KS

SCIENTIFIC AND TECHNICAL ADVISORY CELL

(49th Meeting)

1st March 2021

(Meeting conducted via Microsoft Teams)

PART A (Non-Exempt)

All members were present, with the exception of R. Naylor, Chief Nurse and S. Skelton, Director of Strategy and Innovation, Strategic Policy, Planning and Performance Department, from whom apologies had been received.

Mr. P. Armstrong, MBE, Medical Director (Chair)
Dr. I. Muscat, MBE, Consultant in Communicable Disease Control
C. Folarin, Interim Director of Public Health Practice
Dr. G. Root, Independent Advisor - Epidemiology and Public Health
R. Sainsbury, Managing Director, Jersey General Hospital
Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention
Dr. S. Chapman, Associate Medical Director for Unscheduled Secondary Care
Dr. M. Patil, Associate Medical Director for Women and Children
Dr. M. Garcia, Associate Medical Director for Mental 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
N. Vaughan, Chief Economic Advisor

In attendance -

J. Blazeby, Director General, Justice and Home Affairs Department
C. Landon, Director General, Health and Community Services Department
R. Corrigan, Acting Director General, Economy
D. Danino-Forsyth, Director of Communications, Office of the Chief Executive
S. Martin, Chief Executive Officer, Influence at Work
Dr. M. Doyle, Clinical Lead, Primary Care
M. Knight, Head of Public Health Policy
B. Sherrington, Head of Policy (Shielding Workstream), Strategic Policy, Planning and Performance Department
S. White, Head of Communications, Public Health
R. Johnson, Head of Policy, Strategic Policy, Planning and Performance Department
M. Clarke, Principal Officer, Public Health Intelligence, Strategic Policy, Planning and Performance Department
L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department
Dr. N. Kemp, Interim Senior Policy Officer, Strategic Policy, Planning and Performance Department
S. Gay, Senior Public Health Policy Officer

K.L. Slack, Secretariat Officer, States Greffe

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

Minutes.

A1. It was noted that the Minutes of the meeting of the Scientific and Technical Advisory Cell ('the Cell'), which had been held on 22nd February 2021, had previously been circulated and Members were asked to provide any feedback thereon to the Secretariat Officer, States Greffe, by the end of 1st March 2021, in the absence of which they would be taken to have been confirmed.

On a related note, the Chair informed the Cell that the Health and Social Services Scrutiny Panel had asked that published Minutes of the Cell should include attendees' names in the future. No objections were raised and it was agreed that future Minutes would include the same.

Monitoring metrics.

A2. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of its meeting of 22nd February 2021, received and noted a PowerPoint presentation, dated 1st March 2021, entitled 'STAC monitoring update', which had been prepared by the Principal Officer, Public Health Intelligence, Strategic Policy, Planning and Performance Department and heard from her in relation thereto.

The Cell was informed that, as at 28th February 2021, there had been 19 active cases of COVID-19 in Jersey, who had been in direct contact with 128 people, who were self-isolating and that there had been a total of 3,217 positive cases of the virus in the Island since the start of the pandemic. Of the active cases, 9 had been identified through contact tracing, 6 through planned workforce screening, 3 had sought healthcare on experiencing symptoms of the virus and one through cohort screening. It remained the situation that most active cases were in people of working age and there were very few children who were positive for the virus and no Islanders aged over 70 years. There remained an almost equal split of those who were experiencing symptoms of COVID-19 and those who were asymptomatic. Since 13th February 2021, there had been an average of one case per day, but the Cell was informed that there had been no new positive cases on 1st March. The Cell noted that there had been no cases linked to the re-opening of non-essential retail premises on 3rd February and any impact of the reconnection of hospitality settings on 22nd February would be experienced in the coming days.

During the week commencing 22nd February, approximately 1,000 tests had been conducted on week days, which was lower than the previous week when there had been an increase in testing for teachers and relevant year pupils (11 to 13), in addition to those working within hospitality settings. With regard to the number of daily cases of COVID 19, the number of tests and the test positivity rates for various age groups, it was noted that the test positivity rate remained below one per cent for all, including those aged over 70 years. The Cell was provided with an overview of the positive cases of COVID-19 in the Island and in certain priority groups by the Chair of the Analytical Cell (the Interim Director, Public Health Practice, Strategic Policy, Planning and Performance Department) for the whole of February and with details of the positive cases in priority groups *inter alia* staff working within health and care settings, retail, hospitality and school pupils.

