Centralised COVID Governance Minutes

Meeting Name: STAC
Date & Time: 06/05/2020 0900-1100 hrs
Room: Boardroom 4th Floor PCH

1. Introduction and status update

Minute	-Currently awaiting clarification of the committee's line of reporting and authority. -ToR reviewed due to amendments. -The main outcome of today's meeting is to agree how safe we are to move to level 3 next week. -Also to bottom out testing strategy and process. Particularly around consent and how the testing strategy can affect the outcome.

2. Intelligence overview and recent changes

Minute	Presentation There is content to be confirmed, hence the presentation is titled as preliminary Test positivity rate is fraught with difficulty. Deaths recorded in the environmental health database are those reported as +ve. On the SPPP website this includes cases where GPs have recorded probable cause of death. Should this incorporate hospital data? Yes: there are other dashboards to incorporate this data. This will be helpful in managing tolerances We are having difficulty in managing hot and cold services in the same facility. This is key in the success of the future. This is reflected in how we have moved forward in managing Covid and shielding Do we think the pattern of test positivity may be an artefact of the initial quite restrictive testing policy? Yes; to an extent but rate has remained broadly constant over the time period; would expect that going forward with 500 tests a day, the 'noise' in results should be lessened. Discussion (slide 1) Screening policy at ports is essential for people arriving on island, screening of health workers is key. Why don't we use Nightingale as an isolation centre? This is the current plan. The shielding in care homes has caused concern that we need to facilitate autonomy for these people to have quality of life. Care home care has improved as nurse to resident ratio is improved. The problem is the community carers moving between private homes across the island. Yes agree; this is where the data needs to be interrogated. The cluster of cases has been in care homes. The trickle of cases has not been clear if it is from a risk from domiciliary care. The increased screening of HCW will help to capture these people and information. There are 4 % of cases that have been identified as community care. The ownership of community care has been captured but as they are private businesses there does need to be a different dialogue going forward. The risk to patients in residential

	care need to be communicated to both patients and staff. Ethically there needs to be consideration of people living their last days, weeks or months of their lives to see their loved ones. Decision: PA in terms of advice to Government there needs to be increased standards and legislation to private care sector to increase and allow quality of life. Increased testing of domiciliary care workers may be fearful of presenting for testing. This will need to take into account that these workers are often low paid and will need Government support to ensure they are not financially impacted. It was highlighted that we need to look at movement of staff off island that do not live in Jersey. Their limitation to see family risks us losing staff. The limiting factor is availability of PCR testing. We will need to do PCR testing 3- 7 x per week for first 14 days. Suggestion we may need to move to PCR 700. It is understandable that people wish to visit family off island. There will be rapidly increasing pressure due to the economic nature of travel and the wider picture of people moving off island to see families. The programme of testing is under review and planning to utilise testing capacity. There is considerable work going on. What are the UK doing? Planning on continuing with 14 day quarantine at the moment. The UK are also looking at a 14 day quarantine. And we need to bear in mind other countries restrictions Action: A paper around testing will be brought to STAC next week Decision: This is something that needs more time and taken outside of this meeting. Is our sample size robust enough as it is so small? We are looking at the cases we have, not necessarily a sample. The big unknown is the number of asymptomatic cases and their impact on transmission. The evidence now is that asymptomatic cases have less of a role to play in transmission than symptomatic cases. PCR testing paper presented GPs are happy with proposed testing in recommendation 3 Concerns that people are not engaging as much in testing and reporting and there is a risk they may not come forward as they want to get back to normal and fear being in quarantine. Decision: People need to come forward, testing needs to be done. In terms of providing advice from this group we must re inform that there is a need for clinical prioritisation. We need to reinforce the availability of testing and making it clear the difference in the testing available. The more testing we have the more people will want to be tested this also needs to be kept in mind. But testing does have a ceiling. There was discussion of capacity and consent. How do we manage people that cannot or will not consent to testing? As an employer we cannot force someone to be tested, this is assault. There are people in the community who are asymptomatic, not wanting to be tested as do not want to have time off work. How do we swab people in care homes that do not have capacity to consent? We are doing it to protect fellow residents and the care home. Example that a care home with no cases did not understand why they should be swabbed.

