KS

SCIENTIFIC AND TECHNICAL ADVISORY CELL

(19th Meeting)

14th September 2020

PART A (Non-Exempt)

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

Minutes.

A1.   The Scientific and Technical Advisory Cell received and noted the Minutes from its meeting of 7th September 2020 and members were asked to provide any comments thereon by close of business on 14th September 2020 to the Secretariat Officer, States Greffe. If no requests for changes were received by that time, the Minutes would be deemed to have been approved.

Matters arising.

A2.   The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A6 of its meeting of 7th September 2020, in relation to RAG (Red / Amber / Green) ratings and the borders, recalled that some politicians had questioned whether it would be possible to recategorize amber areas as those where there had been more than 50 cases per 100,000 population over the previous 14 days, rather than 25 cases, as was currently the case and that this matter had been discussed by the Competent Authority Ministers at a meeting held on 11th September 2020.

The Director of Strategy and Innovation, Strategic Policy, Planning and Performance Department, informed the Cell that Policy Officers had been asked to work on various options around the thresholds for RAG in the context of the Safer Travel Policy in time for Wednesday 16th September, when it was anticipated that the Cell and the Competent Authority Ministers would reconvene. It was suggested that, in formulating the guidance, the Cell should be asked for its opinion on specific questions and it was noted that the Director of Strategy and Innovation and the Director of Communications, Office of the Chief Executive, would discuss this matter further outside the formal meeting.

Monitoring Metrics.

A3.   The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of its meeting of 7th September 2020, received and noted a PowerPoint presentation entitled 'Scientific and Technical Advisory Cell monitoring update', dated 14th September 2020, which had been prepared by the Principal Officer – Public Health Intelligence, Strategic Policy, Planning and Performance Department.

The Cell was informed that, as at 11th September 2020, there had been 11 active cases of COVID-19 in the Island, of which 7 were asymptomatic and 4 symptomatic. These individuals had had 87 direct contacts. The Cell noted a new slide, which provided forecast end dates for the 11 active cases. Since the borders had re-opened, on 3rd July 2020, there had been 37 positive cases from green countries, 14 from amber and one from red. Deaths in the Island from COVID-19 remained static, at 32.

Since the start of the pandemic, there had been 380 positive cases for COVID-19, excluding infections which had subsequently been shown to be 'old', following serology testing. The last positive case had been confirmed on 11th September and in the previous 14 days, 9 positive cases had been identified as a result of inbound travel testing and 5 through contact with symptomatic individuals. The rate of Jersey cases per 100,000 population over the last 14 days stood at 12.99. Since May 2020, the Island had been continually 'green' based on its categorisation of cases.

The number of people calling the COVID-19 Helpline with a cough had decreased when compared with the previous week, as had the number of calls from, or relating to, children aged from birth to 11 years. The number of inbound travellers to the Island had decreased since the end of August, with the busiest week having been 17th August. Since the start of the pandemic, there had been a total of 95,594 tests undertaken, 69,874 of which had been on inbound travellers. Jersey's weekly testing rate per 100,000 population was 8,400, which was lower than in previous weeks – following a reduction in the number of inbound travellers – but far exceeded the rate in the United Kingdom (1,913) and other jurisdictions with which the Island had close links. Jersey's weekly test positivity rate remained static at 0.1 per cent, as did that of the United Kingdom at 0.6 per cent. France had increased to 5.0 per cent and Spain to 9.5 per cent.

The Independent Advisor - Epidemiology and Public Health, suggested that it would be of assistance to compare the inbound testing rates over time and to receive data on the results of inbound testing at day zero (with day 5 testing screened out). This would give a clearer idea of the imported cases, as the number of positive cases would be expected to increase because of the change in categorisation of surrounding countries / regions. The Cell also asked if it was possible that some of the inbound travellers – who might have been to the United Kingdom for a short break, as an example – who had tested positive on arrival back home, had, in fact, already been infected with the virus at the time of their departure from the Island. The Principal Officer, Public Health Intelligence, indicated that she would undertake some further research in this regard.

