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SCIENTIFIC AND TECHNICAL ADVISORY CELL

(17th Meeting)

2nd September 2020**PART A (Non-Exempt)**

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

Minutes. A1. Members of the Scientific and Technical Advisory Cell were asked to provide any comments on the Minutes of the previous meeting, which had been held on 24th August 2020, to the Secretariat Officer, States Greffe. The Chair noted that, at Minute No. A2 of the previous meeting, it had stated that 2 individuals had tested positive for COVID-19 at day 5 of testing, having arrived from an amber country. He queried what percentage of those tested this equated to. The Principal Officer – Public Health Intelligence, Strategic Policy, Planning and Performance Department, indicated that she would confirm this figure.

Monitoring metrics. A2. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of its meeting of 24th August 2020, received and noted a PowerPoint presentation, entitled 'Scientific and Technical Advisory Cell monitoring update', dated 2nd September 2020, which had been prepared by the Principal Officer – Public Health Intelligence, Strategic Policy, Planning and Performance Department.

The Cell was informed that, as at 1st September 2020, there had been 15 active cases of COVID-19 in the Island and over the previous 14 days there had been 17 cases. The rate of Jersey cases per 100,000 population over the previous 14 days, stood at 15.77. Of the 15 active cases, 7 were symptomatic and 8 asymptomatic and they had been in direct contact with 109 individuals. Since 3rd July 2020, when the borders had re-opened, 44 positive cases had been identified as a result of arrivals screening, of which 25 were Jersey residents. There had been no change in the number of deaths from COVID-19 since the last meeting and the overall number of deaths for the year to-date had increased to 442, which remained lower than for the same period in 2019 and over 100 lower than in 2018, when there had been 547 deaths.

A total of 378 positive cases of COVID-19 had been recorded in Jersey since the start of the pandemic, of which 347 had recovered and the majority had fallen into the age bracket of 18 years to 59 years (248). Over the previous 2 weeks, there had been 14 confirmed cases from inbound travel testing and 4 arising from direct contact with a symptomatic individual. Over the previous 14 days, there had been 17.63 cases per 100,000 of the population. It was noted that this figure differed from that given in the previous paragraph, because this figure was based on the date the positive case had been recorded, whereas the previous figure used the swab date. The Cell was informed that the European Centre for Disease Prevention and Control ('ECDC') employed the date recorded when compiling its statistics.

Since the start of the pandemic, a total of 84,199 tests had been undertaken, of which the majority (60,484) had been on arrivals. The Cell noted that Jersey's weekly testing rate per 100,000 of population was 10,300, which far exceeded the United Kingdom, at 1,769 and other jurisdictions, with which the Island had close links, but it was noted that the United Kingdom had not yet submitted its testing figures for week 34 and Germany's figures for weeks 33 and 34 remained outstanding. Jersey's positivity rate

was still at 0.1 per cent, whilst the United Kingdom was at 0.7 per cent, France at 3.3 per cent and Spain at 9.0 per cent.

Since 3rd July 2020, there had been 60,382 arrivals into the Island and 57,102 swabs taken, which included day 5 swabs. Since 1st July 2020, 44 inbound travellers had tested positive, of which 37 were considered to be active infections. The other 7, who had tested positive on arrival, had subsequently undergone serology tests that demonstrated that their infection was 'old'. Of the aforementioned positive cases, 38 per cent had arrived from red or amber countries and 84 per cent by air. 25 of the 44 travellers were Jersey residents and 19 visitors. The Cell noted that the average turnaround time for the testing of arrivals over the previous 7 days had been 29 hours.

The Cell was shown a new slide, which set out the number of positive cases for COVID-19 since 3rd July 2020, including the swab date and the reason for screening (arrivals screening, hospital admissions screening, contact tracing, or workforce screening). It also showed the number of tests undertaken by month, broken down by inbound travel and non-inbound travel. It was noted that, in July and August, the inbound rate of positive cases had been 0.07, whereas for non-inbound travel this was higher, at 0.09.