The Cell noted the Hospital occupancy rates and the daily admissions of people who had been positive for COVID-19 on admission - or in the 14 days prior - and those who had tested positive for the virus after entering the Hospital (based on the definitions used by the United Kingdom ('UK')) for the period from 1st November 2020 to 28th February 2021 and was informed that there were currently 2 people in Hospital with COVID-19 and that admissions were sporadic and in low numbers. As a consequence,

the 7-day admission rate, per 100,000 population, remained very low and aligned with the 7-day case rate. Since the start of the pandemic, there had been 69 deaths registered in Jersey with COVID-19 referenced on the death certificate, of which 37 had occurred in the second wave (since 1st October 2020). The Cell was provided with the PH Intelligence: COVID-19 Monitoring Metrics, which had been prepared by the Health Informatics Team of the Strategic Policy, Planning and Performance Department on 23rd February 2021 and was informed that, during that week, there had been a decrease in the number of calls to the Covid Helpline, when compared with the previous week, which had been half term. There had been a dramatic decline in the number of inbound travellers and only a small number of positive cases had been encountered at the borders. The Principal Officer, Public Health Intelligence, was asked to provide details at the next meeting of the Cell on the proportion of arrivals that had tested positive for COVID-19 at days zero, 5 and 10 with effect from the start of 2021 and indicated that this would be possible. The data had been requested, but had not been provided in time for the current meeting.

In respect of testing, the local weekly testing rate, per 100,000 population, had increased to 8,000 during the week ending 21st February 2021, which was higher than the UK, which had tested 5,409. There had been 1,150 tests on inbound travellers, 7,120 as part of on-Island surveillance and 300 on people seeking healthcare. The weekly test positivity rate locally had remained at 0.1 per cent as at 27th February and in the UK had been 2.1 per cent on the 21st. On the same date, it had not been possible to provide the estimated effective reproduction number (R_t) in Jersey because the low number of cases meant that the statistical model was at the limit of what it could calculate, so any estimate of the R_t could not be considered conclusive, albeit it would be kept under review.

The Cell was presented with the graphs that tracked attendance at Government primary and secondary schools, on a daily basis and noted that during the week commencing 22nd February, primary school attendance had averaged just below 98 per cent and 94 per cent in the secondary schools. In all settings, absences related to COVID-19 had been below one per cent. It was recalled that there had been a number of COVID-19 cases in children of school age over the half term, but the overall numbers in the schools had been low since the start of the year. The Cell noted the data in respect of the volume of Lateral Flow Device ('LFD') tests by school, result and date, including the number of positive, negative and inconclusive results and was reminded that there had been only one positive result from an LFD test, which had subsequently been shown to be a false positive when the relevant individual had been tested using a PCR test.

The Cell was provided with the published data, to 21st February 2021, in respect of COVID-19 vaccinations in Jersey and was informed that a total of 29,312 doses had been administered, of which 26,025 had been first dose vaccinations and 3,287 second dose. There had been a very high level of vaccine uptake in older Islanders and now that people at moderate risk were being invited for vaccination, coverage was also increasing in younger age groups. It was recalled that focus remained on the first dose vaccinations and, as a consequence, there had been little increase in the cumulative numbers of second doses administered. To 21st February, 95 per cent of care home residents had received their first dose of the vaccine and 81 per cent their second dose. In respect of the staff employed in those *loci*, these figures were noted to be 81 per cent and 62 per cent respectively. In respect of Islanders classed as 'clinically extremely vulnerable' (excluding those aged over 69 years), 79 per cent had received their first dose of the vaccine and 4 per cent the second. Of those at moderate risk (for all age groups), 38 per cent had received the first dose of the vaccine and 5 per cent the second.

The Cell heard from the Senior Informatics Analyst, Strategic Policy, Planning and Performance Department, who had undertaken an analysis of those people who had tested positive for COVID-19 at least 14 days after receipt of one dose of the vaccine.

She informed the Cell that whilst it remained the situation that the large majority of positive cases (93 per cent) had been in people who had not been vaccinated, there had been 34 cases identified in people who had received one or more doses at least 14 days previously. However, there had been no further positive cases in vaccinated Islanders aged over 65 years since mid-January. During the previous week, one case had been identified through planned workforce screening.

The Cell was shown a map of the UK, which set out the geographic distribution of cumulative numbers of reported COVID-19 cases, per 100,000 population, as at 26th February 2021, which demonstrated the reduction in cases across much of that jurisdiction. With regard to the maps, which had been prepared by the European Centre for Disease Prevention and Control ('ECDC'), for weeks 6 to 7 of 2021 (8th and 15th February) when compared with the previous week, the further decline in cases in Spain and Portugal was noted, whilst there had been an increase in cases in some areas of France. The Cell was informed that the ECDC had prepared some maps based on the vaccination rates across the European countries, which could be included in future presentations.

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

Covid high level impact for Health and Community Services Department provided and commissioned services.

