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SCIENTIFIC AND TECHNICAL ADVISORY CELL

(53rd Meeting)

(Meeting conducted via Microsoft Teams)

29th March 2021**PART A (Non-Exempt)**

All members were present, with the exception of C. Folarin, Interim Director of Public Health Practice, R. Naylor, Chief Nurse, Dr. M. Patil, Associate Medical Director for Women and Children and S. Skelton, Director of Strategy and Innovation, Strategic Policy, Planning and Performance Department, from whom apologies had been received.

Mr. P. Armstrong, MBE, Medical Director (Chair)
 Dr. I. Muscat, MBE, Consultant in Communicable Disease Control
 Dr. G. Root, Independent Advisor - Epidemiology and Public Health
 R. Sainsbury, Managing Director, Jersey General Hospital
 Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention
 Dr. S. Chapman, Associate Medical Director for Unscheduled Secondary Care
 Dr. M. Garcia, Associate Medical Director for Mental Health
 S. Petrie, Environmental Health Consultant
 A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department
 I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department
 N. Vaughan, Chief Economic Advisor

In attendance -

J. Blazeby, Director General, Justice and Home Affairs Department
 C. Landon, Director General, Health and Community Services Department
 R. Corrigan, Acting Director General, Economy
 D. Danino-Forsyth, Director of Communications, Office of the Chief Executive (for items A3 to A5 only)
 S. Martin, Chief Executive Officer, Influence at Work
 R. Johnson, Head of Policy, Strategic Policy, Planning and Performance Department
 S. White, Head of Communications, Public Health
 J. Lynch, Policy Principal, Strategic Policy, Planning and Performance Department
 M. Clarke, Principal Officer, Public Health Intelligence, Strategic Policy, Planning and Performance Department
 L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department
 Dr. C. Newman, Senior Policy Officer, Public Health and Wellbeing, Strategic Policy, Planning and Performance Department
 Dr. N. Kemp, Policy Principal, Strategic Policy, Planning and Performance Department

J. May, Senior Policy Officer, Strategic Policy, Planning and Performance Department
K.L. Slack, Secretariat Officer, States Greffe

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

Minutes. A1. The Scientific and Technical Advisory Cell received and noted the Minutes from its meeting held on 22nd March 2021, which had previously been circulated. Members were asked to provide any feedback thereon to the Secretariat Officer, States Greffe, by the end of 29th March 2021, in the absence of which they would be taken to have been confirmed.

Monitoring Metrics. A2. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of its meeting of 22nd March 2021, received and noted a PowerPoint presentation, dated 29th March 2021, entitled 'STAC Monitoring Update' which had been prepared by the Principal Officer, Public Health Intelligence and the Public Health Analyst, Strategic Policy, Planning and Performance Department and initially heard from the former in relation thereto.

The Cell was informed that, as at Friday 26th March 2021, there had been 4 active cases of COVID-19 in Jersey, who had been in direct contact with 43 individuals, who were self-isolating and the 14-day rate, per 100,000 population, had been 2.78. None of the active cases were experiencing symptoms of the virus and one had been in the General Hospital. Three of the cases had been identified as a result of arrivals testing and one through screening before admission to Hospital. Since 12th February 2021, the number of daily average cases had been below one. During the week ending 26th March, an average of approximately 1,000 tests had been undertaken on weekdays, which aligned with the position in previous weeks, with the majority of tests having been as part of the workforce screening programme.

With regard to the number of daily cases of COVID-19, the number of tests and the test positivity rates for various age groups, the latter remained very low for all, including those aged over 70 years. The Cell was provided with details of a number of positive cases that had been identified over the weekend of 27th / 28th March 2021 and was reminded that, since 1st March, there had been just 9 positive cases, of which 5 had been identified through inbound travel testing, 2 through workforce screening, one through testing pre-admission to Hospital and one person had sought healthcare on experiencing symptoms of the virus.

