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SCIENTIFIC AND TECHNICAL ADVISORY CELL

(59th Meeting)

17th May 2021

(Meeting conducted via Microsoft Teams)

PART A (Non-Exempt)

All members were present, with the exception of R. Sainsbury, Managing Director, Jersey General Hospital, R. Naylor, Chief Nurse, I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department 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
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 (for items A3-A7 only)
S. Petrie, Environmental Health Consultant
A. Khaldi, Interim Director, Public Health Policy, 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. Sherrington, Head of Policy (Shielding Workstream) and Head of the Vaccination Programme, Strategic Policy, Planning and Performance Department
S. White, Head of Communications, Public Health
C. Keir, Head of Media and Stakeholder Relations, Office of the Chief Executive
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 Public Health Intelligence Analyst, 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

S. Huelin, Senior Policy Officer, Strategic Policy, Planning and Performance Department
Senior Sister R. Young, Executive Support
S. Nibbs, Temporary Secretariat Officer, States Greffe
K.L. Slack, Secretariat Officer, States Greffe

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

Minutes.

A1. The Scientific and Technical Advisory Cell received and noted the Minutes from its meetings held on 26th April, 4th May and 10th May 2021, which had previously been circulated. Members were asked to provide any feedback thereon to the Secretariat Officer, States Greffe, by the end of 17th May 2021, in the absence of which they would be taken to have been confirmed.

Monitoring metrics.

A2. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of its meeting of 10th May 2021, received and noted a PowerPoint presentation, dated 17th May 2021, entitled 'STAC Monitoring Update', which had been prepared by the Principal Officer, Public Health Intelligence and the Senior Public Health Intelligence Analyst, Strategic Policy, Planning and Performance Department and initially heard from the former in relation thereto.

The Cell was informed that, as at Friday 14th May 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. One was asymptomatic, whilst the other was experiencing symptoms of the virus and they had been in direct contact with 45 individuals as a consequence of travelling to Jersey by air. The 7-day and 14-day case rates, per 100,000 population, were both currently 1.86 and there had been no on-Island cases identified since 29th March 2021. The Cell was provided with further details of the 2 active cases by the Interim Director of Public Health Practice, Chair of the Analytical Cell.

During the week ending 14th May, approximately 1,000 tests had been undertaken on work days, the majority on arriving passengers and as part of the workforce screening programme. There had been no COVID-19 positive hospital admissions in the last 7 days and no positive cases in vaccinated individuals since early March. 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. 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 number of PCR tests for all cohorts, with the exception of those aged under 18 years, was relatively high.

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 14th May 2021 and was informed that the number of calls to the Covid Helpline had declined further and were at the levels last experienced in Summer 2020. The volume of inbound travellers had increased since the Red / Amber / Green ('RAG') categorisation had been reintroduced for the Common Travel Area (excluding Eire) on 26th April. During the week ending 9th May 2021, there had been 4,160 tests on inbound travellers, 3,740 as part of on-Island surveillance and 90 on people seeking healthcare. The weekly test positivity rate locally, as at that date, had remained at zero per cent and at 0.2 per cent in the UK. The local weekly testing rate, per 100,000 population, had increased to 7,400 and in the UK had been 10,104, mindful that that jurisdiction included tests undertaken on Lateral Flow Devices ('LFDs').
During the week ending 15th May 2021, COVID-19 related absences in the Government primary schools had been 0.1 per cent and in the secondary schools 1.6 per cent. It was recalled that there had been no positive cases linked to the schools since

early April and prior to that in February. 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 whilst it was believed that some data was not being collected, 18,699 LFD tests had been carried out to-date and there had been just 3 positive results, which had subsequently been shown to be 'false positives' when tested using a PCR swab, in addition to 65 inconclusive results, which had been re-tested.

