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SCIENTIFIC AND TECHNICAL ADVISORY CELL

(50th Meeting)

8th March 2021

(Meeting conducted via Microsoft Teams)

PART A (Non-Exempt)

All members were present, with the exception of Mr. P. Armstrong, MBE, Medical Director (Chair), R. Naylor, Chief Nurse, Dr. M. Patil, Associate Medical Director for Women and Children, A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department and S. Skelton, Director of Strategy and Innovation, Strategic Policy, Planning and Performance Department, from whom apologies had been received.

Dr. I. Muscat, MBE, Consultant in Communicable Disease Control (Acting Chair)
C. Folarin, Interim Director of Public Health Practice
Dr. G. Root, Independent Advisor - Epidemiology and Public Health
R. Sainsbury, Managing Director, Jersey General Hospital
Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention
Dr. S. Chapman, Associate Medical Director for Unscheduled Secondary Care
Dr. M. Garcia, Associate Medical Director for Mental Health
S. Petrie, Environmental Health Consultant
I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department (for items A1 to A6 only)
N. Vaughan, Chief Economic Advisor

In attendance -

J. Blazeby, Director General, Justice and Home Affairs Department
R. Corrigan, Acting Director General, Economy
S. Martin, Chief Executive Officer, Influence at Work (for items A1 to A6 only)
Dr. M. Doyle, Clinical Lead, Primary Care
M. Knight, Head of Public Health Policy
B. Sherrington, Head of Policy (Shielding Workstream), Strategic Policy, Planning and Performance Department (for items A1 to A6 only)
R. Johnson, Head of Policy, Strategic Policy, Planning and Performance Department
L. Perez, Head of Internal and Change Communications, Office of the Chief Executive
J. Lynch, Policy Principal, Strategic Policy, Planning and Performance Department (for items A1 to A6 only)
M. Clarke, Principal Officer, Public Health Intelligence, Strategic Policy, Planning and Performance Department
L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department
Dr. N. Kemp, Interim Senior Policy Officer, Strategic Policy, Planning and Performance Department

J. May, Senior Policy Officer, Strategic Policy, Planning and Performance Department
S. Gay, Senior Public Health Policy Officer, Strategic Policy, Planning and Performance Department
S. Harvey, Strategic Policy Officer, Strategic Policy, Planning and Performance Department
K.L. Slack, Secretariat Officer, States Greffe

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

Minutes.

A1. It was noted that the Minutes of the meeting of the Scientific and Technical Advisory Cell ('the Cell'), which had been held on 1st March 2021, had previously been circulated and Members were asked to provide any feedback thereon to the Secretariat Officer, States Greffe, by 10th March 2021, in the absence of which they would have been taken to have been confirmed.

The Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, requested that future Minutes of the Cell should include a list of action points. Subject to the agreement of the Chair of the Cell, Members endorsed this proposal.

Monitoring metrics.

A2. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of its meeting of 1st March 2021, received and noted a PowerPoint presentation, dated 8th March 2021, entitled 'STAC monitoring update', which had been prepared by the Principal Officer, Public Health Intelligence and the Public Health Analyst, Strategic Policy, Planning and Performance Department and initially heard from the former in relation thereto.

The Cell was reminded that, as agreed by Competent Authority Ministers on 3rd March 2021, no weekend reporting of cases was being undertaken at the current time due to the low case numbers. It was informed that, as at Friday 5th March 2021, there had been 7 active cases of COVID-19 in Jersey, who had been in direct contact with 56 people, who were self-isolating and that there had been a total of 3,220 positive cases of the virus in the Island since the start of the pandemic. Of the active cases, 4 had been identified through planned workforce screening, 2 as a result of arrivals screening and one through cohort screening. The majority (5) were asymptomatic and it remained the situation that most active cases were in people of working age and there was just one case in an Islander aged over 70 years. Since 13th February 2021, there had been an average of one case per day and the Cell was informed that positive cases were arising on a sporadic basis.

