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SCIENTIFIC AND TECHNICAL ADVISORY CELL

(78th Meeting)

15th November 2021

(Business conducted via Microsoft Teams)

**PART A (Non-Exempt)**

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

Professor P. Bradley, Director of Public Health (Chair)  
 Dr. I. Muscat, MBE, Consultant in Communicable Disease Control  
 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  
 B. Sherrington, Senior Nurse Adviser in Public Health (Items A1-A3)  
 I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department (Items A1-A5)  
 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

In attendance -

R. Williams, Director, Testing and Tracing, Strategic Policy, Planning and Performance Department  
 S. Martin, Chief Executive Officer, Influence at Work  
 S. White, Head of Communications, Public Health  
 E. Baker, Lead Nurse, Infection Prevention and Control, Health and Community Services  
 J. Norris, Principal Policy Officer, Strategic Policy, Planning and Performance Department  
 J. Lynch, Principal Policy Officer, Strategic Policy, Planning and Performance Department  
 K.M. LARBALÉSTIER, Secretariat Officer, States Greffe  
 L. Plumley, Secretariat Officer, States Greffe

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

Minutes

A1. The Minutes of the Scientific and Technical Advisory Cell ('the Cell') dated 25th October and 1st November 2021, which had previously been circulated, were taken as read and duly approved by the Cell for onward provision to Scrutiny.

Intelligence  
overview,  
including  
Analytical Cell  
update and  
HCS activity

A2. The Scientific and Technical Advisory Cell (the Cell) with reference to Minute No. A2 of its meeting of 1st November 2021, received a PowerPoint presentation dated 15th November 2021, entitled 'STAC Monitoring Update' which had been prepared by Ms. M. Clarke, Head of Public Health Intelligence and Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department and heard from them in connexion therewith.

The Cell was informed that, as at Friday 12th November 2021, there were 736 active cases of COVID-19 in the Island, from which 6,355 direct contacts had arisen. As at the same date, the 14-day case rate, per 100,000 population, had been 855 and the 7-day rate 459. Of such active cases, 424 had sought healthcare, 240 were direct contacts, 21 had been identified through arrivals screening, and the remainder had been identified through planned workforce, admission or cohort screening. The Cell noted the decrease in cases identified through arrivals screening subsequent to changes in the border testing regime.

The majority of cases (212) were in those aged between 10 and 19 years and in those aged between 40 and 49 and between 50 and 59 years, which when combined, accounted for 229 cases. Cases amongst those aged 30 to 39 years had increased to 85. Most of the active cases (76 percent) were symptomatic and one third were fully vaccinated, it was noted that cases were increasing in school aged children, many of whom were not eligible for vaccination. The number of daily tests had decreased to around 1,000 due to changes in the border testing regime and tests being undertaken on individuals who had been contact traced now accounted for a large proportion of the total.

The daily incidence rate, which had averaged 52 cases per day over the period of 25th October to 6th November 2021, had increased since that date to an average of 91 cases per day. The Cell noted that results from Lateral Flow Device ('LFD') testing were being fed into the data and that the test positivity rate would be impacted by increased LFD testing rates as a positive LFD test result frequently translated into a positive polymerase chain reaction ('PCR') test result. The overall test positivity rate was increasing across all age groups, and currently stood at 5.4 percent, and when the inbound travel figures were removed, the on-Island rate was 7.3 percent.

For those aged under 18 years, the test positivity rate was 5.4 percent and there had been a slight decrease in the rate for those aged between 40 and 49 years to just over 2 percent, whereas for the other age groups, it was continuing to increase above one percent. The Cell reviewed a graph of the 7-day case rate, per 100,000 population, for Islanders of different ages and noted the increase over the last 3 weeks to 896 for those aged under 18 years. A lesser increase was also noted for those aged 40 to 59 years and those aged 18 to 39 years, whilst the rate had remained relatively stable for those aged over 60. The Cell noted that the test positivity rate for those who had had a test after seeking healthcare had increased to 30 percent, and now included individuals who had tested positive after reporting a positive LFD test result.

