

KS

SCIENTIFIC AND TECHNICAL ADVISORY CELL

(51st Meeting)

15th March 2021

(Meeting conducted via Microsoft Teams)

PART A (Non-Exempt)

All members were present, with the exception of C. Folarin, Interim Director of Public Health Practice, R. Naylor, Chief Nurse, Dr. M. Patil, Associate Medical Director for Women and Children 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) (for items A1 – A4 only)
 Dr. I. Muscat, MBE, Consultant in Communicable Disease Control (Acting Chair for item A5)
 Dr. G. Root, Independent Advisor - Epidemiology and Public Health
 R. Sainsbury, Managing Director, Jersey General Hospital
 Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention
 Dr. S. Chapman, Associate Medical Director for Unscheduled Secondary Care
 Dr. M. Garcia, Associate Medical Director for Mental Health
 S. Petrie, Environmental Health Consultant
 A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department
 I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department (for items A1 – A4 only)
 N. Vaughan, Chief Economic Advisor

In attendance -

J. Blazeby, Director General, Justice and Home Affairs Department (for items A1 – A4 only)
 R. Corrigan, Acting Director General, Economy
 D. Danino-Forsyth, Director of Communications, Office of the Chief Executive
 S. Martin, Chief Executive Officer, Influence at Work
 M. Knight, Head of Public Health Policy
 B. Sherrington, Head of Policy (Shielding Workstream) and Head of the Vaccine Programme, Strategic Policy, Planning and Performance Department (for items A1 – A4 only)
 R. Johnson, Head of Policy, Strategic Policy, Planning and Performance Department
 S. White, Head of Communications, Public Health
 J. Lynch, Policy Principal, Strategic Policy, Planning and Performance Department
 M. Clarke, Principal Officer, Public Health Intelligence, Strategic Policy, Planning and Performance Department
 L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department

Dr. C. Newman, Senior Policy Officer, Public Health and Wellbeing,
Strategic Policy, Planning and Performance Department
Dr. N. Kemp, Interim 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.

Minutes. A1. It was noted that the Minutes of the meeting of the Scientific and Technical Advisory Cell ('the Cell'), which had been held on 8th March 2021, had previously been circulated and Members were requested to provide any feedback thereon to the Secretariat Officer, States Greffe, by the end of 15th March 2021, in the absence of which they would be taken to have been confirmed.

In response to a request, which had been made at the previous meeting by the Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, that the Minutes should have an action list appended, the Chair agreed and requested that this should be the responsibility of the Executive Assistant, Office of the Medical Officer of Health.

Monitoring Metrics. A2. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of its meeting of 8th March 2021, received and noted a PowerPoint presentation, dated 15th March 2021, entitled 'STAC Monitoring Update' which had been prepared by the Principal Officer, Public Health Intelligence and the Public Health Analyst, Strategic Policy, Planning and Performance and initially heard from the former in relation thereto.

The Cell was informed that, as at Friday 12th March 2021, there had been 4 active cases of COVID-19 in Jersey and the 14-day rate, per 100,000 population, had been 6.49. Of the active cases, 2 had been identified through planned workforce screening and 2 as a result of arrivals testing. Only one was experiencing symptoms of the virus and it remained the situation that most active cases (3) were in people of working age and there was just one case in an Islander aged over 70 years. Positive cases were arising on a sporadic basis and, since 17th February 2021, the daily average had been below one. During the week commencing 8th March, there had been a high number of tests undertaken on the Monday, with fluctuating levels throughout the remainder of the week, averaging approximately 1,000 tests on weekdays.

With regard to the number of daily cases of COVID-19, the number of tests and the test positivity rates for various age groups, it was noted that the test positivity rate remained significantly below one per cent for all, including those aged over 70 years. There was currently nobody in the General Hospital with the virus and the admission rates remained extremely low. There had been no deaths, with COVID-19 referenced on the death certificate, since the last meeting. 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 12th March 2021 and was informed that work continued to correct the data included therein, but that the number of calls to the Helpline during the previous week had reduced. The number of inbound travellers remained low but, as aforementioned, 2 of the active cases had been encountered at the borders.

