

KS

SCIENTIFIC AND TECHNICAL ADVISORY CELL

(56th Meeting)

26th April 2021

(Meeting conducted via Microsoft Teams)

PART A (Non-Exempt)

All members were present, with the exception of, R. Naylor, Chief Nurse, Dr. S. Chapman, Associate Medical Director for Unscheduled Secondary Care 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 (for items A1 – A5 only)
 Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention
 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 (present for items A4 – A8 only)
 I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department
 N. Vaughan, Chief Economic Advisor

In attendance -

R. Corrigan, Acting Director General, Economy
 S. Martin, Chief Executive Officer, Influence at Work
 Dr. M. Doyle, Clinical Lead, Primary Care
 B. Edwards, Head of Health and Social Care Informatics
 B. Sherrington, Head of Policy (Shielding Workstream) and Head of the Vaccine Programme, Strategic Policy, Planning and Performance Department (for items A1 – A5 only)
 R. Johnson, Head of Policy, Strategic Policy, Planning and Performance Department
 S. White, Head of Communications, Public Health
 L. Daniels, Senior Public Health Intelligence Analyst, Strategic Policy, Planning and Performance Department
 S. Gay, Senior Public Health Policy Officer, Strategic Policy, Planning and Performance Department
 Dr. C. Newman, Senior Policy Officer, Strategic Policy, Planning and Performance Department
 Dr. N. Kemp, Senior Policy Officer, Strategic Policy, Planning and Performance Department
 J. Lynch, Senior Policy Officer, Strategic Policy, Planning and Performance Department
 K.L. Slack, Secretariat Officer, States Greffe

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

One year anniversary of the first meeting of the Scientific and Technical Advisory Cell.

A1. The Chair of the Scientific and Technical Advisory Cell ('the Cell') informed Members that the first meeting of the Cell had taken place almost one year ago, on 27th April 2020. The current meeting was the 56th formal meeting of the Cell and the Chair thanked everyone for their hard work and input over the previous 12 months and hoped that the Cell had played a positive role in tackling the COVID-19 pandemic.

Minutes.

A2. The Scientific and Technical Advisory Cell received and noted the Minutes from its meeting held on 19th April 2021, which had previously been circulated. Members were asked to provide any feedback thereon to the Secretariat Officer, States Greffe, by the end of 26th April 2021, in the absence of which they would be taken to have been confirmed.

Monitoring metrics.

A3. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of its meeting of 19th April 2021, received and noted a PowerPoint presentation, dated 26th April 2021, entitled 'STAC Monitoring Update', which had been prepared by the Senior Public Health Intelligence Analyst, Strategic Policy, Planning and Performance Department and heard from her in relation thereto.

The Cell was informed that, as at Friday 23rd April 2021, there had been 2 active cases of COVID-19 in Jersey, both of which had been detected as a consequence of arrivals screening, as was the situation for all the positive cases over the previous 3 weeks. They were of working age and one was asymptomatic but the other was experiencing symptoms of the virus. Since 12th February 2021, the number of daily average cases had remained significantly below one and there had been no on-Island cases identified since the end of March 2021. During the week ending 23rd April, approximately 1,000 tests had been undertaken on 4 days, the majority on arriving passengers and as part of the workforce screening programme. With regard to the number of daily cases of COVID-19, the number of tests and the test positivity rates for various age groups, the latter remained very low for all, including those aged over 70 years.

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 25th April 2021 and was informed that there was currently no-one in Hospital with COVID-19 and the 7-day admission rate, per 100,000 population, was zero, which aligned with the 7-day case rate. There had been no further deaths since the last meeting of the Cell and the figure since the start of the pandemic, where COVID 19 had been referenced on the death certificate, remained at 69.

