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SCIENTIFIC AND TECHNICAL ADVISORY CELL

(30th Meeting)

23rd November 2020(Business conducted via Microsoft Teams)**PART A (Non-Exempt)**

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

Welcome. A1. The Chair of the Scientific and Technical Advisory Cell ('the Cell') welcomed new attendees to the meeting and indicated that the Director General, Justice and Home Affairs Department, the Group Director, Financial Services and Digital Economy and a behavioural scientist, who would shortly be nominated, were to receive standing invitations to future meetings of the Cell.

He reminded those present that the Cell represented a 'safe space' where attendees could ask questions and raise issues without judgment and should feel free to talk openly about the matters under discussion. However, what was said within the meeting was confidential until such time as the Minutes had been formally approved and should not be discussed with others who had not been party to the meeting.

Minutes. A2. The Scientific and Technical Advisory Cell received and noted the Minutes from its meetings of 9th and 13th November 2020, which had previously been circulated. Those in attendance were asked to provide feedback to the Secretariat Officer, States Greffe, by close of business on 23rd November, in the absence of which they would be taken to have been approved.

Monitoring Metrics. A3. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A1 of its meeting of 13th November 2020, received and noted a PowerPoint presentation, dated 23rd November 2020, entitled 'STAC monitoring update', which had been prepared by the Principal Officer, Public Health Intelligence, Strategic Policy, Planning and Performance Department and heard from her in relation thereto.

The Cell was informed that the data had been prepared on Friday 20th November 2020, and that, as at that date, there had been 168 active cases of COVID-19, who had been in direct contact with 1,632 individuals. Since the start of the pandemic, there had been 811 positive cases of the virus. Over the weekend of 21st / 22nd November, a further 23 cases had come to light and work was ongoing to extrapolate the reasons for them having been swabbed, but it was known that some had been identified through contact tracing and others through workforce screening. Of the aforementioned 168 cases, 27 were asymptomatic, 4 were unknown and 117 were displaying symptoms. 18 had been identified through arrivals screening, 93 as a result of contact tracing, 32 had sought healthcare after experiencing symptoms of the virus, 19 had been identified during planned workforce screening and 6 had tested positive pre-admission to hospital.

Five of the active cases were in children aged under 11 years, 23 in those aged between 12 years and 17 years and 18 in individuals aged between 18 years and 24 years. The largest number of cases was in those aged between 50 years and 69 years, of which there were 46. The Cell agreed that it would be helpful if these figures could be presented in decades (such as 20 years to 29 years, 30 years to 39 years) and if it could also be provided with the case rate per population within the age bands. It was agreed

that this could be added to the presentation for the next meeting of the Cell, but it was noted that the data had been presented in that way in line with the Office for National Statistics' (ONS) data sets.

The overall number of deaths in Jersey for the year to-date had increased to 579, which remained lower than for the same period in 2019, when there had been 645 deaths and more than one hundred lower than in 2018 (689). The Cell was presented with graphs which set out the number of positive cases by age band since the start of the pandemic and noted the way in which the positive cases over the preceding 14 days had been identified. The number of inbound travellers had continued to decline, but the positivity rate per 100,000 remained relatively high. During the last, incomplete, week (14th November) there had been 4 positive cases, which equated to a positive rate per 1,000 arrivals of 12.99, or a positivity rate of 1.09 per cent.

With regards to testing, the combined rate per 100,000 population of both arrivals and non-travellers was at 7,100, which far exceeded the United Kingdom ('UK') (3,486) and other jurisdictions with which the Island had close links, mindful that the UK did not undertake on - arrival testing. During the week ending 15th November 2020, 1,230 tests had been carried out on inbound travellers - noting that arrivals from all categories of areas were now required to submit to testing at days zero, 5 and 10 – 6,030 as part of the on-Island surveillance screening (which included workforce screening, admissions testing and contact tracing) and 400 on symptomatic individuals, who had sought healthcare. The weekly test positivity rate in Jersey had increased to 1.2 per cent and stood at 7.4 per cent in the UK. In Poland the rate exceeded 50 per cent and, consequently, extended beyond the scale of the graph.