During the week ending 7th March, there had been 1,230 tests on inbound travellers, 4,670 as part of on-Island surveillance and 240 on people seeking healthcare. The weekly test positivity rate locally remained at 0.1 per cent and had decreased to 0.8 per cent in the UK. As at the same date, the local weekly testing rate, per 100,000 population, had been 5,600 and in the United Kingdom ('UK') had been 8,211, mindful

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that that jurisdiction included tests undertaken on Lateral Flow Devices ('LFDs'). The Principal Officer, Public Health Intelligence, informed the Cell that the test positivity rate, as at the date of the meeting, was zero. There were so few cases that the statistical model was unable to calculate the estimated effective reproduction number (R_t) in Jersey. However, it would continue to be monitored internally and reporting would recommence should case numbers increase to a level sufficient to produce an estimate.

The Cell was informed that attendance at Government primary schools during the week commencing 8th March had averaged 96.7 per cent and 93 per cent at secondary schools and that, in all settings, absences related to COVID-19 had been approximately 0.1 per cent. There had been no positive cases in students since 22nd 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 there had been a number of inconclusive results and 3 positive results from LFD tests, which had subsequently been shown to be 'false positives' when the relevant individuals had been tested using a PCR swab. In excess of 9,000 LFD tests had been carried out.

The Cell was shown the published data, to 7th March 2021, in respect of COVID-19 vaccinations in Jersey and was provided with indicative data – subject to verification – that as at 14th March, a total of just under 45,000 doses had been administered, of which 39,367 had been first dose vaccinations and 5,600 second dose, resulting in a vaccine rate, per 100 population, of 41.7. Vaccine uptake in older Islanders continued at very high levels and, as at 7th March, approximately 100 per cent of those aged over 80 years, 95 per cent of those aged between 75 and 79 years and 93 per cent of those aged between 70 and 74 years had received their first dose of the vaccine. Focus remained primarily on the first dose vaccines, but there had been a small increase in the cumulative numbers of second doses administered. As at the same date, 95 per cent of care home residents had received their first dose of the vaccine and 84 per cent their second and in respect of staff employed in those settings, these figures were noted to be 83 per cent and 66 per cent respectively. With regard to Islanders classed as 'clinically extremely vulnerable' (excluding those aged over 69 years), 82 per cent had received their first dose of the vaccine. Of those at moderate risk (for all age groups), 71 per cent had now received the first dose. The Cell was informed that figures relating to vaccination rates would henceforth be published twice weekly, on Mondays (with figures from the previous Wednesday) and on Thursdays, as currently.

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 informed that 91 per cent of those working in frontline health and social care positions had received their first vaccine and 37 per cent their second and 70 per cent of other workers in those settings had received their first dose and 26 per cent their second.

The Cell was provided with the 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 for the first dose of the COVID-19 vaccine in adults, as at 7th March 2021 and was informed that it remained the case that most countries averaged between 5 and 10 per cent, whereas approximately 41 per cent of those aged over 18 years in Jersey had been vaccinated and 40 per cent in the UK.

The Cell heard from the Senior Informatics Analyst, who had undertaken an analysis of those people who had tested positive for COVID-19 at least 14 days after receipt of one dose of the vaccine. She informed the Cell that there had been little change since the last report. However, those people who had received a positive result using a DiaSorin serological test were now having this confirmed by PCR test and some were producing negative results. The Consultant in Communicable Disease Control explained that as prevalence of the virus decreased, so the likelihood of a false positive result being

received would increase.

