently widespread understanding of the role firefighters play in providing emergency trauma and medical care and this, in the earliest stages, affect guidance on and access to the relevant Personal Protective Equipment (PPE). This was later addressed satisfactorily.

What have you learned and what would you do differently?
A key feature emerging for the Fire & Rescue services nationally is the increased use of online platforms for Fire Safety work, especially in the field of prevention activity (online home fire safety self-assessments as an example).

Additionally, instead of simply not conducting fire safety enforcement inspections in high-risk settings (i.e., residential care facilities to protect residents), increased and more flexible use of mobile video conferencing would be an option were it needed in similar circumstances in future.

Customs & Immigration

What worked well?
Aside from business continuity measures JCIS was involved in the Pilot scheme to introduce testing at the border which involved setting up the infrastructure to test arriving air passengers into Jersey. The scheme was later widened by other government stakeholders to include all passengers arriving into the Island. Such a scheme had never been in operation before and there were significant logistical challenges around technology and turnaround testing times (the initial method was to

send samples to the UK). Certainly, if such a framework had to be re-introduced there is now a tried and tested operation that received positive feedback from those that passed through it.

In conjunction with this pilot, together with external relations and other key stakeholders, JCIS designed and administered the Essential Travel Scheme which was the permission framework for those that qualified for travel at the time travel was restricted to those who had essential reasons for travel. Again, there were lessons learned from setting up a completely new concept and continuous improvement led improved efficiencies around decision making and response times.

JCIS was also involved in ensuring compliance for those that had to self-isolate under Covid restrictions and this involved visits to home address within the island. By far the majority of Islanders were compliant in the respect.

Prison

What worked well?
Reducing the regime to ensure that prisoners didn't mix across wings, if there was ever covid on one wing it was well contained. Excellent cleaning regimes in activities areas further supported this to ensure all prisoners could take part in the range of activities (use the range of equipment), albeit and different times.

Coming under the same legal framework as care homes gave a wider evidence base and more defensible position in imposing restrictions and this was easier for prisoners and visitors to understand.

Early vaccination of prisoners and staff (ahead of age group) helped reduce the risk of covid coming into the prison and the impact if it did, this gave confidence to step the regime up and down according to covid risk.

A really robust testing regime for prisoners and staff and very quick response by infection control to have multidisciplinary meetings where covid was identified in staff or prisoners ensure that we could respond quickly to the risk with the most up to date information and advice, we felt well supported by infection control as soon as they were invited to engage.

What didn't work so well?
Early concerns about lack or prioritisation of the prison regarding lack PPE supplies

What have you learnt and what would you do differently?
The prison acted in an independent way in decision making and risk assessment in the early days sometimes drawing from anecdote in the public domain. Engaging with infection control really improved decision making and confidence in taking some risk and the prison could have benefited from better multidisciplinary working and making better use of the knowledge and experience of other Government departments earlier on in the pandemic.

Ambulance

What worked well?
The Ambulance Service initially took the lead along with the Infection Prevention and Control team (HCS) in arranging the initial home testing of the public prior to any test and trace systems being set up. The Service was then involved in the setup of the first testing station at Five Oaks. Whilst cases numbers were low, this had insignificant impact, however as testing requirements increased,

and business continuity became essential we slowly withdrew from the process of ambulance clinicians home testing, whilst continuing to support the testing team with vehicles and drivers (non-clinical staff and volunteers).

Testing arrangements worked well within the Service as staff had already been trained to provide this and were therefore able to provide regular testing arrangements for our own staff.
Outbreak management worked well in phase one, whereby additional staff had been employed, however during the November 2020 wave, more than 50% of the emergency ambulance staff were affected by either Covid directly or isolation requirements because of being direct contacts. BC (Business Continuity) arrangements were then stretched as short-term contracts had ended. Mutual aid support was arranged with Guernsey, this worked well, though cost containment was an issue due to the volume of staff losses throughout the year.

