

LP/PLC

SCIENTIFIC AND TECHNICAL ADVISORY CELL

(83rd Meeting)

(Business conducted via Microsoft Teams)20th December 2021**PART A (Non-Exempt)**

All members were present with the exception of Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention, Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department, Dr. M. Doyle, Clinical Lead, Primary Care, and Ms. B. Sherrington, Senior Nurse Adviser in Public Health, from whom apologies had been received.

Professor P. Bradley, Director of Public Health (Chair)
 Dr. I. Muscat, MBE, Consultant in Communicable Disease Control
 Dr. G. Root, Independent Advisor - Epidemiology and Public Health
 S. Petrie, Environmental Health Consultant
 A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department
 I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department
 M. Clarke, Head of Public Health Intelligence, Strategic Policy, Planning and Performance Department

In attendance -

E. Baker, Head of Vaccination Programme, Health and Community Services
 J. Mason, General Manager, Health and Community Services (for a time)
 S. Martin, Chief Executive Officer, Influence at Work
 R. Williams, Director, Testing and Tracing, Strategic Policy, Planning and Performance Department
 J. Norris, Principal Policy Officer, Strategic Policy, Planning and Performance Department
 J. Lynch, Principal Policy Officer, Strategic Policy, Planning and Performance Department
 Dr. L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department
 S. Huelin, Senior Policy Officer, Strategic Policy, Planning and Performance Department
 K. Posner, Director of Policy and Planning, Children, Young People, Education and Skills Department
 D. Danino-Forsyth, Director of Communications, Office of the Chief Executive (for a time)
 D. Houseago, Group Director Economy, Office of the Chief Executive (for a time)
 S. O'Reagan, Group Director of Education, Children, Young People, Education and Skills Department (for a time)
 L. Plumley, Secretariat Officer, States Greffe
 P. Le Conte, Secretariat Officer, States Greffe

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

Minutes.

A1. The Scientific and Technical Advisory Cell ('the Cell'), received and noted the Minutes from its meetings of 29th November, 6th and 13th December 2021, which had previously been circulated. The Minutes were approved by the Cell.

It was recalled, with reference to Minute No. A6 of its meeting of 6th December 2021, that following the adoption by the Cell of the 'Code of Practice for the Jersey Scientific and Technical Advisory Cell ('STAC')', dated 3rd December 2021, the 2 most recent sets of Minutes had been drafted in line with the requirements of that Code and consequently discussions were now unattributably recorded in the Minutes. It was noted that one of the members of the Cell preferred the previous style of Minutes.

Intelligence overview, including Analytical Cell update and HCS activity.

A2. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A1 of its meeting of 13th December 2021, received a PowerPoint presentation, entitled 'STAC Monitoring Update', dated 20th December 2021, which had been prepared by Ms. M. Clarke, Head of Public Health Intelligence and Dr. L. Daniels, Senior Informatics Analyst, both of the Strategic Policy, Planning and Performance Department.

The Cell was apprised of the current situation with regards to public health monitoring, noting that as at Friday 17th December 2021, there were 1,177 active cases of COVID-19 recorded in the Island, from which 4,722 direct contacts had been identified. The majority of cases (407) had been identified in individuals seeking healthcare, with smaller numbers being identified through contact tracing (194) and the remainder through positive Lateral Flow Test ('LFT') results and various screening programmes. The age ranges, gender and vaccination status of the active cases were shown. Around 2,000 tests were being undertaken on a daily basis and an average of 120 cases per day had been identified since 6th November 2021, though it was noted that 140 cases had been reported on 19th December, which was a higher figure than usual for a weekend day. The highest proportion of cases were among those aged 10 to 19 years and 40 to 49 years, although an increase was noted in those aged 30 to 39 years. A breakdown of cases in those aged 18 years and under showed greater levels of infection in the secondary school age group than in the primary school cohort. It was noted that 80 per cent of the active cases were symptomatic.