During the previous week, approximately 1,000 tests had been conducted on week days and with regard to the number of daily cases of COVID-19, the number of tests and the test positivity rates for various age groups, it was noted that the test positivity rate remained below one per cent for all, including those aged over 70 years, albeit the recent positive case in that cohort had resulted in an uptick. The Cell was provided with an overview of the positive cases of COVID-19 in the Island and in certain priority groups by the Chair of the Analytical Cell (the Interim Director, Public Health Practice, Strategic Policy, Planning and Performance Department) for the first week of March and was informed that there had been no clusters, or outbreaks during that period and that the number of active cases was low.

The Cell noted the Hospital occupancy rates and the daily admissions of people who had been positive for COVID-19 on admission - or in the 14 days prior - and those who had tested positive for the virus after entering the Hospital (based on the definitions used by the United Kingdom ('UK')) for the period from 1st November 2020 to 7th

March 2021 and was informed that there was currently one person in Hospital with COVID-19. As a consequence, the 7-day admission rate, per 100,000 population, remained very low and aligned with the 7-day case rate and there had been no further deaths since the last meeting of the Cell.

The Cell was provided with the PH Intelligence: COVID-19 Monitoring Metrics, which had been prepared by the Health Informatics Team of the Strategic Policy, Planning and Performance Department on 5th March 2021 and was informed that it was not possible to report on the number of calls to the Covid Helpline over the previous week, due to technical issues. The number of inbound travellers remained low, but some positive cases had been encountered at the borders and it was noted that the test positivity rate, for the week commencing 1st March, had been 0.54 per cent.

In respect of testing, the local weekly testing rate, per 100,000 population, as at 28th February had been 6,600, which was comparable with the UK, which had tested 6,381. The Cell was reminded that the UK included tests undertaken on Lateral Flow Devices ('LFDs') and it was noted that the Jersey figures included PCR tests and results from the DiaSorin diagnostics reagent kits but not, as yet, from LFDs. There had been 1,050 tests on inbound travellers, 5,760 as part of on-Island surveillance and 270 on people seeking healthcare. The weekly test positivity rate locally remained at 0.1 per cent and had decreased to 1.2 per cent in the UK. It was not possible to provide the estimated effective reproduction number (R_t) in Jersey because there were so few cases that the statistical model was unable to calculate the same. However, the R_t model would continue to be monitored internally and reporting would recommence should case numbers increase to a level sufficient to produce an estimate.

The Cell was informed that attendance at Government primary schools during the first week of March had averaged 97.5 per cent and 93 per cent in secondary schools and that, in all settings, absences related to COVID-19 had been approximately 0.1 per cent. Positive cases in students, since the start of 2021, remained low. The Cell noted the data in respect of the volume of LFD tests by school, result and date, including the number of positive, negative and inconclusive results and was informed that there had been 3 positive results from LFD tests, all of which had subsequently been shown to be 'false positives' when the relevant individuals had been tested using a PCR test. In excess of 7,000 LFD tests had been carried out, but it remained the case that some data was not being reported.

The Cell was provided with the published data, to 28th February 2021, in respect of COVID-19 vaccinations in Jersey and was informed that, as at that date, a total of 33,511 doses had been administered, of which 30,191 had been first dose vaccinations and 3,320 second dose. As at 8th March – subject to verification - those figures were noted to be 39,432, 36,053 and 3,379 respectively and the number of doses, per 100 population, was 36.58. Vaccine uptake in older Islanders continued at high levels and, as at 28th February, 99.6 per cent of those aged over 80 years, 94 per cent of these aged between 75 and 79 years and 93 per cent of those aged between 70 and 74 years had received their first dose of the vaccine. Focus remained on the first dose vaccinations and, as a consequence, there had been little increase in the cumulative numbers of second doses administered. As at the same date, 95 per cent of care home residents had received their first dose of the vaccine and 84 per cent their second and in respect of staff employed in those settings, these figures were noted to be 83 per cent and 66 per cent respectively. With regard to Islanders classed as 'clinically extremely vulnerable' (excluding those aged over 69 years), 81 per cent had received their first dose of the vaccine. Of those at moderate risk (for all age groups), 65 per cent had now received the first dose, which represented a significant increase on the previous week, when this figure had been 34 per cent.

The Cell received the weekly estimate of coverage for the various priority groups, as

recommended by the Joint Committee on Vaccination and Immunisation ('JCVI'), by cohort size and the numbers of first and second doses of the vaccine and was informed that 90 per cent of those working in frontline health and social care positions had received their first vaccine and 63 per cent of other workers in those settings. It was noted that this information had been published for the first time on 4th March and would henceforth be made public on a weekly basis, following a recommendation by the Statistics Users Group to the Chief Minister.

