LP

SCIENTIFIC AND TECHNICAL ADVISORY CELL

(79th Meeting)

22nd November 2021

(Business conducted via Microsoft Teams)

PART A (Non-Exempt)

All members were present with the exception of Professor P. Bradley, Director of Public Health, Dr. M. Doyle, Clinical Lead, Primary Care and Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department from whom apologies had been received.

Dr. I. Muscat, MBE, Consultant in Communicable Disease Control (Acting Chair)
Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention
Dr. G. Root, Independent Advisor - Epidemiology and Public Health
S. Petrie, Environmental Health Consultant
B. Sherrington, Senior Nurse Adviser in Public Health
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 -

R. Williams, Director, Testing and Tracing, Strategic Policy, Planning and Performance Department
S. Martin, Chief Executive Officer, Influence at Work
S. White, Head of Communications, Public Health
E. Baker, Lead Nurse, Infection Prevention and Control, Health and Community Services
K. Posner, Director of Policy and Planning, Children, Young People, Education and Skills Department (Items A1-A3, Item A4 for a time)
J. Norris, Principal Policy Officer, Strategic Policy, Planning and Performance Department
J. Mason, General Manager, Health and Community Services (Item A1, Item A2 for a time)
J. Lynch, Principal Policy Officer, Strategic Policy, Planning and Performance Department
Dr. L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department
K.L. Slack, Secretariat Officer, States Greffe
L. Plumley, Trainee Secretariat Officer, States Greffe

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

Minutes.

A1. It was noted that the Minutes from the last meeting of the Scientific and Technical Advisory Cell ('the Cell'), which had been held on 15th November 2021, were being finalised and it was hoped that they could be presented to the Cell for approval at its next meeting.

Intelligence overview, including Analytical Cell update and HCS activity.

A2. The Scientific and Technical Advisory Cell ('the Cell') with reference to Minute No. A2 of its meeting of 15th November 2021, received a PowerPoint presentation dated 22nd November 2021, entitled 'STAC Monitoring Update' which had been prepared by Ms. M. Clarke, Head of Public Health Intelligence, Strategic Policy, Planning and Performance Department.

The Cell was informed that, as at Friday 19th November 2021, there were 1,059 active cases of COVID-19 in the Island, from which 10,243 direct contacts had arisen. As at the same date, the 14-day case rate, per 100,000 population, had been 1,034 and the 7-day rate 358. Of the active cases, 615 had sought healthcare, 381 were direct contacts, 10 had been identified through arrivals screening, and the remainder had been identified through planned workforce, admission or cohort screening. The Cell noted that there were 4 cases in care homes.

The majority of cases (455) were in those aged under 20 years and in those aged between 40 and 49 and between 50 and 59 years, which when combined, accounted for 336 cases. Cases amongst those aged 30 to 39 years had increased to 104. The majority of the active cases (77 per cent) were symptomatic and just over one third (36 per cent) were fully vaccinated. The number of daily tests had increased to around 2,000 with tests being undertaken on individuals who had been contact traced now accounting for a significant proportion.

Ms. Clarke informed the Cell that the daily incidence rate had increased to an average of 106 cases per day, though it was noted that this figure included provisional data for the last two days. This represented a significant step change over the course of November 2021. The overall test positivity rate was increasing and currently stood at 7.4 per cent, and when the inbound travel figures were removed, the on-Island rate was 8.1 per cent. Test positivity rates were highest in those aged 40 to 49 years at 8.4 per cent and both lowest and declining in those aged over 60 years at 2.2 per cent.

The Cell reviewed a graph of the 7-day case rate, per 100,000 population, for Islanders of different ages and noted the increase to 1,559 for those aged under 18 years. A lesser increase was also noted for those aged 40 to 59 years and those aged 18 to 39 years, whilst the rate had remained relatively stable for those aged over 60. The Cell noted that the test positivity rate for those who had had a test after seeking healthcare was now over 30 per cent, and included individuals reporting a positive result from Lateral Flow Device ('LFD') testing. Work was ongoing to separate these results from positive polymerase chain reaction ('PCR') test results.

The Cell was provided with details of the current cases in the Hospital including the age and vaccination status of the patients. It was noted that as at Friday 19th November 2021, there had been 3 patients in the Hospital with COVID-19, and one had sadly passed away. The death had yet to be registered so would be reflected in the mortality figures in due course.

Regarding COVID-19 cases in hospital, it was noted that since 28th June 2021, the beginning of the 'third wave', there had been 121 admissions and 118 discharges. Details of the number of clinical COVID-19 cases, Intensive Care Unit admissions, age ranges and vaccination status of the patients were shared.

