PLC

SCIENTIFIC AND TECHNICAL ADVISORY CELL

(94th Meeting)

(Business conducted via Microsoft Teams)

29th March 2022

PART A (Non-Exempt)

All members were present with the exception of Professor P. Bradley, Director of Public Health (Chair), A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department and Dr. M. Doyle, Clinical Lead, Primary Care, from whom apologies had been received.

Dr. I. Muscat, MBE, Consultant in Communicable Disease Control (Acting Chair)
Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention
Dr. G. Root, Independent Advisor - Epidemiology and Public Health
S. Petrie, Environmental Health Consultant
I. Cope, Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department
M. Clarke, Head of Public Health Intelligence, Strategic Policy, Planning and Performance Department
Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department
E. Baker, Head of Vaccination Programme, Strategic Policy, Planning and Performance Department

In attendance -

Dr. E. Klaber, General Practitioner, Primary Care Body representative
L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department
J. Lynch, Policy Principal, Strategic Policy, Planning and Performance
G. Norman, Deputy Director of Public Health
R. Williams, Director, Testing and Tracing, Strategic Policy, Planning and Performance Department
S. Huelin, Senior Policy Officer, Strategic Policy, Planning and Performance Department
S. White, Head of Communications, Public Health
S. Martin, Chief Executive Officer, Influence at Work
P. Le Conte, Secretariat Officer, States Greffe

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

Minutes.

A1. The Scientific and Technical Advisory Cell ('the Cell'), received and noted the Minutes of the meeting of 1st March 2022, which had previously been circulated. A Cell member requested revisions to Minute No. A4. These offered factual background to the delivery of a PCR laboratory expansion and provided clarity which did not change the context. The alterations were accepted and the Minutes approved.

Intelligence overview, including Analytical Cell update and HCS activity.

A2. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A1 of its meeting of 15th March 2022, received a PowerPoint presentation, entitled 'Scientific and Technical Advisory Cell (STAC) Monitoring Update', dated 29th March 2022, and heard from Mrs. M. Clarke, Head of Public Health Intelligence, Strategic Policy, Planning and Performance Department in connexion therewith.

The Cell was apprised of the current situation with regards to public health monitoring, noting that as at 28th March 2022, there were 2,109 active cases of COVID-19 recorded in the Island. The majority of cases were in adults aged 30 to 59 years, with lower numbers among those aged under 30 and over 60.

Seeking healthcare was the most common reason for testing, accounting for 1,111 cases; 938 had been identified following positive Lateral Flow Tests ('LFTs'); and the remainder through various screening programmes. The age ranges, gender and vaccination status of the active cases were shown, with a further breakdown by age for active cases in those aged 18 and under. Just under 1,000 tests were carried out on an average weekday with just under 500 each day at the weekend.

An average of just under 300 cases per day had been identified over the previous 2 weeks, which was a similar number to the start of the year but the continuation of an increased figure from the 220 cases per day recorded in mid-February. The overall test positivity rate (measured as a 7-day rolling average) had decreased to 42 per cent. The relatively high Polymerase Chain Reaction ('PCR') test positivity rate was due to people coming forward for testing following a positive LFT result.

The 7-day case rate per 100,000 population was fluctuating at around 2,000, with cases recorded for those aged 40 to 59 being just slightly higher than the other age groups.

The Cell reviewed the clinical status of cases in hospital and noted that as at 28th March 2022, there were 14 patients in the hospital, a considerable reduction from the peak of just under 50 at the start of March. A decrease in the number of cases in care homes to 18 was also noted. It was reported that 67 Health and Community Services staff were absent from work with COVID-19.

Details were provided of the positive cases linked to schools, which had seen a decrease since the peaks experienced in February 2022. A total of 492 students and 137 staff had been reported with Covid in the last 10 days.

The total number of deaths now stood at 120, with 42 registered since the start of the 4th wave on 1st October 2021, with 30 of those in Hospital and 12 in the community. The majority of the deceased were aged over 80.