In respect of the inbound travel / non-inbound travel rates, the Independent Advisor - Epidemiology and Public Health questioned whether the latter rates were not, in fact, directly linked to the former and the contact that people had with them. He suggested that in some models, only 60 per cent of positive cases for COVID-19 were identified by testing on arrival, which suggested that 40 per cent were not being captured and unless they were all asymptomatic, one would expect to have encountered them at a later date. If this had not happened, it was suggestive that the sensitivity of the testing regime was higher than originally thought. The Consultant in Communicable Disease Control, informed the Cell that on 26th August 2020, of the 6 non-inbound travel cases that had tested positive for COVID-19, 4 had been found through contact tracing as household members of other positive cases, one had been identified during pre-admission screening and one as part of routine workforce screening. This breakdown was on a par with previous and subsequent results. With respect to the 'leakage' of positive cases, as the instances of COVID-19 increased in surrounding jurisdictions, so the numbers in Jersey would grow. It was also the case that some people were not reporting symptoms, because they did not believe them to be significant and only when they tested positive for the virus would they recall that they had previously experienced symptoms, such as a sore throat, for example.

The Cell noted maps, which set out the geographic distribution of 14-day cumulative numbers of reported COVID-19 cases per 100,000 population on a worldwide and European basis. These showed that the Americas remained red, with over 120 cases per 100,000 and that was still also the case in Spain. France was amber, with a higher number of cases in Paris. Globally, there had been over 25 million cases of the virus since the start of the pandemic and over 850,000 deaths.

From 2nd September 2020, the United Kingdom, France and Eire would be divided into regions for the purpose of categorisation under the COVID-19 traffic light system and it was noted that Public Health would be classifying the cumulative cases of COVID-19 for 344 individual regions on a weekly basis. These comprised 149 local authorities in England and 22 in Wales; 32 council areas in Scotland; 11 local government districts in Northern Ireland; 26 counties in Eire and 104 départements in France, to include the overseas territories. The data would be taken from Public Health England, Public Health Wales, Public Health Scotland, the Northern Ireland Department of Health, Ireland's Open Data Portal and Santé Publique (Public Health France) respectively, rather than being provided by the ECDC. Of the 344 regions, 11 were presently

17th Meeting  
02.09.20

classified as red, 106 as amber and 227 green. Nine per cent of the départements in France, 9 per cent of the Northern Ireland government districts and 4 per cent of the counties in Eire were red at the current time. With the move to regional classification, the Cell suggested that it would be useful to have a weighted rate for the origin of inbound travellers. As had been discussed at previous meetings, the Cell was mindful of the risk posed by amber countries, particularly as a third of all positive cases for COVID-19 came from them, but they accounted for only 10 per cent of all countries. On a related note, the Cell was aware that England's rate per 100,000 population over the previous 14 days, currently stood at 25.01 per cent and was extremely close to becoming amber (25.1 per cent).

Travellers were required to disclose where they had spent a night over the previous 14 days, but because the regionalisation was not retrospective, a full regional picture would not be obtained from people until mid-September, a fortnight after the new system had been introduced. The Consultant in Communicable Disease Control opined that there would be merit in requiring all arriving passengers from green countries to undertake PCR tests at days zero and 5 – without the requirement to quarantine – in order to prevent any undue seeding of the virus.

The Cell received information relating to influenza, based upon data provided by the ECDC and World Health Organisation and was informed that flu activity was at inter-seasonal levels. Whilst caution was urged in interpreting the flu surveillance data, instances were at lower levels than expected for the time of year, with very few cases reported. In the Southern Hemisphere, there had been virtually no positive cases for flu during weeks 34 and 35, whereas, during week 36 of 2019, there had been in excess of 800. Flu activity was, accordingly, at record low levels and whilst the amount of testing for influenza had remained at similar levels, or had increased, very few cases had been detected. This was also the case in the Northern Hemisphere. The Principal Officer – Public Health Intelligence was asked to ascertain if there had been an increase in vaccinations for flu, which might account for these lower figures and to provide the information for the next meeting of the Cell.