The Cell was shown the weekly epidemiological update graph, which included figures for those people who had contacted the helpline with 2 or more symptoms of the virus (marked in a dashed line) in addition to those who had reported a fever (the solid line). It was noted that the number of asymptomatic positive test cases was higher than at the start of the pandemic and had increased as enhanced surveillance screening had been introduced. The 14 day rate per 100,000 population up to 15th November 2020 had been 155.8, with the symptomatic 14 day rate 100.19 and 55.66 for those not displaying symptoms.

The Cell was presented with maps, prepared by the European Centre for Disease Prevention and Control ('ECDC'), which set out the geographic distribution of cumulative numbers of reported COVID-19 cases per 100,000 population on a European basis, for weeks 45 to 46 of 2020 (2nd to 9th November) when compared with 13 days during weeks 43 to 44. The Principal Officer, Public Health Intelligence, indicated that the thresholds for the colours used on the most recent map had been changed, which rendered any direct comparison between them challenging.

The Cell viewed charts, which showed the proportion of areas within the British Isles, France, Germany and Italy by RAG (Red / Amber / Green) categorisation for the period from 29th September to 21st November 2020 and noted that 99 per cent of areas in England were now Red, Scotland had retained 13 per cent of its areas as Green, 82 per cent of Wales was Red (which was an improvement on the previous week) and Northern Ireland had remained totally Red. On a positive note, Eire now had 51 per cent of its areas Amber and 4 per cent Green. All of mainland France was Red, 100 per cent of Italy and 88 per cent of Germany. For those countries and territories that were not included within the regional classification, there had been a slight decrease to 56 per cent which were categorised as Green.

The Cell noted information from the local EMIS central records system in relation to flu-like illness. Information from Flu News Europe was that influenza activity remained at inter-seasonal levels, although in France, 2 detections had been reported in

30th Meeting
23.11.20

hospitalised patients who had a history of travel to West Africa.

The Principal Officer, Public Health Intelligence, informed the Cell that, on a seasonally adjusted basis, the number of people actively seeking work was 120 lower than the previous month and, as at 31st October, had stood at 1,470. The number of Income Support claimants had also continued to decline since the peak during the first wave of COVID-19. The total number of vehicles passing through the Tunnel was on a par with the figures for 2019, whereas the total number of bus passengers during the week ending 1st November had been 44 per cent lower than during the comparable week of 2019. In St. Helier, there had been a 2.3 per cent uplift in footfall, but the figure was almost a quarter down on the previous year.

The Cell noted the position and thanked the Principal Officer, Public Health Intelligence, for the update.

Active Cell mapping of recent positive cases of COVID-19.

A4. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A3 of its meeting of 9th November 2020, was provided with data by the Senior Health Analyst – COVID-19, Strategic Policy, Planning and Performance Department, relating to the current cases of COVID-19 within the Island.

The Cell was shown infographics, which had been prepared by the Active Cell and which mapped the direct contacts of the positive individuals. It was noted that 16 positive cases had originated from one cluster and 10 from another and the Cell was informed that these demonstrated how unrelated events could potentially be linked through one individual.

Latest case data – insights.

A5. The Scientific and Technical Advisory Cell ('the Cell') received and noted a PowerPoint presentation, dated 23rd November 2020, entitled 'Insights into latest case data', which had been prepared by the Principal Officer, Public Health Intelligence, the Senior Policy Officer, Public Health and Wellbeing and the Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department.

The Cell was shown graphs, which set out the daily cases of COVID-19, the daily tests, the test positivity rates and the reasons for testing by positive cases for people aged under 18 years, between 18 years and 39 years, between 40 years and 59 years and those aged over 60 years. It was noted that the number of daily cases for individuals aged under 18 years had been between 2 and 3 in early November – which had links to a specific event – but was now averaging around one. The number of daily cases for those aged between 18 years and 39 years, into which a larger proportion of Islanders fell, was between 4 and 5 and there had been a recent increase in the number of daily cases for those aged over 60 years, despite the rate of testing not having increased.