A3. The Scientific and Technical Advisory Cell ('the Cell') received and noted a PowerPoint presentation, dated 1st March 2021, entitled 'Covid High Level Impact HCS and Commissioned Services (with additional input from CYPES & CLS)' and heard from the Managing Director, Jersey General Hospital, in connexion therewith. He informed the Cell that the Health and Community Services Department, in conjunction with the Public Health team and wider health and care providers, was undertaking extensive work to understand the impact of COVID-19 across not only the health and care sector, but wider stakeholders, such as other Government Departments, the States of Jersey Police, commissioned services and representatives of the Third Sector. The work was ongoing and activity data from the relevant services and stakeholders was being gleaned. Many of the statistics had been obtained from Government of Jersey Departments, but consideration had also been given to information held by Public Health England and some commissioned services. The Cell noted the outstanding key lines of enquiry, particularly around primary care, long term conditions and unmet need through unscheduled care and the delay in people presenting to the Accident and Emergency Department, which it was important to understand.

The key area of focus was on activity in mental health services. It was intended to draw from the Jersey Mental Health Indicator Library and it was noted that Public Health England had published a 'Spotlight' report, which considered the relationship between people's mental health and their income or employment and had found that during the COVID-19 pandemic there had been a high correlation between those adults with lower incomes (below £16,000 *per annum*) and self-harm and thoughts of the same, or death. Colleagues within the Customer and Local Services Department had assisted with local data, *inter alia* on the number of people registered as actively seeking work, which had increased significantly after March 2020 and still remained at higher levels than before the start of the pandemic, which was enforced by the longer unemployment trends that were being experienced. Work was underway to understand the impact that this would have on younger Islanders, in particular. Since March 2020, the number of people requiring emergency accommodation had increased and there was the added complexity of the link between accommodation and people being able to remain in Jersey, which was the source of some anxiety.

With regard to the number of suicides during 2020, these had been at lower levels than in previous years, but there had been some complex cases of self-neglect, which were being reviewed. Jersey had recorded its highest number of deaths from suicide in 2009

(26), the year after the global recession. Employment and housing security were noted to be closely linked to the risk of suicide and work was underway with local partners on suicide prevention, one example of which was Thrive Jersey, whose key message had been to ensure that there was a plan to support people's mental health and wellbeing.

The Cell was informed that the most challenged area of mental health activity related to young people. The Child and Adolescent Mental Health Service ('CAMHS') team was relatively small and had been experiencing high levels of activity and pressure before the pandemic, which had compounded the situation. There had been a concerning increase in the demand for CAMHS, evidenced by the size of the team's caseload, the length of the waiting list, waiting times and the duration of stay in hospital. There had been a 105 per cent increase in the number of paediatric hospital bed nights in 2020 when compared with the previous year, with over 55 per cent required for young people's mental health, rather than physical health, needs. Many of the CAMHS inpatient admissions had related to eating disorders, which had increased during COVID-19 locally and in other jurisdictions. Instances of deliberate self-harm had grown in 2020 and it was anticipated that 2021 would follow a similar trajectory. Difficulties were being experienced in accessing off-Island residential placements for young people requiring tertiary care, due to increased use by the NHS, where there had likewise been an increase in CAMHS referrals, although that jurisdiction had also experienced a significant increase in substance abuse by young people, which had not been evidenced in Jersey. It was noted that the local CAMHS caseload, per 100,000 population, was higher than in the United Kingdom ('UK') and had grown by 19 per cent during 2020.

In January 2019, there had been some peaks in mental health caseload for young people and in 2020 those aged between 12 and 18 years had accounted for the majority of cases, with adult caseload having reduced. Mental health services had been improving since 2018 and had been the subject of multiple reviews. Key areas for improvement had been identified and a Mental Health Improvement Plan ('MHIP') had been drawn up and an Oversight Board established. However, the MHIP had been significantly impacted by COVID-19 and work to improve the facilities at Orchard House had been delayed by 6 months, but good progress was now being made.

The Cell was informed that the target for acute admissions, per 100,000 population, to adult mental health facilities was below 20 per month, but this figure was now routinely being exceeded and on 3 occasions during 2020, it had been necessary to accommodate CAMHS inpatients on the adult ward. The Listening Lounge, which was a direct access service, had seen a significant increase in referrals, most notably towards the end of 2020 and attributed 50 per cent of that growth to anxiety and depression associated with COVID-19. Adult mental health caseload had experienced a spike in demand during the first wave of the pandemic when the Crisis and Home Treatment team had contacted existing mental health patients, but adult services were generally not witnessing the same variation in caseload as CAMHS, although some residual pressures remained with an increase in the acuity of existing clients with severe mental illness caused by the pandemic.

There had been a notable reduction in waiting times for access to the Jersey Talking Therapies service, with referrals for first assessment having dropped from 621 to 76. Whilst this represented a considerable improvement, the service was not attaining the target objective of 98 per cent of referrals commencing treatment within 18 weeks.