The Head of the Vaccine Programme, Strategic Policy, Planning and Performance Department, provided the Cell with a forecast of the vaccine programme, which she indicated would not be completely without change, due to fluctuations in the vaccine delivery. However, it was anticipated that first dose vaccinations for Islanders aged in their 40s could commence earlier than anticipated, in early to mid April. From early May those in their 30s would receive the first dose and late May for those aged between 18 and 29 years. It was envisaged that, by August, all eligible Islanders would have received both doses of the vaccine.

The Cell was shown a map of the UK, which set out the geographic distribution of cumulative numbers of reported COVID-19 cases, per 100,000 population, as at 14th March 2021, on a 7-day rolling basis, which demonstrated the continuing reduction in cases across much of that jurisdiction, although there were higher rates in the North of England and in the area around Glasgow. With regard to the maps, which had been prepared by the ECDC, for weeks 8 to 9 (1st to 8th March) when compared with the previous week, on 14-day case rates per 100,000 population, instances in Eastern Europe and Scandinavia had increased.

It was noted that, as at the end of February 2021, 1,410 people had been registered as actively seeking work. The number had increased slightly over Christmas, but was much lower than during the period from March to May 2020. During the last week of February, the number of vehicles using the overpass had been 3 per cent lower than the same time the previous year and the number of bus passengers during the same week been higher than the previous week, but 45 per cent lower than the comparable period of 2020.

The Cell noted the position and thanked officers for the update.

Future testing
strategy.

A3. The Scientific and Technical Advisory Cell ('the Cell') recalled that, on 8th February 2021, Members had received a future testing strategy, via electronic mail, which they had endorsed. On 10th February, Competent Authority Ministers had agreed the same in principle and had requested a reconnection roadmap, which would set out the transition arrangements from the existing testing strategy to the new strategy. The Cell was informed that, on 18th March, papers would be taken to Competent Authorities for approval in relation to the transition arrangements and options for cost recovery.

The Cell received and noted a PowerPoint presentation, dated 15th March 2021, entitled 'Future testing strategy – Policy into Practice' which had been prepared by the Senior Policy Officer, Public Health and Wellbeing, Strategic Policy, Planning and Performance Department and heard from her in connexion therewith. It was recalled that the high level of testing that was undertaken in the Island positioned it favourably when compared with other jurisdictions and the intention was not to change this in the new testing strategy. It was not possible to accurately predict what the situation would be in 6 months' time, but it was expensive to undertake such a high level of testing and the aim was to have a flexible testing platform that could be scaled up, or down, as required. At a certain point it would be necessary to transition from a pandemic emergency status, where the Government took responsibility for testing, towards an environment where this rested in part with organisations and individuals.

It was recalled that, in conjunction with most of Europe, Jersey was pursuing a suppression strategy in relation to COVID-19. The strategy comprised 4 levers, namely the border policy (with strict testing and isolation), internal controls through non-Pharmaceutical Interventions ('NPIs'), which were being gradually relaxed, the vaccination programme and the high levels of testing and tracing that were required to

mitigate the spread of the virus, particularly whilst vaccinating as much of the population as possible. The future testing strategy would aim to suppress case levels by effectively managing active cases, rapidly responding to any outbreaks and providing an early warning of increased community transmission of the virus, through 4 new testing programmes *viz* 'active case control', 'travel', 'safe places' and 'community testing', making effective use of new and existing testing technologies. Wherever possible it was anticipated that the testing should be delivered at a community level, with the facility to increase, or reduce, capacity as required.

Active case control would identify and isolate any positive cases of COVID-19 to prevent them from becoming clusters and, subsequently, outbreaks. The testing methodology would be PCR, undertaken by the clinical and test and trace teams. PCR testing would also continue to be employed at the borders in line with current arrangements, to prevent the importation of new cases and especially new variants of COVID-19. Safe places aimed to protect the vulnerable (those in care homes and in receipt of domiciliary care as an example) and enclosed populations, such as prisoners, by requiring asymptomatic testing for anyone entering, living and working in enclosed environments. It further preserved the integrity of critical health and emergency services by testing those delivering the same. It was envisaged that staff would be tested every 1 or 2 weeks, with the current frequency maintained for patients. Where possible, peer-to-peer swabbing would be used, employing primarily DiaSorin antigen testing but PCR for new admissions and care home visitors. Community testing would provide an early warning of any on-Island transmission and prevent spread by testing of asymptomatic individuals. Businesses would be encouraged to deliver frequent testing safely within their own organisations, potentially using Lateral Flow Devices ('LFDs'), noting that an extant arrangement existed with the Department for Health and Social Care in the United Kingdom ('UK') to provide these *gratis*.

