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SCIENTIFIC AND TECHNICAL ADVISORY CELL

(80th Meeting)

29th 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 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  
 A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department  
 I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department  
 Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department  
 M. Clarke, Head of Public Health Intelligence, 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. Mason, General Manager, Health and Community Services (for a time)  
 Dr. L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department  
 K. Sharman, Office of the Chief Executive  
 S. Huelin, Senior Policy Officer, Strategic Policy, Planning and Performance Department  
 L. Plumley, Trainee Secretariat Officer, States Greffe  
 K.L. Slack, Secretariat Officer, States Greffe

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

Minutes.

A1. It was noted that the Minutes from the meetings of the Scientific and Technical Advisory Cell ('the Cell'), which had been held on 15th and 22nd November 2021, were being finalised by the States Greffe and it was hoped that they could be presented to the Cell for approval at its next meeting.

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 22nd November 2021, received a PowerPoint presentation dated 29th 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.

The Cell was informed that, as at Friday 26th November 2021, there were 1,304 active cases of COVID-19 in the Island, from which 8,557 direct contacts had arisen. As at the same date, the 14-day case rate, per 100,000 population, had been 1,537 and the 7-day rate 844. Of the active cases, 786 had sought healthcare, 441 were direct contacts, 18 had been identified through arrivals screening, and the remainder had been identified through planned workforce, admission or cohort screening. The age ranges, gender and vaccination status of the active cases were shown, and the Cell noted that cases had been reported in care homes.

The majority of cases (302) were in those aged 10 to 19 years, followed by those aged between 40 to 49 years, who accounted for 270 cases. Case rates remained stable in those aged over 60 years. The majority of the active cases (78 percent) were symptomatic and just under half were fully vaccinated. The number of daily tests had increased to around 2,000 with tests being undertaken on individuals who had been contact traced and symptomatic individuals seeking healthcare now accounting for a significant proportion. This latter group represented almost 60 percent of the daily positives by test reason over the last 3 weeks.

Ms. Clarke informed the Cell that the daily incidence rate had continued to increase and had reached an average of 130 cases per day. This represented a significant step change over the course of November 2021. The on-Island test positivity rate was increasing and currently stood at 9.8 percent. Test positivity rates were highest in those aged 40 to 49 years at 10.2 percent and a slight increase to 3.3 percent had been observed in those aged over 60 years.

The Cell reviewed a graph of the 7-day case rate, per 100,000 population, for Islanders of different ages and noted that the rate for those aged under 18 years had decreased (to 1,370) as had the rate for those aged 40 to 59 years. The rate for those aged 18 to 39 years had continued to increase and for those aged over 60 years, it had also increased slightly to 288. The Cell noted that the test positivity rate for those who had had a test after seeking healthcare was just over 30 percent, and included individuals reporting a positive result from a Lateral Flow Test ('LFT'). Work was ongoing to separate these results from positive Polymerase Chain Reaction ('PCR') test results. It was observed that the test positivity rate for inbound travel had increased slightly in the past week.

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 26th November 2021, there had been 6 patients in the Hospital with COVID-19. The Cell was apprised of the age range and vaccination status of cases in hospital since 28th June 2021.

Details were provided of the positive cases linked to health and care settings, Government departments and schools. It was recalled that from 25th November

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2021, the requirement for children, young people and staff members identified as direct contacts from positive cases in education settings to undertake a PCR test had been replaced with a requirement to self-administer LFTs for 10 days and report the results to an online portal. A slight increase in the test positivity rate for the schools LFT programme had been observed and now stood at 0.92 percent, however there had been a decrease in the number of active cases identified in schools. An increase in staff absence due to COVID-19 was noted in the Children, Young People, Education and Skills ('CYPES') Department.

Ms. Clarke informed the Cell that there had been no new deaths in the previous week and discussions had begun about whether to classify cases since 1st October 2021 as part of a '4th wave'.

With regards to border testing, an increase in the test positivity rate to 1.56 percent had been observed for inbound travellers for the week commencing 15th November 2021. In terms of weekly testing, during the week ending 21st November, Jersey's testing rate, per 100,000 population, had increased to 10,300, above the United Kingdom ('UK') rate of 9,550, noting that the latter figure included tests undertaken on LFTs. The positivity rate locally had been 6.9 percent compared with 4.5 percent in the UK. The majority of tests (9,130) were now being undertaken as part of on-Island surveillance and on people seeking healthcare on experiencing symptoms of the virus which accounted for 1,330 tests.