A slide from the Further Mortality Report (2020) ('Figure 11: Excess Mortality by month in Jersey, All Persons (2020))' revealed an increase in April (12 per cent) and December (25 per cent), which coincided with the first and second COVID-19 waves but otherwise there was a deficit as the excess mortality was lower than normal compared to the number of deaths in previous years.

Another graph entitled: 'Figure 10: Excess winter mortality index, Jersey 2007/2008 – 2020/2021' compared the mortality during the winter (December to March) compared to the preceding August to November and the following April to July. This revealed a difference of around 80 excess deaths in winter 2020/2021 which was due to the second COVID-19 wave. This figure was not significantly out of

alignment with the range seen previously, with a similar level in the 2014/2015 winter. A minus figure was recorded for 2019/2020, which reflected the lower levels of deaths in the January and February and the second COVID-19 wave occurring in the summer months. This showed that the seasonal effect of COVID-19 was not necessarily linked to the mortality that would normally be seen.

The main causes of preventable mortality in Jersey and England and Wales were diseases of the circulatory system and neoplasms (cancers). The rates for diseases of the circulatory system in Jersey (22 per 100,000) were lower than the rates in England (34), Scotland (39) and Wales (42 per 100,000 population); the rates for neoplasms (20 per 100,000) were lower than the rates in England (26), Scotland (29) and Wales (31 per 100,000 population).

Coronavirus (COVID-19) deaths in those aged under 75 were now included in the avoidable mortality definition. The 2020 avoidable mortality rate for deaths due to coronavirus (COVID-19) in Jersey was around a quarter of that seen in the UK, with 8 deaths per 100,000 people in Jersey compared to 35 deaths per 100,000 people in England, 36 in Wales, and in Scotland. It was noted that most deaths in Jersey were among the over 80s so would not be included.

The Cell noted that 384 patients were currently recorded in the EMIS clinical IT system as suffering from 'Long COVID'. Women aged 40 to 49 years continued to be most affected. 41 patients had attended the Long COVID clinic at the Hospital, and a total of 106 patients had been referred.

It was noted that footfall in St. Helier had not returned to pre-pandemic levels but was higher at present than it had been in March 2021. Traffic movements on the overpass were similar to 2021, and bus usage was higher than 2021 but remained lower than 2019 and 2020.

Details regarding the COVID-19 vaccine programme were shared and it was noted that as at 20th March 2022, 226,090 doses had been administered, of which 61,448 were third 'booster' doses and 2,498 were Spring Booster (fourth) doses. The Spring Booster programme for the over 75s and Immunosuppressed over 12s had resulted in a quarter of the cohort being vaccinated.

The Cell was informed that 13 episodes of flu-like illness had been reported in primary care during the week ending 27th March 2022. Overall, levels of flu-like illness were similar to those seen during the 2020/21 winter season and significantly lower than in previous pre-pandemic winter seasons.

The Cell was apprised of the situation in the United Kingdom ('UK'), noting that over the 7 days to 28th March 2022 (22nd March 2022 for hospitalisation figures), cases had decreased by 3.3 per cent, hospitalisations had increased by 15.8 per cent and deaths by 27 per cent.

A graphical comparison of 14-day case rates per 100,000 population showed that Jersey's rate had continued to increase to 3,990, while the UK had experienced an increase generally with Scotland at 3,060, England 1,650 and Wales 800, while Northern Ireland had plateaued at 1,570. The Cell was informed that 14-day case rates across Europe were inconsistent with a decrease noted in eastern Europe and Portugal and an increase in Spain.

An update on the risk assessment of the SARS-CoV-2 variant: VUI-22JAN-01 (BA.2) produced by the UK Health Security Agency was provided. It was noted that the competency level had moved from moderate to high otherwise there were no

other significant changes.

The Cell was informed of 'Deltacron' recombinants. These could form when someone was co-infected with 2 strains with a recombinant forming from a mixture of the 2. 3 recombinants had been designated: XD, XE and XF. XD was the recombinant of the most concern. Mainly seen in France and not yet detected in the United Kingdom, it was of interest because of its Delta base with Omicron spike. Recombinants would continue to be monitored with a report included in the weekly technical briefing.