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 April 2021 and was informed that the number of calls to the Covid Helpline had remained comparable with the previous week, but there had been fewer relating to Islanders aged under 11 years and it was recalled that the number of calls often increased in advance of a new school term. The volume of inbound travellers had also remained fairly static, but was anticipated to increase during the coming week, on the basis that the Red / Amber / Green ('RAG') categorisation had been reintroduced at the borders from 26th March 2021, initially for the Common Travel Area only (with the exception of Eire), with the rest of the world due to follow on 17th May (excluding the UK 'banned list' countries). It was noted that, during the

week ending 18th April 2021, there had been 1,960 tests on inbound travellers, 5,120 as part of on-Island surveillance and 220 on people seeking healthcare. The weekly test positivity rate locally, as at that date, had remained at zero per cent and had reduced to 0.2 per cent in the UK. The local weekly testing rate, per 100,000 population, had increased to 6,800 and in the UK had been 9,833, mindful that that jurisdiction included tests undertaken on Lateral Flow Devices ('LFDs').

Attendance at Government primary schools, during the first week after the Easter holidays (week commencing 19th April 2021), had averaged 97.4 per cent and 87.1 per cent at secondary schools and there had been no positive cases linked to the schools since early April. The Cell noted the data in respect of the volume of LFD tests by school, result and date, including the number of positive, negative and inconclusive results and was informed that in excess of 15,500 LFD tests had been carried out and there had been just 3 positive results from LFD tests, which had subsequently been shown to be 'false positives' when tested using a PCR swab, in addition to 61 inconclusive results, which had been re-tested.

The Cell was presented with the data, to 18th April 2021, in respect of COVID-19 vaccinations in Jersey, which demonstrated that 77,185 doses had been administered, of which 49,413 had been first dose vaccinations and 27,772 second dose, resulting in a vaccine rate, per 100 population, of 71.6. Vaccine uptake in older Islanders continued at very high levels and of the Islanders aged between 45 and 49 years, who had been invited for vaccination from 11th April, 57 per cent had already received their first dose. The number of first doses had slowed in recent weeks, as focus had been directed to the second doses, but had recently increased as the younger cohort were invited for vaccination. The Cell was provided with a map, which had been prepared by the European Centre for Disease Prevention and Control ('ECDC'), which set out an estimate of the national vaccine uptake in Europe for the first dose of the COVID-19 vaccine in adults, as at 18th April 2021 and was informed that most countries now averaged between 20 and 29.99 per cent, whereas approximately 57 per cent of those aged over 18 years in Jersey had received at least one dose of the vaccine, with similar figures in the UK. The Cell was also shown an ECDC map, which showed the cumulative number of fully vaccinated adults and noted that Jersey had now attained 32 per cent, whereas much of Europe remained at an average of between 5 and 10 per cent. In respect of the local uptake of first and second doses of the vaccine by gender, there was little discernible difference in the cohorts that had been invited for vaccination by age. However, in the younger age groups, there were more females than males, which reflected the gender balance amongst employees working in health and care settings, who had been vaccinated.

As at 18th April 2021, 98 per cent of care home residents had received their first dose of the vaccine and 91 per cent their second and in respect of staff employed in those *loci* these figures were noted to be approximately 100 and 87 per cent respectively, mindful that this workforce fluctuated. With regard to Islanders classed as 'clinically extremely vulnerable' 90 per cent had received their first dose and 67 per cent their second and for those at moderate risk, those figures were noted to be 78 and 52 per cent respectively. The Cell received the weekly estimate of coverage for the various priority groups, as recommended by the Joint Committee on Vaccination and Immunisation ('JCVI'), by cohort size and the numbers of first and second doses of the vaccine and was reminded that 1,484 people working in frontline health and social care positions had received their first dose of the vaccine, which was greater than the cohort size, for the aforementioned reason of fluctuation in that workforce and 81 per cent their second. Eighty six per cent of other workers in those settings had received their first dose and 61 per cent their second. However, these percentages were still allocated an Amber rating, which was indicative that a small amount of the data was of questionable quality. The Cell was informed that there had been no further active cases identified amongst those who had been vaccinated at least 14 days previously, but this remained under

review.

