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SCIENTIFIC AND TECHNICAL ADVISORY CELL

(86th Meeting)

(Business conducted via Microsoft Teams)10th January 2022**PART A (Non-Exempt)**

All members were present, with the exception of Ms. B. Sherrington, Senior Nurse Adviser in Public Health and Dr. M. Doyle, Clinical Lead, Primary Care, from whom apologies had been received.

Professor P. Bradley, Director of Public Health (Chair)
 Dr. I. Muscat, MBE, Consultant in Communicable Disease Control
 Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention
 Dr. G. Root, Independent Advisor - Epidemiology and Public 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
 M. Clarke, Head of Public Health Intelligence, Strategic Policy, Planning and Performance Department
 Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department

In attendance -

B. Edwards, Head of Health Informatics, Health and Community Services (for Item A6 only)
 J. Mason, General Manager, Health and Community Services
 E. Baker, Head of Vaccination Programme, Strategic Policy, Planning and Performance Department
 R. Williams, Director, Testing and Tracing, Strategic Policy, Planning and Performance Department
 J. Lynch, Principal Policy Officer, Strategic Policy, Planning and Performance Department
 Dr. L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department
 R. Corrigan, Director General, Economy (for a time)
 K. Briden, Acting Director General, Justice and Home Affairs Department (for a time)
 S. Martin, Chief Executive Officer, Influence at Work
 S. White, Head of Communications, Public Health
 L. Plumley, Secretariat Officer, States Greffe

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

Intelligence overview,

A1. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of its meeting of 5th January 2022, received a PowerPoint

including
Analytical Cell
update and
HCS activity.

presentation, entitled 'STAC Monitoring Update', dated 10th January 2022, which had been prepared by Ms. M. Clarke, Head of Public Health Intelligence and Dr. L. Daniels, Senior Informatics Analyst, both of the Strategic Policy, Planning and Performance Department.

The Cell was apprised of the current situation with regards to public health monitoring, noting that as at Friday 7th January 2022, there were 4,137 active cases of COVID-19 recorded in the Island, from which 3,299 direct contacts had been identified. The majority of cases continued to be in those of working age, with those aged 20 to 30 years making up the highest proportion, followed by those aged 30 to 39 years, along with an increasing number of cases in those aged under 20 years. Seeking healthcare was the most common reason for testing, accounting for 1,896 cases; 1,574 had been identified through Lateral Flow Tests ('LFT'); 228 through contact tracing; 223 through arrivals screening and the remainder through various screening programmes. It was noted that the number of cases identified through contact tracing was decreasing following a change in testing policy. The age ranges, gender and vaccination status of the active cases were shown.

Around 2,000 tests were being undertaken on a daily basis and an average of 463 cases per day had been identified since 25th December 2021, which represented a significant increase over the course of December 2021. The daily incidence rate had reached 600 on one occasion during the previous week, a figure that was significantly higher than that observed during the peak of the 'third wave' in July 2021.

The overall test positivity rate had increased to 31 per cent and the Island rate (excluding inbound travel) to 36 per cent. The 7-day case rate per 100,000 population had decreased slightly for those aged 18 to 39 years, however was still high at 4,852, and the rate for those aged over 60 years, which had been increasing, now appeared to be slowing down and stood at 1,755, with a similar pattern observed for the 7-day case rate in those aged 40 to 59 years. The rate for those aged under 18 years had reached a similar level to that seen during the peak of the third wave in July 2021.

The Cell reviewed the clinical status, age range and vaccination status of cases in hospital since 28th June 2021 and noted that as at the beginning of the day on 10th January 2022, there were 20 patients in the Hospital with COVID-19, a figure which had increased to 23 at the present time. A number of cases in care homes were noted.

The Cell was provided with an update on Hospital capacity which confirmed that safe levels of staffing and care were being maintained and that there was sufficient capacity at the present time, however it was noted that there continued to be several medically fit COVID-19 patients who were unable to be discharged to care settings until their isolation periods had been completed. The Cell was informed that there had been an increase in COVID-19 cases noted at the Hospital over the weekend of 8th and 9th January 2022, which had been identified through patient screening, and which was associated with a small number of visitors who had attended whilst symptomatic.

Details were provided of the positive cases linked to health and care settings, Government departments and schools, where an increase in cases had been observed since the start of term on 4th January 2022. It was noted that 990 positive LFT results had been reported as part of the schools LFT programme during the period from 6th September 2021 to 9th January 2022.

