KS

SCIENTIFIC AND TECHNICAL ADVISORY CELL

(52nd Meeting)

(Meeting conducted via Microsoft Teams)

22nd March 2021

PART A (Non-Exempt)

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

Mr. P. Armstrong, MBE, Medical Director (Chair)
Dr. I. Muscat, MBE, Consultant in Communicable Disease Control
C. Folarin, Interim Director of Public Health Practice
Dr. G. Root, Independent Advisor - Epidemiology and Public Health
R. Sainsbury, Managing Director, Jersey General Hospital
Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention
Dr. S. Chapman, Associate Medical Director for Unscheduled Secondary Care
Dr. M. Patil, Associate Medical Director for Women and Children
Dr. M. Garcia, Associate Medical Director for Mental Health
S. Petrie, Environmental Health Consultant
A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department
I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department

In attendance -

J. Blazeby, Director General, Justice and Home Affairs Department
R. Corrigan, Acting Director General, Economy
D. Danino-Forsyth, Director of Communications, Office of the Chief Executive
S. Martin, Chief Executive Officer, Influence at Work
Dr. M. Doyle, Clinical Lead, Primary Care
M. Knight, Head of Public Health Policy
B. Sherrington, Head of Policy (Shielding Workstream) and Head of the Vaccine Programme, Strategic Policy, Planning and Performance Department
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. N. Kemp, Policy Principal, Strategic Policy, Planning and Performance Department

J. May, 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. The Minutes of the meeting of the Scientific and Technical Advisory Cell, which had been held on 15th March 2021, having previously been circulated, were taken as read and were confirmed.

Monitoring Metrics.

A2. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of its meeting of 15th March 2021, received and noted a PowerPoint presentation, dated 22nd 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 Department and initially heard from the former in relation thereto.

The Cell was informed that, as at Friday 19th March 2021, there had been 3 active cases of COVID-19 in Jersey, who had been in direct contact with 20 individuals, who were self-isolating and the 14-day rate, per 100,000 population, had been 2.78. None of the active cases were experiencing symptoms of the virus and one was currently in the General Hospital. Two of the cases had been identified as a result of arrivals testing and one through screening before admission to Hospital. Since 12th February 2021, the number of daily average cases had been below one. During the week ending 19th March, an average of approximately 1,000 tests had been undertaken on weekdays, which aligned with the position in previous weeks, with the majority of tests having been as part of the workforce screening programme.

With regard to the number of daily cases of COVID-19, the number of tests and the test positivity rates for various age groups, the latter remained significantly below one per cent for all, including those aged over 70 years and, as a consequence of the current low case numbers, the Analytical Cell was not convening on a daily basis. As aforementioned, there was currently only one, asymptomatic, person in 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 and those that had arisen in the second wave of the pandemic – since 1st October 2020 - remained at 37. 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 19th March 2021 and was informed that the issues around the calls to the Helpline had been resolved and there had been very few from symptomatic individuals during the previous week. The number of inbound travellers remained low, below 1,000 per week and 2 of the current active cases had been encountered at the borders.

During the week ending 14th March 2021, there had been 1,370 tests on inbound travellers, 5,240 as part of on-Island surveillance and 270 on people seeking healthcare. The weekly test positivity rate locally was currently below 0.1 per cent and had decreased to 0.4 per cent in the United Kingdom ('UK'). As at the same date, the local weekly testing rate, per 100,000 population, had been 6,400 and in the UK had increased steeply to 13,320, mindful that that jurisdiction included tests undertaken on Lateral Flow Devices ('LFDs') and that the schools – which tested students using LFDs – had re-opened on 8th March in England. The Principal Officer, Public Health Intelligence, informed the Cell that it was intended to include LFD results in the local figures, but it had not, as yet, been possible to obtain a full set of data in this regard.

The Cell was informed that attendance at Government primary schools, during the week

commencing 15th March, had averaged 97 per cent and 93 per cent at secondary schools and that, in all settings, absences related to COVID-19 remained at approximately 0.1 per cent and there had been no positive cases linked to the schools 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 in excess of 10,000 LFD tests had been carried out and there had been just 3 positive results from LFD tests, which had subsequently been shown to be 'false positives' when tested using a PCR swab.