The Cell noted the Hospital occupancy rates and the daily admissions of people who had been positive for COVID-19 on admission - or in the 14 days prior - and those who had tested positive for the virus after entering the Hospital (based on the definitions used by the United Kingdom ('UK')) for the period from 1st November 2020 to 28th March 2021 and was informed that the 7-day admission rate, per 100,000 population, remained very low and aligned with the 7-day case rate. As at 28th March there was no-one in Hospital with the virus and there had been no further deaths since the last meeting of the Cell and the figure remained at 69 since the start of the pandemic, where COVID-19 had been referenced on the death certificate. The Cell was provided with the PH Intelligence: COVID-19 Monitoring Metrics, which had been prepared by the Health Informatics Team of the Strategic Policy, Planning and Performance Department on 26th March 2021 and was informed that there had been very few calls to the Helpline from symptomatic individuals over previous weeks. The number of inbound travellers remained low, but there had been a slight increase over the last week.

During the week ending 21st March 2021, there had been 1,490 tests on inbound

travellers, 5,170 as part of on-Island surveillance and 250 on people seeking healthcare. The weekly test positivity rate locally, as at that date, had been zero per cent and had remained at 0.4 per cent in the UK. The local weekly testing rate, per 100,000 population, had remained at 6,400 and in the UK had increased slightly to 13,903, mindful that that jurisdiction included tests undertaken on Lateral Flow Devices ('LFDs'). The Principal Officer, Public Health Intelligence, informed the Cell that it was remained the intention to include LFD results in the local figures, but it had not, as yet, been possible to obtain a full set of data in this regard. Due to the aforementioned positive cases identified over the weekend, the local test positivity rate had increased to 0.2 per cent as at 28th March 2021.

The Cell was informed that attendance at Government primary schools, during the week commencing 22nd March, had averaged 97.6 per cent and 92.3 per cent at secondary schools. There had been no absences related to COVID-19 in the primary schools and 0.2 per cent in the secondary schools and it remained the case that there had been no positive cases linked to the schools since 22nd February. The Cell noted the data in respect of the volume of LFD tests by school, result and date, including the number of positive, negative and inconclusive results and was informed that in excess of 12,800 LFD tests had been carried out and there had been just 3 positive results from LFD tests, which had subsequently been shown to be 'false positives' when tested using a PCR swab, in addition to 56 inconclusive results, which had been re-tested.

The Cell was presented with the published data, to 21st March 2021, in respect of COVID-19 vaccinations in Jersey, which showed that 52,265 doses had been administered, of which 43,136 had been first dose vaccinations and 9,129 second dose, resulting in a vaccine rate, per 100 population, of 48.48. Indicative figures to 28th March, which were subject to verification, were that 58,989 vaccines had been administered, of which approximately 44,000 had been first dose and 14,700 second and the vaccine rate had been 54.69. Vaccine uptake in older Islanders continued at very high levels and, as at 21st March, approximately 100 per cent of those aged over 80 years had received their first dose (based on population figures from 2019) and 74 per cent their second, whilst 74 per cent of these aged between 50 and 54 years had now received their first dose. Fourteen per cent of Islanders aged between 17 and 49 years had received their first dose and it was noted that these would be those at high, or moderate, risk or who worked in health and social care settings. The Cell was provided with a map, which had been prepared by the European Centre for Disease Prevention and Control ('ECDC'), which set out an estimate of the national vaccine uptake in Europe for the first dose of the COVID-19 vaccine in adults, as at 21st March 2021 and was informed that most countries now averaged between 10 and 15 per cent, whereas approximately 49 per cent of those aged over 18 in Jersey – and a similar number in the UK - had been vaccinated as at the same date.

The Cell was provided with a graph of the cumulative numbers of first and second dose vaccinations, as at 21st March and noted the increase in second doses administered. As at the same date, 97 per cent of care home residents had received their first dose of the vaccine and 88 per cent their second and in respect of staff employed in those settings, these figures were noted to be 86 and 66 per cent respectively. With regard to Islanders classed as 'clinically extremely vulnerable' 85 per cent had received their first dose and for those at moderate risk, that figure was 79 per cent. In respect of the review of the uptake of first and second doses, which focused on gender, it remained the case that there was no significant difference by gender for the eligible age groups, but as those working in health and care settings had been invited for vaccination, there had been more females than males, which was reflective of the gender balance of employees in those *loci*. There had also been more females than males who had received their second dose of the vaccine, but it was anticipated that these figures would even out over time.