The Island test positivity rate (excluding inbound travel) had increased since the previous week to just over 10 per cent. As at 16th December 2021, the 14-day case rate per 100,000 population had decreased to 1,480 and the 7-day rate to 700. The 7-day case rate per 100,000 population had been highest in those aged under 18 years for a number of weeks, however it was now declining for this cohort and an increase in the rate for those aged 18 to 39 years was noted, which now stood at 1,135. The 7-day case rate remained stable for those aged over 60 years, at 204. Contact tracing and workforce screening were the principal testing reasons, with those seeking healthcare accounting for a smaller proportion, however test positivity rates for the latter group were significantly higher, at almost 35 per cent, in part due to the inclusion of individuals seeking a test following a positive Lateral Flow Test ('LFT').

The Cell reviewed the age range and vaccination status of cases in hospital since 28th June 2021 and noted that as at 17th December 2021, there had been 10 patients in the Hospital with COVID-19. During the previous week a high of 18 patients had been noted, and early indications suggested that the figure for the present day stood at 13 cases.

Details were provided of the positive cases linked to health and care settings,

Government departments and schools.

A further 3 deaths had been recorded bringing the total to 87, with 9 registered since the start of the 4th wave on 1st October 2021.

The Cell noted that 287 patients were currently recorded in the EMIS clinical IT system as suffering from 'Long Covid'.

The Cell was apprised of the results of social media sentiment analysis, noting negative reactions to the announcement that cases of the 'Omicron' variant had been confirmed and surprise at measures in response to the arrival of the variant not taking effect until 4th January 2022.

Details regarding the COVID-19 and flu vaccine programmes were shared and it was noted that as at 5th December 2021, 196,865 doses of COVID-19 vaccine had been administered, of which 40,130 were third 'booster' doses and 41,305 flu vaccinations had been delivered. It was noted that 95 per cent of those aged over 75 years had received a booster vaccination and 88 per cent, a flu vaccination, whilst for those aged 60 to 74 years, the booster vaccination rate was over 80 per cent. Overall, as at 16th December 2021, 50 per cent of adults in Jersey had received a booster dose, which compared favourably with the UK rate of 48 per cent.

The Cell was apprised of the situation in UK, noting that over the 7 days to 19th December 2021, an increase of over 50 per cent in the number of cases had been noted, to over 80,000 cases per day; hospitalisations had increased by 8 per cent and deaths had decreased by 6 per cent. It was noted that case rates were increasing across Europe.

The 'UK Health Security Agency Risk Assessment' for the variant, dated 15th December 2021, was shared, which confirmed that Omicron was displaying a growth advantage over the Delta variant and was at least as transmissible. Although there was now high confidence in a component of immune evasion, the very high growth rate and laboratory findings suggested that an increase in transmissibility may also be contributing to the growth advantage. There was insufficient data to fully assess infection severity, but on the limited data available there was no signal that supported a difference in the intrinsic virulence of Omicron compared to Delta.

The 'UK Health Security Agency Technical Briefing 32', dated 10th December 2021, which had been circulated prior to the meeting, estimated that the household transmission risk remained higher for Omicron than for Delta by a factor of 2.9, and that the secondary attack rate in household contacts for confirmed Omicron cases was 15.8 per cent, compared to 10.3 per cent for Delta.

The Cell was apprised of the findings of a study by the Imperial College COVID-19 response team, entitled 'Report 49: Growth, population distribution and immune escape of Omicron in England', dated 16th December 2021, noting that an analysis of data from England estimated that cases of Omicron were growing exponentially and doubling every 2 days. Hospitalisation and asymptomatic infection indicators were not significantly associated with Omicron infection, suggesting at most limited changes in severity compared with Delta, though it was noted that this analysis was based on limited data. With regards to vaccine effectiveness, it was estimated that double vaccination conferred between 0 and 20 per cent protection against Omicron, whilst booster vaccination increased this to between 55 and 80 per cent.

The UK had seen a sharp increase in Omicron cases, particularly in London, and it was swiftly rising to dominance compared to other variants, accounting for over 67 per cent of cases overall. Early modelling, which had been the subject of public

debate, suggested that the UK would experience peak hospital admissions in January 2022.