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 was informed that 248 patients were currently recorded in the EMIS clinical IT system as suffering from Long Covid. Of these, 119 had ongoing symptomatic Covid and 138 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 years continued to be the most affected group.

In respect of community disruption monitoring, the Cell noted that a review of social media sentiment showed mixed responses to the COVID-19 schools vaccinations posts and optimism regarding the COVID-19 statistics posts, particularly regarding the levels of hospitalisation. Weekly footfall on King Street was higher than in 2020, but below 2019 levels and weekly movement through the underpass had dipped compared to previous years. An anecdotal survey of mask wearing in St. Helier on a Saturday suggested that a minority of staff members in shops were wearing masks and that the proportion of shoppers wearing masks was less than one in 10.

Details regarding the COVID-19 vaccine programme were shared and it was noted that, up to 21st November 2021, 87 percent of Islanders aged over 80 years had received their booster dose, whilst 31 percent of those aged between 12 and 15 years had received their first dose. A total of 183,066 vaccines had been administered, of which 28,406 were booster doses. A graph was shown depicting the percentage of the population vaccinated, broken down by age range and number of vaccinations received.

In respect of the estimated vaccine coverage for the Joint Committee on Vaccination and Immunisation ('JCVI') priority groups, the Cell was informed that 74 percent of care home residents had received their booster dose, as had over half (52 percent) of carers working in care homes, those working in frontline health and social care settings and 47 percent of other health and social care workers. 59 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 50 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, which continued to increase for all eligible age groups.

The Cell was informed that the cumulative vaccine uptake amongst people aged over 18 years for first and second dose coverage in Jersey was 88 and 86 percent respectively, which compared favourably with many countries. In terms of vaccine booster doses administered per 100 people, Jersey's figure of 29.7 compared favourably with rate in the UK and European countries, with only Israel and Iceland reporting higher numbers.

A total of 38,735 flu vaccines had been administered as of 21st November 2021, across a number of settings. 84 percent of those aged over 80 years and 75 percent of those aged 65 to 79 years of age had been vaccinated. Flu vaccination uptake compared favourably to the previous year and it was noted that uptake amongst those aged 50 to 64 years was significantly higher and had already reached the 54 percent level that had been achieved by the end of the 2020-2021 Winter season. The Cell noted that reports of cases of flu-like illness in primary care during the week ending 21st November 2021 had decreased to 28.

The Cell was presented with a map of cases in the UK for the 7-day period ending on 16th November 2021 and noted high rates in Northern Ireland and England. The 14-day case rate per 100,000 population as of the same date had increased in England, Northern Ireland and Wales, and decreased in Scotland. There had been an increase of 9.5 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 14.8 percent and deaths by 11.4 percent.

The Cell noted maps prepared by the ECDC, comparing 14-day case rates on 18th and 25th November 2021, showing increases in France, Portugal and much of Central and Eastern Europe.

Dr. G. Root, Independent Advisor - Epidemiology and Public Health questioned whether it would be possible to publish local data demonstrating the relative risk of hospitalisation for those who were not vaccinated and whether levels of infection were beginning to plateau, thus signifying that a turning point had been reached in the current wave of infection. Dr. Newman agreed that whilst it could be helpful to publish information demonstrating the protective effect of vaccination with regards to the risk of hospitalisation, using local data might be problematic given the relatively small numbers involved. Ms. Clarke noted that discussions were needed internally to determine the feasibility of publishing such data as well as determining the appropriate denominator and how the information would be updated in future. The Cell discussed the complexities regarding the denominator, and it was suggested by Dr. L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department that UK data could be used instead. This would avoid setting a potentially dangerous precedent, in that data from Jersey constituted a relatively small population set compared to the UK.