The Cell received the weekly estimate of coverage for the various priority groups, as recommended by the Joint Committee on Vaccination and Immunisation ('JCVI'), by cohort size and the numbers of first and second doses of the vaccine and was informed that 97 per cent of those working in frontline health and social care positions had received their first vaccine and 62 per cent their second and 80 per cent of other workers in those settings had received their first dose and 44 per cent their second. However, these percentages were still allocated an Amber rating, which was indicative that a small amount of the data was of questionable quality and was being reviewed.

The Cell heard from the Senior Informatics Analyst, who had undertaken an analysis of those people who had tested positive for COVID-19 at least 14 days after receipt of one dose of the vaccine. She informed the Cell that there had been little change since the last report. The Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, indicated that the Statistics Users' Group had forwarded a query as to why the data relating to people who had tested positive for the virus after receiving the vaccine was not published. The Cell was informed that this was partly due to the low numbers of cases, which could result in people being identified and also because it had been discovered that the DiaSorin serological tests were providing some 'false negatives', as prevalence of the virus decreased. It was not possible to review all of the results, but some work could potentially be done around the positive results since the change to the protocol, which had resulted in positive DiaSorin tests being verified using PCR tests.

The Cell was shown a map of the UK, which set out the geographic distribution of cumulative numbers of reported COVID-19 cases, per 100,000 population, as at 28th March 2021, on a 7-day rolling basis. This demonstrated the continuing reduction in infection rates across much of that jurisdiction. Mindful that Competent Authority Ministers had decided to re-introduce the Red / Amber / Green ('RAG') categorisation at the borders from 26th March 2021, initially for the UK only, with the rest of the world following on 17th May (with the exception of the UK 'banned list' countries), the Cell was presented with information on the current RAG status for the United Kingdom, Eire, France, Germany and Italy and noted the decreasing number of Red areas in England, that there had been an increase in Red areas in Scotland and that the position was improving in Wales and Northern Ireland. The situation in Europe had worsened and the vast majority of areas in France, Italy and Germany were now Red. With regard to the maps, which had been prepared by the ECDC, for weeks 10 to 11 (15th to 22nd March) when compared with the previous week, on 14-day case rates per 100,000 population, rising rates in Poland and much of Eastern Europe, northern Italy and parts of France, most notably around Paris, were noted and the Cell was informed that these would be kept under close review in light of the upcoming changes to the border policy.

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

Monitoring Metrics to support the reconnection roadmap.

A3. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A4 of its meeting of 22nd March 2021, recalled that it had agreed to establish a Sub-Group to consider what metrics should apply when establishing future stages of reconnection and that it had discussed and suggested potential amendments to the same and had noted that a future discussion would be required in respect of the action that would need to be taken in the event that one of the key metrics was reached.

The Cell accordingly received and noted a PowerPoint presentation, dated 26th March 2021, entitled 'Monitoring Metrics to Support Roadmap' and heard from the Principal Officer, Public Health Intelligence, Strategic Policy, Planning and Performance Department, in connexion therewith. She reminded the Cell of the Competent Authority Ministers' objectives for establishing reconnection, which would be based on a data and information framework. In determining the appropriate metrics to employ, the

Sub-Group had reviewed the direct and indirect harms linked to COVID-19, *inter alia* its effect on Islanders' health and the Health and Community Services Department and the wider impact of the non-Pharmaceutical Interventions ('NPIs'), most notably during the second wave, from October 2020. It had assessed the likely situation for 2021 against a backdrop of the COVID-19 vaccine roll out, the threat posed by variants of concern ('VOC') and the evolving situation internationally and had reviewed the quantitative and qualitative aspects of learning from the second wave, which had included consultation with the Contact Tracing Team, particularly with regard to the period in late 2020 when the latter had experienced considerable pressure.