In the first wave we agreed a complete change in rostering within a few days and moving of personnel between roles to support emergency operations, reducing cross contamination of staff etc.

Mutual aid was brought in from voluntary partners and additional staffing from Student Paramedics the Health and Safety Inspectorate, Airport Fire and Rescue and the Jersey Field Squadron

Further talks were had and offers of support (Drivers) received from liberty Bus, Jersey Lifeboat Association and Mourier Swim School, though these were not progressed.

Welfare pods/portacabin and additional use of St John Ambulance HQ assisted in separating teams to help reduce spread

The Jersey Field Squadron

What worked well?
Major Charlie Martell, Officer Commanding in the Jersey Field Squadron of the Royal Engineers, is quoted in the independent newspaper article of 8 September 2021 as one of those who has helped make the goal of vaccinating as many people as possible, as quickly and safely as possible, a reality.

Together, his unit constructed a centre in Jersey that will be able to handle up to 1,500 vaccinations a day.

The former Network Rail programme manager, who graduated from the Sandhurst military academy, said he and his colleagues had worked "flat out" on the project.

"This is exactly what this squadron is here for, in terms of local resilience. It was a local reserve unit supporting the local area and solving local issues," he said.
"Everyone is working incredibly hard so that the vaccination programme stays on track."

Describe the implications on you/your department/organisation of restrictions on:

- Physical distancing
- Mask wearing
- Self-isolation
- Connectivity and border control

Each JHA Service put a recovery plan in place in summer 2020, focusing on a return to 'normal' operations, taking into account continuing restrictions in place in some areas at the time (for example the continued wearing of enhanced PPE for the Ambulance Service), whilst also having regard to likely arrangements for winter, in line with the winter strategy. Some Services benefitted from guidance from relevant national bodies, so for example, in accordance with National Policing, the SoJP very quickly adopted a Recovery Plan.

There are some consequential effects which are still being managed. For example, the main change in the prison was splitting the regime to ensure that prisoners could attend activities in self-contained 'bubbles' and reduce the risk of spreading any virus. Although this requirement has recently been lifted as part of the recovery programme, there are still some restrictions in place due to staff vacancies while delayed recruitment processes catch up. These restrictions are now an indirect consequence of covid rather than a precaution and anticipated to fully recover by end of March 2022 once trained staff are in place.

Fire & Rescue

The Fire & Rescue service was able to split it teams into two and then three locations. Initially, before the rollout of MS Teams capability, the Service's leadership team, operational teams and specialists working in Fire Safety Protection were posted to both the Headquarters and station in St. Helier and to the Western Fire Station respectively. The purpose was to ensure that any transmission or outbreaks would be less likely to affect an entire team or roster group, the consequences of which would have been severe.

Following the rollout of MS Teams, key people were able to work from home, thus reducing pressure on workspaces with inherently lower occupancies and further reducing transmission risk across teams. This has been very effective in moving from the initial crisis phase to a more enduring risk management phase.

Customs & Immigration (JCIS)

Due to reduced border arrivals JCIS staff were able to be re-directed staff to wider government groups responding to the pandemic (eg 1GCT/home visits/essential travel etc). Some home working was introduced and remote access to CEASAR (good control system) prevented disruption to the supply chain and no loss of revenue.

Physical interaction between teams was limited and the floors in Maritime House (JCIS HQ) was restricted to avoid cross contamination.

For those staff that had to deal with arriving passengers a health and safety risk assessment was conducted and a standard operating procedure with suitable PPE was established. The swift introduction of 'Teams' meeting was invaluable.

Although business continuity plans and a table-top exercises established prior to Covid 19 gave some basis/a starting point, the thinking and subsequent practice required significant development of these plans. Effectively closing the borders had not been part of the scenario planning as the thought was (prior to Covid 19) that effectively closing the borders would not prevent the spread of any virus. The reality was different and a good learning point for future planning.