The Cell was presented with the data, to 9th May 2021, in respect of COVID-19 vaccinations in Jersey, which demonstrated that 92,811 doses had been administered, of which 54,172 had been first dose vaccinations and 38,639 second dose, resulting in a vaccine rate, per 100 population, of 86.10. The Cell noted the percentage of the various age cohorts that had received their first and second doses of the vaccine and noted that amongst Islanders aged over 18 years, 62 per cent had received their first dose and 44 per cent their second. Across the whole population, this equated to half having received their first dose and over one third (36 per cent) their second. The Cell was shown 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 9th May 2021 and was informed that, whilst 62 per cent of adults in Jersey had received their first dose, with a similar percentage in the UK, it averaged between 30 and 40 per cent in many European countries. The Cell was also shown an ECDC map, which displayed the cumulative number of fully vaccinated adults and noted that Jersey had now attained 44 per cent, whereas most of Europe averaged between 10 and 15 per cent. The Cell was provided with provisional vaccination figures as at 16th May and noted that 97,450 total doses had been administered, comprising 57,220 first and 40,230 second doses, resulting in a vaccine rate, per 100 population, of 90.40. In respect of the local uptake of first and second doses of the vaccine by gender, it remained the case that 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 9th May 2021, 98 per cent of care home residents had received their first dose of the vaccine and 93 per cent their second and in respect of staff employed in those settings these figures were noted to be approximately 100 and 92 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 83 per cent their second and for those at moderate risk, those figures were noted to be 79 and 68 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 recorded number of employees, for the aforementioned reason of fluctuation in that workforce and 86 per cent their second, whilst 90 per cent of other workers in those settings had received their first dose and 72 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 provided with updated projections for the vaccination progress, based on the most current JCVI advice on the vaccine administration for people aged under 40 years. This resulted in the first dose vaccination of those aged between 18 and 30 years being delayed by approximately 20 days and the second dose by approximately 30 days. As a consequence, it was anticipated that all adults would have been offered the first dose by early July and the second dose by mid-August.

The Cell was shown a map of the classification of the Common Travel Area ('CTA') by Lower Tier Local Authority Level that would apply from 18th May, based on the 14-day case rate, per 100,000 population and noted increasing cases in the North West of England and in Scotland around Glasgow and Moray. The Principal Officer, Public Health Intelligence, indicated that these outbreaks were being kept under review. The Cell also noted a map of the UK, prepared by gov.uk, which set out the geographic distribution of cumulative numbers of reported COVID-19 cases on a 7-day rolling basis, per 100,000 population, as at 11th May 2021, which mirrored that situation. The Cell was presented with information on the RAG status for the UK, Eire and France, as at 18th May and it was noted that from that date, 81 per cent of England would be Green and 18 per cent Amber. In Scotland there would be a reduction in Green areas and an increase in Amber and some Red, whilst all of Wales would remain Green. There was an improving situation in Northern Ireland, with 45 per cent Green and 45 per cent Amber. 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 to 27 per cent with 23 per cent Green, whereas all of mainland France remained Red. With regard to the maps, which had been prepared by the ECDC, for weeks 17 to 18 (3rd to 10th May) when compared with the previous week, based on a 14-day case rate per 100,000 population, it was noted that case numbers were starting to decrease across France and Poland, which was of relevance to Jersey.

In respect of the economic indicators, which were published on a monthly basis by Statistics Jersey, the Cell noted that 1,210 people were registered as Actively Seeking Work, which represented a reduction on the previous month. There had been an increase in the number of vehicles using the overpass and there had been a significant increase, since January, in the number of passengers using the buses each week.

The Chair of the Cell indicated that there had been no notable change in the situation at the General Hospital and there was currently no pressure on services.

The Cell noted the position accordingly.

COVID-19 Latest evidence and implications for Jersey.

A3. The Scientific and Technical Advisory Cell ('the Cell'), received and noted a PowerPoint presentation, dated 17th May 2021, entitled 'Latest evidence and implications', which had been prepared by the Public Health Team and was informed by the Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, that significant communications had taken place between officers in Jersey and the United Kingdom ('UK') authorities towards the end of the week commencing 10th May 2021, particularly in relation to the Indian Variant of Concern ('VOC') and the implication that it could have locally for the vaccination programme and the policy in place at the borders.