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

Government departments and schools, which showed an increase across all areas. An uplift in the test positivity rate for the schools' LFD testing programme had been observed. Staff absence data for the Children, Young People, Education and Skills ('CYPES') Department showed increasing levels of absence due to COVID-19 over the course of November 2021, and stable levels of absence due to other sickness.

Ms. Clarke informed the Cell that there had been 80 deaths from COVID-19 since the start of the pandemic, 11 of which had occurred since 28th June 2021 (the third wave), and one recent death which had yet to be registered, as detailed earlier.

It was noted that during the week ending 14th November 2021, Jersey's testing rate, per 100,000 population, had been 8,700, a decrease to below the United Kingdom ('UK') rate of 9,300, noting that the latter figure included tests undertaken on LFDs. The positivity rate locally had been 7.2 per cent compared with 4.3 per cent in the UK. The Cell was informed that during the same week, the number of tests undertaken on inbound travellers had decreased substantially due to changes in the border testing regime, with the majority of tests (7,390) now being undertaken as part of on-Island surveillance and on people seeking healthcare on experiencing symptoms of the virus, which accounted for 1,300 tests.

The Cell noted that calculation of the estimated effective reproduction number (R_t) had been paused for the time being due to sharp changes in testing effort and the situation would be kept under review.

The Cell noted that 245 patients were currently recorded in the EMIS clinical IT system as suffering from Long Covid. Of these, 119 had ongoing symptomatic Covid and 135 had post COVID-19 syndrome, but it was recalled that these were not mutually exclusive, and one individual could have both codes assigned to them. Women aged 40 to 49 continued to be the most affected group.

In respect of community disruption monitoring, with reference to Minute No. A6 of its meeting of 15th November 2021, the Cell recalled that additional metrics had been requested and noted that a review of social media sentiment suggested that Islanders felt the current instructions with regard to mask wearing were insufficiently strict and there was a feeling that they should be made mandatory. Regarding LFD testing, responses within social media posts suggested that these were not controversial and generated good sentiment, but not many comments. Islanders appeared to appreciate the addition of hospitalisation data to COVID-19 statistics social media posts and were increasingly keen to know the reason for admission to hospital, vaccination status and age range. Many Islanders were questioning why school figures were reported separately from other statistics.

In respect of the COVID-19 vaccine programme, the Cell noted that, up to 14th November, 83 per cent of Islanders aged over 80 years had received their booster dose, whilst 53 per cent of those aged between 16 and 17 years and 29 per cent of those aged between 12 and 15 years had received their first dose. A total of 179,485 vaccines had been administered, of which 25,233 were booster doses. In respect of the estimated vaccine coverage for the Joint Committee on Vaccination and Immunisation ('JCVI') priority groups, the Cell was informed that 73 percent of care home residents had received their booster dose, as had almost half (49 percent) of those working in frontline health and social care settings and 43 percent of other health and social care workers. More than half (55 percent) of those classed as clinically extremely vulnerable aged from 16 to 69 years had received a booster dose and the figure for those considered clinically at risk was 46 percent. It was noted, however, that a small amount of the data was of questionable quality and was coded Amber. The Cell was shown a graph which tracked the booster vaccine uptake by age group, which continued to increase for all eligible age groups.

A comparison of vaccination rates for those aged between 16 and 17 years and those aged between 12 and 15 years with other UK and Island jurisdictions was shared, the Cell noted that Jersey's rates were not at the top end, but were within range. Similar data for the European Union ('EU') using different age range groupings showed that Jersey's vaccination rate for those aged 10 to 14 years was 18 percent and for those aged 15 to 17 years, 48 percent.

The Cell noted a graph, which had been prepared by the European Centre for Disease Prevention and Control ('ECDC') and which showed the cumulative vaccine uptake amongst people aged over 18 years, including both first and second doses in the same chart. It was recalled that first and second dose coverage in Jersey was 88 and 86 per cent respectively, which compared favourably with many countries. The Cell noted that Austria, where a new lockdown had been announced, had less than 80 per cent vaccination uptake.

The Cell was informed that a total of 35,940 flu vaccines had been delivered as of 14th November 2021, across a number of settings, with the highest number delivered in workplaces and at the Vaccination Centre. This had resulted in almost half (47 per cent) of those aged zero to 16 years, 79 per cent of those aged over 80 years and 72 per cent of those aged 65 to 79 years of age being vaccinated against flu. Information regarding flu vaccination rates by eligibility group showed that 66 per cent of school students in Reception to Year 11, 56 per cent of care home residents and 41 per cent of Health and Community Services Staff had received the flu vaccine, although it was noted that this was based on data considered to be of moderate quality and was coded Amber. The Cell noted that reports of cases of flu-like illness in primary care during the week ending 21st November 2021 had decreased to 31 and the trend for reporting of flu-like illnesses was noted to be similar to previous years. Globally, despite increased testing for flu, levels remained lower than expected for the time of year and the highest rates were in those aged 15 to 44 years.