Prison

The main changes in the prison were splitting the regime to ensure that prisoners could attend activities in self-contained 'bubbles' and reduce the risk of spreading any virus. Although this requirement has recently been lifted as part of the recovery program, there are still some

restrictions in place due to staff vacancies while delayed recruitment processes catch up. These restrictions are now an indirect consequence of covid rather than a precaution and anticipated to fully recover by end of March 2022 once trained staff and in place.
Increase in use of technology for virtual visits (n areal benefit for international prisoners of those with families overseas) and greater availability of technology for prisoners to attend court virtually, at the discretion of the court.

Electronic tagging was brought into place to provide an option for medically vulnerable prisoners where offending risk was considered to be manageable to have a curfew at home. The uptake was low, but this continues to be a tool that is available to the Services in Jersey with a potential new evolution as to how it is deployed.

Ambulance

Physical distancing was difficult due to ambulances being confined in size and activity is 'close contact'. The ambulance station also has limited space and so welfare units were used to create capacity and St John Ambulance HQ was used as second base.

Mask wearing meant that communications were difficult, particularly with patients. There was also a welfare impact on staff due to it being necessary to wear masks for extended periods.

The self-isolation impact on resourcing of specialist staff, worldwide response meant usual support arrangements were in high demand agency/mutual aid etc.

Connectivity and border isolation controls resulted in delayed start dates for arriving support staff.

H S I
There was no significant impact on the HSI team or delivery of core services resulting directly from these restrictions. The team adopted a hybrid system of working which involved splitting the small team into two 'bubbles' for a period of time but, due to the nature of our work and time typically spent as lone workers 'out in the field', together with the design of the office these restrictions did not pose an operational challenge.

The balance of public health and harm with regard to wider societal impacts
Describe impacts felt on you/your department/organisation • What community groups/sectors of the population have been impacted?
Not applicable for JHA
Describe how the work undertaken by you/your department/organisation impacted on different population groups
As above

Questions for particular stakeholders (see question header)

Public Health and other relevant stakeholders
Provide a self-assessment of the effectiveness of public health interventions – both restrictions and guidance such as : lockdowns, physical distancing, shielding – in protecting Islanders
Not applicable for JHA

Please provide a high-level evaluation of the efficacy of decision making and how it was informed by learning from evidence and actions of other jurisdictions
Not applicable for JHA

Health and Community Services, relevant external/commissioned/voluntary sector stakeholders
Outline the operational impacts on the delivery of healthcare and social care services during the pandemic response
Not applicable for JHA

Children, Young People, Education and Skills and other relevant stakeholders
Outline the operational impacts on the delivery of education during the pandemic response
Not applicable for JHA
Public Health; Health and Community Services; Children, Young People, Education and Skills; other relevant stakeholders
Provide a self-assessment of the effectiveness of strategies and systems put in place of testing, outbreak management (including in schools, care homes, etc) and self-isolation • What worked well? • What didn't work so well • What have you learnt and what would you do differently?
Not applicable for JHA
Provide a self-assessment of the effectiveness of strategies and systems for vaccination • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
Not applicable for JHA
Economy; Treasury and Exchequer; Customer and Local Services; other relevant stakeholders
Provide a self-assessment of the impact and effectiveness of mitigations such as support to individuals, businesses, and other organisations • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
Not applicable for JHA

STATES OF JERSEY POLICE

The States of Jersey Police serves a resident population of just over 107,000 people as well as over 700,000 visitors to Jersey each year.