A further death had been recorded, bringing the total to 90, with 12 registered since

the start of the 4th wave on 1st October 2021.

The Cell was informed that the number of inbound travellers had increased to over 10,000 arrivals for the week commencing 27th December 2021, with 126 positive cases identified, equating to a test positivity rate of 6 per cent.

During the week ending 2nd January 2022, Jersey's testing rate, per 100,000 population, had been 9,900, compared to the United Kingdom ('UK') rate of 14,750, which included LFTs. The test positivity rate locally had remained at 24.8 per cent compared to a slight increase to 12.6 per cent in the UK. A member of the Cell noted the significant difference in test positivity figures and queried whether they were measured consistently in both jurisdictions. The Cell was informed that the inclusion of LFTs in the UK figures accounted for a measure of comparative inflation in the local figures, as people who had a positive LFT test result (which were not included in the Jersey figures) were more likely to subsequently receive a positive PCR test result, which was borne out in the Jersey figures.

The Cell noted that 322 patients were currently recorded in the EMIS clinical IT system as suffering from 'Long Covid'.

The Cell was apprised of the current situation with regards to Primary Care, noting that a number of General Practitioners and staff were absent due to COVID-19 and that practices were being supported to enable continued service provision.

It was noted that footfall in St. Helier had not returned to pre-pandemic levels, but was higher than it had been in 2020, whilst traffic levels and bus use displayed a similar pattern.

The Cell was apprised of the results of social media sentiment analysis, noting queries around whether fourth booster doses would be rolled out more widely, debate regarding the appropriate technique for LFT swabbing, demands for air filtration and monitoring units to be used in schools, concern about the Hospital and requests for further information about hospitalised cases. A member of the Cell noted that the ability to travel appeared to be a key driver for vaccination uptake and expressed an opinion in favour of charging for COVID-19 testing at the border.

Details regarding the COVID-19 vaccine programme were shared and it was noted that as at 2nd January 2022, 211,427 doses had been administered, of which 52,744 were third 'booster' doses, with high rates of coverage in older age groups and increasing uptake rates across younger eligible populations. It was estimated that 77 per cent of care home residents, 72 per cent of carers working in care homes and 75 per cent of front-line health and social workers had received a booster vaccination, though it was noted that the assessments were coded Red or Amber due to questionable or moderate data quality.

Overall, as at 2nd January 2022, it was estimated that 62 per cent of adults in Jersey had received a booster dose, which compared favourably with the UK rate of 60 per cent. It was recalled that a slowing down in the uptake of the booster vaccine had been observed over the last few weeks both in Jersey and in the UK.

The Cell was informed that over 42,000 flu vaccines had been administered and given the high levels of coverage that had been achieved in older age groups, weekly reporting of this data to the Cell would cease, though monthly internal reporting would continue, and a report would be provided at the end of the Winter flu season.

The Cell was apprised of the situation in UK, noting that over the 7 days to 9th

January 2022, cases had increased by 6 per cent, hospitalisations by 57 per cent and deaths by 30 per cent. The 14-day case rate per 100,000 population ranged from 2,806 in Scotland to 3,405 in Northern Ireland, whilst the rate in Jersey was presently 5,120. In London, cases appeared to be plateauing and had decreased in those aged up to 59 years, and there were early indications of a slowing down in case rates in those aged over 60 years. It was noted that the number of COVID-19 patients in mechanical ventilation beds in London had not increased at the same pace as case numbers over the previous 6 weeks.

A member of the Cell noted that the data from London appeared to show early indications of a plateauing in case numbers, however another member noted that the most recent figures remained provisional due to reporting delays from certain NHS Trusts, so it was too early to conclude that a similar pattern might emerge in Jersey in the coming weeks, assuming that there was a 2-to-3-week lag in infection levels locally compared to London. A third member expressed optimism regarding the London data, noting that transmission there appeared to be declining, in a similar pattern to that which had been seen in the Gauteng province and in South Africa as a whole. The member opined that Jersey was 1 to 2 weeks behind London in terms of infection levels, and therefore expected local transmission levels to begin to fall shortly. A member noted that it would be helpful for primary care to be apprised of developments for operational planning purposes.

Summarising, the Chair noted that despite high rates of infection, levels of severe illness had not occurred to the same degree as they had in previous waves and given the possibility that cases were beginning to plateau in London, some members of the Cell had reason to cautiously believe that a similar pattern might emerge locally, based on the assumption that case levels in Jersey were lagging behind those in London by a matter of weeks.

