OFFICIAL REPORT

OF THE

STATES OF GUERNSEY

SCRUTINY MANAGEMENT COMMITTEE

Committee *for* Health and Social Care – COVID-19 crisis

Public Hearing

HANSARD

Guernsey, Tuesday, 14th July 2020

No. 3/2020

Further information relating to the Scrutiny Management Committee can be found on the official States of Guernsey website at www.gov.gg/scrutiny

Published by The Scrutiny Management Committee,
Longue Rue, St Martin, Guernsey GY4 6LD © States of Guernsey, 2020

Members Present:

Panel Chair: Deputy Chris Green, President,
Deputy Jennifer Merrett, Member,
Advocate Peter Harwood, Non-States Member,
Scrutiny Management Committee

Mr Mark Huntington – Principal Scrutiny Officer

Business transacted

Scrutiny Management Committee

Committee *for* Health and Social Care
Public Hearing

The Committee met at 9.30 a.m.
in the Castel Douzaine Room

[DEPUTY GREEN *in the Chair*]

Procedural –
Remit of the Committee

The Chairman (Deputy Green): Right, good morning, welcome.

I would like to welcome everybody here today, including elected representatives, senior public servants and members of the public. Our session today is with the Committee *for* Health and Social Care and will focus on the work undertaken to deal with the COVID-19 crisis. The primary focus of the hearing is on the impact of COVID-19 on our operational services and the health and well-being of Islanders, and on the decisions made surrounding the imposition of lockdown.

Our panel today comprises Advocate Peter Harwood, Non-States Member on the Committee, Deputy Jennifer Merrett and myself, Deputy Green. Following this event, my Committee will decide whether any further review activity will be commissioned on these areas. This is the first of three public hearings in relation to COVID-19 that we are conducting this July.

Turning to the arrangements for today, I can confirm that a *Hansard* transcript from this proceeding will be published in due course. Please can I ask anybody with mobile devices to put them to silent, as it is essential during our session that we can hear the answers that are given without interruption from the public gallery.

EVIDENCE OF
Deputy Heidi Soulsby, President, and
Dr Dominic Bishop, Consultant Psychiatrist,
Committee *for* Health and Social Care;
Dr Nicola Brink, Director of Public Health;
Dr Peter Rabey, Medical Director

The Chairman: So if I could start by turning to our witnesses; if you could just introduce yourselves from this end to that end, please.

Dr Rabey: I am Dr Peter Rabey, I am the Medical Director for Health and Social Care.

The Chairman: Thank you.

Deputy Soulsby: Deputy Heidi Soulsby, President of the Committee *for* Health and Social Care.

The Chairman: Thank you.

Dr Brink: Dr Nicola Brink, Director of Public Health.

The Chairman: Thank you.

Dr Bishop: Dr Dominic Bishop. I am the Clinical Director for Mental Health and Adult Disability Services.

The Chairman: Thank you very much and welcome.

Can I start by saying on behalf of the panel, on behalf of my Committee, we would like to commend your Committee, Deputy Soulsby, and the many other healthcare professionals on how COVID-19 has been dealt with in the Bailiwick. Your actions and the team's expertise have no doubt contributed to the Island now being COVID-free for so many days. So thank you very much in advance.

Right; okay. Happily, we avoided the Island's health system being overwhelmed by COVID-19. Was our small size as a jurisdiction a key part of that, do you think?

Deputy Soulsby, to begin with.

Deputy Soulsby: Can I start by saying I think we are in … I do not want us to get in danger of feeling that we are at the end of the COVID crisis. For us it is very much we are still in the middle of it, albeit that for the public it is as normal as it can be within the community, bar the borders. But from our point of view, we are still looking at what happens with a potential second wave, how do we deal with vaccines, and also how do we deal with the fallout from the first lockdown that we have had, in terms of getting people healthy and sorting out issues over waiting times, etc. (**The Chairman:** Yes.)

Clearly we have had advantages as a small jurisdiction. I think if you compare us to the UK you can see the problems logistically that they have had both in terms of the public not necessarily being fully behind measures that have been taken there, but also I think getting messages out. But at the same time we were far more vulnerable than such a large jurisdiction because we only have one hospital and only one main hospital. So we forget very easily that we also were managing smaller Islands, in particular Alderney and Sark, who did not have those facilities.

There are advantages, (**The Chairman:** Yes.) in that we were, as a local community probably … The track and trace team: they were local to the community and that has helped. But counter to that, no resilience in terms of having just one hospital. If it was overrun then we would have been a *very* serious position. So really at the heart of this was protecting the Hospital.

The Chairman: Okay. I think the question arose because often our lack of scale, our size, is a real problem across Government, isn't it? And the thought was really, actually, in a sense the small size of the jurisdiction lent itself quite nicely to being able to contain the problem. (***Deputy Soulsby:*** Yes.) Would you accept that?

Deputy Soulsby: I think also in terms of being able to get communications together far more easily with fewer people. I think one thing, if you compare with the UK, they had lots and lots of experts and there was one interview, it might have been on the Today Programme one morning, and they were interviewing one of these experts on the alternative to SAGE, and really what came out of it was that they had so many experts they kind of were cancelling out what each other were saying. So they ended up being slightly slower in what they were doing and saying. Yes, we had Dr Brink – thank goodness we have had Dr Brink – but also, behind her we had a team. (**The Chairman:** Yes.) So it was not just Dr Brink. There was challenge, but in a more manageable way.

Politically I think very early on we understood the importance of communication both internally and externally. So we could contain … make sure that we had clear communication lines. So very early on myself, Deputy St Pier, the Chief Executive and Head of People Policy had daily briefings every day at midday. That was every day; that was through the weekends. Now we still have them, it is just during the working week, but we still have those meetings. That enabled information to be both passed to us about what was going on, but also for us to be able to relay issues that we were seeing from a political point of view and what we saw needed to be done. So I think being small in that way has really helped.

The Chairman: I am going to bring in Advocate Harwood in a moment and Deputy Merrett. I understand what you are saying about the benefits of one expert, but could it be said that perhaps we had only one version of the science, Dr Brink? Is that fair? Is that a limitation?

Dr Brink: I think we were a small team and with regard to was it easier for us because we are small jurisdiction, it was both easier and harder. So I think it was easy in that we had really good communication across all sectors and really worked in the barrierless way. I think this was a huge example for us. From the political, to Frossard House, to the operational, Health and Social Care, primary care, we worked as a single team. I think that was *really* important for us.

But I think also, for us, our smallness also made us more vulnerable. So for example, during the height of March and April we were – certainly my team was – getting in at half past five/six in the morning and we were working until 10/11 every evening. So there was a critical community group of contact tracers, in the laboratory we quickly trained up six people to do our analysis, but it still was a relatively small group.

With regard to relying on a single individual, we were acutely aware that we needed to make sure that our evidence was robust. So we had in the first instance the Scientific and Technical Advisory Cell, which then moved on to the Tactical and Strategic Coordinating Group, but we also linked with Public Health England and we have also linked with other smaller jurisdictions. So some of the modelling we did, for example, was sent to the Isle of Man to be peer reviewed, (**The Chairman:** Oh, right.) just for scientists to look at how it was modelled, and we linked through the European early warning system.

So we were using multiple data sources, (**The Chairman:** Right, yes.) but collating that together. So no, it was not dependent on just me or indeed the Public Health team – it was far wider.

The Chairman: Okay, that is very clear.

Deputy Soulsby: No. I can add to that. Certainly our challenge was, look, we have got Dr Brink, she is *really* good, but we are only hearing from Dr Brink. That was an early challenge and we got the absolute assurance from Dr Brink about that, but also knowing that she was in the same virtual room as directors the Public Health in the UK. (**The Chairman:** Yes.) She managed to get herself in to really high-level meetings in the UK. She knew what was going on; and yes, it is not just words. When Dr Brink says evidence, the evidence was there, challenge has been there from day one. I know we are not here to talk about CCA, but certainly from CCA point of view and HSC.

We spent hours, we have had hours of meetings where that challenge was there, how far can we go. And, of course, we do not live in a bubble either. We are seeing what is going on in the UK and saying, 'Well, what about this? They are doing this over there. What about temperature testing at the airport? What about doing …' this and that. We got that challenge coming back and we had that confidence in what was being told to us because we knew it was not being done … it was not somebody saying, 'Well, I believe this and I don't care what anybody else is saying'. It was always backed up by evidence.

The Chairman: Yes, okay.

Should we go to Advocate Harwood?

Advocate Harwood: Can I make an observation? One of problems in other jurisdictions, and the UK is a classic example, is that they have totally different groups of people. They have the NHS, Public Health England and goodness knows what else. As an observation, one of the advantages we have here, small government when you are all in under one organisation, you have got Dr Rabey, and Dr Brink, who are all under the auspices of the HSC and if ever there is an argument for saying we should not have separate quangos, I think that has demonstrated it.

Deputy Soulsby: Yes, that is true. But I think I would say it goes further than that. I would say I have been absolutely bowled away by how all staff within the States of Guernsey and outside have just stepped up to the plate and gone beyond what you would expect anybody to do. I am not just saying it: everybody has worked together. The States of Guernsey in different teams working for each other. But it is not just one HSC. This has been, as Dr Brink said a moment ago, we have had primary care, secondary care, voluntary sector all coming together and doing their thing and helping out. So yes, it has been a really great advert for the Island, about how people can work together.

The Chairman: Deputy Merrett.

Deputy Merrett: Yes. Dr Rabey, Deputy Soulsby said earlier it was very much about protecting the Hospital. I am sure we actually mean protect the community by protecting the Hospital. It links together. But upon reflection, lessons learnt if we get second wave, how could the Hospital be managed differently if we had, for example, another wave?

Now, what I mean is could wards and operating theatres for example be isolated so that the majority of our community could still access the healthcare system? I mean surely there must be lessons learnt? There has to be a balance, because the figures that have come out recently about the waiting list are of huge concern and there has to be a balance of what did we do to confine COVID-19, shall we say, but what was that counterbalance to the rest of our community?

So if there was a second wave, what lessons do you believe have been learnt in management of the Hospital?

Dr Rabey: Yes, it is a good question, one we have asked ourselves and continue to ask, really, because we successfully protected the Hospital infrastructure. Part of the reason for closing down elective surgery when we did is because the early evidence was that people who have surgery and then contact COVID do very badly. So you are very high risk in the post-operative period if you get the disease. So bringing somebody into a hospital where there are COVID cases, where staff are necessarily coming into contact with COVID, puts them at high risk as well.

I am not convinced that we would not do very similar again, that we would go back to just emergency and urgent surgery and stop elective surgery, and the reasons for that include: (a) protecting the patients, but (b) it is protecting the infrastructure of the Hospital itself. The way we can overflow beds if the ward gets full is to stop doing elective so we have got those beds available for medical care, and that is still part of our escalation plans. We will use the surgical wards as overflow medical beds except for the priority one and priority two cases.

So we can look at can we keep an isolated theatre running for electives. We certainly would look at it and we did do, actually, on an almost day-by day-basis: 'Can we do some electives in the theatre three?' type of approach. We will stay flexible on that. But I do not think we will get big volumes of elective work done during a COVID second wave when it is in the Hospital, no.

Deputy Soulsby: Can I just add into this about the waiting times? I think it needs to be remembered also that the waiting times have gone up because we have had outpatient appointments ongoing during this period. So the MSG have been working and doing as many as they can, either in surgery or through telephone consultations if they can. So that is why, that people are being seen so they are being added to a waiting list, whereas you compare it with elsewhere, and particularly the UK, people are not being seen at all. So their bulge will happen much later when

things get back to normal. And also, at same time, we did deal with category one and two, so emergency cancer patients. So if people were in that really high risk area, the operations did take place.

The Chairman: Peter.

Advocate Harwood: Can I just ask Dr Brink, really scroll back when all this started. Can I ask the question when were you first alerted to the risk of COVID-19 and when did you first alert the HSC Committee or Deputy Soulsby?

Deputy Soulsby: I can say that – 14th January is when you first told me!