The Cell was shown a map of the UK, prepared by Gov.UK, which set out the geographic distribution of cumulative numbers of reported COVID-19 cases, per 100,000 population, as at 25th April 2021, on a 7-day rolling basis. This demonstrated that many areas had fewer than 50 cases, per 100,000, with a few in the range 50 to 99 cases. The Cell was presented with information on the current RAG status for the UK, Eire and France. It was noted that from 27th April, there were increasing areas designated as Green in England, Scotland and Wales, but the situation had slightly worsened in Northern Ireland, with a growth in Amber areas. It was recalled that a blanket Red categorisation would continue to apply to Eire, but those areas that would have been classified as Red (if that were not the situation) had decreased, whereas 97 per cent of France remained Red (including some of the overseas territories). With regard to the maps, which had been prepared by the ECDC, for weeks 14 to 15 (12th to 19th April) when compared with the previous week, on a 14-day case rate per 100,000 population, it was noted that there had been little change in Italy and France, but there was a deteriorating situation in Germany, Spain, Belgium and the Netherlands.

On the basis that more travel would be facilitated from 17th May, with the exception of the UK's red list countries, the Associate Medical Director for Primary Prevention and Intervention suggested that there would be merit in applying a RAG rating to the whole of Europe, rather than reporting on case numbers. The Independent Advisor – Epidemiology and Public Health asked that in reporting on arrivals, the data should be disaggregated by the type of traveller, whether returning resident, business visitor or holidaymaker, for example. The Senior Informatics Analyst indicated that some of this information would be held on the BATS system, which could be used for this purpose.

On a related note, the Chair provided the Cell with details of an active case that had been identified over the weekend of 24th and 25th April, following arrival into the Island, in the anticipation that it might attract some media coverage.

The Cell noted the position with regard to the metrics and thanked the Senior Public Health Intelligence Analyst for the update.

Airborne transmission of COVID-19 and the latest science on masks.

A4. The Scientific and Technical Advisory Cell ('the Cell') received and noted a briefing paper, dated 26th April 2021, entitled 'Airborne transmission of SARS-CoV-2', a comment paper, dated 15th April 2021, entitled 'Ten scientific reasons in support of airborne transmission of SARS-CoV-2', which had been published by *The Lancet*, an undated paper, entitled 'Physical distancing and Indoor Spaces', an undated paper entitled 'Evidence related to mouth and nose coverings' and a PowerPoint presentation, dated 26th April 2021, entitled 'Airborne transmission of SARS-CoV-2. Latest science on masks', which had been prepared by Senior Policy Officers from the Strategic Policy, Planning and Performance Department and heard from them in connexion with airborne transmission of COVID-19 and the latest science on masks.

In addition to the aforementioned paper by *The Lancet*, they referenced a paper, which had been published by the World Health Organisation ('WHO') on 1st March 2021, entitled 'Roadmap to improve and ensure good indoor ventilation in the context of COVID-19' and papers published by the *British Medical Journal* entitled 'COVID-19 has redefined airborne transmission', which had been published on 14th April 2021 and 'Two metres or one, what is the evidence for physical distancing in COVID-19'. The Cell was informed that the paper by *The Lancet* propounded a well-researched and scholarly argument that most infection of COVID-19 occurred through inhalation. It advocated caution around those who were selective of the evidence used to refute that claim. It indicated that superspreading events were linked to aerosol transmission and could not be adequately explained by droplets, or fomites. This also accounted for the

long-range transmission of COVID-19 between people in adjacent rooms, but not in each other's presence, such as in cruise ships, or quarantine hotels. It continued that in order to reduce the airborne transmission of the virus, ventilation was key and the creation of draughts should be encouraged. Air recycling and air conditioning should be avoided in favour of air filtration, ideally using HEPA (high-efficiency particulate air) filters and people should wear high quality, well-fitted masks when indoors. The time spent indoors should be limited and close contact avoided. It was proposed that in communicating to Islanders the risk posed by airborne transmission, 'hands, face, space, fresh air' or 'hands, face, space, replace' should be encouraged and the 3 Cs avoided, *viz* Confined spaces, Crowded places and Close contact settings.