The Cell recalled that, during the second wave, 37 people had died, between 60 and 100 people had suffered serious illness and approximately 1,800 had been symptomatic, whilst 1,000 had not experienced symptoms of COVID-19. This had resulted in 16,000 Islanders being required to self-isolate as a consequence of being direct contacts of active cases, whilst the NPIs, which had been introduced in order to address the spread of the virus in the Island, had impacted the whole community, by affecting people's wellbeing and the economy, leading to the closure of the schools and restricting personal liberties. Modelling had been undertaken to determine what might happen if a third wave were to occur in the near future, which demonstrated that the vaccine coverage would significantly reduce the risk of death and serious illness and also somewhat diminish transmission, which would reduce the impact on health services. However, direct contacts of active cases would still be required to self-isolate and all Islanders would be subject to NPIs, irrespective of their vaccination status. This would place pressure on services, whereas avoiding a third wave altogether would alleviate the Covid harms to the majority of the population.

As the on-Island restrictions were eased, so the risk of cases leading to outbreaks would increase, particularly at Stages 6 and 7 of the reconnection roadmap when travel to and from the United Kingdom ('UK') from 26th April and then internationally from 17th May would be facilitated (with the exception of the 'banned list' countries), whilst there would be minimal mitigations in place locally. There would be a high risk of seed cases causing large outbreaks, with this further growing if travel volumes increased, or if there was a growth in prevalence of the virus amongst arrivals. The Cell was reminded that some modelling had been undertaken to show the impact of cases passing undetected through the border on the case rate on-Island which assumed some vaccine coverage, as at the end of April. With some mitigations in place, a greater seeding rate would be tolerable before another wave was triggered and modelling suggested that with an effective reproduction number (R_t) of 1.6 – which had been the situation in November 2020 - one seed case per week could take 6 months to give rise to 30 cases per day. However, with minimal mitigations in place and an R_t of 3.0, it was suggested that one seed case per week could lead to 30 cases per day in under 3 weeks.

The Cell was mindful that effective suppression of transmission remained critical to prevent the emergence and spread of new variants of COVID-19, which were able to escape vaccine acquired immunity. It was informed that the E484K mutation, which was associated with immune escape, had been detected on samples from Jersey sent for sequencing to Porton Down, as had the B.1.1.7 variant, which had substantially increased transmissibility and was associated with an increased risk of death. It was important to retain low levels of infection, to avoid the test, trace and isolate strategies becoming overwhelmed and in order to prevent the success of vaccination programme being undermined. It was recalled that the Contact Tracing Team had undertaken a review of their learning and experience in the second wave, as their workload had rapidly escalated when 10 new cases per day had come to light towards the end of 2020. If this rate was maintained over a 14-day period the Team would require 56 staff members to sustain the appropriate capability and a lead-in time would be needed to onboard staff. Accordingly, robust metrics were required, noting that the thresholds

might need to adapt over time, as the situation both locally and internationally altered.

The Cell recalled that it had provided feedback on the proposed metrics to support the delivery of the reconnection roadmap, which had resulted in them being amended. It was now proposed that the key qualitative metrics should be the appearance of unlinked on-Island cases, noting that these would be based on intelligence received from the Analytical Cell, cases in high risk, or high priority areas, which had the potential to lead to a super-spreading event (such as the cases in early 2021 linked to the supply chain), evidence of non-compliance with isolation requirements and the Contact Tracing Team coming under strain and losing the ability to trace backwards. The latest information on VOCs and public sentiment would be supporting metrics. With regard to the key quantitative metrics, it was proposed that these should be a test positivity rate which exceeded 0.3 per cent and continued on an upward trajectory over the subsequent 4 days, which included inbound travel positives, a 14-day case rate that surpassed 25 and continued upwards over the next 4 days and 3 positive cases within one week identified through individuals seeking healthcare, or as a consequence of screening pre-admission to Hospital. Supporting metrics in this respect would be surveillance of prevalence of the virus in neighbouring jurisdictions.