Dr Brink: So on 30th December a case of a cluster of unusual cases of pneumonia were reported in Wuhan City in the Hubei Province of China. By 1st January they had announced that this was caused by a coronavirus and by 7th January they had sequenced the virus to show that this indeed was a novel coronavirus. When we practised our pandemic flu exercise last year in November, we were always cognisant that we were practising for a pandemic flu, but this was equally applicable to the emergence of a novel respiratory virus. So we were always aware that this was a potential risk. Indeed, we knew it was a risk which is why we insisted that the practice occurred in November despite us also preparing for Brexit at the same time. So it was really important that this was a high risk on our risk register and we needed to be prepared.

Advocate Harwood: Did that exercise actually prove to be worthwhile?

Dr Brink: Yes, absolutely.

Deputy Soulsby: Yes.

Advocate Harwood: As it manifested.

Deputy Soulsby: Absolutely it was. And at the time I remember we had people from – was it Public Health England? – (***Dr Brink:*** Yes.) helping to facilitate it. We had the Army over and people from the UK government, (**Advocate Harwood:** Yes.) and they were bowled away by just how many people had turned up. We took up the whole big area within the peninsular, masses of people there. So –

Advocate Harwood: Had that test been planned for some time (***Deputy Soulsby:*** Yes.) or was it just coincidental? (***Dr Brink:*** No.) I mean the timing is amazing, but it …

Dr Brink: It was part of our planning. So we look at planning and practising our pandemic flu exercise. We had just completed a Channel Islands pandemic plan looking at some commonality in approaches and we then practised it then.

Advocate Harwood: I was aware, you mentioned I think, the risk register has always recognised pandemic. But it was always the context really of flu rather than viral.

Dr Brink: We have always recognised that, particularly if you dial back a bit to the first SARS and MERS. At the time when those occurred in 2007 and earlier we had a close look at those because this was always a concern: that we would end up with a coronavirus-type pandemic. From our perspective, going back to the events of January, we were concerned about this from the beginning and we started meeting regularly in Public Health and then, as Deputy Soulsby said, went to Health and Social Care a few weeks later.

We believed that this virus had pandemic potential, although it was only officially declared as a pandemic on 11th March. (**Advocate Harwood:** Yes.) It was declared before that as a public health issue of emerging concern; so a public health emergency of international concern. So it was declared as a PHEIC before that, but only as a pandemic on 11th March. But we felt it had pandemic potential before.

Deputy Soulsby: That is right, and we worked on the basis that it was going to be a pandemic before then.

Advocate Harwood: Yes. So if HSC were, you said 13th January or 14th January?

Deputy Soulsby: I was advised by email by Dr Brink – I remember it – on 14th January. *(Laughter)*

Advocate Harwood: Engraved in your memory!

Deputy Soulsby: I thought, 'Oh God no!'

Deputy Merrett: The time, minute and second.

Advocate Harwood: And from that point onwards was that when you started having your daily briefings or did that evolve later?

Deputy Soulsby: Not from a political point of view, no.

Dr Brink: So we started preparing from a Public Health point of view with our regular meetings and we had what we called our 'Public Health huddle' where we looked at the emerging evidence every morning to see if anything fundamentally had changed. We also were absolutely cognisant of the need to run a response that was suitable for our jurisdiction and this was not a one-size-fits-all response. So we needed to look at what was right for the Bailiwick in planning our response. So – sorry.

Advocate Harwood: Sorry. But at that stage what was the question of testing in your mind or in your planning?

Dr Brink: At that stage we were accessing our testing through Public Health England and the early testing, I think we tested our first patients on 3rd February and our early testing – I would have to check but I am pretty sure it was 3rd February – was focused on Public Health England's. We were going to test within their laboratory, as indeed we did with swine flu. However, as events unfolded, the UK changed their testing strategy and we always planned from the beginning to run a community-based test, track and trace. So the fundamental strategy from the beginning was a community-based programme to protect our single hospital asset. So we were aware in the UK what you see, indeed you are seeing now, is regional outbreaks. So if one area is badly affected they can use a hospital 40 miles away. We do not have that, (**Advocate Harwood:** Yes.) and we are very aware that transporting people out, particularly if they were severely unwell from a respiratory point of view, was certainly not without its risks.

So we wanted to very much focus on a –

Advocate Harwood: So you are saying I think you started testing about 3rd February. At what stage did you then recommend to HSC, or what is the actual appropriate process for declaring an emergency and then having the CCA up and running? When did that start manifesting itself?

Dr Brink: So I will refer to Deputy Soulsby with that, (**Advocate Harwood:** Yes.) but are you asking about when we decided to change our testing strategy?

Advocate Harwood: Well, when did it lead you to believe that there was an emergency and you needed to declare an emergency for the purposes of the CCA, or to establish the CCA?

Deputy Soulsby: Well, it is a CCA that would declare an emergency, and it –

Advocate Harwood: Sorry, yes; but I mean the advice obviously from …

Deputy Soulsby: Some time in February.

Dr Brink: Yes, it was sometime in February. So how the procedure worked is that we moved from a pre-assessment team to a strategic gold and a tactical command and that then informed the CCA. So it went through – all of the decision making – the strategic gold and then on to the CCA.

Advocate Harwood: I suppose really what I am just trying to identify is the sort of time lag between –

Dr Brink: We will give it to you.

Advocate Harwood: It may be just useful because there was some slight criticism one or two people early who said we were a bit slow in the lockdown, and I know the same thing has been said in the UK and elsewhere.

Deputy Soulsby: Well, I would absolutely refute that. We went into lockdown in a stage of containment when the UK went into lockdown in a stage of delay and we did so absolutely when … up to that point it was fine and controllable, but we went into lockdown the moment when we were getting the UK saying they were not going to do any community testing – and we were absolutely reliant on that. Also, the delays that were coming through and the evidence that there was community seeding which we could not track back. No – absolutely refute.

I think you have got to look at it – and it is always easy to say it in hindsight, isn't it? And a lot of this will be about that, but – if we had gone into lockdown two weeks earlier, say, I do not know if the community would have been able to cope with any longer because we would have had to have been in lockdown longer, given where the UK was. So, yes.

The Chairman: Given that we are in the mindset of hindsight, what would you say were the weaknesses of our approach, in hindsight, if any?

Deputy Soulsby: I do not know if there are some weaknesses in our approach as the weakness we found with our system. So being reliant on the UK was a real issue. (**The Chairman:** Yes.) We had to – Deputy St Pier and I – have meetings with Lord Keen from the MoJ at least twice over this, because by stopping community testing that meant we were absolutely vulnerable – it could have spread right across the Island. When we had the email from the testing centre saying, 'No, we are not going to do any more testing for you' that was completely worrying.

Advocate Harwood: Did you have any fall-back position to adopt at that stage or did it come out of the blue?

Deputy Soulsby: It came completely out of the blue by an email to Nicky one morning.

Dr Brink: Yes. So we received an email saying that the UK had moved to hospital-based testing and they would not be doing any more community testing. I responded immediately saying this does not suit our community-based test, track and trace programme. What followed was a week or so of emails going backwards and forwards. I got escalated up to Lord Keen and indeed eventually we got a letter from Boris Johnson confirming that our testing capacity would be retained but capped at 35 a day.

Advocate Harwood: So was there a period of time when actually you could not access the UK –?

Dr Brink: They never absolutely stopped testing, but what we were having is delay of what we call 'swab-to-test result', so we were waiting three or four days. So just to explain, the procedure is that we aim to have a swab-to-test result within 24 hours. In a positive case, we aim to start contact tracing within 1hour. So if a result came out at 10 at night, we would have a contact tracer with us to start contact tracing and we would get to the initial, what we called, the emergency actions; so making sure that everyone was out of the community and so on. And so that was really important.

Going back to your question about going into lockdown, at the time we went into lockdown we had 23 positive cases. So we ended up with 252 positives. So if anything, people said, 'Did you go in too early?', and there were three distinct decision-makings about going into lockdown.

The first was the identification of our first case of unexplained community seeding. So prior to that we had been able to track back to travel-associated.

The second was the worry about our availability of testing and our delay in swab-to-test result and whether we would be dependent on any further changes in UK testing.

The third was we were aware of intelligence coming in from the community – and this is very subtle intelligence, but things we do listen to – that there were fevers and coughs appearing in the community. At that time we could only test travel-associated cases. So what we wanted to do was to be able to control our own testing programme.

So we went into lockdown on the 25th, we commissioned our in-house machines on the 27th and we ran our first clinical samples on the 28th. And then after that, from 35, we were getting up to 170/180 a day, which is a lot for a small team. (***Deputy Soulsby:*** Yes.) So that was the narrative of that.

Deputy Soulsby: I think if you remember it was around about 17th or 18th March that the UK told us, 'No, to community testing', and then we had all the to and fro. Of course, the same was happening with Jersey and we were working on that. So we had a pincer movement, both of us, on Lord Keen to get tests. We were only asking for 35 tests a day at that moment in time, so it was not like it was major to the UK. But that is what we did and then, yes, a week later in to lockdown.

But I have to say, the team getting the path lab sorted out so we could do the testing and change everything – and the procurement, getting all that up and running – in such a short space of time was unbelievable, because that was a big worry, when we were going to get the testing equipment, because we knew that would be the game-changer for us.

The Chairman: Deputy Merrett.

Deputy Merrett: I just want to take us back a step if that is okay; thank you, Deputy Green.

So Dr Brink sees this coming down the track, CCA declares an emergency, or forms a CCA, if we had … I know it is the gift of hindsight – it is a very valuable commodity, by the way; if I bottle it I would be very rich. We did not have on the Island. We did not go to our version of Phase 6. The most risk point as Dr Brink has just said was the travel-associated cases. Was it a case of, well, we need to experience COVID, we need to see it to believe it in our community before we can actually move in to something …? Did we have to actually have it in our community?

Arguably the risk was travel association, if we had done some testing up at the Airport for people coming in when Dr Brink had seen it coming down the road, could we have avoided it coming to our community at all, avoiding the extraordinary cost, not just the fiscal cost but the mental and physical cost in our community?

Deputy Soulsby: No, the aim was never to stop the virus and I do not think you can ever stop it. You are only delaying it whatever you do. So our aim was never to stop it ever reaching Guernsey or the Bailiwick of Guernsey.

So we got our first positive case 9th March, we do not know whether there were other earlier positive cases. We are still hearing about people who said that they had something back in December or January, in February. So we do not know. People might have had something before then. But all we can say is the first positive case that we found was on 9th March.

So absolutely no desire to say, 'Right, we need it here so the public are all really scared of it'. We do not think we needed to do that; you only had to see what was happening throughout the whole of China and then particularly when it got to Italy and then when it started to go really mad in the UK. I do not think that there was any need to do that and I think that would have been absolutely the wrong attitude. It was just saying, well, you cannot ever hold it back. That is why even now we have said, despite the fact we have got no active cases that we are aware of, it has never been the aim to eliminate the virus. At some point we are going to have to live with it and so that is our next stage. It is why I am saying this is not the end of COVID, this is like a mid-COVID review.

The Chairman: Yes.

Deputy Merrett: But it is arguable, is it not, that the actions of the CCA and primarily the actions of our community, is that we have actually managed to, to all intents and purposes, stop it on the Island?

Deputy Soulsby: Absolutely. It has gone beyond our wildest expectations.

The Chairman: Okay. Can I ask a few questions about care homes/nursing homes? (***Deputy Soulsby:*** Yes.) As we understand it a large majority of the cases and indeed the unfortunate deaths were in care homes. First of all, why was that? Who is best to answer that? Dr Rabey?

Dr Rabey: Yes, sure.

The Chairman: Why was that?

Dr Rabey: Because as it turns out the virus was particularly vicious in the elderly population. This is all stuff that has become obvious now, but it was not obvious at the time, as we go into the crisis. We did not know it was going to affect the elderly in particular, and when it gets into a care home, it has proved really hard to eliminate, particularly in one of the two badly affected care homes.

So one of the things we look back on, because hindsight is a wonderful thing, is what would we do differently to prevent it getting into the care homes. We have had two care homes with residents affected out of all the care homes in Guernsey, so I am going to say that I think the record is good and I am proud of the record of our support that we have put into care homes. But –

The Chairman: Sorry, go on.