The Cell was presented with the published data, to 14th March 2021, in respect of COVID-19 vaccinations in Jersey, which showed that 45,758 doses had been administered, of which 40,137 had been first dose vaccinations and 5,621 second dose, resulting in a vaccine rate, per 100 population, of 42.45. Indicative figures to 21st March, which were subject to verification, were that 52,294 vaccines had been administered, of which approximately 43,000 had been first dose and 9,000 second and the vaccine rate had been 48.51. Vaccine uptake in older Islanders continued at very high levels and, as at 14th March, approximately 100 per cent of those aged over 80 years had received their first dose and 42 per cent their second. 95 per cent of these aged between 75 and 79 years, 81 per cent of those aged between 55 and 59 years and over half of those aged between 50 and 54 years had now received their first dose. The Cell was provided with a map, which had been prepared by the European Centre for Disease Prevention and Control ('ECDC'), which set out an estimate of the national vaccine uptake in Europe for the first dose of the COVID-19 vaccine in adults, as at 14th March 2021 and was reminded that most countries averaged between 5 and 10 per cent, whereas approximately 46 per cent of those aged over 18 in Jersey – and a similar number in the UK - had been vaccinated as at the same date.

The Cell noted the cumulative numbers of first and second dose vaccinations, as at 14th March and the mid-week figures from 10th March and was informed that the data from 17th March would be released later during the day. As at 14th March, 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 and 66 per cent respectively. With regard to Islanders classed as 'clinically extremely vulnerable' 84 per cent had received their first dose and for those at moderate risk that figure was 74 per cent. The Cell was informed that a review of the uptake of first and second doses had been undertaken, focusing on gender. It was noted that there was no significant difference by gender for the eligible age groups, but as those working in health and care settings had been invited for vaccination, there had been more females than males, which was reflective of the gender balance of those working in those *loci*. 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 50 per cent their second and 72 per cent of other workers in those settings had received their first dose and 37 per cent their second. However, the Principal Officer, Public Health Intelligence, drew attention to the Amber rating allocated to those percentages, which was indicative that a small amount of the data was of questionable quality and was being reviewed.

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 21st March 2021, on a 7-day rolling basis, which demonstrated the continuing reduction in infection rates across much of that jurisdiction. With regard to the maps, which had been prepared by the ECDC, for weeks 9 to 10 (8th to 15th March) when compared with the previous week, on 14-day case rates per 100,000 population, rising rates in Eastern Europe and part of France were noted and the Cell was cognisant that certain countries were re-entering 'lockdown' in the face of a third wave of the pandemic,

whilst there had been a decline in the number of cases in Spain, Portugal and Eire.

Mindful that the Competent Authority Ministers had decided to re-introduce the Red / Amber / Green ('RAG') classification for areas, based on their 14-day case rate per 100,000 population, with effect from 26th April in respect of the UK, the Consultant in Communicable Disease Control emphasised the importance of reminding the public that the UK reported on 7-day case rates per 100,000. The Director of Communications, Office of the Chief Executive, informed the Cell that because the UK default map (which used 7-day case rates and reported on Upper Tier Authority areas) could not be used in Jersey, an officer transposed the same into 14-day case rates and Lower Tier Authority areas for the purpose of categorising areas.

The Cell heard from the Managing Director, Jersey General Hospital, in relation to the Health and Community Services Department's operational position. He indicated that the escalation status, as at 22nd March, remained 'Green', which was indicative that the health and care system capacity was such that the organisation was able to meet anticipated demand within available resources. There was currently, as aforementioned, one patient in the General Hospital with COVID-19. Bed occupancy in both the General Hospital and across mental health settings was below 85 per cent and there were no significant pressures on the Department.

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

Nightingale Wing.