In respect of secondary scheduled care, the Cell was informed that a clear trajectory had been set to reduce the inpatient waiting list. This had not yet been achieved and the figures were on a par with January 2020, although the impact of COVID-19 locally had not been as dramatic as in the UK in this regard. Outpatients had been more adversely

affected and this would require work by the relevant teams to prioritise appointments and the Cell was provided with the breakdown of patients by specialty. During 2020, attendance at the Accident and Emergency Department had reduced quite significantly, but the conversion to admissions had slightly increased, which meant that those Islanders, who had presented at that Department, had been more unwell and further work was underway to understand the impact of individuals delaying their access to urgent care. During 2020, a number of patients had been discharged into the community care home sector, rather than to their own homes, due to the impact of COVID-19 on domiciliary care services and it was understood that some of these had remained within institutional care. It was noted that the pandemic had adversely impacted cervical, breast and bowel screening, but the Cell was informed that business cases had been submitted to increase capacity in respect of cervical and breast screening and the opportunity had arisen to move to 'fit testing' for bowel screening, which would reduce the waiting times.

The Cell noted the position accordingly and thanked the Managing Director, Jersey General Hospital, for the presentation.

QCovid.

A4. The Scientific and Technical Advisory Cell ('the Cell') received and noted a paper, dated 1st March, entitled 'QCovid key information summary for consideration by STAC', which had been prepared by the Interim Senior Policy Officer, Strategic Policy, Planning and Performance Department, in respect of the QCovid model, which was an algorithm tool that had been developed by the University of Oxford and allowed clinicians in the United Kingdom ('UK') to identify an additional 1.7 million patients to add to the shielding list, by analysing a combination of risk factors, including age, ethnicity, deprivation data by postcode, body mass index ('BMI') and certain medical conditions and treatments, which might mean that they were more vulnerable to COVID-19 than had previously been anticipated.

The Cell was informed that the QCovid model was a research tool and had not been validated as a clinical tool, with various issues still due to be resolved. As an example, the algorithm had identified certain women, who had experienced gestational diabetes whilst pregnant, as being at risk and they had unexpectedly been instructed to shield, despite no longer having the condition. However, it was being kept under review locally and the viability of using it at a later juncture, once the glitches had been remedied, was being considered. However, it was possible that it might not be required, because the local vaccination programme was already accessible to Islanders at high and moderate risk, which accounted for 8.5 per cent of the population (9,000 people), which was wider than the UK's at risk group, which comprised 5.7 per cent of the population.

In determining those at risk in Jersey, BMI was taken account of, but ethnicity data was not routinely captured in primary care and Jersey did not record deprivation data by postcode. Accordingly, it was not proposed to employ the QCovid model at the current juncture and the Cell supported this stance, mindful that it had not been validated as a clinical tool, it was not deemed to be accurate at this time, the approach taken to at risk groups had been more inclusive locally than in the UK and the current system for determining vaccination priority was working well.

Long Covid.

A5. The Scientific and Technical Advisory Cell ('the Cell') received and noted a PowerPoint presentation, dated 1st March 2021, entitled 'STAC Presentation: Long COVID', which had been prepared by the Interim Senior Policy Officer, Strategic Policy, Planning and Performance Department and was also provided with the World Health Organisation's policy brief 39, entitled 'In the wake of the pandemic. Preparing for Long COVID' and the National Institute for Health and Care Excellence ('NICE') and Scottish Intercollegiate Guidelines Network ('SIGN') guideline entitled 'COVID-19 rapid guideline: managing the long-term effects of COVID-19'.

The Interim Senior Policy Officer informed the Cell that the NICE and SIGN guideline incorporated various clinical definitions for the initial illness and Long COVID at different times, *viz* 'Acute COVID-19', which was where signs and symptoms of the virus were experienced for up to 4 weeks, 'ongoing symptomatic COVID-19' where signs and symptoms were experienced from 4 to 12 weeks and 'Post-COVID-19 syndrome' where signs and symptoms that had developed during or after an infection consistent with COVID-19 continued for more than 12 weeks and were not explained by an alternative diagnosis. 'Long COVID' was a much-preferred term, which had been accepted by those individuals affected by the illness and the advocacy groups that supported them and it was accepted that this was the terminology that should be used.

The Cell was notified that Long COVID was recognised as a potential outcome to acute COVID-19 infection but there had been, to-date, relatively few peer reviewed papers on the subject, albeit a number of studies were underway, with funding having been allocated thereto. Patient groups had reported several months of symptoms, but this was not entirely unexpected and several acute viral infections were capable of resulting in long term health effects, including fatigue and myalgia. The Cell was reminded that it was important not to overlook other patient groups, such as those suffering with myalgic encephalomyelitis ('ME') and chronic fatigue syndrome ('CFS').