The daily testing rate for those aged under 18 years had increased in early November and the Cell was mindful that certain school groups had undergone PCR testing at that juncture. There had been increased testing for those aged between 18 years and 39 years and 40 years and 59 years, largely linked to targeted workforce screening. As aforementioned, the testing for those aged over 60 years had remained relatively static in recent weeks, but the increase in the positivity rate amongst that age group could be suggestive of unidentified cases spreading within the community. With regard to the reasons for the testing, contact tracing was the predominant reason in those aged under 18 years. Over half the tests in those aged between 18 years and 39 years was as a result of travel and in those aged between 40 years and 59 years, travel and contact tracing together accounted for over 75 per cent of tests, but those seeking healthcare had also increased when compared with the younger age groups. In those aged over 60 years, there was an increased number of people seeking healthcare and also being detected as a result of screening pre-admission to hospital. Of the 31 people aged over 60, who had tested positive for COVID-19 since 1st November, 11 had been symptomatic and 20

asymptomatic. Of the latter group, 14 had been identified as a result of contact tracing, one through inbound travel and 5 as a consequence of admissions screening.

More people who contacted the helpline were being sent for testing, but it was not currently possible to link those calls to the swab data. It was noted that in respect of the workforce testing, there was the potential for a bias cohort of proactive individuals. The Cell was shown graphs which set out the positive cases by test reason category over the previous 3 weeks and noted that almost 55 per cent of cases were now being identified through contact tracing, whereas inbound travel only accounted for just over 14 per cent.

The Cell was informed that a group of individuals from various specialist areas, met on a daily basis with the Deputy Medical Officer of Health, in order to give detailed consideration to any new cases of the virus and to formulate qualitative insights into the emerging picture of its transmission in the Island. Overall, there had been a transition from positive cases resulting from inbound travel and their direct contacts, to a spread of the virus on-Island. There had been an increase in test positivity in all areas – most significantly in those seeking healthcare as a result of experiencing symptoms - and more cases with an unknown source of infection were coming to light. The Cell was shown a table, which provided an overview of the cases with unknown sources, as at 20th November 2020. It was noted that, in September 2020, there had been just one single case with an unknown source. In October, there had been 2 single cases, 2 small clusters and 2 large clusters and in November, to the 20th, there had been 19 single cases, 3 household groups, 7 small clusters and 7 large clusters. The small clusters comprised up to 5 people, whereas the large clusters ranged from 8 people up to 26 and beyond. Moreover, the cases were becoming more complex and there was an element of overlap, but it was not necessarily possible to definitively link them, although most clusters and groups had commenced with a symptomatic individual. In other jurisdictions, cases appeared to be transmitting from younger people to the middle aged and thence to older residents and there was a suggestion that this might be starting to occur in Jersey.

The Consultant in Communicable Disease Control expressed disquiet that there had been 36 unknown source individual and group cases to-date in November, 19 of which were not linked to any other person and he queried whether the exposure notification App had played a role in identifying direct contacts. The Senior Policy Officer, Public Health and Wellbeing, indicated that she would obtain some additional information, but was aware of 2 or 3 of the cases where the contact had been located as a consequence of the App and this had then linked to a cluster, of which the contact tracing team was aware. The Independent Advisor - Epidemiology and Public Health, was concerned about the complex nature of some of the clusters of positive cases. He suggested that some clusters were perhaps being linked erroneously, particularly if the virus was spreading within the community. He suggested that some form of alternative testing strategy might be required, such as mass testing, particularly targeted at the higher risk groups. He opined that it would be helpful to understand more about the socio-economic background of the positive cases, as he had the impression that those in the lower income bracket were being disproportionately affected. It was noted that those people who lived in high density accommodation, who frequently worked in sectors that were higher risk (for example hospitality and health and care) had been at double the risk of contracting COVID-19 during the first wave and one would expect to see the same trend during the second wave. The Senior Policy Officer, Public Health and Wellbeing indicated that additional work was required in this regard, but suggested that there was also a significant number of middle-aged people, who were worried about their health, who were presenting to be tested. The Interim Director, Public Health Policy, expressed some concern at the test positivity rate in those people aged over 60 years, which would suggest a concerning level of spread in the older and, potentially more vulnerable, population. He felt that the Cell might wish to consider whether there

30th Meeting
23.11.20

should be targeted testing of those older than 60 years. It was agreed that there was a need to refresh the testing strategy for those aged over 60 and the vulnerable and the Interim Director, Public Health Policy indicated that he and his team would prepare a paper for the next meeting of the Cell. It was felt that it would be a positive move to test more of the over 60s, but it was important to gain an understanding of the transmission dynamics and why that cohort was becoming infected.