A brief update on the situation in the General Hospital as at 29th March 2022, was received, with 10 patients suffering with COVID-19 and some increased sickness within the staffing groups. However, green status was being maintained with phase one of the COVID-19 approach, with no additional surge areas in use.

With the 4th wave having now included the highest number of deaths, at 42, the Cell was advised that approximately 2 deaths per week were being recorded. It was recognised that Jersey's case rates appeared to be much higher than the devolved nations and a member asked whether there was any insight into this. Another Cell member referenced hospital admissions, which showed that UK rates were going up by 16 per cent, whereas Jersey's current rate stood at 10 individuals, having recently been between 10 and a maximum of 20. Mrs. Clarke suggested that there had been a significant reduction in case rates since the start of March 2022, which differed from the UK pattern where levels had returned to similarly high levels of late January 2022. A member questioned whether differences in the approach to testing could account for the high number of reported cases in Jersey. Admissions and cases in hospital were well documented and comparable, but case enumeration was dependent on testing regimes. Mrs. Clarke responded that in the UK a positive Lateral Flow Test ('LFT') counted as a case whereas in Jersey only positive PCR tests were included. On that basis it could be expected that UK case numbers would be higher.

Another member suggested that the foregoing highlighted how this particular graphic could potentially be misleading. A lot of the drive of Jersey's testing policy was in essentially a mass screening programme for the school aged population as well as a large number of businesses in the finance sector. These were identifying more cases than the UK and this could explain the higher perceived caseload in which case the graphic was misleading.

A member revisited a suggestion made previously in relation to splitting the 4th wave into an autumnal phase from October to the end of December 2021, which was largely attributable to the Delta variant, with the emergence of Omicron. The period from January to date was largely, but not entirely, attributable to the Omicron variant. This would enable the representation of the different characteristics of the variants and divide approximately 30,000 cases to around 10,000 at the end of 2021, and 20,000 since the beginning of 2022 and give a more accurate representation of the situation. It was also acknowledged that the mortality reports that had been circulated prior to the meeting and summarised in the presentation were most helpful. Reference was made to the Cell paper published in The Lancet on 10th March 2022, which revealed excess mortality from 191 countries across the world for a combined average of 2020 and 2021. It was suggested that it would be helpful to identify Jersey's excess mortality rate average over the 2 years to be able to measure the results against the numbers published in The Lancet, acknowledging that the methodologies would be different but this would give an indication of where the Island stood in comparison with other jurisdictions. The UK excess mortality figure was 126 per 100,000 head of population whereas Jersey's figure was much

lower, and closer to zero for the 2-year period. It was suggested that it might be helpful if Public Health Informatics could look at those statistics in a more formal fashion to establish where Jersey stood to date when compared with the estimates from other countries. Whilst it was recognised that most of the information requested would have been received at the Cell meeting when The Lancet paper was presented, the view was held that this would still be a useful exercise.

The Cell noted the position and thanked Mrs. Clarke for the update.

PCR laboratory update.

A3. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A1 of its meeting of 1st March 2022, received a verbal update from Dr. I. Muscat, MBE, Consultant in Communicable Disease Control, in connexion with the provision of a Polymerase Chain Reaction ('PCR') laboratory.

The Cell heard how it had been the ambition of Jersey to establish a PCR testing laboratory. The first target had been to establish a temporary laboratory in part of a ward in the General Hospital and that was up and running and continued to provide a very good service, although it was not up to laboratory standards because of its location. Therefore, funds had been sought to relocate the PCR facility in rooms adjacent to the main laboratory. The Competent Authority Ministers had now authorised the allocation of the necessary funding and this had been confirmed in a letter to Mrs. C. Landon, Director General, Health and Community Services, which indicated that work could proceed to affect the transfer to the permanent location within the General Hospital. The work was expected to take 14 weeks and would start as soon as possible.