The Cell was advised that the most recent SPI-M-O (Scientific Pandemic Influenza Group on Modelling, Operational sub-group) modelling scenarios were more optimistic than previous iterations, primarily due to recent evidence that the COVID-19 vaccines significantly reduced onwards transmission in infected people by between 40 and 50 per cent, despite the estimated R_0 of the B.1.1.7 Kent VOC increasing to between 4.5 and 5.5. It represented an opportunity to suppress the next wave if policies to reduce transmission remained in place and the vaccine deployment progressed. However, in the central scenario, neither waning immunity, nor the future emergence, or dominance, of VOCs were accounted for and there remained the potential for a significant number of hospitalisations and deaths. The modelling from Imperial College London, University of Warwick and the London School of Hygiene and Tropical Medicine all projected a further wave, but these were considerably smaller than had been anticipated. It was estimated that there could be between approximately 30,000 and 50,000 cumulative hospital admissions, that peak hospital occupancy would be between 4,000 and 6,000 and that there would be between 7,000 and 11,000 deaths. However, a VOC

with high immune escape and high transmissibility had the potential to result in a significant number of additional hospitalisations and deaths, with the latter potentially exceeding 100,000.

The Cell was informed that since the start of the COVID-19 pandemic, an ongoing survey of UK adults, known as CoMix, had been monitoring the mean number of daily contacts for adults and children and was shown a graph which demonstrated that the figures were now slowly increasing as the UK lockdown eased and were commensurate with those seen in October 2020, but significantly below the pre-pandemic average.

In respect of the VOCs, it was important to assess whether there was community circulation of immune escape variants in the country of origin. Accordingly, the Joint Biosecurity Centre (JBC) had developed a dynamic risk assessment methodology, which comprised several parts. New variants were monitored and evaluated and in assessing the risk posed by a territory, had genomic sequencing capacity, would consider evidence of the VOC in the territory and any travel links with other territories where there was community transmission of the VOC. Locally, genomic sequencing enabled targeted public health action, reaction to the VOCs and the ability to efficiently trace contacts. Samples were sent to Porton Down, but it could take 3 weeks for the results to be obtained and inbound travellers and cases in people who had been vaccinated were prioritised for sequencing. Work was underway to pilot the use of the Micropathology laboratory, to reduce the turnaround time to between 2 and 3 days. It was also envisaged that the sewage testing that had been discussed by the Cell at its meeting of 10th May (Minute No. A5 referred) could provide additional information.

Any decision taken to relax non-pharmaceutical interventions ('NPIs') would need to be taken against a backdrop of new variants, with the ability to revoke the decision as required. Those individuals, who tested positive for a VOC, would undergo enhanced contact tracing, with heightened community and surge testing in areas defined by the local authorities and regional teams and the current recommendations from the European Centre for Disease Prevention and Control ('ECDC') was that NPIs should be maintained during travel, irrespective of the vaccination status of the person travelling. The new VOCs posed a significant threat to the vaccination programme and vaccine deployment would increase the possibility of other vaccine evading variants emerging. The risk posed by an area would increase with the circulation of VOCs.

The Cell was informed that the Consultant in Communicable Disease Control and Head of the Vaccination Programme, Strategic Policy, Planning and Performance Department, participated as observers in meetings of the Joint Committee on Vaccination and Immunisation ('JCVI') and there had been significant discussion recently in relation to VOCs. It was currently recommended that the 2 doses of the COVID-19 vaccine should be administered between 4 and 12 weeks apart, with an average of 10 weeks between doses. However, in light of concerns around the VOCs, the most recent advice from the JCVI was to reduce the gap between doses, in order to vaccinate as many people as possible before a potential 3rd wave of cases, as the current time was considered to be one of high risk. The impact of the vaccines on the VOCs was being examined, but there was early evidence that the second dose was important to prevent hospitalisations and death. Mindful that the risks associated with COVID-19 increased with age, it was imperative to administer both doses of the vaccine to Islanders aged over 50 years as soon as possible and to emphasise to individuals in that cohort, who had not taken up the invite to receive their first dose of the vaccine, of the importance of so doing. There was an increased risk of mortality in those aged over 40 years and in respect of people under that age, the interval between doses would need consideration, but if possible it should be reduced to 7 weeks. It would also be necessary to determine if the Oxford AstraZeneca vaccine should be administered to those under 40 years if necessary during a period of a wave of cases.