The Interim Director of Public Health, suggested that evidence from the United Kingdom ('UK') and the rest of the world, was that those from BAME (Black, Asian and Ethnic Minority) groups were significantly affected by COVID-19, but that the Cell did not appear to have discussed this and the data was not being collected. The Principal Officer, Public Health Intelligence, indicated that when incoming travellers were excluded from the swabs, 43 per cent of those tested were either of 'unknown', 'not stated' or 'null' ethnicity, so any data from the remaining 57 per cent around ethnicity would be skewed. The Independent Advisor - Epidemiology and Public Health, suggested that there were relatively few BAME people in Jersey and it was perhaps, as a consequence, less of an issue in the Island than the UK. What was of concern was those people whose occupations and living conditions placed them at higher risk of contracting COVID-19, many of whom were of Portuguese, Polish or Romanian origin.

Transmission of COVID-19 appeared to be frequently occurring in environments which included enclosed spaces, were poorly ventilated and involved prolonged exposure, such as vehicles, hospitality settings, family homes and offices. It was suggested that there should be increased messaging around the wearing of face coverings in cars, particularly taxis, where Ministers were best placed to influence practice. With regard to school children, it was noted that before the new cases which had been identified over the weekend, there had been 7 positive cases in children of primary school age and 30 in young people of secondary school age. Those primary school children who had tested positive for the virus generally had a positive case in their household and did not transmit to their peers. The opposite was true of secondary school pupils, but the transmission usually occurred outside their household.

The Cell noted the position.

Testing for
COVID-19 in
care home
residents.

A6. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of its meeting of 13th November 2020, recalled that the Competent Authority Ministers had agreed that care home residents and their visitors should undergo PCR tests on a regular basis, to align with the frequency of testing of those employed within the homes.

The Consultant in Communicable Disease Control opined that the Island was at the stage where it was important to protect those at the greatest risk – namely those in Hospital, in care homes and the elderly – and to introduce improved screening of those who were most likely to contract COVID-19 and to transmit it on to those at risk groups. Those working in health and care settings would be PCR tested every 2 weeks, but he suggested that they should perhaps also undergo weekly antigen tests. This could be offered from the end of November 2020 and there would be capacity to analyse 100 tests per hour. The DiaSorin machine had undergone validation and the swabs were available.

The Director General, Justice and Home Affairs Department, informed the Cell that the programme of testing care home residents and visitors had commenced and those operating the care homes understood the need for this testing programme.

The Cell noted the position accordingly.

Temperature

A7. The Chair of the Scientific and Technical Advisory Cell ('the Cell'), indicated

checks on entering health premises.

that the Cell's views were sought on whether all people entering health premises should be required to undertake a temperature check.

Having discussed the foregoing, the Cell was of the view that there was no evidence that such checks had a significant impact on the transmission of the virus. They could only provide a snapshot of the situation at the point when the temperature was taken and did not give an indication of whether an individual would subsequently develop COVID-19. Moreover, they were of limited sensitivity.

Accordingly, the Cell felt that emphasis should, instead, be placed on encouraging good hand hygiene and asking people not to enter health premises when they felt unwell.

Mandatory testing of staff working in the Health and Community Services Department.

A8. The Chair of the Scientific and Technical Advisory Cell ('the Cell'), indicated that the Cell's views were sought on whether all staff working within the Health and Community Services Department, should be required to undertake mandatory PCR testing for COVID-19. He acknowledged that this was a difficult subject, because the Department preferred to encourage people to undertake testing on a voluntary basis, but the Hospital did require certain professionals to undergo testing for HIV and Hepatitis B before they were permitted to undertake high exposure procedures, so a precedent existed.

The Consultant in Communicable Disease Control informed the Cell that when screening for Methicillin-resistant Staphylococcus aureus ('MRSA') in an operating theatre, it was not just the surgeons, but everyone who had access to that setting, who was required to undertake exposure procedures. If it was decided that testing for COVID-19 should become mandatory, the same approach would need to be adopted and it was felt that there would be the need for consistency.

The Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, indicated that the data that had been garnered, to-date, from the workforce screening, was not sufficiently 'cleansed' to make a judgment on what percentage of the workforce was undergoing testing, but he suggested that it was highly likely that a significant minority was not presenting itself for testing and that was the cohort that it was most important to reach. The team working with the Head of Informatic, Health and Social Care, was undertaking a review of the data, to ensure that the testing was targeted to the correct workforce groups and it was hoped that the information would be available in time to be presented to the next meeting of the Cell.