The Cell was presented with a map of cases in the UK for the 7-day period ending on 16th November 2021 and noted high rates in parts of Northern Ireland and Wales. The 14-day case rate per 100,000 population as of the same date had decreased to 680 in England and 886 in Wales and had increased to 693 in Scotland and 1,038 in Northern Ireland. There had been an increase of 9.4 per cent in the number of people testing positive for COVID-19 in the UK when compared with the previous week, whilst hospital admissions had decreased by 5.9 per cent and deaths by 4.7 per cent.

The Cell noted maps prepared by the ECDC, comparing 14-day case rates on 11th November and 18th November 2021, showing increases in Germany, Austria and France, and high case rates in much of Central and Eastern Europe.

Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention noted that the situation in schools was 'chaotic', with children being repeatedly contact traced and tested, having to isolate if they had a cough or a cold and increasing absence rates. Dr. Noon expressed his concerns regarding the impact on parents and grandparents of school absences and the psychological impact of the disruption on children and questioned whether a different approach to contact tracing was needed in the schools.

Dr. G. Root, Independent Advisor - Epidemiology and Public Health, agreed that schools should not be disrupted to such an extent. He noted that anecdotally, he had observed only a relatively small number of people wearing masks and questioned whether social media served to amplify minority sentiments as it appeared that the majority did not want to wear masks.

Mr. A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department asked for an overall situation assessment regarding the impact of Winter viruses on hospital capacity and to what extent limitations in ICU capacity were relevant. Mr. J. Mason, General Manager, Health and Community Services noted that there were currently 3 patients in hospital and if more than 5 patients were admitted, this would trigger cohort arrangements where patients would be isolated in groups by virus type due to limitations caused by the ward environments. Up to 20 patients could be cared for in the ward environment, after which additional areas would need to be opened up to COVID-19 patients. The ICU had tried and tested plans to scale up response and the capacity in Critical Care was 2, after which a split location would have to be implemented, with associated staffing consequences. Mr. Mason noted that capacity assessments were updated regularly and took into account overall activity in the hospital. Mr. Khaldi thanked Mr. Mason for the update and noted that it was helpful to understand the context. In respect of hospital staffing capacity, Mr. Mason outlined the use of the 'Safecare' platform, also used by the National Health Service in the UK, to determine whether safe levels were being maintained. Details of staffing levels, activity in wards and acuity of care were input into the system and 'Green' status had been maintained despite an increase in the number of staff absent for sickness reasons. An increase had been noted in the number of patients considered 'medically fit for discharge' over the last 2 months although it was not considered to be linked to COVID-19. The Cell thanked Mr. Mason and he retired from the meeting.

Mr. S. Martin, Chief Executive Officer, Influence at Work, cautioned against the assumption that people not wearing masks implied a stated preference and expressed his view that in a context of uncertainty and the absence of a mandate, such behaviour might be based on what people observed others to be doing.

The Cell turned to consideration of the situation in schools. Mr. K. Posner, Director of Policy and Planning, Children, Young People, Education and Skills ('CYPES') Department, noted that there was significant disruption with both staff and students being contact traced and having to leave schools to undertake, in some cases, multiple PCR tests in the same week due to being contact traced more than once. Although the option existed for staff to change their appointment times, this was not the case for students. Schools were increasingly under pressure and a class had had to be closed at one school that week, with closures narrowly avoided at other schools. High levels of sickness amongst staff exacerbated the situation as they were unable to return to work until they received a negative PCR test result and these delays meant further class closures could be expected. Schools had been undertaking contact tracing for over a year now and the time and effort this required, 7 days a week, was taking its toll. Representations had been made to the CYPES Director General and Mr. Posner in the past week, including from the President of the Head Teachers Union requesting a solution to the increasing pressure on schools.

Dr. I. Muscat, MBE, Consultant in Communicable Disease Control, noted that consideration was being given to the idea that it would be sufficient for asymptomatic individuals, who had been contact traced in schools, to undertake LFD tests for 10 days, with a PCR test only being required in the event of a positive LFD test result. Dr. Muscat, MBE, noted that high levels of infection amongst children would impede the rollout of the schools' vaccination programme due to the requirement to wait 12 weeks for vaccination following a positive PCR test result.

