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SCIENTIFIC AND TECHNICAL ADVISORY CELL

(73rd Meeting)

(Meeting conducted via Microsoft Teams)

13th September 2021**PART A (Non-Exempt)**

All members were present, with the exception of C. Folarin, Interim Director of Public Health Practice, R. Sainsbury, Managing Director, Jersey General Hospital, R. Naylor, Chief Nurse, Dr. M. Patil, Associate Medical Director for Women and Children, Dr. M. Garcia, Associate Medical Director for Mental Health, S. Skelton, Director of Strategy and Innovation, Strategic Policy, Planning and Performance Department and N. Vaughan, Chief Economic Advisor, from whom apologies had been received.

Professor P. Bradley, Director of Public Health (Chair)
 Dr. I. Muscat, MBE, Consultant in Communicable Disease Control
 Dr. G. Root, Independent Advisor - Epidemiology and Public Health
 Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention
 Dr. S. Chapman, Associate Medical Director for Unscheduled Secondary Care (for items A1 – A3 only)
 S. Petrie, Environmental Health Consultant
 A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department
 I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department

In attendance -

S. Martin, Chief Executive Officer, Influence at Work
 M. Clarke, Head of Public Health Intelligence, Strategic Policy, Planning and Performance Department
 S. White, Head of Communications, Public Health (for items A4 – A6 only)
 K. Posner, Head of Office (Education), Children, Young People, Education and Skills Department
 Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department
 J. Norris, Principal Policy Officer, Strategic Policy, Planning and Performance Department
 A. Maltman, Press Officer, Office of the Chief Executive
 K.L. Slack, Secretariat Officer, States Greffe

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

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| Minutes. | A1. The Minutes of the meeting of the Scientific and Technical Advisory Cell that had been held on 6th September 2021, having previously been circulated, were taken as read and were confirmed. |
| Intelligence | A2. The Scientific and Technical Advisory Cell ('the Cell'), with reference to |

overview,
including
Analytical Cell
update.

Minute No. A2 of its meeting of 6th September 2021, received a PowerPoint presentation dated 13th September 2021, entitled 'STAC Monitoring Update', which had been prepared by Ms. M. Clarke, Head of Public Health Intelligence, Strategic Policy, Planning and Performance Department and heard from her in connexion therewith.

She informed the Cell that, as at Friday 10th September 2021, there had been 316 active cases of COVID-19 in the Island, who had been in direct contact with 1,262 individuals, which brought the 14-day case rate, per 100,000 population, to 336. Of the active cases, seeking healthcare (129) had overtaken those identified through arrivals screening (103), whilst a further 60 were direct contacts. As during the previous week, many of the active cases were aged between 10 and 19 years and 40 to 59 years. It was noted that there had been a decrease in the number of tests undertaken each day, which were currently averaging 2,000, whereas in excess of 4,000 had been carried out on a daily basis at some points during the Summer. Since the start of August, there had been an average of 34 daily cases and these figures remained relatively stable. For most age groups, the test positivity rate remained at approximately one per cent, but for those aged under 18 years it had increased to 7.2 per cent. The Cell was shown a graph of the positivity rates and swab volumes amongst different testing cohorts and noted that, during the previous week, there had been a decrease to approximately 13 per cent for those seeking healthcare and to *circa* 5 per cent for direct contacts, whilst other groups remained at approximately one per cent. The 14-day case rates, per 100,000 population, for those aged under and over 60 years were noted to be 348 and 252 respectively and it remained the case that of those Islanders aged over 60 years, almost 100 per cent were fully vaccinated, whereas this was only the case for 60 per cent of those under the age of 60. As at 10th September, there had been 2 patients in the General Hospital with COVID-19, both of whom were clinically Covid.

Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department, provided the Cell with the Analytical Cell summary for 10th September. It was noted that, since the start of the third wave of the pandemic (28th June 2021), there had been 77 admissions to the General Hospital and 75 discharges. She indicated that more information on the age and vaccination status of those who had been hospitalised would be presented to the Cell at its next meeting. The Cell was provided with details of the positive cases linked to health and care settings and the schools and was informed that, at the meeting of the Cell on 20th September, the Children, Young People, Education and Skills Department would be providing an operational update in terms of the treatment of direct contacts within educational settings. Dr. Newman indicated that the current requirement was for a direct contact to provide a negative result to a PCR test before they could return to school. Thereafter, they would undertake lateral flow device ('LFD') testing for 10 consecutive days. It was currently the case that someone, who had tested positive for COVID-19 within the last 28 days, was presumed to be immune and was not treated as a direct contact. This would be expanded to 90 days across all policies, in line with stance taken in the United Kingdom ('UK'), which should serve to reduce some disruption. Since the start of the Autumn term, during the week commencing 6th September, over half the pupils and teachers had registered to participate in the LFD testing programme. As at 12th September, 2,610 individuals were reporting test results and there had been 13 positive results. It was intended to bring information to the Cell on 20th September on the conversion rate from LFD positives to PCR positives and the Cell was informed that whilst it had previously been the case that most LFD positives had been identified as 'false' when the testing programme had commenced in January, the conversion rate was likely to have increased. Dr. Newman provided the Cell with details of the clusters of cases that had arisen in the community.

Ms. Clarke informed the Cell that there had been 78 deaths from COVID-19 since the start of the pandemic, of which 9 had occurred since 28th June 2021 (the third wave).

Details of the ages and gender of the deceased were provided.

It was noted that the number of travellers into Jersey had increased week on week over August, but the test positivity rate had decreased. During the week commencing 30th August, 69 active cases had been identified, compared with 130 during the week of 19th July. During the week ending 5th September, Jersey's testing rate, per 100,000 population, had been 21,100, which far exceeded the UK rate of 10,150, despite that jurisdiction including tests undertaken on LFDs and the Cell was informed that it remained the intention to include that data within the local results. The positivity rate locally had been 0.8 per cent compared with 4.1 per cent in the UK. The Cell was informed that when inbound travel tests were excluded, the on-Island test positivity rate, as at 11th September, had been 2.7 per cent, whereas it had been below 2 per cent at the end of August.

Based on data to 5th September, the effective reproduction number (R_t) was locally noted to be between 1.1 and 1.4, which was evidence of infection spreading exponentially. However, this could be due to the slightly higher number of on-Island cases and the Cell was reminded that future changes to testing might make it difficult to continue to provide the R_t , but this would be kept under review on a weekly basis. The Cell was informed that the R_t for England was between 0.9 and 1.1 over the same reporting period.

The Cell noted that 177 patients were currently recorded in the EMIS clinical IT system as suffering from Long Covid. Of these, 97 had ongoing symptomatic Covid and 85 had post COVID-19 syndrome, but it was recalled that these were not mutually exclusive and one individual could have both codes assigned to them. The majority of people with Long Covid were aged between 20 and 59 years. In respect of the vaccine programme, the Cell was informed that up to 5th September, 76,630 first dose vaccinations and 73,118 second dose had been administered, resulting in a vaccine rate, per 100 people, of 138.92. 82 per cent of Islanders aged over 16 years were now fully vaccinated, which equated to 68 per cent of the total population. It was noted that 44 per cent of young Islanders aged between 16 and 17 years had received their first dose. The Cell was shown graphs which tracked the vaccine uptake by age group and noted the increase in this cohort, whilst there had been a plateauing amongst the older groups.

In respect of the estimated vaccine coverage for the Joint Committee on Vaccination and Immunisation ('JCVI') priority groups, the Cell noted that for those working in health and social care settings, more people than the denominator had been fully vaccinated, but a small amount of the data was noted to be of questionable quality and was coded Amber. Of those aged between 12 and 15 years, who were at risk or were living with someone whose immunity was suppressed (priority group 14), 42 individuals had received their first dose. However, the Cell was reminded that the quality of the data relating to this latter group was questionable, as it was challenging to estimate the size of the relevant population and to extract the information from different data sets. It was noted that, by 5th September, 87 per cent of adults had received their first dose of the vaccine, which was comparable with the UK, whilst this figure increased to 91.4 per cent for residents of Eire and France. As aforementioned, 82 per cent of adults were now fully vaccinated in Jersey, compared with 87.8 per cent in Eire and 75.2 per cent in France.