There were currently 6,700 people who had received their first dose of the vaccine more than 4 weeks previously, who required a second dose and 8,000 second dose appointment slots were available during the remainder of May. The second doses would be offered between 4 and 6 weeks after the first to Islanders aged over 50 years and it was anticipated that 95 per cent of people falling into that category would have received both doses by the end of May. The first dose of the Pfizer or Moderna vaccines would be administered to between 2,000 and 3,000 younger Islanders each week, with the view to achieving vaccination coverage of over 80 per cent with both doses by mid-August.

The Cell was reminded that, as part of recent changes to the Safer Travel Policy, Competent Authority Ministers had agreed to introduce an 'emergency brake' safeguard in response to VOCs and / or high infection rates in specific geographic locations, mindful that Ministers had decided to introduce the Red / Amber / Green ('RAG') categorisation at a national level, within the Common Travel Area, with effect from 28th May 2021. Notwithstanding the move to national reporting, Officers continued to monitor case rates at a Lower Tier Local Authority ('LTLA') level and whilst the infection rates overall in England had been decreasing since the peak in January, a small number of LTLAs were experiencing high and increasing rates of the virus. During the week commencing 10th May, 200 LTLAs had seen decreases in cases, but in 116 LTLAs the numbers had increased, although it was noted that the majority were small fluctuations. In Bolton, Erewash, Blackburn with Darwen and Bedford there had been large increases, which resulted in the 14-day case rate, per 100,000 population, exceeding 120, thereby rendering them 'Red' should categorisation at LTLA levels for travel purposes continue, but noting that these increases would be effectively 'masked' under national reporting.

The Cell was informed that the Sanger Institute produced maps and graphs based on genomic surveillance of various variants, but the data reflected the situation several weeks previously. However, the reporting was undertaken at LTLA levels, which was of assistance. Dr. D. Robertson had produced graphs of the cumulative cases of COVID-19 variants, which clearly demonstrated the drastic uplift associated with the Indian VOC (B1.617.2) and which had surpassed the figures resulting from the South African VOC. The Cell noted a graph, produced by Public Health England, which set out the proportion of cases that had been sequenced in England from October 2020 through to May 2021. As the number of positive cases declined, so the percentage that were sequenced increased but it was noted that it could take between one and 2 weeks for the results to be forthcoming, which would impact the targeted surge testing. In May to-date, in excess of 40 areas in the UK had undergone surge testing, with all seeking to identify the South African VOC, but only the testing in Bolton had specifically targeted the Indian VOC. In Wandsworth and Lambeth, surge testing had been introduced on 12th May, due to the South African variant. However, whilst in excess of 40,000 of tests had been conducted, only a small number of VOCs or variants under investigation ('VUIs') had been identified and it was noted that a range of VOCs and VUIs had been encountered, not only the variant that had given rise to the surge testing. The Cell was informed that not all areas where surge testing was undertaken would be reported on the gov.uk website and might only be referenced in the local media, or on council websites, so it could be challenging to locate the information, but conversations had been held with Public Health England to ascertain what data could be made available locally. It was noted that surge testing was to be implemented on a more sophisticated basis by Public Health England, by considering community links with a view to identifying cases in a more targeted manner.

In considering whether an 'emergency brake' should be applied, the criteria for triage were that the area had a 14-day case notification rate that exceeded 120, that variants and mutations of the virus had been identified, which were being surge tested and where there were patterns of transmission deemed to be of concern to the Medical Officers of Health, or the public health team. A further risk assessment would then be conducted

of each area to provide further information for decision making Officers would continue to monitor rates at an LTLA level to ensure that any changing patterns were identified, would review notifications from Public Health England and other jurisdictions in respect of surge testing and the location of identified variants and would continually monitor professional networks to ascertain where patterns that caused concern were emerging internationally. As necessary, deep dives to gather evidence and assess risk would be undertaken and the evidence passed to the Medical Officers of Health for a decision on whether an area should continue to be monitored, or moved to a 'Red' category. Any such decision would be communicated to the Minister for Health and Social Services before wider distribution. Rather than introduce specific thresholds, it was intended that an adaptable approach should be adopted, mindful of the potential for things to change at pace.

