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SCIENTIFIC AND TECHNICAL ADVISORY CELL

(88th Meeting)

(Business conducted via Microsoft Teams)

24th 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 -

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. Lynch, Principal Policy Officer, Strategic Policy, Planning and Performance Department
Dr. L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department
S. Huelin, Senior Policy Officer, Strategic Policy, Planning and Performance Department
B. Edwards, Head of Health Informatics, Health and Community Services (for Item A4 only)
S. White, Head of Communications, Public Health
S. Martin, Chief Executive Officer, Influence at Work
K. Sharman, Office of the Chief Executive
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 meeting of 10th January 2022, which had previously been circulated. The Minutes were approved by the Cell subject to a minor typographical amendment.

Intelligence overview, including Analytical Cell update and HCS activity.

A2. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A1 of its meeting of 17th January 2022, received a PowerPoint presentation, entitled 'STAC Monitoring Update', dated 24th 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 21st January 2022, there were 2,506 active cases of COVID-19 recorded in the Island, from which 4,037 direct contacts had been identified. The majority of cases were in those aged under 20, followed by cases in those aged 30 to 39.

Seeking healthcare was the most common reason for testing, accounting for 1,316 cases; 922 had been identified through Lateral Flow Tests ('LFTs'); 91 through arrivals screening; 35 through contact tracing and the remainder through various screening programmes. It was noted that the number of cases identified through contact tracing was decreasing following a change in testing policy. The age ranges, gender and vaccination status of the active cases were shown, with a further breakdown by age for active cases in those aged 18 and under.

Around 1,500 tests were being undertaken on a daily basis and an average of 285 cases per day had been identified since 12th January 2022, which represented a significant decrease in comparison to the figures for the post-Christmas period, when a daily average of 472 cases had been identified.

The overall test positivity rate (measured as a 7-day rolling average) had decreased to 20 per cent for both all testing and non-seed positivity (previously referred to as the Island rate excluding inbound travel).

The 7-day case rate per 100,000 population had increased slightly and appeared to be plateauing in those aged under 11 years, at 4,104. Though the rate had dipped for those aged 12 to 17 years, it was now increasing again and stood at 3,406. A sharp fall to 1,506 had been observed in the rate for those aged 18 to 39, while falling more modestly for those aged 40 to 59 to a similar level, and for those aged over 60, where the figure had decreased to 741.

It was estimated that 2.8 per cent of cases in December were probable re-infections, the figure having increased since June 2021, when it was estimated that 0.8 per cent of cases were re-infections. It was recalled that Omicron was first identified in the Island on 13th December 2021.

The Cell reviewed the clinical status of cases in hospital since 28th June 2021 and noted that as at 21st January 2022, there were 27 patients in the Hospital with COVID-19. A fall in the number of cases in care homes was noted.

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

A further 4 deaths had been recorded, bringing the total to 96, with 18 registered since the start of the 4th wave on 1st October 2021.

The Cell was informed that the number of inbound travellers had continued to decline, to around 4,500, during the week commencing 10th January 2022, with 67 positive cases identified, equating to a test positivity rate of 5.4 per cent.

During the week ending 16th January 2022, Jersey's testing rate, per 100,000 population, had been 8,300, compared to the United Kingdom ('UK') rate of 14,450, which included LFTs. The test positivity rate locally was 25.4 per cent compared to 6.4 per cent in the UK.

The Cell noted that 353 patients were currently recorded in the EMIS clinical IT system as suffering from 'Long Covid'.

The Cell was apprised of the improved situation with regards to Primary Care, noting that levels of General Practitioner and staff absence caused by COVID-19 had decreased.

It was noted that footfall in St Helier had not returned to pre-pandemic levels but was higher at present than it had been in January 2021. Traffic levels had fallen over January 2022, however the number of bus passengers had increased.

The Cell was apprised of the results of social media sentiment analysis, noting that the campaign around walk-in vaccination had been updated after being poorly received. Islanders were anticipating announcements regarding the easing of restrictions and continued to campaign for air filtration and monitoring devices to be installed in schools. Calls for Digital Covid Status Certificates to be valid for longer than 30 days were noted, particularly from Islanders with children in university. Questions around the COVID-19 statistics included requests for confirmation of the dominant variant, the vaccination status of hospitalised cases (it was recalled, with reference to Minute No. A4 of the extant meeting, that this information had recently been published) and the vaccination status of those who had died as well as the age range for each reported death.

Details regarding the COVID-19 vaccine programme were shared and it was noted that as at 16th January 2022, 217,598 doses had been administered, of which 57,847 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 78 per cent of care home residents, 79 per cent of carers working in care homes and 81 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.