By the end of June 2021 it was intended to transition to a PCR service of between 500 and 2,000 tests per day, which would be delivered by the Government of Jersey, rather than the current provider and was sustainable, flexible, scalable and cost effective. This would require a competitive tendering process to source the laboratory equipment and space in the Hospital to house the new service, which was estimated to cost £150,000. It would also need to be connected to the BATS system, which provided a single point of entry to the testing programme. It was noted that the ability to test to scale in the future was also the aim of Public Health England and the Cell was informed that in the event that the equipment was no longer required, it could be returned and the clinical space within the Hospital put to another use. In the meantime and in light of a suggested 3rd wave of the pandemic, which was forecast to impact the UK, based on modelling, skills were being developed on-Island in respect of the testing, which would provide some future proofing. The ability to undertake genetic sequencing (for new variants of COVID-19) would form part of the service and it was noted that the cost investment would be recovered after approximately 4,300 tests had been processed – which could be achieved within as little as one week - due to the lower cost per test. In order to operate the system, a maximum of 9 new laboratory staff would need to be recruited, of which 3 would be biomedical scientists. It was noted that one had already been identified and officers were confident that there were people on-Island with the relevant skills. The remaining 6 would be medical laboratory assistants and the Cell was informed that the last time such a post had been advertised, a large number of good candidates had applied. There were 3 people currently employed, who would normally cease work in April, who it was hoped to retain for the future.

By the end of April, it was proposed to maximise the potential of the DiaSorin antigen testing platform up to 10,000 tests per week, noting that 3,000 were currently being undertaken and that they offered a much lower cost per test. This would require the recruitment of 7 new laboratory staff (medical laboratory assistants) in the event that the system was operational at maximum capacity. The BATS system would need to connect to the DiaSorin platform and improve user experience for peer-to-peer

swabbing, which was likely to enhance uptake.

Between April and June a standardised Community Testing programme would be developed and deployed, offering a low-cost solution for high levels of testing, predominantly using LFDs, but with PCR tests for those who did not want to be tested using LFDs and to confirm any positive results from the former, mindful that with the low instances of the virus, the percentage of 'false positives' was likely to increase. The Consultant in Communicable Disease Control informed the Cell that testing using 2 different tests consecutively was standard for low prevalence diseases that had significant implications and he indicated that all HIV tests were confirmed using a separate, second, test. On the basis that the LFDs were provided to the Island by the Department for Health and Social Care, it was anticipated that testing would be undertaken in the UK to ensure they could identify variants of COVID-19.

A design team had been assembled from across Government to develop a standardised product for all businesses and a small team would be required for the delivery. The Behavioural Science Design Group had been actively involved in the challenge to encourage organisations to use LFDs to test staff and a charter for businesses had been drawn up. Work was already underway to develop an overarching information technology solution to meet the requirements of the 4 new testing programmes, which would provide a charging mechanism, if required and the overall costs were noted to be £700,000, which would be included in a separate Modernisation and Digital business case.

The Cell was informed that the new testing strategy would provide approximately 1.2 million tests at a cost of £26.3 million for the period from March to December 2021, which represented a saving of £16.4 million from using the current providers and technology. The costs included the recruitment of the 9 staff for the PCR tests, 7 for the upscaled DiaSorin provision, the development of a standardised LFD testing programme, relocation of the PCR equipment to the Hospital and development of the overarching IT solution.