Dr Rabey: – you want to learn from it. (**The Chairman:** Yes.) And I think that when Dr Brink's team wrote to all the care homes very early in March asking them to get their business continuity plans in place for a coming pandemic, we trusted them as independent businesses to do that to the best of their ability. I think there would be a place now for going back to those care homes and

saying, 'We want to see your business continuity plan. We want to see that you have got your PPE in place, you have got staffing plans, you are not sharing staff between care homes, how you are going to lockdown your residents if you get a suspected case, what you will do if all these scenarios happen'. We trusted them; well, we did not have the powers anyway, and it turned out that most of them got it right, didn't they? But the two that got the problem –

Advocate Harwood: Do you still lack the powers to effectively sort of …?

The Chairman: Direct them.

Advocate Harwood: Yes.

Dr Rabey: We can do it collaboratively now anyway, to be honest. The care homes have worked really closely with us. But I think if we went and said, 'We want to see something', and they said no, we would probably have a bit of a battle. I do not think they would ever say no now.

Deputy Merrett: So Dr Rabey, you just said you think there is a case to check the business continuity plans. Are you saying their business continuity plans have not been checked at this juncture?

Dr Rabey: No, we have a care home cell that works ever so closely now, but at the time, before COVID had arrived, when they were being asked to prepare plans for a pandemic, we did not go then and check. Now we know exactly what they would do and they know exactly what they would do.

Deputy Merrett: Okay. So there was a lesson learnt there?

Dr Rabey: Yes.

Deputy Soulsby: Yes, we had no responsibility for them, at that point of view – they are not regulated. But as you will know, Health and Social Care Committee put a policy letter to States saying and recommending one of the early areas would be regulation of care homes.

The Chairman: So just to try and capture that, you wrote to the care homes in March, prior to lockdown, essentially saying, 'Make sure you've …'

Deputy Soulsby: 3rd March.

The Chairman: 3rd March: 'Make sure you have a plan in place to deal with this'. But at that stage you could not, from a statutory point of view, (***Deputy Soulsby:*** No.) adopt a more directional approach, is what you are saying.

Dr Rabey: We did phone every care home twice during that pre-period. So every care home was telephoned to check, 'Are you content with any issues; any live issues?' and we had no concerns from any of affected care homes with those phone calls.
So we did do some checking.

The Chairman: Right.

Advocate Harwood: Can I just follow up?

The Chairman: Peter.

Advocate Harwood: Having written to the care homes, and again with the benefit of hindsight, going forward would you have been in a position to advise the care homes not to allow any visitors, for example, and/or to check whether or not they had any agency staff or staff that were working in more than one care home, which I think has been a problem in the UK particularly? Would you have had that knowledge, would you have had that information available to you?

Dr Rabey: Not at the time, no. When it presented in the care home, it did not present in the typical way. The symptoms we were all looking were fever, cough, shortness of breath – did not present like that. It presented with some elderly patients having vague symptoms that actually Nicky has used – early on – to change our case definition. But people were getting a worsening of their dementia, there was some diarrhoea; there were some odd symptoms, *(Interjection)* but they were not the classical fever, shortness of breath, cough. (**The Chairman:** Right.) So even when we got the thing, it felt more like it was likely to be a norovirus outbreak or something. But even that should have been locked down because that is what you do with a virus outbreak whatever it is.

But yes, now of course you look back and you say, yes, should we have stopped visitors going into care homes? People were coming back from skiing trips in Austria bringing the virus with them, did they go into a care home and visit? I do not know, we may never know. It got there somehow, didn't it?

Advocate Harwood: But you did not have the powers to stop it, (***Deputy Soulsby:*** No.) which I think is a key point to note.

The Chairman: When those first positive cases were identified in the care homes, what kind of tangible steps/measures did HSC take in terms of practical and medical assistance to those care homes?

Deputy Soulsby: A lot.

Dr Rabey: Yes, a lot. The first thing was to establish that we had coronavirus in the care home, because it did not sound like we did. But staff were worried about a few patients, weren't they? This was exactly the time when the UK was telling us that they would only test hospital-based cases, they were not going to test community-based cases. Nicky probably needs to speak to this.

The Chairman: Dr Brink.

Dr Brink: So basically, we commissioned our new piece of equipment on 27th March to offer on-Island testing. On the 28th we heard that there were some people with atypical symptoms in the care home, and I will come back to the revised case definition in a moment.

On the 29th we started sampling through to 30th March and we also made what was then an unusual decision to actually sample everyone irrespective of symptoms and sample all of the staff members as well. Now, we did that because what became quite apparent to us on the weekend of the 28th and 29th was we were not seeing typical symptoms, and that concerned us. And so we felt it was impossible for us to be sure who was potentially coronavirus. So what we did is we initially tested a few with more typical symptoms, found that they were positive, but then looked and realised that they had been pre-run with it … Before they started coughing they had some quite atypical symptoms. So we ended up testing all of one residential home; all of the care home residents together with all of the care home staff.

What we then did on 8th April is we had a look at the first 100 cases, and it was absolutely clear to us that the Public Health definition of fever or cough or shortness of breath was too restrictive, and we felt that there were two things that were jumping out to us that needed to be included in the case definition. One was loss of sense of smell and taste, and with testing some of the care home staff who were younger we were seeing that as quite a prominent feature; and the second

was the atypical presentation of older people. Now of course that is all known at the moment; is all known at this point in time. But when we were doing it, it was not known.

So we changed our case definition on 8th April, which was weeks before Public Health England changed their case definition. But we felt that we could not respond on that data. So it goes back to: was this decision made by a single individual? No, because what we then did was we backtracked on what had been published.

Now, one of the problems when you are dealing with a pandemic situation is a lot of the literature is not peer reviewed, so you do not know what sort of scrutiny the data that has been published has gone through. But we went through the data that we could and it was very clear that loss of sense of smell and taste was a prominent feature. So that was the basis for the change of the case definition and then –

Dr Rabey: Yes.

The Chairman: Dr Rabey.

Dr Rabey: So you asked what we did for the care home. When we got the first positive on the 28th we immediately provided the affected care home with personal protective equipment, (**The Chairman:** Right.) because it turned out they had not got it; they did not have PPE in the place that they needed. We put in some nurses to support the care home that afternoon and that night, overnight, because they needed nursing support and then leadership and we did that same … By the 29th we were putting nursing support in, yes.

The Chairman: Was there a case for moving the positive patients to the Hospital?

Dr Rabey: Yes, it is a really important question. I am still absolutely content with the way we did this. We should have put into Hospital any patients who would have benefited from being in hospital, yes – and we did. But when a patient is not going to benefit from hospital care, so when they are on basically an end of life pathway because they are going to die, to move them to an unfamiliar surrounding and do that just for no benefit to the patient is not humane.

The Chairman: I can see that, yes.

Dr Rabey: So we took every case on its merits.

Deputy Soulsby: And some had DNRs on them as well: 'do not resuscitate'.

The Chairman: And just so I understand it, whose decision would I have been in terms of …?

Dr Rabey: We early on changed that way the primary care worked for the care home. This is I think something that we have … I am really pleased we did this. The primary care … every patient in a care home traditionally is under their own GP who they have seen all their life. So you might have 15 patients under 15 GPs in a care home. We put one GP in for each care home, so that that GP went and reviewed every patient with support from geriatricians backed by telephone if they needed. So every patient had a review by a single GP: what is their risk; how are we dealing with them? So yes, every patient was assessed by a single GP.

The Chairman: Right, okay. I think we had a question on this in terms of would those patients have been charged by the GP surgery?

Dr Rabey: We have not charged patients for any COVID-related work. This primary care was funded by the States of Guernsey.

The Chairman: Right.
Deputy Merrett.

Deputy Merrett: Dr Rabey, I am going to ask you a very difficult question, I think, because you said about care homes that that particular person's was end of life pathway. (***Dr Rabey:*** Yes.) But is it arguable that by keeping that person who, in your own words, was going to die anyway, put the other members of that care home at a higher risk?

Dr Rabey: Well, I am going to say it should not, no, because if you use PPE properly in a hospital or in a care home it will have the same protective effect. Now, I accept that cases continued to pop up in one of the care homes over a longer period of time than it should and I think that indicates that personal protective equipment was not being used as effectively as it can be, but also that the level of contagion in the home was very high. We sent trained nurses from our COVID ward who knew how to use PPE and successfully had used PPE in our Covid ward and two of our nurses we sent there got the virus as well.

So it should not have made any difference to the risk to staff, (**Deputy Merrett:** Okay.) but as it turned out it probably did in one of the care homes.

Deputy Merrett: But Dr Rabey, you said earlier that in part of the planning and support for care homes they were not visited, they were called for the business continuity. (***Dr Rabey:*** Yes.) However, you then just said that one of these care homes did not even have PPE. Would that not have been a key question to the care homes when you rang them – not your good self – but whoever rang them as part of their planning for this pandemic. I am a little bit shocked, actually, that those phone calls were made and yet when it happened they did not have PPE. I mean that would to me, and I am not a doctor, but that would be quite a pertinent question.

Dr Rabey: Yes, it was really hard to get PPE at the time. There were days in this crisis when we were down to a few days' supply of certain items of PPE. But yes, we would have wished, wouldn't we, that every care home had obtained lots of PPE. You look back and these things are … everyone has learnt, the care homes have learnt and we have learnt. But yes, that is how it turned out.

Advocate Harwood: Going forward, are the care homes required now to maintain stocks of PPE?

Dr Rabey: We procure the PPE now for the Island.

Advocate Harwood: Oh, you are procuring it for them?

Dr Rabey: So we have got six months' supply of PPE for the highest level of use that we can envisage for the whole Island, and we will provide that to the care homes and buildings.

Deputy Soulsby: I think that it is really important to add to this, through this our whole procurement team created a whole distribution service for PPE, and done through a push system, rather than a pull, so people got what they needed. I think it was about 130 locations that were all managed out of the PH, boxed up and sent off through a distribution system to make sure everybody got what they needed throughout that. They did an absolutely fantastic job.

Advocate Harwood: Could I just do a follow-up question for Dr Rabey? We looked at the position of possibly moving patients who were in a care home into the Hospital. The reverse, which has been a situation in the UK, was there ever any active policy to put patients back from the Hospital back into care homes?

Dr Rabey: We did not need to do that and we never put anybody from the Hospital during this period into any of the care homes that were affected. We did discharge into a care home when a patient needed discharging – we tried to. It was actually very difficult to get a patient into a care home at this time because the care homes were scared of COVID coming from the Hospital. So we tested patients that we sent out. We got that right well ahead of schedule, because the UK did not start testing until the middle of April.

Advocate Harwood: So nobody went into a care home without being tested?

Dr Rabey: No, we did not discharge a COVID patient into a care home.

The Chairman: Can I just try and distil something? There are two things. You have been very clear I think in saying that there was potentially a lack of PPE in some of the care homes. But you also mentioned I think, just a moment ago, that there had been a lack of skill in actually using it before you had to step in. Could you just elaborate on that, in terms of …?

Dr Rabey: Well, I am going to say, to be fair, none of us have lived through anything like this, including the healthcare workers. People had to learn how to use PPE properly: how to put it on, take it off, dispose of it, when to wear it; this was a really steep learning curve for everybody involved. And I have a lot of sympathy for care home staff, actually. Nobody expected them to be in the frontline and it turned out they were faced with this *horrible* disease just rampaging through the home. Hats off: raw, physical courage to go in there and put on your mask, your gloves and your apron and do your work. (**The Chairman:** Absolutely.) And yes, they got some of that wrong, but they have been –

Deputy Soulsby: Yes, there were a lot of very nervous, very frightened people in there working on the frontline.

The Chairman: Okay. Just PPE more broadly, did the Island ever have a problem with the supply of PPE at any stage?

Deputy Soulsby: Yes, we got *very* low. We were hoping we could rely on the NHS supply chain, but they were very difficult to deal with. At one point they were sending **–** eventually they got their act together in terms of distribution **–** and I think we were getting about 5,000 masks a week, but we needed 4,000 a day at one point. So we were getting nowhere at one particular moment in time. But the procurement team absolutely just shot into action, found different supply lines … because the whole public was saying, 'We know you can get it from here, there and everywhere'.

The Chairman: I can imagine!

Deputy Soulsby: You got other people who said they can supply it. So they have sifted out absolutely everything – nothing was ignored from anybody that approached them. But they did work out very early on they could not rely on the NHS supply chain.

We got a connection, one the best ones was a connection through a Guernsey business who then had direct links into a Chinese supplier and that *really* made a difference; and a few other local suppliers helping as well. That really was an example of the community wanting to come together and support us. But the procurement team, it became a really slick action.