The Cell noted the position and thanked Ms. Clarke and Dr. Daniels for the update.

Omicron
update.

A2. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A3 of its meeting of 5th January 2022, noted that the 'UK Health Security Agency Risk Assessment' for the Omicron variant, dated 22nd December 2021, was still current and that an update was expected to be issued shortly. It was recalled, with to the 'UK Health Security Agency Technical briefing: Update on hospitalisation and vaccine effectiveness for Omicron', dated 31st December 2021, that Omicron was estimated to be responsible for 95 per cent of cases in the United Kingdom ('UK') overall.

The Cell noted the position.

Critical
services
update.

A3. The Scientific and Technical Advisory Cell ('the Cell') with reference to Minute No. A4 of its meeting of 29th December 2021, heard from Ms. K. Briden, Acting Director General, Justice and Home Affairs Department, in respect of the current levels of resilience within the Island.

The Cell was informed that the Strategic Co-ordination Group ('SCG') had been convened on 5th January 2022 and reported that although COVID-19 related absence levels had reached around 10 per cent across all organisations, they remained resilient and able to cope. SCG meetings would be held on a weekly basis going forwards and regular updates would be provided to the Cell.

The Cell noted the position and thanked Ms. Briden for the update.

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Testing and
Tracing
update.

A4. The Scientific and Technical Advisory Cell received a presentation, dated 8th January 2022, entitled 'Contact Tracing – Update and Review', which had been prepared by Ms. R. Williams, Director, Testing and Tracing, and Mr. J. Lynch, Principal Policy Officer, both of the Strategic Policy, Planning and Performance Department and heard from them in connexion therewith.

The Cell was apprised of the current contact tracing context, namely an environment with high prevalence and community transmission of COVID-19. In response, the Covid Safe Team had prioritised their workload and were making focused contact tracing calls. The Cell was informed that, given the high levels of public awareness around COVID-19 and the move towards self-administered testing via Lateral Flow Tests ('LFTs'), it was apt to review the focus and priorities of the Covid Safe Team in the coming weeks. It was noted that a number of other jurisdictions had begun reconsidering their approach, including Ireland, which was moving away from individualised contact tracing.

The Cell noted that all positive cases received a telephone call from the contact tracing team, which often prompted individuals to recall people they had been in contact with and places they had been to, thus allowing for clusters to be identified and for the Covid Safe team to undertake visits to locations where improvements in practice could help to keep staff and customers safe. The Director of the Testing and Tracing team was of the view that the Covid Safe team continued to perform a valuable role and from a business continuity and resilience perspective, contributed to helping slow down the transmission of COVID-19 by addressing some of the reasons for the development of clusters.

Operational changes had been made within the team to increase productivity, the details of which were shared, and which had enabled the team to make calls to 600 positive cases on Sunday 9th January 2022. It was noted that the recent changes to the isolation policy had created additional short-term work and resulted in the need for the team to quickly make adjustments in practice, but once the changes were embedded, processes were automated which improved productivity in the long run. Routine booking of Polymerase Chain Reaction ('PCR') tests for direct contacts had recently ceased in response to the change in policy. In addition, the online portal had been updated to enable self-booking of tests including for people who tested positive on LFTs. Whilst positive cases were encouraged to notify their direct contacts themselves if possible, the Covid Safe team was able to notify direct contacts in the event that an individual did not wish to do so themselves, thus allowing confidentiality to be maintained.

It was recalled that the original purpose of contact tracing had been to reduce the spread of infection by breaking the chain of transmission, and it had been particularly effective in the early days of the Delta variant. Contact tracing enabled a degree of smoothing in terms of spikes of infection and helped to maintain resilience in the Island. The Cell was asked to consider the operation of the contact tracing service given the current infection context, focussing on the following points: a move to individual responsibility, increased automation and refocusing Covid Safe resources. The Chair thanked Ms. Williams and Mr. Lynch for the update and views from Cell members were sought.

A Cell member thanked the team for opening a conversation about the role of contact tracing in the current context, noting the need for evidence and an options paper to be presented to the Cell in due course. The member noted that the situation had changed since the contact tracing team was set up and praised the team for coping

with and adjusting to the pressures caused by the current wave of infection. Given the relatively high level of protection afforded by vaccination and the reduced severity of the Omicron variant in terms of severe disease, the member anticipated that a downshift in contact tracing would take place in the near future, though was cognisant of the increased infectiousness of the variant, which the Cell would need to weigh up when presented with an options paper. The member noted that the discussion was likely to encompass wider considerations in light of the move towards increased individual responsibility, including a potential review of the standing of legally mandated isolation requirements.

