

SN

SCIENTIFIC AND TECHNICAL ADVISORY CELL

(71st Meeting)

23rd August 2021**PART A (Non- Exempt)**

All members were present with the exception of R. Sainsbury, Managing Director, Jersey General Hospital, Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention, and Dr. S. Chapman, Associate Medical Director for Unscheduled Secondary Care, from whom apologies had been received.

Mr. P. Armstrong, MBE, Medical Director (Chair)
 Dr. I. Muscat, MBE, Consultant in Communicable Disease Control
 Professor P. Bradley, Director of Public Health
 Dr. G. Root, Independent Advisor - Epidemiology and Public Health
 Dr. M. Garcia, Associate Medical Director for Mental Health
 Dr. C. Newman, Senior Policy Officer, Strategic Policy, Planning and Performance Department
 M. Clarke, Principal Officer, Public Health Intelligence
 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
 S. Martin, Chief Executive Officer, Influence at Work
 Dr. M. Doyle, Clinical Lead, Primary Care
 S. White, Head of Communications, Public Health
 C. Keir, Head of Media and Stakeholder Relations
 J. Lynch, Principal Policy Officer
 S. Nibbs, Secretariat Officer, States Greffe

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

Minutes

A1. The Scientific and Technical Advisory Cell ('the Cell') recalled that it had approved the Minutes of its meeting dated 2nd August 2021, at its meeting dated 16th August 2021. However, since that time, certain revisions had been proposed by A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, who had been taking annual leave when the minutes of the meeting dated 16th August had been circulated and approved. The revisions proposed by Mr. Khaldi related to his recollection of specific comments that he had made, in connexion with the wearing of face coverings, on 2nd August 2021. It was agreed that such revisions would be provided to the Secretariat Officer of the States Greffe following the extant meeting, and that the Minutes dated 2nd August 2021 would then be revised and re-circulated as necessary, for review by the Cell.

Intelligence
overview
including
Analytical Cell
Update and
HCS service
activity

A2. The Scientific and Technical Advisory Cell ('the Cell') received an Intelligence overview including an Analytical Cell Update and Health and Community Service (HCS) activity overview, prepared by M. Clarke, Principal Officer, Public Health Intelligence, Strategic Policy, Planning and Performance Department.

The Cell was advised that there were 374 active cases of COVID-19 in the Island as of Friday 20th August 2021, from which 1249 direct contacts had arisen. There was a 7-day rate of 216 and a 14-day rate of 415. There had been a total of 9055 positive cases in total over the past three outbreaks of the virus in the Island. It was noted that the largest amount of positive cases were now being diagnosed following travel arrivals to the Island, followed by diagnoses of those seeking healthcare. More than 2000 daily tests were still being undertaken, with this figure arising to 3000 as at Friday 20th August 2021.

Eleven COVID-19 positive patients remained in hospital as of 20th August 2021, with four having been hospitalised due to clinical Covid-19 as their primary reason for admission. Two patients were being cared for in the Intensive Care Unit. It was noted that six Covid-19 related deaths had been registered during the third wave of COVID-19 in Jersey.

A testing rate of 19,400 per 100,000 of the population (with a 1.1 percent positivity rate) was noted, which compared favourably against the 3.9 percent positivity rate within the UK. The effective R rate estimate within the Island was now between 0.6 and 0.7. Long COVID in EMIS (the system within which the Island's General Practitioners recorded patients' medical conditions) was noted as having affected 145 patients, with 80 patients listed as having ongoing COVID-19 symptoms, and 68 patients noted as suffering with Post Covid syndrome. An overlap in recording both the conditions was also noted.

The Cell was apprised that a total of 146,439 total COVID-19 vaccinations had now been provided, with 75,506 first doses having been given and 70,933 second doses of the vaccine having been provided. It was noted that this worked out as 135.85 doses per 100 people in the population. In terms of age group distribution, two thirds of the 18 – 29 years age group had now received their first dose and 50 percent of the same age group had now received their second vaccination.