The Cell was provided with a map, which had been prepared by the European Centre for Disease Prevention and Control ('ECDC'), which set out an estimate of the national vaccine uptake for the first dose of the COVID-19 vaccine in adults, as at 28th February 2021 and was informed that most countries averaged between 5 and 10 per cent, whereas approximately 35 per cent of those aged over 18 in Jersey had been vaccinated.

The Cell heard from the Senior Informatics Analyst, Strategic Policy, Planning and Performance Department, who had undertaken an analysis of those people who had tested positive for COVID-19 at least 14 days after receipt of one dose of the vaccine. She informed the Cell that whilst it remained the situation that the large majority of positive cases (93 per cent) had been in people who had not been vaccinated, there had been 36 cases in 2021 identified in people who had received one or more doses at least 14 days previously and there had been only one positive case in a vaccinated individual aged over 65 years since mid-January, but they had travelled off-Island and were asymptomatic.

The Cell was shown a map of the UK, which set out the geographic distribution of cumulative numbers of reported COVID-19 cases, per 100,000 population, as at 7th March 2021, which demonstrated the continuing reduction in cases across much of that jurisdiction. With regard to the maps, which had been prepared by the ECDC, for weeks 7 to 8 (22nd February to 1st March) when compared with the previous week, the further decline in cases in Spain and Portugal was noted, whilst there had been an increase in Germany, Poland and the Czech Republic and rates in France had plateaued.

The Principal Officer, Public Health Intelligence, informed the Cell that she had been requested to compile a framework of metrics that would be used to support the 5 objectives included within the Roadmap, which had previously been referenced as 'tests'. It was recalled that the first objective was to deliver reconnection as rapidly and safely as possible, based on consideration of the balance of harms, including disease risk, health, education, economy and wellbeing. Consideration would be given to the impact on services, the ability of the vaccine programme to deliver, whether the schools were closed or a large number of pupils isolating, any business closures and the impact on the economy. Other important metrics in this regard would be the number of people unemployed, actively seeking work, or claiming Income Support, the number of people shielding or in self-isolation and the impact thereof. Islanders' mental health and any increase in instances of domestic violence and drug or alcohol use would also be considered. The Independent Advisor – Epidemiology and Public Health, indicated that when considering the balance of harms, it would be important to consider what volume of transmission of the virus the Island was willing to tolerate in the future and proposed that the relevant figures should be included. The Managing Director, Jersey General Hospital, suggested that greater input on the economic impacts was required.

With respect to the objective to deliver a highly effective vaccination programme, supply levels would need to remain at, or better than, provisional estimates received from the UK each week and the volume of uptake and vaccine hesitancy amongst Islanders was a matter for consideration. With regard to the prevention of a significant 'third wave' of infection during the first phase of the vaccination programme, the metrics would be the number of people seeking healthcare, any evidence of clusters, the identification of transmission chains for each case, the impact of any easing of

restriction on case numbers, the test positivity rate and compliance with inbound travel isolation requirements. The Independent Advisor – Epidemiology and Public Health, indicated that mention should be made of prevention of severe cases of infection, which was the concern, rather than individuals who were either asymptomatic, or mildly symptomatic.

The fourth objective was to maintain high levels of on-Island testing and high-capacity contact tracing and enforcement capability to provide an early warning and control system over the Spring period. It would be necessary to implement an approved testing strategy and to monitor the numbers of tests and types of individuals tested, maintain the current quality contact tracing capability, monitor compliance checks on those in self-isolation, or identified as direct contacts and keep adherence to guidelines under review. The Managing Director, Jersey General Hospital, indicated that it would be helpful to understand the optimum efficiency under which the contact tracing team could operate in order to inform the future management of outbreaks and clusters of the virus. With regard to the objective to monitor and respond to developments in relation to Variants of Concern, risks in other jurisdictions would be reviewed and assessed, consideration given to the latest literature and scientific research relating thereto and on-Island cases would be sequenced.