Ms. R. Williams, Director, Testing and Tracing, Strategic Policy, Planning and Performance Department, agreed with the concerns raised regarding the current situation across the Island and particularly in schools. She noted the increased number of positive cases in schools was resulting in repeated instances of contact tracing and testing. She also noted that a number of people were not attending their appointments, which impacted the ability to offer tests quickly. Ms. Williams emphasised the importance of listening to the concerns of parents, teachers and schools and reviewing the efficacy of testing regimes, noting that officers were giving consideration to the implementation of an updated, risk-based testing policy.

Mr. Khaldi expressed his agreement with the suggestion to dispense with the requirement for a PCR test for asymptomatic individuals contact traced by schools and, given the improved effectiveness of LFD testing, he felt it would be preferable to require such tests to be undertaken for 10 days. Unless there was strong evidence to the contrary regarding the effectiveness of LFD tests, Mr. Khaldi supported the suggestion, which would address the circular nature of contact tracing in schools, minimise disruption to learning and increase protection against the spread of COVID-19. It was not envisaged that nursery schools would be included in this arrangement. Regarding the contact tracing methodology used in schools, this was being reviewed by Public Health and CYPES, it was noted that further work was needed to arrive at a sensible and risk-based contact tracing regime in schools and an update would be provided to the Cell in due course.

Dr. Noon recognised the pressing nature of the issue for the Island as a whole, noting the difficulties caused by non-attendance at testing appointments, agreed with the suggestion to move to LFD testing as discussed and he questioned whether single swab quadrivalent testing, which tested for COVID-19, flu and respiratory viruses could be employed more widely to minimise disruption. Dr. Muscat, MBE, noted that flu and respiratory viruses were being managed as before and separately from COVID-19, and that single swab quadrivalent test usage was limited to hospital consultations and admissions due to technical limitations and to enable appropriate infection control at the hospital.

Ms. Williams clarified that individuals who received a positive test LFD test result would need to book a PCR test and that contact tracing would still be undertaken by the Covid Safe team for non-school activities. She noted that there continued to be a high conversion rate from positive LFD test results to positive PCR test results which demonstrated the value of the LFD testing regime. Sustained emphasis on communications was needed to ensure a high uptake rate and it was encouraging to see that registrations for the schools' LFD testing programme had increased over the last week.

Dr. Root recognised that the nature of children's social interactions and contacts meant it was likely that they would be exposed at multiple points through many individuals to the infection and as COVID-19 moved towards being an endemic disease, it would be wise to consider how useful or appropriate contact tracing was as a way of managing the illness. He suggested that there might be a need to acknowledge that the virus should be allowed to circulate in the school population and recognition that contact tracing was extremely disruptive and would likely have a negligible impact on reducing transmission in that demographic.

Mr. Khaldi acknowledged Mr. Root's comments and requested that a paper on contact tracing be presented to the Cell to review the available evidence.

Having discussed the present situation in schools at some length, the Cell was in agreement that asymptomatic individuals contact traced by schools should undertake LFD tests for 10 days and not be required to undertake a PCR test unless they developed symptoms or tested positive using an LFD test. The Cell would consider the contact tracing arrangements for direct contacts in schools at its next meeting and noted that work was ongoing in this respect. Regarding the requests on social media for details of the reason for admission to hospital, vaccination status and age range, Dr. Muscat, MBE, noted that providing care was taken to avoid publishing information that could identify individuals, it would be possible to share aggregated data which would have the added advantage of underscoring the benefits of vaccination.

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 No. A3 of its meeting of 15th November 2021 received a presentation, entitled 'COVID-19 Vaccination Programme, Update Head of Programme' dated 22nd November 2021 prepared by Ms. B. Sherrington, Senior Nurse Adviser in Public Health.

The Cell was informed that the focus of the vaccination programme over the previous week had been on increasing uptake in those aged 12 to 15 years, with targeted communications issued on various social media channels, including the option to directly message questions anonymously to medical experts. The schools programme had been launched, consent forms had been sent and were due to be returned on 26th November 2021. Walk-in appointments for those aged 12 to 17 years were now available at the Vaccination Centre and from 29th November 2021 the vaccination team would be visiting one school per day to offer vaccinations in schools. It was anticipated that the schools' vaccination programme would be complete by the end of the 2021 Autumn term.

Further to the updated advice issued by the Joint Committee on Vaccination and Immunisation ('JCVI'), it would be announced on 23rd November 2021 that bookings for booster vaccinations would shortly be opening to all adults aged between 40 to 49 years and all 16- to 17-year-olds not in an at-risk group. The Vaccination Centre was currently fully booked for the next 8 days, with 500 to 600 appointments taking place per day, however 10,000 appointments would be available to book after this date. Uptake of booster vaccinations was good, and the correct balance was being struck between the number of appointments and the doses available.

