PLC

SCIENTIFIC AND TECHNICAL ADVISORY CELL

(93rd Meeting)

(Business conducted via Microsoft Teams)

15th March 2022

PART A (Non-Exempt)

All members were present with the exception of Dr. G. Root, Independent Advisor, Epidemiology and Public Health, Dr. M. Doyle, Clinical Lead, Primary Care and M. Clarke, Head of Public Health Intelligence, Strategic Policy, Planning and Performance Department, from whom apologies had been received.

Professor P. Bradley, Director of Public Health (Chair)
Dr. I. Muscat, MBE, Consultant in Communicable Disease Control
S. Petrie, Environmental Health Consultant
A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department
Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department
E. Baker, Head of Vaccination Programme, Strategic Policy, Planning and Performance Department
I. Cope, Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department
Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention

In attendance -

Dr. E. Klaber, General Practitioner, Primary Care Body representative
L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department
J. Lynch, Policy Principal, Strategic Policy, Planning and Performance
S. White, Head of Communications, Public Health
S. Martin, Chief Executive Officer, Influence at Work
R. Williams, Director, Testing and Tracing, Strategic Policy, Planning and Performance Department
P. Le Conte, Secretariat Officer, States Greffe

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

Intelligence overview, including Analytical Cell update and HCS activity.

A1. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A1 of its meeting of 8th March 2022, received a PowerPoint presentation, entitled 'STAC Monitoring Update', dated 15th March 2022, and heard from Ms. L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department in connexion therewith.

The Cell was apprised of the current situation with regards to public health monitoring, noting that as at 14th March 2022, there were 2,274 active cases of COVID-19 recorded in the Island. The majority of cases were in adults aged 40 to 49 years, followed closely by those aged 50 to 59 years and 30 to 39 years.

Seeking healthcare was the most common reason for testing, accounting for 1,207 cases; 966 had been identified following positive Lateral Flow Tests (‘LFTs’); and the remainder through various screening programmes. The age ranges, gender and vaccination status of the active cases were shown, with a further breakdown by age for active cases in those aged 18 and under.

An average of between 290 and 300 cases per day had been identified over the previous 2 weeks. The overall test positivity rate (measured as a 7-day rolling average) had increased to 48 per cent. The relatively high Polymerase Chain Reaction (‘PCR’) test positivity rate was due to people coming forward for testing following a positive LFT result.

The 7-day case rate per 100,000 population had fallen for those aged over 60 years, as evidenced by the number of active cases in the hospital which had reduced to 15 compared to the previous week’s peak of 49. A slight increase was noted for the other age groups.

The Cell reviewed the clinical status of cases in Hospital and noted that as at 14th March 2022, there were 13 patients in the Hospital. A decrease in the number of cases in care homes from 30 to 27 was noted. It was reported that 87 Health and Community Services staff were absent from work with COVID-19, the highest number in any week since the pandemic began, which was causing a problem for service delivery particularly in the acute medical wards. This situation was further complicated with 8 staff absent with norovirus with one ward closed as a result.

Details were provided of the positive cases linked to schools, which had seen a gradual decrease over the course of February 2022. Substantial numbers were being reported as positive each day and, although not as high as early January, there was a significant spread of cases across different age groups and schools. A total of 516 students and 102 staff had been reported with Covid in the last 10 days.

A further death had been recorded, bringing the total to 116, with 38 registered since the start of the 4th wave on 1st October 2021.

The Cell noted that 382 patients were currently recorded in the EMIS clinical IT system as suffering from ‘Long COVID’. Women aged 40 to 49 years continued to be most affected. 28 patients had attended the newly established Long COVID clinic at the Hospital, and a total of 96 patients had been referred.

It was noted that footfall in St. Helier had not returned to pre-pandemic levels but was higher at present than it had been in January 2021. Traffic was similar to pre-pandemic, but bus usage had not quite recovered to those levels.

Details regarding the COVID-19 vaccine programme were shared and it was noted that as at 6th March 2022, 222,803 doses had been administered, of which 61,009 were third ‘booster’ doses, with high rates of coverage in older age groups and a slowing down in uptake rates across younger eligible populations. The Spring Booster programme for the Over 75s and Immunosuppressed Over 12s had begun the previous week and would be added to the published chart.