The Cell noted monitoring and enforcement data in respect of the week of 10th to 16th August 2020, which had been provided by Environmental Health and which showed that there had been 2,352 calls made to people in self-isolation, 233 emails sent, 72 welfare visits undertaken and that 2 case files were under review.

For the period up to 23rd August 2020, the number of people registered as actively seeking work (excluding those claiming through the Covid Related Emergency Support Scheme (CRESS)) continued to decline, when compared with the previous week, whereas the number of active income support claims remained static. Footfall in St. Helier had recently plateaued (up 0.3 per cent on the previous week), but remained significantly lower than for the same period in the previous year (down 39.9 per cent).

The Cell was informed that, on 3rd September 2020, Statistics Jersey would be releasing the Jersey Opinions and Lifestyle Survey 2020, the main focus of which would be on the effects of the COVID-19 pandemic on households.

The Cell noted the position and thanked the Principal Officer – Public Health Intelligence for the comprehensive update.

Next Phase  
COVID-19  
Strategy –  
proposed  
approach.

A3. The Scientific and Technical Advisory Cell ('the Cell') received and noted a report, entitled 'Next Phase Covid Strategy', dated 2nd September 2020 and was provided with a PowerPoint presentation in connexion with the proposed approach for the next phase COVID-19 strategy from the Director of Strategy and Innovation, Strategic Policy, Planning and Performance Department.

The Cell recalled that the current COVID-19 strategy, which had been published on 3rd June and which, in conjunction with the Safe Exit Framework, provided the strategic framing for the Island's response to the pandemic, had been predicated upon the message of 'Suppress, Contain and Shield'. The Island had now paused in Level One of the Safe Exit Framework and it was intended to publish an updated strategy to inform the continued response to the virus. It was emphasised that it was important to communicate to Islanders that the threat posed by the COVID-19 virus had not disappeared and that it was, in fact, returning at an earlier juncture than had been anticipated.

The Cell noted that the PowerPoint presentation had been considered by the Competent Authority Ministers at their meeting on 26th August 2020 and also received a copy of the Chief Minister's speech, which had been made on 28th August, which had contained key messaging, including that cases of the virus were likely to increase with the approach to autumn and of the importance of adhering to public health guidelines to keep the Island safe. The Director of Strategy and Innovation indicated that it was helpful to remind the public that Jersey was 'in a good place', when compared with other locations.

Other members of the Cell, whilst acknowledging that the Island was in a relatively good position in respect of COVID-19, emphasised the need to be more proactive and to enhance and enforce some of the measures that were currently in place, mindful, for example, that only 50 per cent of establishments were adhering to the requirement to collect contact details for track and trace purposes and that private parties – including illegal bunker parties - were taking place with large groups of people attending. The prevalence of COVID-19 in neighbouring jurisdictions remained a threat and the Consultant in Communicable Disease Control indicated that the aim should be to keep the Island safe until such time as a vaccine became available and a sufficient number of people had been vaccinated locally.

The Director of Strategy and Innovation agreed that the specific risk factors should be identified and targeted, noting that these would include the night-time economy and the borders. A new rapid action framework would be developed, which would set out those indicators that required close monitoring, the events that might trigger further action to be taken and the interventions that might follow. Ministers would need to be prepared to take quick and decisive action in the case of a re-escalation and effective communication to the public would prepare them to accept these measures. Consideration was being given to whether additional legislation should be introduced to ensure that Ministers had the necessary *vires* to take action in an effective and targeted way, but the Cell was notified that some Ministers were of the view that it was preferable to mandate some behaviours more forcefully, rather than legislate for the same.

The Cell felt that the introduction of legislation to address behaviours during the current crisis would be a 'blunt tool' and that it was preferable to use communication to impart to Islanders - particularly the younger cohort - the need for adherence to public health measures and to caution against flouting the same, which could lead to the health service becoming overwhelmed in the event of more cases and Ministers taking the decision to reintroduce a lockdown, which people had found challenging. It was key to be proactive in the measures taken, as opposed to reactive.

The Cell was informed that the next phase strategy would be developed over the coming weeks, in tandem with a medium-term communication strategy. It was envisaged that the former would be presented to the Cell at its meeting on 14th September 2020.