The work of the contact tracing team in what was clearly a difficult situation was recognised by another member of the Cell, who also noted the change in context. Observing that during periods of low infection levels, contact tracing was effective in slowing transmission levels, the member opined that this was not the case in the current environment of high prevalence and transmission, which combined with Omicron's shorter incubation period, reduced the potential for contact tracing to significantly impact transmission in the Island. Whilst there was a need for resilience and to maintain the ability to increase contact tracing efforts should future circumstances warrant it, the member favoured actions that would have a demonstrable effect on transmission in the current context. The member agreed that the Cell should review the contact tracing policy as a matter of priority.

A third member agreed with this sentiment, noting that contact tracing could be powerful when infection levels were low, if connected with mandatory isolation. In the present situation, the member opined that high levels of prevalence precluded contact tracing from effectively reducing transmission.

A fourth member concurred and whilst commending the team for their hard work and success, agreed that a downshift in contact tracing was likely, given the current context. The member noted that the team's skills and experience should be preserved and the capability to rapidly ramp up contact tracing should form part of the Government's resilience and emergency planning.

Summarising, the Chair noted the Cell's appreciation of the work undertaken by the contact tracing team and requested that a paper be presented to the Cell at its next meeting, in connexion with a review of contact tracing policy, given the high levels of infection currently being experienced in the Island.

Vaccination
update.

A5. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A5 of its meeting of 5th January 2022, received a PowerPoint presentation, entitled 'COVID-19 Vaccination Programme, Update to STAC/CAM' dated 10th January 2022 which had been prepared by Ms. E. Baker, Head of Vaccination Programme, Health and Community Services.

The Cell was informed of the progress of the COVID-19 vaccination programme, noting that as at 10th January 2022, an estimated 64 per cent of Islanders over the age of 18 had received a COVID-19 booster dose vaccine and the uptake rate amongst those eligible, namely those aged over 18 who were double vaccinated (74,634 individuals), was 74 per cent.

It was recalled that the booster uptake rate had slowed down in recent weeks, both locally and in the United Kingdom ('UK') and the Cell was apprised of the actions being taken to address this matter, which included a refreshed communications campaign and a review of operational delivery plans and resilience planning. Walk-in vaccination appointments were now available and accounted for around 20 per

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cent of vaccinations delivered over the previous week.

Current priorities for the vaccination programme included increasing vaccination rates in those aged over 18, health care workers and those aged 12 to 17 years as well as operational planning for the delivery of vaccines to ‘at risk’ children aged 5 to 11 years, in conjunction with the Children, Young People, Education and Skills Department and the Children’s Commissioner.

A member of the Cell recalled, with reference to Minute No. A5 of the extant meeting, that 77 per cent of care home residents had received a booster vaccination and asked whether additional efforts were being made to reach them given their increased risk of severe disease and mortality. The Cell was informed that work was ongoing in relation to the data upon which this figure was based, which was currently rated ‘red’ as a result of poor or questionable data quality, either due to quality of the vaccine or population data. In reality, it was likely that the outstanding population was lower than the 23 per cent suggested. In addition, it was noted that the vaccination team was undertaking repeat visits to care homes to ensure that residents with a recent history of COVID-19 infection could be offered booster vaccinations after the appropriate interval of time following infection had elapsed.

A member of the Cell requested further details regarding the booster uptake rate amongst Hospital staff and was informed by another member that this request would be progressed with the dedicated lead in Health and Community Services.

Vaccination
status of
hospitalised
patients.

A6. The Scientific and Technical Advisory Cell (‘the Cell’), with reference to Minute No. A2 of its meeting of 5th January 2022, received a presentation dated 10th January 2022, entitled ‘Update on Vaccine Status of COVID hospitalisations’, which had been prepared by Ms. M. Clarke, Head of Public Health Intelligence, Strategic Policy, Planning and Performance Department and Ms. B. Edwards, Head of Health Informatics, Health and Community Services, and heard from them in connexion therewith.

It was recalled that a local report regarding the vaccination status of positive cases had been published by the Government on 7th January 2022, which showed that between July to November 2021, unvaccinated people were more likely to test positive for COVID-19 than those who had received vaccination. There was continuing, significant public demand for further data, specifically regarding the vaccination status of patients in Hospital with COVID-19. A sub-group of the Cell had been convened and was meeting regularly to discuss the feasibility of and methodology for publication of such information, the principal issues being data quality, data validation and the need to ensure patient confidentiality.