Mr. I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning

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and Performance Department, opined that the work could be progressed whilst addressing Ms. Clarke's concerns. Mr. S. Martin, Chief Executive Officer, Influence at Work, expressed his agreement, with an important caveat regarding the delivery of the message. Studies suggested that fear inducement messages could be effective if they were accompanied with an immediate action that people could take to avoid the risk, although he noted that the messages in the studies were delivered personally, not publicly. Ms. S. White, Head of Communications, Public Health, mooted the idea of a press conference and Mr. Martin suggested exploring whether it would be possible to deliver a personalised message to those who were due a first or second vaccination dose. Mr. S. Petrie, Environmental Health Consultant, expressed his agreement with Mr. Martin.

The Cell was in agreement that further work should be undertaken to determine the feasibility and methodology for publishing such information.

Regarding whether a plateau or peak of infections had been reached, Mr. A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, was of the opinion that it was too early to say definitively and based on a relatively small population size, it was possible that a non-linear trajectory would become apparent. He noted the importance of continuing to watch the situation carefully and to review changes in test positivity rates, particularly in older adults. Dr. I. Muscat, MBE, Consultant in Communicable Disease Control, agreed and noted that it was crucial to communicate the benefits of vaccination with regard to reducing the severity of disease. He was cognisant of the difficulties inherent in demonstrating this using local data and the need to define 'fully vaccinated' which would vary depending on age and eligibility. Summarising, Professor P. Bradley, Director of Public Health, noted that whilst infection rates were increasing, the future trajectory of the current wave of infection was unclear.

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

Vaccination  
update.

A3. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A3 of its meeting of 22nd November 2021, received a presentation, entitled 'COVID-19 Vaccination Programme, Update to STAC/CAM' dated 29th November 2021 prepared by Ms. B. Sherrington, Senior Nurse Adviser in Public Health.

It was recalled that eligibility for booster vaccinations had been extended in the previous week to all adults aged between 40 to 49 years and eligibility for a second dose extended to all 16- to 17-year-olds not in an at-risk group following an announcement from the Joint Committee on Vaccination and Immunisation ('JCVI') and a further announcement was anticipated shortly, recommending that eligibility for booster doses be extended to include all those aged over 18 years and the interval between the second dose and booster dose be reduced, potentially to 5 months rather than the current 6 months. The Cell noted that 65.4 percent of those who were currently eligible to receive a booster vaccination had taken up the offer and Ms. Sherrington informed the Cell that the booster trajectory estimate would be updated subsequent to the JCVI announcement to reflect the increased eligibility.

The Cell was informed that following a period where all available appointments at the vaccination centre had been fully booked, with a waiting time of 6 days for the next available appointment, additional slots had been factored in and the current waiting time was 3 days. The high uptake rate of co-administered flu vaccinations to those who were eligible, meant that the flu vaccination programme had achieved good rates of coverage, particularly for older age groups, at an earlier stage in the year compared to 2020. It was therefore proposed to increase capacity for COVID-19 booster vaccinations by ending co-vaccination with flu, which would still be available through primary care providers. Other options that had been considered to increase capacity included increasing the number of vaccinators, extending opening hours and cancelling home visits. Ending co-vaccination was, however, the preferred option and it was proposed that it would be recommended to the Competent Authority Ministers ('CAM') at their meeting during the week commencing 29th November 2021. Ms. Sherrington noted the need for cross-government support to prioritise the extension of the COVID-19 vaccination programme.

Mr. A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, noted the possibility of consequences, whether unintended or otherwise, of ending co-vaccination, and asked for CAM to be apprised of the progress of the flu vaccination programme. Ms. Sherrington acquiesced, noting that the number of people eligible for co-vaccination was declining due to the high uptake rates.

Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention, expressed his support for the proposal, praising the excellent effort that had been made with regards to flu vaccination and believed that, as a consequence, it was desirable to increase capacity to provide booster vaccinations. Dr. Noon noted his concern that the primary care network might not be able to provide home vaccination visits if this particular service was cancelled. Dr. I. Muscat, MBE, Consultant in Communicable Disease Control, also expressed his support for the proposal, noting that resourcing should be directed at delivering the COVID-19 vaccinations as a priority. Dr. G. Root, Independent Advisor - Epidemiology and Public Health concurred, as he believed that vaccination was the most effective intervention available.