The Cell was provided with information in respect of inbound travellers to the Island since the start of 2021 and noted that there had been a total of 87 positive cases identified through arrivals screening, of which 64 had tested positive at day zero, 18 at day 5 and 5 at day 10. These individuals had been in direct contact with 616 other people. 56 per cent of the positive cases had been asymptomatic, 54 per cent male and most had been of working age. During the period from September 2020 to March 2021 there had been 42,300 inbound travellers, with the peak in September when the majority of travellers had been aged between 45 and 64 years. Since November, people's reason for travelling had been recorded and it was noted that Jersey residents returning home constituted the majority of travel, with lower numbers of people visiting friends and family, returning home from university and coming to the Island as critical workers. It was suggested, however, that this data would not be representative of the reasons for travel over the whole year. The Independent Advisor – Epidemiology and Public Health, suggested that it would be useful to receive more information in relation to those people who had tested positive at day 10 to understand if these had occurred throughout the pandemic, or only when there had been higher levels of transmission. He queried whether they had become infected with COVID-19 whilst on the plane, or in the airport, or having arrived in the Island, potentially due to transmission within the *locus* in which they were staying.

The Consultant in Communicable Disease Control suggested that it would be interesting to know on which days the people, who had travelled to and from the UK, in November 2020 had tested positive. He emphasised the need to collect the data relevant to the Roadmap objectives and for them to be included in the Cell's briefings in the future. He also requested a regular update on the anticipated vaccination schedule, which would inform any decision on the relaxing of restrictions. The Head of Policy (Shielding Workstream), Strategic Policy, Planning and Performance Department informed the Cell that the estimated vaccine figures and deployment line had been prepared to May, but information on the vaccine quantities thereafter had not yet been received from the UK, but work was underway to obtain the same.

It was agreed to establish a Sub-Group of the Cell to elaborate on the Roadmap objectives. The Cell noted the position and thanked officers for the briefing.

COVID-19 – Health and Community

A3. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A3 of its meeting of 1st March 2021, was provided with a verbal update by the Managing Director, Jersey General Hospital, in relation to the Health and

Services Department's operational position.

Community Services Department's operational position.

He informed the Cell that the overall Health and Community Services Department's escalation status, as at 8th March 2021, remained 'Green', which was indicative that the health and care system capacity was such that the organisation was able to meet anticipated demand, within available resources.

Bed occupancy in the General Hospital was at 74 per cent and there had been an improving situation across all mental health settings, where bed occupancy had reduced to 75 per cent. Occupancy in critical care had increased over the previous week and currently stood at 67 per cent, which was the equivalent of 8 of the 12 beds, mindful that capacity could be increased, if required, although this had not been necessary during the whole of 2020. None of the expansion beds within the General Hospital, or the Nightingale Wing, were in operation and attendance at the Emergency Department during the previous week had exceeded 550 for the third successive week.

The Cell noted the position and thanked the Managing Director for the update.

COVID-19 Vaccine prioritisation – Phase 2.

A4. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A6 of its meeting of 2nd September 2020, recalled that it had endorsed the first phase of the deployment of the COVID-19 vaccine, based on guidance from the Joint Committee on Vaccination and Immunisation ('JCVI') on the priority groups for receipt and was provided with a PowerPoint presentation, dated 8th March 2021, entitled 'STAC Presentation: Phase 2 COVID-19 Vaccine Prioritisation' and a supporting paper, entitled 'Policy Briefing: COVID-19 Vaccine Prioritisation for Phase 2', which had been prepared by the Head of Policy (Shielding Workstream) and the Interim Senior Policy Officer, Strategic Policy, Planning and Performance Department and heard from the latter in relation thereto.

She informed the Cell that availability of the COVID-19 vaccine was always the limiting factor and that the aim in Phase 2 of the vaccine prioritisation was to achieve the protection of the whole population from the virus, whereas it was recalled that, in Phase 1, the aim had been to prioritise the prevention of mortality and to protect the health and social care staff and systems. Implementation, to-date, had been very successful and 33,511 doses had been administered, which placed the Island ahead of many other jurisdictions. A number of lessons had been learned from the first phase of the deployment, one of which was that simple communications, based on age, had resulted in a faster uptake of the vaccine by those in priority groups. It had been challenging to correctly identify sub-groups, which had led to some Islanders raising concerns that they had been omitted from the priority lists, or not booking a vaccine in the erroneous belief that they did not form part of the sub-group. There had been some disproportionate lobbying for exemption from professional groups and there had been far fewer applications from those in lower-skilled roles, thereby leading to a risk of inequality. It had been challenging to 'police' eligibility when Islanders attended the vaccination centre, which had posed difficulties for the operational team.

