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SCIENTIFIC AND TECHNICAL ADVISORY CELL

(87th Meeting)

(Business conducted via Microsoft Teams)17th January 2022**PART A (Non-Exempt)**

All members were present, with the exception of Ms. B. Sherrington, Senior Nurse Adviser in Public Health and 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
 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
 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 -

J. Mason, General Manager, Health and Community Services (for a time)
 E. Baker, Head of Vaccination Programme, Strategic Policy, Planning and Performance Department
 R. Williams, Director, Testing and Tracing, Strategic Policy, Planning and Performance Department
 J. Norris, Principal Policy Officer, Strategic Policy, Planning and Performance Department
 J. Lynch, Principal Policy Officer, Strategic Policy, Planning and Performance Department
 S. Gay, Senior Public Health Policy Officer, Strategic Policy, Planning and Performance Department
 Dr. L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department
 R. Corrigan, Director General, Economy (for a time)
 K. Posner, Director of Policy and Planning, Children, Young People, Education and Skills Department (for a time)
 S. Martin, Chief Executive Officer, Influence at Work
 L. Plumley, Secretariat Officer, States Greffe

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

Minutes. A1. The Scientific and Technical Advisory Cell ('the Cell'), received and noted the Minutes from its meetings of 29th December 2021 and 5th January 2022, which had previously been circulated. The Minutes were approved by the Cell.

Vaccination status of hospitalised patients. A2. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A6 of its meeting of 10th January 2022, received an update from Mr. I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, regarding the work being undertaken by a sub-group of the Cell in relation to the publication of information regarding the vaccination status of patients in Hospital with COVID-19.

The Cell was informed that data validation work was progressing well, and it was hoped that the information could be published on 21st January 2022, as agreed by Competent Authorities Ministers at their meeting of 12th January 2022. It was noted that 'live' data could not be disclosed for reasons of patient confidentiality, however data aggregated over a number of months would be released, accompanied by a media briefing.

Intelligence overview, including Analytical Cell update and HCS activity. A3. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A1 of its meeting of 10th January 2022, received a PowerPoint presentation, entitled 'STAC Monitoring Update', dated 17th January 2022, which had been prepared by Ms. M. Clarke, Head of Public Health Intelligence and Dr. L. Daniels, Senior Informatics Analyst, both of the Strategic Policy, Planning and Performance Department.

The Cell was apprised of the current situation with regards to public health monitoring, noting that as at Friday 17th January 2022, there were 3,020 active cases of COVID-19 recorded in the Island, from which 2,515 direct contacts had been identified. The majority of cases continued to be in those of working age, with those aged 30 to 39 years making up the highest proportion, followed by those aged 20 to 29 years. Seeking healthcare was the most common reason for testing, accounting for 1,644 cases; 1,041 had been identified through Lateral Flow Tests ('LFT'); 140 through arrivals screening, 20 through contact tracing; and the remainder through various screening programmes. The age ranges, gender and vaccination status of the active cases were shown.

A reduction was noted in the number of tests being undertaken, to around 1,500 per day. The average daily incidence had fallen from around 470 cases per day to 284 over the course of the previous week.

The overall test positivity rate had decreased to 26 per cent and the Island rate (excluding inbound travel) to 29 per cent. The 7-day case rate per 100,000 population had decreased significantly for those aged 18 to 39 years and to a lesser extent for those aged 40 to 59 years and for those aged over 60 years, whilst plateauing in those aged under 18 years.

The Cell reviewed the clinical status of cases in hospital since 28th June 2021 and noted that as at 14th January 2022, there were 25 patients in the Hospital with COVID-19. A number of cases in care homes were noted.

Since the first Omicron case had been detected in Jersey on 13th December 2022, an increase had been noted in the number of people who had been reinfected with COVID-19 after previously testing positive. In November 2021, 0.8 per cent of new positive cases on-Island were reinfections, and in December 2021, this figure had

risen to 2.8 per cent, with a similar pattern noted in the United Kingdom ('UK').

Details were provided of the positive cases linked to schools, which had resulted in several class closures during the previous week.

A further 2 deaths had been recorded, bringing the total to 92, with 14 registered since the start of the 4th wave on 1st October 2021.