The Cell was informed that the European Centre for Disease Prevention and Control ('ECDC') and the WHO had updated their guidance in respects of masks and had respectively concluded that 'although the evidence for the use of medical face masks in the community to prevent COVID-19 [was] limited, face masks should be considered as a non-pharmaceutical intervention in combination with other measures as part of efforts to control the COVID-19 pandemic' and 'WHO continued to advise the use of masks as part of a comprehensive package of prevention and control measures.' Masks were considered a non-pharmaceutical intervention ('NPI') which had a high disease impact, low societal impact and posed a low risk of harm to individuals. Evidence had shown that they could be tolerated during vigorous exercise and if transmission of COVID-19 did occur, they resulted in less symptomatic severity of the virus. There was no evidence that wearing a mouth or nose covering was detrimental to health, even for those with underlying conditions, but it could induce anxiety and discomfort, which was more likely to increase for those with the same and it was noted that they could give rise to certain skin conditions and could cause headaches if worn too tightly.

The Managing Director, Jersey General Hospital, suggested that caution should be exercised when determining harm, because it could be very difficult for certain sectors of society to wear masks, *inter alia* those with a disability or learning difficulties, those in the deaf community who did not communicate using sign language, people with mental health difficulties or a cognitive impairment, such as dementia. It could also be challenging to care for and communicate with people when mask wearing was required. The Senior Policy Officer indicated that communications had taken place with various groups when drawing up a list of exemptions and they were mindful of the secondary societal harms that could arise if people were compelled to wear masks. On a converse note, the Chair indicated that he understood that some primary care patients had become dependent on their masks and were experiencing anxiety at the notion of removing the same.

The Consultant in Communicable Disease Control suggested that the consensus remained that masks were helpful in the event of community transmission of COVID-19, particularly in indoor public settings, in the presence of vulnerable people or in households where there was a probable, or confirmed, active case of the virus. However, there was the need to apply them sensibly, to ensure that they were not causing more harm than benefit. He indicated that the aforementioned paper by *The Lancet* on airborne transmission of the virus was compelling and provided an explanation as to how outbreaks had occurred within care home settings, despite the use of Personal Protective Equipment ('PPE'). He placed considerable emphasis on the importance of good ventilation, which should be more easily achievable as the Summer approached. He also reminded the Cell that COVID-19 could be transmitted through the gastrointestinal tract.

The Independent Advisor – Epidemiology and Public Health, indicated that there was little doubt that the main form of transmission of COVID-19 was a combination of droplets and aerosols and that there was far less evidence that fomites had an impact, which could lead to less emphasis being placed on surface cleaning. Whilst he recommended masks as an effective intervention, the benefits of any NPI was

dependent on the level of transmission of the virus in the community and he suggested that at the current low levels, their effect was likely to be negligible. They were not generally worn within household settings, which were known vectors of transmission and he queried whether it would be preferable to re-deploy them in the Autumn, when they were more likely to have an impact. The Chief Economic Advisor supported a robust stance on retaining masks whilst introducing clarity around those individuals who were exempted from wearing them and suggested that they could be provided with lanyards on which it was clearly endorsed that they were 'mask exempt' as an example. The Associate Medical Director for Primary Prevention and Intervention suggested that there should be clear guidance on where to wear masks due to the risk of transmission and with respect to their use in primary care settings, questioned whether there was a point at which their use outweighed the difficulties in providing care, or communicating with patients.

The Chief Executive Officer, Influence at Work, recommended that all-encompassing guidelines would be required if the wearing of masks was to continue to be mandated, which should not subject to frequent change, mindful that this could cause confusion. He indicated that his team was following the work that was underway in the United States in respect of the previously referenced 3Cs and would always encourage the avoidance of at least 2. The Head of Communications, Public Health, informed the Cell that a meeting would be taking place during the week commencing 26th April on the communications around good ventilation and she opined that if people were informed that they were no longer required to wear masks at this juncture, it could prove challenging to encourage them to wear them again in the Autumn.

