States of Jersey
States Assembly

États de Jersey
Assemblée des États

# Public Accounts Committee

## Response to COVID-19

## Witness: Director General, Strategic Policy, Planning and Performance

Wednesday, 23rd February 2022

**Panel:**

Connétable A. Jehan of St. John (Acting Chair)

Connétable J.E. Le Maistre of Grouville

Mr. G. Phipps

Dr. H. Miles

Mr. P. van Bodegom

Ms. L. Pamment, Comptroller and Auditor General

**Witnesses:**

Mr. T. Walker, Director General, Strategic Policy, Planning and Performance

Professor P. Bradley, Director, Public Health

Dr. I. Muscat, Deputy Medical Officer of Health

Mr. I. Cope, Chief Statistician and Director of Statistics and Analytics

Mr. A. Khaldi, Interim Director, Public Health Policy

Ms. M. Clark, Head, Public Health Intelligence

Dr. C. Newman, Principal Public Health Officer

[14:01]

**Connétable A. Jehan of St. John: (Acting Chair):**

Welcome to all both in person - it is great to see you in person - and to those joining us online. I should start by offering the apologies of our chair, who is unwell today. Also start by thanking you

all for your efforts over what is around 2 years of seriously hard work helping the Island to get to where we are today. We certainly offer our thanks to you all. It is normal hearing standards that will apply. The hearing will be recorded and transcribed. Those of you who are on Teams, if you can just put your hand up if you want to speak and I will try and recognise that fact. We would like you, if you are speaking, to show your picture on video for those people watching today. If we run out of time we will write to you and publish the answers on the panel's webpage. We will start off if all speakers can introduce themselves in the usual way for the transcript. Andy Jehan, Constable of St. John, acting chair of this panel.

**Connétable J.E. Le Maistre of Grouville:**
John Le Maistre, Constable of Grouville, member of the committee.

**Comptroller and Auditor General:**
Lynn Pamment, Comptroller and Auditor General.

**Dr. H. Miles:**
Dr. Helen Miles, independent member of the P.A.C. (Public Accounts Committee).

**Mr. P. van Bodegom:**
Paul van Bodegom, independent member of the P.A.C.

**Mr. G. Phipps:**
Graham Phipps, independent member of the P.A.C.

**Director General, Strategic Policy, Planning and Performance:**
Tom Walker, director general for Strategic Policy, Planning and Performance.

**Director, Public Health:**
Peter Bradley, director of Public Health.

**Deputy Medical Officer of Health:**
Ivan Muscat, Deputy M.O.H.

**Chief Statistician and Director of Statistics and Analytics:**
Ian Cope, I am the chief statistician and director of statistics and analytics.

**Director General, Strategic Policy, Planning and Performance:**
Then we have 3 colleagues joining us online. Perhaps if we could start with Alex.

**Interim Director, Public Health Policy:**

Good afternoon. Alex Khaldi, interim director of Public Health Policy.

**Head, Public Health Intelligence:**

Good afternoon. Marguerite Clark, head of Public Health Intelligence.

**Principal Public Health Officer:**

Good afternoon. I am Clare Newman, I am the principal public health officer.

**The Connétable of St. John:**

Director General, if we can open today with some general questions for you before calling on the directors of Public Health and Public Health Policy to respond to questions that fall under their remit. Can you please explain to us when did you begin working on a COVID-19 strategy and what responsibility did your department have in designing and delivering the strategy in subsequent revisions?

**Director General, Strategic Policy, Planning and Performance:**

The department for Strategic Policy, Planning and Performance includes responsibility for public health, and has done for a number of years. My department has been involved since the outset of the pandemic. So since the beginning of 2020. Our responsibilities have been largely unchanged for the last 2 years. So the department has led the work on development of a public health strategy for COVID-19 and also led on policy advice to Ministers. We have also led on public health emergency legislation. All of the over 50 pieces of novel legislation that needed to be developed were done by officers in my department. We have also led on public health intelligence, analysis and statistics and on public health briefings; briefings to States Members, briefings for the media, as well as specific communication and guidance for Islanders at different stages of the pandemic. We also lead on the Scientific and Technical Advisory Cell. It is our responsibility to stand up the cell and then to work with the chair and vice-chair to make sure that it works effectively. Lastly, the other thing that we have done throughout is to support the director of Public Health and the consultant in Communicable Disease Control, so Professor Bradley, as it is now, and Dr. Muscat, and to help them function effectively throughout the pandemic so that we can make best use of their expertise. Then the last area that we have had of responsibility is since 15th October last year we have also taken on the operational responsibility for the vaccination programme, test and trace, and COVID safe. We have had quite a broad suite of responsibilities throughout the pandemic. Most of which we have been doing for the last 2 years, some of which we have taken on more recently.

**The Connétable of St. John:**

You mentioned the beginning of 2020. Can you be more specific as to when at the start of 2020?

**Director General, Strategic Policy, Planning and Performance:**

I think that we were involved around February time when both the former medical officer of health, Dr. Turnbull, and Dr. Muscat first started to need to galvanise support and the Government more widely on the response. So I think probably it was February 2020 when we first started to work on this. Then it was March when we swung more fully into action. Three things happened in March that really galvanised us. There was the first identification of a proven case in Jersey. Then on 10th March there was the declaration of a pandemic by the World Health Organization, which I think was 9th March possibly. Then there is also the first meeting on COVID-19 of the Emergencies Council, which also took place at the same time. Those 3 things together were the things that then galvanised the rest of the department into action, not just the public health function.

**The Connétable of St. John:**

How did you determine what role Public Health and subsequently the Public Health Policy team would play in the development of each strategy, particularly in the period prior to the appointment of Professor Bradley and Mr. Khaldi to the directorship of those teams?

**Director General, Strategic Policy, Planning and Performance:**

In March 2020, when it was clear that this was going to be a very serious matter that was going to involve impacts across the whole Island and for everyone, at that point we determined that we were going to need a lot more resource to be deployed on this. Not just on strategy and policy advice but also in support of, as it was then, Dr. Turnbull and Dr. Muscat in particular. So middle of March was when we reorganised the department. Probably at the start of 2020 the Public Health function was a fairly discrete function of maybe 8 or 9 people. By the middle of March over half of the department was working on Public Health and that meant that we took a lot of people who were working on other functions and asked them to move across and to work on public health matters. So you asked in the run up to this hearing whether we could involve people who were around at the time and, indeed, Dr. Newman is one of those in that she was with us working on children's policy. At the time she was doing work for us on early years but Dr. Newman has a background in not just clinical matters but in public health as well. So we asked her to move across. She is just one example of how flexible and adaptable the department was in responding to the crisis. I think that our approach to this was to view it as our single highest priority and then to move as many people as we could on to working on it because we needed to support Dr. Muscat, who could not do everything on his own, and needed to be wrapped in a team. So it was fairly clear at the time, from Dr. Muscat's advice, that we needed to solve lots of problems, we needed to work out how to reduce transmission across the community and implement that. We needed to work out how to get testing at scale, at mass in the Island. There were a whole series of challenges that we needed to support the experts in

delivering. What we did with the rest of the department was to look at the things which were either statutory or were things that we thought we would need to keep ticking over so that when we came out of the pandemic we could still deliver. Examples of that are things like the Government Plan process, which might have had 3 or 4 officers on it and we just left one officer on that. The bridging Island Plan, again the staff working on that came across and helped in things like medical decision support and we left one officer on it. We left a kind of skeleton crew doing the things that we felt we needed to continue and then everyone else in the department just moved across.

**The Connétable of St. John:**

What would you say the key reason for the reintegration of the public health delivery into S.P.P.P. (Strategic Policy, Planning and Performance) during the COVID-19 pandemic was?

**Director General, Strategic Policy, Planning and Performance:**

The public health function had been with S.P.P.P. for a few years by then. It used to be part of the Health Department at one time and the former medical officer of health, Dr. Turnbull, recommended that it was separated from Health because she felt that there were some governance conflicts in having it embedded within the Health Department. So it was separated a number of years ago and it was part of my responsibility in the former department of Community and Constitutional Affairs that I headed up. Then when the new departments were formed in 2018 it formed part of S.P.P.P., along with a number of other policy functions that had been in C.C.A. (Community and Constitutional Affairs), so we had had responsibility for it in the policy centre a number of years before the pandemic.

**The Connétable of St. John:**

How was a clear audit trail established within the relevant teams for the development of each iteration of the COVID-19 strategy?

**Director General, Strategic Policy, Planning and Performance:**

If we move on to the strategy itself - we have had a number of strategies over the last 2 years - so at the outset in March 2020 we had a stated strategy, which was to delay, contain and shield. So that was the strategy that we started with in March. Some of your colleagues may remember there was then a debate in the Assembly in May 2020, which was whether the Island should pursue an elimination strategy or adopt a suppression strategy. The Assembly voted to adopt a suppression strategy and also ask that a strategy be published.

[14:15]

After that we responded to that and we published a COVID-19 strategy in June 2020 whose objectives were to suppress and contain and shield. That was the bedrock strategy, which was in response to the Assembly's decision. Since then we have had a number of strategic updates. So we had the safe exit framework, for those of you do not remember that, that took us from level 4, the stay-at-home order, down to level one; just physical distancing. That got us through summer 2020 and then in November 2020 we published the winter strategy update, which was for winter 2020, based around the themes of prepare, prevent and protect. After that winter and the successful deployment of that strategy, we then had the reconnection roadmap.