The Cell was informed that, compared to the previous week, the number of inbound travellers had fallen during the week commencing 3rd January 2022, with 182 positive cases identified, equating to a test positivity rate of 6 per cent.

During the week ending 9th January 2022, Jersey's testing rate, per 100,000 population, had been 11,700, compared to the UK rate of 18,300, which included LFTs. The test positivity rate locally had increased slightly to 26.7 per cent whilst the UK rate had decreased to 8.7 per cent.

The Cell noted that 335 patients were currently recorded in the EMIS clinical IT system as suffering from 'Long Covid'.

The Cell was apprised of the current situation with regards to Primary Care, noting that levels of absence due to COVID-19 had improved and resilience was being maintained.

Details regarding the COVID-19 vaccine programme were shared and it was noted that as at 9th January 2022, 215,231 doses had been administered, of which 55,975 were third 'booster' doses, with high rates of coverage in older age groups and increasing uptake rates across younger eligible populations. It was estimated that 77 per cent of care home residents, 76 per cent of carers working in care homes and 78 per cent of front-line health and social workers had received a booster vaccination, though it was noted that the assessments were coded Red or Amber due to questionable or moderate data quality.

Overall, as at 9th January 2022, it was estimated that 60 per cent of those aged over 12 years in Jersey had received a booster dose, compared with the UK rate of 62 per cent.

The Cell was informed that 19 episodes of flu-like illness had been reported in primary care during the week ending 16th January 2022 and levels were noticeably lower than during previous Winter seasons, Winter 2020 to 2021 excepted.

The Cell was apprised of the situation in UK, noting that over the 7 days to 16th January 2022 (10th January 2022 for hospitalisation figures), cases had decreased by 38 per cent, hospitalisations by 1.4 per cent and deaths had increased by 41 per cent. The 14-day case rate per 100,000 population ranged from 2,806 in Scotland to 3,405 in Northern Ireland, whilst the rate in Jersey was presently 5,457. It was noted that case rates were increasing in parts of Europe including Germany and Central Europe, as well as Scandinavian countries.

The Cell was provided with an update on Hospital capacity which confirmed that safe levels of staffing and care were being maintained and that there was sufficient capacity at the present time, though it had been necessary to employ temporary staff to mitigate the impact of positive cases amongst staff. The position with regards to the Testing and Tracing team had improved, with lower levels of staff sickness over the previous week.

The decline in infection rates amongst children was welcomed by a member of the Cell, who also observed that infection rates in schools would be a key metric for the Cell to focus on going forward. Given the relatively low vaccination rate for this cohort, the member expressed concern about the risk of infection rippling from children to older populations in the future. The member asked whether an estimated trajectory of infection in children and breakdown by age group (namely for those aged zero to 9 years and 10 to 18 years) could be provided, which officers undertook to investigate. The member welcomed the efforts being made to improve vaccination cover amongst those aged 12 to 15 years, given the risks associated with having a large unvaccinated population cohort. It was imperative in their view, to maintain focus on infection and vaccination rates amongst children. The Cell was informed by one of the observers that a working group had been established and was working closely with colleagues in the Children, Young People, Education and Skills department, the Children's Commissioner and the Communications team to understand and respond to questions and concerns of young people with regards to vaccination and try to increase uptake amongst eligible children.

In response to a question from a member regarding the reason for the increase in cases amongst inbound travellers over the festive season, another member confirmed that the number of travellers had been higher over the Christmas period and the change to the definition of 'fully vaccinated' from 4th January 2022 had resulted in more people being tested.

Another member noted that the data, particularly with regards to test positivity rates, was encouraging and the assumption that Jersey was around 2 weeks behind London in terms of infection rates appeared to be borne out. The member did not share the view that vaccination rates in children posed an infection risk going forwards, given that the majority had most likely already been exposed to COVID-19. The member also noted that rates were declining in that age group. Turning to the restrictions that were currently in place, namely mandatory mask wearing in indoor public environments and the recommendation to work from home where possible, the member questioned when they would be lifted, given the member's view that the measures had little impact on transmission rates. Another member countered that it was premature to declare victory on COVID-19 at this stage, however thought was being given to the government response and Competent Authorities Ministers would be considering the matter in due course.