The Chair concluded that the Cell accepted that airborne transmission of COVID-19 occurred and, as such, this should inform Public Health guidance in the future, which should include emphasis on good ventilation. It was felt that the matrix on the risk of transmission, which identified certain activities as posing low, medium or high risk, which had been prepared by the *British Medical Journal* in its paper entitled 'Two metres on one: what is the evidence for physical distancing in COVID-19' was helpful with regard to identifying where masks were beneficial, or not and agreed that a sensible approach should be adopted, which might be dependent on the quantum of virus in the Island at any time and mindful of the need to provide consistent messaging to have the greatest effect.

The Interim Director, Public Health Policy, indicated that officers would further develop the paper and re-present it to the Cell at its meeting on 10th May 2021. The Cell thanked officers for their work in this regard.

COVID-19:
Variants of
concern.

A5. The Scientific and Technical Advisory Cell ('the Cell') received and noted a PowerPoint presentation, dated 26th April 2021, entitled 'Variants of Concern. Availability and timeliness of data / intelligence' which had been prepared by the Senior Public Health Intelligence Analyst and the Principal Officer, Public Health Intelligence, Strategic Policy, Planning and Performance Department and heard from the former in relation thereto.

She informed the Cell that Variants of Concern ('VOCs') of COVID-19 were currently being widely discussed and whilst the deployment of the vaccine decreased the threat posed by the virus, some VOCs, which could evade vaccine protection, could undermine this advantage. Accordingly, there was widespread consideration of the potential to include the prevalence of VOCs in any risk assessments, particularly around policy at the borders. The Cell was cognisant that viruses frequently mutated and this occurred as they replicated in the population. Where the prevalence of a virus was high, there was a greater likelihood of mutations arising. If the variant had epidemiological, immunological or pathogenic properties that caused concern and required specialist analysis by virologists or geneticists, the variant would initially be classified as a

Variant Under Investigation ('VUI'). In the event that it was found to present increased risk, due to increased transmissibility, severity or vaccine evasion potential, as an example, Public Health authorities would classify it as a Variant of Concern. It was noted that it could take at least 3 months until it was so categorised and most identification was retrospective.

The Cell noted that the sequencing surveillance of variants varied widely across the globe and was reported upon by the GISAID initiative, which promoted the rapid sharing of data from all flu viruses and the coronavirus causing COVID-19. It provided details on the percentage of cases sequenced by country, the timeliness in undertaking the sequencing and how open the authorities had been in sharing the data. Other available resources were weekly publications from Public Health England, monthly or bi-monthly risk assessments from the European Centre for Disease Prevention and Control ('ECDC') and weekly epidemiological reports from the World Health Organisation. The principal VOCs at the current time were the Kent, South African and Brazil variants and the Indian variant was currently designated as a VUI. Raw data was available through Co.Variants.org and the PANGO lineage reports, which were powered by information from GISAID. However, the quality of the data varied widely by country, was not produced in 'real time' and involved significant processing requirements.

It was noted that the Kent variant (B.1.1.7) had first been identified as being in the United Kingdom ('UK') in September 2020, but had not been classified by Public Health England as a VOC until 3 months later, on 20th December 2020, by which time it was dominant in that jurisdiction. On the same day, the South African variant (B.1.351) had been classified as a VOC and it was noted that it had been first identified in October and had been present in the UK since December 2020. The Brazil variant (P.1) had first been identified in January 2021, had been classified as a VOC by Public Health England on 21st January and the first case in the UK had come to light in February 2021. The Indian variant (B.1.617) had first been identified in October 2020, had been classified as a VUI by Public Health England on 21st April and had been present in the UK during that month. It was noted that there was no global consensus on the categorisation, or the naming conventions for variants, but work was underway to address this.

The Indian VUI had come to light as a consequence of a concerning increase in cases in March in India and that country had been added to the UK's 'Red list' on 23rd April 2021, albeit its 14-day case rate, per 100,000 population, had been 108 on 11th April, which would result in it being considered as Amber under the local Safer Travel Policy. The Cell was informed, however, that the rate of testing in India was low and it was suggested that consideration should be given to the appropriate categorisation for such areas where this was the situation. The Cell noted a graph of the proportion of cases in England relating to the 4 new variants, excluding the 'Kent' VOC, which gave rise to between 98 and 99 per cent of active cases.