A3. The Scientific and Technical Advisory Cell ('the Cell') recalled that the Nightingale Wing of the General Hospital, which had officially opened on 11th May 2020, had been constructed as a temporary 180 bed field hospital for COVID-19 positive patients and had been designed to accommodate patients who required oxygen but not intensive care and had not, to-date, been brought into operation. The Cell accordingly received and noted a PowerPoint presentation, dated 22nd March 2021, entitled 'Nightingale Wing' and heard from the Managing Director, Jersey General Hospital, who informed it that Members' views were sought on whether the Wing would be required beyond the end of March 2021.

He provided the Cell with figures, which had recently been released in response to a request made under the Freedom of Information (Jersey) Law 2011, which were that between 1st February 2020 and 31st January 2021, 121 patients had been admitted to the Hospital, who had been diagnosed with COVID-19, of which 69 had it as their primary diagnosis. During the same period, 24 patients had required treatment in the Intensive Treatment Unit ('ITU'). However, until such time as the clinical coding was complete, it was not possible to undertake an analysis of whether all of the patients had been in Hospital for COVID-19, so the figures were liable to change. During the peak of the second wave of the pandemic, there had been 36 patients in Hospital, mostly on Corbière Ward, Bartlett Ward and in ITU. Mitigations introduced by the Health and Community Services Department at this juncture had been to suspend all elective activity, to spot purchase beds with a local care provider and to establish its own domiciliary care team.

There were 180 expansion beds at the Nightingale Wing, 35 in the Hospital and 48 at St. Saviour's Hospital, but none of these had been required during 2020 and overall bed occupancy had not exceeded the NHS benchmark of 85 per cent in the Hospital, or critical care, over the same period. The Managing Director informed the Cell that oxygen capacity was a key indicator. The resilience in this respect at the Hospital had increased, with 4 PSA (pressure swing adsorption) generators providing 900 litres per minute, with 300 litres on the reserve. During the second wave of the pandemic, average oxygen utilisation had averaged between 200 and 300 litres per minutes.

The Cell was shown a graph, which mapped peak demand on beds in the Health and

Community Services Department since 2013, which demonstrated that there had been decreasing pressure on beds in secondary care. Total bed requirements had occasionally peaked at 180, but during 2020 the numbers had significantly reduced and the point had not been attained where the core bed base had been adversely impacted to a notable extent. The reduction in elective activity had resulted in good capacity resilience.

In conclusion, there was sufficient oxygen resilience within the Health and Community Services Department, adequate beds available and advances had been made in the management of COVID-19 since the start of the pandemic. Clinical capacity had not been exceeded and there had been very low rates of in-patient elective cancellations as a result of pressures on beds. Modelling had been undertaken on future bed capacity and it was suggested, as a consequence, that the Nightingale Wing would not be required beyond March. The Cell recalled that it had been mooted in 2020 that the trigger point for putting that Wing to use would be 10 patients in the Hospital with COVID-19, but at the peak of the second wave there had been 36. The Managing Director explained that the figure of 10 had been set in a controlled situation, when it had been intended to introduce ‘hot’ and ‘cold’ settings and continue elective procedures. However, in the context of the second wave and the speed with which cases had increased, this had not been possible. Accordingly, elective procedures had been suspended and, in light of the presence of active cases of COVID-19 in the Hospital at the time, the decision had been taken to continue to function within a single site, rather than transfer those with the virus to the Nightingale Wing.

On a related note, the Director General, Justice and Home Affairs Department, informed the Cell that the Excess Death Group had recently met and had decided to discontinue the temporary mortuary capacity beyond the end of the month.

The Cell accordingly agreed that the Nightingale Wing was not required beyond the end of March and that even if a third wave of the pandemic was to arrive in the Island, its impact could be managed within the Hospital, mindful that it was likely to be smaller than the second wave. It decided, however, that the communications should be managed carefully to ensure that Islanders did not perceive that the dismantling of the same was indicative that the virus no longer posed a threat.

Reconnection roadmap – metrics.

A4. The Scientific and Technical Advisory Cell (‘the Cell’), with reference to Minute No. A8 of its meeting of 22nd February 2021, recalled that it had agreed to establish a Sub-Group to consider what metrics should apply when establishing future stages of reconnection.