Summarising, the Chair noted that infection rates were declining, and although rates remained high in those aged under 18 years, with associated disruption in schools, the overall situation had improved.

The Cell noted the position and thanked Ms. Clarke and Dr. Daniels for the update.

Omicron
update.

A4. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of its meeting of 10th January 2022, received the 'UK Health Security Agency Risk Assessment' for the Omicron variant, dated 12th January 2022, and the 'UK Health Security Agency Technical Briefing 34', dated 14th January 2022, and heard from Dr. L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department, in connexion therewith.

The Cell noted that an additional indicator for severity of infection in children had been added to the risk assessment, and had been assessed as 'Amber', with a low confidence level. The Cell was informed that increased numbers of hospital admissions in young children with COVID-19 had been reported in the United Kingdom ('UK') and some other countries, although early data suggested that

87th Meeting
17.01.22

admitted children were not severely unwell, showing symptoms consistent with respiratory infection. Further analyses were required to compare the risk of hospitalisation between the Omicron and Delta variants, and to assess the clinical nature of the illness in children.

The Cell noted that Omicron was now estimated to be responsible for 98 per cent of cases in the UK overall and that overall reinfection rates had increased significantly in the UK since mid-December 2021 and were continuing to rise.

The Cell noted the position and thanked Dr. Daniels for the update.

Care home
resilience.

A5. The Scientific and Technical Advisory Cell ('the Cell') with reference to Minute No. A1 of its meeting of 10th January 2022, heard from Mr. J. Mason, General Manager, Health and Community Services, in respect of resilience within care homes.

The Cell was informed that a joint policy position between Public Health and Health and Community Services had been issued during the week of 10th January 2022, to address inconsistencies across the care home and domiciliary care sector, regarding COVID-19 patients being discharged to such settings. Discussions had been held with the care sector regarding the policy position, which was not perceived as problematic however wider concerns regarding staff resilience and insurance had been noted. The policy outlined the position with regards to patients who were deemed 'medically fit for discharge' but still within their mandatory self-isolation period, namely that there was no requirement for such patients to await a negative COVID-19 test result and complete their self-isolation period before they could be discharged. Several such patients had been discharged since the implementation of the policy.

A member informed the Cell that there were currently over 50 active cases in care homes, though illness was not severe and, based on discussions with representatives from the sector, the situation remained reasonably robust. Supplies of Lateral Flow Tests ('LFTs') and Personal Protective Equipment were available, and the use of air filtration devices was being investigated, with some settings already employing them. No requests for Restricted Isolation Release for critical workers had been received at the present time.

A member of the Cell noted that care homes were reporting a drop in resilience due to staff receiving positive LFT results and consequently being unable to work whilst awaiting confirmatory Polymerase Chain Reaction ('PCR') test results. This was an issue that affected health care workers more broadly and the member noted that improvements to the process would be helpful. In response, an observer informed the Cell that there was capacity for people to access PCR tests promptly at present and that same day appointments were available.

Summarising, the Chair noted the policy position; that regular meetings were being held with care sector representatives; that the implementation of the policy had enabled COVID-19 patients who were medically fit to be discharged from Hospital to care settings and that this had the effect of improving resilience within the Hospital.

The Cell noted the position and thanked Mr. Mason for the update.

Testing and
Tracing
update.

A6. The Scientific and Technical Advisory Cell, with reference to Minute No. A4 of its meeting of 10th January 2022, received a presentation, entitled ‘Future Policy for Contact Tracing and Covid Safe Activity’, and a paper, entitled ‘Annexe A: Management of Direct Contacts – Selected International Analysis’, both dated 17th January 2022, which had been prepared by Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department and heard from Dr. Newman in connexion therewith.

