

KDC

SCIENTIFIC AND TECHNICAL ADVISORY CELL

(1st Meeting)

4th June 2020**PART A (Public)**

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

Introduction. A1. The Chair advised the Cell that its meetings would now be attended by a Secretariat Officer from the States Greffe, to produce an impartial and comprehensive written Minute, to record each meeting. The meeting number and page numbering used by the States Greffe would only reflect the Cell's record from this Minute onwards.

The Cell welcomed the Secretariat Officer to the meeting.

Metrics A2. The Cell received a brief status update from Dr. A. Muller and noted the content of a report in connexion with the metrics used for analysis of Covid-19 and its prevalence in Jersey.

The Cell noted that there were currently 3 known active cases of Covid-19 in Jersey. Dr. Muller provided the Cell with details of the 3 cases, noting that the information was of a sensitive nature. Detailed information was available for each case and it was confirmed that contact tracing had been completed or was underway. The Cell noted the number of direct contacts for each active case had been provided, but it had not been provided with information on how many had been successfully traced and tested. It was requested that the information was made available in the future.

Whilst noting that information and data sharing was complex, the Cell queried whether a legal issue had been identified in that area and highlighted the importance for the relevant groups to receive and act on data quickly. It was confirmed that information was available to the Cell, but there was a wider issue of whether all of the detail was shared further, for example with teams analysing the data.

The Cell noted that there had been no positive PCR tests as a result of the increased flights into the airport on Tuesday.

The Cell discussed the data available in respect of care home cases. It was identified that there was information missing in the report on the number of deaths which had occurred in hospital, following the transfer of a patient from a care home. Data was also required to ascertain the total number of care home patients who had been transferred to hospital for treatment. The Cell requested that the data be identified and included in future reporting.

In relation to care homes, Mr. D. Danino-Forsyth, Director of Communications, referenced recent news reports from the United Kingdom, which had suggested that there had been a movement of infected patients out of hospitals and into care homes and he queried whether any similar actions had taken place in Jersey. In response, it was suggested that many cases of Covid-19 in Jersey care home residents could be traced to within their care home. The Cell advised that any public messaging on the matter should clarify that the prevalence and impact of the virus in Jersey was not consistent with the United Kingdom and that where care homes (approximately 8 in

number) had been affected, the spread of the virus had been managed and, as a consequence, the mortality rate was relatively low. It was further advised that a choice of care setting had been provided to the families of care home residents unwell with Covid-19. Where deaths had occurred in care homes as a result of Covid-19, it was often after discussion with the patient's family on whether the resident should move to hospital for treatment or remain within the care home environment under the care of a General Practitioner. XXXXXXXX  
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX  
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

The Cell received and noted the content of the metrics spreadsheet developed by Ms. S. Davis, Senior Statistician, which identified a number of measurements alongside red, amber, or green (RAG) ratings (the RAG spreadsheet). The Cell noted that the RAG spreadsheet was not tabled for in depth discussion and approval at this meeting, but that comments from members on its content would be welcome. The RAG spreadsheet would be used as a starting point to identify areas that experienced significant changes, particularly if a factor was to move into a 'red' zone that required a decision to act, or 'amber' that was required to be monitored for changes that caused concern. The Cell noted that the RAG spreadsheet provided a retrospective view of past behaviour and queried whether there was capability for a similar report to measure the risk going forwards, for example, measurement of public behaviour, or screening.

Dr. G. Root emphasised that context for the metrics was essential, for example, if 15 cases were to be identified in a cluster within a care home, he suggested that this would be less threatening than a number of widespread individual cases. The two scenarios would have different contextual implications for the Island, and the latter would require a more detailed epidemiological study of the affected individuals to identify the source. Dr. Muller advised that there would be 3 information records available to assess context of cases in the future. One would be the RAG spreadsheet (once operational), the second was the 'active cases' spreadsheet, and the third was the Dashboard.