At face value, the challenges involved in policing Jersey may seem to equate to policing a small town in the United Kingdom. But Jersey's status as a Crown Dependency with its own government and legislation create a distinct policing environment:

- the main difference is that the States of Jersey Police must be largely self-sufficient in developing and maintaining services that are provided through a local, regional and national level police service infrastructure in the United Kingdom

- the States of Jersey Police provide a range of functions that would normally be delivered by other service providers in the United Kingdom. For example, we play an enhanced role in supporting the administrative requirements of the criminal justice process, provide a vetting and barring service, manage the town CCTV system and maintain Jersey's central firearms register

- we must also police Jersey's ports. Jersey Airport serves about 40 destinations and handles around 1.5 million passengers a year. Another 750,000 travel through Jersey's sea ports

- Jersey's role as an international finance centre means that we have a key function as a Financial Intelligence Unit that works with enforcement agencies around the world to combat money laundering and terrorist funding

The States of Jersey Police currently operates with a funded establishment of 214 police officers and 118 civilian staff. The high ratio of police officers to civilian staff reflects a practical need to maintain operational resilience. Many officers are trained in specialist skills over and above those needed for their normal duties so that they can be called upon at any time to perform specialist roles. These might include firearms, search, surveillance, siege negotiation, collision investigation, public order, CBRN response and family or sexual offence liaison.

A large investment in training is needed to keep officers at the required level of expertise

SELF-ASSESSMENT TEMPLATE

Questions for all stakeholders

Governance
Please respond as appropriate: What governance arrangements did you establish to support decision making for the Covid-19 response? And/Or How did you/your department/organisation plug into governance arrangements for the Covid-19 response?
• Membership SCG, TCG, CAM, OneGov Hub, Enforcement Team, Safer Jersey Team, T&T board, Borders, Excess Deaths Cell. Honorary Police Hub structure. • Operation name linked to UK Forces (Op Talla) • SOJP Gold Strategy, BCP plans, Force Plan created and implemented by SOJP (copies available) • Gold/Silver/Bronze structure in place internally from March 2020 – March 2022. Initially daily meetings of Gold and Silver teams, reducing to weekly and monthly as restrictions eased and risk level reduced. Over 100 Gold meetings held. • Power BI data suite created and used for Management Information in order to dynamically assess Demand & Resourcing availability.
Please provide an appraisal of how suitable these governance arrangements were: • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?

Well:

- Internal SOJP Governance arrangements.
- Good connectivity between all levels (Gold, Silver, Bronze).
- Good connectivity with National Police Chiefs Council and National Police Coordination Centre.

Not so well:

- Governance arrangements across government including absence of a Jersey resilience forum.
- Lack of consultation around law drafting, for example notified on Friday of a law change starting on the following Monday with no consultation and insufficient time to adapt and plan resourcing.
- Insufficient data sharing specifically from HCS.
- CAM didn't use SCG / TCG structure.

Learnings:

- Adopt a Jersey Resilience Forum earlier in the process.
- Ensure SOJP had a place on the Law drafting panel – or were consulted earlier in the process.
- Data sharing agreements in place with other GoJ Depts.

What implications did the introduction of new legislation have on these governance arrangements?

- Lack of sufficient consultation and insufficient consideration to practical application of legislation.
- Timing of new legislation (released on Friday for implementation on Monday – or early the following week).

How did the communications directorate support you/your department/organisation operation during the Covid-19 response?

- Were appropriate systems in place to support your department?
- What communication was required?
- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Well

- Weekly communications received from GoJ Internal comms.
- Good communications amongst partners.
- Embedded communications within SOJP.

Not so well:

- Overwhelming amount of communications and constantly changing situation at the beginning (early 2020).