The Interim Director, Public Health Policy, opined that, depending on the working environment of the relevant employees, it might be possible to link the mandate to be tested to relevant professional standards, or Health and Safety requirements. The senior management team within the Health and Community Services Department, together with representatives from the Jersey Care Commission, could advise staff to undertake PCR tests, without the need to make it mandatory. He indicated that the issue would be reviewed over the coming days and he would give consideration to whether the Unions should be involved in the matter.

The Cell noted the position.

Trax – secure collection of contact details: possible use in the Hospital and care homes.

A9. The Consultant in Communicable Disease Control, informed the Scientific and Technical Advisory Cell ('the Cell') that the Chief Executive Officer, Digital Jersey, had suggested that the Trax QR codes, which were currently used in many hospitality settings in order to collect people's contact details in a secure manner, could be used in care homes and the Hospital for the same purpose, to obviate people having to use a pen and paper to sign in.

At the Hospital, visitors' details were currently taken on arrival at the relevant ward. It

30th Meeting
23.11.20

was agreed that further discussions would need to be held with the ward managers and those with a clearer understanding of the relevant technology, as to whether it was preferable for the Trax QR codes to be in place at the entrance to the ward, or at the entrance to the Hospital. The Cell noted that the Consultant in Communicable Disease Control would discuss this matter further with the Chief Executive Officer, Digital Jersey.

Options for
'lockdown'.

A10. The Scientific and Technical Advisory Cell ('the Cell') was cognisant that many jurisdictions were introducing, or had introduced, some form of lockdown - whether reactive, or a 'circuit break' - and that it was an opportune time for the Cell and officers to give it consideration on a proactive basis, in order that Ministers could be advised appropriately, if and when the time arose. It was agreed that it would not be ideal for the Island to find itself in a position where it had been earlier in the year, when the schools had been closed.

The Consultant in Communicable Disease Control, informed the Cell that he had gained the impression that there was currently a less significant growth in positive cases than a few weeks previously, which might have coincided with the schools' half-term week. He indicated that it would be important to bear this in mind when considering how things could be affected by Christmas and the likely arrival of some COVID-19 vaccines by mid-December. The Cell was reminded that it was not possible to administer the vaccine to someone who was unwell and the recommendation of the Joint Committee on Vaccination and Immunisation ('JCVI') was that someone who had tested PCR positive for the virus within the previous 4 weeks should also not be vaccinated. Consequently, the importance of protecting those in at risk groups was emphasised.

The Independent Advisor - Epidemiology and Public Health, agreed that the half-term break might have caused an uplift in positive cases of COVID-19. He indicated that when policy officers were considering what might be effective for Jersey, it was important to consider similar places, where the population density was relatively low and there was an absence of cities. With regard to Christmas, he felt that to reduce the restrictions for one day could lead to a marked increase in positive cases several weeks later. The Associate Medical Director for Primary Prevention and Intervention, suggested that it would be key to receive an update on the number of students who might be returning for Christmas and other travel bookings, because that would impact on any plans for the festive season. The Director General, Justice and Home Affairs Department, indicated that he would liaise with the Director, Economic Development, Tourism, Sport and Culture Department, in order to obtain details of the position on travel and informed the Cell that the Chief of Staff, Office of the Chief Executive, had established a working party to consider Christmas from a vulnerability perspective, to include community task forces in the Parishes and the Connect Me help and support that was available for Islanders.

Accordingly, the Cell indicated that it wished to receive a paper at its next meeting, which set out *inter alia* various options for lockdown (to include pros and cons), analysed the balance of harms of various proposals and considered the potential economic impacts of the same.

Matters for
information.

A11. In association with item No. A3 of the current meeting, the Scientific and Technical Advisory Cell received and noted the following –

- a report entitled 'PH Intelligence: COVID-19 Monitoring Metrics', dated 20th November 2020, which had been produced by the Strategic Policy, Planning and Performance Health Informatics Team;
- a weekly epidemiological report, dated 19th November 2020, which had been prepared by the Strategic Policy, Planning and Performance Department;

212
30th Meeting
23.11.20

- death statistics for the week to 19th November 2020, from the Office of the Superintendent Registrar;
- economic indicators for October 2020, prepared by Statistics Jersey; and
- a footfall report for King Street, St. Helier, for week 46 of 2020 (9th to 15th November 2020), which had been prepared by Springboard.