The Cell was informed that 18 episodes of flu-like illness had been reported in primary care during the week ending 16th January 2022. Overall, levels were marginally higher than those seen in Winter 2020 to 2021 but were following the same pattern and it was noted that levels were significantly lower than in previous Winter seasons.

The Cell was apprised of the situation in UK, noting that over the 7 days to 23rd January 2022 (17th January 2022 for hospitalisation figures), cases had decreased by 15 per cent, hospitalisations by 9 per cent and deaths had increased by 1.9 per cent. The 14-day case rate per 100,000 population ranged from 1,060 in Wales to 2,644 in Northern Ireland, whilst the rate in Jersey was presently 3,996. High 14-day case rates per 100,000 population were noted across Europe, with an increase in cases in Poland noted over the week ending 20th January 2022.

The Cell was provided with an update on Hospital capacity which confirmed that although the Hospital was experiencing a degree of pressure, admission rates had been lower than predicted during the previous week and safe levels of staffing and care were being maintained. Difficulties in discharging medically fit patients were

still being encountered. The position with regards to the Testing and Tracing team was satisfactory, and the reshaping of the Covid Safe resource in line with current priorities was underway.
A member of the Cell asked whether the temporary restrictions with regards to visitors to the Hospital had had an impact on the number of Hospital-acquired COVID-19 infections. Another member noted that anecdotally, they were not aware of any infections seeded in the Hospital in the previous 4 days and undertook to verify the same with the Infection Prevention and Control team. As at 19th January 2022, 11 patients had been identified as being likely to have acquired COVID-19 in the Hospital from a small number of symptomatic visitors. It was noted that the Hospital had a responsibility to protect patients and the restrictions had been necessary given the gravity of the situation. The Chair requested that an update be provided to the Cell at its next meeting.

A member of the Cell noted that infection rates in children locally were consistently high whilst overall case numbers appeared to be declining in London. The member wished to know if further detail was available to determine whether local case rates in children were following a similar trajectory to those in London. One of the observers noted that consistently high infection rates in children had been observed in the UK and undertook to provide the Cell with further information at its next meeting.

Another member of the Cell suggested that it would be desirable going forwards, to be provided with test positivity rates, broken down by age grouping, rather than absolute numbers of cases. The member opined that high rates of infection in children could be explained by relatively low vaccination rates and the high frequency of testing that was being undertaken, which resulted in higher detection rates. It was confirmed by an observer that PCR test positivity data by age group was available and currently showed that rates were higher amongst children compared to adults. It was noted however, that increasing reliance on LFTs would impact the available data due to the difficulties in encouraging people to self-register negative results. The member suggested reconvening the surveillance working group, which another member concurred with.

A member noted the public interest with regards to the dominant variant in Jersey and the vaccination status of those who had died and asked whether consideration could be given to providing this information. It was noted by another member of the Cell that Omicron was now the dominant variant locally. With regards to the vaccination status query, the Cell was informed that there had been 27 deaths since the introduction of the COVID-19 vaccine and the matter would be discussed during the next item on the agenda, namely the update on the publication of information relating to the vaccination status of hospitalised patients (with reference to Minute No. A4 of the extant meeting).

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

Omicron update.

A3. The Scientific and Technical Advisory Cell (‘the Cell’), with reference to Minute No. A4 of its meeting of 17th January 2022, noted the ‘UK Health Security Agency Risk Assessment’ for the Omicron variant, dated 12th January 2022, and heard from Dr. L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department, in connexion therewith.

The Cell was apprised of the latest update in relation to Omicron, which was that the Omicron sub-lineage BA.2 had been designated as a variant under investigation (VUI-22JAN-01) by the United Kingdom Health Security Agency. The proportion

of BA.2 cases was currently low however the designation had been made on the basis of increasing numbers of BA.2 sequences identified both in the United Kingdom and internationally. Further analysis was being undertaken to determine the significance of changes to the viral genome.

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

Vaccination status of hospitalised patients.

A4. The Scientific and Technical Advisory Cell ('the Cell') with reference to Minute No. A2 of its meeting of 17th January 2022, received a report and presentation, both dated 21st January 2022 and entitled 'Report on Vaccine status of COVID-19 patients in Jersey General Hospital', and heard from Ms. B. Edwards, Head of Health Informatics, Health and Community Services in connexion therewith.