Data from the Gauteng province of South Africa, where Omicron had initially been identified, showed that cases and test positivity were peaking there at present, however it was still too early to make concrete conclusions regarding disease severity.

The Cell was informed that studies by vaccine manufacturers were showing positive results in terms of protection against severe disease due to Omicron, however these were based on laboratory analysis as opposed to real world data; which might explain why the results had not been included in the UK Health Security Agency Risk Assessment. It was emphasised that severity of disease was better assessed using real life experience and further data was expected in the following week, which would help to inform decisions. In relation to the current situation in Jersey, 2 theories were postulated. Firstly, it was possible that Omicron had arrived in the Island later than in the UK and that the level of community transmission was low or lesser than the UK. Another scenario was mooted, which was that Omicron had been present in the Island at a similar time to its emergence in the UK, but that mitigation measures had slowed its spread, particularly the vaccination programme, which would explain the relatively consistent plateau of cases since the beginning of November 2021. The situation with regards community transmission of Omicron was a key question in terms of what the Island could expect in the weeks ahead.

It was observed, by one of the members of the Cell, that studies from Cambridge and Hong Kong had shown that Omicron was less efficient at replicating in the lungs than previous variants, which suggested that its intrinsic severity could be less than that of the Delta variant. In response, it was noted that immune response was also an important factor, so it was difficult to speculate on disease severity based on viral replication data alone. It was conjectured by the aforementioned member of the Cell, that the Gauteng experience could mean a relatively short-lived Omicron wave and that England's Chief Medical Officer had hinted that the variant could rise swiftly and decline rapidly.

It was noted that genome sequencing data would provide valuable evidence of the incidence of Omicron in the Island. Currently a minimum of 10 per cent of positive samples were being sent for sequencing on a daily basis and it was hoped to increase this figure to 20 per cent, subject to operational and capacity constraints.

In terms of vaccine coverage, one of the members of the Cell suggested that a better comparator would be a market town in Southern England rather than the UK or devolved nations and that Jersey might not compare as favourably. It was noted that the suggestion would be explored but conclusions should not be drawn in the absence of data.

The Cell discussed the current situation with regards to Hospital admissions and it was confirmed that safe levels of care were being maintained and that there was sufficient capacity at the present time. It was recognised that bed capacity might become a more pressing issue as the Winter progressed and discussions led by Public Health were ongoing, with the aim of optimising care pathways and ensuring that patients who were 'medically-fit for discharge' could be discharged more promptly to care settings.

It was recalled that work to progress the publication of local information demonstrating the protective effect of vaccination with regards to hospitalisation was underway. The Cell was reminded of the risk of retrospective identification when referring to small numbers of patients at a particular point in time. The

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collation of data over a longer period of time and the use of an appropriate denominator were being considered by a sub-group of the Cell, as well as the issue of confirmation of vaccination status by cross reference to recorded data rather than reliance on self-reported information. It was acknowledged that it was an important piece of work which involved a high degree of complexity.

It was noted, in response to the cluster of cases at the Prison, that visitors were now required to undertake a Polymerase Chain Reaction ('PCR') test within 72 hours prior to attending. This precautionary step was among a number of short-term measures introduced following an Infection Control meeting, which included a requirement for staff to undergo PCR testing every 3 days. One of the members of the Cell viewed the visitor testing requirement as somewhat draconian and questioned why reliance could not be placed on LFTs instead. It was agreed that this matter should be discussed outside of the extant meeting.

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

Vaccination
update.

A3. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of its meeting of 13th December 2021, received a PowerPoint presentation, entitled 'COVID-19 Vaccination Programme, Update to STAC/CAM' dated 20th December 2021 which had been prepared by Ms. E. Baker, Lead Nurse, Infection Prevention and Control, Health and Community Services.