The Cell was presented with a map of cases in the UK and noted the high rates in Scotland, Northern Ireland and Wales, whereas cases in the South West had reduced. The 14-day case rate, per 100,000, had been 602 in England on 9th September (up from 580 the previous week), but had increased to 1,447 from 1,163 in Scotland. There had been an increase of 1.1 per cent in the number of people testing positive for COVID-19 in the UK when compared with the previous week and an increase of 4.8 per cent in hospital admissions, but deaths had increased significantly by 22.6 per cent. In

Scotland, the infection rate was currently higher than at any point in the pandemic to-date, with a 14-day case rate, per 100,000 population, in excess of 1,100. However, the number of people admitted to hospital was approximately 45 per cent of the Winter 2020/2021 peak but was increasing. It was suggested that the easing of many restrictions in that jurisdiction on 8th August and the re-opening of the schools on 18th August could have contributed to the uplift in infection rates, which was primarily in children. Eighty three percent of the eligible population in Scotland were noted to have been fully vaccinated, which was comparable with Jersey.

The high infection rates that had previously been experienced in France were now declining, but case numbers in Germany were increasing, whereas in respect of those countries that were not categorised at a regional level there had been little change. The Cell was presented with maps, which had been prepared by the European Centre for Disease Prevention and Control ('ECDC'), which compared 14-day case rates on 9th and 2nd September. The decreasing cases in France and Spain were noted, as was the uptick in cases in Germany.

Mr. A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, indicated that it had been some time since the Cell had received data in respect of calls to the COVID-19 helpline and queried the reason therefor. He stated that such information was of value to the Cell, as there had been a spike in calls before the third wave of the pandemic. He also asked whether it would be possible to split out those aged under 18 years who had tested positive on-Island from those encountered at the borders and queried whether there had been an upward trend in active cases over recent days and weeks. Ms. Clarke indicated that the helpline data was not being received by the informatics team, but work was underway to produce information for the next meeting of the Cell. Over the last few days, there had been a decrease in the test positivity rate in those seeking healthcare and direct contacts of active cases. At the height of the third wave, this had peaked at 45 per cent but there had been a downward trend since August, whilst there had been an increase in the number of tests. She subsequently provided the following details in respect of the active cases in those aged under 20 years –

- 53 cases aged 10 to 19 years, of which 47 per cent had sought healthcare, 25 per cent related to inbound travel and 23 per cent had been contact traced; and
- 30 cases aged up to 9 years of which 60 per cent had been contact traced, 36 per cent had sought healthcare and none had been identified on arrival into the Island.

Dr. G. Root, Independent Advisor - Epidemiology and Public Health, suggested that the test positivity rate for those seeking healthcare was indicative that transmission was plateauing or declining, rather than increasing. He questioned whether the cases linked to the schools had been identified through the voluntary LFD screening programme and was informed that the data would be reviewed and presented to the next meeting of the Cell. Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention informed the Cell that, anecdotally, primary care had been very busy treating small children with temperatures, as had also been the case in the Accident and Emergency Department ('A and E'). He queried whether work was underway to analyse where this was caused by COVID-19 or other viruses. Dr. I. Muscat, MBE, Consultant in Communicable Disease Control, indicated that virology swabs were being taken in A and E and Robin Ward for COVID-19 and other respiratory diseases and within one month all 4 diseases could be checked for with one test.

The Cell noted the position and thanked the Head of Public Health Intelligence for the update.

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Reference for
the Scientific
and Technical
Advisory Cell.

to make some alterations to the membership of the Cell and received and noted updated terms of reference for the Cell, dated 10th September 2021. It was further recalled that the Cell provided a common source of health, scientific and technical advice to Government and Gold Commanders during public health emergencies. Responsibility for forming the Cell lay with the Director for Public Health, but when it had been established in response to the COVID-19 pandemic, that post had been vacant, so the Director General, Strategic Policy, Planning and Performance Department had activated the Cell.