Mr. N. Vaughan, Chief Economic Advisor, asked the Cell to consider whether the situation in Jersey was similar or different to the United Kingdom and, if it perceived a difference, queried if it would be useful to understand this further. Noting its previous discussions, the Cell suggested that there was a clear difference in the transmission context between Jersey and the United Kingdom. It was identified that Jersey had a much lower population density than the UK and, also, that initial levels of infection coming into the Island were lower by comparison. Mr. R. Sainsbury, Managing Director, Jersey General Hospital advised that an additional major difference was that, in Jersey, the care homes had been identified as an extension of the hospital at the start of the emergency, for matters such as the provision of personal protective equipment *et al.* Jersey had also adopted shielding for the vulnerable groups from a very early stage (7th March 2020), which was estimated to include 17,000 people.

The Cell noted the update, including the request for members to provide any further comments on the RAG spreadsheet.

Article in *The Lancet*.

A3. The Cell noted the content of a recent article in *The Lancet* entitled 'Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV2 and Covid-19: a systematic review and meta-analysis' (published online, 1st June 2020).

Members of the Cell expressed the opinion that much of the information in the article was not new, but that it was important as it provided evidence and observational data specific to Covid-19 that had previously been absent.

The Cell discussed physical distancing requirements, as the article had referenced that a physical distance of 1 metre had reduced the risk of Covid-19 transmission in healthcare and community settings by 82 per cent, and that every additional 1 metre of separation (data was available up to a 3 metre distance) more than doubled the relative protection. The Cell noted that the current guidelines (and legislation) required a 2 metre physical distance to be maintained by individuals in public and it considered whether there was sufficient evidence to suggest that the physical distancing could be reduced to 1 metre with the move to Level 2 of the lockdown exit strategy. The Cell discussed whether the change to 1 metre could be accompanied with a recommendation to retain a 2 metre physical distance where possible. Members of the Cell favoured the change of the physical distance requirement to 1 metre and suggested that a clear message and the ability for the public to practically apply the guidelines was key. The Cell stated that the ability to step up measures, with a potential to return to 2 metres in future, should be a factor for consideration.

Referencing a discussion in a previous meeting, the Cell noted that it had recommended that the distancing within schools be reduced to a space of 1 metre, however, members had received anecdotal reports that this had not been communicated within the guidelines schools had received (which had stated 2 metres). It was requested that the matter be addressed. The Cell also clarified its advice that shielded children (approximately 70 in number) could return to a school setting, as their colleagues were not 'super spreaders', however, it was emphasised that this decision should be taken by parents in consultation with the child's Consultant Paediatrician or General Practitioner.

The Cell was of the opinion that legislation for physical distancing should not be relied on in the future, as there would be issues with enforcement (or lack of) and the public tiring of the requirements. It recommended that legislation should be used to prevent large groups of people coming together, as this posed a greater risk to public health. The Cell suggested that effective prevention would be better met by effective communication of the message to the public.

Members recalled that the Cell's terms of reference included the provision of advice to the Government and weighing up the balance of harm to the general public. Therefore, the Cell noted a concern regarding the control of crowding in an equality and diversity context, namely that measures to prevent large crowds, or to ensure that physical distancing was maintained, could have a disproportionate effect on certain demographics, such as those with lower socio-economic means. For example, it was acknowledged that recent cases of crowds at the St. Helier seafront were more likely to be individuals living in smaller town apartments rather than houses with gardens. The Director of Communications advised that the Chief Minister had recognised the issue and the Government was consequently alert to the matter. The Cell agreed to provide formal advice to suggest: (i) recognition of the disproportionate effect of the measures on those at a disadvantage; and, (ii) to recommend that there should be a group responsible for reviewing the problem.



1st Meeting  
04.06.20

xxxxxxxxxxxxxx. However, the Cell was mindful that a number of points in the policy could be contentious and therefore, its medical advice was vital to this.

The Cell reflected that it's earlier comments on physical distancing (Minute No. A3 of this meeting refers) would need to be incorporated to the updated Level 2 policy. Dr. Mathias explained that Level 2 was scheduled to commence on 12th June 2020, however, as the 2 metre distancing was part of legislation, the change to 1 metre would likely be phased in at a later stage of Level 2. It was requested that clarification of the continued requirement for physical distancing was inserted to the policy wording on social gatherings, where it currently stated 'people typically intermingle quite freely... [therefore] these social gatherings should be limited to a maximum of 20 people in Level 2'. It was further recommended that the policy change from 2 metres of physical distancing to 1 metre of physical distancing was reflected for all environments.