Yes, PPE has been in short supply all over the place. There have been bad practices all over the world and in some instance you would have PPE that you would think would be on its way to you but then that might be taken off because somebody else was willing to pay more for their PPE to be shipped off somewhere. So all manner of dubious practices going on – profiteering – and the procurement guys had to weed their way through all that and keep us, so we never ran out.

The Chairman: How low did we go, though, as it were? *(Laughter)*

Dr Rabey: We had five days' supply of surgical masks at one point. But we knew that we had the higher quality FFP3 masks – we had quite a lot of FFP3 masks – we would have had to use. We were planning to re-sterilise masks … this was a global shortage of PPE. It was a cowboy market. We were planning to re-sterilise them, write people's names on them, put them under ultraviolet lights and give them back to people after 24 hours … We were planning for, really, stuff that you would not want to do. (**The Chairman:** Yes.) But five days' was the worst it got with the surgical masks.

Advocate Harwood: Can I just ask –

Deputy Soulsby: And the prices went –

Deputy Merrett: This is my question.

The Chairman: Deputy Merrett and then Advocate Harwood.

Deputy Merrett: Because you said 4,000 a day and Dr Rabey said that care homes will be basically supplied and billed, (***Dr Rabey:*** Yes.) I think were the words you may have used. So do we therefore expect to see a rise in some of the fees in our care homes? How much – I have no idea, and that is why I ask the question – does PPE cost? Now, cost should never be a barrier, but of course we mentioned care homes and businesses. The two do not really mix that well on occasions and this may be one such occasion.

Dr Rabey: I think the whole of health care is going to be running with higher levels of PPE for the foreseeable future now because we have learnt from this, and that is going to involve extra cost. Now, the cost went crazy one point. Do not trust me on the prices, but I think a surgical mask was like 95p or something, and –

Deputy Soulsby: Yes, we had some that got up to –

Dr Rabey: No, you have got it there!

Deputy Soulsby: Right, they are normally 4p for a surgical mask. At one point they have got to £1.30.

Dr Rabey: There you go.

Deputy Soulsby: And that is pure …

The Chairman: Supply and demand.

Deputy Soulsby: But we could not have it and that was the case and everybody was like that. (**The Chairman:** Yes.) But the procurement team, they have been absolute stars in this. It is generally not the sexiest thing to do and you think, 'Oh it's …', but really, if it was not for them, we would not have been able to do half of the stuff that we have done.

The Chairman: Advocate Harwood.

Advocate Harwood: Can I just ask two questions on PPE? And this really, I suppose, is to Dr Brink initially. Given the preplanning back in November and when you did your exercise, the nature of the

PPE that was going to be required for a COVID pandemic, does that differ fundamentally from the normal PPE that you would have for a flu pandemic?

Dr Brink: No, is the answer. We looked at some stockpiles of PPE at that stage; we recognised the need to stockpile PPE. We were writing up the learning lessons during December and in January we had a pandemic. So I think going forward, looking at our resilience is going to be really important in a number of ways. What we have shown is that we can do an on-Island diagnostic molecular capacity. So from our point of view, we have got in-house testing for a novel agent. We have done it once, we should be able to do it again very quickly and we have got the appropriate equipment in place. But also looking at what other lessons we can learn and I think, as Dr Rabey said, enhanced use of PPE, not only during a pandemic but for the foreseeable future, is going to be something that we need to plan for.

Advocate Harwood: Linked with that, I suppose, is the concern that, how long can you hold a PPE before it gets time expired? Is there a time expiry issue?

Dr Brink: So it varies. Left over from swine flu we had quite a few of the high quality masks which initially did not have an expiry date on, but then the manufacturers put an expiry date on them. (**Advocate Harwood:** Right.) So again, it is usually, what, about six months or so? (**Dr Rabey:** Yes.

Advocate Harwood: So the difficulty is holding these large stocks and then you find that they are time expired by the time you actually need them.

Deputy Soulsby: But we are looking at building stocks up for a potential second wave around October/November and for vaccinations as well.

Dr Brink: Yes, if we are immunising in a second wave, the vaccine is going to be a replication-incompetent vaccine. So we do not think we will need PPE to actually administer the vaccine, if that is the vaccine we go for. But, if we are in a second wave and delivering, we would not want to delay the administration of a vaccine programme, even if we were in a second wave, which means that we will need another whole raft of PPE for our frontline healthcare workers because we are estimating that we will have to deliver at least 35,000 doses of vaccine.

Advocate Harwood: Obviously going forward there are concerns about China across a number of different political areas. Is the industry totally reliant upon China for production of PPE? You mentioned you had been able to source on Island, is that something you can build up a greater resilience?

Deputy Soulsby: We could do and I think the world has learnt about its reliance on China. I think that has been a lesson learnt for the whole world: where our dependencies were and just in time ordering. So yes, I think we will see that theme …

Advocate Harwood: Do you think we can get resilience on Island if we have a second wave or a resurgence?

Dr Brink: We will not make it, no.

Deputy Soulsby: We will not make it all, no.

Dr Rabey: We made some on Island; people were incredibly helpful 3D printing visors and stuff. But no, the big volume stuff we will buy in.

Advocate Harwood: We will have to buy in.

Dr Rabey: But we have got six months' of maximum use already stored …

The Chairman: Deputy Merrett.

Deputy Merrett: Thank you. We have tripped really nicely from care homes into PPE, but I do just want to take us back one step, because some of the questions that Advocate Harwood said regarding having the right powers and legislation for care homes. Now, we appeared as a Government, or the CCA of the Government, to not have any problems with telling other businesses what they can and cannot do. So is it not – and I put this question to Deputy Soulsby in her guise as a member of the CCA – that the CCA could have put powers into legislation if they did indeed need to have extra powers to enforce, for example, things in the care homes?

I am uncomfortable with standing behind, 'The Government didn't have powers', but arguably, as a member of the CCA, the CCA could have put in powers, couldn't they? Specifically for those businesses, just as they did specifically to, for example, bars and restaurants; they are a business.

Deputy Soulsby: But that is, for the benefit of hindsight, the CCA was not aware, and nor was it under its remit to be aware, of the situation in care homes. I think what you would look at, as Dr Rabey has referenced, whether regulation should be part of … We need to bring in regulation of the care homes instead and then rely on that regulation. I do not think by the CCA down the line saying, 'Right, now you need to have PPE', that would have made much of a difference at that particular moment in time.

Deputy Merrett: But could it now be part of the lessons learnt, and that if we have a second wave that the CCA obviously … Well, I might not say obviously, I am not on the CCA, but the CCA will take into regard that if they have not got the legislation in place at the moment to enforce things in the care homes that in fact that could be done under emergency regulation?

Deputy Soulsby: We could do, and I do not know if it would be CCA. It might be extra powers given to the Director of Public Health. (**Deputy Merrett:** Okay.) But all that is being looked at as part of the, effectively, modernisation of the health laws, because we were reliant on laws going back to the 19th century and Victorian stuff – *Santé Publique*. Some of Dr Brink's powers go back that far. So we have that as work in progress. It is something that I would like to see prioritised as part of legislation changes.

Deputy Merrett: But in the interim the CCA could in fact enforce those regulations, couldn't they, for the care homes if they needed to?

Deputy Soulsby: They could do and should this happen again it might be something that we want to do, but I suspect everybody has learnt on this, not least the care homes in this regard about how prepared they need to be. You do not want to have to create laws unless you really need to and I think if we can work together without needing legislation and particularly given what we have gone through I would hope that would be sufficient.

The Chairman: Advocate Harwood and then I think we need to move on.

Advocate Harwood: Deputy Merrett very neatly segued into the CCA. *(Laughter)* Can I ask, really for Deputy Soulsby: in your opinion, with the benefit of hindsight, did the CCA swing into action early enough? In other words, was the emergency declared early enough?

Deputy Soulsby: It does not need an emergency to be declared for things to be done and certainly I cannot … I am here as a Member of the Committee *for* Health and Social Care, (**The Chairman and Advocate Harwood:** Yes.) rather than a member of the CCA, so I have not got all the dates from the CCA. But the CCA were updated in February about what the situation was and they had meetings. Then it was decided whether their powers, by virtue of what was happening around, should be brought in. I really do not think we could have done anything any faster – I really do not – because Dr Brink made it clear what her concerns were and as soon as that happened and when an action needed to be made, then that was done absolutely at a political level. I think we swung into action as fast as we possibly could in terms of what there was that we could do. It all very well saying, 'Oh look, it's an emergency', but if there is nothing that … Does that make any difference from the actions you will take?

Advocate Harwood: I recall that when the new CCA legislation was introduced, which I think was 2012-13, that one of concerns previously was that the old emergency powers legislation require there to be an emergency before you could … It was always going to be reactive. The idea of the CCA was that it could be proactive before the emergency.

Deputy Soulsby: Yes, and we were.

Advocate Harwood: That worked, did it, as far as you are concerned?

Deputy Soulsby: Yes, absolutely, because we met and considered the situation and I think we understood when our powers had been …

Advocate Harwood: Triggered?

Deputy Soulsby: Triggered – that is right. (**Advocate Harwood:** Yes.) But then it was another week before we said, right, we needed to give emergency powers to Dr Brink in terms of making sure that we could have controls over and enforcing 14-day isolation.

Advocate Harwood: And – (**The Chairman:** Sorry.) sorry, just a follow on. Given that the CCA – and sorry, I am firing these questions at you as a member of the CCA, but – obviously had excellent advice from Dr Brink and her colleagues, are you satisfied that you had, as the CCA, equivalent advice and level of advice from other sectors, including the economic, the financial, fiscal?

Deputy Soulsby: Yes. As I say, I am here as the Committee *for* Health and Social Care and I think if you want to have something on the CCA you might want to have my other three political colleagues here. But yes, certainly we had update from the States' Treasurer throughout this and other … But when it comes to the economy, absolutely, the States' Treasurer was asked to present the impact analysis, particularly as we were going in and out of lockdown what the implications of that would be, and also, when we were coming out of lockdown earlier, just how much we had improved the economic situation by doing so.

The Chairman: Just before we have a break, can we ask a few questions about testing in terms of our current policy on testing? What exactly are our criteria at the moment, currently employed, for testing in the current circumstances of the Island being COVID-free, Dr Brink?

Dr Brink: Okay. So first of all, we have a low threshold of testing everyone who is symptomatic. We absolutely acknowledge that we have a very low threshold because there are various variations of symptoms and some of them are very mild. So for example, in the last 24 hours we have tested four symptomatic people on the Island. None of the recent symptomatics, as you know, have come up positive.

We then launched the Bailiwick extended testing programme. Now, this strategy was to sit behind our exit strategy which was a test, trace and quarantine, our adaptive triggers; so to sit behind that with the phased release. The Bailiwick extended testing strategy then focused on cycling through our frontline health and care staff to see if there was any evidence of infection in those groups. We went through – and this is direct viral detection, so this is looking for active, ongoing virus – emergency staff, St John's Ambulance, day care, people that work in Brock Ward, care home staff, primary care; so a large group of individuals. We tested, gosh, it was just under 1,000 people in that group and found no positives. So that is that group.

So we have stopped just going repeatedly through frontline staff because we know that all our evidence is that we have got no COVID activity. We have then moved on to focus on other groups of individuals. Now, as Dr Rabey alluded to earlier, the group that there is some concern about is preoperative patients. We have no evidence of COVID activity at the moment on the Island. However, we do know that if we operate on someone and they get COVID in the perioperative period it can impact quite profoundly on their recovery. At the moment we are still testing preoperative patients.

We are also testing women who come into our labour ward. The reason being is that in the extremely unlikely event of a category 1 caesarean section – that is a caesarean section that has got to be done really fast – we do not want there to be any delays. For example, putting on extra PPE and so on. It means that that process can occur seamlessly.

We have got our staff that we have cycled through, we have got our preoperative patients, we have got our labouring women. The preoperative patients we are focusing mainly on what we call the aerosol-generating procedures now. Those are the ones that we are doing, we are focusing our efforts on.

Then we also looked at whether we can use testing in a border pilot, which we are doing at the moment. You may ask why we have selected day seven for our testing. There are two scenarios that we may be faced with in our border situation.