The Cell was provided with a demonstration of a travel dashboard that was being developed to assist officers to undertake the relevant risk assessments. It would identify percentage changes in rates and case numbers over a period of time, allocating the RAG based on the 14-day rate and weekly changes. It would also reference the matrix employed by Public Health England and introduce data on vaccination coverage, which was available for most LTLAs, thereby furnishing a complete picture.

The Interim Director, Public Health Policy, indicated that the Indian VOC had caused officers' alert level to heighten and the vaccination programme in the UK was being reworked as a consequence thereof, as was also the situation locally. He envisaged that Competent Authorities would wish to receive advice from the Cell on the 'emergency brake' at some point during the current week, noting that it was currently a work in progress, but would probably result in a 'watch list' comprising LTLAs that fulfilled part of the aforementioned triage criteria. A decision could then be reached now, or after 28th May, whether to apply the 'emergency brake' thereto. It was possible that, by that juncture, one or more of the UK nations might have changed from Green to Amber. According to Public Health England, the Indian VOC had seeded in 150 areas of the UK so it was not possible to eliminate it, but its spread could be slowed in order for the vaccine programme to take effect.

The Consultant in Communicable Disease Control informed the Cell that the doubling time for the Indian VOC was currently around 7 days. It was distributed across the UK, with 30 per cent of instances occurring in London and cases had also been identified in France. It was envisaged that it would overtake and replace the Kent VOC in the same way that the latter had replaced the wild type. As at 12th May, the Indian VOC had been responsible for 4 deaths in the UK and its impact on hospitalisations and intensive treatment unit beds would come to light over the coming weeks. The severity of the impact of the virus increased with age and infection in younger individuals had the potential to transmit to those at greater risk, with disease occurring due to primary or secondary immune failure, or recipients not having been vaccinated. There was good evidence that the second dose of the vaccine was important to mitigate against the effect of the Indian VOC, so it was important to ensure Islanders over the age of 50 years received the same, in order to prevent mortality and morbidity in advance of that VOC potentially arriving in Jersey and he emphasised the importance of encouraging those who were vaccine hesitant to come forward. He suggested that initial thoughts around relaxing restrictions at the border might require reconsideration to enable the vulnerable to be vaccinated appropriately. The Interim Director, Public Health Policy, opined that, at the current time, focus was on the operation of the 'emergency brake' on a targeted basis. Arriving passengers would continue to be required to provide their 14 day travel history at a LTLA level and it had been anticipated that the 'emergency brake' might be applied to a small number of LTLAs, but if it emerged that it was necessary for a large number of local authorities, or the nations became Amber, then this raised more significant issues around the travel policy. Ministers had decided to introduce a scheme at a national level with the caveat that the 'emergency brake' might need to be applied

to certain LTLAs and the focus would be on drawing up a list of areas for which this might be necessary. Where an 'emergency brake' was introduced, that area would become Red and anyone with a travel history related thereto would be treated as a Red arrival.

In terms of encouraging eligible Islanders to take up the invitation to vaccination, the Chief Executive Officer, Influence at Work, indicated that a meeting of the Behavioural Science Design Group was scheduled for the afternoon of 17th May. Approximately 4,500 aged over 50 years, or deemed at high risk, had not yet received their first dose of the vaccine and he envisaged employing 2 strategies to encourage take up, namely a blanket approach and more personalised and tailored communications.

The Independent Advisor – Epidemiology and Public Health, referenced the results of an observational study of healthcare workers who reported to Indraprastha Apollo Hospital, New Delhi, which indicated that 2 doses of the vaccine afforded more than 97 per cent protection from infection and the hospitalisation rates for those that were fully vaccinated were extremely low *viz* 0.06 per cent, with similar reports in the UK media. It was important to be flexible in the thinking around the Indian VOC as the understanding in respect of the risk it posed was in its infancy. The Clinical Lead, Primary Care indicated that there was little data on the effectiveness of the vaccine against the Indian VOC, but from the 3 papers that were available, it appeared that the current vaccines were less effective against the same.

On the basis that clusters of infection appeared to emerge in communities with lower rates of vaccination coverage, the Independent Advisor – Epidemiology and Public Health, questioned whether there were specific areas in Jersey where there appeared to be greater vaccine hesitancy. He suggested that it was moot whether it was preferable to prioritise the second dose to those aged over 50 years, or to start vaccinating younger Islanders. He supported the approach taken towards the 'emergency brake' which was adaptable and flexible, but had concerns that it would not be deployed with sufficient alacrity.