	Decision: The area of consent and capacity to be taken to the LOD to get advice to proceed in these cases. Please note following the Silver command meeting after this STAC meeting we are aware the LOD is involved in reviewing the ethics of people lacking capacity to consent to testing, this information will be brought to the next meeting. There is occupational health element to this for example with MRSA, we screen routinely as well as when there is +ve case on a ward. Agree there is need for testing. But we must incorporate HR and the Unions to ensure we get it right first time. In regard to care homes we need a global view and experience. There are incidents in the community that families are taking legal action against care homes because of movement of residents/patients. Would be good if we could introduce serological testing in these papers. Serology testing will be part of the strategy- more sensitive lab based testing will be introduced in the next 1-2 weeks and we can then add this in. There is no agreement that antibodies equals immunity at the moment although this is likely to be the case. Has there been discussion of the agricultural workers accommodation and close living? We have had contact from Oxford and getting involved in vaccination trials. Currently they cannot accommodate us at the moment due to availability but will keep us in mind. Continue to push this through. The previous death peak in March/April still appears to be the historical peak we would usually see at the end of April/May.

3. Issues for discussion

Minute	Lockdown phasing presentation There are 2 phases currently being suggested Phase 1) Outdoor activities, outdoor businesses, house viewings, increasing to groups of 5 people outside of immediate household Phase 2) Opening of indoor business -At this time we will not be looking at level 2 and 1. -Can we reiterate the time scale moving between levels. This is being discussed by the ministers -Guidance to be reviewed for MOH approval before adoption by public health -Proposed changes to personal movement should the time outdoors be extended? There are some legislative areas around this outside of STAC. Decision: The group are: 1) accepting of the document. 2) Levels 1 and 2 need a more detailed review. 3) Agree the principles of the content in level 3.

	-The next discussion is to the need of level 3 to be introduced in 2 phases. In phasing are we suggesting that we have 2 weeks between phases or 2 weeks between levels? Yes. -Why are we phasing? To be safe. The first part is activity. The second is indoor business which are at an increased risk of transmission. To split the levels will cause confusion. We have 4 levels and the proposal is to now introduce sub levels within them. There is underpinning legislation which effect these principles and will affect the order of implementation. If the increase of outdoor activity alone causes an increase in cases we may postpone indoor businesses given that most COVID cases are spread indoors. And avoid a reversal of the direction of lightening lockdown. -Do we have clear triggers and detail about what activities are allowed across the stages to allow us to move through the stages seamlessly? Is there a clear level of Covid activity that is acceptable? The aim is to keep the Ro below 1. Reiteration that we are predicting what we have previously said. That we will not see a rise until 2 weeks after changes to measures due to incubation period. If we shorten the period of moving stages, are we then not following advice that we have previously set out. We are creating risk in these levels. Feels that there may be greater risk in eating out than in retail space. Due to practicalities of sitting over a table and the interaction with serving staff. So should we separate them? If these 2 activities are treated as an equal risk then does splitting the volume of risk into 2 makes sense? There is no evidence to guide us and so it is safer to move one step at a time. It will be harder to go backwards to lockdown if we get it wrong. To better manage risk it should be in 2 phases. Opinion of the room: Decision: The majority agree in 1 stage introduction 1 person disagrees and wishes for 2 phases

4. AOB

Minute	The situation referred to by the press was taken out of context. This was an error interpretation and will be corrected at scrutiny The position of the private dentists is nearing resolution. Public health will be seeking guidance to confirm the closure of practices backdated to 23rd March. Working with the UDC to extend the range of treatments being delivered. Going forward public health will take the dental profession into consideration when considering relaxation of lockdown and return to BAU. Request if any updated research can be shared to public health that may need researching or evidence Next meeting changed to Monday to allow for time constraints of the ministers needs