The Cell requested that the section on 'Education and childcare' was updated to include evidence and to reference research that provided reassurance of safety for children to return to an educational, or childcare setting. Members suggested that the language used in the policy document did not encourage the quick return of schools in Level 2, and noting the forthcoming break for summer holidays, suggested that the wording be amended to reflect greater support and encouragement for the return to education. The Cell was mindful that its advice and approach should remain consistent with the discussions that representatives from the Cell had recently undertaken with teaching unions.

The Cell noted that the draft Level 2 policy required organisers of social gatherings to retain lists of attendees and contacts for a period of 14 days, in case this was required for contact tracing purposes (and it was noted that this was similar to Guernsey's guidelines). The Group Director advised that because individuals would be asked to keep lists, the guidance raised the question of whether service providers should do the same, for example, restaurants and dentists. It was confirmed that legal advice had been sought on the compliance with data protection, however, a number of members voiced concerns about the collation of data in that manner. The Director of Communications suggested that the proposed approach could be met with resistance from the public, especially for provision of information to commercial enterprises, however, suggested that phrasing the guidelines to suggest that individuals keep a diary as part of their civic duty may be better received. Mr. S. Petrie, Environmental Health Consultant, advised that requesting a 'guest list' for events was often met with greater cooperation than a request for a list of attendees. The Cell queried whether the emergency legislation allowed for the collection of data. It was confirmed that clarification was being sought on that matter. Informed consent was acceptable, but guidelines needed to be provided to the relevant parties so that each had the means to obtain the informed consent.

The Cell suggested that the section on 'Enforcement' in the policy should be updated, to reflect its advice that legislation should not be used to enforce physical distancing in the longer term and that it should be encouraged through official guidance and messaging (Minute No. A3 of this meeting referred). However, the Cell recognised the challenges with this suggestion, as the physical distancing legislation had only recently been passed by the States Assembly. On a related matter, it was suggested that the extent of the existing powers of the States of Jersey Police, which were noted to be wider than that of some other forces, had not been explored to full potential in respect of possible avenues for enforcement.

The Group Director for Policy highlighted that there was a change in this version of the draft policy to the permissions given to hotels to open for staycation business,

which had previously been identified as a step for Level one. It was not yet confirmed if this change would be practically possible from 12th June 2020.

The Director of Communications asked the Cell to consider whether the continued closure of public playgrounds, outdoor exercise equipment, and paddling pools remained suitable in Level 2, in light of the range of other businesses and activities which were now, or would shortly be, permitted. It was queried whether the usage of outdoor play equipment and paddling pools could be reconsidered, perhaps on the condition that usage would be personal responsibility and with encouragement for the apparatus to be wiped down before and after use. Mr. M. Knight, Head of Public Health Policy advised that the use of play equipment in public parks (compared to use of play equipment within a school bubble) was that there was a wider group of potential users and the environment could not be managed in the same way. However, he confirmed that there was little evidence to suggest that play equipment increased risk of spreading infection and therefore undertook to review the public health position on playgrounds and public play equipment.

The Cell noted that Level 2 allowed for services involving close personal contact to open where it was able to follow strict sector-specific guidelines. Following a query the Cell received confirmation that mental health services was included in the group. Mr. R. Sainsbury, Managing Director, Jersey General Hospital, requested that the group also included the services which also fell into the commercial sector, such as 'The Listening Lounge', which provided mental health and wellbeing support for adults. He advised that this organisation was partly commercial and partly community funded and it was therefore important to ensure that this, and other similar services, were not disadvantageously treated.

The Group Director for Policy undertook to incorporate the various comments and suggested changes to the draft policy document. The Cell was requested to provide any further comments to the Group Director for Policy during the course of the day (Thursday 4th June 2020).

Border testing scenarios.

A5. The Cell received and noted the content of a report prepared by Ms. S. Davis, Senior Statistician in connexion with possible border testing scenarios that had been mapped to estimate levels of inward infection from inward travellers (seedings).