The Cell was provided with details of the current cases in the Hospital including the age and vaccination status of the patients. It was noted that as at Friday 12th November 2021, there had been 5 patients in the Hospital with COVID-19. Details were provided of the positive cases linked to health and care settings, Government Departments and schools, which showed an increase across all areas. The Cell noted that several schools were experiencing clusters and had implemented measures to mitigate the risk of transmission, although spread was occurring both in and outside of the schools. An increase in the test positivity rate for the schools LFD testing programme had been observed and this now stood at 0.68 percent. The Cell was reminded that the denominator used for this calculation, *viz.* the number of LFD test

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results submitted, may not include all LFD test results as some negative results may not be reported. Work on the interplay between positive LFD test results and subsequent positive PCR test results was in progress and there appeared to be a high rate of conversion from positive LFD tests to positive PCR tests, with only 7 known instances of subsequent negative PCR test results.

Ms. M. Clarke informed the Cell that there had been 80 deaths from COVID-19 since the start of the pandemic, 11 of which had occurred since 28th June 2021 (the third wave).

It was noted that during the week ending 7th November, Jersey's testing rate, per 100,000 population, had been 9,500, a decrease that brought Jersey closer to the United Kingdom ('UK') rate of 9,100, noting that the latter figure included tests undertaken on LFDs. The positivity rate locally had been 4.1 percent compared with 3.9 percent in the UK. The Cell was informed that during the same week, 3,860 tests had been undertaken on inbound travellers, which represented a significant decrease due to the changes in the border testing regime, 5,550 as part of on-Island surveillance and 860 on people seeking healthcare on experiencing symptoms of the virus.

The Cell noted that calculation of the estimated effective reproduction number ( $R_t$ ) had been paused for the time being due to sharp changes in testing and the situation would be kept under review.

The Cell noted that 234 patients were currently recorded in the EMIS clinical IT system as suffering from Long Covid. Of these, 116 had ongoing symptomatic Covid and 127 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. Women aged 40 to 49 were the most affected group.

In respect of the COVID-19 vaccine programme, the Cell noted that, up to 7th November, 80 percent of Islanders aged over 80 years had received their booster dose, whilst 52 percent of those aged between 16 and 17 years and 27 percent of those aged between 12 and 15 years had received their first dose. A total of 176,025 vaccines had been administered, of which 22,212 were booster doses. In respect of the estimated vaccine coverage for the Joint Committee on Vaccination and Immunisation ('JCVI') priority groups, the Cell was informed that 70 percent of care home residents had received their booster dose, as had over 45 percent of those working in frontline health and social care settings and 39 percent of other health and social care workers. 49 percent of those classed as clinically extremely vulnerable aged from 16 to 69 years had received a booster dose and the figure for those considered clinically at risk was 41 percent. It was noted, however, that a small amount of the data was of questionable quality and was coded Amber. The Cell was shown a graph which tracked the booster vaccine uptake by age group, this was increasing for all eligible age groups.

The Cell noted a graph, which had been prepared by the European Centre for Disease Prevention and Control ('ECDC') and which showed the cumulative vaccine uptake amongst people aged over 18 years, including both first and second doses in the same chart. It was recalled that first and second dose coverage in Jersey was 88 and 86 percent respectively, which compared favourably with many countries.

The Cell was informed that a total of 32,666 flu vaccines had been delivered as of 7th November 2021, across a number of settings, with the highest number delivered in schools and nurseries as part of the annual flu vaccination programme, and a similar number being delivered through GP surgeries. This had resulted in almost half (47 percent) of those aged zero to 16 years, 72 percent of those aged over 80 years and 68 percent of those aged 65 to 79 years of age being vaccinated against flu. Information regarding flu vaccination rates by eligibility group showed that 66 percent of school students in Reception to Year 11, 45 percent of care home residents and 37 percent of Health and Community Services Staff had received the flu vaccine, although it was noted that this was based on data considered to be of moderate quality and was coded Amber. The Cell noted that 40 cases of flu-like illness had been reported in primary care during the week ending 14th November 2021, which was a similar figure to the 39 cases reported in the previous week and the trend for reporting of flu-like illnesses was noted to be higher than in previous years. Globally, despite increased testing for flu, levels remained lower than expected for the time of year and the highest rates were in those aged under one year. Only a small number of cases of flu had been confirmed in the Island.