The Director of Communications, Office of the Chief Executive indicated that, as referenced at Minute No. A2 of the current meeting, some Ministers wished to see officials explore a change to the categorisation of countries and if an exemption for countries within the Common Travel Area could be possible, given that the level of infection within the United Kingdom had remained stable at 0.6. He questioned whether it was possible to ascertain where the positive cases were coming from, because the number of positive cases at Jersey's borders had not changed since the beginning of July. He suggested that there might be merit in considering measures other than cases per 100,000 population over the previous 14 days, such as Intensive Care Unit capacity and indicated that the number of cases was not increasing everywhere in Europe, with Finland and Sweden used as examples. He drew the attention of the Cell to recent coverage in Guernsey, where business people had been critical of that Government's handling of the crisis, with potential legal action likely and cautioned against inadvertently shutting the borders in October, because of the categorisation of countries and regions making it problematic for people to travel.

The Medical Officer of Health, indicated that the levels of concern in the United Kingdom around COVID-19 were such that stringent measures had recently been re-introduced. If the Island was to adopt a more relaxed approach to its current measures, because of commercial pressure, there could be an influx of the virus into the Island, thereby causing major problems. Her view was shared by Independent Advisor - Epidemiology and Public Health and the Chair.

The Cell noted graphs containing data relating to the testing of non-travellers, where the positivity rate was 0.113. A total of 12,382 tests had been undertaken during July to September, with many as part of workforce screening and on admissions to hospital, particularly during August.

Since 3rd July 2020, there had been 69,846 arrivals into the Island and 67,090 swabs taken. Since 1st July 2020, there had been 44 positive cases for COVID-19 (excluding those with 'old' infections), of which 66 per cent had arrived from green countries and 34 per cent from amber / red countries. 84 per cent had arrived by air. The average turnaround time for the testing of arrivals over the previous 7 days had increased slightly

to 30 hours. Of the 44 positive cases, 27 were Jersey residents and 17 visitors and the total inbound rate for infections was 0.066.

The Cell noted maps, which set out the geographic distribution of 14 day cumulative numbers of reported COVID-19 cases per 100,000 population on a worldwide and European basis, as at 13th September 2020. Also included were maps from 7th August, which demonstrated the changing prevalence of the virus across the world and Europe. It was noted that the number of cases in Canada had increased from fewer than 20 cases per 100,000 population over the previous 14 days in August, to between 20 and 60 in September. In Europe, France had changed from having fewer than 20 cases in most Départements, to having between 60 and 120 in most areas and over 120 in the Côte d'Azur and around Paris. Spain had also increased from having between 20 and 60 cases – except in Catalonia, which had been over 120 for some time – to 120 cases across the board. Globally there had been almost 29 million cases of COVID-19 since the start of the pandemic and 921,491 deaths.

In addition to providing regional data for the countries within the United Kingdom and France, it was noted that data for 16 regions in Germany and 21 in Italy would henceforth be gathered, based on information from the Robert Koch Institut and Protezione Civile respectively. These had been published, as had the most recent regional data for France. It was noted that the data for the regions within the United Kingdom would not be updated until Wednesday 16th September. Within those countries for which regional data was being provided, as at 10th September 2020, 28 regions (7 per cent) were red, 218 (57 per cent) were amber and 136 (36 per cent) green. The Cell noted similar data from 27th August, when 66 per cent of regions had been green and only 34 per cent red or amber. In France (10th September 2020), of the 104 Départements, only 4 per cent were green, with 72 per cent amber and 24 per cent red. This compared with the data for 27th August, when 40 per cent had been green, 51 per cent amber and 9 per cent red. Likewise, in England, on 10th September, 39 per cent of local authorities were green, 60 per cent amber and one per cent red, compared with 77 per cent green, 23 per cent amber and no red areas on 27th August.

The Director of Communications suggested that it would be of assistance to Ministers to be provided with the daily monitoring updates, to enable them to continue making fact-based decisions. He opined that it would be helpful to have demographic data captured on the arrivals forms, because the case rate at the border had not increased since they had re-opened and this was possibly because of the type of visitors to the Island. He mooted that there should be an element of 'weighting' considered when looking at the risk posed by these travellers. The Independent Advisor - Epidemiology and Public Health felt that by dividing countries up into regions, progress had been made, but it would not be practical, nor perhaps appropriate, to further divide the regions by socio-economic class.