The Cell was advised that inward infections would likely be the combination of 3 groups, namely:

- (a) those who were infectious on the day of travel (parameters used for calculations: 1.6 – 3.8 infected inward travellers per 1,000 inward travellers, assuming 0.25 per cent prevalence);
- (b) those who were infected on the day of travel (by Group a) (parameters used for calculations: 0.8 – 5.7, assuming Group A infect 0.5 – 1.5 fellow travellers each); and
- (c) those incubating on day of travel (parameters used for calculations: 1.3 – 4.9 infected inward travellers per 1,000 travellers, assuming 0.25 per cent prevalence and R in origin country 0.8 – 1.3).

The data reviewed the proportion of infectious travellers and possible length of infection for different groups and, also, provided calculations for different scenarios. Calculations estimated that there would be between 4 – 14 infected inward travellers per 1,000 inward travellers and this would have an effect of 4 – 23 local infections per 1,000 inward travellers (under the defined parameters and assuming no self-isolation).

1st Meeting  
04.06.20

Dr A. Muller, Director of Strategic Planning and Performance, explained that the key calculations for identifying the infections had been undertaken, using the current PCR test sensitivity at 75 per cent. The scenarios identified that:

- (a) travellers given 1 PCR test on day 0, would likely reduce the number of local infections by 25 per cent (i.e. estimate that there would be 2-19 local infections per 1,000 travellers);
- (b) travellers given 2 PCR tests, on day 0 and day 5, would likely reduce the number of local infections by 44 per cent (i.e. estimate there would be 2-14 local infections per 1,000 travellers); and
- (c) travellers given 3 PCR tests, on days 0, 4, and 7, would likely reduce the number of local infections by 55 per cent (i.e. estimate that there would be 2-11 local infections per 1,000 travellers).

The Cell was advised that the calculations at 75 per cent sensitivity had been advised by Dr. I. Muscat in order to accommodate the range, but that calculations had also been undertaken with the assumption that the PCR test sensitivity was increased to 90 per cent. The best case scenario at 90 per cent, where 3 PCR tests were done on travellers on days 0, 4 and 7, identified that this would likely reduce the number of local infections by 63 per cent (i.e. estimate that there would be 1–9 local infections per 1,000 travellers). The Director of Strategic Planning and Performance explained that the key message was that 3 tests were more effective than one test, but that even with a higher sensitivity of PCR test, some infections still “slipped through the net”. It was noted that a SEIR model could be used to show the timing and size of peak from a single infection. This varied from an R number of 2.6 (when unmitigated) to an R number of 0.8 (current median estimate of lockdown).

Some members suggested that the projected rate of infection was impossible to model without knowing where inward travellers had come from and that place’s rate of infection and he also queried the practicalities of undertaking multiple PCR tests on travellers, and suggested that the point of entry was the time to catch and test people. Dr. I. Muscat advised that it was important to have an indicative model as a starting point for projections. With reference to the highest projected R number of 2.6, he explained that this was similar to the rate which had been projected at the start of the pandemic. Dr. Muscat advised that the projections should not be considered unrealistic as seedings of the virus into a freely mobile population had the potential to increase the number of cases quickly. Dr. Muscat suggested that the Island had lived through this scenario in early February 2020, when the number of cases had doubled during the first few days.

The Group Director for Policy queried how confident the Cell was in the Island’s track and trace capability. She acknowledged that it was not as effective as stopping seeding in the first place, but that tracing formed a vital part of the Island’s ability to ‘contain’ the virus. Dr. I. Muscat advised that there was a decent manual track and trace system in place and also an ONS tracing rate. The Cell was mindful that the population would have little appetite for numbers to swell to any great extent after carrying the burden of lockdown to initially bring numbers down.

Mr. S. Skelton, Director of Strategy & Innovation confirmed that a number of projected scenarios were under review to explore the effect of different factors in conjunction with priorities and requirements of the Island for connectivity internally or externally.

The Cell acknowledged the update on border testing scenarios and noted that further discussion would take place at its meeting on Monday 8th June 2020.

Matters for discussion at the next meeting.

A6. The Cell noted that its next scheduled meeting would be on Monday 8th June 2020 at 8 am and that matters for discussion would include:

- a continuation of the border scenario conversation (Minute No A5 referred);
- an update from Dr. A. Muller in connexion with recent evidence and research from Denmark;
- a piece on safeguarding, including facilities available for young people; and
- formal sign off on the Level 2 Safe Exit Framework policy advice, including advice to Ministers.