The Office for National Statistics had estimated that one in 5 respondents, who had tested positive for COVID-19, would exhibit symptoms for a period of 5 or more weeks and one in 10 for a period of 12 weeks or longer ('Long COVID'). When applying those estimates to Jersey, it was estimated that between 200 and 350 Islanders could be affected by Long COVID, as there had been approximately 3,000 cases of the virus confirmed to-date, albeit this could be an underestimate, as a number of people would not have received a positive diagnosis. It was noted that the symptoms reported by people experiencing Long COVID were extensive and affected all systems of the body. Accordingly, not only would primary care be impacted, but specialist services might also be required to address the symptoms.

Locally, it would be important to recognise that Long COVID existed and that policy would be developed in relation thereto and to achieve consensus on definitions and decide whether to adopt the terminology set out by NICE / SIGN. Coding would become key, because the condition would impact both primary and secondary care and different systems could be involved in recording the presentation. Support could be provided to patients locally or, if numbers were low, they could potentially be directed to national support groups. It was felt that it would be of assistance to have a clear referral pathway onto secondary care services, if required and, as aforementioned, it was important to acknowledge that other, similar, conditions existed, such as ME and CFS and to learn from them and the extant pathways that existed and to ascertain if these could be improved as work was undertaken on Long COVID.

The Cell was informed that 15 individuals had held an initial, positive, meeting as the Long COVID Working Group and had agreed that it was key to prevent COVID-19 and onward Long COVID, especially in the younger age groups which had been more adversely impacted by the latter. It was noted that early studies seemed to indicate that those in the middle age bracket (aged from 26 to 44) were most affected by Long COVID and that there was a gender bias. The NICE / SIGN guideline had indicated that there were similarities with the post Intensive Treatment Unit ('ITU') programme, which already existed to support those patients who had been admitted to ITU, acknowledging that not all those who suffered from Long COVID had received treatment in that Unit. It was important not to overlook the psychological impact of the illness, noting that it was linked to cognition issues and mindful of the uncertainty around it. In order to provide the relevant level of support, additional resources would be needed taking account of the scope of the work required. It was acknowledged that there were ongoing pieces of work that were potentially related, including the review

of Jersey incapacity benefit, chronic and hard to diagnose conditions, wellbeing implications and rehabilitation of those conditions.

The Cell agreed that it was crucial to focus on preventing people becoming infected with COVID-19 and thence potentially developing Long COVID as a more chronic condition. A multi-disciplinary team would be required to treat those suffering with it, because it had a widespread effect and would require a global view through primary care, generalists and other support staff including occupational therapists and physiotherapists. The Cell supported the need for a Long COVID Response Strategy and agreed to adopt the NICE / SIGN guideline locally. The Director General, Health and Community Services Department, suggested that it was important to understand and be able to measure the impact of Long COVID before making any firm commitments and the Cell was informed that the Contact Tracing Team would be disseminating a questionnaire to those Islanders who had tested positive for COVID-19, which would gather data on Long COVID.

Members of the Cell were asked to provide any further feedback to the Interim Senior Policy Officer and thanked her for the briefing.

Reconnection strategy – 'road map'.

A6. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A8 of its meeting of 22nd February 2021, recalled that it had previously received a discussion paper on the Reconnection road map, which had set out an indicative schedule of stages for reconnection, based in part on the evidence of risk posed by various activities, as researched by the Public Health Team. It was further recalled that the Competent Authority Ministers had requested such a road map to share with Islanders, as they were becoming impatient to recommence various activities against a backdrop of low numbers of positive cases of COVID-19 in the Island.

The Cell accordingly received and noted a report, dated 1st March 2021, entitled 'Reconnection roadmap' and a PowerPoint presentation of the same date, entitled 'Reconnection analysis and proposed Roadmap', both of which had been prepared by the Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department and heard from him in relation thereto. He set out the design principles for the roadmap and indicated that it had been amplified by the United Kingdom ('UK') version thereof. He suggested that there was merit in having clear, monthly, stages that could be communicated effectively to Islanders with emphasis on major changes, rather than small, gradual, detail which could be confusing and lead to non-compliance. It would be risk based, aiming for a balance between the threat posed by the virus and Islanders' wellbeing and livelihoods, without the need for any retrograde steps. As a result of feedback received from the Cell on 22nd February, the link between the evidence and the proposed approach had been strengthened and it would be governed by policy and data tests, which aligned to Ministerial objectives.

Over the previous week, colleagues had worked hard to undertake a more structured analysis of the relative risk associated with each potential component of future reconnection, had considered the impact of the COVID-19 vaccine over time, with particular emphasis on the prevention of death and serious illness, had been mindful of the additional risk posed by new variants of the virus and had considered how the travel policy might be better refined to offer protection from seeding of the virus in the Island.