It was recalled that initially, the aim had been to suppress all cases and outbreaks in particular, through contact tracing, monitored self-isolation and testing of direct contacts. As vaccination rates increased, a shift had occurred, with the 2021 Winter Strategy indicating a move from suppression to mitigation. It was noted that there had been no self-isolation requirement for direct contacts since July 2021 (with a brief exception in response to the Omicron variant) and since December 2021, testing for direct contacts had changed from Polymerase Chain Reaction (‘PCR’) tests to repeated Lateral Flow Tests (‘LFTs’) instead. The current strategy remained one of mitigation but with different emerging priorities. There was still a need to understand and react to cases in certain settings, for example in the health and care sectors, enclosed communities such as the prison, the emergency services, in critical infrastructure and in schools, as well as monitoring the number of deaths occurring. Maintaining resilience and the continued operation of these critical and essential services were the key priority. In addition, as the underpinning legislation was due to expire during the course of 2022, (though it was noted that it could be extended if necessary), it was apt to consider the reality of a guidance based future position.

The Cell was reminded of the principles that underpinned the contact tracing discipline, which was an essential and well-established public health tool for controlling infectious disease outbreaks. To be effective, contact tracing relied on rapid identification of direct contacts and subsequent isolation of those direct contacts to break the chains of transmission. Contact tracing was less effective in reducing transmission when there were high circulating levels of the virus, although it allowed individuals to know that they had been exposed and were at higher risk of testing positive, therefore enabling risk based, mitigating behaviour. The Cell was apprised of the current structure of the Covid Safe team, whose responsibilities included management of positive cases and their direct contacts, amongst other functions and the current state of the contact tracing process. The Cell was informed that 26,000 individuals were still actively using the Jersey Covid Alert App on their mobile phones, which would notify unknown direct contacts they had encountered over the previous 72 hours from the time of a positive test result, and was noted to have alerted direct contacts in 10 per cent of cases during the pandemic. The Cell was apprised of the approaches followed by other jurisdictions, ranging from heavy case suppression to a cessation of contact tracing activity. Some comparable jurisdictions were reviewing the role of contact tracing in the context of mass Omicron infection and widespread community transmission.

It was proposed therefore, to move away from a strategy based primarily on Non-Pharmaceutical Interventions and isolation of individuals, to a future based on universal measures promoting population level health and resilience, such as vaccination, masks, ventilation and streamlined population testing and screening, as well as improved treatments. A universal approach to LFT screening was suggested, with different levels of testing based on risk (twice weekly for the whole population and daily on working days for those in higher risk settings). This would be supported by a self-managed response to positive results, with personal responsibility and self-reporting at its core. The advice to isolate and book a confirmatory PCR test if an individual developed symptoms, or received a positive LFT result, would remain and a single access point would be established, where Islanders could obtain

guidance and information, book tests and report their results. In high-risk sectors there was the potential for a more supported response to reduce infection and maintain resilience. This would involve repositioning the Covid Safe resource with a greater focus on monitoring and compliance; welfare and support; visits in conjunction with the Infection Prevention and Control Team, with priority given to supporting high risk sectors and large outbreaks in other sectors with a clearly defined source; a greater emphasis on good ventilation and monitoring air quality; and much greater support in gathering high quality information about cases in key priority groups. This would require the retention of contact tracing skill, capacity and knowledge and the ability to prioritise and increase capacity if needed.

The Chair thanked Dr. Newman for the presentation and views from Cell members were sought.

In response to a question from a member, it was confirmed that the timeline for the implementation of the approach had not yet been confirmed. A member commented that further work was needed to ensure that the approach taken was proportionate to the risks posed by COVID-19. The member opined that regular, large scale population-level screening did not constitute the best use of resources, given current vaccination and current case fatality rates. In particular, the member felt it was not warranted or appropriate to require daily testing of the school population, given the risks and impact on children's schooling. It was confirmed by one of the observers that there were currently sufficient supplies of LFTs in the Island for daily testing to be undertaken in education settings at least until the end of the Spring term. The member expressed doubt with regards to the likely usage of proximity-based applications, which they expected would be very low and unlikely to be more effective than manual contact tracing. The member expressed reservations about the approach in general, which they felt may not be necessary in the future in any case, noting that COVID-19 would be better handled in the same manner as influenza currently was. The member agreed however, that it was important to maintain resilience and the institutional memory and capacity that currently resided within the Covid Safe Team.