The Cell was informed that a report had been published on 21st January 2022, which showed that in the six-month period from July to December 2021, 88 people aged 40 years and over had been admitted to hospital with 'clinical COVID', and 35 per cent of these patients had subsequently been admitted to the intensive care unit ('ICU'). The estimated relative risk of admission to Jersey General Hospital due to clinical COVID for those aged over 40 was 3.5 to 14.4 times greater in those who received less than 2 doses of COVID-19 vaccine than in those who received 2 or more doses. The relative risk for admission to ICU with clinical COVID in individuals who received less than 2 doses of vaccine was 7.4 to 30.8 times greater than in those who received 2 or more doses. The report highlighted the importance of vaccination as a means of protecting Islanders from severe illness.

It was noted that the frequency of future updates would depend on the number of patients admitted, due to the need to maintain patient confidentiality.

A member noted the large range of the estimates and queried whether consideration had been given to establishing a mean population for the 2 groups. The Cell was informed that due to the prioritisation of the data validation work and the changes in vaccination status over time, a range had been considered the most feasible option.

Another member thanked Ms. Edwards and her team for the significant amount of work they had undertaken to enable the publication of the report, thus addressing the Cell's request for the information, which had first been mooted at its meeting of 29th November 2021, (Minute No. A2 refers). The Chair also thanked Ms. Edwards on behalf of the Cell for a useful publication.

In relation to the query, with reference to Minute No. A2 of the extant meeting, as to whether similar information could be published with regards to people who had died, the Cell was informed that the issue was not one of patient confidentiality, but related to the small numbers involved, which made meaningful trends harder to discern, and data validation, vaccination status not being included as part of the process of registration of deaths. The data would need to be manually obtained and validated. In response to a question from a member, it was confirmed that, for the minority of COVID-19 patients who had been admitted to, and subsequently died in Hospital, there was no evidence of a different trend with regards to vaccination status and risk of admission to ICU.

The Cell thanked Ms. Edwards for the update.

De-escalation

A5. The Scientific and Technical Advisory Cell, with reference to Minute No. A4

strategy.

of its meeting of 10th January 2022, received a presentation, entitled 'De-escalation of COVID Measures', dated 24th January 2022, which had been prepared by Mr. A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department and heard from him in connexion therewith.

The Cell was apprised of the current risk of disease from COVID-19, noting that very high vaccination coverage had been achieved, particularly in vulnerable groups such as those aged over 50, over 88 per cent of whom had received three doses of COVID-19 vaccine. The case fatality rate had decreased by *circa* 93 per cent since the second wave of the pandemic in Winter 2020-2021, to a 0.1 per cent risk in Winter 2021-2022 so far. The context for de-escalation was set out, in light of strong evidence that suggested the dominant Omicron variant was milder, though it still presented a significant risk to those who were unvaccinated. The continued effects of restrictions on social and economic resilience were noted, set against the incidence of severe disease, which remained within manageable parameters. Appropriate de-escalation would enable a greater focus on other public health risks and provide an opportunity to strategically reset Jersey's approach to the pandemic, in line with the trajectory being adopted by other jurisdictions, such as the United Kingdom and Guernsey.

There remained several risks associated with de-escalation including the uncertainty with regards to disease impacts (including Long Covid); the risk that novel, higher severity variants could emerge in the future; uncertainty with regards to the infection trajectory including the risk of persistent high prevalence and the continued impacts on resilience given the high infectivity of the Omicron variant.

The Cell was informed that the balance of evidence suggested that significant de-escalation was appropriate in the current context, albeit with proportionate safeguards to enable a rapid response and risk management should the threat level increase. Considering de-escalation in a planned way would allow for efficient use of resources, action based on data and evidence, and management of residual risk. A phased de-escalation approach was therefore proposed, with consideration given to the enabling legislation and regulations, the extant governance arrangements and post-emergency strategy. The restrictions and advice in relation to Non-Pharmaceutical Interventions ('NPIs'), the Safer Travel policy and data reporting had been reviewed, as had the key elements of the programme of measures taken in response to the pandemic, including vaccination, testing, contact tracing, isolation and Covid Status Certification.

It was recalled that the Covid-19 (Enabling Provisions) (Jersey) Law 2020 was due to expire on 1st August 2022 and it was proposed to extend the Law to mid-December 2022 based on the continuing public health risk, for contingency purposes and to assist the next administration. With regards to regulations, the COVID-19 related legislation was due to expire on 30th April 2022 and it was proposed to terminate the majority of the regulations on this date, save for those relating to border controls and isolation requirements, and workplace restrictions, once more for continency purposes.