As to what actions it was proposed should be taken when the key metrics were reached, the Sub-Group suggested 'Pause and Alert', 'Review', 'Circuit break' and 'Reverse'. Pause and alert would lead to immediate communication to Islanders that the local situation was being closely monitored because there were signs of an emerging outbreak. They would be encouraged to reduce any behaviours that could lead to spread of the virus and the next reconnection stage would be paused, pending a review over the forthcoming 2 weeks. An immediate review would be undertaken to assess the rationale for the breach of the metrics in order to inform the best course of action. Within approximately one week and depending on the metrics, some temporary circuit break action might be required in order to effectively suppress any outbreak, whilst minimising the disruption to Islanders and the economy. As an example, people might be advised to mix in outdoor settings only. As the situation evolved, so it might be necessary to reverse more of the reconnection stages. The Cell was informed that the Analytical Cell would be responsible for monitoring and escalating the qualitative metrics and the quantitative metrics, in tandem with the Health and Community Services Department's Informatics Team in respect of the latter. The Metrics into Policy Sub-Group would keep the supporting metrics under review. In the event of any cause for concern, the Director, Public Health Policy, Deputy Medical Officer of Health and the Chair of the Cell would be responsible for convening any urgent meetings necessary to provide advice and take key decisions in relation to Pause and Alert, Review, Circuit break and Reverse.

The Independent Advisor - Epidemiology and Public Health, stated that he found it difficult to endorse the paper and proposed metrics because, in his view, insufficient consideration had been given to the likely quantum of severe disease and he had hoped to have received a more sophisticated model in respect thereof. He opined that the test positivity rate would fluctuate, depending on who was being tested and he suggested that it was important to seek to test a relatively constant population over a period of time. In his opinion, the test positivity rate from arriving passengers should be disaggregated from the overall rate, so as to avoid misleading figures. On the basis that most of the active cases in travellers were identified because of the test and isolation requirements - whilst acknowledging that there would be an element of 'leakage' at the borders - he suggested that a higher test positivity rate in that cohort could be tolerated, as opposed to in the wider community. The qualitative data was of the greatest importance in his view and should inform any decision making in the event of clusters arising. With respect to the need for a constant population for screening, the Chair of the Cell indicated that those working in health and care settings were being tested on a

regular basis and agreed that it would be useful to separate out the test positivity rate for travellers into the Island. This was a view shared by the Consultant in Communicable Disease Control, but he reminded the Cell that they were reported centrally as 'Jersey positive' cases and were the Island's responsibility.

The Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, indicated that to pause and review was a sensible approach to adopt, which was proportionate to an unknown situation. With regard to the circuit break, he suggested that different actions would need to be taken in various situations and proposed that some examples should be included in the paper. The Interim Director, Public Health Policy, commended the work of the Sub-Group over the previous weeks and stated that the purpose of the metrics was to lead to the convening of various *fora* – including the Cell - in the event that they were reached, in order to discuss the situation, rather than to automatically precipitate a decision. With respect to severe disease caused by COVID-19, it was challenging to model the impact in Jersey, due to the relatively low case numbers. However, it was accepted that vaccination could lead to a reduction in severe disease, notwithstanding the variants of concern ('VOC')

The Chief Economic Advisor indicated that the Island's policy was around managing expected harms, which could be calculated by probability multiplied by outcome. The demographic data and the vaccination rate were available and he suggested that it should be relatively straightforward to gauge the risk of disease pre- and post-vaccination. He suggested that models could be somewhat 'mechanical', whereas individuals' behaviour was conditioned upon the risk of infection and would adapt as cases increased.

The Consultant in Communicable Disease Control reminded the Cell that during the second wave of the virus, there had been an exponential increase in cases, which had led to a 'lockdown', despite the introduction of mitigating measures and a change in Islanders' behaviours. This was indicative that action had been taken too late to prevent that increase, which was why a test positivity rate of 0.3 per cent and a 14-day case rate, per 100,000 population, which exceeded 25 had been selected as early warning signs. He agreed with the view expressed by the Director General, Health and Community Services Department, that the impact of the second wave of the virus on the Department had been less severe than in the first wave and that the approach that the Department had adopted during the second wave would be further refined as more was learnt about COVID-19. He acknowledged that many positive cases were intercepted at the borders, but some would go undetected and as the positivity rate augmented, so the risk of 'leakage' would increase. He identified the borders as the single greatest threat, particularly in light of the VOCs and the vaccine's reduced efficacy in respect of them. Notwithstanding that a number of assumptions had been made in the models produced by Warwick and Imperial College, both had independently concluded that a third wave would be very likely to impact the UK, with between 30,000 and 80,000 deaths anticipated, which could equate to approximately 21 locally. Even with an assumed efficacy in the vaccines of 80 per cent and full coverage, the percentage of the population that would be protected was of the order of 60 per cent.