Mr. I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, queried the figure for the percentage of care home residents vaccinated against flu as he believed it to be higher. It was noted that the flu vaccine had initially not been administered concurrently with COVID-19 vaccinations as its arrival in the Island had been delayed, so there could be a lag in the reporting of the data. Ms. B. Sherrington, Senior Nurse Adviser in Public Health undertook to provide clarification to the Cell at its next meeting.

The Cell was presented with a map of cases in the UK for the 7-day period ending on 6th November 2021 and noted high rates in the north east and south west, as well as parts of Northern Ireland. In England, the 14-day case rate per 100,000 population as of 9th November 2021, had decreased to 740 and had increased in Scotland to 647 and to 892 in Northern Ireland. The case rate in Wales remained the highest of the devolved nations at 911 but showed a downward trend. There had been an increase of 6 percent in the number of people testing positive for COVID-19 in the UK when compared with the previous week, whilst hospital admissions had decreased by 6.9 percent and deaths by 13.2 percent.

The Cell noted maps prepared by the ECDC, comparing 14-day case rates on 28th October and 11th November 2021, showing increases in Germany and Eire, and high case rates in much of Central and Eastern Europe.

Mr. I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, recalled that the COVID-19 Winter Strategy 2021-2022 set out the circumstances in which the Government would consider the implementation of contingency measures to manage the spread of COVID-19 and asked how the data to support such decisions would be presented. The Chair, Professor P. Bradley, Director of Public Health, noted that this would be considered in more detail in the extant meeting under Item A6.

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Dr. G. Root, Independent Advisor - Epidemiology and Public Health, noted that the test positivity rate was ‘skewed’ by the increasing use of LFD testing, as positive LFD tests frequently translated into positive PCR test results. Dr. Root opined that the variation in levels of LFD testing in schools was interesting and wondered if some schools were better at detecting cases due to pro-actively encouraging students to take LFDs. Dr. C. Newman agreed that whilst some schools had high levels of reporting, it was likely that the first symptomatic cases in a school would trigger a cycle of PCR testing for those individuals and LFD testing for the wider setting, therefore it was not possible to definitively state that some schools were better at detecting cases. In addition, changes to the isolation requirements, specific school-based events and transmission outside of schools were relevant factors for consideration.

The Cell noted the position and thanked officers for the update.

Vaccination  
update

A3. The Scientific and Technical Advisory Cell (‘The Cell’), received a presentation, entitled ‘COVID-19 Vaccination Programme, Increasing Uptake in 12-17 year-olds, Update to STAC, CAM’ dated 15th November 2021 prepared by Ms. B. Sherrington, Senior Nurse Adviser in Public Health.

It was recalled that the Joint Committee on Vaccination and Immunisation (‘JCVI’) had advised earlier that day that all adults aged between 40 to 49 years should be offered a booster vaccine and that all 16 to 17 year olds not in an at-risk group should be offered a second dose 12 weeks or more following their first dose or a positive COVID-19 test result. Ms. Sherrington informed the Cell that bookings would open the following week for individuals in these newly eligible categories. The Cell was shown an updated booster trajectory graph, which anticipated that the booster vaccination programme would be completed by the end of February 2022.

The Cell noted that COVID-19 and flu vaccination in care homes had been completed and the eligibility of residents was being revisited in light of the updated JCVI advice. Mobile vaccination units were visiting private homes and around a thousand vaccinations would be delivered in this manner. The feasibility of automated reminders to book booster appointments was being explored.