The Cell was informed that 13 episodes of flu-like illness had been reported in primary care during the week ending 13th March 2022. Overall, levels of flu-like illness were similar to those seen during the 2020/21 Winter season and significantly lower than in previous pre-pandemic Winter seasons.

The Cell was apprised of the situation in the United Kingdom (‘UK’), noting that over the 7 days to 11th March 2022 (7th March 2022 for hospitalisation figures), cases had increased by 56 per cent, hospitalisations by 16.9 per cent and deaths by 2.8 per cent.

A graphical comparison of 14-day case rates per 100,000 population showed that Jersey’s rate had continued to increase to 3,650, while the UK had experienced an uptick generally with Scotland (2,340), Northern Ireland (1,630), England (880) and Wales (440). The Cell was informed that 14-day case rates remained high across Europe. A graph published by Our World in Data revealed sharp increases in Austria and Switzerland.

A graphic was included in the presentation which had been published in the FT, an analysis of date from John Hopkins Centre for Systems Science and Engineering, it compared the impact of Omicron on two international regions which had operated stringent closed border policies during the pandemic. Whereas Hong Kong had a large majority of unvaccinated over 80s (66 per cent), New Zealand reported just 2 per cent. While both had experienced daily case rates rising to in excess of 100 per 100,000 people, the case fatality rate in Hong Kong was 4.7 per cent compared to 0.1 per cent in New Zealand. This was cited as evidence of the importance of very good vaccination coverage within the elderly population.

An update on the risk assessment of the SARS-CoV-2 variant: VUI-22JAN-01 (BA.2) produced by the United Kingdom Health Security Agency was given. This had not changed although it noted the increased transmissibility when compared to BA.1 which had been attracting attention although there was little evidence of any difference in clinical severity with the original Omicron. BA.2 was now the dominant variant in the UK accounting for between 80 and 90 per cent of cases and 5 out of 6 genomic sequence tests recently returned to the Island were found to be BA.2.

The Cell had been provided with a copy of a study published online on 10th March 2022 by The Lancet entitled ‘Estimating excess mortality due to the COVID-19 pandemic: a systematic analysis of COVID-19-related mortality, 2020–21’, and this was summarised and discussed. Figures showed that for the cumulative period 2020-21 all-cause mortality was much greater than the number of COVID-19 recorded deaths. The method of measurement attempted to correct for differences in reporting between countries and also included deaths that could have been indirectly due to COVID-19 as well as those caused by the disease itself. It was stated that there had been critical review of the methodology and it was noted that this was just one way to examine the impact of the pandemic but that it was right and proper to digest and discuss such studies.

A graphic included with The Lancet article showed that excess mortality was quite low in areas that had eliminated COVID-19, such as Australia and China, unlike countries in Latin America, Russia and Europe where figures were quite high. Another map showed the excess mortality rates versus reported COVID-19 deaths which highlighted the disparate reported official figures. Slide 39 of the presentation offered an approximation of excess deaths in Jersey. The Lancet methodology, described as a complicated ensemble of 6 different models, was not used but rather the simple measure of excess deaths, known as ‘P-score’ (the percentage difference between reported deaths and the previous 5-year average). The table for 2020 showed 56 fewer deaths (-6.9 per cent), similar to the negative excess deaths witnessed in Australia and New Zealand. Caution was needed in interpreting these figures due to the basic methodology, and stochastic nature of small samples. The provisional figures for 2021, as the full mortality data was not yet available, showed

an increase of 5 deaths (+0.6 per cent).

A Cell member commented on being particularly struck by the extraordinarily high fatality rate in Hong Kong. They added that the diagram illustrated how important the protective effect of vaccination was for older and more vulnerable adults and that this also scotched the myth that Omicron did not pose a serious problem. The variant could be inferior in terms of severity of illness when compared with Delta but that did not mean it was not highly threatening in terms of severe disease and as a cause of mortality. The contrast with New Zealand with the vaccination strategy was incomparable and it was an impressive graph to share with Ministers and others about the importance of the pace and intensity of Jersey's vaccination regime and why it needed to be maintained as this was what had prevented Hong Kong's case mortality rate being replicated in the Island. It was described as a very powerful message.