Logistical and operational decision making

What Emergency Planning processes did you/your department/organisation have in place prior to the initial pandemic response? • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
Well: • Well established command and control structure in place at SOJP. • BCP Plans in place before the outbreak of Covid which led to a comprehensive Force Plan. Not so well: • BCPs from other depts. may have assumed police support but SOJP not engaged. As SOJP were not aware, we were unable to plan resources to support. Learning: • If partners are called out in BCP plans they should be consulted to know and understand their obligations.
How have you/your department/organisation Emergency Planning processes evolved during the pandemic response? • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
Well: • Agile working and digitisation of services • Virtual meetings • Digital Courts • Attendance at UK groups (e.g. National BC Recovery Group) & Civil Contingencies Not so well: • Logistics burden in terms of rolling out equipment for home working. • SOJP using different virtual meeting software to rest of GoJ – requirement for O365. Learning: • Issue modern and personal IT equipment to all staff for future BC arrangements (laptops instead of desktops). • O365 to be rolled out in SOJP to improve connections to other GoJ Depts.
Describe the implications on you/your department/organisation on procurement and the continuity of supply chains during the pandemic response? • Were appropriate systems in place to support your department? • What procurement was required? • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?

Well:

- No supply chain issues experienced at SOJP.
- GoJ systems used to acquire PPE and other supplies.

Not so well:

- Long lead times for some equipment (e.g. IT hardware).
- Legacy stock may expire.

Learning:

- GoJ approach to allocating PPE centrally to ensure appropriate stock levels maintained.
- SOJP to be part of central M&D for asset replacement (now achieved by integration of SOJP with M&D Dept.)

Describe the implications on you/your department/organisation of strategies and systems put in place for testing, outbreak management (including in schools, care homes, etc) and self-isolation on your department

- What worked well?
- What didn't work so well?
- What have you learnt and what would you do differently?

Well:

- Rostering function enhanced – additional staff drafted to assist.
- Increased hours for Rostering and other depts.
- Specialist critical services placed on different shifts and working from different locations (Jersey Financial Crime Unit).
- Used Town Centre Police Station and parish halls to separate shifts and Firearms Dept.
- Provision of hotel accommodation for SOJP staff when required to self-isolate away from families.

Not so well:

- SOJP were not included in the exemptions required for critical individual staff to continue working (e.g. where staff were direct contacts within Firearms and FCR staff) – not streamlined process. Applications were required on an individual basis rather than a Force approach.
- Workforce testing and vaccinations for Police was categorised as low priority.

Describe the implications on you/your department/organisation of restrictions on:

- Physical distancing
- Mask wearing
- Self-isolation
- Connectivity and border control

- Requirement to utilise other office spaces to keep staff safe.
- Splitting of CCR staff due to inability of staff to wear masks.
- PPE fatigue.
- Enforcement checks carried out by SOJP following border control policies added resourcing pressures to shifts.
- Impact on staff due to self-isolation (including the care of family members).

The balance of public health and harm with regard to wider societal impacts
Describe impacts felt on you/your department/organisation • What community groups/sectors of the population have been impacted?
• Vulnerable groups including children and young people. • Under reporting of personal crime including domestic and sexual violence. • Positive impact in respect of absence of the night time economy and reduction in violent crime.
Describe how the work undertaken by you/your department/organisation impacted on different population groups
• Adopted a consolidated parish centric model (Island split into East, West and St. Helier) which impacted positively within the community, increasing visibility and engagement. • Deployment of officers to a number of government partnership functions worked well. • Community Impact Assessment (CIA) (copy available) in place and use of Community Advisory Group.

Questions for particular stakeholders (see question header)

Public Health and other relevant stakeholders
Provide a self-assessment of the effectiveness of public health interventions – both restrictions and guidance such as : lockdowns, physical distancing, shielding – in protecting Islanders
Please provide a high-level evaluation of the efficacy of decision making and how it was informed by learning from evidence and actions of other jurisdictions

Health and Community Services, relevant external/commissioned/voluntary sector stakeholders
Outline the operational impacts on the delivery of healthcare and social care services during the pandemic response

Children, Young People, Education and Skills and other relevant stakeholders
Outline the operational impacts on the delivery of education during the pandemic response

Public Health; Health and Community Services; Children, Young People, Education and Skills; other relevant stakeholders
Provide a self-assessment of the effectiveness of strategies and systems put in place of testing, outbreak management (including in schools, care homes, etc) and self-isolation • What worked well? • What didn't work so well • What have you learnt and what would you do differently?
Provide a self-assessment of the effectiveness of strategies and systems for vaccination • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?

