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SCIENTIFIC AND TECHNICAL ADVISORY CELL

(58th Meeting)

10th May 2021

(Meeting conducted via Microsoft Teams)

PART A (Non-Exempt)

All members were present, with the exception of R. Naylor, Chief Nurse 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
C. Folarin, Interim Director of Public Health Practice
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 (for items A4 – A7 only)
Dr. M. Patil, Associate Medical Director for Women and Children
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
M. Rogers, Director General, Children, Young People, Education and Skills Department (for items A1 – A4 only)
S. Martin, Chief Executive Officer, Influence at Work
Dr. M. Doyle, Clinical Lead, Primary Care (for items A4 – A7 only)
C. Maffia, Head of Contact Tracing (for item A5 only)
M. Knight, Head of Public Health Policy
B. Sherrington, Head of Policy (Shielding Workstream) and Head of the Vaccine Programme, Strategic Policy, Planning and Performance Department
S. White, Head of Communications, Public Health
C. Keir, Head of Media and Stakeholder Relations, Office of the Chief Executive
K. Posner, Head of Office (Education), Children, Young People, Education and Skills Department (for items A1 – A4 only)
M. Clarke, Principal Officer, Public Health Intelligence, Strategic Policy, Planning and Performance Department
L. Daniels, Senior Public Health Intelligence Analyst, Strategic Policy, Planning and Performance Department
Dr. C. Newman, Senior Policy Officer, Strategic Policy, Planning and Performance Department

Dr. N. Kemp, Senior Policy Officer, Strategic Policy, Planning and Performance Department
J. Lynch, 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 4th May and agreed that they and the Minutes from its meeting held on 26th April should be recirculated in advance of the meeting on 17th May and ratified at that juncture.

Monitoring metrics.

A2. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of its meeting of 26th April 2021, received and noted a PowerPoint presentation, dated 10th May 2021, entitled 'STAC Monitoring Update', which had been prepared by the Principal Officer, Public Health Intelligence, Strategic Policy, Planning and Performance Department and heard from her in relation thereto.

The Cell was informed that, as at Friday 7th May 2021, there had been 2 active cases of COVID-19 in Jersey, both of which had been detected as a consequence of arrivals screening, as was the situation for all the positive cases over the previous 3 weeks. One was male, one female and whilst one was asymptomatic, the other was experiencing symptoms of the virus. They had been in direct contact with 45 individuals, who were self-isolating. The 14-day case rate, per 100,000 population was currently 0.93 and the 7-day case rate zero and there had been no on-Island cases identified for 49 days (since 22nd March 2021). During the week ending 7th May, approximately 1,000 tests had been undertaken on work days, the majority on arriving passengers and as part of the workforce screening programme, with fewer tests at weekends. There had been no COVID-19 positive hospital admissions in the last 7 days and no positive cases in vaccinated individuals since early March. There had been no further deaths since the last meeting of the Cell and the figure since the start of the pandemic, where COVID-19 had been referenced on the death certificate, remained at 69. 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 number of PCR tests for all cohorts, with the exception of those aged under 18 years was relatively high, with approximately 500 tests being undertaken, per 100,000 population on Islanders aged over 70 years.

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 7th May 2021 and was informed that the number of calls to the Covid Helpline had remained relatively low and stable in numbers over previous weeks. The volume of inbound travellers had also remained fairly static and was noted to be approximately 1,000 per week. During the week ending 2nd May 2021, there had been 2,880 tests on inbound travellers, 4,370 as part of on-Island surveillance and 140 on people seeking healthcare. The weekly test positivity rate locally, as at that date, had remained at zero per cent and at 0.2 per cent in the UK. The local weekly testing rate, per 100,000 population, had increased to 6,900 and in the UK had been 9,279, mindful that that jurisdiction included tests undertaken on Lateral Flow Devices ('LFDs').

During the week ending 9th May 2021, there had been no COVID-19 related absences in the Government primary schools and in the secondary schools it had been 0.7 per cent. It was recalled that there had been no positive cases linked to the schools since early April and prior to that in 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 17,800 LFD tests had been carried out and there had been just 3 positive results, which had subsequently been shown to be 'false positives' when tested using a PCR swab, in addition to 65 inconclusive results, which had been re-tested.