Those views were supported by another Cell member, who stated that it added to the importance of noting the waning immunity in the elderly and immunosuppressed populations and that the Spring Booster programme should be given the chance to have the desired effect before the further de-escalation of COVID-19 mitigation measures. Further to a matter raised at a previous meeting, the member repeated being interested to know if the fourth wave could be divided to separate the effects of the latter days of Delta and the onset of the Omicron variant in Jersey. They suggested that a preliminary split indicated that the mortality rate for the latter was 0.13 per cent which was similar to Delta in the Autumn. Although the number of cases was high in cold numbers in January and February compared to the Autumn, severe illness and death was still being experienced in the Omicron phase, which was more efficient in transmission. Jersey's position comparatively with other jurisdictions across the world in relation to excess mortality was described as impressive, although it was accepted that different measurement methodologies had been used. It was expressed that it would be helpful to look more closely at the Jersey figures compared to the past and other jurisdictions in the hope to provide details of why there had been a decrease in some areas and inform where the general approach had been to the benefit of Jersey.

With the fourth wave having now included the highest number of deaths at 38, there was a question from a Cell observer about whether the waves were of equal length or was it down to the Omicron variant. It was noted that most of the waves lasted for 6 months, but in the others the prevalence was low compared to wave 4 which had high prevalence but a low case fatality rate. This prompted a Cell member to suggest that in terms of pure numbers of deaths, the fourth wave looked the worst, but it needed to be put into context that a lot more people had caught COVID-19. Another Cell member stated that it was very important to note that due to the vaccination programme the mortality rate had dropped to 0.13 per cent and that it remained so in each wave, irrespective of absolute numbers. This was different to what the published evidence suggested about the severity of Omicron. The fact the rate had been pushed to 1 in 1,000 was as a result of the vaccination programme and therefore it should not be allowed to wane or atrophy or the mortality and severe disease rates would undoubtedly return to the levels revealed in the Hong Kong graph.

A Cell observer questioned whether a patient in receipt of palliative care for a terminal illness who had been diagnosed with COVID-19, but was asymptomatic when they died would be counted among the COVID-19 deaths if the virus was mentioned on the death certificate. The Cell was informed that a doctor should only mention COVID-19 on a death certificate if it was thought to be a contributory factor to the death. As reported to the Public Accounts Committee Jersey was not reporting deaths in the same way as the United Kingdom ('UK') where it was recorded if the

death was within 28 days of a positive diagnosis. In Jersey deaths were only counted if COVID-19 had genuinely contributed to the death, in which case it would be included on the death certificate. The 2020 mortality report analysed all the different definitions: recorded on the death certificate, official underlying cause or within 28 days of a positive test and all produced slightly different results, but those noted on the death certificate as a contributory factor was the key measurement.

In summary, the Chair stated that despite the increase in infections, the number of patients in Hospital was down from the recent peak, but a higher level of staff was absent due to COVID-19 than previously experienced. Some interesting evidence had prompted several Cell members to comment on the importance of the vaccination programme and interpretation of that evidence revealed how this had protected the population. Although a relatively high number of deaths had been seen in the fourth wave compared to some other waves, the mortality rate was much lower as it had been experienced over a long period with high levels of people with the infection.

The Cell noted the position and thanked Dr. Daniels for the update.

Discussion of prevalence and risk in de-escalation context.

A2. The Scientific and Technical Advisory Cell ('the Cell') heard from Mr. A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, in connexion with a discussion of the prevalence and risk in the de-escalation context.

The Cell was informed that while prevalence in Jersey remained high (circa 300 cases per day) there were 3 main factors at play:

1. De-escalation of mitigations, and associated behaviour changes;

2. Waning of immunity (several months since 3rd dose for older adults); and

3. Higher transmissibility of BA.2 variant (first detected on-Island on 23rd January 2022).

It was explained that since the de-escalation of mitigation measures process had begun it had been observed, and more than anecdotally, that there was somewhat of a race to the finish within Government, healthcare and also among the population. People had been living with the pandemic for 2 years and it was understandable that they were keen for it to be over. Prevalence of COVID-19 remained high and people in general terms were being less careful, notwithstanding specific provisions of de-escalation measures. Waning immunity would be partly remedied by the Spring Booster. For the older and more vulnerable it had been several months since the original booster and that could have transitioned into the higher numbers seen in Hospital and the care sector recently. The higher transmissibility of the Omicron sub-variant BA.2, which was now prevalent in Jersey, meant that cases were not diminishing. With the Competent Authority Ministers meeting later in the week of the extant meeting in mind, there was a position of prevalence higher than desired and this would impact on loss of learning for people of school age, a depleted or less than resilient workforce as a result of sickness and a rate of mortality which was higher than any other wave as a function of the sheer amount of infections experienced, not necessarily as a result of the level of protection in place or the severity of disease. Looking forward, Ministers could see the mitigation factors ahead with the Spring Booster roll-out and continued efforts to encourage the 18,000 who had received 2 doses but not the third, Booster, dose. This was absolutely vital for the prevention of severe disease, given the waning of protection offered by the vaccine. The vaccination of 5 to 11 years olds would also offer a level of protection

whilst the effect of warm weather in terms of virus transmission and the preponderance of people outdoors in the fresh air were further mitigation factors. However, the planned removal of legal requirements in relation to isolation at the end of March could exacerbate the problem. It would be a factor, but it was difficult to judge the impact it would have on infection rates or overall prevalence when taken together with the expected behaviour change. The Cell was apprised of the considerable uncertainty and informed that any comments individually and then through consensus would be communicated to Ministers when they met as the CAM, which could be the last such meeting this side of the election and was probably the only opportunity the Cell would have to modify the approach being taken. Ministers had agreed the de-escalation strategy and taken the decision to align with other nations of the UK and end mandatory isolation on 31st March and it was highly unlikely they would decide to do otherwise, but even in that context it was important for the Cell to give advice to Ministers, as it had always done, having made a judgment on the variety of factors at play.

The Cell, with reference to Minute No. A3 of the meeting of 8th March 2022, was reminded of the report entitled 'Confirmed COVID-19 Cases – End of Mandatory Isolation Requirement', prepared by Mr. J. Lynch, Policy Principal, Strategic Policy, Planning and Performance and heard from him in in connexion therewith.

The Cell was informed that the aforementioned report had been updated to be considered at the CAM meeting on 17th March 2022. That included the simplification of the isolation guidance once the legislation was ended to remove the differentiation based on vaccination status and a return to normal activity after a period of isolation of 5 days plus 2 consecutive negative Lateral Flow Tests 24 hours apart. It was also made clear that it was essential to ensure as much adherence with the voluntary model as possible once the legal requirement ended. Although it was inevitable adherence levels would decline, work was being undertaken on the communication strategy and approach with the messaging maintaining as much as possible the focus on safe good behaviour in relation to isolation and symptom checking while downplaying the end of the legal requirement. It was essential that the end of the legal requirement was not seen as the end of the need to follow public health guidance. The decision was part of the broader range of COVID-19 de-escalation measures announced on 28th January 2022. Much time had elapsed and Mr. Lynch wanted to ensure the Cell was content to progress with the date of 31st March 2022, in line with other comparable jurisdictions given the persistent high infection rates and ongoing disruption in schools with over 600 cases and pressure on staffing within healthcare settings. There had been no change since the presentation to the Cell at the previous meeting, but thoughts and input were invited.

A Cell member mentioned that Scotland had chosen to keep face masks in public places and on public transport until April as a result of the spike of COVID-19 infections. He described the anticipation that numbers would not continue to increase in the way they had when discussions on de-escalation were held on 28th January 2022. There had been an increase when the first stage was implemented, partly due to the message people received combined with the confidence that Omicron and the BA.2 variant were not as virulent. Should the Island de-escalate further at the end of March, the increase would be greater still and the message would go out that it did not matter what numbers were being seen; the Island was not worried about case numbers, worse death rates or hospitalisations and the population should just use isolate if they believed they should. This would almost certainly propel people away from testing. They would only test and act on the results if the Government told them they needed to. If this legal requirement was removed, they probably would not do the test either. He added that it was difficult to reconcile, when the infection numbers were increasing, to recommend that the Government

was saying it was acceptable to want people to isolate, but it did not want to keep it as a legal requirement on principle.