The Cell accordingly received and noted a PowerPoint presentation, dated 22nd March 2021, entitled ‘Monitoring Metrics to support Roadmap’ and heard from the Principal Officer Public Health Intelligence, Strategic Policy, Planning and Performance Department, in relation thereto. She indicated that in monitoring reconnection objectives and making requisite changes, Ministers would be advised by officers from Public Health and the Cell, based on a data and information framework. The Sub-Group had met on a number of occasions and had reviewed the harms linked to COVID-19, both directly and indirectly *inter alia* effects on Islanders’ health and the Health and Community Services Department and the wider impact of the non-Pharmaceutical Interventions (‘NPIs), most notably during the second wave. The Sub-Group had assessed the current situation against a backdrop of the COVID-19 vaccine roll out, the threat posed by variants of concern (‘VOC’) and the evolving situation internationally and had reviewed the quantitative and qualitative aspects of learning from the second wave, which had included consultation with the Contact Tracing Team, particularly with regard to the period in late 2020 when the latter had experienced considerable pressure and had been unable to undertake all the background tracing that it would have wished. This work had enabled identification of key metrics to support the reconnection.

The Cell noted that, during the second wave, 37 people had died, between 60 and 100 people had suffered serious illness and approximately 1,800 had been symptomatic, whist 1,000 had not experienced symptoms. This had resulted in 16,000 Islanders being required to self-isolate as a consequence of being direct contacts of active cases. The NPIs, which had been introduced in order to address the spread of the virus in the Island, had impacted the whole community, had affected people's wellbeing and economy, had led to the closure of the schools and had impinged personal liberties. Modelling had been undertaken to determine what might happen if a third wave were to occur in the near future, which demonstrated that the vaccine coverage would significantly reduce the risk of death and serious illness and also somewhat diminish transmission, which would reduce pressure on health services to deal with COVID-19 patients. However, direct contacts of active cases would still be required to self-isolate and all Islanders would be subject to NPIs, irrespective of their vaccination status. This would place pressure on services and as more of the virus circulated, so the likelihood of a vaccine resistant strain becoming dominant would increase. Avoiding a third wave would alleviate the Covid harms to the majority of the population.

The Cell was mindful that as restrictions were eased and the Island reconnected, seed cases were more likely to lead to on-Island outbreaks. This was particularly the case at Stages 6 and 7 of the reconnection roadmap, after travel to the UK and thence internationally had been eased from 26th April and 17th May respectively and with minimal mitigations in Jersey at that juncture, because there would be a high risk of seed cases causing large outbreaks, with the risk further augmenting if travel volumes increased or there was a growth in prevalence of the virus amongst arrivals. Accordingly, it would be necessary to remain vigilant and to keep the number of cases locally under close review. The Cell was informed that some modelling had been undertaken to show the impact of cases passing undetected through the border on the case rate on-Island which assumed some vaccine coverage. With some mitigations in place, a greater seeding rate would be tolerable before another wave was triggered and modelling suggested that one seed case per week could take 6 months to give rise to 30 cases per day. However, with minimal mitigations in place, it was suggested that one seed case per week could lead to 30 cases per day in under 3 weeks and it was recalled that, in Guernsey, a small number of active cases had rapidly lead to outbreaks due to the lack of on-Island mitigations in that jurisdiction.

The Cell was cognisant that effective suppression of transmission remained critical to prevent the emergence and spread of new variants of COVID-19 which were able to escape vaccine acquired immunity. It was informed that the E484K mutation, which was associated with immune escape, had been detected on samples from Jersey sent for sequencing, as had the VOC B.1.1.7, which had substantially increased transmissibility and was associated with an increased risk of death.