The Cell was presented with the data, to 2nd May 2021, in respect of COVID-19 vaccinations in Jersey, which demonstrated that 88,404 doses had been administered, of which 52,891 had been first dose vaccinations and 35,513 second dose, resulting in a vaccine rate, per 100 population, of 82.01. Vaccine uptake in older Islanders continued at very high levels and over 60 per cent of Islanders aged between 40 and 44 years had already received their first dose. Of those Islanders aged over 16 years, 59 per cent had received their first dose and 40 per cent their second, increasing to 61 and 41 per cent respectively in relation to those aged over 18 years. Across the whole population of the Island, 49 per cent had received their first dose and 33 per cent their second. In respect of Islanders aged over 80 years, 99 per cent had now received their second dose, 91 per cent of those aged between 70 and 74 years and 83 per cent of those aged between 60 and 64 years. Focus was currently on both first and second doses as the younger cohort were invited for vaccination.

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 2nd May 2021 and was informed that, whilst 61 per cent of adults in Jersey had received their first dose, with a similar percentage in the UK, it averaged between 20 and 30 per cent in many countries. The Cell was also shown an ECDC map, which showed the cumulative number of fully vaccinated adults and noted that Jersey had now attained 41 per cent, whereas France, Spain and Italy had achieved between 10 and 15 per cent and some of northern Europe was between 5 and 10 per cent, or lower. In respect of the local uptake of first and second doses of the vaccine by gender, it remained the case that there was little discernible difference in the cohorts that had been invited for vaccination by age. However, in the younger age groups, there were more females than males, which reflected the gender balance amongst employees working in health and care settings, who had been vaccinated.

As at 22nd May 2021, 98 per cent of care home residents had received their first dose of the vaccine and 93 per cent their second and in respect of staff employed in those settings these figures were noted to be approximately 100 and 92 per cent respectively, mindful that this workforce fluctuated. With regard to Islanders classed as 'clinically extremely vulnerable' 90 per cent had received their first dose and 83 per cent their second and for those at moderate risk, those figures were noted to be 79 and 68 per cent respectively. 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 reminded that 1,484 people working in frontline health and social care positions had received their first dose of the vaccine, which was greater than the recorded number of employees, for the aforementioned reason of fluctuation in that workforce and 86 per cent their second, whilst 90 per cent of other workers in those settings had received their first dose and 72 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.

The Cell was shown a map of the classification of the Common Travel Area ('CTA') by Lower Tier Local Authority Level that would apply from 11th May, based on the 14-day case rate, per 100,000 population and noted that there were small areas of Red in northern England and some Amber across the whole of the UK. The Cell also noted a map of the UK, prepared by Gov.UK, which set out the geographic distribution of cumulative numbers of reported COVID-19 cases on a 7-day rolling basis, per 100,000

population, as at 4th May 2021, which also reflected the higher instances in the North of England and some of Northern Ireland. The Cell was presented with information on the current Red / Amber / Green ('RAG') status for the UK, Eire and France, as at 11th May and it was noted that from that date, 82 per cent of England would be Green and 17 per cent Amber, with a similar situation in Scotland. All of Wales would remain Green, whilst only 27 per cent of Northern Ireland would be Green, with 64 per cent Amber and 9 per cent Red. It was recalled that a blanket Red categorisation would continue to apply to Eire, but those areas that would have been classified as Red (if that were not the situation) had remained at 38 per cent with 19 per cent Green, whereas all of mainland France remained Red. With regard to the maps, which had been prepared by the ECDC, for weeks 16 to 17 (26th April to 3rd May) when compared with the previous week, on a 14-day case rate per 100,000 population, it was noted that case numbers were starting to decrease across much of Europe, with Portugal notably lower than in other jurisdictions.

The Independent Advisor – Epidemiology and Public Health, suggested that in light of the low test positivity rates locally and in the UK, the point had been reached where some of the on-Island non-pharmaceutical interventions ('NPIs'), such as the wearing of masks in enclosed public places, where there was no evidence of community transmission, started to test credulity, because the role they played was negligible. He acknowledged that some members of the Cell had previously indicated that once an NPI was removed, it would be challenging to reintroduce it at a future juncture, but observed that the public did not understand why NPIs remained in place despite the absence of transmission in the community.

The Consultant in Communicable Disease Control indicated that it was reasonable to continue to monitor the NPIs that remained in place, the case rates and anticipated changes with increasing reconnection both internally and across the borders. He suggested that the issue of mask wearing could possibly be discussed at a future meeting of the Cell.

The Cell noted the position accordingly.

Update on the Safer Travel Policy.