**The Connétable of St. John:**
What we are interested in is not the different strategies but how you had a clear audit trail to establish those strategies.

**Director General, Strategic Policy, Planning and Performance:**
The process of strategy development? I can perhaps talk a little bit about it and then I will maybe hand over to Mr. Khaldi to do the detail. But essentially in terms of process, the strategies were developed with the scientific expertise taken from S.T.A.C. (Scientific and Technical Advisory Cell) who would consider the science, the evidence of where we were up to, and that would inform the policy expertise in the department and then that would result in policy advice to Ministers, usually through the Competent Authority Ministers forum, which is fully minuted, as is S.T.A.C. Then that would be communicated through to C.O.M. (Council of Ministers), to States Members, and then usually ended up in a published strategy; one of the ones that we have listed.

**The Connétable of St. John:**
The minutes would be the audit trail?

**Director General, Strategic Policy, Planning and Performance:**
Yes. You can follow that through from the minutes of S.T.A.C. where ...

**The Connétable of St. John:**
We will come to that shortly. I am going to pass you over to my colleague.

**Dr. H. Miles:**
The next area focuses on S.T.A.C. itself. Can you outline how S.T.A.C.'s role and remit evolved since March 2020?

**Director General, Strategic Policy, Planning and Performance:**

I think there have been different phases of the pandemic so when we started the pandemic we very much needed a S.T.A.C. which had a strong presence from secondary care, from the hospital, from those responsible in the hospital, because at that stage, pre-vaccine, pre the build-up of immunity, the main concern was the consequences of COVID if it was not contained for people's direct health and well-being. So we had a S.T.A.C. that had a very strong membership from the hospital community, in particular, and a lot of people from secondary care. Then I think as it has moved on, we have needed fewer people with that kind of background. The science has moved on. The treatments have moved on. That has become more stable. So it has had a stronger public health presence, if you like. It has been more about how we communicate the guidance to Islanders, how Islanders can understand and respond to the different levels of risks of the composition of S.T.A.C. has changed to reflect that. Then right now, we are thinking about what the role of S.T.A.C. should be as we move from the emergency response phase into the emergency recovery phase. Then we will probably have a different composition. But I mean Ivan is an original member of S.T.A.C., who has been there from the very first meeting until now, so I do not know whether you have any reflections to add.

**Deputy Medical Officer of Health:**

I think Tom has summarised the main phases of S.T.A.C., which reflect the function that was required at the time from a group of people. We sensibly evolved to fit in with what was required by the community at the time. At the beginning of the outbreak, there was a complete absence of information and technology to deal with this. There were no diagnostic tools available to us. There was definitely no pharmaceutical response that we could apply. We had slowly increasing information that would teach us how to respond. There were 2 conclusions come from that. One is that the only sensible initial response, apart from pursuing those items, was non-pharmaceutical interventions and that required a pan-government response and the presence of Public Health within the heart of Government certainly helped hugely, I believe, with that. The communication lines, the pre-existing lines were there, but as was indicated by Tom the concern was that because that was the only group of interventions that were possible the potential for significant numbers of people wanting secondary care was huge. So S.T.A.C. had to work with Government to ensure non-pharmaceutical interventions were deployed appropriately. But at the same time, ensure that secondary care had been suitably resourced and evolved to develop, to pick up.

**The Connétable of St. John:**

Can I just ask a question? You said it has evolved over time ...

**Deputy Medical Officer of Health:**

I am still in stage one, sorry if I have gone on too long.

**The Connétable of St. John:**

I am conscious of the time. Who decides the changes to the S.T.A.C. membership and who approves that?

**Deputy Medical Officer of Health:**

I think S.T.A.C. tended to learn itself when it was due to change to another focus. If that required a change in membership then that would be suggested, it would be discussed, and it would be discussed with the S.P.P.P., in particular, but also with the health service, to determine what the next evolutionary step should be.

**Dr. H. Miles:**

Can you clarify what the differences are between Jersey's S.T.A.C and the U.K. (United Kingdom) S.A.G.E. (Scientific Advisory Group for Emergencies). The P.A.C. would like you to outline the differences in the structure and the membership and the role of those bodies?

**Deputy Medical Officer of Health:**

My understanding of S.A.G.E. is that it is primarily there to gather scientific information, analyse it and supply that information forwards to other bodies to help make decisions. S.T.A.C. is, if you like, an amalgam between that S.A.G.E. function but also the next step before going to C.A.M. (Competent Authority Ministers) or the equivalent of C.A.M. in the United Kingdom. It helps determine the operational elements from the information that is available to it. So it analyses the information that is available to it and tries to translate it into what that might mean in terms of policy. What it might mean in terms of what decisions need to be made. Obviously ultimately the decision makers are the Ministers but that information is put together to allow Ministers to make those final decisions.

**Dr. H. Miles:**

So why was the S.T.A.C. model chosen for Jersey and would one which more closely resembled S.A.G.E. be considered in the future?

**Deputy Medical Officer of Health:**

Much of the information that we used in terms of the general properties of COVID and its effects were derived from S.A.G.E. So that very scientific accumulation of information and analysis of information was made, if you like, in that body and we certainly imbibed it into S.T.A.C., but then localised it and translated it for further decision-making down the line.

**Dr. H. Miles:**

Was it the role of S.T.A.C. then to localise it?

**Deputy Medical Officer of Health:**
Yes, it would have been. We do not have that breadth of scientific expertise or access to that degree of detailed information that S.A.G.E. have. We are 100,000 people, they have 70 million.

**Dr. H. Miles:**
Specifically about Jersey, okay. Certainly from previous hearings that we have had, we understand that of the membership of the S.T.A.C. that there is only one fully independent member and that all the remaining members were either employed by Government or contracted as a consultant by them. I think the question that we are trying to understand is whether there was any consideration of increasing the number of fully independent members to enhance that level of scientific expertise in regard to data interpretation and modelling for the local context.

**Director General, Strategic Policy, Planning and Performance:**
I should perhaps say that S.T.A.C. itself is fully independent. Every member on S.T.A.C. operates independently and without control. The code of practice that has been published makes that very clear. It is not as if one member has some sort of superiority in their independence to the others. I would stoutly defend the independence of all members when they are on S.T.A.C. I think they have exercised their independent thinking without exception throughout. I have never known them not operate in a fully independent way as a proper scientific committee, and I can also say nobody has tried to interfere with that independence of their scientific thinking either throughout.

**Dr. H. Miles:**
I guess just from our perspective, having one independent member on a panel that broadly it just raises the question of whether there is a risk that the policy people are arguing from a conflicted point of view as opposed to an entirely independent point of view.

**Director General, Strategic Policy, Planning and Performance:**
I think in a small Island that always has to be a risk that a consensus arrives. I think having one member or 2 members or 3 members who are outside the public service, which I think is the point you are making, can be helpful and indeed we intentionally invited a lay member on who had epidemiological expertise in the Island because we were conscious that there is always a consensus of thinking that can arise in any group. But I mean this is where we rely on the experience and the integrity of the chair and the vice-chair to ensure that, like any other scientific committee, it does not become so familiar with each other that it starts to think along similar lines. It is a common risk to scientific committees that they can arrive at a consensus way of thinking but I think that is something that we rely on the chair and the vice-chair to guard against.

**Dr. H. Miles:**
Was there ever any consideration, did you try to get more independent members with a broad scientific knowledge or were you happy with what you had at the time?

**Director General, Strategic Policy, Planning and Performance:**
I think as a director general I was happy with what I had got. I think that perhaps if there were another 5 or 6 leading either public health or epidemiological scientists in the Island then perhaps they could have added more but, of course, it is a scientific committee and so it needs to be comprised of people with relevant scientific medical and technical expertise. There would have been little value in just looking to have increased numbers of lay members on it because that would defeat the purpose of having a scientific committee.

**Dr. H. Miles:**
Although independent scientists would bring a level of debate that might be different from policy people.

[14:30]

**Director General, Strategic Policy, Planning and Performance:**
Yes, and if in a community of 100,000 we would have had more people who had epidemiological or virologists that had relevant scientific expertise then we may well have invited them on. But in our community we just do not have that depth of scientific expertise in the relevant sciences to bring forward. I am not disagreeing with the thrust of the questioning, I am just saying that in a community of our size we have to use the scientific expertise that we have at our disposal. I am satisfied that we did that. Unless the chair thinks that perhaps there were some opportunities that we might have missed.

**Director, Public Health:**
I will start by saying that I feel my role as director of Public Health comes with it an obligation to provide independent advice to the benefit of Islanders. That has been highlighted to me on a number of occasions and I certainly took that role seriously as chair of S.T.A.C. I absolutely accept the point as well but there was considerable debate about some of the issues that we discussed in the S.T.A.C. Committee and I think that was very helpful. Certainly having the independent members that we have has been very beneficial to us.

**Dr. H. Miles:**
Independent member.

**Director, Public Health:**

Member, yes. Although we do have, for example, a G.P. (general practitioner) member as well, so there was perhaps more than one person working outside of Government. In addition to that, we did seek actively advice from other jurisdictions which did not always agree, and it was our job to make sense of that for the benefit of the people in Jersey. So the challenge came in many ways.