The Cell was informed that delivery of the 'booster' vaccine programme was being accelerated, capacity had been increased and 950 doses per day were currently being delivered at the Vaccination Centre at Fort Regent. In addition, walk-in appointments would be available from 20th December 2021 for all Health staff, pregnant women and those aged 12 to 15 years. The target date for completion of the booster vaccine programme had been brought forward to mid-January 2022. An additional 7 vaccinators (headcount, not Full Time Equivalents) were being trained and a new vaccination pod was being built at Fort Regent which would offer a further 10 vaccine stations to be operationalised when the additional workforce was established. Over the next 3 weeks, around half of the 10,000 available appointments had been booked, and the next few days were fully booked, with the next available appointments currently on 27th December 2021.

It was acknowledged that efforts were needed to increase the rate of booster uptake amongst Health staff, which currently stood at 64 per cent. The provision of fast-track walk-in appointments at the Vaccination Centre for this cohort was an initial step and a daily 'sprint group' had been set up to develop further proposals.

It was noted that whilst walk-in appointments were available for the aforementioned groups of people, they were not more widely available, and the Cell discussed the practicalities of opening them to all. The Cell was informed that the priority at present was to offer boosters to as many people as possible, as quickly as was feasible, in a safe and controlled manner, and this precluded for example, 'rock up' vaccination stations in the Town Centre due to the time and resources needed to set up and operate the same, especially when compared to how many more vaccinations could be undertaken using that capacity at the Vaccination Centre instead.

Over 1,000 home vaccination visits had been undertaken, with another 463 outstanding. Vaccination teams had attended the Prison 11 times during 2021, most recently on 18th December 2021.

The Cell received a PowerPoint presentation entitled 'Boosting Booster Rates', dated 13th December 2021, which had been prepared by Mr. S. Martin, Chief Executive Officer, Influence at Work. Potential interventions to increase the uptake

of booster vaccination were detailed therein, some described as low risk and easy to implement, and others as novel ideas, the context of the 'Omicron' variant adding urgency to the need to accelerate the programme. The key principles behind the proposals were to 'make it easy, praise and publicise, use a range of messengers and make it ok to think again'. It was observed that Omicron provided a new rationale for Islanders who had yet to be vaccinated or who had only received one dose, to be encouraged to present for vaccination.

The Cell was apprised of the potential for a drive through vaccination centre, which had proven effective in other jurisdictions, though implementation would be simpler if the post vaccination observation period was relaxed. Other proposals included making vaccination easy to obtain by setting up a pop-up vaccination centre in a vacant Town Centre shop or other places that people attended on a regular basis. It was suggested that social comparisons could have a strong influence on people's desire to take action, and signals such as badges with 'To Boost Jersey, I'm Boosted' could be helpful.

The Cell discussed the proposals and concern was expressed by a member of the Cell about the time which could be needed to implement some of the suggestions, when the pressing need was to increase the uptake of booster vaccinations in the next 2 to 3 weeks. It was opined that encouragement and coaxing would be desirable as would building the narrative that it was socially unacceptable not to be vaccinated. It was noted that such a message would have to be introduced with caution in order not to further alienate those opposed to vaccination. It was mentioned anecdotally, that when people realised they would face additional hurdles if travelling abroad unless they were fully vaccinated, some who had previously held very firm opinions about vaccination were changing them given the personal inconvenience that would result.

There was general support for easily implementable, low risk proposals to encourage booster uptake such as mobile vaccination units, as long as the efforts did not detract resources and capacity from the Vaccination Centre. One of the members of the Cell would have preferred stronger incentives for people to become vaccinated including requiring proof of vaccination or infection status and charging for such testing. In addition, it was opined that Jersey was at risk of becoming an outlier in not charging for testing in a context where many other jurisdictions now required travellers to pay.

With regards to a drive-through vaccination centre, it was noted that the idea had merit but practicalities including the speed at which it could be established would be important considerations. In terms of location, a preference was expressed for the Harbour rather than the Airport.