Another member expressed agreement with the proposed direction of travel and suggested that working with the Community Infection Prevention and Control and the Environmental Health teams would be a good way to move forward, as well as maintaining and retaining the skill sets which would allow rapid upscaling if necessary. In addition, the member noted that revisions to Building Regulations should be considered with respect to ventilation and air handling to help mitigate future problems. Another member of the Cell noted that consideration should also be given to ensuring that appropriate legislation was put in place to deal with future pandemics. A third member informed the Cell that this was considered a priority by Public Health.

A member of the Cell supported the view that contact tracing should be scaled down (except where targeted action was required) and agreed with the need to retain the ability to scale up the discipline if circumstances dictated. Whilst the proposal was not an overall strategy for the downshifting of the COVID-19 architecture, it was an important step in the right direction. A more fundamental and holistic review would be needed to consider the next steps given the current context.

Another member of the Cell expressed agreement with the direction of travel and observed that it would likely have an impact on the data that was available. It was noted that to make risk-based choices, accurate and relevant data was needed on which to estimate risk and base decisions. The downscaling of activities would impact available data and it would be desirable to ensure that the necessary

technological infrastructure was in place to capture positive LFT results and ensure that the ability to monitor the incidence rate remained, especially for new variants.

A member replied that the response should be proportionate to the burden of disease, which was a function of numbers and severity, amongst other factors, and given the uncertainty of the future trajectory of COVID-19, one option could be to try and stratify the burden and the associated degrees of responses. The member noted that there would come a time where COVID-19 was considered and treated as an endemic disease, but in the meantime, codifying the response to the level of the threat could be one way to ensure that Testing and Tracing efforts were appropriate and proportionate.

Summarising, the Chair noted the Cell's support for the direction of travel with regards to contact tracing, and the debate around the detail of future policy. The members of the Cell were supportive of a reduction in contact tracing proportionate to risk; had discussed the potential timeline for such a shift and noted themes including the importance of public communications, public motivation, particularly with regards to application-based contact tracing; and the need to consider the appropriate scope, frequency and cost benefit analysis of population-level screening. Cell members agreed that contact tracing was an important tool in the infectious disease context and recognised the need to retain capacity within the Covid Safe team, which would enable the discipline to be re-established, should the need arise. The Cell was aware of the impact on data reporting and surveillance, which would need to be considered, and in the longer term, of the need to ensure that appropriate legislation and infrastructure were put in place to manage future pandemics.

Isolation
policy.

A7. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A7 of its meeting of 10th January 2022, received a paper, entitled 'Confirmed COVID-19 Cases – Exit from Isolation' and a PowerPoint presentation, entitled 'Positive Cases – Exit from Isolation', both dated 17th January 2022, which had been prepared by Mr. J. Lynch, Principal Policy Officer, Strategic Policy, Planning and Performance Department and heard from him in connexion therewith.

The Cell was informed that prolonged levels of high COVID-19 infection and widespread community transmission driven by the Omicron variant had resulted in a large number of individuals (over 3,000 as at 17th January 2022) being legally required to isolate following a positive test result. This high number and anticipated ongoing high infection rates necessitated a review of the approach to managing positive cases to ensure the minimisation of unnecessary isolation and the proportionate balancing of all risk of harm considerations.

It was recalled that with effect from 17th January 2022, although the default self-isolation period remained 10 days, people in England could end their self-isolation period after 5 full days, provided they were asymptomatic and received 2 negative Lateral Flow Test ('LFT') results on 2 consecutive days, with testing to start no earlier than day 5. Those who left self-isolation on or after day 6 were strongly advised to wear face coverings and limit close contact with other people in crowded or poorly ventilated spaces, work from home if possible and minimise contact with anyone at higher risk of severe illness if infected with COVID-19. The revised policy had been informed by updated United Kingdom Health Security Agency ('UKHSA') research and analysis.

The Cell was apprised of the results of the UKHSA modelling and analysis, noting the estimated proportion of cases released whilst still infectious under self-isolation policies of varying length. Under the previous policy in England, which allowed

testing to begin from day 6, with potential release on day 7, the risk of infectious individuals being released was estimated at 6.2 per cent. The modelling did not specifically consider the new policy position albeit general conclusions could be inferred, and it was likely that it would result in a higher proportion of infectious release. It was noted that even under a 14-day self-isolation period, with testing from day 6, there remained a 4.1 per cent risk of infectious people being released.