**Director General, Strategic Policy, Planning and Performance:**

Also, where we particularly needed scientific expertise and we did not have it in Jersey, then that was added. For example, we did not have in Jersey any real world-class expertise in behavioural sciences, which we found that we needed, and so we did engage a leading behavioural scientist who then joined S.T.A.C. in order to bring that expertise in.

**Dr. H. Miles:**

Sorry, Dr. Muscat, did you want to add something?

**Deputy Medical Officer of Health:**

The other thing that would also help from sort of crowd think is that there was a change of membership with a change in function. So although some members have been there since the outset, there has been a change in the composition of S.T.A.C., so the risk of saying the same thing, if you like, was diminished as a result of natural change. They came from different backgrounds because they needed to focus on different things.

**Mr. G. Phipps:**

Just along those lines, remember our role is to try and understand and learn from what has happened so that in future things can be done differently. The question of not the right expertise on the Island is valid but there is no reason why you could not bring somebody on to S.T.A.C. from off the Island if you wanted to, to add that. That is a just an observation I think. Following further in the whole area of record-keeping, auditing aspects and disclosure in the context of learning, and also disclosure is very important for the people of Jersey. Is not always clear from the records of the S.T.A.C. meetings, as was outlined in the Comptroller and Auditor General's report on the management of healthcare response to COVID, how alternative options were explored during meetings. What group protocols existed to ensure that due consideration is given of independent views on S.T.A.C. to ensure that alternative views are robustly discussed on this whole issue? How did you ensure that you are not limiting your scope? What are your views on that?

**Director, Public Health:**

I think the first way that we did that was to ensure that there was a very open process. So after every presentation all S.T.A.C. members were invited to comment on the issue and there were no

occasions that I can ever remember when the opinions were, in any way, not heard. There were many occasions where views differed. Occasionally we arrived at a position where there was not consensus so we would further the debate. Eventually we would reach a majority of opinion and on all occasions, when I chaired, we endeavoured to make sure that a minority view was also recorded in the minutes. That was then presented to Ministers at the C.A.M. meeting so that we fully discussed the majority view and then, if you like, the objections that were heard from that minority view. We paid a lot of attention to recording our breadth of opinion.

**Mr. G. Phipps:**

Following our previous public hearing with you, Director General, on October 2021, have any changes been made to improve the records and minute-taking of the S.T.A.C. meetings and of the audit trail, as recommended by the C. and A.G. (Comptroller and Auditor General). We would like to know in particular what has been done to formalise the following areas: how advice is given and has been determined, the action plans rising from the meetings, including timescales and responsibilities for actions, and the follow through of matters and actions taken as was raised. What comments can you make on that?

**Director General, Strategic Policy, Planning and Performance:**

I think that the minutes of S.T.A.C. have improved considerably from the outset. I think that reflects the learning of everyone involved. We have been very fortunate throughout to be supported by the staff from the States Greffe who are very able and very good minute-takers. I think that what we have learned throughout as it has gone on is to have a clear review of what we want in the minutes and how best to capture the discussions, how best to capture the range of views, how best to reflect the conclusions of the group. I think when I look at some of the early S.T.A.C. minutes and when I look at the later ones, I think they are all prepared with the same degree of professionalism by the States Greffe but I think that the more recent ones show a considerable improvement in the maturity of the group in understanding what is important to minute and how to minute it. My personal opinion is that I think they have improved considerably from the outset.

**Mr. G. Phipps:**

That would be nice for us to observe that. I would just like to follow up. There are concerns that the minutes of S.T.A.C. were never released directly to medical professionals on the front line and that the public access remains a point of contention. How has that been addressed?

**Director General, Strategic Policy, Planning and Performance:**

Again, I think that has improved considerably. I think that it is something that when Professor Bradley took over the chair he was conscious of, and I think that the sharing and the release cycle has improved since those conclusions were first drawn. I think the public release is much prompter

than it was and I think that the sharing in confidence with Scrutiny and others is sometimes the same week that the Minister signed off. It is incredibly fast nowadays.

**Mr. G. Phipps:**

That is interesting because timely release of minutes to the public is also very important. But the last release that has been made is 19th December and yet you have weekly meetings. I know that there have been minutes released to Scrutiny Panels, et cetera. So why is there such a delay getting ... minutes are minutes. They happen. It is a record. What are your comments? It is very concerning to the public to follow what is going on. It is a very important concern of theirs.

**Director General, Strategic Policy, Planning and Performance:**

I think that is the balance between the normal process of allowing a scientific committee a safe space within which to develop a consensus and so generally it will discuss a matter maybe for 2 or 3 meetings and then that will result in informing policy advice to ...

**Mr. G. Phipps:**

To be fair, minutes reflect that, that a decision is not made and this is a lot of meetings. I think the concern is between 19th December, at least to the public, and we are sitting here today, it is really aimed at the concerns of the public in getting this. I do not think there is anything wrong with minutes saying we are still discussing this or it has been resolved and stuff. Do you understand the concern?

**Director General, Strategic Policy, Planning and Performance:**

I do and we follow the normal protocols of all scientific committees in that we allow S.T.A.C. the safe space to discuss live issues and as soon as the issues have been concluded then the minutes are released.

**The Connétable of St. John:**

Can I just come in there? I have asked a number of questions at every opportunity. We were told that the chairman was too busy, that is why minutes were not published; we were told that the Greffe was not providing enough resource, we have had confirmed that they are providing enough resource; today you are saying it is about safe space for the people involved in the group. The minutes cannot change. If a meeting happens today ... the last minutes published were 29th December. The minutes cannot change from one meeting to the next so I and many others do not understand the reluctance to publish that because we have seen changes to policy and we have no idea how you have arrived at those decisions because the minutes in some cases have been 3 or 4 months delayed. Yes, there has been an improvement but we were led to believe that when we had a new chair there would not be a problem with delays to minutes.

**Director General, Strategic Policy, Planning and Performance:**
I think under the new chair there have been improvement. It was the case that Mr. Armstrong did often need to balance his duties in clearing minutes with surgical duties and I think that ...

**The Connétable of St. John:**
With respect, the first item of the minutes was to approve the previous minutes.

**Director General, Strategic Policy, Planning and Performance:**
After which they are shared in confidence with Scrutiny.

**The Connétable of St. John:**
And you mentioned "others"; who are the others that it gets shared with?

**Director General, Strategic Policy, Planning and Performance:**
At that stage when they are shared, they come across to Scrutiny. They are also shared with me, with the Minister for Health and Social Services and with the Scrutiny liaison officer in the Ministerial Support Unit who liaises with Scrutiny.

**Mr. G. Phipps:**
Just a few more questions. Have you undertaken work to establish an audit trail of the specialist public advice given to Ministers prior to the formal establishment of S.T.A.C., given the concerns previously raised by the Comptroller and Auditor General in her report on the management of the health response to COVID-19?

**Director General, Strategic Policy, Planning and Performance:**
The deliberations of S.T.A.C. are fully minuted and the advice given to Competent Authority Ministers, the Council of Ministers and the Emergency Council is fully minuted.

**Mr. G. Phipps:**
So your audit trail is per the minutes?

**Director General, Strategic Policy, Planning and Performance:**
Yes.

**Mr. G. Phipps:**
Are you looking at best practices in other jurisdictions, because the challenges you had are not unique to Jersey, in understanding ways to improve the role and function of S.T.A.C. now that we have had this experience, lessons learned; what are your comments on that, looking abroad?

**Director General, Strategic Policy, Planning and Performance:**
Other jurisdictions?

**Director, Public Health:**
We have already mentioned that we have adopted some changes to, for example, S.T.A.C. minutes in the knowledge of good practice in other scientific committees. Part of that was to anonymise their comments in our minutes to ensure that there was free and open discussion. We are in constant conversation with other jurisdictions about policy development. That has become so embedded in our work that it is quite rare now for us to develop policy without considering particularly the policies in the British Isles. So I think in those 2 respects we have really tried to improve and learn from other jurisdictions.

**Mr. G. Phipps:**
I certainly encourage you to get the minutes out to the public and, in particular, to States Members because they are being asked: "Why have you done this? Why have you done that?" and they need this information to do their jobs correctly as well. So I am looking forward to that.

**Dr. H. Miles:**
Can I just ask a further question about the anonymisation of the minutes? Why is it felt necessary to allow members to remain anonymous in their decision-making?

**Director, Public Health:**
To make it absolutely clear, every comment is recorded. There is absolutely full disclose in that respect.

[14:45]

But the advice that we received was that it is best practice for scientific committees to anonymise the comments, to ensure those people cannot be targeted, I guess, and it was felt to be right to follow the best practice advice that is issued in the United Kingdom, for example.

**Deputy Medical Officer of Health:**
Can I just add to that? I hope I am remembering this correctly, but my recollection from reading the S.A.G.E. minutes is that they are anonymised. Also people alluded earlier on to safe space. So people know that these minutes are going to be made public and it may be that they feel reluctant to voice their view if they know that their name is going to be attached to that view, particularly if that view is rather different. Actually anonymising the statements and so forth speaks to what you were

talking about earlier on, about independent views and that you are being able to be open, while retaining a safe space at the same time. I think it answers a number of questions.