It was proposed that the recommendation to work from home where possible, legal requirement to wear masks indoors and requirement for businesses to collect contact tracing information should cease with immediate effect if Competent Authorities Ministers agreed, though it was envisaged that separate policies with respect to continued mask wearing in educational and health and social care settings would be maintained as required. With effect from 7th February 2022, it was proposed to end centralised contact tracing, suspend the Safer Travel policy and simplify the testing offer. A 'Post-Emergency COVID-19 Strategy' would be published by the end of

February 2022. It was envisaged that by 31st March 2022, mandatory isolation of positive cases would no longer be required (though it would be replaced by guidance focussing on self-assessment and testing, as well as guidance for positive individuals to remain at home where possible), emergency governance arrangements would be concluded, and the testing offer reviewed.

The Cell was asked to consider firstly, whether the balance of data and evidence supported the proposed de-escalation approach and, if not, what mitigations could additionally be considered; secondly, the overall de-escalation approach and specific policy changes outlined, with specific reference to the timing of changes to mask wearing requirements and the recommendation to work from home where possible, and any other timing conclusions; and finally, the strategic shift to a 'Post-Emergency' phase of the COVID-19 response and any elements for emphasis.

A member of the Cell noted by way of context, that the COVID-19 mortality rate in Jersey was similar to that for influenza, at around 1 in one thousand, and welcomed the proposals, noting that it was apt for the Cell to consider a pathway for gradual de-escalation.

Another member noted their support for the thrust of the presentation, noting that the proposed de-escalation pathway was balanced and reflected the move from a pandemic situation to one where COVID-19 was considered an endemic disease. The member noted, in relation to the phased reduction of data reporting, that it would be a welcome development and that there was a place for social media communication of some data to continue. It was key, in their view, to bring together details of the data that would be needed to support decision making with regards to scaling up the response in the future if necessary. The member further commented that in terms of timing, the publication of the 'Post-Emergency COVID-19 Strategy', planned for the end of February 2022, should be brought forward and issued prior to the proposed de-escalation of certain measures on 7th February 2022.

A third member of the Cell expressed full support for the proposal however wished to make various points regarding the timing and focus of the approach. With regards to the case fatality rate, the member noted the difficulty in comparing it in different waves over time, due to the changes in testing effort, noting the increasingly widespread use of LFTs over the course of the fourth wave. Another member noted that testing had been extensive during the second wave, which was confirmed by a third member, and it was acknowledged that the full scale of LFTs undertaken was difficult to gauge as negative results were often not reported. The third member opined that the use of LFTs was enabling more positive cases to be identified and it was noted by the Cell that case fatality was not directly comparable over different waves. The third member noted that it was reassuringly low over the Winter 2021-2022 period so far, having decreased to 0.1 per cent.

In comparison with flu, the third member thought that it was likely more COVID-19 cases were being identified due to the differential in testing levels between the two diseases. The member expressed their support for the removal of the work from home guidance and mandatory mask wearing, noting firstly that they had not supported the reintroduction of those measures on 4th January 2022, and secondly, the minor impact of mask wearing on transmission levels, in their view, due partly to their sub-optimal use and the settings in which they were mandated. Another member countered that guidance on mask wearing could be issued to address this. The third member indicated that they did not see the logic of a continued mandatory isolation period for positive cases and that the proposal to remove this requirement should be brought forward from the proposed 31st March 2022 implementation date. The member acknowledged that further thought was needed regarding the

management of COVID-19 in institutional settings, and giving the example of the Prison, noted that suppression was not an appropriate aim in that setting due to the deleterious effects of isolation on prisoners' mental health. In relation to schools, the member advocated de-escalating the perception of risk in schools by reducing testing and preferably ceasing it altogether, given the low risk of severe disease in younger populations. The member reiterated their overall support for the proposal, subject to the comments above.

A member noted the importance of ensuring that the expertise of the Testing and Tracing team was retained within the government skill set and suggested that certain of the Covid Safe team's functions could be transferred to the Environmental Health department's routine work. The member also noted the need for Building Regulations to be reviewed to mitigate issues in future pandemics.

A fourth member expressed their full support for the proposal and commented that the communication of the approach was key, as the gradual de-escalation of measures could be interpreted by some as providing a sense of closure and signalling the end of the pandemic. Measures such as vaccination, however, would remain extremely important and therefore the report on the vaccination status of hospitalised cases, discussed previously (with reference to Minute No. A4 of the extant meeting), was helpful in that the range of risk described therein evidenced a continued degree of uncertainty, and signalled that the pandemic was not yet over.