Early relaxation of NPIs, before sufficient immunity had been established, could precipitate a third wave of infection. Thus it was important to keep levels of infection low by adopting a balanced approach, making use of the test, trace and isolate strategies and attaining high vaccination coverage. The Contact Tracing Team had undertaken a review of their learning and experience in the second wave, as their workload had rapidly escalated. In their view, early warning signals would be a test positivity rate that exceeded 0.3 per cent over the previous 7 days, increased faecal prevalence of the virus and growing rates in surrounding jurisdictions. The contact tracing capacity had come under pressure during October 2020 at 10 new cases per day and if this was to occur over a 14-day period they would require 56 staff members to sustain the appropriate capability, which would require a 3 week lead-in time to on-board staff. The Cell was reminded that, on 30th September 2020, the test positivity rate had exceeded 0.3 per cent over the previous 7 days and the 14-day case rate had surpassed 25, before breaching 50 on 9th October. On 16th October there had been more than 2

people seeking healthcare in the previous 7 days who had been positive for COVID-19 and unlinked on-Island cases had been identified.

In terms of the proposed data, the key qualitative metrics were the appearance of unlinked on-Island cases, noting that these would be based on intelligence from the Analytical Cell and the Contact Tracing Team coming under strain and losing the ability to trace backwards. The latest information on VOCs and public sentiment would be supporting metrics. With regard to the key quantitative metrics, it was proposed that these should be a test positivity rate which exceeded 0.3 per cent and continued on an upward trajectory over the subsequent 4 days, a 14-day case rate that surpassed 25 and continued upwards over the next 4 days and 3 positive cases within one week identified through individuals seeking healthcare. It was noted that the metric thresholds might need to adapt over time as the situation changed locally and internationally and prevalence of the virus in neighbouring jurisdictions would be kept under review.

Members of the Cell acknowledged the hard work that had gone into the analysis and compilation of the proposed metrics. The Associate Medical Director for Primary Prevention and Intervention suggested that the ability to test for VOCs on Island, combined with rapid testing, would be a cornerstone of the testing system in the future, whilst ensuring that there was ongoing robust screening of arrivals into Jersey. The Consultant in Communicable Disease Control indicated that there were plans in train in respect of PCR testing on Island and it was envisaged that sequencing could be incorporated. In the meantime, a maximum of 50 swabs per week could be sent to Porton Down for that to be undertaken. When determining whether or not a variant was a VOC would require many variants to be detected and Jersey would be involved in the UK system of surveillance in this regard. He suggested that an additional metric that could be included related to seeding from travel.

The Director of Communications, Office of the Chief Executive, indicated that whilst a test positivity rate exceeding 0.3 per cent had been identified as a key metric, the positivity rate in Israel was currently 0.8 per cent, but the daily rate of new infections in that jurisdiction had declined significantly, as had the number of people requiring treatment in hospital. He cited, as an example, a large number of positive cases in young people, which did not negatively impact the Hospital and accordingly questioned the validity of test positivity as a metric. The Consultant in Communicable Disease Control indicated that the metrics had been based on the point at which the second wave had taken hold and it was acknowledged that the vaccine would have an impact, but this was difficult to quantify. An early notification of increased transmission would enable an appropriate and timely response and it was important to be mindful that certain variants of the virus had increased vaccine resistance. The Cell was also informed that consideration had been given to the wider harms and the impact of ‘long Covid’, which appeared to disproportionately affect the younger population.

The Interim Director, Public Health Policy, suggested that whilst Israel had experienced a significant reduction in the harm caused by COVID-19 as a result of the vaccine deployment, it had not equated to elimination and, as a consequence, the virus still had the potential to cause harm during the Spring and Summer, notwithstanding that this would diminish as more people were vaccinated.

The Independent Advisor - Epidemiology and Public Health opined that when considering future scenarios it was important to bear in mind that the level of vaccination coverage in the Island meant that there could be an enhanced tolerance of greater transmission of the virus, because the risk of severe disease would be reduced. He cast some doubt on the modelling that forecast 30 cases per day in a 2 to 3 week period from seeding of one case per week, which he believed unlikely. He agreed that it would be useful to have test positivity from arrivals as an early indicator, in addition to those seeking healthcare. With regard to the VOCs, the Island would need to follow

the UK's lead and adapt accordingly, because it would not be feasible to identify the VOCs in Jersey in a sufficiently timely way. He suggested that the Contact Tracing Team would have been more effective during the peak of the second wave if greater resources had been invested in the epidemiology research. The Director General, Justice and Home Affairs Department indicated that the Contact Tracing Team comprised 125 staff and there had been significant improvements in the systems and processes and a review undertaken in respect of future testing practices. He provided reassurance that the Team would be able to respond in a flexible manner to any future challenges. The Clinical Lead, Primary Care, indicated that it would be necessary to be prescriptive in respect of where future active cases were identified – whether through inbound travel, or in the Island – and that mitigations would be tailored appropriately, as they were different scenarios.