As at 15th August 2021, Jersey had therefore fully vaccinated 81 percent of its eligible adult population who were aged 18 years or over. This compared favourably with data available in connexion with vaccination coverage in the rest of Europe. Border monitoring graphs were then reviewed, with an increase of COVID-19 cases noted in Germany, as well as high rates of virus being exhibited within the Republic of Ireland and southern Spain. As schools in Scotland had re-opened for the Autumn term on 18th August, the Cell noted that an uptick in cases had also been observed there.

I Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department commented on the vaccination by age range bar chart and noted that it would be useful to see the time series for the vaccination rate in the various age ranges, and how it changed over time. Ms. Clarke provided this information which showed for all age ranges an initial uptake in vaccines, followed by a levelling off. Younger age groups were levelling off at a lower level than older age groups. There was then a discussion about whether communications were required, to encourage various age groups to become vaccinated.

A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, also noted increasing vaccine hesitancy amongst those

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below the age of fifty years. Mr. Khaldi considered that work needed to be undertaken to understand the reasons for vaccine hesitancy within this age cohort and for the ongoing communications strategy to be viewed in connexion with this. The work was expected to be re-presented to the Cell in a fortnight's time and it was confirmed that S. White, Head of Communications, Public Health and B. Sherrington, Head of Policy (Shielding Workstream) and Head of the Vaccine Programme, Strategic Policy, Planning and Performance Department, had been apprised of the need for the piece of work to be undertaken.

Mr. Khaldi also addressed "Amber" data quality issues arising from the reported vaccination levels of frontline care workers in care homes. Dr. I. Muscat, MBE, Consultant in Communicable Disease Control, opined that the level of vaccine hesitancy, from some of those working in this sector (following anecdotal evidence derived from conversations with care home workers), was high and therefore it was difficult to conclude that 100 percent of care home staff could be vaccinated. Mr. Cope noted that the ethnicity of those receiving vaccinations was not presently available (as it was not usually recorded at the time of uptake) but it was agreed that this should be explored.

Dr. G. Root, Independent Advisor - Epidemiology and Public Health, found the uptake in vaccines by age group of great interest, and noted that the lower the age range, the lower the uptake of vaccination appeared to be, perhaps due to the self-perception of individuals that they were fit and healthy, and therefore did not require vaccination. Dr. Root suggested that a qualitative study should be undertaken in certain chosen care homes over the course of three days to check the uptake (or not) of vaccination by care staff working in these environments. A qualitative approach was also agreed by Professor P. Bradley, Director of Public Health. Dr. M. Doyle, Clinical Lead, Primary Care, also stated that it would be worthwhile researching the wrongful belief held by those who had previously suffered with COVID-19, that they did not require vaccination.

Dr. Muscat, MBE noted that there was increasing hospital admission trend, in the United Kingdom, of those aged below 50 years of age, and in particular of younger age groups, due to COVID-19. Dr. Muscat, MBE wished to emphasise to those in younger age cohorts that the Delta variant of concern (VoC) would remain present and infectious for some time to come. He stated that it remained the case that the best way to protect oneself from transmissibility was to ensure that vaccination had taken place, rather than relying on non-transmissibility. It was agreed that further work was required in order to understand vaccine hesitancy, as understanding this would also be likely to assist in the success of the forthcoming vaccination booster programme.

Office of
National
Statistics
(ONS) /
Oxford Study
and
implications -
discussion

A3. The Scientific and Technical Advisory Cell ('The Cell') received a paper prepared by the Office of National Statistics (ONS) and arising from a University of Oxford *et al* Study, entitled '*Impact of Delta on viral burden and vaccine effectiveness against new SARS-CoV-2 infections in the UK*'. This had been circulated on behalf of Dr. I. Muscat, MBE, Consultant in Communicable Disease Control, and summarised the substance and conclusions of the large, observational, real world study.

The Abstract of the Study was noted by the Cell, as the effectiveness of BNT162b2, ChAdOx1, and mRNA-1273 vaccines against new SARS-CoV-2 infections which required continuous re-evaluation, given the increasingly dominant Delta variant of concern. An investigation had been undertaken into the effectiveness of the vaccines within a large community-based survey of randomly selected households across the UK. It had been found that the effectiveness of BNT162b2 and ChAdOx1 against any infections (new PCR positives) and infections with symptoms or high viral burden was reduced with the Delta variant. A single dose of the mRNA-1273 vaccine had similar or greater effectiveness compared to a single dose of BNT162b2 or ChAdOx1.