Other members of the Cell agreed that it was important to be able to apply the 'emergency brake' extremely quickly. The Interim Director, Public Health Policy, informed the Cell that in the event of an 'emergency brake' being applied to an area, it would be necessary to give the public a degree of notice, so an announcement would be made and the area reclassified within a period of 24 to 48 hours. He confirmed that Competent Authority Ministers were in agreement with this proposal and he was confident that it was achievable, mindful that countries had been reclassified at short notice during an earlier phase in the pandemic.

The Cell accordingly agreed that there was concern around the Indian VOC and was in accord with the approach proposed by the JCVI to administer both doses of the vaccine to the most vulnerable as soon as practicable. The Cell strongly agreed that that the 'emergency brake' should be applied very quickly if required, which might result in a potential review of the travel policy, if numerous areas were to become Red.

Covid Status Certification – children and young people.

A4. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A4 of its meeting of 10th May 2021, recalled that it had been consulted on the status to be afforded to children and young people accompanying fully vaccinated adults, mindful that it was proposed that the adults would be afforded a 'green light' on arrival from Green or Amber areas due to their vaccination status and whilst required to undergo a PCR test on arrival, would not be mandated to self-isolate. The Cell had recommended that any policy relating to children should initially be for the Summer only, that it should be simple and consistent and that the views of the Children's Commissioner should be sought in respect thereof.

The Cell accordingly received and noted a PowerPoint presentation, dated 17th May 2021, entitled 'Children at the borders' and heard from a Senior Policy Officer, Strategic Policy, Planning and Performance Department in relation thereto. She reminded the Cell that, from 28th May, the Red / Amber / Green ('RAG') categorisation would remain for arrivals who were not fully vaccinated, with the attendant testing and self-isolation requirements. However, as aforementioned, for fully vaccinated travellers there would be a step down for arrivals from Amber and Green areas, with Red arrivals continuing to undertake 3 tests at days zero, 5 and 10 and being required to self-isolate until receipt of a negative result from the latter. The COVID-19 vaccine was currently not available to anyone under the age of 18 years and, as a consequence, they would be unable to achieve the 'green light' status independently and could continue to have a requirement for isolation. There were a number of available policy options, namely to link the status of all children to the adults in their party, or to differentiate between those aged under 11 years and those under 18; or to create a separate 'Children's Safer Travel Policy' either for all children or differentiating between the 2 age groups, or a combination of both. Under the third option, those children aged under 11 years would continue to have no requirement to register for travel, or to undergo testing on arrival and would follow the 'green light' of accompanying adults, if applicable. Those aged from 11 to 17 years would continue to register for travel, would be tested on days zero and 8 and be required to self-isolate until receipt of the first negative result, with a blanket Green policy applying if they had arrived from an Amber or Green area. Mindful that older children were more likely to socialise outside the household, it was suggested that this might be proportionate to the slightly increased risk posed by that age group. The Associate Medical Director for Primary Prevention and Intervention questioned why children under the age of 11 years did not undergo PCR testing on arrival, as they were swabbed when admitted to the paediatric ward in the Hospital. The Senior Policy Officer indicated that this had been considered, but was not deemed proportionate given the low level of risk they posed and it would not be supported by the Children's Commissioner.

The Cell was informed that, during 2019, travellers under the age of 25 had accounted for only 3.7 per cent of arriving passengers. Applying a step down from Amber to Green would only relate to between 10 and 20 per cent of those young people and there was no strong evidence that the virus was more prevalent in those aged under 18 years than the general population. Accordingly, this would result in minimal increased risk. The Cell was notified that the Children's Commissioner had been consulted on the proposals and was content that the views of children were being considered, that they wished to be kept safe from harm and that it was proportionate and pragmatic for there to be different proposals for young people aged 11 to 17 years and younger children in order to keep the Island safe.