**The Connétable of St. John:**

We are going to move to Public Health and Public Health Policy, so for the benefit of those watching today, please could you provide an overview of the work of the Public Health and Public Health Policy teams and how they differ and how the functions are divided?

**Director General, Strategic Policy, Planning and Performance:**

So it is one function, but there are aspects to that, so perhaps if I illuminate the different areas of expertise and then how it all comes together that might help the committee. There are probably 3 different sorts of expertise in the public health function, so we have public health experts themselves, so people like Professor Bradley and Dr. Muscat, who are professionally qualified in the discipline. We have analytical experts, so people like Margie Clark who is with us today, who has a background in public health and specialised in the analytical sciences and has that expertise, and then we have people with policy expertise. While she has been with us Dr. Newman has specialised a lot in the policy expertise area and so has Mr. Khaldi. Then those 3 strands of expertise within the Public Health function then result in 3 or 4 different outputs, if you like. So perhaps the first one of those is around scientific understanding, scientific communication, so in this instance people understanding what the virus is, what the risks are, how the virus transmits. Understanding the science properly and communicating that is one of the first things that that team of people does. The second one is the development of policy options and those options are usually derived from the professional expertise, science, the data outlook and then what is possible in real life in the community, so the development of policy options is the second point. The third one is the provision of objective and impartial advice. So that is our role in the public service overall, and so provision of advice to Ministers, States Members, to others, so that they can be sure that they are well-informed and that they have got good, reliable, impartial advice. Then also the last one is policy implementation, which is also done by the team. So legislation is policy implementation, guidance for the public, guidance for businesses, guidance for others, provision of briefings, provision of communications, so all of that is implementing the policies that have been decided through the democratic system. Then since October 2021 the public health function also includes the operational expertise and provision as well, so now we have additional colleagues with us who run the vaccination centre, run the swabbing centres, run the testing programme, run the COVID-safe operation. So it is very much an integrated public health function that with that expertise produces those outputs on behalf of the Island.

**The Connétable of St. John:**

Thank you. Professor Bradley, Mr. Khaldi, in relation to your respective teams, what structures were in place to monitor governance procedures at the time of your appointments and how were these revised over the course of the pandemic? We will start with you, Professor.

**Director, Public Health:**

Obviously I inherited the governance mechanisms that were already established for the pandemic, which I think Mr. Khaldi would be able talk to more fully. The main mechanism for governance for me was through the S.T.A.C. Committee and also the planning meetings that we have to ensure that the most important issues were discussed at that committee. The other mechanisms of governance, as I said before, the vaccination programme and the test and trace programme. Mr. Walker is the accountable officer for the vaccination programme and I was the senior responsible officer. In the normal way, minutes are written and issues are escalated to Mr. Walker through a specific meeting where we go through vaccine governance. There is a broader public health function, of course, which we are establishing. That will be subject to its own governance mechanisms as we progress particularly through this year, but I think the focus of your questions today are probably around the pandemic. Mr. Khaldi will be able to answer a bit more about the time before I arrived.

**Interim Director, Public Health Policy:**

If I may, Chair, the main governance mechanisms were set in place when I arrived personally in September 2020, that is the use of Competent Authority Ministers, meetings of the Emergencies Council, S.T.A.C. was part of the committee and a variety of programmes were put in place to deliver key large programmes in COVID response. So in terms of your question, we were continually looking for ways to improve and develop the effectiveness of those through existing mechanisms and on occasion needed to set in place new mechanisms. For example on COVID status certification or vaccine passports it was necessary to set up another internal officer board to run the policy side, sot that work would ensure that it connected to I.C.T. (Information and Communities Technology) function, External Relations and other capacities across Government, but the mechanisms in the main were set in place when both Professor Bradley and I arrived and our job was to make them work as well as we could.

**The Connétable of St. John:**

Can I ask you both how many vacancies there are currently across both the Public Health and the Public Health Policy teams?

**Interim Director, Public Health Policy:**

If I might go first on Public Health Policy - my camera and audio is on, I hope that is okay, I cannot see you all from where I am - but in terms of COVID response we are currently in a de-escalation

phase so considering how in the context of those recent de-escalation policy decisions we would refocus the COVID response capacity, so we are not in a position where there are, per se, vacancies in the COVID response team. I will hand over to Peter on matters within Public Health.

**Director, Public Health:**

We have been very successful in recruitment recently. I would estimate it is certainly less than 5. Part of the reason for some of those vacancies is that we are timing the recruitment processes, so they are slightly staggered over the years, so they meet the major requirements first, but we have had a good round of recruitment recently.

**The Connétable of St. John:**

How have you as accountable officer for your department assigned and monitored the work of senior responsible officers with responsibility for the work undertaken by Public Health and Public Health Policy?

**Director, Public Health:**

There are a couple of major programmes, so there is the vaccination programme where I am the accountable officer and I have delegated the senior responsible officer role to Professor Bradley, and then there is the test and trace programme where again I am now the accountable officer, and I have delegated the senior responsible officer role to Rachel Williams, the director responsible for that area. Then we also have the COVID-safe certification programme, and Mr. Khaldi is the delegated lead for that. So I have 2 major programmes - one slightly less large - so 3 different programmes and we do it through the usual programme management discipline that is laid out in the Public Finances Manual.

**The Connétable of St. John:**

How have the Public Health and the Public Health Policy worked with operational managers at the General Hospital to improve its resilience in relation to COVID-19?

**Deputy Medical Officer of Health:**

This reverts to S.T.A.C. One, if I may call it that, where the principal group enrolled by the Public Health and secondary care providers ... because part of the response was to ensure resilience was available within secondary care, should there be a huge influx of patients into secondary care. Part of that response you will recall was the Nightingale hospital, as a very good example of the increase in resilience in secondary care. So that liaison was reflected in S.T.A.C. It is reasonable to add to the prior question, if I may, that while it is absolutely vital that there is a functioning Public Health Department that delivers public health function on a day-to-day basis ... and apologies, Peter, if I am encroaching on your territory. What I am trying to say is that during a major pandemic like this

you will never have a single department that can muster the resource to respond in the absence of pharmaceutical intervention, in the absence of enough knowledge about the virus, and in the absence of the technology to diagnose the virus at least initially. So spreading your arms out wide from Public Health, whatever the size of the original department, across Government is an absolutely vital part of the response and Public Health being placed in Government allowed for that.

**The Connétable of St. John:**
How have Public Health and Public Health Policy teams fed into any improvements of the emergency planning function?

**Director General, Strategic Policy, Planning and Performance:**
S.T.A.C. itself is a function of our emergency planning framework, so pre-pandemic our Jersey Resilience Forum had a framework for responding and part of that is S.T.A.C. I think that most of our learning has been around how we can evolve and improve that scientific and technical input in different sorts of pandemics, so when we were implementing the recommendation of the C. and A.G. that there should be a code of practice for S.T.A.C. we did that in close co-ordination with the Emergency Planning Office, and that was something that was discussed at the Jersey Resilience Forum and I think, Professor Bradley, you went and discussed it with the forum at that time. That has been a primary contribution towards assisting with that wider piece of work.

**The Connétable of St. John:**
I will pass you over now to Connétable Le Maistre.

**The Connétable of Grouville:**
The acting chair quite rightly thanked you for and recognised all the efforts you have been putting in over the last virtually 2 years, but those thanks must also extend to those working at the front line. My questions relate to staff support and morale.

[15:00]

Director General, your letter to the P.A.C. on 3rd December stated that: “There was a need for the public health function to work 7 days a week and late into the evenings.” How was the health and well-being of officers monitored throughout this period?

**Director General, Strategic Policy, Planning and Performance:**
I think at the time the people in the department just threw themselves into the task. It was clear that their community needed them, that they needed to respond and they very much responded to that call to arms; so they were working 7 days a week sometimes, they were working around the clock.

They really did throw everything they had at it. Then as the pandemic continued it was clear that the emergency was going to last for longer than it normally does. Emergencies are usually fairly short and sharp; they tend not to be extended. Then at the point that it became clear that this was going to be an extended emergency then we sought to normalise the arrangements and to ensure that people got breaks, that they were not working quite as long, and then once the emergency had gone on for 6 to 9 months we started where we could to rotate people. So a number of the policy officers who came across from other policy areas to work on the pandemic went back to those areas and were replaced by other colleagues who came in. A bit like being on active duty, we would rotate them off. It very much felt like the civil service on the front line, and I think it is one of the things that I really learned from this, just how much the civil service has been on the front line of the emergency response, and I think how much we can do in future to think about that and to make improvements. If I take a very simple example, in a normal emergency situation the first responders would be the blue light services and they are set up for an emergency that might last 2 or 3 days, so they have a shift system, people go off shift, other people come on shift. It is built into the way they work that they need more than one team because they need to rotate day-in, day-out to respond to the emergency, and it is built in. Also they are used to doing debriefs afterwards, so when they go through an experience like this there is a pre-arranged system where they debrief, where they can decompress. For the civil service we did not have either of those set up and I think that we have learned that as we have gone, so even though once it became clear that the emergency was going to go on for longer, we started to rotate people out of that work and into other work. I think that if I was to have my time again I would probably have adopted a practice which was more like a blue light service in responding. I think that as a director general it is one of the things that I really take away from this; learning that if we had known then what we know now then probably I would have approached it in a very different way as the director general to look after the well-being. That was why I wanted to highlight it in the letter, because I felt that the civil service do really lay down their own health and well-being to support the Island. I think if we did it again we would learn from other emergency service operations and insist that people take breaks. If I just think about the people around me, it was probably an awfully long time before Ivan took a holiday. It was probably an equally long time before Dr. Newman took a holiday as well, and in hindsight I do not think that is right. I think that if we had known it was going to continue then we would have approached it very differently so that people could stay fresh and so it did not have the same impact, not just upon the civil servants, medics and others on the front line, but on their families. It has been tough.