Effectiveness of two doses remained at least as great as protection afforded by prior natural infection. The dynamics of immunity following second doses differed significantly between BNT162b2 and ChAdOx1, with greater initial effectiveness against new PCR-positives, but faster declines in protection against high viral burden and symptomatic infection with BNT162b2.

There was no evidence that effectiveness varied by dosing interval, however protection was higher among those vaccinated following a prior infection and younger adults. In connexion with the Delta VoC, infections occurring following two vaccinations had a similar peak viral burden to those in unvaccinated individuals. The SARS-CoV-2 vaccination still reduced new infections, but the effectiveness and attenuation of peak viral burden were reduced with the Delta variant.

The following observations arising from the study were made by Dr. Muscat, MBE:

- it was noted that monthly PCR testing had been used as a primary tool in both the Alpha and Delta based pandemics;
- both the Pfizer and the Astra Zeneca vaccines had been found to be effective, as had the Moderna vaccine, against the Alpha variant of COVID-19. There was, however, a reduction in efficacy of the vaccines against the Delta VoC when compared to the Alpha VoC. The study had also encouraged some discussions regarding vector-based vaccinations against the chemical compound of other, mucosal vaccines;
- two doses of either Pfizer and Astra Zeneca vaccines provided greater protection against COVID-19 than contracting it in the community and developing antibodies would.

Dr. Muscat, MBE further stated that the study had concluded that a third dose of the approved vaccines was recommended (as was being planned in Jersey), given the waning effects of vaccination over the course of time. Furthermore, the use of mixed vaccines was being considered in the study for use in the booster vaccine, so in theory a patient could be provided with an Astra Zeneca booster vaccine following two earlier Pfizer vaccines, or vice versa. With regard to viral load, it was noted that in any event those who were fully vaccinated against the Delta variant could still be highly transmissible of this form of COVID-19.

Dr. G. Root, Independent Advisor - Epidemiology and Public Health, expressed concern from the paper's finding that both vaccinated and unvaccinated individuals could seemingly have the same viral load, as well as the policy implications that this finding could have – for example, who to vaccinate first

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with a booster injection, such as those who were categorised as clinically “high risk”, rather than only those within a certain age range.

P. Armstrong, MBE, Medical Director (Chair) asked if anything could be learned from other viruses and vaccine programmes. Dr. Muscat, MBE could not recall another viral epidemic, similar to COVID-19, whereby this was the case. A discussion followed regarding how long a high viral load would last and the following reduction of transmissibility. The Chair summarised such discussions by stating that Government of Jersey Ministers and others would still need to take cautious decisions whilst research and findings were still being made in connexion with COVID-19 and the Delta variant.

Testing
strategy

A4. The Scientific and Technical Advisory Cell (‘the Cell’), with reference to its Minute No. A4 of 16th August 2021, received a presentation entitled ‘Testing Strategy Update’ prepared by J. Lynch, Principal Policy Officer.

The Cell recalled that it had previously considered proposed updates to the Government of Jersey’s testing strategy, including the following matters:

- the progressive move to optional self-administered testing for vigilance purposes;
- the reduced reliance on PCR testing through the deployment of Lateral Flow Testing (LFT) deployment;
- a proposed framework and risk criteria to scale down the testing programme, due to the increase in vaccination protections, including the foreseen and planned vaccination booster programme, and the proposed move on to an active mitigation approach.

The Cell noted the paper prepared in support of the presentation, which expanded upon the considerations set out above, with specific proposals on timing and operations across the testing programmes. The Cell was asked to consider and comment upon the updates proposed within the presentation in order to assist Ministerial decision making.