The first is someone who is infected during transit to our Islands. If someone is infected during, either on the train down to Southampton, at Southampton Airport, if you sample that person on the day of arrival, 100% of people will be negative. The reason being is the incubation period for the virus is two to 14 days with a median of 5.2 days. So that is really important.

There is a second group of individuals who are infected in wherever they live, work or whatever, so they are infected at the time of transit into our Island. So they are not infected during the transit process, they are infected prior to transit and those people will be positive on admission to the Island, on arrival in the Island.

So with the pilot, we then modelled the likelihood of becoming infected over the 14-day period. So the incubation period is two to 14 days, when are we likely to detect most of those positive individuals? And with our modelling we used various data sources – and in fact sent it to the Isle of Man to peer review it – we found that 81% of people would be detectable, if they were infected during transit, on day seven. (**The Chairman:** Right.) That is why we have selected day seven for the pilot.

Now, what we also do, because we have people in self-isolation, anyone who was infected before, they might have resolved their infection already if it was a long time before or they might still be positive. So we would be able to detect 81% of people infected during transit and anyone infected before transit who still had detectable virus. That left us with 19% of people, so what we said from the pilot is you can go on to passive surveillance from the time of a negative result until day 14; passive surveillance being low threshold, to report any symptoms, avoid large crowds. So do not go to restaurants, do not go to crowded areas, but you can get out and about and do most of your daily business. You can go back to work as long as you do not have a front-facing job. So it is a kind of common-sense approach.

So 19% of cases could then occur between day eight and day 14. Now, of those 19% of cases, we know that 60% – if I am giving too much detail just – *(Laughter)*

Deputy Soulsby: We are used to this!

Advocate Harwood: Sixty per cent of 19, okay.

The Chairman: Yes.

Dr Brink: So 60% will be symptomatic and 40% will be asymptomatic. We know that people that are asymptomatic are less likely to transmit. Not impossible, but they are less likely to transmit. So that gave us one out of 10 that was potentially symptomatic that could miss our day seven screening, and if we put passive surveillance, low threshold, to report for testing and so on. So that was the safety net that we put behind day eight and day 14.

So we need to run that pilot, we need to assess the results of it. We need to look at how it can be upscaled. So the type of things that we are looking at is if we wanted to upscale significantly to do large numbers. For example, we can pool samples. So that means that instead of putting one sample into a well, you can put four samples in. So you can quadruple the number of samples you can process.

Now, we were doing some modelling on that and in fact we have got a meeting this afternoon where we are going to do some further modelling with the Isle of Man where we are looking at any potential loss of sensitivity. We think, from our initial modelling, that it will be reasonable to do it. So we are looking at all of that. So as we move forward is how we can then put in some sort of, if we required, testing policy.

The Chairman: Deputy Merrett.

Deputy Merrett: Yes, so it looks like you are doing testing to get a balance of risk, if I could put it as broadly as that. (***Dr Brink:*** Yes.) I am led to believe that there has already been a decision made, regardless of the results of a seven-day trial, that that could not come into effect until the beginning of September. I was wondering the reasons why, because arguably all test results would be by the day 14.

Dr Brink: Well, we need to analyse those. So logistically we have got to learn the lessons from the pilot. We need to look at how we can upscale it. So at the moment we are putting about 150-odd people. So if you are going to put 400 people, if we are going to then do either a seven-day isolation or indeed no isolation, we need to look at what strategies we can put into place with regard to that. I think it is a reasonable question but we need to work out what we are going to do and do it securely. We need to look at how all the IT links. So for example, and I am just going to give you a practical example, not everyone who comes into the Island is a Guernsey citizen. So we have got a get a way of capturing that data on to our pathology systems because they will not have a track healthcare number. So it is looking at those logistics and getting that together. We would rather have a sustainable solution to move forward.

What we do in late summer/early autumn will depend on a number of issues. So it might be it might move further than a seven-day testing, it might settle on a seven-day testing. If we are in a second wave, clearly we will be having a different conversation. But what we are looking at is also, for example, the prevalence of infection in the UK and we are using Office of National Statistics data for that. So we want to map out a more sustainable solution that we know we can deliver on large numbers.

So the seven-day testing has taught us a huge lot of valuable lessons but I think from our perspective, and I think not only from a Public Health perspective but from everyone involved, from the Guernsey Border Agency, to the Pathology Services, to the sampling team, is we need to learn the lesson from that and pull it together into a sustainable programme and look at how we can upscale it more. Because if we bring it in, we are not going to be able to cap it at 250 or 150 a day, we have got to be able to process up to 1,000 samples a day.

So another thing that we are looking at: at the moment sampling is dependent on nasopharyngeal swabs. So that is a pretty nasty thing – it is a sort of swabbed down the nose and throat. So we are looking at what we call buccal sampling, which is a self-taken sample on the inside of the cheek and modelling that. Now, they have used a lot of that in Australia, so we are seeing if we can use that because that will enable us to get large numbers through the ports a lot quicker.

Deputy Merrett: Okay.

Deputy Soulsby: So you can see it was a pilot working with Aurigny and Condor to manage their turnover times. So that all had to be put in place. But it was a pilot. As Nicky said: to bring it in it needs absolutely scaling up to a much bigger amount. At the same time – and Nicky is not saying it – we have got a team who have been working all hours, every day since February on all this and *they* need a bit of downtime in order that we can really focus on September and move to Phase 6.

I think we could do the pilot now but we will not be all there in terms of capacity. We need to plan that out. And also we want to get it right and get it right for Phase 6 and not just something in the interim.

The Chairman: Okay. I am conscious we have still got a few questions about testing, but I think we might just take a five-minute break and we will come back in five minutes.

Thank you very much.

The Committee adjourned at 10.39 a.m.
and resumed at 10.45 a.m.

Public hearing continued

The Chairman: So I think you have got some questions in relation to mental health, and Dr Bishop is here.

Deputy Merrett: Thank you, Dr Bishop.

We have seen uplift in individuals accessing, or trying to access I should say, primary mental health care from the Rule 14 questions I hope you had sight of.

Deputy Soulsby: No they have not, they have gone down.

Deputy Merrett: Okay. What do you consider are the relevant factors that may help us as a community understand the uplift? There were 266 accessing it between the same time period last year, being January to May, and this year it is 618. So what do you think the relevant factors are for that uplift?

Dr Bishop: I think what you have to bear in mind is that initially when the lockdown came in there was a significant decrease in the numbers of people accessing all parts of Mental Health Services – that is both primary and secondary care services – and that is for a few reasons. That is partly because people were not going out, they were not seeing people, they were not seeing their GP, and they do not really want to attend appointments.

But it is important to acknowledge that during that time, in those initial phases, although we had a decrease in numbers of referrals across all parts of the service, we were open, we were working with people. We continued to work with all people that were open to our service and we were using safer means. We were using video teleconferencing, telephones; we were going into some people's houses on a daily basis wearing PPE. We were continuing to work.

As lockdown eased and as people felt more comfortable in meeting and having appointments, there has been an increase and we are busy, and probably busier now than we have been in quite a long period of time. Certainly our inpatient ward is the busiest it has been since it opened in December 2015, which is lucky for me because I have just taken over responsibility for it.

So we are busy, certainly, but things have not … I am not sure where exactly you got those figures because that is not my understanding of the situation. (***Deputy Soulsby:*** No.) We are back to slightly above the referral level that we were this time last year, but it has not overwhelmed any part of the service.

Deputy Soulsby: If you see on our Rule 14 response it said:

> Between 1st January and 31st May 2019, 618 individuals accessed Healthy Minds …

– which was called primary mental care, Mental Health & Wellbeing Service –

> … compared to 352 individuals during the same period this year.

So it has gone down.

Dr Bishop: So there was an initial decrease but it is now going back to the same levels, possibly slightly higher because there is a bulge of people that are accessing that.

Deputy Merrett: Yes, okay. So is it your expectation that that will continue to rise? And really the question I was asking originally is what do you think the relevant factors are to the impact that this has had on our community's mental health?

Dr Bishop: I think it is difficult to know exactly what is going to happen moving forward, and I think it goes back to what Deputy Soulsby was saying initially: although this is a scrutiny of the process, we are only halfway through. People coped very well in the initial stages of lockdown, from my experience and from the experience of the cell that I was in – the Psychological Health cell. But as that time got longer and longer, people definitely started to struggle.

What we saw particularly was really the indirect effects of COVID. So had we seen a lot of people that were frightened of getting the virus, but I do not think we have seen a single one, to be honest – not clinically, but personally I have. But what you see is all indirect effects: the strain on people's relationships, the strain on childcare, being furloughed, working from home, not working at all, worrying about your finances; all those sorts of things. The fact that people, I think lots of people, have not been using the healthiest coping mechanisms during this period of time. They have been drinking more, and that has its own inherent negative impacts.

So we are seeing those effects. People were isolated, people were lonely. There is a lot of narrative at the moment in the press about the next mental health pandemic. We are not seeing that and I do not think it is helpful to have that narrative out there because the more it is suggested the more it will become a self-fulfilling prophecy, I am afraid. I have seen that before. So we need to be quite careful.

The majority of the population has moved through this, have supported each other and have actually done really well. This has been difficult for everyone. I know we talk about what we have done and what the population has done. Well, actually, everyone here is part of the population. We have all been through this together. We have all managed it probably in slightly different ways, but we have not seen an overwhelming burden.

Deputy Merrett: So your argument was the suggestion may actually cause it in some way. Rather, is it not that maybe our community is able to recognise more symptoms of where they are not coping from a mental perspective and we are having a more, hopefully, holistic approach to

health, where actually our mental health is as important as our physical health? Is it maybe perhaps it is not …?

Dr Bishop: Absolutely, but mental health does not equate to mental illness, just like if you are not quite as physically healthy as you used to be it does not mean you need to have an inpatient admission … That is not the way it works. Actually, the way you create a resilient and a healthy population, both from a physical health point of view and mental health point of view, is people coping with stress. This has been an extraordinary period of stress, but, actually, stress and distress are normal and they are healthy adaptive responses to situations and hopefully the population will be more resilient after they come through this and they have supported each other and they have learnt how to cope with difficult situations, than they were before this.

Deputy Merrett: I agree that stress is a natural process of life, but obviously we are in unusual times and our community has gone through something that we were not … Well, we were to a degree prepared for, but the expectation of being locked down.

My next question to you is this: that I was, as a Deputy, getting many members of our community contacting me with regard to their distress caused by – there was some fear factor, clearly, but also – the impact it was having on their families and friends. I did actually contact the CCA. But I did note that you came on to the panel, but do you think – the media panel, I am discussing – you came on early enough and that the messaging of how to cope in lockdown, for example, excessive drinking, how to cope with that was actually messaged out early enough? By the time you came on the panel I was very pleased to see you. I tuned in, I was like, 'Oh thank goodness there's somebody there from Mental Health'.

But do you think the messaging and your invitation on to that media briefing and the understanding was early enough with hindsight, or do you think our community could have had some coping mechanisms suggested to them earlier in the process?

Dr Bishop: I think in retrospect it could have been slightly earlier. In all honesty, my inclusion on to that panel was slightly accidental because Dr Rabey had another commitment so I was then voted on to it on that basis.

Deputy Merrett: Oh dear. *(Laughter)*

Deputy Soulsby: But I think –

The Chairman: Deputy Soulsby … Sorry.

Dr Bishop: But that was not to say that we were not thought about, that we were not consulted. From the beginning of this process we formed a mental health and disability cell, we formed a psychological health cell that had stakeholders from all parts across the community involved in it, and that fed in higher up to the decisions that the Committee were making and the other cells were making.

So it was not that we were sidelined or ignored. We were perhaps not the public face, but I think we were doing things behind the scenes to be helpful.

Deputy Soulsby: No, and I was quite happy; I wanted Dr Bishop on there for that particular reason. But immediately as we went to lockdown, a lot of information was put together to support people and it was put on the coronavirus website. Various documents were put together and reviewed by Dr Bishop and his team. So how people can use coping mechanisms and all that was put on the website early days – I think exactly when lockdown happened – so people had something to fall back on. But we also I think within my speeches referenced the ability to … a direct referral to

primary care and just telling people the information that was available to them and to seek help when they needed it.