**The Connétable of Grouville:**

Absolutely. I recognise that. You have answered some of my other questions, so that will save a bit of time but it was really how you were looking after the people. Everybody deals with pressure differently and there will be some people who needed support. I was just wondering how you monitored who those people were and what support they got. Some people can throw themselves

into it for months on end, but others cannot, so I was just wondering how you monitored that and how you dealt with it.

**Director General, Strategic Policy, Planning and Performance:**

Yes, I think we did our best, but if we had our time again we could have done it much better. I think it is not only the people working on the front line of the pandemic, because those people were more obvious to check in with, because you can see their work, you can see what they are doing, you can see that they are still going on Saturday, Sunday, Monday morning, at 11.00 p.m. on Tuesday night, you can see they are still going, so they are very visible to you, so you can check on them, you can ask, you can do that work. I think one of the important things that came out of it was how easy it was to miss people who were working on the other work but were very isolated. Some of the people who were left on their own essentially to work on the bridging Island Plan, carbon neutrality, the Government Plan, they were asked to do that almost solo for what turned out to be a quite prolonged period of time. That was really hard for them as well. I remember in the statistical area the people working on the census on their own without much support, without much usual management around them that they would normally have. I think that was an area that we would pay more attention to if we had to do it again. But again at the outset we just did not realise how long it would go on for, and then all of a sudden you realise that somebody has been carrying the entire load of a major piece of work that is not a pandemic piece of work for maybe 6 or 9 months. That is incredibly hard on them. All credit to them for having done it; it was fantastic what they did away from the emergency, what they did to keep that work going in the background was equally amazing, but of course more out of sight and so again, if I had my time again, I would probably spend more time focusing on that cohort of people as well.

**Interim Director, Public Health Policy:**

What Tom said, I am very grateful for the question, because when I arrived in September 2020 that learning was beginning to bed into the services with the continuation of the pandemic situation, so there were a number of working practices within the COVID response team, again expressions of what Tom has spoken about, and rotation was key within that. So there were a few people as we went into 2021 that had been with us from the start of the pandemic that needed a break. What I would like to be able to say is that the team worked in an even more cohesive and collaborative and supportive environment, given that initial experience within the pandemic. So as teams do more generally, and that lasted right through the pandemic, we have become good at spotting the signs of stress and fatigue. The bulk of the work, and we are not making any special pleadings for the civil servants in this context, people have worked hard on the pandemic response right across the Island, involved talking about science with Dr. Muscat on a Thursday, putting together the evidence and the data on Friday or the weekend for a S.T.A.C. meeting on Monday morning, going straight into a competent authorities meeting with really quite important decisions to be taken on the

Wednesday or Thursday and then in the meantime the nature of the pandemic has changed and there are a fresh set of perils and issues to be tackled and resolved subsequently. On occasions that would happen twice during the week so S.T.A.C. would be meeting twice, C.A.M. would be meeting twice and the normal time taken to develop policy options, plans and so forth had to be concentrated into an incredibly narrow period. So you will appreciate how intensive that has been and it really only started to let up somewhat towards the last round of 2021 and now into 2022. So for really a period of 18 months, from the start of the pandemic, the team has been in that continuous cycle. I have worked at the highest levels of policy and health policy in the U.K. Government and I have never seen anything quite like it in terms of pace and intensity and it is credit to all those Government of Jersey civil servants that worked in that environment that we have come through it in the way that we have; so thanks for the question and the opportunity to say it.

**The Connétable of St. John:**

Thank you. I think when I welcomed you, we do recognise everybody's efforts, civil servants, front line, and yourselves especially, and we are eternally grateful for that. Can I just check, though, in your resilience planning was there no mention of welfare? I know you could not foresee COVID coming, but other resilience plans, was there no consideration for your staff welfare in terms of breaks and rotation similar to the emergency services?

**Director General, Strategic Policy, Planning and Performance:**

Maybe I can kick off and then you can add, Alex. Not at the outset, no, because there were business continuity plans that were designed to deal with if a number of staff, perhaps, got knocked out with a flu pandemic or there was flooding. So we had business continuity plans that were very good, but I do not think anyone's business continuity plans allowed for a 2-year pandemic from the outset that I can recall. It was inherently novel. I think the experience that we have been through as a community has been novel and I think that people had plans for things that we had experienced before and things that had happened before, so we had plans for a flu pandemic.

**The Connétable of St. John:**

But in those plans would you not have had plans for the welfare of your staff?

**Director General, Strategic Policy, Planning and Performance:**

I do not think in the plans we conceived that the staff would spend 2 years on the front line of a pandemic. So of course we had welfare plans, yes. I mean all government departments have a responsibility and a duty, and the welfare of my people is extremely important to me and I spend a lot of time on it, so of course we work on it. But did we conceive at the outset of what we might be getting into and therefore the consequences that it might have? I do not think anyone did at that stage.

**The Connétable of Grouville:**

A bit more mundane, but how have you tracked department spend and officer working time on the development of and the revisions of the COVID-19 strategy across the various teams and has this changed during the course of the pandemic?

**Director General, Strategic Policy, Planning and Performance:**

The spend?

**The Connétable of Grouville:**

Yes, tracking the department spend.

**Director General, Strategic Policy, Planning and Performance:**

There are 2 aspects to the expenditure or to the use of resources. One is the additional funds that we have received in order to expand the team, so we have had money from COVID reserves that we have deployed on the test and trace programme, on the vaccination programme, that we have deployed on the Public Health Policy team, and that has also been deployed to support the analytical team. So we have had additional resources and they have been managed in the usual way, so allocated to me as an accountable officer and then just using the regular accountable officer mechanisms to monitor, track and report on that expenditure and to make sure that it is being used efficiently and effectively. Then the other resource that has been relevant for us is, if you like, the people in the department. At one time we had almost half of the department working on COVID and what we have done there is to track and report on the consequences of that.

[15:15]

So the annual reporting process, the media reporting process, we have shown all the way along where the impact of moving those resources to COVID has had an effect upon other pieces of work, which have either been paused or delayed, and we have tried to be very transparent about that so that everyone, the public, States Members, everyone, can see the consequences of moving that staff resource from that work on to other work.

**Mr. P. van Bodegom:**

Some questions on statistics for you. How have clear audit trails and lines of accountability for decisions made around the use and publication of statistics by the Government of Jersey during the COVID-19 pandemic been established?

**Chief Statistician and Director of Statistics and Analytics:**

You wrote to me, or the committee wrote to me, last Wednesday and I replied yesterday, so just to repeat what I said in my response. I joined the Government of Jersey on 4th January last year in an interim role and was appointed to that role formally at the end of December, so I have no experience of the Jersey pandemic response during 2020, but in response to the letter that you sent I have spoken to those who were involved. I will talk about 3 teams. There is Statistics Jersey and then there is the Public Health informatics and the H.C.S. (Health and Community Services) intelligence people as well; so 3 teams that have been involved in this. In terms of Statistics Jersey, as I explained in the letter that I wrote to you, early on it was all hands to the pump and we had a member of staff who had public health expertise and she was doing work on modelling, R. numbers, et cetera, and was supporting S.T.A.C., Ministers and the media and so on. The decisions about deployment of resources at that time were made by the then chief statistician in the normal way. As a bit of context, obviously when the pandemic happened some of the activities that we were doing had to stop. We were running surveys on people's households and running the exit survey at the border, so those activities, because of COVID restrictions, had to stop, so that freed up some resources that the then chief statistician could deploy. In terms of governance decision-making, that was within the normal remit of the chief statistician. You will be aware that the Statistics and Census (Jersey) Law makes Statistics Jersey independent and the chief statistician independent, so the then chief statistician would have made those decisions at the time, balancing the various requests. Like statistics offices around the world, the then chief statistician would have been deployed and the resources he had basically helped to help save lives and livelihoods. I joined last year and most of Statistics Jersey's work last year was not around the pandemic-related work; it was around the other activities, the 2021 census. One thing that is relevant is that we had to stop the Living Costs and Household Income Survey in March 2020 and we have restarted that; so that is a pandemic impact and that was a decision that I made with my team to balance the resources. Statistics Jersey came into the fray at the beginning because it was all hands to the pump, but the other 2 teams have done most of the reporting on statistics since then. So that is the H.C.S. intelligence team who have been producing the statistics on the number of cases, number of deaths, hospitalisations, those kinds of things and then the public health informatics, the Public Health Intelligence team, and Margie who have done the reporting into S.T.A.C. and so on. They will be governed under their normal line management. I have a role across the statistical system on things like career and professional development, but also the upholding of the code of practice for statistics, so on a few issues I have supported the best practice in the H.C.S. informatics and the Public Health Intelligence teams when we have been dealing with difficult issues. When we were considering publication of the vaccine status of COVID hospitalisations there were some really quite tricky issues around the quality of the data and also maintaining the non-disclosure of personal data, so I was very much involved with those, advising and supporting the heads of those teams. Does that answer your question?