Summarising, Professor P. Bradley, Director of Public Health, noted that the Cell was supportive of the proposal to end co-vaccination in order to prioritise the extension of the booster vaccination programme. Ms. Sherrington re-iterated the need for cross-government backing to support the delivery of the programme.

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

B1.1.529  
variant –  
Omicron.

A4. The Scientific and Technical Advisory Cell ('the Cell'), received a briefing from the UK Health Security Agency, dated 26th November 2021, entitled 'SARS-CoV-2 variants of concern and variants under investigation in England' and heard from Dr. I. Muscat, MBE, Consultant in Communicable Disease Control.

The Cell was informed that a novel variant, initially named 'B.1.1.529', had been detected on 23rd November 2021 in South Africa, Botswana and Hong Kong and was undergoing further rapid assessment. This variant had been designated a 'Variant under Investigation' ('VUI-21NOV-01') on 25th November 2021 and subsequently declared a 'Variant of Concern' and named 'Omicron' by the World Health Organisation on 26th November 2021, due to 32 mutations which were likely to be biologically significant, and which could change the behaviour of the virus with regards to immune escape, transmissibility, and susceptibility to some treatments. Cases had been identified in England, Scotland, across Europe and in Canada which indicated it was already spreading widely and it was anticipated that further cases would emerge.

The emergence of the Omicron variant in South Africa had coincided with a rise in the number of daily cases there to around 4 or 5 thousand, however it was not clear if this was due to the variant. It was known that the mutations in the spike protein included deletion of a particular segment associated with S gene target failure in some widely used polymerase chain reaction ('PCR') tests. Consequently, it was possible for PCR results patterns from affected tests to be used to assess spread, as had been the case for the Alpha variant in the second wave. The PCR tests used in Jersey were not affected by the deletion, and the Lateral Flow Tests ('LFT') in use would continue to detect the presence of the SARS-CoV-2 nucleocapsid antigen. Dr. Muscat, MBE, informed the Cell that confirmation was awaited regarding whether antibody tests would be affected, noting that such tests were currently processed outside of the Island.

Whilst a number of mutations had been identified, it was not yet known what characteristics they would endow the virus with, in particular with regards to immune escape, transmissibility and severity of disease although the same distribution of severity with age as previous variants was expected and direct acting antivirals were likely to continue being effective. Dr. Muscat, MBE, noted that confirmatory laboratory and epidemiological information was awaited with regards to the behaviour of the virus and that the lead time for producing vaccines in response to variants was around 100 days.

Comments from Professor Sir Andrew Pollard, Director of the Oxford Vaccine Group at Oxford University, cautiously suggested that the existing 'wild type' derived vaccines would continue to prevent serious disease, though it would be several weeks before this could be confirmed. Professor Deenan Pillay, Director of the Wellcome Trust-funded Africa Centre for Health and Population Studies in South Africa, had observed that patients hospitalised in South Africa were largely unvaccinated, supporting the notion that vaccination provided continued protection. Symptoms reportedly included fatigue, but not loss of taste and smell and were often mild.

Dr. Muscat, MBE, noted that whilst awaiting further information, the focus should continue to be on maximising vaccination coverage and an announcement was expected shortly from the Joint Committee on Vaccination and Immunisation ('JCVI') that all those aged over 18 years should be offered a booster vaccination and the interval between the second dose and booster dose reduced. It was recalled that the interval between first and second dose vaccinations was currently 4 weeks and Dr. Muscat, MBE expressed his opinion that anything which prolonged this interval would be detrimental as immediate immunity was more important at present than prolonged immunity, which could be achieved by way of booster vaccination. It was therefore essential, in his view, for the vaccination programme to remain a key focus and to ensure that the anticipated JCVI recommendation could be implemented promptly.

Regarding treatments, Dr. Muscat, MBE, noted that discussions to facilitate the roll out of direct acting antivirals were taking place with pharmacies and primary care representatives with regards to the necessary protocols.

Professor P. Bradley, Director of Public Health, thanked Dr. Muscat, MBE, and noted that the Cell was cognisant of the uncertainty regarding the infectivity and severity of disease associated with the Omicron variant and the continued importance of vaccination as a protective measure.