If the requirement to isolate if a person tested PCR positive continued for a month or so it would give more time for the infection to not flow at speed through the community, but for sickness rates to trickle through patients and staff. This would allow more time to roll out the Spring Booster to protect the vulnerable, looking back to the Hong Kong graph, and try and catch the 25 per cent who were due a third, Booster, dose but had not yet received it. Less importantly it would give some time to the Universal 5 to 11 programme. The warmer weather would encourage more people outside and more ventilation inside and the delay would also allow the delivery of antiviral drugs programmes to mature. These drugs were available to those that were eligible, but the UK programme was hampered by logistical problems. Plans for the Jersey programme were gathering pace and once arrangements had been finalised these would allow for early treatment within the community of those with COVID-19. Another month would offer many benefits and the Cell was encouraged to consider recommending the extension to Ministers.

Another Cell member offered support for the suggestion and claimed that the Government's messaging was confused as it stated that it wanted isolation to continue, but it no longer wanted it to be a legal requirement. There was a risk of losing credibility by following that path. People should be legally required to isolate until the point at which the legal requirement could be removed. The views of another Cell member were shared with the suggestion that mitigation factors were not effective at present apart from the vaccination programme which was fully supported. Hence, keeping them in place was not particularly logical with the exception of a few high-risk settings such as healthcare. They suggested that the best approach would be for people to be vaccinated when it was offered and to isolate if they tested positive and, if that was not possible, at least stay away from elderly people. The experience of Hong Kong was a good case in point – very strong mitigation measures which had little impact on transmission (and lowish vaccination rates and lack of previous exposure among the elderly had meant high death rates). Obviously, the settings and approaches were very different, but it demonstrated how difficult it was to interrupt the transmission of Omicron.

In response to the Cell members, it was noted that the objections were logical in terms of suspending the law and replacing it with strong recommendations, however it was important to understand the extraordinary circumstances which had created the situation. The COVID-19 pandemic had created the need for legal measures to be put in place to test and isolate the population, and Ministers and the States Assembly had been deeply uncomfortable throughout about the legal requirements and had signalled on many occasions that, given the opportunity, they wished to remove them as soon as they could. The Cell had to understand that was why consideration was being given to departing from the law as written at some point whilst still returning to the more usual method of making recommendations in relation to controlling infectious diseases with advice on behaviour. It was emphasised that Ministers would find it very difficult to 'row back' on the commitment they had made, although that did not mean it was not the right thing to do if the consensus of the Cell was that Ministers needed to be given the option of extending the period of mandatory isolation a little further. The hope of lower prevalence at the end of Winter had not transpired and there was no way of knowing, given the infectivity of the BA.2 variant, when or whether it would transpire and so there was an element of 'if not now, when' in relation to this decision which did not make the situation any easier. Ministers would be looking closely at the case mortality rate and seeing that it was far reduced would likely want to make the decision to stick to the agreed plan and policy and confirm that decisions at the CAM

meeting on Thursday.

The Chair suggested that, although it was clear there was a political reality about the decision, the Cell's opinions were made based on the science and data.

Another Cell member suggested that this was the most complicated situation facing the Cell over the past 2 years and there was no obvious right answer. The comments on Hong Kong were pertinent, Omicron was incredibly transmissible and even with the legal requirement to isolate, case rates were settled at 300 per day with associated deaths and impact on population health. Understanding what the impact would be of removal of the legal requirement was very difficult to quantify. They added that the published figures failed to reflect the health impact on people who were not in Hospital and there was a misconception that people who contracted COVID-19 were all well but simply had to stay at home for 5 days just waiting to be released from isolation. Information from the Covid Safe team, who had been talking to the positive cases, reported that many COVID-19 positive cases were symptomatic adults who reported how unwell they felt and that they had to take time off work. Whatever could be done to measure that impact on the people not in Hospital, but off work, should continue whether there was a mandatory isolation period or not. It was important that this information was more widely understood; also to note the Covid Safe team had reported that over 50 per cent of those taking an LFT on day 6 were still positive.