The Cell was informed that the UK had introduced 4 tests, which had been adapted for a Jersey context to provide the governing framework for managing risk, rather than to provide trigger metrics. It was assumed that over the Spring, high levels of on-Island testing would continue and high capacity contact tracing and enforcement capability would be required. Evidence showed that the COVID-19 vaccines were sufficiently effective in reducing hospitalisation and death in those vaccinated, so it was important to ensure that the Island's supply remained as currently, or better than planned. The

challenge was to prevent a third wave of the pandemic during the period from March to June, to avoid serious illness, wellbeing harms and deaths as the most vulnerable were being vaccinated. In determining reconnection steps, or, conversely, any tightening of non-Pharmaceutical Interventions ('NPIs'), consideration would be given to data and information relevant to the balance of harms, including health, education, economy, disease risk and wellbeing. The new variants would not fundamentally alter the assessments of the relevant risks.

The Interim Director, Public Health Policy, informed the Cell that the various components would be populated by a set of metrics which would not be static, but would be informed by useful data at the relevant time, to provide a governing framework. Professionals from a range of areas, including Environmental Health, Infection Control, the Health and Safety Inspectorate, Public Health and the Contact Tracing Team had undertaken a multi-criteria decision analysis ('MCDA' analysis') of those activities that had not yet been reconnected and had weighted the scoring based on various aspects associated with the activities, such as duration, touchpoints, numbers involved, whether personal details were collected and ventilation. An effort had been made to quantify matters of evidence leading to the judgment on the scores, so the way in which these had been developed was as important as the score itself. The scores included the size of risk involved in reconnecting each activity, whilst highlighting the relevant wellbeing and / or economic benefits associated with such reconnection. It was hoped that these provided a stronger underpinning for the rationale for deciding the order of reconnection.

With regard to the likely effectiveness of the vaccine, noting that supply levels were a critical factor but assumed, reference was made to data from Israel, which demonstrated a drop in cases and the test positivity rate and a reduction in levels of severe disease in those who had been vaccinated, which was encouraging, given the aim locally to deliver the vaccine as quickly and effectively as possible, because as more of the older age groups attained protection by vaccination, the risk of any given infection requiring hospitalisation would decrease. The Cell was reminded that the vaccination programme would not protect everyone, because those aged under 18 years were currently ineligible to receive the vaccine, there would be some people who would be vaccine hesitant and others would remain unprotected, despite having received the vaccine. As a consequence, it was possible that some hospitalisations and deaths could still arise.

In England, it was anticipated that a further wave of infections could occur as restrictions were relaxed and this was borne out by the various models that had been presented to SAGE. It was incumbent upon the Cell and Competent Authority Ministers to be mindful of this, whilst accepting that the quantum of hospitalisations and deaths was likely to be reduced. As a consequence, it was anticipated that certain NPIs would continue to be required to prevent severe effects and was the rationale for prevention of the third wave locally forming one of the aforementioned proposed tests.

With regard to travel, it was suggested that the policy adopted in the UK in respect of new variants of concern ('VOC') and banned countries should be mirrored in Jersey. Whilst seeking to prevent VOC from entering the Island, it was important to maintain low corresponding infection and positivity rates. Accordingly, the Red / Amber / Green ('RAG') rating for areas would need to be effective and timely in order to cope with both exponential growth and decline in other jurisdictions. Experience from previous waves of the pandemic showed that where positivity rates were rising exponentially in other areas, this posed a risk to the travel policy. It was mooted that the RAG categorisation should be reintroduced on 19th April, after the Easter break and should be based on larger regions in the UK and France, to obviate the need to cope with a mixed picture around certain regions that might not be a true reflection of the levels of infection in some communities. As previously referenced, it was intended to adhere to the UK policy on banned countries with regard to the VOC, of which there were

currently 33. It was anticipated that carrier capacity was likely to be relatively low in April and May and work was underway on a vaccination and test certification project, mindful that this would need to be linked to international consensus on that subject, which was being kept under review. It was suggested that a test certificate could be used for some on-Island purposes, but this had the potential to raise some ethical questions, which would need to be addressed. There would be cost challenges associated with requiring arrivals to be tested on 3 occasions and a new policy in respect thereof would be required by June, in anticipation of a strong summer tourist season. The Cell was informed that any pre-departure testing for arrivals would need to be in addition to on-Island arrival testing.