Dr. G. Root, Independent Advisor - Epidemiology and Public Health, speculated that low vaccine coverage and low levels of the Delta variant in South Africa could have contributed to the emergence and spread of the Omicron variant there, and it was unclear how effective it would be in competing with the Delta variant which was more prevalent in Jersey. There was a possibility, in his view, that the Delta variant might afford a degree of protection against the Omicron variant, but this would only become apparent over time.

COVID-19  
Winter  
Strategy: Step  
1 Contingency  
Measures.

A5. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A4 of its meeting of 22nd November 2021, received a presentation dated 29th November 2021, entitled 'COVID-19 Winter Strategy: Step 1 Contingency Measures' prepared by Mr. A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department.

It was recalled that the Winter Strategy envisaged two steps in terms of implementing contingency measures; 'Step 1' measures where there was a need to mitigate against the risk of major economic and societal consequences by appealing to personal judgement and the intention was to change individual behaviour, and 'Step 2' measures consisting of legal restrictions, introduced as a last resort, where there was a risk to business continuity and a strong possibility of widespread severe disease or hospitalisation.

Professor P. Bradley, Director of Public Health and Chair of the Cell, noted that in the context of rising levels of infection and uncertainty regarding the impact of new variants, in particular the recently identified Omicron variant, the Competent Authorities Ministers ('CAM') had requested that the Cell's view be shared at its meeting during the week commencing 29th November 2021, on whether the threshold for considering the introduction of mandatory contingency measures had been reached and if that was not currently the case, for the Cell's recommendations in respect of any additional Step 1 measures to be considered.



Mr. Khaldi noted that the key drivers for reviewing and strengthening the Government response were the continuing rise in COVID-19 infections and ensuing likelihood of increased risk of severe disease and mortality in the next 3 months and reducing or slowing the seeding in the Island of the Omicron variant. The first question to consider was whether the threshold for considering mandatory contingency measures had been reached. Mr. Khaldi noted that although it was unclear yet whether infections had reached a plateau, he was firmly of the view that Step 1 measures continued to be the appropriate response for the time being. He noted, however, that it was for the Cell to reach a collective decision as to whether the threshold was met and the increased likelihood of severe disease and hospitalisation alongside of the spectre of the Omicron variant were relevant considerations. The strong reaction by the United Kingdom ('UK') to the Omicron variant, notably the reintroduction of testing and isolation requirements for all travellers arriving from outside the Common Travel Area ('CTA') regardless of vaccination status and mandatory wearing of masks in shops and on public transport, provided a driver for consideration of whether any actions should be taken to reduce or slow the local seeding of the Omicron variant, which would, in his view, inevitably occur in due course.

The following areas were proposed for consideration:

- non-Pharmaceutical Interventions ('NPI');
- travel;
- contact tracing;
- vaccination; and
- sequencing.

The Cell discussed the option to review the genomic sequencing policy to target testing towards detecting cases of the Omicron variant on Island and to review the actions required for suspected cases and direct contacts, in the context of the move to hospital laboratory testing for COVID-19 samples. The Cell was informed that at present, a small number of samples were sent to the Micro pathology laboratory in the UK for genomic sequencing to identify which strain of the virus was responsible for the infection. Dr. I. Muscat, MBE, Consultant in Communicable Disease Control, noted that it was not possible to undertake this testing in the Island, nor was it planned to establish such capability, and the turnaround time for results was approximately 3 days, in line with UK testing times. This meant a delay of 24 to 72 hours before a positive case could be confirmed as an Omicron case. The Cell noted that this delay would need to be considered when reviewing the isolation requirements for suspected Omicron cases and direct contacts of confirmed cases.

The Cell was in agreement that the genomic sequencing policy should be reviewed, and testing targeted towards detecting cases of the Omicron variant in the Island. Details of the current testing capability and ongoing work on genomic sequencing would be shared with CAM to inform the discussion on isolation requirements.

Turning to vaccination, the Cell was apprised of the option to expand the vaccination programme in light of the expected announcement from the Joint Committee on Vaccination and Immunisation ('JCVI') that all those aged over 18 years should be offered a booster vaccination and the interval between the second dose and booster dose reduced. The Cell was in agreement that eligibility for the vaccination programme should be expanded and the booster vaccination process be expedited as per the anticipated JCVI recommendations. Dr. Muscat, MBE, noted that CAM would need to be cognisant of the resource implications and Dr. G. Root, Independent Advisor - Epidemiology and Public Health noted that vaccination efforts should be focused on older age groups as a priority. The Cell noted its agreement with Dr. Root's view.