It was recalled that, to date, the Government of Jersey had pursued a robust COVID-19 suppression strategy and that key features of this strategy had included the use of a range of Non-Pharmaceutical Interventions (NPIs), which had been designed to substantially lower infection rates. The Cell further noted that the proposed mitigation strategy would take some action to control the further spread of COVID-19, but would not seek to deploy NPIs at the level and scale associated with a suppression strategy. In the context of widespread vaccination (which the Cell noted was the case in Jersey), the strategy would be adaptable to counter threats of new variants which might cause more severe disease and/or navigate the protection afforded by vaccines.

The Cell recalled that the testing strategy aims had been:

- (a) the identification and targeted management of actively infectious positive cases;
- (b) holding infection rates at a manageable level to support normal societal function;
- (c) to provide an early warning sign of escalating risk to avoid the need for later, overly restrictive, NPIs;

- (d) the differentiation of COVID-19 infection from other seasonal viruses entering Autumn and Winter, to enable correct treatment and infection control;
- (e) to provide added protection to high-risk settings such as hospitals and care homes; (Bespoke testing mitigations were recommended in such environments and other vulnerable communities)
- (f) to enable identification of Variants of Concern (VoC) and to reduce onward infection seeding; and
- (g) to support community confidence whilst exiting the 'suppression' phase, as defined above.

The Cell also noted the following key points:

- (1) timings and amendments would be dependent on continued manageable risk levels reflected through hospitalisation rates, COVID sickness related disruption levels, vaccination and booster uptake and both external and internal variant of concern surveillance;
- (2) any reduction in testing would require contingency planning to facilitate rapid re-deployment of mitigations in the event of escalating or unforeseen risk. This could include the deployment of restrictive mitigations in the absence of immediate testing resources;
- (3) VoC risk would be prioritised through genomic sequencing and adherence to UK assessments and mitigations;
- (4) Proposed changes were in line with the Government of Jersey's understanding of UK Government and comparable jurisdictions' intentions; and
- (5) the policy was intended to be used as an internal framework to guide strategy and resource planning.

It was noted that timings and amendments would be dependent on continued manageable risk levels, reflected through hospitalisation rates, COVID-19 sickness related disruption levels, vaccination and booster uptake, external and internal variant of concern surveillance. Furthermore, any reduction in testing would require contingency planning to facilitate the rapid re-deployment of mitigations in the event of escalating or unforeseen risk. It was likely that this would include the deployment of restrictive mitigations in the absence of immediate testing resource.

Variant of Concern (VoC) risk would be prioritised through genomic sequencing and adherence to UK assessments and mitigations. Any proposed changes would have to be in line with the Government of Jersey and comparable jurisdictions' intentions.

The Cell recalled that the extant Safer Travel Policy ensured that arriving passengers were currently able to undertake one PCR test on arrival into Jersey, but that in due course, this would be likely to be phased out, although a pre-registration form would still need to be completed. It was likely that a universal 'no test' requirement would be introduced, although where the arrival was from a UK mandated 'red list country', the need for ten days isolation would still apply (though without a test being undertaken in addition to such isolation, unless the isolating person felt unwell).

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The Cell considered the options and noted that it was anticipated that there would be a peak in travel volume immediately prior to the Autumn term and also during half term in October 2021. The lateral flow test (LFT) regime would be maintained in schools on a twice weekly basis. P. Armstrong MBE, Medical Director (Chair) enquired about the measures that could be put in place for children who would, for example, leave the Island for one day and return that evening following a sports trip or similar. It was agreed that this would be discussed further in due course.

Dr. G. Root, Independent Advisor - Epidemiology and Public Health, discussed the epidemiological considerations for continuing border testing until 1st November 2021 and the rationale for this. Thereafter, Dr. Root proposed moving to a surveillance-based system at the border and to randomly select certain arriving passengers for PCR testing, in order to maintain an overview of testing data and findings available to the Cell and the Government of Jersey. Without this safeguard, it was arguable that Jersey might not have sufficient volume or quality of data going forward. Dr. Root therefore agreed that there should be far less testing than the current quantity undertaken, however some should be maintained on the basis of surveillance and quality monitoring.