The Cell was informed that a Schools vaccination programme had been established and would commence offering vaccines to those aged 12 to 18 years from Monday 29th November, with walk in appointments also available for this age group. The programme was designed in line with the principles adopted by the Competent Authority Ministers (‘CAM’) to ensure minimal disruption to schools and the Vaccination Centre and mobile unit operations. Gillick competency would be applied at the Vaccination Centre only. Communications and consent forms would begin to be sent from 17th November 2021, and the programme was anticipated to be complete by the end of the 2021 Autumn term.

The Cell noted that a resilience-based proposal had been approved by the Vaccination Programme Board to extend contracted vaccinators to the end of the first quarter of 2022 and that an agile model would be implemented. Vaccination operations would continue over the Christmas and New Year period except on days when Fort Regent was closed.

Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention, noted that adults aged from 40 to 49 years would be offered a COVID-19 booster vaccination, but would not automatically be eligible for a flu vaccine at the same time and asked for this to be made clear in communications. In relation to the vaccination status of those aged 12 to 15 years, Dr. Noon noted that they would not be considered 'fully vaccinated' for the purposes of travel if they had received only one dose. Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department confirmed that this was the case for travel to Europe and that the JCVI's position was continually under review.

Dr. G. Root, Independent Advisor - Epidemiology and Public Health, expressed his support for the Schools Vaccination Programme whilst noting that 'some ships had sailed' given the increasing levels of infection amongst school aged children. In response to Dr. Root's query as to whether any resistance to the offer of booster vaccinations had been encountered, Ms. Sherrington did not feel this was the case at present and noted that the Vaccination Centre was fully booked for the following 8 days, undertaking 500 appointments per day.

Dr. I. Muscat, MBE, Consultant in Communicable Disease Control noted that documentation of COVID status for travel purpose for school aged children could include a confirmed positive polymerase chain reaction ('PCR') test result and Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department confirmed that Quick Response ('QR') codes to this effect were being developed for the Jersey digital COVID Status Certification scheme, although the certification of booster doses was currently being prioritised for implementation.

The Cell noted the significant progress made by the COVID-19 Vaccination Programme and thanked Ms. Sherrington for the update. Ms. Sherrington withdrew from the meeting.

Forecasting  
update

A4. The Scientific and Technical Advisory Cell ('The Cell'), received a presentation entitled 'Forecasting update' dated 15th November 2021 prepared by Ms. M. Clarke, Head of Public Health Intelligence, Strategic Policy, Planning and Performance Department, and a report dated 13th October 2021, entitled 'SPI-M-O: Summary of modelling for scenarios for COVID-19 autumn and winter 2021-22'.

Ms. Clarke informed the Cell that Ministers had requested modelling and scenarios on the direction of cases in the next few weeks and noted that modelling had become highly uncertain due to the multifactorial nature of the situation. Ms. Clarke apprised the Cell of the current trends that had been identified, namely high levels of cases in those aged under 18 years and in those aged 40 to 59 years, as well as growth in cases in those aged 18 to 39 years, whilst those aged over 60 years remained protected from rising infection levels by booster vaccination. Changes in the border testing programme had resulted in fewer cases being identified through inbound travel. As there had not been any days with zero cases identified since 28th June 2021, (the start of the third wave), a graph using an artificial start date of 1st October 2021, was shared to illustrate the doubling rate. This was considerably slower at 12 days presently than it had been in June 2021, when cases were doubling every 6 days. At the point in June 2021, where more than 50 cases per day were being identified the estimated effective reproduction number ( $R_t$ ) was greater than 2, whereas it was now estimated as being between 1.1 and 1.5 with a similar daily case identification rate, suggesting that the rate of spread was considerably slower at present than it had been in July 2021. Turning to the cumulative cases since 1st October by age group, Ms. Clarke noted that it had taken 21 days for cases to double in those aged over 60 years, whilst the doubling rates for all other age groups varied from 11 to 14 days. In the UK, cases were falling, most notably in older age groups who were eligible for booster vaccination and due to the high number of cases in children since September 2021, which had resulted in many children and young people acquiring natural immunity.