The Acting Director General, Economy opined that in order to totally prevent any third wave of the virus, it would be necessary to close the borders. The alternative was to accept that there would, in all likelihood, be an increase in cases of COVID-19, but against a background of the vaccine roll out. In light of the impact that vaccination would have in reducing severe illness and death, he suggested that the metrics were too low, but acknowledged that they were intended to act as early warning signs. In October / November 2020, decisive action had not been taken in a timely manner, which had resulted in the growth in cases. He suggested that it was important to have robust data

on the number of instances of people breaching the requirement to self-isolate and to ensure that the enforcement team had the appropriate *vires* to deal with such cases.

The Associate Medical Director for Mental Health expressed concerns around the impact that any further mitigations could have on Islanders' mental health in the event of a third wave reaching Jersey. The Associate Medical Director for Primary Prevention and Intervention indicated that the Island was in a good position to move forward and was confident that there was sufficient capacity within the Health and Community Services Department to deal with a third wave of the virus. This view was shared by the Managing Director, Jersey General Hospital.

The Interim Director, Public Health Policy, informed the Cell that the proposed metrics and suggested actions were a counterpart to the paper that was due to be considered at Minute No. A4 of the current meeting, which proposed a concertinaing of the roadmap timetable and would be presented to Competent Authority Ministers later in the day. It was important to ensure that they understood the risks that a third wave of the virus could pose to the Island and to have a robust system in place to enable meetings to be convened in short order to consider any metrics that could potentially cause concern.

It was agreed that some examples of potential actions should be included in the proposal before presentation to Competent Authorities and the Cell noted the position accordingly.

Reconnection
roadmap.

A4. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A7 of its meeting of 22nd March 2021, recalled that Senator L.J. Farnham, Minister for Economic Development, Tourism, Sport and Culture and Senator I.J. Gorst, Minister for External Relations had requested that the Cell consider the social and economic benefit of advancing the timetable for the remaining stages of the Island's internal social and economic reconnection in light of the consistently low levels of COVID-19 in the community and the excellent progress of the vaccination programme. They wished for some of the non-Pharmaceutical Interventions ('NPIs') to be removed and for some of the relaxations contained within Stage 6 (no earlier than 10th May) of the reconnection strategy to be moved into Stage 5 (no earlier than 12th April).

The Cell accordingly received and noted a PowerPoint presentation, dated 29th March 2021, entitled 'Review of Reconnection Roadmap' and heard from the Head of Policy, Strategic Policy, Planning and Performance Department, who indicated that the reconnection roadmap inadvertently contained some disparities and complexities that required resolution and simplification to support understanding and encourage compliance. It was proposed that the rules should be based on 2 variables, *viz* whether the location was indoors or outdoors and whether the gathering was controlled or uncontrolled and the NPIs were to be applied consistently across these variables. Mindful that the Island was pursuing a suppression, rather than an elimination, strategy in relation to COVID-19, it was necessary to anticipate a degree of presence of the virus giving rise to sporadic cases. In the event that these led to increased community transmission, it was possible that the NPIs would need to be re-introduced. It was suggested that a gap of a month should be retained between stages to enable the impact of the relaxation of any measures to be assessed and for more Islanders to be vaccinated, particularly in light of the variants of concern ('VOC').

The Cell was informed that it had initially been proposed that all of Stage 5 should be advanced from 12th April to 2nd April (Good Friday), before the Easter weekend, but this would require some alterations to the legislation around 2 metre distancing relating to specific places and conditions and this would not be achievable by that date.