Dr. G. Root, Independent Advisor - Epidemiology and Public Health, noted that given the infection levels prevalent in schools, it was likely that some children would have been infected with COVID-19, but not diagnosed, and asked whether this would pose any issues when they presented for vaccination. Dr. I. Muscat, MBE, Consultant in Communicable Disease Control, acknowledged that this was a possibility and the only method of confirming an undiagnosed infection was though a blood test which was not standard practice in Jersey nor in the United Kingdom. Vaccination would be delayed for 12 weeks following a confirmed diagnosis. When asked whether this could constitute a barrier to uptake, Dr. Muscat, MBE, acknowledged that it might be, but the potential side effect rate of COVID-19 infection was very similar to that of the first vaccination dose, giving the example of myocarditis. It was necessary in his view, to act within the realms of possibility based on available information, as other countries had chosen to do. Whilst some might query the notion, there was no practical way of confirming undiagnosed infection within the 12 weeks prior to vaccination and the immunity conferred by vaccination following infection was significantly better than that conferred by a single or even 2 doses of the vaccine.

In response to Dr. Root's question about whether booster vaccine appointment prompts could be sent automatically to those eligible, Ms. Sherrington confirmed that the Modernisation and Digital Department were investigating the possibility.

Dr. Muscat, MBE, noted that in light of the worsening situation in Europe and recent announcement of a full national lockdown in Austria, it was important to remember that one of the reasons for the difficulties that jurisdiction and other countries were experiencing was their relatively lower rates of vaccination, and it was therefore crucial to ensure that Jersey maintained its advantage by ensuring high uptake of booster vaccinations and protecting children from infection.

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

Contingency measures.

A4. The Scientific and Technical Advisory Cell ('the Cell'), received a report dated 19th November 2021 entitled 'COVID-19 contingency measures' prepared by Mr. J. Norris, Principal Policy Officer, Strategic Policy, Planning and Performance Department.

It was recalled, with reference to Minute No. A5 of its meeting of 15th November 2021, that the Cell had reached a consensus that the threshold for considering the introduction of mandatory contingency measures had not been reached at that time. In the context of the increasing rate of infection, whilst recognising that vaccination was essential to curbing the spread, the Cell was asked to consider whether to recommend that any contingency measures should be implemented in the run up to Christmas, noting that the Winter Strategy envisaged two steps in terms of implementing such measures. 'Step 1' measures where there was a need to mitigate against the risk of major economic and societal consequences by appealing to personal judgement and the intention was to change individual behaviour, and 'Step 2' measures consisting of legal restrictions, introduced as a last resort, where there was a risk to business continuity and a strong possibility of widespread severe disease or hospitalisation.

Mr. Norris outlined the potential additional measures for consideration, noting they included a mixture of both Step 1 and Step 2 measures:

1. strong recommendation to work from home where possible;
2. mandatory mask wearing in indoor public environments;

3. stronger advice to take regular Lateral Flow Device ('LFD') testing 2 times per week; before attending a gathering and before visiting a vulnerable person;
4. stronger advice for food and drink premises, including nightclubs and large gatherings, to require individuals to provide proof of negative lateral flow test before entering premises;
5. continued activities to encourage vaccine uptake amongst eligible populations – e.g., 12- to 17-year-olds, and the vaccine booster;
6. stronger advice to reduce the frequency of attendance at higher risk gatherings such as parties and nightclubs;
7. investigation of charging unvaccinated travellers for polymerase chain reaction ('PCR') testing at border and
8. consider amendment to testing requirements for single dosed 11- to 18-year-olds under Safer Travel Policy.

Mr. Norris noted that the first measure was effective but acknowledged the economic impacts; the second and third measures were also considered effective; and the fourth measure had been enquired about by some businesses though there were concerns regarding proportionality and implementation in practice. The measures were due to be considered by the Competent Authority Ministers ('CAM') later that day.

Mr. A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, informed the Cell that following internal conversations with colleagues, the importance of economic activity in the run up to Christmas was a key consideration and the first measure was likely to have a significant impact, in their view. There was more sympathy in respect of the second measure, except in relation to gyms and pubs and there was a finely tuned balance needed between sensible measures to be taken now which would ensure a smoother run up to Christmas in terms of trade and economic activity. A desire had been expressed to maximise the effect of the Vaccination Programme by potentially introducing measures to incentivise individuals, by way of the seventh measure.