A Cell member who had spoken earlier wanted to know details of the anticipated completion of the Spring Booster vaccination programme, with reference to the Hong Kong graphic and bearing in mind the waning immunity, increasing case numbers and rising admissions and deaths in the United Kingdom. Time was needed to push the Spring Booster roll out and could that be done if the population was told that mandatory isolation was no longer required. That was partially answered by the earlier contributor who had stated that people with symptomatic COVID-19 were feeling so unwell they would be staying off work and therefore isolating. That could be the let-out clause, along with those who had tested positive continuing to do the right thing as long as they were not pressurised into going into work. Vaccination of the over 75s had started on the Friday of the previous week and was expected to be completed by the end of March. Visits to care homes had begun on the morning of the extant meeting and were also expected to be completed by the end of the month. Reaching the individual housebound and immunosuppressed was expected to take a little longer, possibly until the end of April or early May. The previous speaker said that it would take a further 2 weeks from the vaccination to boost immunity. It was further stated that a 'baby Hong Kong' amongst Jersey's elderly should be avoided.

In summary, the Chair suggested that the Cell had arrived at a position where people felt there was no obvious right answer, but recognised that the pandemic was not over. There was possibly a tendency towards showing some caution and an argument for delaying the announcement of the end of testing and isolation to allow the vaccination programme to run its full course, recognising from information received that the majority would receive their booster doses by the end of March. Other factors including the proliferation of medicines could also justify that action. The Cell also noted comments about the potential for confusion when moving from a legal mandate to guidance on isolation, albeit accepting that this could be difficult politically to maintain. There were comments about this not being a mild disease for many and the need to think about future risks particularly within vulnerable groups. An alternative way of managing this was to accept that those requirements for testing and isolation would stop as planned and this would be used as an opportunity to learn, although the communication implicit in that had to be very carefully reviewed in terms of the impact of those decisions. The Cell had ended up with those 2 options.

A Cell observer suggested that whereas the previous message had been to stay away from everyone, if the legal requirement to isolate was to end on 31st March 2022, perhaps the new message could be for people to isolate as much as they could but particularly to keep away from the vulnerable.

A member of the Public Health communications team gave an insight into the campaign which had been produced with Behavioural Sciences input. The message was that, should the legal isolation requirement end on 31st March 2022, Islanders would be reminded that they should continue to do the right thing and avoid the risks presented by Omicron. It was also necessary to address the confusion among some people that post-emergency was post-COVID-19 and strive to leverage the community spirit evident in what had been achieved so far. Meetings had been held to discuss the guidance that needed to be communicated, that COVID-19 remained a risk and that the right thing to do was stay at home if you had symptoms and isolate and take a test. Understanding personal risk in different settings and scenarios for those Islanders at greater risk and those who were pregnant would also be addressed.

A Cell member questioned whether the elderly could think they had been abandoned, which was how they had felt at the beginning of the pandemic in 2020, if legal restrictions for everyone else were lifted, but people were told to keep away from the elderly. The political appetite for the end of mandatory regulations at the end of March was understandable but the communications in relation to those most at risk had to be handled very carefully.

Another Cell member questioned whether, ahead of the CAM Meeting, the views of other colleagues and stakeholders had been canvassed, particularly the care homes sector which had been keen to be treated as a key stakeholder. The same could be said of the education sector, where concerns had been raised in other jurisdictions when policies changed and also given the number of positive cases in the school aged group. A range of levers and tools were available to encourage the type of behaviour desired and the support of the care sector and education within individual organisation policies could help achieve the aim to keep vulnerable populations safe and reduce transmission. It was questioned whether the behavioural influence could help reverse the perverse incentive for those on zero hours contracts who did not get paid if they did not go to work. It was further questioned whether the right behaviour of testing and adhering to non-mandatory isolation could be encouraged, against the negative impact of being tested and testing positive.

A further Cell member mentioned the twice weekly Community Bronze cell meetings (which covered the General Hospital, mental health, primary and community care, social care, learning disability services and also wider partners like FNHC, Jersey Hospice, care homes and care providers at home) and suggested that, rather than the organisations, it was important to put it into the setting of care for the patient whether in Hospital, GOP surgeries, nursing or residential homes and treating them as one rather than individual entities. It was an important point as the Island moved towards the greater freedoms people were desperate for and could take for granted and which needed to be put into perspective in terms of relative risks to the vulnerable who could still get COVID-19.