The Chief Economic Advisor, suggested that, within a region, the average infection rate could remain static, based on some distinct areas having high instances of the virus and others having very few. The categorisation of the regions was an attempt to assess the risk posed, but the actual inbound data was the manifestation of that risk. He felt it would be beneficial for the politicians to receive the data on the inbound cases, accepting that there would be a slight time lag. He further noted that there had been a recent article, which had suggested that PCR tests were only 50 per cent accurate. He postulated that if that was correct, in addition to the 11 positive cases that had been identified, there would be a further 5 in the community, but, this notwithstanding, there had not been any clusters. The Consultant in Communicable Disease Control, agreed that the testing was flawed and that the limitations were causing cases to be missed. He indicated that part of the reason was that nasopharyngeal swabbing captured fewer virus particles than saliva-based testing, which provided better samples. Moreover, because arrivals from green countries / regions were only tested at day zero, there would be an

element of leakage, because it had been shown that some people - who tested negative at day zero - were subsequently positive by day 5. He was not sure why no clusters of the virus had come to light, but stated that it was important to increase testing on non-arrivals. Whilst 5,000 tests were currently undertaken each week on arrivals, only 1,000 non-travellers were currently tested and, in his view, this was inappropriately skewed. Once Open Cell became operational on-Island, there would be sufficient capacity to undertake greater testing and this would increase as the number of arrivals at the ports declined. The Associate Medical Director for Primary Prevention and Intervention suggested that one reason for the lack of clusters could be that those people, who had the virus and were not being identified through testing, were asymptomatic and had a low viral load.

In respect of influenza, particularly in the Southern Hemisphere, the Cell noted a 'flu tracking map', which showed those presenting with influenza-like illness (fever and cough) in Australia and New Zealand, for the week ending 6th September 2020. This demonstrated that the levels were very low in both countries. Interestingly, other infectious diseases, such as whooping cough, salmonellosis and meningococcal disease had also decreased significantly when compared with the previous year. The uptake of vaccinations for flu had been at record high levels, necessitating the ordering of additional stock.

For the period up to 6th September 2020, the number of people registered as actively seeking work (excluding those claiming through the Covid Related Emergency Support Scheme (CRESS)) continued to decline, when compared with the previous week, as did the number of active income support claims. Footfall in St. Helier had also declined when compared with the previous week and remained significantly lower than for the same period in 2019 (down 43.2 per cent).

The Cell noted the position and thanked the Principal Officer, Public Health Intelligence, for the comprehensive briefing.

Exposure notification App.

A4.   The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A1 of its meeting of 4th August 2020, received a demonstration and a PowerPoint presentation in connexion with a COVID-19 exposure notification app for Jersey and heard from the Chief Executive Officer and an officer from the Jersey COVID Alert App Team, Digital Jersey and an officer from the Jersey COVID Alert App Team, Digital Health.

The Cell recalled that an Irish development company (NearForm), which was already working with Eire, Northern Ireland, Scotland and Gibraltar, in addition to some states in the United States, had been chosen to develop a white-label app, which would be tailored for Jersey. The Chief Executive Officer, Digital Jersey, indicated that the app had been designed and links to the IPHR (Integrated Public Health Record) completed, so testing could be undertaken during the week of 14th September 2020, although the formal contract with NearForm had not yet been signed. Google and Apple had both been contacted to ensure that the app would be available for IOS and android from the App Store and Google Play on a global basis, in order that it could be downloaded by anyone (provided they were aged over 16 years), irrespective of where they lived and to facilitate maximum coverage. The information within the app would be translated into Polish, Portuguese, Romanian and Bulgarian and a marketing plan was being developed.

The Cell was informed that by basing the app on the Android / IOS operating systems, it would perform well, with fewer bugs, would cost less than if it had been necessary to develop the whole thing and it would be easier to attain international compatibility. On the downside, the performance was not perfect, because the requirement to scan for other devices would impact on battery life and the base design could not be altered.

It was noted that the notification app in England and Wales was due to be launched on 24th September and, on the basis that some people would see the promotional material associated with it, clear communications would be issued to indicate that that particular app would not function in Jersey. The Chief Executive Officer, Digital Jersey, indicated that NHSX had been prevented from advertising locally.