Mr. I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, noted the increase in cases and the additional details regarding cases in care homes and schools and remarked that the information presented to the Cell at the current meeting capturing the wider impacts of the pandemic was helpful and should continue to be presented. He expressed the view that there was a stronger case for intervention at present, partly due to the additional information that the Cell had received.

Dr. G. Root, Independent Advisor - Epidemiology and Public Health reminded the Cell of the rationale for implementing the measures and noted that hospital admissions, whilst ‘lumpy’, had remained broadly constant over the last 3 to 5 months and the test positivity rate for those aged over 60 years remained low. The Cell had received a report, dated 21st October 2021, entitled ‘Effectiveness of public health measures in reducing the incidence of covid-19, SARS-CoV-2 transmission, and covid-19 mortality: systematic review and meta-analysis’, published in the British Medical Journal, which suggested that personal and social measures, including handwashing, mask wearing, and physical distancing were effective at reducing the incidence of COVID-19. Dr. Root noted the findings and expressed his view that the results should not be taken out of context; the data quality was variable; it was difficult to separate out and assess the impact of multiple interventions and causality could not be implied. He questioned the accuracy of the finding that mask wearing showed a 53 per cent reduction in COVID-19 incidence and felt that the impact of the second measure would be modest at best, especially given the environments in which masks would be worn in Jersey. Dr. Root noted that legal restrictions should only be considered in a state of emergency, which was not the case at present, and he would only feel comfortable recommending such measures in exceptional circumstances, on the contrary, in his view, the disease was moving towards becoming endemic. He expressed his support for the seventh measure.

Dr. I. Muscat, MBE, Consultant in Communicable Disease Control, noted that messages from the Government signalling that people needed take the situation seriously would spill over from one intervention into others, so it was important to maintain the emphasis on communications.

Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention, noted that people wanted to see leadership from the Government and while he was hesitant to recommend that mask wearing should be made mandatory, many people would be comfortable with wearing them and perhaps were simply waiting to be told that they should. It was important to get the message across in the right way and to consider how the restriction would be enforced. In his view, the first measure was important and even if people worked from home some of the time, this would be helpful. He expressed his support for the firm encouragement of mask wearing and working from home, whilst recognising it would be difficult to enforce. Dr. Noon agreed with Dr. Root’s assessment that the situation did not constitute an emergency, however if levels of infection continued to increase, he indicated that he would be supportive of measures to make the wearing of masks indoors mandatory.

Mr. Khaldi noted that, speaking in his capacity as a member of the Cell, he was sufficiently concerned about the data that he wished to prevent an emergency situation from arising. Although COVID-19 was heading towards becoming an endemic disease, it was estimated that this would not be fully the case until 2023 and in his view, the Government needed to show leadership prior to Christmas. Mr Khaldi suggested that the following measures were proportionate at the current time and should be suggested to CAM:

- continued and strengthened efforts to increase vaccination uptake including incentivisation by way of the seventh measure;
- in view of the disruption to schools and businesses, a quick review of contact tracing should be undertaken and focus on LFD testing increased; and

- to demonstrate leadership and ensure that Islanders were aware of the risks going into Winter, mandatory mask wearing indoors should be introduced for a limited period of time. Mr. Khaldi noted that his understanding from the business community was that the effect of the current strong recommendation was that businesses who were doing the right thing (requesting that people wear masks) were losing out to those that were not. Compliance with the recommendation was poor and making it mandatory would have a low impact on businesses.

Dr. Root expressed his opinion that vaccination would prevent an emergency situation from arising, not the wearing of masks and indicated that he would support mandatory vaccination. Notwithstanding the emergence of new variants, vaccination remained the most effective measure and all efforts should be focused on increasing uptake and ensuring that people received booster vaccinations. Dr. Root felt that making masks mandatory would be an ineffectual intervention and had observed posters asking people to wear masks when it would be preferable for the focus to be on vaccination. Dr. Muscat, MBE, agreed that vaccination was the most effective measure and should be promoted in every possible way and noted that there were 2 posters in circulation, the second of which did advise a number of measures including vaccination. Inviting ideas about how to increase vaccination uptake, Dr. Muscat, MBE noted that the seventh recommendation had been mentioned and the hospital data and favourable comparison to other countries experiencing difficulties in Europe might be helpful in public messaging underlining the effectiveness of vaccination. Automated reminders to book booster vaccinations could also be effective and were in development. Dr. Root asked whether hinting that three doses would be needed in future to be considered ‘fully vaccinated’ would be helpful and Dr. Muscat, MBE, confirmed that this was being reviewed from an international perspective and the definition of ‘fully vaccinated’ was likely to be updated so this might be sensible. Mr. J. Lynch, Principal Policy Officer, Strategic Policy, Planning and Performance Department, noted that there was an opportunity to further incentivise vaccination by way of the eighth measure, as an update to the definition of ‘fully vaccinated’ for those aged 11 to 18 years would allow families to be considered ‘fully vaccinated’ at the border. Mr. Lynch agreed with Dr. Root that the definition of ‘fully vaccinated’ would likely be moving away from 2 doses to ‘as fully vaccinated as you can be’ so it made sense to begin considering the messaging around this at the present time.