It was noted that indicating that the Vaccination Centre was very busy could be both helpful, in terms of showing the popularity and urgency of the booster vaccination programme, but also risked putting people off if they translated this into long waiting times and inconvenience, when in fact the process was streamlined and efficient, aided by measures such as free parking.

The Cell was informed that the results of focus groups held with unvaccinated under 40-year-olds would be shared at a future meeting, and early indications were that inconvenience might be a motivating factor in deciding to become vaccinated.

The Chair noted that the Cell was in agreement that measures likely to bring about the biggest benefit in terms of vaccination uptake should be prioritised, mindful that any resources used did not detract from the Vaccination Programme.

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Mr. Martin thanked the Cell for a helpful discussion.

COVID-19
Winter
Strategy
update,
Omicron
context.

A4. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A3 of its meeting of 13th December 2021, received a PowerPoint presentation, entitled 'Omicron policy - Shifting from prevention to resilience', dated 20th December 2021, which had been prepared by Mr. A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department.

The Cell was informed that data from the United Kingdom ('UK') and locally, regarding the 'Omicron' COVID-19 variant, suggested that Jersey was likely to experience a large wave of Omicron cases in December 2021 and January 2022. Given that the variant displayed a known growth advantage over the currently predominant Delta variant, this represented a change in context and the Cell was asked to consider the current range of preventative measures in place. It was noted that the Island setting resulted in a limited surge capacity, and consequently, it was necessary to ensure that resources were allocated appropriately and that essential services remained resilient over the Winter period.

The Cell was presented with a 'Comparative analysis of COVID-19 restrictions in other jurisdictions', dated 20th December 2021, noting that the analysis was necessarily limited given the time urgency posed by Omicron. Restrictions and guidance imposed in France, the UK, Ireland, Denmark, Iceland and Guernsey were detailed therein, as well as the approach to the treatment of direct contacts of active cases.

It was recalled that an Omicron Testing and Tracing policy had been adopted by the Competent Authorities Ministers ('CAM') at their meeting of 29th November 2021 and was now in operation. Direct contacts of Omicron cases were required to self-isolate for 10 days, in contrast with non-Omicron cases, where there was no requirement for direct contacts to isolate. As of 17th December 2021, 7 cases of Omicron had been detected, from which 25 direct contacts had arisen, and this number was likely to rise. The Cell was reminded of further decisions made by CAM in response to the Omicron variant, namely that 'booster' vaccinations should be offered to all adults immediately, with the aim of allowing eligible Islanders to receive a third dose by mid-January 2022 and the following measures that would come into effect on 4th January 2022: updating the definition of 'fully vaccinated' (to 2 weeks post 3 doses for adults and 2 weeks post 2 doses for children); suspension of the Safer Travel variation for 'natural immunity'; voluntary advice for people to work from home where possible and the introduction of mandatory mask wearing in all public indoor settings with some exemptions.

The Cell was asked firstly, to consider the effectiveness of the current Testing and Tracing policies in the context of an anticipated Omicron wave, particularly with regard to contact tracing of positives and direct contacts; secondly, the key resilience priorities for Government from a Public Health perspective and the point at which a shift from a preventative to a resilience strategy would be warranted; and finally, the stage at which legal restrictions ought to be considered.

The prospect of large numbers of Islanders being required to isolate as direct contacts of an Omicron case under the current Omicron Testing and Tracing policy during the anticipated Omicron wave was concerning in terms of both individual welfare and the potential impact on staffing levels, business continuity, essential national infrastructure and the economy. Consequently, the Cell was apprised of a number of Testing and Tracing policy options for consideration.

- Maintaining the current, differentiated policies for Omicron and non-

Omicron direct contacts. It was noted that some European jurisdictions were following this approach, however it would lead to a high level of disruption, in particular the longer it was in place, as the number of Omicron cases was expected to rise sharply. The policy had been intended as a short-term measure to slow the spread of the variant and needed to be balanced against the potential impact of large numbers of people having to self-isolate as Omicron cases increased.