The Cell was presented with 2 sets of options, noting that the second moved more

rapidly through the relaxation of measures and discussed the impact of the reconnection of travel on 26th April to the United Kingdom ('UK') and 17th May to all other jurisdictions, with the exception of those on the UK's 'banned list'. It was accepted that there was an increased risk of seeding as travel increased, particularly against the backdrop of the VOCs and the Cell mooted whether the aforementioned dates could be adjusted to align with the Stages, to avoid a situation where there was no longer a clear gap between significant steps, but was informed that Ministers were content with the chosen dates. The Cell discussed the strategy in relation to COVID-19 that had been adopted by Guernsey and some members suggested that rather than remaining aligned to the reconnection strategy, that had been originally timetabled, there were sufficient defences in place through the Test and Trace teams and the vaccine to mitigate the risks. With very few active cases in the Island and little risk in the community, it was suggested that the public no longer understood why measures had not been relaxed and it was important to retain Islanders' goodwill in the event of a third wave, which might require them to adhere to public health guidance afresh.

The Interim Director, Public Health Policy, indicated that it was his responsibility to present the Public Health viewpoint, which was to protect the public from disease and he stated that the rationale for a staged approach had been to reduce the harm caused by a third wave. He acknowledged that Islanders should be able to reap the reward of low case numbers, but emphasised the importance of having some mitigations in place in the event of an uptick in cases as restrictions were eased. It was his and his officers' role to take a professional view of what actions it was safe for the Island to take. He cautioned against making direct comparisons with Guernsey, but indicated that there had been a clear willingness by politicians in that Island to introduce lockdown arrangements at the first sign of any significant transmission of the virus in the community. The Cell agreed that if Competent Authority Ministers wished to accelerate through the stages of the roadmap, they would need to be prepared to also take rapid and decisive action in the event of VOCs coming to light in the Island, or increased instances of severe disease, for example.

On the basis that they were acknowledged to be a vector of transmission, the Cell did not wish for the size of permitted household gatherings indoors to be increased until Stage 6 and also wished for the requirement to wear masks in indoor public spaces to remain in place, as they served as a visual reminder of the ongoing risk posed by the virus. The Chief Executive Officer, Influence at Work, suggested that the opportunity should be taken to provide the public with an unambiguous message that thanks to the considerable efforts of the whole community, certain restrictions were being eased, but that there would be no compromise around household mixing of more than 10 people and mask wearing at this juncture.

The Cell accordingly agreed to recommend that from Good Friday (2nd April) alcoholic drinks could be consumed, without the requirement for a substantial meal to accompany the same, with service at the table only, that standard licensing hours could be reinstated, that there would be no dwell limit and masks would not need to be worn by patrons seated at tables. The 10 person limit per table would be retained, with 2 metres' distance or a screen between tables and contact details would be taken. From 12th April it would no longer be necessary to adhere to 2 metres' physical distancing in public places, the guidance to work from home would be removed and singing and the playing of brass and woodwind instruments would be permitted indoors, with guidance. Gatherings inside households would remain limited to 10 and increased to 20 in gardens and the requirement for masks to be worn in indoor public places would remain, as would the requirement for contact details to be taken in hospitality settings. With effect from 10th May, household gatherings indoors could increase to 20 people and saunas and jacuzzis could re-open.

Impact of
vaccination.

A5. The Scientific and Technical Advisory Cell ('the Cell'), received and noted a PowerPoint presentation, dated 29th March 2021, entitled 'STAC: Impact of vaccination (interim)' which had been prepared by the Senior Policy Officer and Public Health Analyst, Strategic Policy, Planning and Performance Department and initially heard from the former in relation thereto.

The Cell was informed that the aim of the vaccine programme was to protect Islanders from the threat posed by COVID-19. The first phase had prioritised the prevention of death from the virus and the protection of health and social care staff and systems, whilst the aim of the second phase was to achieve the protection of the whole population. During the pandemic, the Island had adopted a balance of harms approach and sought to preserve the physical and mental health and wellbeing of residents against a backdrop of the risk posed by new and emerging variants of COVID-19. Reliance was placed on the controls at the borders, the test, trace and isolate requirements and the high vaccine coverage, in addition to the non-pharmaceutical interventions ('NPIs') of good hand hygiene, adhering to distancing requirements and encouraging good ventilation.