The Cell noted the following points highlighted by UKHSA: there was strong confidence in the use of multiple LFTs to support exit decisions; the importance of enhanced post-exit public health guidance on mask wearing and reduced social scenarios to counter residual risk; that universal release at day 10 without testing or symptom check was relatively risky (5 per cent of those released being infectious) and caution as to the use of LFTs only without a minimum isolation period.

The Cell was informed of the approaches adopted by other jurisdictions including relatively lengthy fixed periods without testing (14-day mandatory self-isolation as in South Africa), shortened universal release without testing (release after 5 days if asymptomatic as in the United States), testing only (release after 2 negative LFT results at any point as in the Isle of Man) or combinations of each.

Given the current infection context and updated UKHSA guidance, the Cell was asked to consider the following proposal in relation to the management of exit from isolation for positive COVID-19 cases:

- the retention of a minimum mandatory 10-day self-isolation period in all cases;
- a reduction in the minimum self-isolation period to 5 full days in line with the updated England position (however unlike in England, only for those who were fully vaccinated);
- the retention of the requirement for 2 negative LFT results for early exit;
- the retention of a variation in arrangements by vaccination status, based on data indicating higher viral load and period of infectiousness for unvaccinated people;
- the introduction of enhanced post-exit public health guidance until day 14.

A member of the Cell expressed their support for the proposals and in response to a query as to whether individuals would be required to register the results of their LFTs, received confirmation that would be the case. The member noted that clear public communications would be of the utmost importance when outlining the change in approach. Another member agreed, noting that managing expectations was key, and the expectation was that testing could now begin at day 5, not that isolation had been reduced to 5 days. The member noted their support for the variation by vaccination status. A third member concurred with the points made by the aforementioned member.

A member queried how the proposals would impact on travel, and it was noted that they would discuss this with officers separately.

Summarising, the Chair noted that the members of the Cell were in agreement and supported the proposed approach to the management of exit from isolation for positive COVID-19 cases, and that the change in policy should be accompanied by clear public communications.

disinfection
devices.

by officers from the Children, Young People, Education and Skills ('CYPES') Department, and a presentation dated 17th January 2022, entitled 'Air purification and UV-C devices in education settings', which had been prepared by Mr. J. Norris, Principal Policy Officer, Strategic Policy, Planning and Performance Department and heard from him in connexion therewith.

The Cell was asked to review the evidence in relation to air purification and Ultraviolet-C ('UV-C') disinfection devices and consider whether CYPES should proceed with the purchase and widespread use of such devices throughout school buildings in order to mitigate the risk of COVID-19 infection in schools. The Cell's advice was also sought on the type of unit to be purchased.

The Cell was apprised of the evidence base, which suggested that there was a higher risk of COVID-19 infection in close proximity indoor spaces, where people were exposed to high concentration of airborne pathogens. It was recalled that ventilation measures had been implemented in schools, alongside other Non-Pharmaceutical Interventions ('NPIs'), throughout the pandemic. Air purification devices and UV-C technology constituted a type of additional, less intrusive measure that could be used in support of or as an alternative to other NPIs, such as face masks. Air purifiers were designed to filter pollutants or contaminants out of the air passing through them and helped reduce airborne contaminants, including particles containing viruses, whilst ultraviolet germicidal irradiation used ultraviolet energy to kill or inactivate microorganisms suspended in the air. Although the evidence base was limited at present, studies suggested that air purifiers could be effective as part of a broader strategy to prevent COVID-19 infection and that air filtration units on COVID-19 hospital wards eliminated almost all traces of virus. A Center for Disease Control and Georgia Public Health study of school level prevention strategies suggested that ventilation could decrease the incidence of COVID-19 by 39 per cent, air filtration by 31 per cent and a combination of both measures by 48 per cent. Studies also suggested that UV-C technology was effective in reducing infection rates by 73 per cent.