Deputy Merrett: Yes. I am sure we can appreciate that not every member of our community has access and takes great joy in going into gov.gg and we had –

Deputy Soulsby: No, and I was not all online either. Absolutely as part of this we were well aware that some people did not have access to IT, although I think it is about 97% of people, of the Island, might well do so. But I think virtually everything we did we made sure that there was paper copies and everything available to people.

Deputy Merrett: Okay. So my question is this: that all our Island homes received a doorstep leaflet which was quite useful – I think it was A5 and mine is very well used – and that was telling us what we can or could not or should not do. Would it have been, with hindsight, an idea to have done a similar doorstep drop of all these **–** 'Consider this ...' – all the things that you believe could have helped support people in the community in isolation from a mental health perspective? We have the two hours of get out and exercise, so we have the physical direction of, 'Come on, you can get out and exercise, you can do this', but would it not have, with hindsight, been an opportunity to actually have put something else in that to recognise the impact it could have?

Dr Bishop: I think possibly, with hindsight, yes, it could have been, is the answer to that. But I guess at the beginning of this no one knew which direction this was going to go in. (**Deputy Merrett:** Yes.) So although it is incredibly important to have that community messaging, actually we were emergency planning for a huge death rate, for services to be paralysed, for our doctors to be redeployed to all other areas of the service. I appreciate absolutely what Deputy Soulsby and Dr Rabey have said about us only having one hospital – we have only got one ward. So if we had had a case in that ward, the entirety of our inpatient service would have been absolutely paralysed. So we had to prioritise at the time what we saw the urgent and emergency things were.

You are right: if we would have had hindsight and we had had more time then absolutely would have done this. But it was another example of really excellent teamwork. Never before has Occupational Health and primary care and secondary care psychology and Educational Psychology – and you had other third sectors – all got together on a weekly basis to think about the different parts of the community, the different needs: what is it for children; what is it for adults; what is it for carers; what is it for the elderly? We did *really* think about it, but I guess you are right: we did not start doing that until we were a month in. But because we were really thinking we did not know what was going to happen.

Deputy Soulsby: I think also it is not as if we were just relying on pieces of paper through people's doors. That is only part of what the comms team did. The comms team were absolutely fantastic throughout all this. The importance of the mail drops was people had the basic information that they needed based on the changes that were being made. You could have had an A4 brochure setting everything to do with COVID and all the things we do. People would not have read them. We needed something A5: 'This is what it means to me. This is what I need to do now'.

They also had helplines on there – I think it is important to point out – helplines where people could contact if they were distressed or anything that they needed. So you could not put any more than that if you are trying to tell people the key messages. Also, the community monitoring tool. That had about 5,000 people taking part in that and that gave us information about how people were feeling, as Dominic was mentioning about the stresses, the anxiety, about all manner of aspects that could then be understood and knowing how we could approach it.

So yes, it is very easy in hindsight to say we could say even more, but I think we need to remember people were being bombarded with information all over the place. We did highlight the

primary care facilities available – I think we did that within briefings – and then Dr Bishop came along. It was not long after lockdown, I am absolutely sure of that.

I think it was after two or three weeks, because we were contacting Dr Bishop and saying, 'How do we think things are? We asked primary care about this, what are you seeing? They're saying they're not seeing increase in people being concerned' – in fact quite the opposite. I think in the first two weeks people's stress levels went down. They were enjoying the two weeks where the sun was shining, people could go out for a walk, we were seeing people everywhere enjoying that. And it is not just physical health that it helps, going out and having exercise, it absolutely is good for your mental health. But it was after that, and I think it was about a week later, where it felt that people were starting to get concerned and then think about their jobs and then how long this would be and seeing we were still having COVID cases going up.

So there was all that stress and that is when I think we … So I know what Dr Bishop was saying, but I thought it was actually a reason because I had certainly mentioned it in our daily briefings that I wanted Dr Bishop on the panel.

The Chairman: I have got a couple of points here. Firstly, Dr Bishop, where are we with the current Mental Health waiting lists in terms of where we are today on that? Are you able to give figures on that?

Dr Bishop: Mental Health waiting lists are a bit of a myth, really. We have not operated significant waiting lists for over two years and the only waiting lists we have ever had have been for psychological therapy. And actually, for there to be a small wait for psychological therapy is entirely appropriate, because one does not give emergency psychological therapy. It is not indicated, it is not appropriate.

What we have seen over the last six months is that for non-COVID-related reasons we have had a degree of staff churn within our psychological therapy department. We have lost a few of members of staff and the recruitment process, although it is going in, is being delayed by COVID. So we have got a new person starting at beginning of September. Only because of that reason there is now starting to be a waiting list for that particular part of the service and it is up to about two and a half to three months.

The Chairman: Right, I see. And what would it normally be?

Dr Bishop: We have not operated a waiting list for two years.

The Chairman: Right, I see.

Dr Bishop: But this is not specifically COVID-related, this is staff change.

The Chairman: This is non-COVID related, okay.

Dr Bishop: If you want to look at when I came here almost 10 years ago, 18 months to two years was the waiting list.

The Chairman: Yes. The second question is what exactly are the kind of preliminary conclusions to draw about the impact of lockdown on mental health? It must be a mixed picture. Deputy Soulsby just referred to the fact that certainly there were some advantages. Every individual patient is different, aren't they? Somebody with a particular sort of –

Dr Bishop: Well, every individual person is different, I would say. (**The Chairman:** Yes.) So yes, people have responded very differently. Some people have thrived during this time. Some people

that we have worried about the most have done absolutely brilliantly. So it has been a real mixed picture.

The Chairman: So from a policymaking point of view – possibly too early to say – what would your advice be to policymakers in Guernsey about this so far? On the evidence that you have seen, is it too early to say in terms of that or is it a work in progress?

Dr Bishop: We are getting busier now, is the real answer to that. I think there is a delay in people presenting and the next three to six months will be the amount of time that we need to make a really good and helpful conclusion, and have an opinion and recommendations that have any value. (**The Chairman:** Okay.)

Based on what we have seen so far, I accept what Deputy Merrett was saying: there are some things that we could have done earlier if we would have known how things were going to pan out. Apart from that, I do not think there have been any huge mistakes and I do not think there have been any huge problems to date.

The Chairman: Okay.

Deputy Soulsby: I think what it will show is the 'Revive and Thrive' recovery plan will be important, and that goes to making sure that we get the economy back on track and beyond, making sure people have got jobs and the health and care action plan will be really important.

Deputy Merrett: Dr Bishop, can I just ask, because I am very concerned about the waiting times. So people that are waiting for a period of time and they have a mental health concern, shall we say, what are they actually relying on? Are they relying on drugs? What are they actually relying on to give them the support they need while they are waiting to see a specialist?

Dr Bishop: So the people that you are talking about are the people with psychological issues, not acute mental illness and who are not actually at risk. (**Deputy Merrett:** Okay.) There will have been nobody sat on a waiting list who is in a state of desperation or distress or if there were any concerns regarding risk. If you are an urgent case, you are an emergency case, emergency we see in the same day and urgent cases we see in the same week. That has always been thus. We operate a 24/7 service. For people that are triaged as needing talking therapy and that can wait for that, there is a waiting list, but it is probably shorter here than anywhere in the country.

The Chairman: Okay. Right, I know we touched upon the backlog of non-urgent surgery before. I think the number quoted in the media was 1,400 people. Perhaps we could take that up, Dr Rabey, in terms of how can that be tackled? I think I saw a reference in the media saying it was going to take years to deal with that. Is that correct? Have you got a plan for dealing with that?

Dr Rabey: I think it will take a long time to get it down and the experience that leads me to that is tackling the big orthopaedic waits that we had this time last year. We had 640 cases on the waiting list in orthopaedics, it took us a year of extraordinary measures to get that down by 200. So if you extrapolate the same, we have added those 200 back on to the orthopaedic waiting list during this COVID period, by the way, so we are exactly back to where we were.

So we have got about an extra 500 operations waiting to be done compared to when we went into the COVID period over all the specialties, and it is going to be really hard to do that. We are doing the right things, but it is just very hard yards. The number of things that have to go right for an operation to get done are the hospital bed, the pre-assessment, they need COVID testing, the anaesthetist, the surgeon, the bed afterwards. All those things, physiotherapy and everything has to just be tickety-boo. Any one failure means that you lose an operation that day that you never make up because that operation opportunity has gone.

I think it is really hard to say exactly how long it is going to take, but have we put in two extra anaesthetists. The MSG started … This time last year we had nine anaesthetists, we have got 11 there now. So that is a huge increase in our capacity for anaesthetics. The Hospital Modernisation Programme will deliver the right number of operating theatres, but we do struggle for operating theatre capacity.

The Chairman: That is going to take a while though, isn't it?

Dr Rabey: Yes. We use them pretty hard. Our operating days are longer than UK hospitals. But we may have to use them harder and later into the evenings and more at weekends. With orthopaedic, we send quite a lot of stuff off Island. Not a lot, but a significant amount of work off Island to be done in UK hospitals. It just does not seem to be open to us because the UK is in a *desperate* position with waiting lists, and then the private hospitals are not open either because they have been taken over and made to do cancer care. So we are just going to have to … It is every week. It is looking every week at what we can get done this week is how we are going to have to do that.

Deputy Soulsby: But the fortunate, the good thing is because we managed to ease out of lockdown far faster than we expected it has limited the growth of the waiting times. So that is a good thing. As Dr Rabey said, the UK is in dire straits and will be for a very long time. But yes.

Also, as I say, the waiting times look bad also, because we have had outpatient appointments throughout this time, so we have been adding to that list without being able to deal with them.

Advocate Harwood: Is this not a question then, it is appropriate now, to actually reset your key performance indicators or your target waiting times to be honest with the public, actually?

Deputy Soulsby: Yes. I do not know if you want to talk about that, Peter, because we have been –

Dr Rabey: Yes, just to jump in there. Guernsey has very high expectations of healthcare, to be honest, and people are used to very short waiting times here; the eight-week target for your outpatient appointment, the eight-week target for your operation. In the UK it is longer than that and the UK is nowhere near achieving the 18-week wait that they have for surgery – absolutely nowhere near. Can you do it? I –

Advocate Harwood: Will you ever be able to achieve that original target?

Dr Rabey: It is very difficult in that –

Advocate Harwood: It sounds as though impossible from what you are saying!

Dr Rabey: It does not mean it … I am torn on this, because changing the waiting times only helps while they are going out, doesn't it? But you still eventually have to get into equilibrium and you have to do as many operations as you are putting on the list. That is the case if your waiting time is 18 weeks or eight weeks or whatever you have got. Eventually, you have to take as many off the list as you are putting on the list.

So it would help us for a short term. Some patients come to harm by waiting longer – it is just a fact. And where that is the case we should not move the target down. We should still have the right target that says, 'We want to operate on you within eight weeks' or whatever the right week that is.

It could be done in some specialties I think without seriously disadvantaging most patients; and remember we still continue to prioritise the urgent and the emergency surgery. So if you need operating within two weeks we have always, even during COVID, gotten it done within two weeks: the cancer work, the urgent stuff.

Advocate Harwood: Okay.

Deputy Merrett: Can I ask a question?

The Chairman: Just while I think of it, (**Deputy Merrett:** Okay.) obviously you cannot put a timeframe on how long this is going to take to catch up – understandable. What about the cost implications of this?

Dr Rabey: Well, potentially huge, because if you have got to pay overtime to staff it is a big cost, if you have got to pay the theatre teams to work the weekends. The theatre teams run pretty lean and if you are asking the same staff repeatedly to come in also on their time off and do extra operation stuff they run out of enthusiasm, and to be honest, they would rather their time. We found that even with the orthopaedic waits. Trying to get a few weekend lists was really hard because the staff just valued their time off. (**The Chairman:** Yes.)

So you could throw huge amounts of money at this. Sending stuff off-Island is expensive anyway, even when you can do it.

Deputy Soulsby: On the plus side, we are getting good responses to adverts for staff. So theatre nurses are like hen's teeth – we are hardly getting any responses to any adverts put out. I think the last advert that we put out was we had 46 – (***Dr Rabey:*** Forty seven.) 47 people applied for those jobs. So they are here; a lot has happened in Guernsey. We are COVID-free, working in an environment where you are not restricted and where you go out, (**The Chairman:** Yes.) you do not have to do this and you do not have to do that –

Advocate Harwood: So does that mean the MSG could also recruit additional resource in certain key areas if they needed?