It was noted that the communications associated with the different options had the potential to seem complex, depending on the age of the young person and the vaccination status of the adult they were accompanying. Having discussed the foregoing, the Cell agreed that any individuals aged under 18 years arriving from Green or Amber areas would be afforded a Green status, with Red arrivals continuing to be categorised as such. Any accompanied child aged under 11 years would be required to complete the most stringent isolation period of those they travelled with, noting that this could be a 'green light' status if applicable, but also cognisant of any household guidance, or policy relating to the schools policy that might be applicable. The Senior Policy Officer indicated that she would liaise with colleagues from the Communications Team in respect of the messaging.

Reconnection roadmap – Stage 7.

A5. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A6 of its meeting of 26th April 2020, 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 7 no earlier than 14th June 2021, at which juncture it was mooted that standing alcoholic drink service could resume, an unlimited number of people would be permitted in homes and gardens, nightclubs could fully reopen, to include dancing and larger indoor and outdoor events would be permitted, subject to case numbers and risk assessments.

The Cell accordingly received a PowerPoint presentation, dated 17th May 2021 and heard from the Head of Policy, Strategic Policy, Planning and Performance Department, who indicated that by permitting nightclubs to fully reopen on 14th June, with the attendant dancing, loud music, removal of masks and vertical drinking, higher risk events would be *de facto* permitted due to the shared characteristics. She explained the difference between the various local events, some of which required the permission of the Bailiff, whilst others required approval under legislation. Most events, however, required no permission. The Cell was shown a matrix, which had been drawn up by the World Health Organisation and modified for local use, which set out lower and higher risk events, noting that the latter were usually indoors, with people in close proximity, where there was loud music, queueing, security staff and the consumption of alcohol.

The Cell was informed that nightclubs and large events had the potential to become super-spreading settings, as had been experienced in Guernsey and India and mindful that the demographic that attended the former was less likely to have been vaccinated against COVID-19. A third wave of infection was anticipated in the United Kingdom ('UK') and the Variants of Concern ('VOCs') such as the Indian VOC could impact on the magnitude of that wave. Furthermore, there were significant contact tracing challenges associated with nightclubs and events, due the numbers attending, people moving in and out, lack of compliance with the provision of contact details and intoxication. The Cell was informed that, in contrast with Guernsey's stance, the Government's current position was to decline to publish details of locations linked to active cases and encourage any attendees at the event forward for testing. The Cell had received a copy of the letter that the Comité des Connétables had written to the Chief Minister, highlighting concerns around the ability to police larger events, noting that this was not a public health issue and did not fall within the remit of the Cell except where the Honorary Police was required to enforce legislation related to COVID-19. The Cell was informed that when events and nightclubs were permitted to re-open, guidance would be issued and additional measures could be implemented, to include testing using Lateral Flow Devices.

The Cell was presented with 3 options, either to proceed to Stage 7 as per the published roadmap on 14th June, to proceed to Stage 7 for lower risk events only (not including nightclubs) or to delay Stage 7 until 19th July, to enable more Islanders to be vaccinated and it was noted that the first dose would be offered to those aged from 18 to 24 years on 19th June. The Cell was also asked if the Government should publish a 'call for testing' in the media in the event of a positive case associated with a nightclub or event and whether an unlimited number of people should be permitted in homes and gardens at Stage 7 (14th June) or if that should be delayed.

The Independent Advisor – Epidemiology and Public Health was supportive of proceeding with Stage 7 of reconnection as planned. Whilst he accepted that nightclubs and larger events could lead to spread of the virus, he repeated the view that household mixing was also a vector of transmission and didn't believe that a significant risk was posed to the health of the Island. The Consultant in Communicable Disease Control suggested that any decision reached should be subject to the evolving situation around the Indian VOC between the current time and 14th June, as it was not possible to foresee what impact it could have. There would be benefit in more people receiving the vaccine before further relaxing measures and he suggested that it might be preferable to only permit lower risk events from Stage 7. The Interim Director, Public Health Policy, indicated that proceeding to Stage 7 on 14th June was the current policy position and it

was important that anyone organising an event over the Summer did not perceive the roadmap as a guarantee that the event could proceed, mindful that the it was not yet known how the Indian VOC would develop. His preference was to indicate to Competent Authority Ministers that the Cell was continuing to monitor the situation and that advice might change at pace, depending on the situation.