In respect of the Delta sublineage AY.4.2 variant under investigation, the Cell was informed that it was slowly increasing in prominence and now accounted for around 15 percent of all sequenced cases in England. The situation in Europe was one of rising cases with growing hospitalisation and death rates, with Belgium, Germany and the Netherlands particularly affected. The Cell, with reference to Minute No. A2 of its meeting of 19th July 2021, recalled the high levels of uncertainty with regards to the Scientific Pandemic Influenza Group on Modelling, Operational sub-group ('SPI-M-O') models that had been drawn up with reference to the United Kingdom ('UK') and the difficulties of modelling with Jersey data. The Cell noted the latest SPI-M-O conclusions that further waves of infection were still expected, the pattern of transmission since 19th July 2021, had been very unexpected with considerable changes in the prevalence of age groups and communities but overall hospital admissions had been essentially constant, short term trajectories to the end of 2021 were driven by behaviour, and future peaks in 2022 would be driven by the speed and level of waning protection and booster regimes. Modelling scenarios had a high degree of uncertainty due to uncertainties around behavioural change, variants and vaccine uptake. In addition, many assumed that the Delta variant would remain dominant and did not take into account pressures that could be caused by other respiratory illnesses. Illustrations of the projected daily hospital admissions in England produced by the Warwick and London School of Hygiene and Tropical Medicine models were shared. These showed a wide variation of possible outcomes depending on assumptions on waning protection from vaccination and how quickly mobility would return to pre-pandemic levels.

The key points from SPI-M-O were that it would take “both a rapid increase in transmission rates and repeated waning of protection from vaccination to lead to hospital admission levels in the order of magnitude of those seen in January 2021”. It was suggested that the festive period could see mixing behaviour similar to that during the Euro 2020 football tournament in June and July 2021. The Cell noted that the University of Bristol alternative analysis, which had assumed no mitigation measures were in place, that the presence of antibodies reduced mortality by 95 percent, infection by 70 percent and transmission by 60 percent, estimated that the effective reproduction number would be in the range of 1.1 to 1.6 should pre-pandemic levels of mixing return with current vaccination levels. The Cell noted that under these assumptions, the addition of a booster programme and vaccination for those aged 12 to 15 years (with 65 percent uptake) would reduce the reproduction number to between 0.9 and 1.3.

The latest variant risk assessment on the Delta sublineage AY.4.2 variant under investigation showed an increased growth rate compared to Delta with limited information about severity and reinfection. However, vaccines appeared to be similarly effective so far.

Ms. Clarke noted that there was continuing uncertainty over the duration of post-vaccine immunity for different groups, the amount of natural immunity remaining in the population, the impact of new variants and new treatments, the resurgence of other infectious respiratory diseases, uptake of vaccination amongst under 18 year olds, behaviour, willingness to be tested and adhere to future recommendations and the timing of future waves, which meant that any future modelling or forecasting would provide a wide window of possibilities with a high degree of uncertainty. The capacity to produce modelling analysis in Jersey was also a factor that needed to be considered. Ms. Clarke expressed her concern that any modelling analysis would be ‘at best unhelpful, and at worst, misleading’.

Dr. G. Root, Independent Advisor - Epidemiology and Public Health, thanked Ms. Clarke for the presentation and cautioned that as COVID-19 transitioned from a pandemic to an endemic disease, modelling would become increasingly difficult and somewhat meaningless, with flatter peaks and troughs. He was in agreement with Ms. Clarke that there was insufficient justification to undertake modelling analysis in Jersey at present.

It was confirmed, in response to a question from Dr. I. Muscat, MBE, Consultant in Communicable Disease Control, that the SPI-M-O modelling did not take into account the updated Joint Committee on Vaccination and Immunisation (‘JCVI’) advice issued earlier that day, which recommended the extension of the booster vaccination programme to those aged 40 to 49 years and that all 16 to 17 year olds not in an at-risk group should be offered a second dose 12 weeks or more following their first dose or a positive COVID-19 test result. Dr. Muscat, MBE, emphasised the important role of vaccination and the need to continue with efforts to extend coverage. He expressed support for and recognition of the work of the Vaccination Programme.