- Returning to a single consistent policy for all direct contacts in line with the requirement of the standard (non-Omicron) direct contacts policy (an initial Polymerase Chain Reaction ('PCR') test, followed by 10 days of self-administered Lateral Flow Tests ('LFTs') and no isolation). It was noted that the extent to which the current policy was slowing the spread of Omicron and the point at which it would be implemented were important factors to consider, as booster vaccination rates would be increasing over the coming weeks.
- Contact tracing only for those contacts who were not fully vaccinated, (excluding children under 12 years, who were not eligible for vaccination). It was noted that from a policy perspective, this would align Jersey with the UK and Ireland, however from an operational perspective it would pose challenges, due to having to manually validate vaccination status before direct contacts could be confirmed.
- Contact tracing only household direct contacts. It was noted that this option could be considered as a 'fallback' position in the event of contact tracing becoming unworkable due to a significant wave of infection.
- The cessation of all contact tracing, whilst retaining the requirement for positive cases to isolate. It was noted that this was a 'radical' option and it was not considered to be a proportionate or appropriate response at the current time. It was acknowledged that contact tracing had a protective effect and played a part in mitigating the spread of infection in the context of Omicron.
- A shorter isolation period for positive cases. It was noted that this was an option being considered by the UK government and further study of the risk and impact of the measure was needed, which the Public Health department could undertake if requested.

The Cell was also asked to review the schools contact tracing policy in the light of broader consensus on the options outlined. It was noted that maximising learning in face-to-face settings remained a priority for Ministers and the administration of contact tracing currently placed a significant burden on teachers and other school staff, though this had to be balanced against the risk of spread into families, and within the school population. Given the relatively large population of unvaccinated children in schools, the Cell's view was sought with regards to implementing a less onerous contact tracing approach in schools, subject to the effectiveness of other mitigations in place.

The Cell noted a number of relevant factors to consider as part of a potential shift to a resilience, rather than preventative model. Such a move could have a negative behavioural effect that would need to be managed, however staffing resilience was a greater pressure in many services than bed or other service capacity and therefore it would arguably be appropriate for Government bodies other than the Cell and Public Health to control the response to ensure that key services could cope with anticipated levels of sickness and isolation over January and February 2022. The Cell noted that in the event of reduced preventive controls, and where the impact of Omicron was severe, a scenario whereby 'Step 2' measures (legal restrictions) were required was plausible and should be planned for.

The Cell turned to discussion of Testing and Tracing policy options, having regard

to the 'UK Health Security Agency Technical Briefing 32', dated 17th December 2021, which had been circulated prior to the meeting. It was noted that a proportion of positive PCR test results were sent for sequencing to determine which variant had caused the infection, a process which took 72 hours. The current policy was therefore not considered to be sustainable in the long term and an alignment to a single consistent policy would be preferable. One of the members of the Cell expressed support for contact tracing only for those contacts who were not fully vaccinated, due to it providing an incentive for vaccination uptake, though it was noted that operational challenges precluded this policy from implementation at the current time. It was suggested that it would be simplest to return to requiring all direct contacts to undertake a PCR test followed by 10 days of LFTs, with no requirement to self-isolate and this would also restore a degree of individual liberty and a healthier lifestyle for direct contacts. There was general agreement to recommend this approach and it was confirmed that it was sensible from an operational perspective.

In relation to the effectiveness of contact tracing more generally, it was recognised that the process was valuable, particularly when addressing the initial spread of new variants, however as Omicron was expected to become the predominant variant, efforts expended on contact tracing were likely to show gradually lowering returns over time, in terms of slowing the spread of infection. The Cell acknowledged the benefits of contact tracing in that it allowed direct contacts to make informed decisions about their behaviour and consequently had a smoothing effect both on 'spikes' in infection rates and on the workload of the contact tracing team. It was noted that recruitment into the team was ongoing and aligning the Testing and Tracing policies for Omicron and non-Omicron direct contacts would be beneficial in increasing capacity and allowing the team to focus on personally contacting positive cases and direct contacts.