Another Cell observer agreed with the previous speakers and stated that when the legal requirements no longer applied, they should become social requirements. The messaging needed to speak to the social approval of those who behaved in the morally correct manner. The idea to give a voice to the care homes was important as when it came to the communication of social issues the wider the variety of messengers the better and more acceptable the message would be in terms of its

reception. It was preferable for the message to be heard not just from the Government but GPs and care homes as well. That was particularly important when the legal lever was removed from the armoury. The importance of a support mechanism for those on zero hours contracts was emphasised once again. Another Cell member added that they would reflect on the helpful points raised and that the public health team would support care homes with guidelines and colleagues in education with the development of future policy.

The report author confirmed that although the bespoke COVID-19 financial resources in terms of business and personal support were coming to a natural end, there were options in place for Ministers to continue with some financial support for those on zero hours contracts as the Island transitioned from mandatory isolation to strongly recommended as de-escalation in the Island progressed. He also suggested that the consensus of the Cell was that the public health rationale for retaining financial support beyond 31st March 2022 for those on weak terms and conditions was very strong and that was the input that would be given to Ministers.

In summary of the further discussions, the Chair recognised the importance of communications moving forwards based around social requirements and targeted messaging of the more vulnerable and older Islanders. The views of the care and educational sectors would be sought and there had been helpful comments about framing the exposure risks so people were aware of the context in which they found themselves and what the risks were to others. It was important to support individual organisation policies and explore how behavioural science underpinned a number of those approaches. The issues around those who found themselves in jeopardy in terms of income as a result of isolation would be raised with Ministers and the work of the COVID-19 team which had already begun would be built upon with comments from the meeting which would be helpful to further develop the communications.

Vaccine update.

A3. The Scientific and Technical Advisory Cell ('the Cell') with reference to Minute No. A4 of its meeting of 8th March 2022, received a presentation, dated 10th March 2022, entitled 'Vaccination Coverage by Priority Groups', which had been prepared by Ms. E. Baker, Head of Vaccination Programme, Strategic Policy, Planning and Performance Department and heard from her in connexion therewith.

The Cell was informed that vaccination was the key mitigation to the risks of de-escalation with the focus currently on 4 main areas:

1. Evergreens: 100 over 18s had attended for first or second doses in the previous week;
2. Outstanding boosters: While there had been 82,709 first doses and 79,088 second doses, only 61,009 Booster (third) doses had been given;
3. 12-17 year olds: A second tranche of 340 vaccines had been delivered compared to 455 in December. The lower uptake could have been due to recent high numbers of positive cases. Children, Young People, Education and Skills, the Children's Commissioner, Behavioural Science and Communications were part of a working group looking to boost the uptake;
4. At Risk 5 to 11 year olds: The first dose update had been approximately 35 per cent with plans in progress for the second dose.

On Thursday of the previous week, the Spring Booster programme for those aged over 75 or the over 12 Immunosuppressed, a cohort size of approximately 10,000, had begun. This was ahead of England which was due to start the week after the extant meeting. It was further reported that the uptake had been positive. The immunosuppressed had been written to and invited to attend for the fourth dose when due. This was a precautionary measure to prevent serious illness in older Islanders

who had received the Booster (third dose) in September or October and whose protection from disease would continue to wane gradually.

Operational planning for the Universal 5 to 11-year olds roll out had started and involved discussions with Communications, Behavioural Scientists, the Children's Commissioner and Children's Minister before the start at the beginning of the school Easter Holidays in order that disruption to young Islanders would be minimal. A paediatric formulation of the vaccine would be given.

In response to a question from a Cell observer, it was confirmed that due to the recent high rates of infection in care homes, the vaccination team would revisit those individuals who could not be vaccinated due to the required 4-week interval following a positive Polymerase Chain Reaction ('PCR') test.

A Cell member commented that should the lifting of the mandatory isolation go ahead on 31st March 2022, then it was important to roll out the Spring Booster as rapidly as possible and progress the maturation of the anti-viral deployment programme as well and ensure the appropriate well-balanced messaging to protect the vulnerable and elderly without making them feel under undue risk

The Chair commented that the Cell noted the intention to continue to progress the vaccination programme.

Matters for information.

A9. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A1 of the current meeting, received and noted the following –

- a weekly epidemiological report, dated 10th March 2022, which had been prepared by the Strategic Policy, Planning and Performance Department; and
- statistics relating to deaths registered in Jersey, dated 11th March 2022, which had been compiled by the Office of the Superintendent Registrar.

There being no further business to discuss, the meeting was concluded at 4.30pm.