The Cell recalled that policy decisions had already been taken in respect of Stages one to 3, most of which had been implemented. It was proposed that Stage 4 should be reconnected no earlier than March 22nd and would include a partial return to workplaces, potentially on a week-on / week-off basis, mixing in gardens for up to 10 people and the reopening of soft play areas for up to 20 children. The resumption of some indoor sport would also be permitted and work was underway with the sector to develop risk guidance to mitigate some activities. No earlier than 19th April, it was proposed, as aforementioned, to reintroduce the RAG regional travel classification, to increase the outdoor gatherings limit to 20 and to permit the resumption of close contact indoor sport (such as martial arts) and higher intensity gym activity. Stage 6 would be reconnected no earlier than 17th May and would permit saunas, jacuzzis, changing rooms and showers to re-open and people to gather inside private households (up to a maximum of 10 people) and for a gatherings exemption to be introduced for sport spectators. To align with the UK, there would be further relaxations no earlier than 21st June, to include the replacement of legislative Orders with guidance and permitting nightclubs to re-open and larger events to take place, including the re-opening of cinemas and theatres. It was, however, possible that certain NPIs would need to remain in place until a later date, such as the requirement to wear masks in indoor public places. Before each Stage of the reconnection, the Cell would consider the same in detail and it was proposed that at its next meeting it would be presented with the precise details of Stage 4 of reconnection, including any additional mitigations that were required, or Public Health guidance. In considering the communications around the Stages of reconnection to Islanders, the Behavioural Science Design Group would be involved.

The Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, questioned the disjunct between permitting swimming pools to open at one point, but not changing rooms until later and noted that the RAG categorisation locally had been based on the 14-day rate, whereas the UK reported on a 7-day basis, which could cause confusion. The Acting Director General, Economy, agreed that it would be helpful to have clarity around whether the RAG categorisation would be the same as, or different from, the UK as it could impact on bookings to the Island. He suggested that June was too late for drinks-only service to resume and indicated that it could be implemented at an earlier stage by introducing mitigations, such as 'table only' service. In his view, as the warmer weather arrived, people would be inclined to invite friends to their own homes for drinks, if they were not able to meet in the pub. He felt that the timetable of a further 3 to 4 months until full reconnection could be attained was too long and informed the Cell that the business support packages were mostly due to come to an end in April and were costing several million pounds each month. If reconnection was not achieved until June, there would be a fiscal impact. He referenced the successful legal challenge by Greater Manchester's night-time economy advisor to the UK Government's requirement for people to order a 'substantial meal' if they wished to drink alcohol, which had been deemed 'discriminatory towards certain sections of society'.

The Director of Communications, Office of the Chief Executive, welcomed the concrete stages that were proposed, but suggested that people would wish to be able to gather in

each other's homes over the Easter period – as for Christmas 2020 - and that it was important to be mindful of the importance of Passover to the Jewish community when determining the days on which this might be possible. He reminded the Cell that the UK proposed to permit domestic travel, which would include the Crown Dependencies, from 12th April and suggested that the Island should be either deliberately aligned, or unaligned, with this date, noting that it was proposed to reintroduce the RAG classification no earlier than 19th April. He was of the view that it was important to link up with Guernsey and potentially open the Island to visitors from there – rather than the UK – for Easter, which would be beneficial to the economy and Islanders. He mooted a more holistic approach to travel and suggested that rather than always having the UK at the forefront of people's minds, there could be merit in establishing travel links with other places, where there were few positive cases of COVID-19, such as Israel.

The Independent Advisor – Epidemiology and Public Health, opined that the paper was too informed by the UK and the situation in that jurisdiction, where their modelling was different due to the higher incidence of COVID-19. Rather than considering conceptual models for Jersey, he suggested that it would be preferable to review what had occurred locally during the first 2 waves of the pandemic and reflect on what the likely impact would be of a 3rd wave. He referenced electronic mail correspondence that he had sent to the Cell in which he had estimated the number of positive cases that would require hospitalisation under various incidence rates, using Jersey's vaccination figures for 14th February and even under the worst case scenario the total hospitalisations linked to the virus would be in the 20s and would be reducing as more people were vaccinated. As a consequence, the vaccination programme would achieve diminishing returns with regard to impact on severe disease.

In respect of the MCDA analysis that had been undertaken, he suggested that it would be inherently subjective, depending on the bias of the group that had undertaken the work. He recalled that the Cell had reached a consensus view that a certain amount of household mixing should be permitted - potentially by introducing a 'rule of 6' - and expressed surprise that guidance to allow private household gatherings was not to be issued before May 17th, particularly because people were already intermingling and were doing so legally (if there were fewer than 10 people present). In his view, it would be preferable to issue guidance on how to mix inside households in a safe way, rather than dissembling that it was not already occurring. He wished to see sensible measures introduced for the restaurants, because he did not believe it made sense to require people to wear masks at tables until they had received their food, or a drink. With respect to the proposal that larger regions should be referenced for the RAG categorisation in the UK and France, he suggested that this could lead to the extremes -both high and low numbers – being masked and would prefer a more granular approach. If larger regions were retained, he was of the view that the thresholds would need to be increased. Aligned thereto was the evidence in respect of when people were testing positive for COVID-19 after arrival in Jersey, whether at day zero, 5 or 10, because that could permit some flexibility. It was not possible to compare Jersey with the UK, because, as an Island, there was less risk of seeding from neighbouring areas, provided that an appropriate arrivals policy was maintained to minimise the same.