The Cell was informed that the current Testing and Tracing policy was likely to cause detriment to businesses and require CAM to consider the extension of economic support schemes at considerable public cost. In addition, it was observed that the health of the economy depended on a healthy population and people in the UK had begun to exhibit voluntary, precautionary behaviours in response to Omicron, consequently impacting the economy. Whilst this was not an issue for the Cell, it was recognised that maintaining the current Testing and Tracing policy for Omicron direct contacts would likely have a significant economic impact.

It was observed that due to the estimated household 'attack rate' of around 20 per cent, contact tracing household contacts only would be a proportionate approach in the event that the system became overburdened. It would enable some of the benefits of contact tracing to be retained while minimising the difficulties incumbent in managing a large wave of infection and focus attention on household transmission as a key risk. The Cell was reminded of the importance of justifying such a change in the public narrative as the perception existed that 'lockdown' had been entered into last Winter due to contact tracing becoming overwhelmed. The reasoning for such a change would be part of a move towards viewing COVID-19 as a re-occurring, seasonal Winter disease and it was important for communications to express this clearly.

With regards to a shorter isolation period for positive cases, support was expressed for this option from several members of the Cell, although it was opined that it should apply only to vaccinated individuals and include the cancellation of isolation benefit for those who chose to be unvaccinated. It was acknowledged that further analysis would be needed before a decision could be reached on this matter.

The Cell turned its attention to the consideration of Testing and Tracing in schools,

observing that as Omicron spread increased, there were likely to be high levels of transmission in classroom settings and it would be sensible to consider all children in an affected class (or appropriately defined group for secondary schools) as direct contacts, then requiring them to undertake LFTs for a period of 10 days. This would remove from teachers the burden of identifying specific direct contacts in a class. There was general agreement that simplifying the contact tracing regime in schools would be beneficial and input from the behavioural science team would be sought to ensure that the need for LFTs to be undertaken was communicated effectively. Discussions would also be held with Public Health regarding more general testing in schools.

It was noted that the Cell would consider other, non-pharmaceutical, interventions at its next meeting.

Summarising, the Chair noted that the Cell was in agreement that the focus should gradually shift towards maintaining resilience in the Island in terms of staffing and capacity. The Cell acknowledged the importance of contact tracing, particularly in the early days of the Omicron variant, and recognised that it had other benefits beyond the immediate control of infection, through behaviour modification. There would come a point where contact tracing became less effective and it had to be viewed in the context of non-pharmaceutical interventions, which the Cell would consider at a future meeting.

As regards the Testing and Tracing policy, there was agreement that a consistent approach should be adopted for all direct contacts and it was noted that members of the Cell regarded the incentivisation of vaccination as an important consideration. The second option (a single consistent policy for all direct contacts in line with the requirement of the standard (non-Omicron) direct contacts policy) and fourth option (only contact tracing household direct contacts) were the most favoured. In addition, the Cell requested further work to be undertaken with regards to the final option (shorter isolation period for positive cases) and for the matter to be considered at a future meeting. It was recognised that the third option (contact tracing only for those contacts who were not fully vaccinated) was not workable in the current context, although its attractions were noted. With regards to schools, it was agreed that all children in an affected class (or appropriately defined group for secondary schools) should be considered direct contacts and required to undertake LFTs for a period of 10 days.

Mr. Khaldi thanked the Cell for a helpful discussion.

Matters for
information.

A5. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of the current meeting, received and noted the following –

- a weekly epidemiological report, dated 16th December 2021, which had been prepared by the Strategic Policy, Planning and Performance Department;
- statistics relating to deaths registered in Jersey, dated 16th December 2021, which had been compiled by the Office of the Superintendent Registrar;
- a report on COVID-19 vaccination coverage by priority groups, dated 16th December 2021, which had been prepared by the Strategic Policy, Planning and Performance Department; and
- a report on Flu vaccination coverage by priority groups, dated 16th December 2021, which had been prepared by the Strategic Policy, Planning and Performance Department.

There being no further business to discuss, the meeting was concluded at 12.53pm.