**Mr. P. van Bodegom:**

It does, thank you. You are new to the Island. Where were you previously?

**Chief Statistician and Director of Statistics and Analytics:**
I had worked for the U.K. Government Statistical Service for 34 years and 29 years at the Office for National Statistics. I had worked across economic statistics, business and household surveys and I was the director of operations for the 2021 census from 2003 to 2012 and the 2021 census director from 2014 until I left the O.N.S. (Office for National Statistics) in 2018; so I have got 29 years working in a large national statistics office.

**Mr. P. van Bodegom:**
Were you experiencing the pandemic where you were in your previous employment?

**Chief Statistician and Director of Statistics and Analytics:**
I left the O.N.S. in 2018 and was doing contractual work, so I had no work for 4 months, because the work that I was supposed to be doing to support the Albanian census I could not do when they closed their borders, so I was in a very different situation.

**Mr. P. van Bodegom:**
I ask because I am curious whether you could bring any expertise to the Island, any insight.

**Chief Statistician and Director of Statistics and Analytics:**
I remain engaged with colleagues at the O.N.S. so people who worked for me who set up a COVID infection survey in the U.K. very rapidly, working with a range of policy colleagues and I have spoken to them and also the work that they had to do in terms of things like measuring the R.P.I. (retail price index), when you could no longer go into shops to measure prices how do you deal with that? So I have got all those kinds of contacts which I have been able to bring to the Island, although I was not directly involved in that work in 2020. But I have remained engaged with the people who are leading that work and have been able to, where relevant, put people in touch from Jersey with my U.K. colleagues, although within Statistics Jersey there were already very well-established contacts. The O.N.S. had shared information around the census, for instance, with Jersey colleagues for a very long time.

**Mr. P. van Bodegom:**
Could you please outline the role and remit of the special adviser from Public Health England in the Channel Islands, including when they were appointed, what advice they provided and how you worked with them?

**Chief Statistician and Director of Statistics and Analytics:**

Who is that question to?

**Mr. P. van Bodegom:**
I think it is Tom.

**Director General, Strategic Policy, Planning and Performance:**
I might ask Dr. Newman to talk about that one, because right at the outset we did have an excellent contact, as you say, in Public Health England and perhaps if Clare could just talk a little bit about the work that we did early on, on things like testing and modelling, where the Public Health England team were really helpful to us.

**Principal Public Health Officer:**
Thank you, Tom. So right at the very start when COVID restrictions were not completely in place we did have contact with some of our colleagues in Public Health England through contacts that Ivan already had, and he also may wish to comment on that. So people again in Public Health England we were able to find when we were looking at that very early stage on our best approach to testing. So most of the stuff that I was involved in was looking at how should we be testing and lots of these new products that were coming along. That continued all the way through into 2021 when we were beginning to use lateral flow tests, when again we were able to speak to colleagues in Public Health England to ask for their independent and also confidential views on the products that were coming through, and we could use that to help us to steer towards the products that would be useful for us to be thinking about using. Also within the Department of Health as well we had huge support in working our way through what was at the time a huge amount of information around testing. A lot of products were being developed in lots of different places but by taking the advice from P.H.E. (Public Health England) and also through the Department of Health we were able to concentrate on products that were going to have longevity and that would prove useful for us more generally. I was also part of the conversation with Dr. Muscat, so I do not know if he wishes to add to that.

**Deputy Medical Officer of Health:**
I can certainly echo what you have said, but it is true that Public Health England did go out of its way to support the Crown Dependencies, not just Jersey but various other jurisdictions as well, and it was not one individual in Public Health England, it was a number of them. There were regular meetings with the Crown Dependencies who all had their own rather different problems to contend with and Public Health England orchestrated meetings to bring them together so that they could exchange information, ideas and so forth. There was huge collaboration with and from the U.K. and that was very helpful indeed earlier on. Like other Crown Dependencies we learned as we went along and adapted our relationship with them accordingly.

**Chief Statistician and Director of Statistics and Analytics:**

The same was true in the statistics space. The Public Health Intelligence team were meeting regularly with Public Health. I think they held a monthly meeting with the various statistical leads in the public health space around the Crown Dependencies and we were learning from the data they were producing how it was being presented.

**Deputy Medical Officer of Health:**

That is consistent, to add to that, with the fact that they provided us with free lateral flow tests, they provided us with flu testing where we are, and they still do, but it is less cumbersome to go through that route. So there has been huge support from them.

**Mr. P. van Bodegom:**

Okay, thank you. When did it commence? Was it March time, 2020, the engagement with them?

**Deputy Medical Officer of Health:**

Public Health England, as it was then, used to send out information updates quite regularly and we used to be in receipt of those, and then when it became clear that something was evolving those missives became more frequent. I cannot tell you the date of our first meeting with them, but it would have been February-March time as I recall, but I cannot give you an exact date.

**Mr. P. van Bodegom:**

What is the current status of the involvement with Public Health England or its current iteration?

**Director, Public Health:**

The meetings with the U.K. authorities have continued. There is a meeting that is held by Chris Whitty, chief medical officer, to which all the directors of Public Health are invited and the Crown Dependencies are invited to that meeting as well. They are held on an average of every week, every fortnight and, in addition to that, Dr. Muscat, along with the head of the vaccination programme, attend meetings of the Joint Committee on Vaccination and Immunisation. Maybe you want to say a bit more about that.

**Deputy Medical Officer of Health:**

The Joint Committee on Vaccination and Immunisation look at the evidence for and against broad vaccination programmes as a matter of routine. Their bread and butter is to assess the risk-benefit of vaccination in general, that includes COVID latterly of course, and it is an extremely useful general tutorial, almost, to attend their 3-hour meetings on a Thursday morning, because they go through a huge amount of information which eventually culminates in a decision about whether a vaccine on

a particular age group or a particular group of patients should be rolled out, and when it should be rolled out. That has of course helped us with our thinking in general, but also with decision-making. When their deliberations have matured to such an extent that we can share that thinking with S.T.A.C. and colleagues and staff then we would do so, thinking about what that means for our programme.

**Mr. P. van Bodegom:**
Is that easy to facilitate? Is it a Teams meeting?

**Deputy Medical Officer of Health:**
Yes, absolutely, so we are there not as members of J.C.V.I. (Joint Committee on Vaccination and Immunisation). We cannot, if you like, take part in the discussion.

[15:30]

That is among about 20 experts, individuals, who have been part of J.C.V.I. for ever and a day. We are there as observers, so it is literally a learning process which has been extremely useful, but it also is useful in understanding why decisions are made and what decisions are made.

**Mr. P. van Bodegom:**
What influence did senior officers from Public Health and Public Health Policy, as distinct from the Statistics Jersey and Statistics and Analytics team, have in determining the production and dissemination of statistics regarding the COVID-19 pandemic? I think that is an Ian or a Margie question.

**Chief Statistician and Director of Statistics and Analytics:**
Yes, I will start with Statistics Jersey. Statistics Jersey, as I mentioned earlier, is independent, the chief statistician is independent. Statistics is always about understanding the user need and responding to the user need, so when you get something like the pandemic you obviously recognise that there is a role for us to help produce statistics, but that is ultimately a decision for the chief statistician to make. There will be conversations with the G.P.s and policy people, et cetera, but ultimately that is a decision for the chief statistician to make. So as I said earlier, Statistics Jersey kind of was engaged early on but then when the Public Health Informatics team was built up, a lot of that kind of activity then transferred across to Margie. So I do not know if Margie wants to try and chip in at this point because she will have that analytic experience in the way that I did not.

**Director General, Strategic Policy, Planning and Performance:**

Yes, I think Margie may not have picked up all of the question but the thrust of the question was really around the decision-making on what statistics to publish and some of those decisions how they were influenced by policy, how they might be influenced by public health medical professionals and others. It is really how you decided what statistics to do and to publish.

**Head, Public Health Intelligence:**

Thank you for the question. So, yes, we had sort of evolution of the statistics that have been provided over the course of the pandemic. Some of the dataset has just become available and has become of a good enough quality for us to be able to produce those with certainty and look to do that so, for example, looking at the cases of COVID positive cases and the vaccination statistics themselves. For that in itself, we did quite a bit of consultation with, for example, the statistics users group to make sure that we were able to show the uptake on different priority groups alongside the data quality assessment and then there is also quite a wealth of information within the reporting that we do to make sure that all the caveats are provided to improve the understanding of the figures that are being published. We also check through with S.T.A.C. on the data that we wish to provide and will discuss, for example, around the work that we did at the end of the year on working with H.C.S. around getting this data of the vaccine status of hospitalisations published. So that was a piece of work that we understood that they would need that information but it was not information that us at Public Health held. It was a piece of work, working with our colleagues in H.C.S. Informatics, to get that data again validated as a good enough quality to be able to publish, again alongside all those caveats, to make sure there was an understanding of the data that was being provided was there alongside the figures themselves. We also often will take the changes to the publication through S.T.A.C. and C.A.M. so, for example, the de-escalation policy and the decisions that were made there. Within that, there were decisions around the de-escalation of reporting that was taken through there. So at the beginning of February, we stepped down reporting on the travel data because that was no longer being collected, and we also changed the reporting on the symptomatic and asymptomatic data as a result of the changes to contact tracing. So we made sure that that is the Government's process that we go through with those changes as well and we made sure that everybody was informed about those changes before they happened.