The Chair expressed his thanks for the work that had been undertaken and suggested that more nuance was perhaps required around the test positivity rates in specific groups, such as arrivals. It was also important to understand the capacity of the Test and Trace team. A future discussion would need to be held in respect of what action should be taken in the event that one of the key metrics was reached and he suggested that it would be helpful for a list of options and priorities to be drafted for consideration by the Cell at its next meeting.

Vaccination Programme.

A5. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A4 of its meeting of 8th March 2021, received a PowerPoint presentation, dated 22nd March 2021, entitled 'Covid-19 Vaccination Programme' and heard from the Head of the Vaccine Programme, Strategic Policy, Planning and Performance Department, in relation thereto. She informed the Cell that 94 per cent of Islanders within the first phase of the vaccine deployment had now received their first dose and half of those aged over 18 years. This was positive news, but she indicated that the figures for second doses were relatively low, at 20 and 11 per cent respectively.

Weekly meetings were held with representatives from the United Kingdom ('UK') Government, who were confident in respect of ongoing availability of the vaccine. There had been a spike in the supply at the end of the week commencing 15th March, which would be used for both first and second doses. Officers had always been cognisant that volumes of the vaccine would be lower in April and had tailored the delivery plan in this knowledge. It was anticipated that more vaccine would arrive towards the end of May, but this was subject to confirmation. The Head of the Vaccine Programme was relatively confident in respect of supplies, but reminded the Cell that these could be volatile. With regard to the safety of the vaccine, 28,000 doses of the Pfizer and 55,000 doses of the Oxford AstraZeneca were allocated to be delivered locally as part of Phase 2, so any concerns in respect of the latter would have had a significant impact on the programme. However, both the European Medicines Agency (EMA) and the Medicines and Healthcare products Regulatory Agency (MHRA) had issued statements to the effect that the Oxford AstraZeneca vaccine was safe and comments from the Joint Committee on Vaccination and Immunisation ('JCVI') in this regard were awaited.

The Cell was informed that the programme decision was to provide second doses for Phase One until 10th April to enable the finalised advice to be obtained from the JCVI in respect of Phase 2, noting that the UK was not due to commence the second phase until the end of April. It remained the case that all eligible Islanders should have received both doses of the vaccine by August.

In response to a query in respect of the Johnson and Johnson single dose vaccine, the Consultant in Communicable Disease Control indicated that it did not provide any greater protection than the first dose of the Pfizer or Oxford AstraZeneca vaccine and any decision around what would be acceptable for an 'immune passport' would have to

be made internationally. The Head of the Vaccine Programme stated that the Johnson and Johnson vaccine was not yet included in the supply forecast locally and apart from the Pfizer and Oxford AstraZeneca vaccines, just a small number of doses of the Moderna (7,000) were anticipated to be received in Jersey.

The Cell noted the position and thanked the Head of the Vaccine Programme for the update.

Returning school aged children.

A6. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A7 of its meeting of 12th October 2020, recalled that a policy had previously been introduced by Competent Authority Ministers in respect of young Jersey people who attended off-Island residential education or care placements – most of which were boarding school children in the United Kingdom ('UK') - which enabled them to apply to be treated as if they had travelled from an area categorised as Green under the Safer Travel Policy, irrespective of the location of the school, when they returned to the Island for half-term or Christmas.