A3. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A1 of its meeting of 4th May 2021, recalled that it had discussed possible alterations to the Safer Travel Policy for the Summer, based on scientific evidence and against a backdrop of excellent progress with the vaccination of Islanders and had provided advice to the Competent Authority Ministers in respect thereof.

The Cell was advised by the Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, that Competent Authorities had met on 5th May and had been provided with a range of options and recommendations, with the key aim to prioritise connectivity with the Common Travel Area ('CTA') for the Summer. He provided the Cell with a brief summary of the decisions that the Ministers had taken at the that meeting.

With regard to the level of geographical granularity at which the Red / Amber / Green ('RAG') categorisation would be applied, Competent Authority Ministers had decided, as recommended, to retain the regional assessment of France and Eire until such time as there had been greater progress in those jurisdictions on vaccination and COVID-19 infection rates had declined. Further to the discussion at the meeting of the Cell on 4th May, the favoured option of the majority had been to retain regional assessment, but some had referenced national classification as their preference. The Cell was informed that its role was to consider evidence and place it before Ministers, so the Competent Authorities had been provided with the Cell's advice and had been apprised of the seeding risks associated with either regional or national classification and had taken the policy choice to report on a national level. In respect of the timing of the proposed

change to the Safer Travel Policy, the Cell recalled that it had recommended one single major change on 28th May, with the caveat that this should be for the Summer only, as it was not yet known what impact Variants of Concern ('VOCs') might have, or how the virus might be mitigated against by an Autumn COVID-19 'booster' vaccine. It was noted that the Competent Authorities had agreed with this recommendation.

In respect of testing, Competent Authority Ministers had been given the option to either retain the current triple testing regime for all arrivals on days zero, 5 and 10, or to test arrivals from Green areas on days zero and 8 only, of which latter option the Interim Director, Public Health Policy, felt that the Cell had broadly been supportive. Having taken into account the public health advice, economic factors and connectivity, the Competent Authorities had opted for testing of Green arrivals on days zero and 8 and had agreed that there should be further exploration of the feasibility of exit testing departures, which work would be undertaken over the coming days. As regards status certification, Competent Authority Ministers had agreed that any fully vaccinated individual (who had received 2 doses of an approved COVID-19 vaccine more than 2 weeks previously) and who arrived from within the CTA would only be required to undergo a PCR test on arrival in the Island, but would not be mandated to self-isolate until receipt of the result thereof and would not undertake a further test at day 8. The Cell was informed that the policy in respect of any minors accompanying fully vaccinated passengers was due to be considered at Minute No. A4 of the current meeting.

Competent Authorities had agreed that it would be prudent to align with the United Kingdom ('UK') Joint Biosecurity Centre's RAG assessment for countries outside the CTA, except where there was direct connectivity from the Island, where the position had been reserved. This might include such places as France, Tenerife or Germany where it might be possible to introduce a bespoke regional approach that enabled a degree of connectivity, even if the UK had applied a blanket Amber or Red categorisation.

In respect of safeguards where there were either VOCs or rising infection rates in specific localities, the Competent Authorities had agreed that it was important that some localised action or intervention might be advised to the Minister for Health and Social Services by the Medical Officers of Health, notwithstanding that the national categorisation was overall Green. Accordingly, officers from within Public Health would continue to review the case rates at a Lower Tier Local Authority ('LTLA') level, even as the categorisation moved to country level and travellers would continue to be required to furnish details of where they had spent a night in the 14 days prior to travel. This would provide a safeguard that any uplift in cases at LTLA level, or presence of VOCs leading to surge testing could still be identified, despite the move to reporting at national level. The Cell was informed that these changes to the Safer Travel Policy would be announced in a press conference to be held on 10th May.

The Consultant in Communicable Disease Control opined that the COVID-19 vaccine would have a significant impact on transmission of the virus and the creation of infection, but digital verification of vaccine status was some time off and it would be helpful to have an interim system in the meantime. He had heard that it was possible to purchase a National Health Service ('NHS') vaccine card on line, which included a pre-printed lot number and vaccine date, for under £5 per card and therefore it was important to be aware of the potential for people to endeavour to use counterfeit documents to circumvent the testing and isolation requirements. He indicated that this was particularly significant for visitors under the age of 50 years, who were less likely to have received both doses of the vaccine, so it was key to be able to verify their vaccination status. He suggested that consideration should be given to what action should be taken in the event that there was a lack of confidence around the vaccine status of an individual.