The potential opportunities for cost reduction and / or recovery were noted in relation to each of the 4 testing programmes. The most significant area was Travel, which was anticipated to cost almost £15 million, based on an assumption around the volume of arriving passengers (220,000 from July to December). If a political decision were to be made to charge arriving passengers for testing, between £7.5 million and £10.8 million could potentially be recoverable by charging £36.00 per test. The Independent Advisor – Epidemiology and Public Health, suggested that in light of the age profile of those people who travelled to Jersey, it was possible that fewer tests would be required if proof of full vaccination provided an exemption from testing and isolation requirements. The Chair of the Cell suggested that charging for testing for travel could discriminate against those from a lower socio-economic background and migrant workers, who might be less able to afford to be tested, which could act as a disincentive for them to come and work in Jersey, with the associated economic impact. The Chief Economic Advisor indicated that it might be necessary to draw a distinction between Islanders and those travelling to Jersey and that free testing for visitors would be an implicit subsidy to the tourism sector, which would require further consideration. The Interim Director, Public Health Policy, acknowledged that the issues raised around equity and demand were valid, but that future work would be undertaken on the principles and that the paper sought to provoke thought around the subject of charging, rather than recommending it as policy.

The Senior Policy Officer, Public Health and Wellbeing, informed the Cell that Jersey was the exception in providing testing for free and that most jurisdictions levied a charge, including the Isle of Man, which required a mandatory £150 for the 3 tests, in the absence of which arriving passengers were required to self-isolate for 14 days.

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There was ongoing work with officers in the UK Cabinet Office in relation to COVID-19 ‘passports’ which would be linked to vaccination and negative results, but a clear policy had yet to be determined.

The Cell noted the position and thanked the Senior Policy Officer for the presentation.

Safer Travel
Policy.

A4. The Scientific and Technical Advisory Cell (‘the Cell’), with reference to Minute No. A5 of its meeting of 8th March 2021, recalled that it had received a presentation on a safer travel policy, but had decided, at that juncture, that it had insufficient information on which to make a decision in relation to the borders. Opening the same and making the Island more accessible would be a significant step and Members of the Cell had expressed the wish to see the proposed policy and understand how it would work in practice, with relevant data to support a decision.

The Cell accordingly received and noted a PowerPoint presentation, dated 15th March 2021, entitled ‘Safer Travel Policy – STAC Update’, which had been prepared by the Policy Principal, Strategic Policy, Planning and Performance Department and heard from him in relation thereto. He indicated that the presentation contained a number of questions, on which the Cell’s views were sought, before presentation to Competent Authority Ministers at their meeting scheduled to take place on 18th March 2021.

The Cell recalled that the Safer Travel Policy, that had been introduced in July 2020, categorised areas as Red, Amber or Green (‘RAG’) depending on the 14-day case rate per 100,000 population. Green areas were currently under 50 cases and Red over 120 cases, with Amber in between, but when the policy had first been introduced, the threshold for Green had been 25 cases. All arrivals were required to undertake PCR tests at days zero, 5 and 10 and to self-isolate for a period, with release points linked to their travel history, noted to be after a day zero negative result for Green arrivals, a day 5 negative result for Amber arrivals and a day 10 negative result for those designated as Red.

The Cell was shown a graph of infection rates in neighbouring jurisdictions on a 14-day case rate, per 100,000 population basis and was informed that in England and the devolved nations, there was a downward trend towards Amber, noting that 12 per cent of areas within England were currently categorised as Green, whereas a feature of European countries, including France, was a plateau at a relatively high number of cases.