Dr Rabey: Well, they could, but the thing we are not short of, to be honest, is surgical time. We have got the right number of surgeons. The surgeons are chomping at the bit to do more operating.

Advocate Harwood: Yes, it is the operating theatres.

Dr Rabey: It is the actual theatre capacity. That is where we –

The Chairman: Right, yes. Deputy Merrett.

Deputy Merrett: So my question is actually very closely linked to Deputy Green's. We are talking at the moment about additional cost, doing extra overtime. But we were also told earlier in this hearing that actually elective surgeries and certain surgeries were all cancelled. So I just wondered: have any savings been made? Were any of those surgeons furloughed or did they go on the minimum wage co-funding scheme, because if they were not able to work then the rest of our community were asked … (***Dr Rabey:*** Yes.) So were there no savings made or were they just paid as normal regardless of whether they could work or not?

Dr Rabey: We trained the surgeons who were going to be on the frontline. And not just the surgeons, by the way, everybody who was in that Hospital got trained to work in emergency intensive care and on the emergency ward. We had to train staff because we were envisaging opening a COVID intensive care that we had no staff for, that was going to need 24/7 cover with patients dying and being turned and needing procedures.

So the staff were all trained and we knew exactly who would have been working 12-hour shifts, seven days a week on the Intensive Care Unit. That was plan one. Plan two was to continue to do as much routine work as we possibly … Well, we had to do the priority work, so the urgent and

emergency surgery had to go ahead and did, and those staff were busy. Then we had as much routine work done as we could. So we ramped up the outpatient activity, telephone triage, a lot of it done remotely, but a lot of the staff that were not able to operate were running extra clinics to get the outpatient work done.

So we have not had a lot of people sat on their hands, actually, and certainly not medics. They have been busy, nurses have been busy. We just have redeployed people.

Deputy Merrett: So everyone was basically redeployed?

Advocate Harwood: Still needed?

Dr Rabey: Yes.

Deputy Merrett: All hands to the pump, redeployed.

Dr Rabey: But we have not penalised them financially for that either, no.

The Chairman: I think what we would like to discuss, really, is what the indirect effects on health outcomes have been of lockdown and the pandemic. So we have discussed the position in relation to non-urgent surgery, but as I understand it, certain screening services were paused during lockdown. (***Dr Rabey:*** Yes.) Is there any evidence to suggest that is going to come back and haunt us in the longer run?

Dr Rabey: Well, Nicky will speak to this as well. (**The Chairman:** Yes.) Really important question and we have been watching it ever so closely. The thing I will say is I have been looking at the cancer diagnoses we make every month. We normally make about 30 new cancer diagnoses a month and we have done every year.

The Chairman: Thirty? Three zero?

Dr Rabey: Three zero a month. During the first six months of this year we have made 32½ cancer diagnoses a month, which indicates that we may not be missing a lot. But you have mentioned the screening programmes. They have been paused. So the bowel cancer screening programme might have given us four cancers in that time that we might not have picked up, for example – that is a rough figure. (**The Chairman:** Yes.) Similarly with the breast cancer screening stuff; we will get these kicked off again. I know Nicky will –

Deputy Soulsby: But they are postponed.

Dr Rabey: They are postponed and not cancelled.

Deputy Soulsby: Yes.

The Chairman: Postponed and not cancelled, yes.

Dr Rabey: The other thing is Nicky has been tracking carefully excess mortality during this period and you might as well hear it from the horse's mouth. *(Laughter)*

I am so sorry …

The Chairman: Dr Brink.

Dr Brink: So excess mortality is really important. The two issues with regard to excess mortality are … One of the things we were concerned about was during COVID were people not coming forward to get management for their stroke, heart attack, chest pain and things like that. So we mapped the excess mortality through the peak of our COVID activity and what we saw is that there was a peak of excess mortality in, I think it was week 16, and that was related to COVID deaths. But if you then took that out and looked at what we call 'all cause' mortality – you took the COVID mortality out – if anything, the mortality was slightly lower or equal to the previous 10 years.

So what we do, because we deal with small figures, we are very careful to make sure that we are not subject to wobble from year to year, because you get two or three different and it can make a huge variation when you look at percentages, for example. So that has been fairly constant. What we are now doing is mapping out the next couple of months, the next eight weeks, and so we are busy doing that piece of work. We will continue doing that every couple of months to now look to see if there is any impact, for example, on cancer diagnoses and particularly the stage of cancer diagnoses.

Now, one of the things Dr Rabey did in the interim was just look at how many diagnoses we were making during that period of time, because if it had gone down to five and we normally diagnose 30, that would be a cause of concern. So what we are trying to do is backtrack and check our data as much as we can. But what we can say is that over the peak of our COVID activity there did not appear to be an excess mortality from cardiovascular complications and that was really important from our point of view.

We tried to message out, throughout our press interviews, that we are open for business. The one week we had slightly fewer children attending immunisations, we had the nurses then reporting in, so we immediately messaged out and immunisation appointments picked up again. So we tried to be really proactive with every single touchpoint we could see and the moment we saw a couple of people – and you could argue we were being too proactive, but – if we saw a slight decrease we then messaged out and the very next press conference I went out saying we need to immunise our children.

So we looked at every single touchpoint as we were going along. But yes, the screening programmes of cervical, breast and bowel need to and are being restarted. That is really important.

The Chairman: Do we know when?

Deputy Soulsby: Well, some have started.

The Chairman: Some have started already?

Dr Brink: Some of them have started, the cervical screening has started again –

Deputy Soulsby: Breast screening has started.

Dr Brink: – breast screening has started; (**The Chairman:** Okay.) so all of those have been restarted. Obviously that is really important because one of our other really big programmes that we are working on is the elimination of cervical cancer in the Bailiwick as a public health problem. So we want to make sure that we push those targets. You are absolutely right: we need to make sure that we do not lose sight of those targets and we push those forward as well.

The Chairman: Peter.

Advocate Harwood: Can I just ask a couple of questions? In terms of data – firstly to Deputy Soulsby – are you satisfied you have access to sufficient data and the data that you need as part of your CCA role to make your decisions? In the past I know the Island has always been

concerned we do not have access to enough data or there are data gaps, and I just wonder whether that has been a problem for you in practice over the last few months?

Deputy Soulsby: No, because I think Dr Brink has ensured that all the decisions we could make were evidence based and –

Advocate Harwood: And again, question for Dr Brink, really: you were satisfied you had access to all the data you needed, really, to take your decisions?

Dr Brink: Yes. I think we had access to the data we needed to take our decisions. I always want more, that is just in my nature, but I think to make all our key decisions … I think what became really apparent to us early on is that we had to scrutinise any national or international data ourselves. So, for example, we would have missed the first case on this Island if we had stuck to the Public Health England case definitions. We decided to rate the whole of Tenerife, not just the hotel of concern, as an area of concern for us and we did that by looking at the data and there were clusters of outbreaks – and I do not like clusters of outbreaks. When you look at that you say something is going on there.

So we were looking at a number of data sources. We were looking at the WHO, we were looking at the European data sources, we were part of the UK Crown Dependencies and Overseas Territories. So we had number of national data sources we could look at, and international, (**Advocate Harwood**: Yes.) and then the local data sources were dependent on our Health Intelligence Team and because we were collating that we were able to respond in quite an agile way.

Advocate Harwood: Okay. So data was not really an issue for either …?

Deputy Soulsby: I think we need to remember, thinking back to that time, there was lots and lots of new stuff coming in all the time. (**Advocate Harwood:** Yes.) We were working from a blank sheet of paper, we had nothing else to go on, but it was information coming in live. What was happening around the rest of the world, what we were feeling, what was going on here, how testing was going. I do not think we could have had any more … We were given the information we needed to be able to make evidence-based decisions. That goes for the CCA, in terms of whether it needed to extend regulations to HSC and to Dr Brink, and for HSC to be able to make its decisions in terms of going into lockdown as well as all the process of easing out of it.

Advocate Harwood: Good. Thank you.

Dr Brink: And we were using quantitative and qualitative data, and we used that. (***Deputy Soulsby:*** Yes.) So every morning, before we started our day, we used to analyse what had happened in the past 24 hours. So some of the directions, for example, opening of children's clothing shops, that was purely based on qualitative data that we were getting in from our community who were saying, 'It's May, the seasons are changing, our children need clothes'.

So we were trying to integrate what we were getting in from our community with that qualitative data, with quantitative, what we were measuring, but then backtracking on national and international data.

Deputy Soulsby: I think you also need to understand that although we are politicians – and take that as you will – we have not been living in (**Advocate Harwood:** *No.*) our own private bubble immune from what has been going on elsewhere. *(Laughter)* So we had lots and lots of questions for Dr Brink, and I think it was Deputy Tooley who referenced as well children's clothes shops being needed, (**Advocate Harwood:** Yes.) because we are all part of the same community and we are thinking of the same things.

The Chairman: Okay. Can we talk about what the key criteria will be from an HSC perspective on the decision to transition to Phase 6? What data in particular are we going to look at there, Deputy Soulsby?

Deputy Soulsby: Well, HSC is not actually responsible for Phase 6. That sits with the CCA and the powers of Dr Brink at the moment. So we did our job up to Phase 5. (**The Chairman:** Yes.) That does not mean to say that we are not going to be involved in terms of having the data –

The Chairman: That is what I mean, yes.

Deputy Soulsby: – and knowing what is going on. So it will require a close relationship through CCA and Dr Brink, making sure that we are aware. But the decision-making will sit with the CCA.

The Chairman: Yes. In terms of the data, though, that HSC will be particularly looking at before advising those who will make the decision, where –

Deputy Soulsby: It does not go through HSC; it will be Dr Brink directly.

Advocate Harwood: Could we ask the question of Dr Brink?

The Chairman: Can we ask the question of Dr Brink, as Director of Public Health?

Deputy Merrett: What is your risk appetite, Dr Brink?

Advocate Harwood: According to the movement to Phase 6, it says only likely to occur 'when there is a vaccine available' – well, there clearly is not at the moment:

> … or the public health risk assessment indicates that Covid-19 no longer poses a significant threat to the health and well-being of islanders.

I was very interested to know what information you are going to need to make that assessment?

The Chairman: Yes.

Dr Brink: So the epidemiological context that we are operating in now is that we are COVID-free and every one of our neighbouring jurisdictions has COVID activity. So it goes back to the second of those criteria: at what level are we happy with the transmission within a neighbouring jurisdiction with community activity to ascertain that it no longer poses a significant threat? So just to remind you that 16 Islanders lost their lives during this pandemic, 13 confirmed and three presumptive. None of those Islanders had travelled off Island. All of them had their infection brought to them. So we have to mindful of the situation that we are actually operating in.

So that goes back to what is a reliable data source? We have considered a number of data sources, and I will not go through all of them because it is a lot of detail, but the Office of National Statistics does a community-based prevalence survey and they publish results on that weekly. Those results are from random household samples. So they are not the hospital activity, they are not the outbreak activity, they are random household prevalence across England, and that gives us a prevalence of infection.

So what we are doing is we are looking at the prevalence of infection based on the ONS statistics. We are trying to define exactly what that cut-off should be. But you have also got to consider, what is the upper limit as well? Because you have got to remember that if you have a positive result, the positive predictive value – in other words, is this a true positive? – is dependent on the prevalence of infection in your population. So you have got to be really careful. You have got to select, 'Well, I

am happy with that as a risk', but you have got to also think at what level is the data so unreliable that you cannot actually rely on it?

Now, I do not think the ONS will publish at that level. I think they will stop publishing, because obviously they are statisticians, they will be aware of all of this. So what we want to do is we want to look at the ONS data and what we want to then try and put behind that is at certain levels should we do no testing at the border, should we be doing two time points of testing. If we were going to do two time points of testing, there would be quarantine free or very little quarantine. So going back to what I said earlier, it will be the infections that have occurred prior to travel and infections during travel. Should we be doing a day one, day seven test?

So what we are doing is we are modelling those scenarios which will be all ready … And against that, the question we want to ask is if we look at the ONS data, is data that we will get from a pilot, is the ONS data reflective of our travellers? So all the time I am trying to backtrack to ascertain how accurate our data is and now reliable the data is. So we will have data from the pilot as well to see if we get any positives in the pilot and that will then enable us to do a risk profile, so we can say, well, if the ONS data, for example, is one in 5,000 or less, can our community track and trace, then cope, with one in 5,000 cases potentially coming in positive? We know that 60% of those will be symptomatic.