It was noted that it was essential to maintain such a resource on the Island in case of future need. COVID-19 was expected to continue and it was important to be able to monitor the number of admissions and maintain the safety of vulnerable places. The resilience to scale up the laboratory should there be a new variant of concern was also recommended. However, should demand decrease, the PCR laboratory could be refocussed to other elements of infectious or non-infectious diseases. It would be a useful and valuable resource even in the absence of overwhelming demand from COVID-19.

Vaccine update.

A4. The Scientific and Technical Advisory Cell ('the Cell') with reference to Minute No. A3 of its meeting of 15th March 2022, received a presentation, dated 24th March 2022, entitled 'Vaccination Coverage by Priority Groups', which had been prepared by Ms. E. Baker, Head of Vaccination Programme, Strategic Policy, Planning and Performance Department and heard from her in connexion therewith.

The Cell was informed that vaccination was the key mitigation to the risks of de-escalation with the focus currently on:

1. Evergreens and outstanding boosters: over 18s continued to attend for first or second doses. Whilst there had been 82,777 first doses and 79,327 second doses, only 61,448 Booster (third) doses had been given. Behavioural Science and Communications were looking at ways to boost the uptake with consideration being given to a general booster text reminder to all those who were eligible;

2. At Risk 5 to 11 year olds: the uptake was 35 per cent which compared well with other jurisdictions such as Scotland (20 per cent). Second doses were expected to be completed by the Easter weekend; and

3. Spring Booster: The programme involved those aged over 75 or the over 12 Immunosuppressed, a cohort size of approximately 10,000. Further to the confirmed figures given in Minute No. A2 of the meeting (2,498), the uptake had reached 40 per cent based on unvalidated data. 34 care homes included in the first tranche were expected to be completed by 30th March 2022, with visits to the housebound due to commence on Monday 4th April 2022, with the aim of completion within 8 to 10 weeks. Promotional activities had included a live phone-in on BBC Radio Jersey.

Operational planning for the universal 5 to 11 year-olds roll out, a cohort of approximately 8,000, was well advanced and had involved discussions with the Children's Commissioner and Children's Minister, the Children, Young People, Education and Skills Department, Communications and Behavioural Scientists. A children's rights impact assessment had been drafted and shared with the Children's Commissioner and Children's Minister. A paediatric formulation of the vaccine would be given. The programme was due to be launched in the week commencing 4th April 2022, with the vaccinations being delivered from the start of the Easter school holidays in order that disruption to the education of young Islanders would be minimal. Promotional activities included an Ask the Experts event and a film of a young person on the vaccination journey and explaining its importance. Child-friendly leaflets had also been developed.

The Cell noted the update.

Mandatory isolation advice questions.

A5. The Scientific and Technical Advisory Cell ('the Cell') with reference to Minute No. A2 of its meeting of 15th March 2022, received a report, dated 29th March 2022, entitled 'Confirmed COVID-19 cases – end of mandatory isolation requirement', which had been prepared by Mr. J. Lynch, Policy Principal, Strategic Policy, Planning and Performance and heard from him in connexion therewith.

The Cell was informed that the report contained recommendations for the next meeting on 20th April 2022 when advice would be provided to Competent Authority Ministers ('CAM') on whether mandatory isolation should remain beyond 30th April 2022. CAM had met 2 weeks previously (17th March 2022) to consider removing the mandatory isolation after a positive Polymerase Chain Reaction ('PCR') test (this requirement had been due to end on 31st March 2022 under the Post-Emergency Strategy timeline) and had chosen to extend the legal requirement. The reasons for the extension included the persistent high case rate, with an average of 275 cases per day, recent peak hospitalisation of 49 and the significantly reduced mortality rate but consistently regular number of deaths as a result of mass infection. There was also the ongoing disruption of business continuity and education and the continued observed fall in adherence to voluntary public health measures with increasingly cautious messaging from comparable jurisdictions, including Scotland, which had extended mask wearing, and Guernsey, which had reported continuity problems in the business community.