**Mr**. **P**. **van Bodegom:**

How frequently are they updated and reissued between the departments?

**Chief Statistician and Director of Statistics and Analytics:**

When you say "how frequently", are you talking about the production of the statistics?

**Mr**. **P**. **van Bodegom:**

The statistics and then on to the public beyond that.

**Chief Statistician and Director of Statistics and Analytics:**
Margie, do you want to handle that?

**Head, Public Health Intelligence:**
Yes, no problem. So we have a range of frequencies at the moment, so we still have the daily publication of the cases tested and the occupancy of the hospital, which you will see gets updated on the website. We have recently just set down the frequency of the vaccine data, so that was twice weekly on a Monday and on a Thursday. At the beginning of February that has changed just to weekly, on a Thursday, so that is still ongoing. We also have a weekly epidemiological report which contains information on testing rates and the 7-day rolling case rates, for example. We also have monthly reports so, once a month, we update the re-infection rate now and we also do a monthly report of the vaccine status of COVID positive cases.

**Chief Statistician and Director of Statistics and Analytics:**
I will just add that Statistics Jersey introduced in 2020 statistics around the economic impact. We need to get the data from Treasury and Resources and C.L.S. (Customer and Local Services) and Transport and Technical Services, et cetera, and that was initially weekly and then as we progressed through the pandemic, it became monthly and now it is quarterly. So some of this is responding to the intensity of the pandemic and how critical it is to produce statistics that enable people to make the big decisions. So like vaccinations that Margie referenced, it started off being weekly and then, as the systems bedded down and became automatic, it then became twice weekly and, as Margie said, now that we have reached a certain maturity in that space, it can go back to being weekly again, so we have responded to the interest. We have partly responded to feedback from the statistics users group who have made comments around, in particular, a presentation for the vaccination status. I had a meeting with them and Margie and the H.S.C. Informatics team in the spring of last year and, where we could, we responded to some of that feedback as well. We have also looked at the kind of media interest as well and, since you have referred it to me, interest of the public and where that has been. We have adjudged that as important to respond to and done that as well.

**Mr. P. van Bodegom:**
Great, thank you. You have almost answered my next question as well. Just to ensure a joint approach to data gathering in relation to the pandemic across Government, I can see you have that in hand. I think that has been adequately answered.

**Chief Statistician and Director of Statistics and Analytics:**

Yes, it is a mixture of Statistics Jersey on the economic statistics side and Public Health and Health and most of that data comes together through Margie, so she is kind of holding the wheel on that. As Margie alluded to, we have needed to work jointly between Public Health and Health. Like Peter asked me to chair a task and fitness group as a group of S.T.A.C. to look at a particular issue, for instance, and I brought together the relevant players.

**Mr. P. van Bodegom:**
Okay, great, thank you.

**Director General, Strategic Policy, Planning and Performance:**
Just to add for the future, one of the things that I mentioned in my letter to the committee was the point for the future about being able to join up datasets more easily. I think it is a point that the U.K. Statistical Regulation Authority have highlighted where they made the point that joining administrative datasets can save lives. I think that is one of the main kind of data lessons coming out of the pandemic, not just in Jersey but for many jurisdictions, and I think it is one of the takeaway improvements for the future that I know, Ian, you will be working on, and Peter as well, because it is a key improvement that we can make in Jersey. If we were to tackle that learning and to address that point in the way that has been recommended elsewhere, then probably we would be in a significantly better position if we had to deal with anything similar in the future.

**Chief Statistician and Director of Statistics and Analytics:**
Briefly, the U.K. Office of Statistics Regulation produced a report in this making 10 recommendations, which I can share with the committee if you are interested.

**Mr. P. van Bodegom:**
Great, yes, thank you. Could you please confirm whether there is now enough capacity within Statistics Jersey and the other statistics and analytic teams, including Public Health Intelligence to return to a normal pre-pandemic practice and workload?

**Chief Statistician and Director of Statistics and Analytics:**
I think I said this in my letter, the challenge is resources. Particularly Health and Public Health have had additional resources through the test and trace and rapid response programme. In recruiting skilled statisticians and analysts, we tend to have to kind of bring them in at a more junior level and grow them. So there are a number of vacancies around the system. I have got some staffing statistics to Jersey who are kind of acting up and I am looking to fill the posts and regularise that. I know even in Health and Public Health, they have vacancies so I think the resources and the money is there. The challenge is finding the people with the relevant experience and I think, around the world, what the pandemic has done is made Governments realise the importance of data when you

are taking decisions at a time of uncertainty. So this is not unique to Jersey, although obviously with the Island status, a limited number of people are also competing against the finance industry as well so it is the same skills. So I think the challenge is more in that space as opposed to the money.

**Mr. P. van Bodegom:**
How many posts do you need to fill?

**Chief Statistician and Director of Statistics and Analytics:**
One of my roles across the system is to get a handle on the actual number. The developer is on top of that at the moment. I am aware that, Margie, you have vacancies in your area that you are trying to fill. How many of those?

**Head, Public Health Intelligence:**
I managed to recruit successfully last week so basically they will be starting at the beginning of April.

**Chief Statistician and Director of Statistics and Analytics:**
I know within the Health Informatics team, they have vacancies. I can find out and let you know the number of vacancies.

**Mr. P. van Bodegom:**
Thank you. I will pass to the chair.

**The Connétable of St. John:**
I was encouraged to hear about the teamwork and the collaboration both locally and with others. Has your department worked with our neighbours in Guernsey during this period? I am talking about you, Director General.

**Director General, Strategic Policy, Planning and Performance:**
Well, the different teams have had liaison with their Guernsey counterparts so I know that in Public Health Practice and Policy, there is good liaison and that has been there since the outset. I think when we started, we had kind of weekly phone calls between the Islands at the time. So that has been quite strong throughout and I think I would characterise it mostly as exchanging experience, knowledge, experiences of doing it, so there has been good regular dialogue throughout. I have spoken to my counterpart over in Guernsey quite frequently as well, as they have been coming up to critical decisions and we have. We talk and also just share experiences, so it has been very positive I think across the piece in terms of Guernsey and the Isle of Man to some extent as well. But Guernsey, in particular, has been very collegial and very warm and certainly I have appreciated having somebody else in kind of my situation to talk to as being really useful for Peter and I.

**Chief Statistician and Director of Statistics and Analytics:**
I have regular meetings with the director of Public Health in Isle of Man and Guernsey. We obviously have discussed the pandemic but we have moved on to other topics, particularly in the direct health implications of the pandemic. There is also a very strong network around Public Health Intelligence, so Margie again talking to her counterparts and we have a joint work plan for areas where we can work together. So there are some issues particularly, for example, Jersey and Guernsey are looking at things like the nuclear installations on the coast of France and the risk to those Islands. So where we have issues like that, we just look at them together.

**Chief Statistician and Director of Statistics and Analytics:**
I have regular contact. I have quarterly meetings with my counterparts in Guernsey especially about things like census and use of administrative data, et cetera, and that has been well established. I think it predates the ...

**The Connétable of St. John:**
I am encouraged to hear that. So what is the current position in your department and how many people are still working on COVID and how many have you managed to get back to the day job?

**Director General, Strategic Policy, Planning and Performance:**
We almost have everyone back to their day job who is going back to their day job. To explain that a little more, pre-pandemic in kind of January/February time 2020, we had recognised that we would need to strengthen the Public Health function if we were going to effectively support the delivery of the Jersey Care Model and what we need to do in terms of moving the focus into early intervention prevention.

[15:45]

So it became clear to us at the start of 2020 that we needed to strengthen Public Health in any event. That meant that the Jersey Care Model includes investment for Public Health tucked away in there and so we had always intended to expand the Public Health team. Then what has happened with the pandemic is obviously half the department became Public Health for a little while and then, as time has gone on, a number of those people have been able to move back to regular duties as things have de-escalated but a number of them have chosen to stay with Public Health. So if I look around me, then Margie was working in the Children's Department as their kind of head of analytics. She has a background in public health so she came forward to help the Island and to serve and is now going to stay with Public Health as part of that permanent strengthening. The same with Dr. Newman. She was working on children's policy but had knowledge of public health in the

background in the medical profession so stepped forward and, again, she has decided now that she is very kindly going to stay with Public Health. So what has tended to happen is that people have either consolidated into what now is going to be a much-expanded team under Peter's leadership or they have reverted back to their mainstream roles. So I think we are getting close to what is now going to be the permanent Public Health team moving forward.

**The Connétable of St. John:**
What about those roles which people have moved permanently from now? Have you backfilled those?

**Director General, Strategic Policy, Planning and Performance:**
Yes, and, again, sometimes we have done that the other way around and so Dr. Newman has decided very kindly to stay with Public Health. We now have a colleague working in children's policy who is one of the people that volunteered to work in Public Health and has decided to stay with S.P.P.P., to stay with policy work in Government and is a tremendous asset to us and has moved the other way permanently which is great. Great for the Island and great for public service.

**The Connétable of St. John:**
Have you seen COVID-related workstreams being absorbed into or moved from other departments into the Public Health Department?