17th Meeting  
02.09.20

The Cell noted the position.

COVID-19  
strategy update  
for the Winter.

A4. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A4 of its meeting of 24th August 2020, received a PowerPoint presentation entitled 'Outline of strategic statement: our COVID-19 strategy update for the Winter' and heard from the Head of Public Health Policy.

The Cell was informed that the re-escalation preparation sat alongside more general preparation for the Winter, when the instances of influenza, as well as COVID-19, would be likely to climb. It was proposed to increase community resilience by way of a number of measures, including the provision of support to individuals with chronic conditions, the issuing of guidance to reduce transmission indoors and stricter requirements for adherence to public health measures. It would be key to ensure that health settings and care homes had sufficient PPE, tight procedures in place and a strict infection control regime. This would be combined with the appropriate and rapid distribution of the COVID-19 vaccine, as it became available.

In order to contain the spread of the virus, it was recalled that an initial 3 tier model had been developed (Contain, Tactical Response and Emergency Response). The Cell noted that it was proposed to introduce 2 new tiers (2 and 5) –

- Tier 1. Steady state contain measures - controlled (screening and household) cases, to prevent controlled cases spreading to the community;
- Tier 2. Scaling up contain measures – linked or unlinked community cases, to prevent these community cases from becoming clusters;
- Tier 3. Tactical response – clusters (institutional and community), to respond quickly to prevent early clusters or unknown cases from becoming outbreaks;
- Tier 4. Emergency response – imminent risk of outbreaks / outbreaks, to prevent harm from an outbreak, or outbreaks, or to de-escalate the same; and
- Tier 5. Lockdown response – sustained community transmission – de-escalating an epidemic, preventing mortality and preventing the collapse of the health system.

The Head of Public Health Policy indicated that the intention was to provide clarity around when protective measures should be put into place and preventative action taken to prevent clusters from becoming an outbreak and escalating.

The Associate Medical Director for Primary Prevention and Intervention, opined that there was little distinction between Tiers 2 and 3 and that Tier 5 was, effectively, an epidemic and, as a consequence, uncontrollable and far too late for any action to be taken. If Tier 5 was attained, the health care system would collapse. In March 2020, various measures had been introduced, such as the establishment of 'hot and cold' sites and closer liaison with General Practitioners ('GPs') and he sought clarity around when it was proposed that these should be re-introduced in the event of an outbreak of COVID-19. These views were echoed by other members of the Cell, who suggested that 'Emergency Response' should be the top tier and that 'sustained community transmission' should be reworded, because it was possible that there could be increased transmission, at low levels, amongst young people, who were mainly asymptomatic, without a resultant public health emergency.

Accordingly, it was agreed that some additional discussions should take place around each of the proposed Tiers, outside the formal meeting, in order to determine the appropriate responses, in parallel with the work on the revised Strategy, as referenced at item A3 of the current meeting. It was agreed that it would be useful for Health and Community Services' operational responses to be mapped onto the Tiers, mindful that the greater the Tier, the more health staff would be involved in dealing with COVID-19,

thereby impacting on the ability to provide a general health response. It was noted that the PowerPoint presentation would be circulated to members of the Cell, in order that their views could be sought and fed back to officers from the Strategic Policy, Planning and Performance Department.

COVID-19  
scenario  
projections  
from 1st  
September  
2020 onwards.

A5. The Scientific and Technical Advisory Cell ('the Cell') received a PowerPoint presentation, entitled 'Covid scenario projections 1 Sept 2020 onwards' and heard from the Senior Statistician, Statistics Jersey. The Cell recalled that previous projections had been prepared at the start of the crisis in March / April 2020 and had modelled anticipated cases of COVID-19, based on a range of reproduction ('R') numbers of the virus.