A fifth member indicated their support for the proposal and felt that it was a balanced approach to move from the current to the proposed future situation, with a gradual de-escalation of measures over time. The member agreed that the retention of skills and ability to revive efforts if necessary was critical, although they could be implemented in different ways in the future, based on the evidence available. The member gave the example of border testing, which if re-instated, would not have the same effect without isolation and contact tracing. In relation to schools, the member cautioned against the cessation of all measures to suppress transmission, noting that although small, risks to children existed and the spread of infection should continue to be addressed. Omicron had spread rapidly in the school aged population and the member was in favour of continued measures to stem spread in schools and also of extending vaccine coverage to children aged under 12. Another member agreed on the need for caution in school settings.

With regards to the suggestion that vaccines be offered to children aged under 12, it was noted by the Cell that operational plans had been developed to deliver vaccines to 'at risk' children aged 5 to 11 years and children who were household contacts of immunosuppressed individuals, but a decision to further extend coverage would be considered by the Cell if and when the Joint Committee on Vaccination and Immunisation issued advice on the matter.

A sixth member expressed their strong support for the proposal and the direction of travel. In relation to reporting, the member suggested that alert levels be considered, such as those used by the United Kingdom Health Security Agency. A phased reduction in reporting would be welcomed and enable the focus to shift to the impact of the pandemic on health inequalities.

The third member questioned whether teachers constituted a population at increased risk, and it was noted that further data was needed in relation to this point. The member reminded the Cell that vaccination helped to protect teachers from severe disease and noted data from the UK suggesting that mask wearing had not had a significant impact on transmission in school settings. The member was of the view that masks negatively impacted learning and although there were unknowns with all

diseases, singling out the school population for continuing measures to stem transmission was unwarranted, given the low risk presented by COVID-19 to that population.

An observer noted their agreement with the direction of travel and that they were glad, as most people would be, to see a roadmap out of the pandemic. The observer agreed with the comment regarding the timing of the publication of the 'Post-Emergency COVID-19 Strategy'. In relation to travel restrictions, the observer noted that the interplay with destinations with continued requirements should be considered. The observer suggested engaging with institutional settings such as schools and care homes to gauge their views on the direction of travel going forwards. From an operational perspective, the observer noted that it was desirable for policy changes to be optimally timed to ensure that they were properly planned and implemented at a pace which avoided unintended consequences, particularly if there was a possibility that functions would need to be scaled back up at short notice in the future.

Another observer noted that the overriding principle to consider proportionality, and the impact of border restrictions, was significant both operationally and in terms of the impact on society. Although much had been learnt from the various iterations of the Safer Travel policy, it had not prevented the arrival of variants nor significantly impacted the local trajectory of infections, which had closely followed that of neighbouring jurisdictions. It was therefore appropriate to be realistic in terms of what could be achieved by border restrictions in the new paradigm of widespread infection and high vaccination levels. Any form of stratification of risk at passenger level required significant information gathering and analysis, which the observer noted was intrusive and a source of friction at the border. The observer therefore questioned the wisdom of continued restrictions on travel and reverted to the overriding question regarding the proportionality of the response, which, in their view, should tend towards the lowest possible level of intervention.

Summarising, the Chair noted broad support from members of the Cell for the de-escalation approach. The ability to scale up the response was important, though potentially in a different way to how it had been implemented previously, and it was recognised that there would be a lead time to do so. A proportionate response was needed, given that the current COVID-19 case fatality rate was similar to that of influenza. The communication of the proposals was crucial, and emphasis on the vaccination programme would need to be maintained. The Chair noted that it would be helpful for a sub-group of the Cell to be convened to determine the data reporting requirements going forward, and report back to the Cell on this matter in due course. Areas of the proposal which required further refinement, were the management of COVID-19 in institutional settings such as schools, care homes and the prison, and the arrangements in place at the border. It was recognised that the reduction and removal of measures would enable a shift in focus to indirect health consequences of the pandemic, which would be a key priority for 2022.

Mr. Khaldi thanked the Cell for the discussion and its support for the proposed approach to de-escalation. Next steps would include work to prioritise the publication of the 'Post-Emergency COVID-19 Strategy' and communications planning, as well as consideration of the approach for areas of high consequence such as institutional settings. It was noted that the proposals would be considered by Competent Authorities Ministers at their meeting later in the week.

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 20th January 2022, which had been prepared by the Strategic Policy, Planning and Performance Department;
- statistics relating to deaths registered in Jersey, dated 20th January 2022, which had been compiled by the Office of the Superintendent Registrar;
- a report on COVID-19 vaccination coverage by priority groups, dated 20th January 2022, which had been prepared by the Strategic Policy, Planning and Performance Department; and
- a report, on COVID-19 monitoring metrics, dated 21st January 2022, prepared by the Health and Community Services Informatics Team.

There being no further business to discuss, the meeting was concluded at 12.15pm.