**Director General, Strategic Policy, Planning and Performance:**
Probably the biggest example of that was the changes that happened in October 2021 when we took on the operational responsibilities for the vaccination programme, the test and trace and COVID safe. So that happened when the former director general of Justice and Home Affairs left. Then the morning after I was, from that morning onwards, responsible for those operations. That is probably the most significant change because those, at the time, were quite big operations involving many millions of pounds and an awful lot of really, really good, dedicated people. Then that has changed over the last few months as some of the excellent people that we had who were working on things like test and trace have started to move on to other roles either in the public service or in the community as those functions have downscaled. I think that was probably the major change that happened through the 2-year period.

**The Connétable of St. John:**
What kind of a handover did you have because I presume you did not arrive on a Monday to be surprised that you were now responsible for these areas?

**Director General, Strategic Policy, Planning and Performance:**

No. So we had had the discussions among the senior team with the interim chief executive. We looked at options around how we could best manage those functions. At the time that they were managed through Justice and Home Affairs, was at a time when the Public Health policy, strategy and practice work was particularly intense for us and we were very grateful to Justice and Home Affairs for stepping in and running those operations because it was one thing that we did not have to worry about. We could keep focusing on the vaccination policy, on testing policy and contact tracing policy and somebody else did the operations. I think when the director general was due to leave and we thought about where best to put them, I think my conclusion was that we now had the capacity to be able to take it on, and we saw some considerable advantages in combining policy and delivery together. You do not always have those advantages but quite often in Public Health you do. Public Health is one of those areas where combining policy and delivery can be quite effective and so we decided that that would be the best solution to combine it together and it has continued to be a highly effective service mostly because it is very well managed by Rachel Williams, who is very capable director and deals with it very well and very ably.

**The Connétable of St. John:**
So I suppose my last question will be, with the benefit of hindsight, what would you do differently?

**Director General, Strategic Policy, Planning and Performance:**
That is a very, very big question,

**The Connétable of St. John:**
But one you would expect.

**Director General, Strategic Policy, Planning and Performance:**
I think that in terms of the public service, so if I focus down and think of that, we have talked about some of the areas as we have gone through the hearing. So I suppose that if I knew then what I know now, then we would have done some very practical things about the staffing and the arrangements and having more of an emergency services style response to the public service. I think that we would have taken a different approach to some of the data management and the data sharing in order to make that easier and more straightforward, and I think there are benefits there that we would have had. I think that probably there are also a number of things that I would probably keep. I think some of the things that were true then, and which I am grateful for, were things like the flexibility and adaptability of the public service. I know a lot has been said about the structure of the public service and the pros and cons that the public service, as it is currently configured, demonstrated that it did have that strategic agility and flexibility, and I would not want to lose that. I think probably one of my main learnings coming out of it is that we probably needed a stronger Public Health team and I think that, if I had my time again, I would probably have started the

pandemic with a Public Health team of 15 to 20 people at the outset. If you look at benchmarks on the size of a Public Health team that you would probably have for a jurisdiction of our size, that is probably the size that we would have started with as well, and I think that probably those early phases would have been a lot easier to handle if we had had a team of that size to start off with. But I do not know whether Peter, you want to ...

**Director, Public Health:**

Yes, certainly coming in, that would definitely be my conclusion that having a Public Health function is very important but I also agree that having a data-focused approach is not only for the management of the pandemic but also the endemic impacts on health. I think also having those plans and preparations for any situation that we might find ourselves in, not only the emergency planning side but also health protection risk more generally, we are certainly trying to work on all those as priorities now. I would also echo we really keep the collaboration and the dedication of everybody involved. That is really amazing.

**The Connétable of St. John:**

Thank you. Graham, you have a question.

**Mr. G. Phipps:**

Yes, I just wanted to follow up a little further on the area of data, statistics and information. I have a history in some of that work and the sceptics will say statistics is what would you like it to be. My question pertains to the information recorded with respect to deaths of COVID, which is a sensitive area. Deaths of COVID and the information reported talks to deaths occurring in patients having COVID and then the sceptics and the stories we hear on the street are: “Well, wait a minute. This person I know died from another related issue.” Are you planning to report deaths due to COVID and not related to COVID so there is a clarity and the understanding, and you can stop the sceptics from coming out and saying: “Well, that is not valid” but in other words, is there going to be a deeper cut in this and reported to the public as we look back at what happened and we can point to strongly that this was a death due to COVID and not just they happened to have COVID when they passed away?

**Director General, Strategic Policy, Planning and Performance:**

Yes, I think how jurisdictions report deaths is going to continue to be a debating point for quite a while because different jurisdictions have taken different approaches, so I think it is a really good question. I thought maybe we could just start with just a quick input from Margie because this is one of her specialist subjects and then perhaps just a word from Ivan as well, and that will probably help the committee.

**Head, Public Health Intelligence:**

Thank you, Tom. Yes, the recording of COVID-19 on a death certificate is something that is obviously keenly monitored. The superintendent registrar I believe personally registers each death that has had COVID-19 recorded on the death certificate. The way that the death certificates work, the proforma that they meet, means that if the G.P. or the doctor certifying the death felt that COVID was contributing to the death at all then COVID-19 will be on the death certificate. For some people, they may ... hypothetically say somebody has died in a car accident but happens to be COVID positive, the fact that they were COVID positive would not appear on their death certificate because it was not a contributory factor to their death at the time. However, those deaths that we have seen, for example, in hospital where somebody may have been in for another reason but the doctor certifying may have felt that COVID may have exacerbated their condition leading to their death, those would have been recorded on the death certificate. We have previously had F.O.I.s (freedom of information) where the exact cause of the death and the things that are recorded on the death certificate have been requested and this has been published. So it is possible to see where there are a very small number of deaths where there were no other things recorded on the death certificate other than COVID-19. We have also within the annual death report, so we publish in September the 2020 Annual Mortality Report and we did an additional section in there on COVID-19 deaths. That also included those people who have had COVID-19 at the time of dying but COVID-19 was not on the death certificate and from them we had about 3 or 4 deaths in 2020. We will look to the 2021 deaths later on this year once we have had the deaths coded by the Office for National Statistics in the U.K. so that we can statistically analyse the deaths. That takes a little time to do which means that we will not have that information available until the second half of the year and we will be publishing the 2021 Annual Mortality Report in September of this year.

**Mr**. **G**. **Phipps:**

So that detail will be available and published at that time. For example, those that had no other lists on their cause of death, all that information will be publicly disclosed. I understand you are gathering it but my question is will that be available to the public?

**Deputy Medical Officer of Health:**

That is in the public domain already.

**Mr**. **G**. **Phipps:**

All of it?

**Deputy Medical Officer of Health:**

Because the certificates are in the public domain.

**Mr. G. Phipps:**
Okay, that is good.

**Deputy Medical Officer of Health:**
It is really important I think for us in the general public to understand that it is very uncommon to die from a viral respiratory tract infection in the absence of underlying comorbidities because your resilience as an individual in the absence of underlying comorbidities is often such that they can pull through.

[16:00]

So if you look at a death from flu, for example, you will find a number of comorbidities presenting on the death certificate. All of them contribute to some extent to that death and that is why only about 4 of the 106 death certificates where COVID is mentioned as a contributory cause are solely due to COVID. The others have a number of comorbidities and that is exactly what you would expect and reflective perhaps in the vaccination programme rollout where we started vaccinating those most at risk because of the underlying age of comorbidity and worked our way down. Because there are those old people and those with underlying illnesses who were going to be most at risk of death and, therefore, deserve to get the vaccine first. This is exactly the same as it is seen in England. So, in England, there are 2 ways of reporting deaths due to COVID. One is by P.C.R. positivity in the last 28 days and that number is approximately 235 per 100,000. The other is whether COVID is mentioned at any point in the death certificate, and that number is 268 per 100,000 in the U.K. Our number is 106.

**Chief Statistician and Director of Statistics and Analytics:**
In fact, there is a third measure as well which is the excess deaths compared to the 5-year average and I think, Margie, excess deaths in Jersey in 2020 were negative.

**Deputy Medical Officer of Health:**
They were but that accounts for absolutely everything.

**Chief Statistician and Director of Statistics and Analytics:**
Yes, exactly.

**Deputy Medical Officer of Health:**
Excess deaths are used for flu in general.

**Chief Statistician and Director of Statistics and Analytics:**

Yes, exactly.

**Deputy Medical Officer of Health:**

But in terms of measuring death due to COVID, those are the 2 statistics that are largely used in the U.K. per 100,000 people as to whether death is mentioned in the death certificate or you had a positive P.C.R. within the last 28 days. If you like, our numbers compare reasonably well with that per 100,000 or 106 per 106,000, or whatever precise populations. So I think if we are going to measure things, we have to use approximately the same ruler that other people are using. Otherwise, we cannot compare ourselves with others.

**Mr. G. Phipps:**

The clarity of what is in it has been very helpful. Thank you. That information has been very useful.

**The Connétable of St. John:**

Yes, thank you. I do like to finish on time but that comprehensive answer was very welcome so, once again, can I thank you for your attendance and your contribution this afternoon, both those present and those online. I think the word "dedication" was mentioned a short while ago and we thank you for your dedication and your continued work towards the Island coming out of this pandemic. So thank you all very much and we wish you well. Thank you.

[16:03]