The Senior Statistician indicated that a compartmental SEIR (Susceptible, Exposed, Infectious, Recovered) model had been used to model the historic trend in cases of COVID-19 and to project new cases and hospital bed requirements, based on the current levels of infection and ongoing 'seeding' through the borders. A series of projections were provided, based on a range of R numbers, to track the anticipated peak size and timing of cases and hospitalisation, dependent on the mitigations put into place and the behaviours of the population. Since the previous projections, there had been an improvement in hospitalisation rates, 3.1 per cent compared with 4.8 per cent. Of those hospitalisations requiring treatment in the Intensive Care Unit, the proportion had improved from 30 per cent down to 17 per cent and the mortality rate had improved from one per cent to 0.7 per cent. On the basis of 'seeding' at the borders, it had been assumed that each positive case identified on arrival was representative of 2.87 actual, or incubating, cases. With regard to the assumptions around passenger numbers, 50 per cent of approximate, typical, arrival numbers had been applied from the end of September, through to the summer of 2021.

Caution was urged that the actual cases curve would be unlikely to follow the projected cases curve because the R number was a blunt tool and would vary over time and by virtue of the specific setting and geography.

Amongst other things, the projections showed that with an R number of 1.3, there would be a peak in new cases of COVID-19 towards the end of January 2021, but if reduced to 1.2, the peak would be lower, wider and would be reached at around the end of February. The Cell noted that the difference between these was quite substantial and considered an R number of 1.3 to be the 'danger zone'. An R number of 1.8 – as a consequence of non-adherence to public health measures - would result in a peak in new cases by early November 2020 and the Cell agreed that this could have significant implications pending the roll out of vaccinations.

The Cell noted the position and thanked the Senior Statistician for the presentation.

COVID-19  
Immunisation.

A6. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A3 of its meeting of 24th August 2020, received and noted 2 papers, entitled 'Scientific and Technical Advisory Cell COVID-19 Vaccine Paper – September 2020' and 'STAC Paper COVID-19 Vaccine 2nd September 2020', both of which had been prepared by the Consultant in Communicable Disease Control and the Head of Policy (Shielding Workstream), Strategic Policy, Planning and Performance Department. The Cell was also shown a PowerPoint presentation entitled 'Vaccine Programme' and heard from the Head of Policy (Shielding Workstream).

The Cell noted that the presence of COVID-19, together with other common respiratory viruses, would place significant pressure on the health service. The potential for a person infected with COVID-19 to have other viruses would make them more vulnerable to the disease, potentially requiring prolonged admission to hospital. There

was also the likelihood of misclassification, due to overlapping clinical symptoms.

Consequently, it was intended to undertake an enhanced flu vaccination programme in 2020, which would be fully funded for the eligible recipients, to include those in the age bracket from 50 years to 64 years. It was envisaged that the flu vaccine would be available from the end of September / early October 2020.

In respect of a vaccine for COVID-19, the Cell was informed that there were 2 potential vaccine candidates, which were believed to be in a position to deploy the vaccine in the United Kingdom in mid-October, albeit the initial quantities would be relatively low. It was anticipated that a 28 day gap between the administration of the COVID-19 and any other vaccine would be required and it was also possible that 2 doses of the vaccine would be needed, with a similar time interval in between them. Once the COVID-19 vaccine became available in the Island, it would need to be maintained at a temperature of -70 degrees, which had logistical implications

The Head of Policy (Shielding Workstream), the Consultant in Communicable Disease Control and the Associate Medical Director for Primary Prevention and Intervention, had been working on a list of priority groups for receipt of the COVID-19 vaccine and, by extension, the flu vaccine. In line with the guidance from the United Kingdom Joint Committee on Vaccination and Immunisation ('JCVI') and the U.K. Covid Committee, the priority would be to deploy the vaccine commencing with the health and social care workers employed in areas of the highest exposure, of which there were approximately 3,450, such as accident and emergency department staff, care home staff and paramedics and then extend to other health and social care workers, including general practices. Additional groups would then receive the vaccine based on decreasing risk. The Cell was informed that the intention was to roll out the flu vaccine to the aforementioned groups, in priority order, as it became available and then to wait the requisite 28 days before administering the COVID-19 vaccine, again in priority order. Care home residents had not been included in the first priority group for receipt of the COVID-19 vaccine because, based on previous experience with the flu vaccine, they were unlikely to respond. With the flu vaccine, in order to better improve the responsiveness of the elderly, it was necessary to include an adjuvant to boost the effectiveness, or to double the dose. As people aged, so their immune system became older and weaker. In order to better protect them, it was preferable to inoculate the care home workers, as they were more likely to bring the virus into the care homes and could respond to the vaccination.