The Chief Executive Officer, Influence at Work, informed the Cell that when deadlines were set, people were more likely to take shortcuts, so it was important to continue to maximise their adherence to guidelines. In South East Asia, following the SARS crisis, many NPI behaviours had remained, but it was those that were less familiar, such as adhering to physical distancing that had the tendency to be forgotten as infection rates declined. It was important that Ministers had some pre-prepared reasons for why certain steps were being taken, to inform the public. The Chief Economic Advisor emphasised the benefit to the economy and people's wellbeing of returning to the workplace and opined that it was somewhat incongruous to cease the working from home guidance at

the same point as nightclubs would be permitted to re-open, as he felt that the workplaces posed a lower risk than certain other activities, such as household mixing.

The Managing Director, Jersey General Hospital, was of the view that the proposed timeline would have a disproportionate effect on the younger and less financially well-off Islanders who were less likely to have a garden and would have to wait until 17th May to be able to meet up with friends and family indoors. The re-opening of certain sections of the hospitality sector was already impacting them, because they were required to spend money in order to be able to socialise. He agreed that it would be preferable to have controlled messaging around proportionate mixing, because there was the risk that people would not comply with the guidance and would gather with others indoors, thereby placing pressure on the Track and Trace Team. He questioned what capability would be required from that Team in the future, mindful that it was envisaged that there would always be a certain prevalence of the virus. His view in respect of the disproportionate impact on certain sectors of society was shared by other members of the Cell.

The Director General, Justice and Home Affairs Department, informed the Cell that compliance officers had undertaken 300 visits over the weekend of 27th and 28th February to hospitality venues and had witnessed some good compliance, but some less so and they would continue to monitor this over the coming weeks. He anticipated a risk of more household mixing over the Easter period and questioned whether certain specific days should be nominated. The Consultant in Communicable Disease Control expressed the view that the metrics should be given a priority in dictating the speed of any reconnection, because of the likelihood of things changing. Islanders' mental wellbeing could be considered as a key metric, as was vaccination uptake and it was important to consider the position at various stages of the roll out. The efficacy of the COVID-19 vaccines was central to any decisions and it was not known what impact the VOCs would have and whether people would require a 'booster' vaccine in the Autumn. From an overall health perspective, he suggested that Islanders would benefit more from a relaxation of internal measures, rather than re-opening the borders and he emphasised the importance of exercising caution at the ports and in maintaining appropriate controls to avoid the situation that had been experienced in Guernsey when the Kent variant had entered the Island. He mooted that a relaxation at the borders should only take place when there were low instances of the virus in Jersey and arrivals were only permitted from jurisdictions where there were low case numbers, unless complete isolation was mandated. In his view, a Covid-safe passport would be beneficial.

The Cell noted the position and thanked the Interim Director, Public Health Policy, for the significant amount of work that he had undertaken in preparing the draft Roadmap, which was a difficult piece of work to compile. It was agreed that he and the Chair would discuss the matter further outside the formal setting of the meeting, before it was presented to Competent Authority Ministers later during the week.

Liberation Day and public events for 2021.

A7. The Scientific and Technical Advisory Cell ('the Cell') received and noted a letter, dated 21st January 2021, which had been sent by the Bailiff to the Chair of the Cell, seeking his views on whether Liberation Day celebrations could take place on 9th May 2021, mindful of the extant restrictions on public gatherings.

It was recalled that discussion of the letter had previously been scheduled as an Agenda item for the Cell, but pressing priorities had delayed consideration of the same. The Cell also noted a proposed draft response, which had been prepared by the Head of Public Health Policy and agreed with the views expressed therein, which were that despite the low rates of the virus in the Island at the current time, caution should be exercised and larger scale events, such as Liberation Day, should be deferred until June at least. It was envisaged that, at that time, a better indication of the level of protection afforded by the vaccine and its impact on transmission of the virus would have been

obtained, as would a clearer picture of the risks of severe COVID-19 to the population.

It was further agreed that the Head of Public Health Policy would finalise the wording of the letter with the Chair, prior to it being sent to the Bailiff.

Matters for information.

A8 In association with Minute No. A2 of the current meeting, the Scientific and Technical Advisory Cell received and noted the following –

- a weekly epidemiological report, dated 25th February 2021, which had been prepared by the Strategic Policy, Planning and Performance Department;
- statistics relating to deaths registered in Jersey, dated 26th February 2021, which had been compiled by the Office of the Superintendent Registrar; and
- an estimate of the instantaneous reproductive number (Rt) for COVID-19 in Jersey, dated 24th February 2021, which had been prepared by the Strategic Policy, Planning and Performance Department.