Economy; Treasury and Exchequer; Customer and Local Services; other relevant stakeholders
Provide a self-assessment of the impact and effectiveness of mitigations such as support to individuals, businesses, and other organisations • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?

COMMUNITY TASK FORCE

The Community Task Force coordinated support for Islanders during lockdown. It brought together the help and support available from Government, the Parishes, the voluntary and community sector and local businesses through the Connect Me service.

The Task Force:

- Responded to over 350 requests for support through the Connect Me portal
- Recruited over 3400 volunteers through the Connect Me portal
- Worked with Caring Cooks, Meals on Wheels and Age Concern to deliver an average of roughly 1200 hot meals per week
- Supported Islanders who were advised to shield by coordinating GP letters and phone calls, and working with parishes
- Offered housing advice and support to 198 individuals and families
- Established new ways to fund community support in response to COVID-19

SELF-ASSESSMENT TEMPLATE

Questions for all stakeholders

Governance
Please respond as appropriate: What governance arrangements did you establish to support decision making for the Covid-19 response? And/Or How did you/your department/organisation plug into governance arrangements for the Covid-19 response?
The Community Task Force and ConnectMe linked to both the wider community governance arrangements, the CLS structure as well as linking with Parishes and Civil Society.
Please provide an appraisal of how suitable these governance arrangements were: • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
The governance arrangements worked well an enabled evidence based decisions to be made in a timely manner while ensuring appropriate issues and risks were mitigated or/and escalated. Overall, the governance arrangements worked very well with strong political oversight and leadership. In terms of learning, having a clear focus and collaboration across all stakeholders was the key to supporting islanders as the situation developed. Much of this collaboration and the solution focused strengths based approach should be continued to help deliver key services.
What implications did the introduction of new legislation have on these governance arrangements?
The implication of the new legislation did not impact the governance arrangements, but they did have an impact on our stakeholders/islanders and thus quality information and support was imperative.
How did the communications directorate support you/your department/organisation operation during the Covid-19 response? • Were appropriate systems in place to support your department? • What communication was required? • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
The communications department were very supportive and enable key messages to be provided in various forms. The communication required was for both stakeholders such as civil society groups as well as islanders who needed information and support. As a result of the success of the regular communication during the pandemic we have continued to communicate on a weekly basis to other 400 organisations/individuals. The only area which could have been improved was the timing of some of the press releases. However, due to the speed of change his was inevitable.
Logistical and operational decision making

What Emergency Planning processes did you/your department/organisation have in place prior to the initial pandemic response? • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
The department has business continuity plans in place which were updated to reflect the changing situation across the island. This along with regular communications enabled key services to be delivered to meet islanders needs.
How have you/your department/organisation Emergency Planning processes evolved during the pandemic response? • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
I would suggest that overall the organisations EPP have matured during the pandemic with a whole system approach to managing risk and enabling business continuity. As an organisation I feel we become more of a collective in terms of cross departmental working and working with civil society for example.
Describe the implications on you/your department/organisation on procurement and the continuity of supply chains during the pandemic response? • Were appropriate systems in place to support your department? • What procurement was required? • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
My area of responsibility was not involved in procuring supply chains linked to the pandemic.
Describe the implications on you/your department/organisation of strategies and systems put in place for testing, outbreak management (including in schools, care homes, etc) and self-isolation on your department • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
We have business continuity plans to enable key services to be developed and this included training of staff to provide additional resilience. This worked well and increased the skill set of colleagues and also enabled fluid decisions to be made where appropriate. We had regular communications and meetings to manage the situation, including staffing levels, IT, Comms, BAU et cetera.
Describe the implications on you/your department/organisation of restrictions on: • Physical distancing • Mask wearing • Self-isolation • Connectivity and border control
As the restrictions changed there was an impact on colleagues and islanders. For example our library service moved to more of an online presence. We had a number of challenges at the crematorium for example as well as the Office of the Superintendent Registrar. In general colleagues and islanders went above and beyond to minimise the impact of restrictions, but many people were impacted significantly both in the short and longer term.
The balance of public health and harm with regard to wider societal impacts