It was hoped that the extension of the isolation legal requirement, until 30th April 2022, would allow for the roll out of the Spring Booster programme and the arrival of warmer weather and reduced indoor mixing. The presentation was designed to canvass the opinion of the Cell as the Island progressed towards the decision point on whether the key metrics covered the correct areas and would provide all the information to make the required decision.

In summary, the signalled end of the mandatory requirement to isolate had been

extended to 30th April 2022; the indication being that the requirement would fall away unless there was a compelling public health reason for retention.
The Cell was asked to advise on supporting metrics. The intention was not to establish fixed thresholds but to ensure that the necessary high-level considerations were established.

Cell members were asked:

1. to consider and approve the high-level indicators; and
2. advise on appropriate areas to inform the decision on the removal of the legal requirement to isolate.

The proposed indicators were as follows:

Metrics: a, Case Rate; b, Hospitalisation; c, ICU Admission; d, Deaths; e, Vaccination Uptake; f, Long COVID burden.

Wider Intelligence: g, Critical disruption to essential services; h, Emergence of Variants of Concern; i, Observation of comparable jurisdictions.

Mr. Lynch explained that the wider intelligence (g.) would go beyond the figures for footfall in St Helier, traffic in the overpass and bus usage to include business continuity with staff (in Health and Community Services, for example) and from other forums in relation to supply chain difficulties across essential services. In the case of (h.) data on the emergence of variants of concern and recombinants would continue to be gathered and presented to the Cell to be included in the assessment of risks for Ministers, which would be similar to the process in the Autumn of 2021 when Omicron intelligence informed the mitigation measures. In relation to (i.), the month's delay had enabled Jersey to look at other jurisdictions, in particular in relation to the removal of legal requirements. Whereas most had moved to a non-mandated paradigm in terms of COVID-19 response there had been various degrees of feedback. Guernsey had progressed rapidly to remove the final isolation requirements and had then made a hurried attempt to recover some element for requirement. The Cell was being asked to confirm that the current metrics were appropriate and comprehensive enough to inform the decision making on the removal of isolation as the last regal requirement.

A Cell member explained that attempts would be made to improve the timeliness with which the cause of death was finalised and recorded. When they occurred in hospital causes were identified more quickly, but within the community there was a delay until the death was registered. As part of the de-escalation strategy, the Cell was reminded that COVID-19 updates would move from daily to weekly. This change was initially scheduled to begin at the end of March 2022, but in line with the CAM decision to retain the legal requirement to isolate until 30th April 2022, the daily reporting would also continue until the end of April 2022 should the decision go ahead. Efforts would continue to ensure that Cell members received the most up-to-date information.

It was suggested that the case rate could be misunderstood by the wider population bearing in mind the shifts in testing that were likely to occur in Jersey over the coming weeks and months. As a raw indicator they could be misleading. In terms of what was being measured, the concern related to severe disease and in that regard the focus should be on hospitalisation and ICU admission. One additional suggestion was how the rising transmission would be recorded given the future testing policy. On the assumption that people were routinely tested on admission, the positivity rate would be the most robust indicator and would remove the possible confusion around

changes in testing.

The method of monitoring data on critical disruption to essential services was questioned and when it was revealed that this involved daily readouts of absences among Health and Community Services staff and conversations with other Government Departments, the care sector and businesses, doubt was expressed over whether this information could be defined as metrics. A member agreed that monitoring people on admission to hospital rather than the combined figure of all positive cases, which could be distracting, was a helpful suggestion. It was recalled that information had previously been provided to the effect that the vast majority of those who tested positive were symptomatic with 2 or 3 symptoms, particularly in older age groups, and were off work because they were unwell and not just because they had tested positive and were isolating.