The JCVI had recently published its recommendations for Phase 2, which were that it should be age-based, commencing with the oldest adults first and be deployed firstly to those aged 40 to 49 years, then 30 to 39 years and then 18 to 29 years. This delivery model would facilitate rapid deployment of the vaccine, which had been highlighted by the JCVI as the single most important factor for an optimal programme that maximised public health benefit. The rationale had been demonstrated by a profile of critical care admissions of people with COVID-19, which reflected the increased risk with age.

The 'Vaccine Panel', which had been established to determine exemptions, had met on 3rd March and had given consideration to whether to continue to follow the JCVI recommendations in relation to roll out of the vaccine for Phase 2, to prioritise the

vaccination of people contributing to the critical infrastructure, regardless of age, or to prioritise according to occupational groups which had been linked to outbreaks of COVID-19 in the Island, irrespective of age. The Cell was reminded that any prioritisation would result in unequal access to a potentially lifesaving intervention and having considered the various options, the Vaccine Panel had recommended that the Island should continue to follow the JCVI guidance as the most equitable and efficient way to deploy the vaccine. It was important to ensure the safety of the whole population, because nobody would be safe until everyone was safe and this would be achieved by delivering the vaccine to the eligible as soon as possible and it would be key to make sure that no important groups were missed during Phase 2. The Cell was asked to endorse the decision of the Vaccine Panel in this regard.

The Interim Director of Public Health Practice questioned whether any difference in uptake by ethnic groups had been experienced and was informed that it was not possible to undertake a conclusive analysis by reviewing the information held on the EMIS system, because, in 70 per cent of cases, ethnicity was not captured. The Cell was informed that targeted communications had been prepared for each of the tiers, in consultation with the behavioural scientists and there had been good uptake thus far. The Independent Advisor – Epidemiology and Public Health, supported following the JCVI guidance, but questioned how uptake could be maximised as younger Islanders became eligible and referenced the diminishing impact on severe disease. It was important to vaccinate to interrupt the transmission of the virus and to potentially prevent Long Covid, but he suggested that there was a risk of younger people not feeling incentivised to be vaccinated, which could lead to insufficient demand, which he envisaged would level off. He mooted that the 10 year age gaps for the tiers could be expanded to 15 to mitigate against this and opined that reference to the requirement to hold a 'vaccine passport' in order to travel could encourage uptake.

The Chief Executive Officer, Influence at Work, suggested that expanding to 15 year gaps could be a good thing, but would be dependent on supplies of the vaccine. In the event that the tiers were expanded and demand exceeded supply, this could have a disengaging effect. He reminded the Cell that the Behavioural Science Group was working to create specific communications and outreach messages for the various age groups. The Associate Medical Director for Primary Prevention and Intervention indicated that the uptake of the vaccine had been higher than predicted in all age groups and in those working in health and care settings. He agreed that 'vaccine passports' would encourage people to be vaccinated and informed the Cell that in other jurisdictions where attempts had been made to be flexible in relation to the distribution of the vaccine and to deviate from the JCVI guidance, it had led to people turning up at the wrong times and had not worked well. An age-based delivery model would enable the vaccine to be deployed rapidly and equitably.

Having considered the foregoing, the Cell was unanimous in agreeing that the JCVI guidance should be followed for Phase 2 of the vaccine roll out.

Safer Travel Policy.

A5. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A9 of its meeting of 18th January 2021, recalled that the Safer Travel Policy had been introduced in July 2020, following a trial at the Airport in June and that areas had been categorised as Red, Amber or Green ('RAG') depending on the 14-day case rate per 100,000 population. On arrival, people would be required to undertake PCR tests at days zero, 5 and 10 and to undertake a period of isolation, depending on their 10-day travel history, but this had evolved since the Policy had first been implemented. It was further recalled that the decision had been taken that all United Kingdom ('UK') regions should be classified as Red with effect from 22nd December 2020 (to include people transiting through the UK and day trips to and from that jurisdiction) and this had been expanded to the rest of the world on 16th January 2021.