So again, it is modelling all of those scenarios backwards, and this is the piece of work we are doing in great detail at the moment.

The Chairman: At the moment.

Dr Brink: That is why we want the results of the pilot studied, because what we want to be able to do is come back to CCA with a map saying: this is what we have assessed, we know that the upper end of the data is reliable, this is what we think is a reliable figure to backtrack on to our track and trace, we think we will be able to cope with that. (**The Chairman:** Right.) There needs to either be a risk appetite that infections will potentially come into the Island.

Advocate Harwood: Yes. You mentioned one in 5,000 and I think Jersey reacted when it was one in 2,000. Do you have any sense as to what level you think you would be comfortable in advising the Island can manage? We have to learn to live with the virus at some stage.

Dr Brink: Yes. I think looking into the late summer/early autumn, if at that stage it was sitting at around about one in 5,000 or less, potentially we would be able to cope with it through the track and trace. But I just need to be sure that it aligns with the pilot data, that if we then bring in any testing, testing strategies sit behind that, that we are happy with the implementation of that. So I agree with you: we need to move forward. But we need to move forward in a way that we can manage any risk to Islanders.

The Chairman: Okay.

Deputy Soulsby: Which is why we need to focus on that, instead of doing the continuation on the pilot or extending that. (**The Chairman:** Yes.) It is going to be really important to get that right. *(Interjection by Advocate Harwood)*

The Chairman: Dr Bishop.

Dr Bishop: Can I just say I think one of the reasons why the Island has coped very well with what has been a profoundly uncertain time, and a frightening time, is because they have had trust in the people sat on the panel, (**Deputy Soulsby**: Yes.) and because things have gone in the right direction.

I am from the UK, all my friends and family are in the UK, I desperately want to go back. But what we need to be really careful about is that we do not go back through the phases of lockdown. That

is the one thing that will have the most significant negative impact on the mental health and well-being of our community. I strongly believe will be able to cope with a few cases and we will be able to manage that with the track and trace, but if we are going back into stages of lockdown that would really concern me.

The Chairman: Yes.

Deputy Soulsby: And economically it would be …

Dr Brink: Which is why we want to model it carefully.

The Chairman: Deputy Merrett.

Deputy Merrett: I just want to ask Dr Heidi … Deputy Soulsby, sorry. Dr Soulsby!

So Advocate Harwood asserted that we have to learn to live with it. Arguably, other communities, for example, the UK, have now gone to a mask-in-every-shop scenario. Is it HSC's opinion that indeed we need to live with the virus or that we can remain in this bubble of, in theory, not living with the virus? What is HSC's opinion?

Deputy Soulsby: I would just say that our approach has never been to eliminate the virus. It is because the whole community has been so … (**Deputy Merrett:** Amazing.) amazing, that we have managed to do it. I think for us that kind of makes it difficult, because there is a risk appetite, we know we have to learn … We cannot ever keep it away from our shores forever – we just cannot. This will exist until it blows itself out at some point which we do not know.

So yes, this has always been a risk game and it is understanding the level of risk that we can manage. And, as I say, it was that if the Hospital had been overrun that would have had impacts, not only directly on the Hospital itself, but we would not be able to treat people properly, they would have got diseases and stuff we would not be able to treat, so you would have excess mortality. The economy would have been just as shattered because they would not have people working if we had had the huge numbers of people who were sick and then having to lock down individual places. It would have been *very* messy.

So that is why we have the approach we have, but the public from day one have just said, 'Right, we're listening and we'll do what you say'.

The Chairman: Just on that, Deputy Merrett raised the point about face masks and I happened to hear on the news this morning that the British government is going to –

Deputy Merrett: Make it mandatory.

The Chairman: – advise that they are mandatory for going into shops. No plans for that here?

Dr Brink: Shall I answer?

Deputy Soulsby: Well, I know what you are going to say! *(Laughter)* You can start then.

The Chairman: Dr Brink and then Deputy Soulsby.

Dr Brink: I think from our perspective every single deprivation of people's liberty, every single imposition we put on our population, we have sat in front of them and we have justified it. So when we said we are going to advise face masks on aeroplanes, it was because we have brought in non-essential travel and we knew that the planes would get fuller. So for that reason we did it and we explained to the population and they understood it. So if you are looking at a COVID-free situation,

or very few cases, we have got to make absolutely sure that any deprivation that we do, or any imposition we put on, is justified. (**The Chairman:** Proportional, yes.) So I would want to be proportionate, absolutely. I would want to be having a very close look that it was justified because I do not want to sit in front of people saying, 'Yeah, I think you should do it because the UK are doing it' – I really don't. I want to say, 'I think that this is the right thing to do for Guernsey and we've absolutely run it on what is right for our population'. I think that is the right thing to do for us.

The Chairman: Yes, okay.
Deputy Soulsby.

Deputy Soulsby: I would just say the number of times over the last few months, 'Dr Brink, they are having masks here. Everybody's talking about masks', getting emails and emails. I got, 'Oh we should have masks and you don't …'. No. Absolutely what Dr Brink has said: we have done what we thought would work for the Bailiwick of Guernsey. (**The Chairman:** Right, yes.) And yes, I think it has been confusing for people to see what has been going on elsewhere –

The Chairman: I agree with that, yes.

Deputy Soulsby: – particularly the UK; and I think within lockdown it was quite difficult because there were different things in different places. (**The Chairman:** Yes.) I think people in the UK are probably confused because it is different in Wales, Scotland and England. (**The Chairman:** And Jersey.) So early on, and this is why the press conferences were really important and we had them, firstly they were daily I think at one point, at the height of it, and then three days a week and then two days a week. So people could hear it from the horse's mouth, they could hear what the information was. We were telling people what they needed to know for Guernsey. I think if we had not had those conferences, in the vacuum of that people then get concerned and then they do not know what is going on. So the press conferences were really important so people could hear what they needed to hear directly.

Deputy Merrett: I just want to ask the question about face masks and Phase 6, because is it part of your consideration, for example, that when we get to Phase 6 that people arriving on the Island potentially may be asked to wear face masks as a precaution, or is that too far in the future for you? I do not want to have this scenario where we have an 'H' on a hire car. We do not want to be signposting: 'You've just arrived and you're more of a risk'. But is it something you have taken into consideration in regard to face masks?

Dr Brink: So at the moment what I am saying is people need to wear face masks on arrival until they reach their place of destination. (**Deputy Merrett:** Yes.) That is because they are obviously going into self-isolation. I would have a close look at the prevalence of infection and would do a risk assessment. So every single issue, when the schools were closed, every single step we put our decision making behind that. When we went into lockdown we had our three-pronged decision making. So we would look specifically at the situation, we would do a specific risk assessment and, again, I would sit in front of everyone and I would justify that decision. I think that is my duty.

The Chairman: Okay, I think we are probably going to be evicted by the Castel Constables in a minute, but yes.

Advocate Harwood: Sorry, just a quick couple of –

The Chairman: I will have a final question after you, Peter, and then we will wrap it up.

Advocate Harwood: Okay. In Phase 6 – very quickly, for Dr Brink – to what extent are you going to be urging a tracing app to be used? And secondly, you have bought an antibody test, or you have got the facility. Do you envisage actually enacting antibody testing as part of Phase 6?

Dr Brink: So we have already enacted antibody testing. So we have tested our frontline health and care staff, we have been going back to people who had clinical illnesses during the period of February, March, April who did not fulfil the initial – particularly February and March – Public Health England testing criteria because they did not have the appropriate travel history. So we have gone back, we have offered antibody testing to those groups of individuals. We absolutely –

Advocate Harwood: Have you published the results of those?

Dr Brink: We have not published the results of those, no.

Advocate Harwood: Will you be doing so?

Dr Brink: Yes.

Advocate Harwood: Yes, okay.

Dr Brink: We will when we have got sufficient numbers of those. (**Advocate Harwood:** Thank you.) But going back to antibody testing, we absolutely would not recommend immunity passports, in line with the World Health Organization and the European Centre for Disease Prevention and Control; that you do not know how long an antibody test tests positive. Indeed, you do not know whether it is measuring neutralising antibodies and so on. So the test we are using is a well-based assay which is a *very* well-established and well-evaluated assay.

Advocate Harwood: And tracing app?

Dr Brink: So a contact tracing app, no. We do not envisage using that. The contact tracing apps have been fraught with problems, as I am sure you know. We have shown that by good contact tracing, human-to-human contact tracing, we can do well. Part of the thing is establishing a rapport with the individual, the case, so that you get proper information. If you are using an app and you go into Waitrose and someone comes up positive, it could put everyone in the shop into isolation, whereas we will go back and we might put less than 5% of people into isolation because we will do a detailed analysis. We can do it very thoroughly and we have trained contact tracers and –

Advocate Harwood: So you are not reliant upon –?

Dr Brink: No.

Advocate Harwood: Thank you.

Dr Brink: We have proven that it works.
In the future, I think there might be a role for an app for people, for example, travelling to the UK. So travelling off Island when they are not in such a controlled situation with a good track and trace system.

Advocate Harwood: Thank you.

Deputy Soulsby: But that is why I was saying one thing that we benefit from having our effectively local teams. I think the issue in the UK is it was all so centralised, so they did not have

the local tracing so it has taken a long time to come in. But with us, our team were absolutely brilliant. We had volunteers; some of our own Committee volunteered to support the tracing as well and other Deputies.

So yes, it was really, again, all hands to the pump. People came in, got trained up and did it.

The Chairman: Okay.

Dr Brink: And started within an hour of a positive result, no matter what time of the day the positive result came out. So that was also very effective.

The Chairman: Can I just conclude by asking about what contingency plans we have for a second wave; and what the prospects of a second wave are at the moment?

Dr Brink: So we are planning for four scenarios. We are planning for a re-emergence of a single case, re-emergence of a cluster of cases, a single second wave and winter planning. So those are the four things that we need to be cognisant of. (**The Chairman:** Right.)

So we are keeping our track and trace team operational, so we are keeping ongoing training within that team. We are enhancing our diagnostic capacity further to make sure that we are able to cope with it. We have got supplies of, I am sure you have heard about the dexamethasone to use against inflammatory. So Dr Rabey has confirmed that we have got dexamethasone on Island. PPE stocks are in place for six months, I think Dr Rabey said. (***Deputy Soulsby:*** Yes.) So all of those things we are going through.

We are also simultaneously planning for a mass immunisation campaign. We are told that possibly before Christmas, maybe the first quarter of next year, Public Health England have put out the groups that need to be immunised and we think that is about 33,000 to 34,000 Islanders which we would have to deliver vaccine to in about a two- to three-week period. That is a massive logistical thing that we are planning as well.

So we are planning the main strategy which is seen as focusing on the borders, focusing on the vaccine campaign and making sure we are prepared for a second wave. So those are our three things that keep us awake at night.

The Chairman: Thank you very much.

Advocate Harwood: Thank you.

Deputy Merrett: Can I have one last question?

The Chairman: Yes, and then we will call it a day.

Deputy Merrett: I am trying to do it simply, just so you understand what I am trying to get at, but with capital allocation we do have things like post-implementation reports, and we have a very clear report given to the Assembly … well, not given to the Assembly unfortunately, but it is there. We can access it if we need it.

My expectation, and I am just looking for the assurance, is that there will be some sort of version of a post-implementing report because if we have this going forward we need to have these lessons learnt – this is very much about lessons learnt – so that if it happens again … Can I expect, please, to see some sort of version of a post-implementation report?

Dr Brink: Yes.

Deputy Soulsby: We made an early decision to, and this is something that the Chief Executive has set up, that as we went along issues that arose were logged. So that will have continued

throughout the whole process and we will be doing that clearly, and then Nicky will be adding to that from her own team, yes.

Dr Brink: Create a Public Health report on it, yes.

Deputy Soulsby: Oh yes, I am sure there will be lots and lots of reports coming out of this! *(Interjections)*

The Chairman: Right, thank very much for attending, much appreciated. As I say, there will be a *Hansard* transcript of these proceedings and in due course we will probably get around to hopefully publishing a relatively short summary document of lessons learnt.

Thank you very much for attending this morning.

Deputy Soulsby: Thank you.

The Committee adjourned 11:33