The Acting Chair questioned whether Cell members were considering giving more weight to certain proposed indicators, such as hospitalisation, ICU Admission and deaths as representations of severity. Case rates could be better represented by the testing of admissions which had been consistent throughout. In addition, he suggested adding the testing of staff working in vulnerable places, such as the hospital and care homes, because that had also been consistent for many months and was likely to remain so for some time to come and staff numbers at least partially reflected what was happening in the community. There were minor changes with the improving roll out of anti-viral medication to cases in the community that were at risk of being hospitalised. According to trials, Paxlovid eased hospitalisation rates by 90 per cent. It was the Cell's role not just to measure the situation but to make improvements. Observation of comparable jurisdictions was very important as data had shown in the earlier summary that BA.2 was not considered the major cause of the increase in the number of cases seen in the United Kingdom ('UK'). The corollary was other factors were more important, mixing being one. What was happening with the removal of the mandatory requirement for isolation was best reflected within that observation of comparable jurisdictions. If people were not required to isolate they may test less frequently and even if they tested positive they could decide to attend work if they felt well enough to work and particularly if they were on zero hours contracts. All these aspects could to a greater or lesser extent affect the metrics. The Acting Chair asked whether the Cell was largely content with measures a. to i., but with a particular emphasis on the more robust elements such as hospitalisation, ICU admissions, deaths, observation of comparable jurisdictions, business disruption and the monitoring and discussion of the severity of variants.

It was pointed out that if testing practices were to change and people stopped testing before attending the workplace then the virus would continue to spread and that would potentially increase the risk of infection among the more vulnerable. Less testing could result in fewer cases being identified, but more people would become unwell, and this could be perceived as 'allowing people to become unwell'. There was a lengthy time-lag in identifying cases of Long COVID but it was important to remember the severity of the disease.

A member responded that the intention was that people would continue to isolate if they tested positive but from 30th April 2022, that would become a recommendation rather than a legal requirement. However, the message would be one of greater laxity. How the end point was reached was a difficult balance and all the metrics being explored would flex as a result of the decisions being made, save for testing prior to admission. The view was expressed that asymptomatic transmission would have to be accepted as requiring asymptomatic people who tested positive to isolate would not be 100 per cent effective. It was unclear how effective this policy would be in future if the Omicron and other variants remained as transmissible. The impact

of interventions was likely to be less than earlier in the pandemic.

The Acting Chair reminded the Cell that one of the reasons for the one-month delay in removing the isolation legal mandate was to buy time for the spring booster to be fully or near-fully rolled out by the time it was lifted. To the end of the previous week 25 per cent of those eligible in the over-75 and over-12 immunosuppressed groups had been vaccinated and that number would continue to rise.

The Cell was thanked for its helpful comments. The metrics were not considered unreasonable, and the wider intelligence suggested they would be helpful to the conversation but when examining case rates segregated by reason of testing, admission rates were welcomed. The intention was to provide information on deaths in a more timely manner. The vaccine booster update would be reflected at the end of the month. In relation to critical disruption, it needed to be made clear where the information came from and what was being reflected in terms of the impact on the Island. There had been no further suggestions to the information included in the presentation and this information would be brought back to the Cell on 20th April 2022.

The Acting Chair requested that the observations from comparative jurisdictions could include what happened when they de-escalated historically as well as what happened as a result of the lifting of mandation. The UK and Guernsey had most recently removed the legal requirements and the Acting Chair clarified that he was interested in comparative vaccinated populations with Omicron which had lifted much or all of the mitigation, such as the UK and the Isle of Man and there could be other countries. He highlighted that the summary on BA.2 must have looked at a number of factors that affected transmission in order to conclude that the variant in and of itself was not a major cause of the witnessed increase in transmissibility.

Matters for information.

A6. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of the current meeting, received and noted the following –

- technical briefing 39 (SARS-CoV-2 variants of concern and variants under investigation in England), dated 25th March 2022, which had been prepared by the United Kingdom Health Security Agency;
- statistics relating to deaths registered in Jersey, dated 24th March 2022, which had been compiled by the Office of the Superintendent Registrar; and
- a report titled PH Intelligence: COVID-19 Monitoring Metrics An Overview of the last 12 Months, dated 25th March 2022, which had been compiled by the Health and Community Services Informatics Team.

There being no further business to discuss, the meeting was concluded at 3.12pm.