The Cell agreed to advise moving to Stage 7 on 14th June, subject to ongoing monitoring and with the caveat that the advice could change rapidly. It also agreed to recommend to Ministers that the media should be used to call people for testing if there was a positive case linked to a nightclub or event and further recommended that from Stage 7 an unlimited number of people should be permitted in households and gardens.

Masks.

A6. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A4 of its meeting of 26th April 2021, recalled that it had discussed the wearing of masks and their role in preventing the airborne transmission of COVID-19 and received a PowerPoint presentation, dated 17th May 2021, in relation thereto.

The Cell was reminded by the Head of Policy, Strategic Policy, Planning and Performance Department, that the wearing of masks was required by legislative Order in indoor public places and were required in guidance in communal areas of schools. The relevant Order was due to expire on 31st May and the Minister for Health and Social Services had sought the advice of the Cell on whether the wearing of masks should no longer be mandated from 31st May to align with the expiry of the Order, or at Stage 7 of the reconnection roadmap to coincide with the reintroduction of vertical drinking, thereby negating masks in hospitality settings, or be retained beyond those dates.

The Cell recalled that mask wearing was recommended by Public Health England, the World Health Organisation and the European Centre for Disease Prevention and Control as a key non-pharmaceutical intervention ('NPI') that had a high impact on the disease, low societal impact and posed a low risk of harm to individuals. It was suggested that the removal of the requirement to wear masks before Stage 7 of reconnection would signal a 'return to normal' and potentially impact Islanders' behaviours and adherence to other NPIs.

The Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, opined that Ministers should continue to follow the published roadmap and that the wearing of masks afforded some level of protection that should be maintained at the current time. He suggested that the Cell could consider at a future meeting whether they should continue to be worn beyond Stage 7, particularly against a backdrop of the emerging risks posed by the Indian Variant of Concern ('VOC'). This was a view shared by the Consultant in Communicable Disease Control, who suggested that it could be difficult to persuade people to start wearing masks again at a later juncture if they were no longer mandated after 31st May. The Independent Advisor – Epidemiology and Public Health, disagreed. In his view, the highest risk of transmission of the virus was in households, where masks were not worn. He indicated that masks had zero protective effect because there was no evidence of community transmission of COVID-19 at the current time and opined that the public were sufficiently intelligent to understand when there was a need to wear them and not. Continuing a blanket mandate could lead to increased frustration and he stated that it could be considered patronising to suggest that people would not start wearing masks again at a future date if so required. He agreed, however, that they should be worn in health and care settings, in the Prison, at the airport and potentially in care homes. Rather than enforcing the wearing of masks, he would prefer for Government to strongly recommend the same in guidance.

The Chief Executive Officer, Influence at Work, informed the Cell that whilst people

were still required to wear masks it was a signal that some potential risks remained from COVID-19. Moreover, unlike other NPIs, they represented a decision that Islanders could take full responsibility for. Whilst an individual could not prevent someone else from standing within one metre of them, they could take the active decision to wear a mask and there was evidence from some Asian countries that, following a pandemic, this was an NPI that was most likely to be adhered to after infection rates had diminished. As to whether it would be a challenge to reinstate the requirement to wear masks if this had been discontinued, the evidence was mixed and he was unable to provide a definitive answer.

Noting that there was no consensus of views within the Cell on this subject, the Chair indicated that it would be necessary to present the arguments for and against to Competent Authority Ministers.

Matters for information.

A7. In association with Minute No. A2 of the current meeting, the Scientific and Technical Advisory Cell ('the Cell') received and noted the following –

- a weekly epidemiological report, dated 13th May 2021, which had been prepared by the Strategic Policy, Planning and Performance Department;
- statistics relating to deaths registered in Jersey, dated 13th May 2021, which had been compiled by the Office of the Superintendent Registrar; and
- a report on vaccination coverage by priority groups, dated 6th May 2021, which had been prepared by the Strategic Policy, Planning and Performance Department.

It was noted that the agenda items relating to the Covid Status verification and an analysis of the feasibility of exit testing would be carried forward to the next formal meeting of the Cell, as it had not been possible to discuss them at the current meeting.