The Cell was informed that potential data sources, issues and ways of reporting had been explored and that meetings had been held with Health and Community Services (‘HCS’) and Data Governance to discuss the same. Investigations into the data quality of the available data had revealed a need for additional data validation work and there was agreement within the sub-group and with HCS that the data was not yet of suitable quality to provide analysis, so an action plan had been developed to progress the work. HCS would need to review the Infection Prevention and Control dataset to validate clinical COVID-19 status and ensure that status on admission was available; match this data to the vaccine records in EMIS; complete HCS governance processes; analyse the data and draft a report which clearly articulated the context, caveats and expectations. HCS would be advising Competent Authorities Ministers (‘CAM’) of the timeline for completing the report in due course.

A member of the Cell expressed disappointment at the rate at which the work was progressing, given what was known with regards to vaccine effectiveness. The member was concerned that the delay in presenting the data to the public would fuel misinformation and mistrust and asked whether it would be possible to share real life stories in the interim, to demonstrate that vaccination prevented severe disease and hospitalisation. Another member agreed and asked whether UK data could be used to emphasise the benefits of vaccination. The member noted that an update would be provided to CAM later in the week, setting out the direction of travel and that Ministerial interest in the matter was high.

A third member of the Cell agreed with comments that the benefits of vaccination needed to be re-enforced, if necessary using data from other countries and noted that the aforementioned report regarding the vaccination status of positive cases was very helpful and directly relevant to Jersey. Individual stories could supplement and add to this, however the member opined that there was a definite benefit from understanding the effect of vaccination in the local community. The member approved of the work being undertaken with regards to the Jersey data and noted a degree of concern with regards to the timeline, given the high level of public and political interest in the matter. A fourth member concurred and noted that people tended to be more persuaded by local stories. Another member commented that the presentation to CAM ought to include further detail regarding the timeline, which officers undertook to address. An observer noted that the outcome of the work would result in the release of data that was aggregated over a number of months due to the need to ensure patient confidentiality, so there was a risk that it would not be perceived as answering the public call for immediate, real time information on hospitalised patients, which it was not possible to provide for the reason detailed above.

Summarising, the Chair noted that the members of the Cell recognised the issues with the quality of the underlying data and the potential for disclosure of confidential information, both of which needed to be addressed before the information could be published as originally envisaged. There was a consensus amongst the members of the Cell that the proposal should be finalised and presented to CAM and that it was desirable for additional measures to be taken forward to reinforce the importance of vaccination.

Isolation
policy.

A7. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A6 of its meeting of 29th December 2021, received and noted a paper, dated 7th January 2022, entitled 'Restricted Isolation Release ('RIR') – Critical Workers', and heard from Mr. A. Khaldi, Interim Director, Public Health Policy, and Mr. J. Lynch, Principal Policy Officer, both of the Strategic Policy, Planning and Performance Department, in connexion therewith.

It was recalled that on 30th December 2021, Competent Authorities Ministers ('CAM') had agreed, with immediate effect, that the mandatory self-isolation period be reduced from 10 to 7 days, contingent on certain requirements being met, which included individuals being fully vaccinated, symptom free for 48 hours and evidencing 2 negative Lateral Flow Test ('LFT') results, with the first LFT not to be taken before the sixth day.

The Cell was apprised of a draft policy that had been prepared, which would allow for the variation of isolation requirements for staff working in critical infrastructure and Government of Jersey essential services. In order to maintain minimum safe service delivery across these areas, it could become necessary to invoke contingency arrangements due to the increasing disruption caused by rising infection rates and

increasing levels of staff absence through illness and/or mandatory isolation periods following confirmed infection. A policy framework was outlined by which decisions and arrangements for the restricted release of critical workers could be coordinated. A process was proposed, through which the Directors of Government departments or critical service providers could apply to the Director General of the Justice and Home Affairs for a variation on an individual or group/cohort basis. Approval decisions would be reviewed on a fortnightly basis with the assumption that RIR permissions would be revoked at the earliest possible opportunity. Requests would only be considered if a number of conditions were met, including a credible risk of serious harm to the person or risk of failure of an essential service due to staff absence; the critical worker being symptom free for a minimum 24 hours; the worker's physical presence being required in the workplace; all alternative continuity arrangements having been explored and exhausted; the worker attending the workplace for the least amount of time necessary to complete the minimum required work; the release from isolation only applying to the period of work; at all other times the person would have to adhere to standard isolation guidance until the mandatory period was completed and the completion of a risk assessment and mitigations which minimised the risk of onward transmission while in the workplace and travelling.