The Cell noted that it was anticipated that a booster vaccine would be required, as immunity to the virus appeared to wane over time, based on best evidence from naturally acquired infections. In the event that the vaccine could block transmission – noting that there was currently some uncertainty in this area - it was possible that herd immunity could be attained. This would require sufficient people who were unable to transmit the virus and a basic reproduction rate ('R0') below 1.0 in the absence of any restrictions, with people behaving as they had before the pandemic. The immunity provided by the vaccine could be compromised by certain variants of concern ('VOC') and, as an example, the B.1.1.7 variant had an increased reproduction rate and would require 90 per cent population coverage.

The Cell was reminded that assuming a first dose efficacy of 80 per cent and an optimistic fully vaccinated efficacy of 95 per cent, once all adults had been offered the first dose, 60 per cent of Islanders would be protected and this would increase to 71 per cent after the second dose. It was noted that certain Islanders were ineligible to be vaccinated (most notably those aged under 18 years), some people would have been vaccinated, but would not be protected from the virus and some might experience hesitancy. Evidence from a study appeared to indicate that the South African Variant could reduce the efficacy of the Pfizer vaccine to 60 per cent, thereby affording only 45 per cent of the population protection and the Oxford AstraZeneca vaccine to just 10 per cent, which would result in only 7 per cent of the population being protected.

It was noted that people would be considered 'fully vaccinated' once 2 weeks had elapsed since they had received the second dose of the vaccine (Pfizer, AstraZeneca or Moderna) and consideration needed to be given as to whether this would also be the situation for someone who had received vaccines from 2 different manufacturers. Interim guidance from the Centre for Disease Prevention and Control ('CDC') was that vaccinated people could visit vaccinated people indoors without masks or adhering to physical distancing, could visit unvaccinated people from one household indoors, who were at low risk of severe COVID-19 disease on the same terms and if asymptomatic, could be exempted from quarantine and testing if they were identified as a direct contact. It was noted that neither the European Centre for Disease Prevention and Control ('ECDC'), nor Public Health England, had issued guidance as yet in this respect. The Independent Advisor – Epidemiology and Public Health, indicated that the AstraZeneca vaccine would protect people from severe illness in respect of the South African variant, which was not evident from the modelling. He suggested that the CDC's guidance was interim because the understanding around the efficacy of the vaccines was increasing on a daily basis and it had been issued in response to levels of transmission in the United States.

The Cell was shown a rough estimate of positivity risk in vaccinated as opposed to unvaccinated people. With the current low levels of virus on Island, the likelihood of contracting the same, irrespective of vaccination status, was very low (below 0.1 per cent). As a direct contact of an active case, the likelihood was medium to high (approximately 5 per cent) for unvaccinated people and medium (approximately 2.5 per cent) for those who were vaccinated, based on an assumption of a 50 per cent reduction in transmission risk. For unvaccinated travellers, positivity was estimated at around 0.3 per cent plus variant risk, based on the hypothesis that 70 per cent would arrive from areas designated as Green, 25 per cent from Amber and 5 per cent from Red. For vaccinated arrivals, the risk was approximately 0.15 per cent plus variant risk.

It was mooted that the Red / Amber / Green ('RAG') categorisation would continue to apply to any unvaccinated person, based on the country of departure, but that for fully vaccinated individuals, the RAG would reduce by one step, so a passenger arriving from a Red area would be treated as if they had arrived from an Amber area, which would require them to undertake the 3 PCR tests, at days zero, 5 and 10, but only to self-isolate until they received a negative result from their day 5 test. For all arrivals, it was proposed that a pre-departure test undertaken within the previous 72 hours could replace a day zero test.

The Cell was informed that this work dovetailed with a paper on vaccine certification, which was due to be presented to Competent Authority Ministers on 31st March 2021. The recommendation would be made to Competent Authorities that work should progress apace to enable digital data to be established to house certification around vaccination and possibly in respect of testing and immunity also. The Consultant in Communicable Disease Control suggested that this could be presented as a work in progress, mindful of the statement made by the Prime Minister that 'vaccine passports' could not be used until every eligible person had been offered the vaccine.

It was agreed that the proposal should be re-presented to the Cell once it had been further developed and officers were thanked for their work in this regard.