The purpose of the Cell was to ensure that coordinated and timely health, scientific and technical expertise was made available to inform Government advisers and decision makers during emergencies and advice might be required from the Cell on a wide spectrum of topics and disciplines. It was not the role of the Cell to discuss ‘business as usual’. It was recalled that the focus of the work was not currently on the General Hospital, so it had been proposed to those members from the Health and Community Services Department that they might step down at the current time and they had agreed with this suggestion. It was noted that Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention, would remain as a member of the Cell in order to represent their views. In the event that increased input from Health and Community Services Department colleagues was required, they could be brought back into the membership. The updated membership of the Cell was noted to be as follows –

- Professor P. Bradley, Director of Public Health (Chair)
- Dr. I. Muscat, MBE, Consultant in Communicable Disease Control (Vice Chair)
- Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention
- Dr. G. Root, Independent Advisor - Epidemiology and Public Health (co-opted lay member)
- Mr. S. Petrie, Environmental Health Consultant
- Mr. A. Khaldi, Interim Director of Public Health Policy
- Mr. I. Cope, Interim Director of Statistics and Analytics
- Ms. M. Clarke, Head of Public Health Intelligence
- Dr. C. Newman, Public Health Principal Officer
- B. Sherrington, Senior Nurse Adviser in Public Health
- Dr. M. Doyle, Clinical Lead Primary Care

Other people could be invited to attend a meeting as their expertise was required. It was proposed that sub-groups of the Cell, which would not be formally minuted, could be established on an *ad hoc* basis where discrete pieces of work were necessary and they would provide timely reports to the Cell on their conclusions.

Dr. S. Chapman, Associate Medical Director for Unscheduled Secondary Care, stated that he was happy to step down from the Cell at this time. He indicated that it had been very interesting to form part of the Cell during the challenges faced as a consequence of the COVID-19 pandemic and he had valued the opportunity. He particularly emphasised that it had been positive for members of the Cell to be able to voice differing opinions and he hoped that would continue. He indicated that he would be happy to re-join the Cell as and when required at a later juncture.

The Cell accordingly indicated its support for the revised terms of reference.

Surveillance /
testing.

A4. The Scientific and Technical Advisory Cell (‘the Cell’), with reference to Minute No. A4 of its meeting of 23rd August 2021 in respect of testing strategy, recalled that Competent Authority Ministers had agreed on 2nd September 2021 - based on advice from the Cell and public health officers - that proposals for an epidemiological surveillance system should be developed in order to continue to monitor COVID-19 and also, potentially, other Winter viruses, as the transition was made from the current high levels of testing as part of a suppression strategy. The Cell accordingly received

and noted a paper, dated 13th September 2021, entitled 'STAC covering note: surveillance / testing', which had been prepared by Mr. A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department and heard from him in connexion therewith.

It was suggested that a range of work, combining different perspectives and disciplines, would be required in order to design a system which fitted the medium-term needs relating to COVID-19 and related activity. Accordingly, it was proposed that a sub-group of the Cell should be established to advise and support public health in the development of options and proposals. It was mooted that the sub-group should comprise the following members –

- Dr. I. Muscat, MBE, Consultant in Communicable Disease Control
- Dr. G. Root, Independent Advisor - Epidemiology and Public Health
- Dr. C. Newman, Public Health Principal Officer (public health lead and sub-group co-ordinator)
- Mr. S. Petrie, Environmental Health Consultant
- Mr. I. Cope, Interim Director of Statistics and Analytics

Public Health Intelligence input would be important, so an officer from that field would be invited to attend, in addition to a representative from Digital Jersey, mindful of the need to obtain and utilise data in a meaningful way. It was also suggested that it would be an opportune time to engage someone with international experience of COVID-19 surveillance as an external consultant advisor, which might be undertaken in collaboration with the Isle of Man and Guernsey, both of which jurisdictions had expressed an interest, albeit they were starting from a different point and their needs and requirements might differ from Jersey's.

Mr. Khaldi informed the Cell that he had appended a draft scoping document to his report, which would be for the sub-group to consider and refine at its first meeting. That contained objectives and requirements, in addition to outputs. It was noted that the meetings would not be formally minuted and that proposals were required from the sub-group - ideally by the end of October - for initial consideration by the Cell and thence presentation to Ministers for them to reach a decision. Also included in the scoping document was the anticipated initial requirement for an independent advisor, noting that it was likely that they would be part of, or strongly associated with, an academic or public health institution with notable capability in epidemiology and related disciplines. It was not intended at this juncture to establish an academic partnership, but to get at least 10 days of initial support. In the event that someone was to provide good value and advice, this could be reviewed and further developed. Members of the Cell were asked to inform Mr. Khaldi of any suggestions for the external advisor.

The Cell was informed that Dr. Newman would seek to arrange a meeting of the sub-group during the week commencing 13th September 2021, in order to commence the work and review the initial scoping objectives.