Mr. A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department supported the concerns expressed by Dr. Root about the absolute stoppage of tests at the border post 1st November 2021. Mr. Khaldi opined that decisions were often made during pandemics on the basis of information from that time, but such information and data was also required to be reviewed post-pandemic and to assist with practical and operational issues that may arise if testing measures at the border were dismantled. Mr. Khaldi therefore suggested that measures that could be scaled upwards or back down would be better than absolute change. I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department stated that he had struggled to link the proposed actions discussed to the objectives that were set out in the presentation and expressed uncertainty as to how some of the stated objectives would be met.

There followed a discussion of transmission dynamics of the COVID-19 virus, which would require a representative surveillance system within the Island. Professor P. Bradley, Director of Public Health asked what 'surveillance' would mean on a practical level and whether this was feasible. It was agreed that this subject would be discussed post meeting, as would the need to re-scale the testing programme and strategy, if a further potential variant was noted.

Dr. Muscat, MBE felt that the changes proposed to take place in November 2021 were largely reasonable. The number of COVID-19 positive arrivals in Jersey was outstripping the number of on-Island positive cases seeking healthcare. Dr. Muscat, MBE, reminded those present that Stage 7 reconnection would occur on 26th August 2021 and further that schools would then re-open in early September 2021. Dr. Muscat, MBE therefore urged some caution in proceedings and reminded those present how influenza ('flu') and flu variants were identified via admission to hospital and, following this, serological surveillance, or due to General Practitioners starting to notice the presence of influenza during empiric screening. Some consideration was given to setting up an on-Island study in this regard.

S. Petrie, Environmental Health Consultant, agreed with Dr. Root and others on the need for surveillance. Mr. Cope concurred, stating that surveillance on Island was important and that it should also be representative. The Office for National Statistics (ONS) COVID-19 Infection Survey was used as an example of a random survey of households. Mr. Cope stated that sample size would be important in any such surveillance model.

Dr. C. Newman, Senior Policy Officer, Strategic Policy, Planning and Performance Department, expressed agreement with the discussion and reminded those present that, at this time last year, a piece of work had been undertaken called ‘Surveillance to understand’. Unfortunately, the resources to set up a study following this work had not been available previously and the Cell would need to acknowledge this difficulty. It was suggested by Dr. Newman that a potential way forward could be that the Island might be able to attach itself to a further ONS study, given that there were presently 35,000 unused COVID-19 antibody tests on-Island, some of which could be used for such purpose.

Dr. Root expressed his agreement with the comments made by Dr. Newman, with the caveat that the Cell would not wish to collect the wrong kind of data in terms of quality or too little data in terms of quantity.

Mr. P. Armstrong, MBE, Medical Director (Chair) summarised the discussions regarding the presentation, confirming that ongoing surveillance work needed to be considered, as well as noting the caution expressed by those present about the potential dangers of “dismantling” the work done to better understand COVID-19 to date, if testing for the virus was abolished altogether. Mr. Lynch thanked those present for their input into the discussions around the presentation.

Chair of
Scientific and
Technical
Advisory Cell
– change.

A5. The Scientific and Technical Advisory Cell (‘the Cell’) held a discussion regarding the future chairing of the Cell, with consideration of the same led by P. Armstrong, MBE (Chair) and Professor Peter Bradley, Director of Public Health.

Mr. Armstrong, MBE informed colleagues that he was now handing the chairmanship of the Cell on to Professor Bradley, and that it was a timely moment for this action to be taken. It seemed clear that COVID-19 was a virus that would continue to make its presence felt, and Professor Bradley was well placed to chair the Cell in his position as the Island’s Director of Public Health.

Mr. Armstrong, MBE wished to thank all colleagues from within the Cell, past and present, for their support during his tenure as Chair for the past 71 meetings. He further thanked the Secretariat Officers from the States Greffe and supporting Officers for their “massive support” and stated that he was proud of many of the things that the Cell had achieved and in particular of it had conducted its business through professional and respectful conversations about often difficult subjects.

Those present thanked Mr. Armstrong, MBE for the quality of his leadership and excellent chairmanship abilities, which had enabled diversity of views and enhanced the quality of debate and he would be well remembered for his ability to balance outcomes following complex discussions. Mr. Armstrong, MBE wished the Cell well for the future.

There being no further business, the meeting ended at 1207 hrs.