The Interim Director, Public Health Policy, indicated to the Cell that it was anticipated that digital verification of Islanders' vaccination status could be achieved by 28th May. All arrivals would be required to submit a travel declaration and provide proof of vaccination status, potentially by means of a PDF document, or via the NHS App. He acknowledged that views varied in respect of the short-term risk of fraud associated with that policy in the absence of digital verification, but indicated that some felt that it was reasonable, mindful that uploading a false declaration could attract a fine of up to £10,000. He indicated that progress was being made towards digital verification for Islanders and more detail of the potential use of the NHS App would be forthcoming and that the Cell would be updated in due course. The Director General, Justice and Home Affairs Department, indicated in the 'chat' function of the meeting that a Vaccination Certification Status project board meeting was due to be held on 11th May, in which all interested parties would participate, including Digital Jersey.

The Cell noted the position accordingly.

Covid Status Certification – children and young people.

A4. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A3 of the current meeting, was informed that Competent Authority Ministers had met on 23rd April 2021 and had received a presentation on the proposed first use case of Covid Status Certification and had been advised that the Cell would be consulted on the status to be afforded to children under the age of 11 years accompanying fully vaccinated individuals. It was recalled that under the Safer Travel Policy, accompanied children under the age of 11 years were not require to complete a travel form during the 48 hours prior to arrival in Jersey, or to undergo a PCR test, but were required to complete the same isolation period as every person aged over 11 years with whom they travelled. The Cell accordingly received and noted a paper, dated 10th May 2021, entitled 'STAC Briefing paper: Consideration of children and young people in the context of COVID Status Certification' and heard from the Senior Policy Officer, Strategic Policy, Planning and Performance Department, in connexion therewith.

The Cell was provided with scientific evidence for COVID-19 prevalence and transmission in children and noted that younger children appeared to have lower susceptibility to the virus than older children, mindful that the latter were more likely to socialise independently from their parents. It was recalled that those under the age of 18 years were currently not included in the vaccination roll out, but scientific studies from Israel demonstrated that when most adults in a population were vaccinated, the positive cases in children fell, so there was a lower absolute risk when community transmission of COVID-19 was at low levels. It was noted that there was a knowledge gap in respect of new Variants of Concern ('VOCs') and their potential transmissibility and disease severity in children, with very few studies having been published on the subject.

The Cell was shown various scenarios and implications for children under the current policy and noted, for example, that if the accompanying adults were given the 'green light' as fully vaccinated individuals – and therefore not subject to self-isolation requirements - on arrival from an Amber area, there would be a discrepancy where the child would be required to self-isolate until a negative result from a day 5 test, but not the adults. There would be a range of potential policy implications, depending on the way in which the travelling party was constituted. Any additional risk of seeding at the border by conferring a step down RAG rating to unvaccinated children travelling with vaccinated adults would largely depend on the cohort size of such travellers.

It was noted that, on 3rd May 2021, the European Commission had proposed easing current restrictions on non-essential travel into the European Union and had indicated that children should be able to travel with their vaccinated parents if they had provided a negative PCR COVID-19 test no more than 72 hours prior to arrival and that Member

States could require additional testing after arrival. The Cell was shown various policy options and ways of dealing with children and opined that this was a complex issue that gave rise to a number of permutations and that there were certain situations, such as unaccompanied minors, or group travel, that required further consideration. The Cell noted that evidence supported a decision for children under the age of 11 to be afforded the same status as their parents, adopting the 'green light' if applicable. The level of risk would increase with children aged between 12 and 17 years and consideration could be given to pre-departure testing for this cohort, mindful that they were already required to undertake PCR tests on arrival.

The Director General, Children, Young People, Education and Skills Department, indicated that – although cognisant of the complex nature of the issue - the Department welcomed a simple and consistent approach, both in the future and taking into account any previous decisions to treat children under the age of 11 differently from those above that age. The Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, noted that whatever decision was reached, it was likely that some inconsistencies would arise and indicated that a 17 year old arriving in the Island on their own would be treated differently from the same young person travelling with their fully vaccinated parents.

The Cell suggested that any policy relating to young people should initially be for the Summer and then reviewed in the Autumn. The Independent Advisor – Epidemiology and Public Health, indicated that most areas of the United Kingdom ('UK') were currently categorised as Green, so the risk of transmission by young people was currently very low so he suggested adopting a liberal policy, where any minor aged from 12 to 18 years, accompanying a fully vaccinated person, would be tested on arrival but not have to self-isolate and for those children aged 11 and under there would be no test and no mandate to self-isolate. He acknowledged that the situation might change in the Autumn.