The Cell recalled that positive cases could be sent to UK laboratories for sequencing, which could take between 2 and 3 weeks, resulting in this being neither protective nor preventative. However, the retrospective intelligence was useful with a view to informing policy and the local response. The sequencing would identify if any positive cases locally matched the profile of a known VOC by comparison with a database of pre-defined variants. As a consequence, the Island remained reliant on research from international scientists to identify and classify VOCs. In order to reduce the spread of VOCs, the ECDC recommended that non-essential travel should be avoided, that the testing and quarantining of travellers should be maintained, in particular those from areas with a higher incidence of the new variants and that travel restrictions should also be considered from areas where there was a continued high level of community transmission in the event that sequencing was inadequate to exclude the possibility of

their existence, because high case rates were indicative of a higher risk of VOCs.

The Consultant in Communicable Disease Control informed the Cell that work was underway to either enable more rapid sequencing of active cases by a private provider off-Island, or to source suitably automated equipment to undertake the analysis locally. However, this would require an information technology solution to link to the system in the UK to facilitate the interpretation of the genetic sequencing by comparison with the existing national database and also to provide data thereto in the event of a VOC being identified locally. Mindful that most travel to the Island came from the UK, he opined that the variants encountered locally were likely to reflect those found in that jurisdiction, most of which had been the Kent variant. The Independent Advisor – Epidemiology and Public Health, indicated that it would be helpful to be sighted on the impact of the VOCs on severe disease amongst a vaccinated population. The Senior Public Health Intelligence Analyst stated that work would be undertaken on this subject and referenced a case study in Chile where there was a high level of vaccine coverage, but there had been a large number of infections with the P.1 Brazilian VOC, which appeared to cause reinfection. She stated that this type of research would be important going forwards, but due to the retrospective detection of the VOCs, the evidence only emerged weeks, or months, after they had first been present.

The Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, indicated that the VOCs gave rise to some policy questions, depending on the severity of their potential impact. The Island was operating within the context of the UK's strategy on VOCs, but had the freedom to set its own policy if it wished. The presence of VOCs regionally within the UK, such as the recent outbreak of the South African VOC in West London, raised certain issues, such as whether a situation of that nature was of sufficient concern to cause the Red / Amber / Green ('RAG') categorisations for that region to be altered. He stated that a future paper might be presented to the Cell, which dealt with the level of concern that should be applied to the VOCs in light of the Island's strategy, particularly in respect of the vaccination programme.

The Cell accordingly agreed that it would be helpful for officers to continue to monitor the international situation and available data and resources. It wished to receive a regular update on VOCs, which it perceived as the greatest current risk and for any imminent announcements from the Joint Biosecurity Centre to be reviewed, as the UK assessed its border policy and mindful that most arrivals in Jersey came from that jurisdiction. It felt that it was important to be open and transparent with the public on the VOCs, but not to report on local sequencing results, as mutations only became VOCs when they had the characteristics to make them significantly different and it was for larger authorities, such as Public Health England to declare them as such.

Reconnection
roadmap –
Stage 6.

A6. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A4 of its meeting of 29th March 2021, recalled that Competent Authority Ministers had agreed to advance the timetable for the remaining stages of the Island's internal, social and economic reconnection in light of the consistently low levels of COVID-19 in the community and the excellent progress of the vaccination programme. It was further recalled that the published roadmap proposed the reconnection of Stage 6 no earlier than 10th May and Stage 7 no earlier than 14th June 2021.