Mr. I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, recalled that the high levels of uncertainty and difficulties associated with local modelling analysis remained unchanged and it was not obvious that decisions could or would be made based on the data.



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Dr. Root requested confirmation regarding the extent to which the University of Bristol alternative analysis had considered current levels of infection in those aged 12 to 15 years. Ms. Clarke noted that she would revert to the Cell with confirmation following the extant meeting.

In summary, Professor P. Bradley, Director of Public Health (Chair), noted that the Cell was in agreement that local modelling analysis was not a priority and that it would continue to review and consider the SPI-M-O outputs and it would be open to the Cell to reconsider its position in due course.

Mandating of  
masks

A5. The Scientific and Technical Advisory Cell ('The Cell'), received a report dated 15th November 2021 entitled 'Mask Wearing in indoor public spaces' prepared by Mr. J. Norris, Principal Policy Officer, Strategic Policy, Planning and Performance Department.

It was recalled that the 'Winter Strategy: Step 1 contingency measures' which had been partially implemented on 5th November 2021, had included a strong recommendation to wear face masks in indoor public environments. At a meeting of the Competent Authority Ministers ('CAM') on 8th November 2021, CAM had noted its concern with regard to the uptake of this recommendation and had requested that the Cell consider whether there was a case to be made for legally mandating mask wearing in public indoor spaces sooner than anticipated under the Winter Strategy.

It was recalled that the Winter Strategy identified that 'Step 2' restrictions would only be used as a last resort where there was a risk to business continuity and a strong possibility of widespread severe disease or hospitalisation. These measures could, for example, include legally mandating masks in certain settings and limits on the number of persons who could attend gatherings.

The Cell was informed that mask wearing was an effective measure in reducing the transmission of COVID-19. Reviews of data in other countries suggested that masks could reduce transmission typically by 6 to 15 percent but potentially up to 45 percent. It was also a measure that had a low non-COVID impact, when compared with other measures such as working from home. The Cell noted that masks were still legally required to be worn in Wales, Scotland and Northern Ireland on public transport and in some indoor public areas, whilst they continued to be strongly recommended in Guernsey and the Isle of Man.

Based on the latest data, Public Health was of the view that the point at which 'Step 2' measures should be recommended to CAM had not been reached. Any decision in respect of mandating mask wearing should be linked to the various community disruption metrics such as school attendance, general staff sickness across the Government and broader industries, evidence of critical service infrastructure disruption, Town footfall and calls to the Helpline.

Dr. I. Muscat, MBE, Consultant in Communicable Disease Control, expressed his concern that any measures attempting to reduce case numbers should happen in such a way that Christmas was not disrupted, as this would be 'catastrophic' in his view, so it was important to consider the timing of such measures. Additionally, irrespective of whether mask wearing was strongly recommended or legally mandated, its impact was conditional on levels of adherence by the public.

Mr. I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, noted that whilst many European countries were introducing new measures, the Winter Strategy set out the parameters within which Jersey would consider introducing more stringent measures, and there was no evidence that these had been reached at present. On that basis, he did not see any reason to change the policy position, although he felt that public communications could be strengthened.

Dr. G. Root, Independent Advisor - Epidemiology and Public Health, was in agreement with Mr. Cope, noting that the impact of mask wearing on transmission rates was modest. Masks were unlikely to be worn in homes, where transmission was overwhelmingly occurring, so mandating their use in indoor public places such as restaurants and shops, was unlikely to have a material impact on transmission rates. Given the slow rate of growth of transmission, the fact that the risk of severe disease and mortality was not heightened and the lack of evidence of disruption to society, Dr. Root was of the view that there were not compelling reasons to mandate mask wearing at present and if introduced, results would be modest at best.

Mr. S. Martin, Chief Executive Officer, Influence at Work noted that whether mask wearing was voluntary or mandatory, compliance was a key issue, and it would be helpful to communicate that the wearing of masks could avoid the need for more stringent restrictions.