The Cell was led through an online demonstration of the app, which contained details of how it functioned and addressed issues around privacy and data. The app used Bluetooth to exchange random codes with other phones in close proximity, which also had the app and would check on a regular basis whether any of those codes were associated with phones where a person had received a positive diagnosis of COVID-19. The basic premise was that if a person had spent 15 minutes or more within 2 metres of someone with the virus, they would receive a notification. The aforementioned codes would not reveal an individual's location (it did not use GPS), nor their identity. Mindful that some people chose to switch off Bluetooth on their phones, the Cell was informed that users of the app would need to keep it active, to ensure that the exposure notifications functioned appropriately.

In the event that a person tested positive for the virus, they would be telephoned by the Contact Tracing Team, who would enquire whether they had downloaded the app onto their phone and, if so, would provide a code, which the person would input into the app, should they decide to do so, to enable other apps to check for matching codes, which would indicated that an exposure had occurred. If someone had been in close enough proximity to that person, for sufficiently long, as referenced in the previous paragraph, the app would show an Exposure Alert. It was accepted that it was challenging to estimate distance with complete accuracy, because of such factors as signal strength, orientation of the phone and whether the person was indoors or outside, but it gave a good indication.

The data held on the COVID Alert server, that facilitated the exposure alert, was encrypted. Throughout the person's use of the app, explicit consent was sought for the gathering of any information and the sending of an Exposure Alert, with options to opt out, change permissions and remove the app at any time. It was noted that in the event of a person being a direct contact of a recently diagnosed person, they might themselves receive a telephone call from the Contact Tracing Team, in addition to the notification via the app. Once a person received a call from the Contact Tracing Team, they were obliged to adhere to guidelines issued by the Government, to include returning home and isolating. It was noted that the wording in this respect on the app would not indicate that isolation should be enforced, as it had been determined that there was insufficient legal basis to cause someone to isolate based purely on an Exposure Alert.

Data, which was being collected in Europe, particularly Germany, revealed the accuracy of the tracing apps to be almost 80 per cent. It was acknowledged that there might be some false positives locally, until sufficient data had been acquired, but it was anticipated that the system would rapidly mature and could be used to apply to the Safe Exit Framework. Clearly, if only a few people participated, many contacts with positive cases would be missed, but if an uptake of between 60 and 70 per cent could be achieved it would be beneficial, although there were current research projects into the theoretical finding that lower levels of uptake would also deliver benefit, possibly due to the clustering effect of family and friend groups using the app amongst themselves. Information from Eire provided reassurance that it was unlikely that the deployment of the app would lead to the Contact Centre becoming overwhelmed with additional calls. It was noted that the larger employers in the Island, including the Government, would be asked to promote the app to their staff.

Ultimately, it was hoped that the various contact tracing apps could become

interconnected across the Common Travel Area, as had already occurred between Eire and Northern Ireland. There would be no issue around data sharing, because the information was anonymous and simply comprised a series of random numbers.

The Chief Executive Officer, Digital Jersey, informed the Cell that, following testing, it was intended to launch the app on 5th October and Digital Jersey was currently developing a communication plan in conjunction with the Director of Communications, Office of the Chief Executive. Consideration was being given to whether the launch should be announced as part of a suite of measures, or separately.

The Cell noted the position, thanked officers for the presentation and indicated its ongoing support for the app.

Future meetings of the Scientific and Technical Advisory Cell.

A5.   The Chair of the Scientific and Technical Advisory Cell, indicated that the current meeting slot of 8.00 a.m. to 10.00 a.m. on a Monday morning was rather problematic for staff within the Health and Community Services Department, for operational reasons. He suggested that the meetings should, instead, take place between 11.00 a.m. and 1.00 p.m. on a Monday and undertook to circulate revised meeting requests to members.

Matters for information.

A6.   In association with item No. A3 of the current meeting, the Scientific and Technical Advisory Cell received and noted the following –

- A report entitled 'PH Intelligence: COVID-19 Monitoring Metrics', dated 11th September 2020, which had been produced by the Strategic Policy, Planning and Performance Health Informatics Team;
- A weekly epidemiological report, dated 10th September 2020, which had been prepared by the Strategic Policy, Planning and Performance Department;
- Death statistics for the week to 10th September 2020, from the Office of the Superintendent Registrar;
- A report on the economic indicators for week 36 of 2020 (31st August to 6th September), which had been prepared by Statistics Jersey; and
- A weekly footfall report for week 36 of 2020, provided by Springboard.