The Cell accordingly received and noted a PowerPoint presentation, dated 26th April 2021, entitled 'STAC Reconnection Roadmap: Stages 6 and 7', which had been prepared by the Head of Policy, Strategic Policy, Planning and Performance Department and heard from her in relation thereto. She reminded the Cell of the updated timeframe for the reconnection and indicated that the proposed relaxations at Stage 6 could have some potential implications for Stage 7. At Stage 6, it would no longer be necessary to remain seated at a table for eating and drinking; last orders at 11.00 p.m. with a closing time of 11.30 p.m. would cease to be applicable across all hospitality

settings (if Competent Authority Ministers did not take a decision on 28th April to remove this on 30th April) and saunas and Jacuzzis would also be permitted to re-open. It would remain against the law for more than 20 people to gather in homes and gardens and at uncontrolled outdoor gatherings – subject to an exception for weddings in gardens where 50 people could congregate - and for individuals not to wear masks and provide contact details in shops, gyms, food and drinks premises and entertainment venues, except when eating or drinking. People would continue to be advised to keep at least one metre physical distance between them, guidance would encourage venues to accommodate only half their normal capacity, to facilitate such distancing, dancing would be discouraged and it would be recommended that live and pre-recorded music should only be played at a low volume indoors.

The Head of Policy indicated that the implications of these changes were that nightclubs would be able to open until 2.00 a.m. with stand-up drinking and indoor and outdoor events with stand-up, or seated stadium, drinking could recommence. If the guidance was adhered to, this would result in fewer people in these settings and no dancing. However, if the guidance was not followed, the nightclubs would be open for all purposes at full capacity and there could be unlimited people at events. The move to stand-up drinking on 10th May would permit more people to gather, mindful that the tables restricted total numbers and supported compliance with physical distancing and this was more likely to result in unrestrained behaviour, as people would be consuming alcohol and not wearing masks whilst drinking and intermingling. On the basis that the stand-up drinking effectively negated the requirement to wear masks in food and drink premises, it was queried whether it was logical to retain this in shops and gyms, as an example. Because people would be able to stand up, drink and mingle, it was questioned if it was logical to continue to advise against informal dancing and if any number of people could meet up in nightclubs and pubs, this begged the question whether it was logical to continue to limit gatherings in people's homes. In summary, if stand-up drinking were to be permitted from early May, it would have the effect of removing most non-pharmaceutical interventions ('NPIs') from legislation and rendering them ineffective in guidance, thereby resulting in significant disparities if controls were to continue to be applied at those large events that required the permission of the Bailiff.

The Cell was informed that the Competent Authority Ministers were due to meet on 28th April and would be presented with 2 options in relation to the foregoing issues, *viz* Option 1: to implement stand-up drinking at Stage 6, as per the published roadmap or, Option 2: to delay it until Stage 7, thereby allowing for the logical retention of masks and controls on dancing and gatherings in homes. It was envisaged that the Competent Authorities would wish to receive the Cell's views on the potential risk associated with the same. The rates of infection were currently low in the Island and there was anecdotal evidence of increasing pandemic fatigue, leading to lower levels of compliance with guidance on COVID-19. However, 10th May fell before the programme milestone of vaccinating all eligible Islanders and mindful that more travel to the Common Travel Area was being facilitated since the reintroduction of the Red / Amber / Green ('RAG') categorisation for those jurisdictions from 26th April, there was increased risk of seeding and Variants of Concern ('VOCs') arriving in Jersey as the inward travellers would also stand, drink and mingle. There had already been a significant acceleration of the roadmap, with certain restrictions having been eased earlier than published and a staged approach had been agreed, to enable the impact of any relaxations to be assessed. In considering the balance of harms, the negative economic impact of restricting stand-up drinking was evident, but the negative societal impact of the same was not as clear. Permitting people to stand, drink, socialise and potentially dance without masks presented a very high risk of transmission and bodies such as the European Centre for Disease Prevention and Control and the World Health Organisation assessed bars and nightclubs as being high risk settings and amplifiers of transmission. If stand-up drinking and dancing were permitted, this would effectively

remove all controls on all large scale events, except where the Bailiff's permission was required.

The Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, indicated that if the restrictions had remained in place at the borders, in light of the low number of active cases in the Island, he would have had no strong preference for either option, but with the risk associated with travel and the VOCs, he advised caution in order to assess the impact of the RAG and increasing passenger numbers before relaxing further NPIs. Accordingly, he favoured Option 2. The Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, did not wish for the Island to experience a third wave that would need to be halted by the imposition of stringent NPIs and if Ministers decided to relax further restrictions early, they would need to be prepared for a period of risk that would reduce as Summer progressed and more Islanders were vaccinated. By releasing restrictions at the borders and permitting stand-up drinking, this could pose a threat and Ministers had been presented with the modelling of the third wave with the effective reproduction rate at various levels, so would be cognisant thereof.

The Independent Advisor – Epidemiology and Public Health, noted that those researchers in the UK, who had predicted a third wave had been required to review their modelling on the basis that they had originally overstated the potential risk. He suggested that there was evidence that nightclubs posed a high risk, but did not believe that it was appropriate to 'demonise' that particular sector of the economy. He emphasised that the highest risk of COVID-19 transmission was inter-household mixing. People did not necessarily wear masks and could dance and drink alcohol without controls in place. He suggested that there would be greater risk in June as there would be an increased number of travellers and attendant risk of seeding and VOCs, rather than in May, when the flights would be slowly re-established. The Summer would reduce transmissibility of the virus as people would spend more time outdoors and he opined that the Island was almost at the point where 'herd immunity' had been attained, in light of the number of vaccinated and previously infected individuals.

The Consultant in Communicable Disease Control acknowledged that those who had modelled a third wave had reduced it in magnitude, taking into account vaccination coverage, but had not factored in the VOCs or seasonality. They were still predicting a significant risk of a third wave unless all individuals down to the age of 10 years were vaccinated and that people did not exceed half their daily contacts from pre-pandemic times and envisaged that mask wearing would remain necessary until after the Summer. Testing before major sporting events had been evidenced over the weekend, which was indicative of ongoing concerns and he envisaged that this would be required locally. He questioned whether relaxing the NPIs by one month for a relatively small percentage of the population was worth everyone risking the new-found freedoms that they had experienced over the previous months. He acknowledged that household mixing was risky, but the wellbeing benefits of permitting people to gather were evident. He opined that if stand-up drinking were permitted in nightclubs, this could appear to convey the message that the threat posed by COVID-19 had disappeared, thereby resulting in more 'risky' behaviour from the public. The Clinical Lead, Primary Care, reminded the Cell that whilst household gatherings often involved people from a wide range of ages, some of whom would have been vaccinated, it was primarily the younger Islanders who would frequent nightclubs, the majority of whom would not have been vaccinated.

Having discussed the foregoing, the Members of the Cell were unanimous in voicing their support for Option 2 and advising a delay to the reintroduction of stand-up drinking to Stage 7 of the reconnection.

56th Meeting
26.04.21

advice on a proposal that Jersey should be the base for 4 PRO14 rugby teams from South Africa during the Rainbow Cup in May and June 2021.

The Cell received a brief update, dated 23rd April 2021 and noted that the South African Rugby Union had decided to withdraw its teams from the PRO14 tournament based on the challenges and uncertainty around bringing groups to Europe in the light of the COVID-19 pandemic. Those concerns were not specific to Jersey and the organisers of the PRO14 had expressed their thanks to the Government of Jersey for its efforts to facilitate the proposal.

The Cell noted the position accordingly and members were thanked for their contributions in this regard.

Matters for
information.

A8. In association with Minute No. A3 of the current meeting, the Scientific and Technical Advisory Cell ('the Cell') received and noted the following –

- a weekly epidemiological report, dated 22nd April 2021, which had been prepared by the Strategic Policy, Planning and Performance Department;
- statistics relating to deaths registered in Jersey, dated 23rd April 2021, which had been compiled by the Office of the Superintendent Registrar; and
- a report on vaccination coverage by priority groups, dated 22nd April 2021, which had been prepared by the Strategic Policy, Planning and Performance Department.

The Cell was informed that the next formal meeting would take place in 2 weeks, on Monday 10th May 2021.