In 2019, 2.36 million passengers had travelled to Jersey, of which 73 per cent had flown and 72 per cent had arrived from the United Kingdom (‘UK’) and Eire, which emphasised the significance of the Common Travel Area to the Island. It was recalled that, in accordance with the UK roadmap, self-contained holiday accommodation would re-open on 12th April at the earliest and was, as such, the first point at which Jersey residents could travel to the UK and stay there without breaching the guidelines, but it was noted that they would not be able to visit any family or friends until Step 3 - 17th May – when a maximum of 6 people, or 2 households, could meet indoors and hotels and Bed and Breakfast accommodation would re-open. On 12th March, it had been announced in Guernsey that RAG categorisation would be re-introduced from 30th April and that, with effect from 22nd March, non-essential travel could be undertaken. It was noted that the regime adopted by Guernsey in respect of both the RAG ratings and testing and isolation requirements differed from that employed locally.

It was projected that, by 12th April, 50 per cent of all Islanders would have received the first dose of the COVID-19 vaccine and an estimated 40 per cent would be protected, increasing to 62 and 49 per cent respectively by 10th May and 68 and 55 per cent by 14th June.

The Cell recalled that the level of regional detail in the context of the RAG categorisation had been the subject of some discussion and that the higher level of granularity did not always provide the best assessment of risk. It was informed that the Metrics Group had met and had discussed the pros and cons of adopting the current Lower Tier Local Authority level, which provided 381 data points and resulted in greater accuracy in cases of regional fluctuation, or in assessing the risk at regional level (including the Isle of Man and Channel Islands), which resulted in 13 data points that better reflected the reality of passenger behaviour, addressed the risk posed by transiting individuals, encouraged safer travel behaviour and would be simpler to communicate and comprehend. It was noted that the Metrics Group had expressed a preference for the latter.

The Policy Principal informed the Cell that the Metrics Group had also given consideration to the thresholds for the RAG, which were currently, as aforementioned, Green below 50 cases per 100,000 population, Amber from 50 to 119 and Red above 120 on a 14-day basis. The key issue for discussion had been whether, in the alternative, to adopt the assessment by the European Centre for Disease Prevention and Control ('ECDC'), which also took into account test positivity rates. Where this was below 4 per cent, areas where there were fewer than 25 cases, per 100,000 population, were categorised as Green, but as Amber where the test positivity rate exceeded 4 per cent. Areas where there were more than 25, but fewer than 149 cases per 100,000 population and the positivity rate was below 4 per cent were categorised as Amber, but where it exceeded 4 per cent they were Red and all areas where there were more than 150 cases, per 100,000 population, were designated as Red, irrespective of the test positivity rate. The ECDC also assessed areas on which they did not hold data, or the information was unsatisfactory, as Grey and the same requirements as for Red areas were applicable. If the ECDC classification was applied to the current rates in England, the number of Amber areas would increase, but there would be no Green areas.

The Cell was provided with details of additional elements pertaining to the travel policy and noted that it was intended to announce any changes to the reclassification of areas on a Thursday, in order to align with the ECDC publication, for implementation at 00.01 a.m. on the following Tuesday. Any escalation to such classification would be introduced with immediate effect, but any de-escalation would not be applied until 14 days had elapsed. With regard to day trips off the Island, it was proposed that rather than be automatically classified as Green, as had previously been the case, they would be assessed on the categorisation of the port of origin, such as Gatwick or Southampton. In a similar vein, anyone transiting through another country would attract the highest categorisation of transit port, or port of origin. In respect of the variants of concern, it was mooted that Jersey should mirror the UK and adopt the 33 red list countries, which were classified as Red, irrespective of the metrics pertaining thereto. The Cell was informed that work was underway to enable vaccination status to be introduced into the travel policy and consideration was being given to how it might impact thresholds and testing and isolation requirements. However, there was currently insufficient evidence to factor it in at this juncture.

The Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, indicated that he would like the travel policy presented in terms of the risk of reseeding that the Island was prepared to accept. He understood that some work had been undertaken in 2020 on risk modelling and this had been passed to the Principal Officer, Public Health Intelligence, for review. He questioned whether the purpose of vaccination was to prevent serious illness, or to suppress transmission of the virus, because that would lead to different solutions. He reminded the Cell that there were Islanders at University in the UK, who were currently being impacted and wished to return to Jersey and it was important to bear them in mind. The Independent Advisor – Epidemiology and Public Health, indicated that the Island was now in a different position from when the RAG categorisation had been devised and risk tolerance and the

vaccine should be factored in. There was growing evidence to suggest that the latter both impacted transmission and prevented severe disease and in light of the current trajectory in the UK, he suggested that all areas would have a 14-day case rate of lower than 50 cases per 100,000 population by the time the safer travel policy was reintroduced. Accordingly, he opined that there was no need for complexity in an era of decreasing risk, particularly in light of the good test and trace capacity in the Island and vaccine roll out, so mooted that the Green categorisation should be aligned with a 14-day case rate of 50.

The Consultant in Communicable Disease Control referenced the modelling that had been undertaken by Imperial College London and the University of Warwick and had been presented to the Scientific Advisory Group for Emergencies (SAGE). It had not taken into account the variants of concern, nor travel or seasonality, but had concluded in every case that a third wave of COVID-19 would be experienced in the UK and there would be a further 30,000 deaths, as a minimum, which equated to 43 deaths per 100,000 population. On a *pro rata* basis, twice the number of deaths had been experienced in that jurisdiction than locally during the pandemic, so it was possible that approximately 21 people might die in Jersey if a third wave were to occur in the Island and it was important to be mindful of this when developing travel policy. The purpose of the vaccine was to suppress the virus and prevent severe disease and it was having a significant impact, but it was important to determine what the metrics should be for the relaxation of restrictions within the Island and until that had been decided it was difficult to equate the travel metrics with what was happening locally. He mooted that those areas that would require consideration would be infection rates, levels of severe disease, hospitalisations, the rate of the change of infection and prevalence, because according to Public Health England, once this exceeded 0.5 per cent, test and trace would be unable to manage outbreaks. If the policy was viral suppression, he proposed that a 14-day case rate of 25 per 100,000 population should be used and this same figure could then be employed to designate areas as Green. He opined that vaccination rates should be considered when re-establishing connectivity and was of a view that linking with the UK made sense as a first step, mindful that their rates were on a par with Jersey and he also emphasised the need to consider variants of concern.

The Interim Director, Public Health Policy, indicated that when Competent Authority Ministers met later in the week they would not be seeking to determine travel policy for the next 9 months, but rather to move away from the blanket Red categorisation of areas, which might require a transition period. It was important to exercise caution at first, mindful of the variants of concern and their potential to limit the effectiveness of the vaccine policy, with the potential to relax measures further at a later time. It would be key to consider the epidemic dynamics in other jurisdictions and he cited the example of France and suggested that Jersey should align with the UK relaxation of travel in May, rather than at an earlier point.

The Director of Communications, Office of the Chief Executive, suggested that there would be merit in considering more closely the situation in Israel, where the test positivity rate had declined sharply and the majority of cases were in people under the age of 19 years, who had not been vaccinated. There were very few patients in the Intensive Care Units and that jurisdiction intended to ease all non-Pharmaceutical Interventions ('NPIs') by the end of March. He indicated that Jersey was only a few months behind Israel in terms of the deployment of the vaccine. For ease of purpose, he mooted that Jersey should align with the UK RAG categorisation and potentially facilitate travel only within the Common Travel Area as the first step.

In response to the specific questions on which its views were sought, the Cell decided to advise resumption of the RAG classification process for the British Isles only as the first stage of the safer travel policy, mindful that this would need to change, potentially relatively early, but further work was required by the Borders Sub-Group. It was noted

that Eire would not be included at this juncture, due to its current low vaccination rate.