Mr. Khaldi noted that the Cell was supportive of a proposal to charge unvaccinated adult arrivals for testing undertaken at the border, which would be considered by CAM at its meeting during the week commencing 29th November 2021, although there was opposition to the idea from several stakeholders.

The Cell turned to consideration of the Safer Travel policy. It was recalled that the UK had recently announced that all travellers arriving from outside the CTA, regardless of vaccination status, were required to be tested and to isolate until receipt of a negative result. In addition, travel had been restricted from a number of African countries placed on the travel 'Red List', with all arriving travellers required to quarantine. It was noted that Jersey mirrored the UK Red List classification. Mr. Khaldi outlined the options for consideration, which included reintroducing testing for all arrivals regardless of Covid Safe Certification ('CSC') status; mirroring the UK CTA based system with enhanced testing and isolation for non-CTA arrivals; a blanket isolation requirement for all arrivals and no change from the current policy. Mr. Khaldi noted that the UK requirements formed a 'protective wall', and it would be proportionate, in his opinion, to mirror the measures to provide a firm barrier with regards to Red List countries. Professor Bradley noted that the CTA included the Republic of Ireland. Dr. Muscat, MBE, observed that whilst the barrier might offer some protection against the Omicron variant, there was a risk of seeding from within the CTA and Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention, noted that community spread cases had been reported in Scotland.

The Cell discussed the impact of a CTA based approach, noting that travellers from Red List countries would not be able to transit to Jersey due to the UK quarantine requirement and that non-CTA arrivals into Jersey would include a significant number of residents travelling for business, holidays and other reasons. The Cell was in agreement that further work was needed to identify the number of travellers who would be captured by such an approach.

Dr. Root questioned how quickly testing could be scaled back up again at the border and was informed that whilst capacity was available, the question had been asked of the Modernisation and Digital Department as to how quickly the online pre-departure registration form could be updated. Mr J. Lynch, Principal Policy Officer, Strategic Policy, Planning and Performance Department, was hopeful that it would be possible to implement the changes fairly quickly.

Dr. Noon signalled his support for the reintroduction of testing for all arrivals whilst Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department was of the view that a key cohort to capture were non-CTA arrivals transiting via the UK to Jersey, as they would avoid the UK requirement to test and isolate on arrival. Although she also noted that it might be easier in practice to reinstate testing for all arrivals. Mr. Khaldi expressed his support for Jersey to align with the UK CTA based approach. Dr. Root questioned whether changes to the Safer Travel policy would be effective, based on the rapidity with which new cases of the Omicron variant were being detected in the UK. It was more desirable, in his view, to focus efforts on increasing vaccination rates and the rollout of booster vaccinations. Mr. S. Petrie, Environmental Health Consultant agreed with this sentiment. Dr. Muscat, MBE, noted that border testing played a valuable role in detecting incoming cases so reintroducing it with a review of the situation in 3 weeks' time would allow cases in travellers not screened by the UK to be detected and the addition of documented Lateral Flow Tests (LFT) and spot checks should be considered. He noted that border testing had not prevented the arrival of prevalent variants in the past and the focus should be on vaccination and testing. Ms. R. Williams, Director, Testing and Tracing, Strategic Policy, Planning and Performance Department agreed that vaccination was a key priority and noted that the vaccination and testing resources were not interchangeable.

Summarising, Professor Bradley concluded that there was mild support for the testing of non-CTA arrivals with a number of caveats including the operational implementation of such a testing regime and that CAM would need to consider the matter in the round. Mr. Khaldi agreed that it would be for CAM to consider whether the gap in testing in relation to the UK should be closed.

Turning to contact tracing, the Cell discussed the option to introduce an isolation period for direct contacts of Omicron cases, regardless of vaccination status. Mr. Khaldi cautioned that further work was needed to underscore this policy position in particular with regards to how quickly Omicron cases could be confirmed, and whether they had originated from inbound travel or in the community. Dr. Muscat noted that direct contacts of an Omicron case should be considered as such until proven otherwise and that there could be a delay of up to 72 hours in identifying such cases. Professor Bradley noted the probability that some contact tracing could take place based on increased genomic sequencing as discussed earlier in the meeting and that further work was needed to support this. CAM would be apprised of the position as understanding of testing capability and the impacts of the Omicron variant developed.