The Cell received and noted a PowerPoint presentation, dated 8th March 2021, entitled 'Safer Travel Policy – STAC update' and heard from the Policy Principal, Strategic Policy, Planning and Performance Department, who reminded them that Jersey had not shut its borders during the COVID-19 pandemic, but had managed the risk posed by the virus by the default 14-day isolation period on arrival. During the Summer 2020, there had been a relatively large number of arrivals into the Island, but the volumes had reduced dramatically in the Autumn and remained low. Once people were required to isolate for more than 12 hours, travel for pleasure declined and essential travel only remained.

Whole countries had initially been afforded a RAG categorisation, but case rates in those jurisdictions with which the Island had greater connectivity, *inter alia*, France, Germany, Scotland, England and Eire had been assessed in more detail and there were currently 765 individual data points, which would be a feature of the travel policy in the future, albeit debate was to be held as to whether that level of detail afforded a true reflection of the level of risk in those regions. The 14-day case rates in neighbouring areas would be kept under close consideration. It was noted that in the UK there had been a peak in cases at the start of 2021, but these had declined consistently to an average of 334 and there were currently 76 Amber regions and 9 Green out of a total of 381. In Eire, there had been an unprecedented rapid increase to a peak in early January 2021, followed by a fall in infection rates to an average of 294. Of the 26 counties, 4 were Amber and one Green. In France, there had been an upward trend in mid-November, a rapid decline in December, but rates had remained resolutely above the Red threshold with an average of 399. There was currently only one region in mainland France that was not Red (Finistère).

In accordance with the UK roadmap, self-contained holiday accommodation would re-open on 12th April at the earliest and was, as such, the first point at which Jersey residents could travel to the UK and stay there without breaching the guidelines, but it was noted that they would not be able to visit any family or friends. At Step 3 of the UK roadmap - 17th May – a maximum of 6 people, or 2 households, could meet indoors and hotels would re-open. The Cell was informed that when the Competent Authority Ministers had met on 3rd March, they had discussed the indicative stages of reconnection for Jersey and had mooted that the RAG categorisation for travel could be re-introduced at Stage 6, at the earliest, which was to be no earlier than 10th May, but wished to obtain the Cell's views on that proposal.

The level of regional detail in the context of the RAG categorisation had been the subject of some discussion. It was noted that the higher level of granularity did not always provide the best assessment of risk and the example of a person travelling to London and visiting many different boroughs, despite staying in one area, was given. There was also the issue of people congregating in areas where airports were located and the fact that small changes in case rates could cause large fluctuations in smaller areas. The Cell was informed that these issues would be kept under review and it would be asked for its advice before implementation. A more nuanced analysis of the profile of passengers would be undertaken, to include day trippers, as some research demonstrated that the shorter the time a person spent in a higher risk area, the greater the threat they posed in relation to the spread of the virus. The viability of the requirement for all arrivals to undertake 3 PCR tests was questioned as demand increased, because it was costly, so consideration would need to be given to alternative solutions. In respect of the risk posed by the new variants of COVID-19 (VOC), the Cell was informed that Competent Authority Ministers had agreed that the Island should mirror the stance adopted in the UK, where there were 33 countries from which only UK residents could travel, subject to them spending time in a managed quarantine hotel. Work was underway on the implications of the COVID-19 vaccine for travel and the viability of vaccine passports, as referenced at Minute No. A4 of the current meeting.

The Policy Principal reminded the Cell that the 14-day case rate, per 100,000 population, had been the mainstay of the travel policy, but there was an opportunity to consider other metrics, such as test positivity, vaccine coverage and hospital admissions when assessing the risk posed at the border. The Associate Medical Director for Primary Prevention and Intervention indicated that the COVID-19 vaccine would be key in relation to travel and was likely to be the subject of many discussions internationally. He suggested that Islanders might wish to be able to travel from Easter and indicated that communications should emphasise that Jersey was in a very good position at the current time, but that other jurisdictions still had high case rates. The Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, indicated that consideration should be given to the level of reseeding that the Island was prepared to accept. With regard to the size of regions for RAG purposes, he suggested that metrics in Glasgow and Edinburgh would be very different from the Highlands and Islands, as an example. He opined that the risk profile of Islanders returning from University, or people coming to work in the Island, might be different from those travelling for tourist purposes. He stated that the economic impact would need to be considered, noting that tourism accounted for between 3 and 4 per cent of GDP and employment. Of those travelling to Jersey, 80 per cent came from the UK and 20 per cent were day trippers, predominantly from France.