A 3-tier process was proposed, with different release criteria depending on the impact and imminence of the risk occurring. It was envisaged that the highest level of risk would include where failure to release a uniquely skilled worker to perform an essential role or as an emergency response would result in immediate harm to others or the critical failure of an essential Government service, and the risk of onward transmission of COVID-19 was assessed as a substantially lesser risk of harm than failure to release from isolation. In such high-risk instances, the release criteria would include no minimum time since symptom onset or positive test for asymptomatic cases, and no release testing, whereas for medium risk situations, a minimum 5-day period and a negative LFT would be required. Example scenarios were provided to illustrate the situations in which RIR would be considered.

The Cell was informed that the policy had been formulated in anticipation of disruption to service resilience due to rising infection rates and to ensure that a framework was in place to respond if necessary. It was proposed to present the policy to CAM for consideration shortly and the Cell was asked to provide comments on the draft policy.

A member of the Cell observed that the interplay between individual requirements and the application process at group level would benefit from clarification. In response to a question, it was confirmed that the policy would be applicable to Health and Community Services staff, would be outlined in the final document.

Another member of the Cell felt that the process ought to be simplified and, given the widespread levels of transmission in the Island, that the Cell should consider a reduction in mandatory self-isolation for all fully vaccinated individuals from 7 to 5 days. It was recalled that work was currently underway in connexion with this matter and that a paper on the topic would be presented to the Cell at its next meeting. The member re-iterated their support for a further reduction in the self-isolation period and questioned the necessity for asymptomatic individuals to self-isolate at all, as well as the rationale for excluding the private sector from the RIR policy. It would be simpler, in their view, to reduce the isolation period for all rather than complicating the situation further. One of the other members cautioned against this perspective, noting that it could have unintended consequences, citing the example of General Practitioners who had been advised that they would not be covered by their indemnity insurance in such circumstances. In addition, there was likely to be

a public backlash if people who tested positive for COVID-19 were allowed to circulate freely with no restrictions at the present time, given the risk of infectiousness and high case levels.

Another member noted that jurisdictions where mandatory self-isolation had been reduced to 5 days had done so due to critical infrastructure and essential services reaching breaking point. Given that peak infectiousness occurred between 3 and 6 days after exposure to the virus, reducing the self-isolation period to 5 days would, in their view, risk increasing case numbers. The member also noted that the majority of cases (60 to 70 per cent) were symptomatic and therefore may not be ready or able to return to work after 5 days, however the member recognised the need to have in place a mechanism to release critical workers from isolation if necessary.

The Cell was informed that time was of the essence and it would be desirable for CAM to consider the policy for implementation at its meeting that week, although its operation could be short lived, were it to be superseded by the outcome of the review of the reduction of the isolation period more widely to 5 days, which the Cell would be considering at its next meeting.

A member of the Cell commented that the policy should outline the current context, namely high vaccination coverage and the relatively low case fatality rate of the dominant Omicron variant. Another member noted the need for an interim arrangement to be put in place to ensure that resilience could be maintained whilst the wider review of isolation requirements was being undertaken.

Another member of the Cell noted that the policy should be simple to understand and implement. The member suggested that the final policy be drafted with this in mind, ensuring that requirements were clearly set out and easy to understand, for example it should define more precisely when the 5-day minimum isolation period for medium and medium high-risk situations would begin.

Summarising, the Chair noted that on the balance of risks, the members of the Cell supported the proposed RIR policy, although it would benefit from simplification and clarification; requested that an update on the details of the implementation of the policy be provided in due course and noted that the Cell would review the evidence for a further reduction to the mandatory self-isolation period at its next meeting.

Matters for
information.

A8. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A1 of the current meeting, received and noted the following –

- a weekly epidemiological report, dated 6th January 2022, which had been prepared by the Strategic Policy, Planning and Performance Department;
- statistics relating to deaths registered in Jersey, dated 7th January 2022, which had been compiled by the Office of the Superintendent Registrar;
- a report on COVID-19 vaccination coverage by priority groups, dated 6th January 2022, which had been prepared by the Strategic Policy, Planning and Performance Department; and
- a report on Flu vaccination coverage by priority groups, dated 6th January 2022, which had been prepared by the Strategic Policy, Planning and Performance Department.

There being no further business to discuss, the meeting was concluded at 12.45pm.