The Cell had regard to the proposed NPI measures, namely working from home, mandatory mask wearing in public indoor settings, recommending that event organisers requested negative LFT results from attendees and considering the same for the hospitality sector, and stronger shielding advice. Dr. Noon expressed his support for all of the proposed measures. Dr. Muscat, MBE, noted that each option on its own would not be completely effective, but cumulatively the package of measures would have a positive impact so he also recommended that they should all be put to CAM for consideration. Given the importance of surveillance by means of LFTs, Dr. Muscat, MBE, believed that some thought should be given as to how the results of such testing could be documented and evidenced, noting that there was a degree of reliance on accurate reporting by individuals. Mr. Petrie also indicated his support for all the measures whilst being cognisant of the economic impact of the recommendation for people to work from home where possible.

Dr. Root, dissenting, noted that in his opinion, the current level of risk did not warrant such measures, notwithstanding the fact that the impact of the Omicron variant was relatively unknown at the present time. He believed that the UK stance on mandatory mask wearing, which was restricted to the retail and transport sectors, was sensible and measured. If the Omicron variant was more transmissible, such a measure would not be particularly effective given the amount of transmission occurring in homes so if it was implemented, Dr. Root believed that Jersey should follow the UK approach to mandatory mask wearing. Whilst he was supportive of the recommendation for event organisers to request LFT results, it was not practical in his opinion to extend this 'gatekeeping' role to the hospitality sector. Stronger shielding advice should be focused on those who were unvaccinated to encourage the uptake of vaccination.

Mr. Khaldi noted that the recommendation for people to work from home would take the form of a public statement that people should do so, if they could, on a voluntary basis. Whilst he acquiesced to a small measure of agreement with Dr. Root regarding the effectiveness of mandatory mask wearing, Mr. Khaldi believed that working from home would be a more effective measure as it more decisively interrupted patterns of travel and activity and its efficacy had been demonstrated previously in Jersey. He was cognisant of the economic impact of this measure and agreed with Dr. Root's comments regarding the LFT recommendation and stronger shielding advice. Mr. S. Martin, Chief Executive Officer, Influence at Work also indicated his approval for this last measure. Dr. Newman noted that confirmatory electronic mail messages acknowledging the registration of negative LFT results were sent to those who had registered for the LFT programme. Results submitted by direct contacts did not currently receive such confirmation, but it would be possible to update the system to do so.

Summarising, Professor Bradley observed that on balance, the majority of the members of the Cell supported the recommendation for people to work from home where possible, acknowledging that the potential to do so was dependant on the nature of the business. He also noted the Cell's support for mandatory mask wearing focussed on the retail and transport sectors, the recommendation for event organisers to request negative LFT results from attendees, though not for the extension to the hospitality sector and for stronger shielding advice directed at those who were not vaccinated, whilst recognising that some people were unable to receive the vaccine for medical reasons. Dr. Root re-iterated his dissent with the recommendation to work from home, due to the significant effect it would have on the economy and hospitality sector. It would be preferable, in his view, to defer consideration of this recommendation for a week whilst further information regarding the impact of the Omicron variant emerged.

Mr. Khaldi thanked the members of the Cell for a helpful discussion and for providing a clear steer on the measures to be recommended to CAM. He expressed his concern that a stronger response was needed in the current context and that a varied response in terms of the implementation of the recommendations might ensue, given the political considerations at stake. Dr. Noon concurred and noted that it was for CAM to weigh the balance of the Cell's recommendations against the economic consequences that would result from the implementation of additional contingency measures.

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 –

- a weekly epidemiological report, dated 25th November 2021, which had been

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- prepared by the Strategic Policy, Planning and Performance Department;
- statistics relating to deaths registered in Jersey, dated 25th November 2021, which had been compiled by the Office of the Superintendent Registrar;
  - a report on COVID-19 vaccination coverage by priority groups, dated 25th 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 25th 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 12.45pm.