The Independent Advisor – Epidemiology and Public Health, suggested that there was a lack of clarity around whether the purpose of the strategy was to minimise severe disease, or transmission of the virus, mindful that they were different. He opined that the metrics used for the RAG categorisation should be reviewed, because testing volumes were far greater now than when the Safer Travel policy had initially been introduced, which meant that direct comparisons could not be drawn. With regard to the size of the regions, a balance needed to be struck and he indicated that as more data was aggregated, so the thresholds would need to increase, because averages were being considered, which had the potential to 'mask' some higher levels in certain areas. He indicated that officers would need to be prepared to take action at an earlier stage than 10th May, as he envisaged there might be pressure to re-establish travel connectivity before that time and he suggested that the Island might experience large volumes of people travelling to Jersey for a holiday – rather than to Europe - and it was necessary for the system to be able to accommodate the same.

The Consultant in Communicable Disease Control suggested that the Sub-Group that was due to be established in order to review the metrics and establish the speed of reconnection (Minute No. A2 of the current meeting referred) should also give consideration to travel, because the issues were intrinsically linked.

Having discussed the foregoing at some length, the Cell felt that it currently had insufficient information on which to make a decision at the current time. Opening the borders and making the Island more accessible was an extremely important step and Members of the Cell wished to see the proposed policy and understand how it would work in practice, with the relevant data to support the same. The Head of Policy, Strategic Policy, Planning and Performance Department, undertook to relay this to the Competent Authorities.

Reconnection strategy – 'road map' – move to Stage 4.

A6. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A6 of its meeting of 1st March 2021, recalled that it had previously received the Reconnection road map, which set out indicative steps for relaxing various measures, subject to the prevailing metrics and was advised that Competent Authorities had published the higher level details of the various Stages, each of which would be presented to the Cell to obtain its views before being enacted.

The Cell accordingly received and noted a PowerPoint presentation, dated 8th March 2021, entitled 'Stage 4 Reconnections' and an undated paper entitled 'STAC position

on fitness and sport reconnection' and heard from the Head of Public Health Policy on the elements of the reconnection that it was proposed could come into effect from 15th March.

Indoor sport and exercise, to include gyms and swimming pools

The Cell was asked for its advice on whether to proceed with opening indoor sport at all levels of intensity, to include swimming and whether there should be fixed time slots for activities, followed by a fallow period of 10 minutes ahead of cleaning before the next session. It was suggested that any classes should be limited to 10 people with 2 metres physical distancing and that gym equipment should be spaced to ensure a minimum of 2 metres between items. It was mooted that masks should be worn when not exercising or engaging in sport.

The Cell agreed that ventilation was key in these settings and suggested that although the changing rooms could open, it would be preferable for clients to 'gym and go' or 'swim and go', because it was less easy to attain compliance with distancing requirements in these *loci*. It did not feel that there was the need to limit class sizes to 10, provided that it was possible to achieve 2 metres' distance between users and supported this figure being increased to 15 people. With regard to the wearing of masks, it was suggested that this required some thought, to avoid the confusion that had arisen in some hospitality settings.

Outdoor sports

The Cell was informed that sporting bodies wished for the current outdoor limit of 35 adults playing sport to be increased to 40 or 45. The rationale was that it was not always possible to accommodate 2 teams, plus coaches, officials and supporting staff within the current limit. The Cell was informed that there had been no positive cases of COVID-19 in the United Kingdom as a direct result of playing sport outside and that any transmission had occurred in the changing rooms, or in sharing vehicles to travel to and from the games.

The Cell accordingly agreed to increase the outdoor limit for sport to 45, with guidance to be issued.