Dr. Muscat, MBE, asked whether Covid Status Certification could be used in the Island as well as for travel purposes, noting that the idea had not gained traction during previous discussions. Dr. Root expressed his support for the idea, noting that while a similar scheme had not appeared to work in Scotland, the French ‘pass sanitaire’ scheme appeared to have been successfully implemented. Ms. M. Clarke, Head of Public Health Intelligence, Strategic Policy, Planning and Performance Department suggested that the fourth measure could constitute an alternative approach.

Mr. Khaldi noted that Christmas was five weeks away and although he agreed with Dr. Root that vaccination was hugely important, he expressed his disappointment that some measures had not been made into policy and observed that the effect of vaccination would not be seen until January and mask wearing might have a more immediate impact. Dr. Muscat, MBE noted that various levers were available, and the Cell was in agreement that vaccination was key and increased vaccination rates would result in fewer non-pharmaceutical interventions (‘NPIs’) being needed.

Mr. S. Martin, Chief Executive Officer, Influence at Work, noted that carefully crafted communications could be helpful in increasing uptake rates, and there was evidence that suggested automated reminders referring to '*your* booster vaccine is waiting for *you*' were effective. It could also be helpful to communicate that the Vaccine Centre was fully booked until 26th November 2021 as a perception of scarcity and popularity might motivate people to make appointments.

Turning to the third measure, Dr. Muscat, MBE, noted that the Cell was in agreement that LFD testing was important and should be further encouraged, and the question was how best to use them, noting that a consensus had been agreed with respect to their use in schools.

Dr. Noon expressed his agreement regarding the value of LFD testing, and noted that evidence of vaccination was necessary to enter certain countries or professions. COVID-19 vaccination had been offered and taken up by many people, but there remained a proportion of individuals who had chosen not to be vaccinated and Dr. Noon expressed his view that they constituted a risk both to themselves and others. He felt that the scales were now tipping and questioned why there was hesitation to look at the full range of options available, his view on mandatory measures having changed as part of the discussion. Dr. Muscat, MBE, noted that Covid Status Certification could include both vaccination status and recent test results. Dr. Root agreed that the emphasis should be on encouraging people to undertake LFD tests in situations where they would be most useful, such as prior to visiting a vulnerable individual. Summarising, Dr. Muscat noted that the Cell was in agreement that LFD testing was useful in many contexts.

Returning to the second measure, Dr. Muscat noted that some members of the Cell were of the opinion that mandatory mask wearing would increase compliance, although transmission was occurring mostly in homes and schools, such a measure would send the message that more action was needed and the sense of importance that this would convey could extend to other interventions. Whilst the Cell had not reached a consensus, the majority of the members were in agreement. Mr. Khaldi confirmed that this was his understanding. Dr. Noon expressed his agreement, but felt that a note of caution regarding the effectiveness of mask wearing should be sounded and the importance of vaccination emphasised to CAM. Mr. Martin also expressed his agreement and noted that increased wearing of masks could be a useful social signal that might lead to increased uptake of booster vaccinations. Ms. B. Sherrington, Senior Nurse Adviser in Public Health, noted that uptake levels were high, and bookings were good so the situation was not parlous. Dr. Root expressed his disagreement, noting that he was in the minority in thinking that it was not the right approach and that masks were no longer mandatory in England. Mr. Cope observed that despite masks still being mandatory in Wales, case rates there remained high. Dr. Root noted that making mask wearing mandatory would undermine the clear message of confidence in the vaccination programme and given that hospitalisation rates were not increasing, such a move could be perceived as contradicting the thinking of the United Kingdom ('UK') Government and the majority view of the Scientific Advisory Group for Emergencies ('SAGE').

Mr. Khaldi was cognisant of the success of the vaccination programme and whilst it had performed exceedingly well, its impact on spread had not been as decisive as had been anticipated. Whilst it remained the most effective protective measure, it was not a completely solid defence against COVID-19, meaning pressure was increasing on the marginal numbers of unvaccinated individuals. Mr. Khaldi wished to emphasise that the vaccination programme should not be seen to have underperformed, merely that he wished to see coverage extended as much as possible. Dr. Muscat, MBE, expressed his agreement and noted that he shared Mr. Khaldi's wish to improve on what he considered to be a good situation.