The Cell was informed that Public Health supported measures to reduce airborne transmission of COVID-19 in schools, which were vital for protecting pupils and staff, minimising disruption and ensuring in-person learning. As standalone measures, air purification or UV-C technology were not considered sufficient but used in conjunction with a broader strategy including an emphasis on ventilation and CO² monitoring to ensure adequate ventilation, they were supported by Public Health. Air purifiers were considered more appropriate than UV-C devices by Public Health, based on cost and availability.

The Cell was apprised of a proposal by CYPES to purchase and implement air purifiers and UV-C technology disinfection units to mitigate the transmission of COVID-19 in educational settings. The Cell noted the options available, their benefits and disadvantages, costs, and lead in times. The proposal covered areas in schools where pupils and or staff gathered for more than 15 minutes at any one time, including staff rooms, and the scope varied from 830 rooms for maintained non-fee paying and fee-paying schools and colleges, 957 rooms should non-maintained schools in receipt of grants be included and 1,012 rooms should independent schools be included.

An observer noted that the introduction of air purification and or disinfection devices should be considered in the longer-term context, noting that it may be beneficial in the event of future waves of infection or the emergence of new variants.

A member concurred regarding the importance of considering the long-term view,

given the uncertainty around how COVID-19 might continue to affect society in the future. In addition, the proposals would be beneficial in terms of mitigation against other diseases. The member noted that it was not known if reducing exposure to circulating viruses could unintentionally impact the development of children's immune systems going forwards. There was a need to balance the benefits of air filtration against the unknown effects of placing children 'in a bubble' at school. The member expressed a view that the devices would help schools to address the transmission of COVID-19 and noted the lead in times for installation, which varied from weeks to months, depending on the devices selected.

Another member of the Cell opined that teachers, who had been most vocal in calling for such units to be installed in schools, did not have a higher risk of contracting COVID-19 than the general population and noted that the impact of the devices on transmission in schools had not yet been fully quantified. The member questioned whether the units would be installed in time to have any meaningful impact on transmission, given the lead in times for delivery of some of the devices. The member noted that a wealth of evidence supported the notion of improving ventilation by opening windows, which was proven to reduce the risk of transmission and agreed with the point that the impacts of 'sterilising' classrooms were not known. In conclusion, the member noted that they did not support the installation of such devices in schools and questioned the motivation behind the proposal.

A member of the Cell noted that the devices might be helpful and whilst the results of further studies were awaited, suggested that it would be worthwhile trialling them. The member also noted that the overall costs of the proposal appeared reasonable in comparison to other COVID-19 expenditure.

Another member noted that the evidence suggested the devices could reduce levels of transmission, concurred with the assessment that they constituted a relatively low-cost intervention and opined that they could provide a medium to long term solution if COVID-19 persisted. The member concluded by saying that they supported the proposal, particularly given the low vaccination rates in children.

A member of the Cell agreed that whilst ventilation from opening windows was a proven and effective measure, in situations where this was not possible, it would be a sensible idea to trial the devices, concentrating the deployment in areas where there was poor ventilation.

Another member noted that the devices could help to reduce the incidence of viruses in addition to COVID-19 and it was fortunate that children and young people had not been seriously affected by the variants identified so far.

A member of the Cell expressed strong support for the proposal, noting that the devices appeared promising, and had the advantage of being passive, rather than actively having to remember to open windows. The member was in favour of implementing the devices on a risk assessment basis, focusing on installation in areas where ventilation was poor or non-existent. The member noted that some care homes were already using the devices and there was a case for considering their use more widely in the care home sector, which the member wished to pursue. The member observed that measures such as these could enable more intrusive restrictions to be relaxed and noted the relatively low cost involved.

A member, who had previously spoken, concurred with the focus on installing the devices in areas with poor ventilation and re-iterated that in the context of high-risk sectors, singling out schools was not necessary. The member felt that the proposal

was overly reactive and that the Cell should await further evidence before reaching a conclusion on the matter. The member also disagreed that the proposal was relatively low cost and questioned how much of an impact it would have given the timing of its implementation. The member confirmed their lack of support for the proposal on this basis.

A member informed the Cell that air filtration and UV-C devices had been in use in high-risk areas within the Hospital for some time. The member agreed that the devices should be deployed in schools on a risk-assessed basis, in areas where they were most likely to be effective, and that their use in care homes should be considered. The member noted the need for further thought to be given to the potential risks of reducing childhood exposure to common infections, given that the devices were effective against a number of viruses. Another member concurred with this point.