Household mixing

Current public health guidance advised against gathering in other people's homes or gardens unless for essential reasons. Gatherings of more than 10 were governed by legislation, which would remain in force, but the guidance would be relaxed to enable Islanders to meet up for social and wellbeing reasons. People would be encouraged to limit the number of people with whom they met and the number of occasions and, where possible, to keep 2 metres away from people in other households. It was acknowledged that meeting in outdoor spaces was safer.

The Cell was cognisant that many Islanders were already meeting, contrary to guidance and emphasised the importance of limiting the numbers of people at any gathering and increasing the consistency of the contacts where possible. Mindful that 14th March was Mothering Sunday, it was suggested that the guidance relating to household mixing for social purposes should change from that day, rather than the 15th March.

Soft play areas

It was proposed that soft play activities should be re-opened to groups of up to 10 per activity, with all shared surfaces to be sanitised between sessions. In light of the inability to sanitise ball and foam pits, which were higher risk areas where bodily fluids were often dispersed, it was suggested that these should remain closed until a later Stage.

The Cell agreed with the proposal and was cognisant that although the younger age

groups, who used such facilities, were at lower risk of severe illness from COVID-19, they had the capacity to transmit the virus to their parents.

Singing and playing brass and woodwind instruments

The Cell recalled that all Islanders were currently able to sing and play brass and woodwind instruments in groups of up to 10 outdoors, with mitigations and that up to 10 children and young people could also sing and play in indoor settings. It was proposed that from Stage 4 of the reconnection roadmap, up to 10 adult singers and players would be permitted indoors and the Cell was asked to consider whether, in school and education settings only, up to 30 should be able to participate in these activities, without physical distancing, but with other mitigations.

The Cell was of the view that to increase from 10 to 30 represented a significant jump and agreed that a maximum of 15 young people could sing and play brass and woodwind instruments – in educational settings only – provided that they adhered to the requirement to be 2 metres apart.

Care home visiting.

A7. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A6 of its meeting of 1st February 2021, recalled that as a consequence of a number of positive cases of COVID-19 being identified in care home settings, Competent Authority Ministers had taken the decision, on 8th December 2020, to severely curtail visits until the residents had been vaccinated, or in end of life circumstances. Updated guidance had been issued on 2nd February, which permitted vaccinated care home residents to have 2 named visitors (one visitor per visit) up to 2 visits per week. Those who were not yet fully vaccinated were permitted one named visitor up to 2 visits per week. Residents had been strongly discouraged from taking trips outside the care home. It was noted that people were deemed to be 'vaccinated' 2 weeks after they had received the second dose of the vaccine.

The Cell received and noted a PowerPoint presentation and heard from the Public Health Policy Officer, Strategic Policy, Planning and Performance Department, who indicated that she would be providing updates to it every 3 weeks.

The Cell recalled that 95 per cent of care home residents had now received their first dose and 84 per cent the second and very few had either declined the vaccine, or contraindicated. There had been continuing low levels of COVID-19 activity in the care homes and feedback from that sector was that residents would greatly benefit from an increased number of visits. Accordingly, it was proposed that the visiting policy guidance in respect of the care homes should be updated in order that, with effect from 12th March, vaccinated residents could continue to have visits from 2 named visitors, one at a time, but with no limit on the frequency of the visits. Trips out of the home would no longer be strongly discouraged, but public health advice should be followed. Those who were not fully vaccinated could have one named visitor, but with no restrictions on the frequency of the visits and trips outside the home should be with that named person only, with public health advice followed.

Having discussed the foregoing, the Cell agreed with the proposed changes to the care homes visiting policy guidance and noted that it was anticipated that it would be asked to consider increasing the number of named visitors at a meeting in early April, mindful that it was important to avoid crowding in the care homes at the current time.

Matters for information.

A8. In association with Minute No. A2 of the current meeting, the Scientific and Technical Advisory Cell received and noted the following –

- a weekly epidemiological report, dated 4th March 2021, which had been prepared by the Strategic Policy, Planning and Performance Department;

- statistics relating to deaths registered in Jersey, dated 4th March 2021, which had been compiled by the Office of the Superintendent Registrar; and
- an estimate of the instantaneous reproductive number (R_t) for COVID-19 in Jersey, dated 3rd March 2021, which had been prepared by the Strategic Policy, Planning and Performance Department.