Mindful that the COVID-19 vaccination would become available in mid-October, it was envisaged that the first supplies would arrive in the Island in November, initially in small numbers. Because of the aforementioned 28 day gap between vaccines, an efficient, prioritised, flu programme would be rolled out in October, in preparation for the deployment of the COVID-19 vaccine to start before Christmas. It was anticipated that 48,000 doses might be available by then, based on a distribution from the U.K. proportionate to the size of the population in the Island. This would enable the priority groups, down to those aged 50 years to be vaccinated, if no ring vaccination – the vaccination of all those around each infected individual – was required, or down to 60 years if it was. In order to achieve 'herd immunity', approximately 65 to 70 per cent of the population would need to be vaccinated. The Cell was informed that it was not possible to vaccinate anyone who was unwell, which was another driver to keep the number of cases of the virus under control, to prevent it interfering with the vaccination programme. It was hoped that if this was sustainable until March 2021, it would have been possible to vaccinate as many people as possible.

The Cell discussed the issue of whether the COVID-19 vaccines were licensed and issues around indemnity, particularly as the liability would rest with the prescriber. The

Head of Policy (Shielding Workstream) indicated that it was on the risk register and she was in discussion with the Director of Treasury and Risk Management in this regard. The Medical Officer of Health stated that the U.K. had announced that the MHRA (Medicines and Healthcare products Regulatory Agency) was working towards obtaining a temporary licence.

The Cell endorsed the high level priority groups for receipt of the vaccines, based on interim JCVI guidance and endorsed a decision to delay the COVID-19 vaccine deployment to the same (primarily Health and Community Services Department workers) in the event that the doses were to arrive on Island before the 28 days from the administration of the flu vaccine had elapsed.

Workforce screening policy.

A7. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of its meeting of 6th July 2020, received and noted a paper entitled 'Planned Workforce Screening Policy: Testing to Protect', dated 2nd September 2020 and was given a PowerPoint presentation on the subject.

The Cell heard from the Head of Policy, Strategic Policy, Planning and Performance Department, who indicated that the focus on workforce screening had, to date, primarily been on staff working within health and social care settings on the basis that the screening policy had focused on those who were likely to be positive for COVID-19 because of where they worked and because they were more likely to transmit the virus to vulnerable individuals, or enclosed communities, such as care homes. It was intended to extend the PCR screening, with the facility to escalate certain groups as required and people would be reminded that the programme was a public health, rather than operational health, initiative. The programme would be accessible, to facilitate workers being able to book the test and would align with some technologies being employed as part of the track and trace programme.

The Cell was informed that the planned workforce screening would be divided into groups, dependent on the level of risk of contracting and spreading the virus. Those individuals in Group A, which was those deemed to be at the highest risk and were those working in the hospital and community health care services, would be tested every 4 weeks. Group B, moderate risk individuals, would be screened every 6 weeks and it was noted that Ambulance Service employees, Jersey Hospice Care staff and those working in residential and care homes and dental practices were amongst those in this category. Group C comprised those working in schools and colleges, cleaning services, security and facilities management services and they would be tested every 8 weeks. It was also suggested that there might be merit in testing staff working in the hospitality sector to ascertain if they were at greater risk of contracting COVID-19 than others, for the purpose of understanding the spread of the virus.

The Head of Policy stated that based on the experience of offering serology testing to workers, it was envisaged that the uptake would be lower, particularly because the PCR test was more intrusive than the serology test. The Independent Advisor - Epidemiology and Public Health, suggested that residential and home care workers should be included in Group A, particularly because the instances of COVID-19 in the care homes had been greater than in the hospital and they had been disproportionately affected by the virus. The Consultant in Communicable Disease Control, proposed that ambulance staff and those operating within 'hot' General Practitioner practices should also be in Group A.