Turning to the first measure, Dr. Muscat, MBE, noted that a strong recommendation to work from home where possible should be considered as one of the available options to respond to rising cases and maximise vaccine uptake. Dr. Root expressed his opinion that such a measure would be extremely disruptive to the economy and society and he did not support its recommendation. Given that hospitalisation rates were remaining stable despite increasing infection rates, he felt that it was not necessary and would have a negative economic impact.

Mr. Khaldi agreed that whilst such a measure would have a significant negative impact on certain sectors of the economy, the public health benefits merited consideration. It was likely that the measure would have some public health benefits, however these would come at a high cost to the economy, and it was, in his view, for CAM to judge the balance of those considerations, noting that they were not directly comparable. Mr. Khaldi noted that businesses accepted that ongoing dialogue should continue regarding risk management more generally in the busy pre-Christmas period, to include advice to work from home if possible, ensure adequate ventilation and maintain social distancing in the workplace if possible. Mr. Khaldi noted that strongly recommending people to work from home where possible was likely to lead to significant debate and opposition at a time when leadership and a united front were needed to tackle COVID-19. He favoured the implementation of a range of options with lower negative impact, rather than placing importance on this proposed measure.

Dr. Noon commented that he held the opposite view to Dr. Root and was of the opinion that there were instances where working from home was beneficial. He was not in favour of making it mandatory, but supported it being encouraged, whilst noting the points eloquently raised by Mr. Khaldi regarding the economic considerations. Mr. Petrie indicated his agreement with Dr. Noon’s remarks. Summarising, Dr. Muscat, MBE, noted that the Cell was in agreement that working from home should not be mandated, but it should be open to businesses to consider encouraging it where appropriate, in conjunction with measures to maximise ventilation and maintain appropriate social distancing where possible.

Ms. Clarke asked whether people should be encouraged to take LFD tests before going to work and Dr. Muscat, MBE, confirmed that it was already recommended to test twice a week, and asked the Cell to consider whether to encourage daily testing. Mr. Khaldi expressed concern that this could lead to supply issues and that he was satisfied with the current recommendation. He questioned whether 2 metre distancing should be encouraged where possible, in addition to regular LFD testing, working from home where possible and ensuring adequate ventilation, noting that it might result in lower densities in some workplaces.

Ms. R. Williams, Director, Testing and Tracing, Strategic Policy, Planning and Performance Department, noted that additional LFD test kits could be purchased on the commercial market if needed. A campaign encouraging people to test on Mondays before work and Fridays before the weekend was being considered, as well as continued messages for workplaces regarding hand washing and cleaning surfaces. Dr. Muscat, MBE, thanked Ms. Williams for the reminder regarding the importance of maintaining good standards of hygiene.

Dr. Root noted that fomites were not considered to be a major source of transmission and adequate ventilation was more important. It was important, in his view, to remain proportionate and he expressed concern at the increasing levels of worry evidenced during the meeting, which were not warranted in his opinion, given the hospitalisation and vaccination data. He expressed concern that the discussion was deviating from the subject. Mr. Cope signalled his agreement with Dr. Root, noting that although the evidence of impact was stronger during the current week than had been the case during the previous week, apart from in relation to schools, he did not consider there was sufficient evidence to warrant the need for further 'Step 1' measures.

Ms. Williams noted that hygiene measures played a part in protection from a range of Winter viruses and noted the need for a balanced and measured response in terms of the risks to the Island. Given the number of individuals currently identified as direct contacts, it was wise, in her view, to take steps to protect oneself from being exposed to COVID-19 and other Winter illnesses.

Dr. Muscat, MBE, summarising the discussion, noted that businesses could send a powerful message by encouraging people with a plurality of messages to respond to COVID-19, in conjunction with Government action. Mr. Martin noted that meetings were held on a daily basis to consider and revise communications and would continue to take business and workplace messaging into account.

Matters for information

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

- a weekly epidemiological report, dated 18th November 2021, which had been prepared by the Strategic Policy, Planning and Performance Department;
- statistics relating to deaths registered in Jersey, dated 18th November 2021, which had been compiled by the Office of the Superintendent Registrar;
- an estimate of the instantaneous reproductive number ('R_t') for COVID-19 in Jersey, dated 18th November, which had been prepared by the Strategic Policy, Planning and Performance Department;
- a report on COVID-19 vaccination coverage by priority groups, dated 18th November 2021, which had been prepared by the Strategic Policy, Planning and Performance Department; and
- a report on Flu vaccination coverage by priority groups, dated 18th November 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 12.50pm.