Summarising, the Chair noted guarded support from Members of the Cell for the proposal, due to the need for a clear implementation timeline and the need to ensure that the potential for harm was minimised. There was support amongst the members for a risk-based approach and incremental implementation, and the measure was noted to be less intrusive than other NPIs.

Fomites.

A9. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A1 of its meeting of 13th December 2021, received and noted a paper, dated 14th January 2022, entitled 'Briefing paper on Fomites' and received a presentation, dated 17th January 2022, entitled 'Fomites / surface to person infection', which had been prepared by Mr. S. Gay, Senior Public Health Policy Officer, Strategic Policy, Planning and Performance Department.

The Cell was apprised of the evidence in relation to the potential for COVID-19 to be spread by fomites. The literature suggested that transmission was primarily caused by inhalation of respiratory droplets or aerosols from symptomatic cases. Infection by fomites was deemed rare or low risk, however, was not considered non-existent, due to large data gaps and a lack of observational studies. Fomites likely played a role in transmission and should be considered a low or additional risk. Hand and surface cleaning was considered an effective Non-Pharmaceutical Intervention ('NPI').

It was recommended therefore, that the emphasis should remain on ventilation due to the higher risk presented by droplets and aerosols. Due to the additional risk posed by fomites in respect of transmission of COVID-19 and other respiratory viruses, surface and hand hygiene should remain as a recommended NPI for the time being and should continue as a general precaution when the burden of COVID-19 decreased, and other respiratory viruses began to circulate. The Cell was asked to advise on any changes to operational practices in light of the evidence in relation to fomites.

A member of the Cell noted that the Center for Disease Control ('CDC') considered the risk of acquiring COVID-19 from fomites to be extremely low, at less than 1 in 10,000. The member acknowledged that although the risk was low, fomites could be a small contributory factor in transmission. The member opined that in light of the risks, the Covid Safe team had perhaps appeared somewhat over-zealous with regards to deep cleaning advice that it had issued to businesses. Another member interjected, noting that surface and hand hygiene were vitally important 'business as usual' processes and helped to mitigate the spread of other viruses, such as Norovirus. The member opined that the focus on ventilation was important, which

87th Meeting
17.01.22

the first member agreed with. Notwithstanding this, the first member thought it would be desirable to move away from advice to deep clean premises and adopt a more proportionate approach to hygiene advice.

Another member observed that a certain amount of zeal had been necessary in tackling the transmission of COVID-19 and disagreed with the criticism of the Covid Safe team's approach. Emphasising the need for ventilation could be done without detracting from advice related to hygiene, they suggested.

A member suggested that COVID-19 measures should be considered as environmental health measures going forward and be integrated into environmental health inspections.

The first member re-iterated their view that the focus on fomites was unnecessary and noted that it could lead to unwarranted anxiety and worry within institutional settings.

Summarising, the Chair thanked Mr. Gay for the presentation, and noted that the Cell was aware of the small, continuing risk presented by fomites with regards to transmission of COVID-19 and other infections. Whilst ventilation was the most important measure and should remain the principal focus of the advice issued by the Covid Safe team, the members of the Cell recognised the role played by fomites and supported the continued provision of hygiene advice, whilst being mindful of the implications of that advice. It was suggested that the emphasis of the advice might benefit from reassessment, which officers undertook to review.

Matters for
information.

A10. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A1 of the current meeting, received and noted the following –

- a weekly epidemiological report, dated 13th January 2022, which had been prepared by the Strategic Policy, Planning and Performance Department;
- statistics relating to deaths registered in Jersey, dated 13th and 14th January 2022, which had been compiled by the Office of the Superintendent Registrar;
- a report on COVID-19 vaccination coverage by priority groups, dated 13th January 2022, which had been prepared by the Strategic Policy, Planning and Performance Department; and
- a report, on COVID-19 monitoring metrics, dated 14th January 2022, prepared by the Health and Community Services Informatics Team.

There being no further business to discuss, the meeting was concluded at 1pm.