When considering an extension of the PCR testing, the Cell agreed that it was important to consider both the current and future capacity for testing. The Director of Strategy and Innovation, Strategic Policy, Planning and Performance Department, indicated that if the services of Micro Pathology were retained, once Open Cell was operational on-Island, there would be sufficient ability to undertake the aforementioned testing.

17th Meeting  
02.09.20

The Cell noted the position accordingly.

Use of face coverings.

A8. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A4 of its meeting of 20th July 2020, heard from the Independent Advisor - Epidemiology and Public Health in respect to the use of face coverings. He indicated that the scientific evidence for the use thereof was somewhat questionable, but the lack of evidence did not mean that they would not be effective. Consequently, he proposed that Jersey should adopt the same stance as the United Kingdom and require people entering shops and those working in hospitality to wear them with effect from October 2020. One of the primary benefits of requiring them to be worn was as a reminder to the public that the COVID-19 virus continued to pose a risk. The Independent Advisor - Epidemiology and Public Health mooted that the requirement to wear face coverings should be included in legislation, which would take some time to draft.

The Consultant in Communicable Disease Control, concurred. He reminded the Cell that wearing of face coverings had been strongly recommended during the first wave of COVID-19, but as the number of positive cases of the virus had diminished, less emphasis had been placed thereon. It was important not to mandate the wearing too early, but to find an appropriate point at which to emphasise that they should be worn.

The Cell agreed that it wished for people to wear face coverings in public enclosed spaces and decided to make a formal recommendation to this effect. On a related note, the Cell was aware that, unlike other jurisdictions, there was currently no *vires* for Police Officers to impose fixed penalty notices for failure to comply with this type of requirement.

Singing and music in schools.

A9. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A8 of its meeting of 24th August 2020, heard from the Head of Public Health Policy, in connexion with the playing of wind instruments and singing in schools.

It was noted that it was proposed that group sizes would be allowed up to the minimum required by the exam board, which was usually between 3 and 5 people, including the teacher. Physical distancing of no less than 2 metres and ideally 3 metres, where practicable, would be required and any non-essential activities, such as choirs, would be strongly discouraged.

The Cell agreed the change in guidance in respect of singing and the playing of wind instruments, to permit the same in schools. It was noted that advice would be provided to the schools on such matters as hygiene.

Government employees taking holidays off-Island.

A10. The Consultant in Communicable Disease Control, informed the Scientific and Technical Advisory Cell ('the Cell'), that there had recently been some instances of employees taking holidays off-Island where the categorisation of the country to which they had travelled had changed during the course of their stay, resulting in them having to isolate on return, which had implications for staffing levels. This was particularly the case if they were employed within the Health and Community Services Department, where more stringent requirements were in place. Equally, if they had taken a short break away and tested positive for COVID-19 on return from the holiday, it raised issues around whether they might have been infected with the virus before departure, requiring screening of other employees.

It was suggested that it would be helpful to make the information around the rates of infection per 100,000 population over the previous 14 days in countries / regions widely available to employees, so that they could be aware of whether their destination was

likely to change from green to amber, for example. It was also felt that there should be messaging around the risks associated with falling unwell whilst abroad.

It was noted that the issue of travel would be included within the updated Strategy document referred to at item A3 of the current meeting.

Matters for  
information.

A11. In association with item No. A2 of the current meeting, the Scientific and Technical Advisory Cell received and noted the following –

- A report entitled ‘PH Intelligence: COVID-19 Monitoring Metrics’, dated 1st September 2020, which had been produced by the Strategic Policy, Planning and Performance Health Informatics Team;
- A weekly epidemiological report, dated 27th August 2020, which had been prepared by the Strategic Policy, Planning and Performance Department;
- Death statistics for the week ending 27th August 2020, from the Office of the Superintendent Registrar;
- A report on the economic indicators for week 34 of 2020 (17th to 23rd August), which had been prepared by Statistics Jersey; and
- A weekly footfall report for week 34 of 2020, provided by Springboard.