The Cell was informed by the Policy Principal, Strategic Policy, Planning and Performance Department, that approximately 45 students had applied for a variation to the isolation requirements for the October half-term and 170 for Christmas, which was more than had been anticipated. Of the 170 who had returned in December, 10 had tested positive for COVID-19 (3 at day zero, 6 at day 5 and one at day 10). Under the reconnection roadmap, the Island was due to reintroduce the RAG categorisation for travel to the UK from 26th April and some parents of children at school in that jurisdiction had queried whether the variation could again be applied, potentially from the May half-term. Mindful that it was not possible to predict what the position would be with regard to COVID-19 by the end of April, or May, an in-principle view was sought from the Cell on the proposal.

It was hoped that, by the May half-term, any such variation would be otiose because much of the UK might be categorised as Green by that juncture in any event. However, should it prove necessary, it was suggested that the policy would require students to provide evidence that they had not been in contact with any active cases within their school group, or 'bubble' in the 14 days prior to travel and that there was regular testing in the school. It was agreed that this should be communicated to parents before the Easter holidays in order that they could reach a decision as to whether to send the children to the UK for the Summer term and that the policy could be revisited in the event of a deteriorating situation in that jurisdiction.

Letter from the Ministers for Economic Development, Tourism, Sport and Culture and External Relations.

A7. The Scientific and Technical Advisory Cell ('the Cell') received and noted a letter, dated 21st March 2021, which had been sent by Senator L.J. Farnham, Minister for Economic Development, Tourism, Sport and Culture and Senator I.J. Gorst, Minister for External Relations to Deputy R.J. Renouf of St. Ouen, Minister for Health and Social Services, copied to Senator J.A.N. Le Fondré, Chief Minister, the Chair of the Cell and the Consultant in Communicable Disease Control. In the letter, they asked that the Cell consider the social and economic benefit of advancing 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.

The Chair informed the Cell that an exchange of emails had taken place since receipt of the letter and that the Ministers wished for some of the non-Pharmaceutical Interventions ('NPIs') to be removed and for some of the relaxations contained within Stage 6 (no earlier than 10th May) of the reconnection strategy to be moved into Stage 5 (no earlier than 12th April). The Minister for Health and Social Services had asked that the Cell consider the request, but also discuss whether in advancing reconnection stages for the business sector, equal consideration should be given to relaxing other

restrictions affecting the social, cultural and educational sectors and he questioned what the likelihood was of increased infection rates amongst younger – unvaccinated - people if there were to be a significant divergence from the previously announced reconnection stages and the effect of that on the vaccination programme.

The Interim Director, Public Health Policy, indicated that it was important for the Cell to consider the request by the Ministers, but suggested that it should take the week to study the proposals and revert with evidence-based and properly measured views on whether the current framework could cope with any changes and what the attendant risks might be, mindful that there remained the potential for a rapid increase in cases, so caution was required. The Independent Advisor - Epidemiology and Public Health, suggested that there would be benefit in streamlining some of the current rules relating to the hospitality sector that would not significantly increase the risk of transmission of the virus and he repeated the view that household mixing posed the greatest threat and this was already permitted. He suggested that the Cell might be exceeding its remit if it were to provide advice on economic harms, because its primary role was to consider the risk posed by COVID-19 to the health of the Island, either directly or indirectly and he suggested that it was for Ministers to assess economic harms.

The Acting Director General, Economy, informed the Cell that he had spoken to the relevant Ministers and they wished for Stages 5 and 6 to be combined and brought forward to 5th April, rather than the 12th. They were coming under pressure from some of the larger firms, which were not able to have their staff in the workplace, but they were able to mix in restaurants, which led them to believe that the balance of harms was out of kilter.

The Chair suggested that in order to make an informed decision on the request by the Ministers, the Cell would require greater detail on the harms that were being caused to the hospitality and business sectors, such as the levels of economic support that had been provided. Over the coming days, thought could be given to any measures that could potentially be relaxed and to the merits of combining Stages 5 and 6 of the reconnection roadmap and the Cell would reconsider it at its next meeting.

Matters for information.

A8. 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 18th March 2021, which had been prepared by the Strategic Policy, Planning and Performance Department; and
- statistics relating to deaths registered in Jersey, dated 18th March 2021, which had been compiled by the Office of the Superintendent Registrar.