It was noted that the Cell would continue with its responsibilities and would meet on a weekly basis (or more frequently as required), whilst this parallel work stream was underway and the Cell noted the position accordingly.

Schools –
carbon dioxide
testing.

A5. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A6 of its meeting of 6th September 2021, recalled that in discussing the measures to ensure that pupils and staff could return to school safely during the week commencing 6th September 2021, it had been informed that carbon dioxide ('CO₂') monitors had been acquired for use in the schools, as part of a wider ventilation policy.

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The Cell accordingly received and noted a paper, dated 13th September 2021, entitled 'Briefing paper: ventilation and CO2 monitors in schools', with attendant appendices, entitled 'Practical steps for the deployment of good ventilation practices in schools', which had been prepared by the Children, Young People, Education and Skills Department and was dated September 2021 and a 'CO2 monitor infographic' and heard from Mr. J. Norris, Principal Policy Officer, Strategic Policy, Planning and Performance Department, in relation thereto. He indicated that good ventilation had been highlighted as a non-pharmaceutical intervention ('NPI') throughout the pandemic and with the aforementioned return to schools for the Autumn term, officers were monitoring the situation in order to ascertain what else could be done to mitigate any increase in cases in educational settings and the disruption that such an event had the potential to cause.

As a consequence, the Children, Young People, Education and Skills Department had acquired 200 portable CO2 monitors, which would be deployed initially as a pilot study in order to ascertain where ventilation could be improved. This aligned with the position in the United Kingdom, where a similar scheme had been introduced. If the pilot was successful, more monitors could be used. It was proposed, initially, to deploy them in *loci* where there were more people, such as school assemblies, but because they were portable, they could be relocated as required. Mr. Norris informed the Cell that he was aware that there were some concerns in respect of the effectiveness of the monitors. Although they were straightforward to use, care was needed to ensure that they did not create a 'false sense of security' and they were not a substitute for other NPIs in the schools, such as the wearing of masks or keeping pupils within class bubbles. The pilot would be monitored during the term before a decision was taken on the effectiveness of the monitors.

Mr. A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, indicated that the data and learning from the use of the CO2 monitors would be valuable for the Cell, so it was important to pay attention to how they were used. Dr. G. Root, Independent Advisor - Epidemiology and Public Health, emphasised the need to be as clear as possible when communicating with the schools in relation to the monitors. Effort was required to make sure that the teachers understood that the risk was not as great as perceived and that it was necessary to recommend proportionate interventions in their working environment. This view was shared by Dr. I. Muscat, MBE, Consultant in Communicable Disease Control, who wished to ensure that the introduction of the monitors was not perceived as a signal of significant risk from COVID-19, but an indication that officers were seeking to minimise the risk by emphasising the need for good ventilation.

In summary, there was a consensus within the Cell that ventilation was a sensible area to consider and that it was appropriate for the monitors to be used, with the *caveat* that appropriate guidance was required to avoid both false reassurance and exaggeration of risk. It was suggested that, as part of the learning from the pilot scheme, a mechanism could be introduced, whereby if surprising data emerged, the pilot could be halted, or changes made to the way in which the CO2 monitors were used.

It was agreed that officers from within public health policy and the Children, Young People, Education and Skills Department would create an ongoing evaluation of the pilot scheme. It was suggested that Mr. Norris and Mr. K. Posner, Head of Office (Education), Children, Young People, Education and Skills Department, should hold preliminary discussions in this regard and Mr. S. Martin, Chief Executive Officer, Influence at Work, offered to provide behavioural science input as required.

The Cell noted the position accordingly.

Matters for

A6. In association with Minute No. A2 of the current meeting, the Scientific and

information. Technical Advisory Cell ('the Cell') received and noted the following –

- a weekly epidemiological report, dated 9th September 2021, which had been prepared by the Strategic Policy, Planning and Performance Department;
- statistics relating to deaths registered in Jersey, dated 9th September 2021, which had been compiled by the Office of the Superintendent Registrar;
- an estimate of the instantaneous reproductive number (R_t) for COVID-19 in Jersey, dated 9th September 2021, which had been prepared by the Strategic Policy, Planning and Performance Department; and
- a report on vaccination coverage by priority groups, dated 9th September 2021, which had been prepared by the Strategic Policy, Planning and Performance Department.

END.