Differing views were expressed on the appropriate stage of this resumption within the reconnection roadmap. The Interim Director, Public Health Policy, was of the view that it should not take place until Stage 6 – not before 10th May – because the relaxations of the measures to-date had afforded Islanders greater freedoms and by 12th April they would be able to gather in numbers of up to 20 outdoors and drinks only table service would resume. He favoured a hiatus between such significant steps in order that the impact of the easing of the restrictions could be assessed. Mindful of the situation in the UK, very little travel would be possible before May in any event, but he suggested that an exception could be made to establish a link with Guernsey from April, subject to the metrics. This was a view shared by the Consultant in Communicable Disease Control, the Associate Medical Director for Mental Health and the Environmental Health Consultant. The Managing Director, Jersey General Hospital, suggested that it could be advanced to Stage 5 – not before 12th April – because the Island had a robust test and trace system, in which it was important to have confidence. The Interim Director of Statistics and Analytics agreed and referenced Islanders in the UK who might wish to return home and *vice versa*. The Chief Economic Advisor also favoured April, due to the low levels of risk and anticipated volumes of travel. The Independent Advisor – Epidemiology and Public Health, indicated that the activity that was the greatest risk in terms of transmission of the virus, *viz* household gatherings, had already been permitted and relaxing other measures at Stage 5 would not add to that risk. The Associate Medical Director for Unscheduled Secondary Care agreed that it was important to have faith in the test and trace system and to take the opportunity to lead from a safe place. The Associate Medical Director for Primary Prevention and Intervention concurred.

With regard to the level of sub-national detail at which areas should be classified, the Cell was broadly supportive of the use of a regional analysis, but agreed that there were pros and cons to both methodologies. The Director of Communications opined that Upper Tier Local Authority rates should be considered, mindful that this was the default situation in the UK and the Policy Principal acknowledged that a position in between the 2 included within his presentation might be viable.

In considering the most appropriate threshold to risk assess and classify areas, views differed around whether areas should be categorised based on the 7-day case rates, as in the UK, or the 14-day rates used in the rest of the world. There were also differing opinions on whether the threshold for Green should be set at 25 or 50. Accordingly, it was decided that this should be discussed at the Borders Sub-Group before being re-presented to the Cell at its next meeting, mindful that the Competent Authority Ministers did not require its advice on this matter for its next meeting. It was also agreed that the Sub-Group should consider the additional elements pertaining to the travel policy, most notably the variants of concern and the vaccine and to provide input to the Cell.

Liberation
Day.

A5. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A6 of its meeting of 8th March 2021, recalled that when it had discussed Stage 4 of the reconnection roadmap, which had occurred on Monday 15th March, it had advised Competent Authority Ministers to bring forward the provisions in relation to household gatherings by one day, to 14th March, to enable families to meet up for Mothering Sunday.

The Acting Chair informed the Cell that Competent Authorities had noted that Stage 6 reconnection was scheduled for no earlier than May 10th and had asked that the Cell give consideration to whether a similar change of date could be accommodated for Liberation Day on 9th May 2021. It was recalled that Stage 6 included gatherings of up to 20 people (both indoors and outside), the lifting of the physical distancing order

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and a full return to the workplace.

The Head of Public Health Policy indicated that, recognising the importance of Liberation Day and Islanders' wish to be able to reconnect, the Parishes and organisations had put measures in place to enable people to participate in the celebrations virtually and any attendees in person would observe the public health guidance.

The Cell agreed to recommend that Stage 6 reconnection should be brought forward by one day to include Liberation Day.

Matters for
information.

A6. 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 11th March 2021, which had been prepared by the Strategic Policy, Planning and Performance Department;
- statistics relating to deaths registered in Jersey, dated 11th March 2021, which had been compiled by the Office of the Superintendent Registrar;
- a report, dated 11th March 2021 in respect of vaccination coverage by priority groups, which had been prepared by the Strategic Policy, Planning and Performance Department; and
- economic indicators for February 2021, which had been prepared by Statistics Jersey.

It was noted that an invitation to a meeting of the Cell had been circulated for Monday 5th April, which was Easter Monday and it was agreed that the Cell would either not meet that week, or that the meeting would be rescheduled.