Ms S. White, Head of Communications, Public Health, informed the Cell that a new communications campaign entitled 'Keep Jersey in Business' would be launching the following day, featuring local independent businesses emphasising key public health messages including vaccination, mask wearing and testing. The thrust of the campaign was to enable businesses to continue trading. Dr. I. Muscat, MBE, stated that he wished to discuss the content with Ms. White following the meeting. Professor P. Bradley, Director of Public Health (Chair), concluded that the Cell welcomed the campaign and was supportive of improving communications regarding the importance of mask wearing, which was one of a number of measures designed to manage rising case numbers

Dr. I. Muscat, MBE agreed that transmission appeared to be strongly concentrated within households, with evidence of spread amongst those aged 10 to 19 years and those aged 30 to 59, presumed in many cases to be parents. In his view it was important for communications to focus on vaccination, Lateral Flow Device ('LFD') testing and mask wearing; and increasing vaccination uptake was crucial to reducing transmission. Dr. Root agreed with this sentiment and cautioned that mask wearing was not a panacea and there were credibility issues around presenting it as such, given its limited effectiveness in reducing transmission in isolation of other measures. Noting that he had not supported the introduction of all of the 'Step 1' contingency measures, such as the recommendation to work from home where possible, Dr. Root thought it preferable to focus efforts on measures that had a demonstrable impact on transmission rates. Professor Bradley noted that the Cell was in agreement that vaccination and LFD testing were important elements of the future plan to manage the pandemic and measures should be focussed on areas of high transmission.

Professor Bradley summarised the position, noting that the Cell was in agreement that compelling reasons were needed to support the introduction of mandatory measures and the majority of the Cell had reached a consensus that the threshold for considering the introduction of such 'Step 2' measures had not been reached. It was open to the Cell to revisit its position should circumstances change.

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Metrics for  
community  
disruption

A6. The Scientific and Technical Advisory Cell ('The Cell'), received a presentation dated 15th November 2021, entitled 'Community disruption metrics' which had been prepared by Ms M. Clarke, Head of Public Health Intelligence, Strategic Policy, Planning and Performance Department and Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department.

The Cell was informed that although cases were increasing, there was a lag in corresponding hospitalisation rates, so the Department had reviewed other metrics that could provide an indication of the effect on the community. The metrics that had been considered included school attendance, school absence figures, school staff cases, social media sentiment, Government services, contact tracing team coping, adherence to guidance, helpline calls, Short Term Incapacity Allowance and sickness absence, travel data, St Helier footfall data and soft data from key industry groups.

The Cell was asked to consider whether any additional metrics should be added to the list, whether particular metrics should carry more weight and at what point increases in the metrics should trigger a response.

Mr. S. Martin, Chief Executive Officer, Influence at Work requested that consideration be given to whether data could be collected from citizen's interactions with Government services. Dr. G. Root, Independent Advisor - Epidemiology and Public Health expressed his support for the 'soft data' metrics which he felt were useful, but was unsure whether it could be used to trigger a response, given the data on infections that was already available. Dr. I. Muscat, MBE, Consultant in Communicable Disease Control, noted that a separate piece of work was needed to determine the impact of the pandemic on 'business as usual' health service provision.

Professor P. Bradley, Director of Public Health (Chair), noted that the Cell was supportive of the suggested community disruption metrics as they would provide context to aid decision making and evidence to back up assertions. The Cell requested that a final version of the metrics be presented at a future meeting.

Matters for  
information

A7. The Scientific and Technical Advisory Cell, with reference to Minute No. A2 of the current meeting, received and noted the following –

- a weekly epidemiological report, dated 11th November 2021, which had been prepared by the Strategic Policy, Planning and Performance Department;
- statistics relating to deaths registered in Jersey, dated 11th November 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 11th November, which had been prepared by the Strategic Policy, Planning and Performance Department;
- a report on COVID-19 vaccination coverage by priority groups, dated 11th November 2021, which had been prepared by the Strategic Policy, Planning and Performance Department; and
- a report on Flu vaccination coverage by priority groups, dated 11th November 2021, which had been prepared by the Strategic Policy, Planning and Performance Department.

There being no further business to discuss, the meeting was concluded at 12.35pm.