Describe impacts felt on you/your department/organisation • What community groups/sectors of the population have been impacted?
The pandemic has impacted the whole community in some way with certain groups perhaps impacted on more than others. For example we know that older islanders had to isolate and this has had an impact on their wellbeing. We know children and young people missed education and their friends and activities. We know that vulnerable people had to shield, again losing their support network and we know that we had an increase in domestic abuse and homelessness during the pandemic. We have seen an increase in the number of islanders access mental health services. However, we have also seen the strengths of our community and resilience. The GoJ , civil society, the private sector, funders, volunteers, Parishes all worked together for the benefit of the island.
Describe how the work undertaken by you/your department/organisation impacted on different population groups
We worked right across the community, linking with our cluster network as well as Parishes, civil society and through the Financial Impact Action Group organisations such as Caritas and the Salvation Army. We also worked with the Learning Disability Cluster to support the vaccination programme for example. Through the Community Task Force and ConnectMe we were able to support over 700 islanders with practical support as well as supporting civil society organisations with information and guidance. We also set up a Crematorium User Group with faith, non faith membership as well as funeral directors.

Questions for particular stakeholders (see question header)

Public Health and other relevant stakeholders
Provide a self-assessment of the effectiveness of public health interventions – both restrictions and guidance such as : lockdowns, physical distancing, shielding – in protecting Islanders
I think that the effectiveness of the public health measures was successful in protecting islanders, saving lives and also opening up the island as soon as practicable. I think that the correct balance was achieved.
Please provide a high-level evaluation of the efficacy of decision making and how it was informed by learning from evidence and actions of other jurisdictions
I think overall decision making was good, based on evidence and was timely. We did learn from other jurisdictions both in terms of identifying good practice and avoiding actions that would have increased risk.

Health and Community Services, relevant external/commissioned/voluntary sector stakeholders
Outline the operational impacts on the delivery of healthcare and social care services during the pandemic response
There were a range of impacts as the pandemic developed that changed how services were delivered, what services were delivered and by whom. Services responded to the initial emergency and how now moved from the initial shield and protect mode to one of recovery. Due to the pace of change services had to be agile and able to change. One area that was pressured and remains so is the care sector and when restrictions were imposed it did limit the amount of carers available on the island.

Children, Young People, Education and Skills and other relevant stakeholders
Outline the operational impacts on the delivery of education during the pandemic response
There was a considerable impact on education as well as key services and activities that children and young people access.

Public Health; Health and Community Services; Children, Young People, Education and Skills; other relevant stakeholders
Provide a self-assessment of the effectiveness of strategies and systems put in place of testing, outbreak management (including in schools, care homes, etc) and self-isolation • What worked well? • What didn't work so well • What have you learnt and what would you do differently?
Aside from my experience from our children's perspective I do not have an insight into the strategies and systems used. That said schools did an incredible job under pressure and continue to do so now.
Provide a self-assessment of the effectiveness of strategies and systems for vaccination • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
The vaccination programme was a success, well organised, well delivered and well promoted across the island. While improvements can always be made, the system worked very well on the island.

Economy; Treasury and Exchequer; Customer and Local Services; other relevant stakeholders
Provide a self-assessment of the impact and effectiveness of mitigations such as support to individuals, businesses, and other organisations • What worked well? • What didn't work so well? • What have you learnt and what would you do differently?
The GoJ worked quickly to support businesses in a number of ways, and this is supported by record low unemployment. Aside from the support provided the fiscal stimulus projects helped the local economy as did the Spend Local Card.