The Head of Media and Stakeholder Relations, Office of the Chief Executive, agreed that a simple policy would be preferable and indicated that the public would rapidly identify if things did not appear to be consistent. The Associate Medical Director for Women and Children informed the Cell that whilst young people appeared to be less at risk from the B.1.1.7 VOC, there was evidence of other VOCs leading to increased transmission in children. He questioned whether any children required to self-isolate would have access to remote learning. The Director General, Children, Young People, Education and Skills Department, indicated that if this occurred during term-time, home learning could be provided and certain learning devices were available for that purpose. He suggested that it was important to include young people themselves in the formulation of this policy, which would affect them and it was proposed that consultation in this regard should take place with the Office of the Children's Commissioner outside the formal setting of the meeting.

The Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, suggested that whilst the risk associated with minors might be low, there was, nevertheless, a degree of risk. As larger areas of Red / Amber / Green ('RAG') classification for the UK had been introduced, there was the potential for some seeding, so the policy for the Summer required consideration and he counselled against too relaxed a view, particularly in respect of those children aged from 12 to 17 years. He indicated that officers from Public Health would work with colleagues from the Children, Young People, Education and Skills Department in order to produce a firmer policy for the next meeting of the Cell, which would aim to be simple and consistent, with children under the age of 11 being treated in a different manner from those older children.

The Cell noted the position and thanked officers from the Children, Young People,

Education and Skills Department for attending.

COVID-19 – sewage testing.

A5. The Scientific and Technical Advisory Cell ('the Cell') welcomed the Head of Contact Tracing to the meeting and received and noted a PowerPoint presentation, dated 10th March 2021, entitled 'Estimating the presence of COVID-19 from our untreated waste water'. The Cell was informed that Jersey was participating in a wider United Kingdom ('UK') surveillance programme to ascertain what information could be gleaned from waste water in respect of the virus. The initiative would focus on how long COVID-19 remained infectious in sewage, whether before or after treatment and consider the various factors that might impact on the survival of the virus in wate water. The programme would introduce robust surveillance of the virus to monitor how changes in Islanders' behaviour, the relaxation of mitigating factors at the border and contact might affect transmission pathways for COVID-19. This would provide an early warning signal to assist the Cell in formulating advice to Ministers and would also serve as an early indication for the Test and Trace programme that the recruitment of additional team members should be undertaken.

The Cell was informed that the study formed part of research programme funded by the United Kingdom Research and Innovation ('UKRI') Natural Environment Research Council ('NERC') on waste water surveillance methods, which comprised 9 academic research partners, of which Jersey's direct link to the programme was through the London School of Hygiene and Tropical Medicine ('LSHTM'). Locally, daily samples would be taken from the pre-treatment waste water, which would be frozen and held on site before being delivered weekly to the laboratory for processing. The LSHTM saved all samples at minus 70 degrees centigrade in a frozen reference library and processed one sample per week as part of background monitoring. In the event that the prevalence of COVID-19 appeared to increase, they would liaise with the Government of Jersey and analyse further samples from the reference library. The LSHTM had the ability to attempt genome sequencing for the presence of variants if COVID-19 was detected, but could not look for new variants of the virus.

The Cell noted that the initiative had commenced in July 2020, at which time Jersey had expressed an interest in participating. Agreed standards had been drawn up in August 2020 and the Island had agreed to commence a pilot from April 2021, at which point there were very few active cases of COVID-19 locally and restrictions were being eased but the Red / Amber / Green categorisation at the border had not been reintroduced, so it was a good opportunity to establish a bench level. The Head of Contact Tracing indicated that the UKRI NERC sought to obtain data from different catchment areas with a view to identifying any 'hotspots' of infection. The work had not been underway for long and had commenced at a time when there had been a significant number of positive cases in the UK. As the instances in that jurisdiction declined, it would be interesting to see if the research pinpointed any increases going forward.

The Consultant in Communicable Disease Control indicated that it would be helpful to receive any data in due course that linked the concentration of the virus in waste water with the number of active cases and it was noted that a regular update on the initiative could potentially be included in the monitoring metrics that were presented to the Cell.

The Cell noted the position and thanked the Head of Contact Tracing for attending.

COVID-19 Vaccination Programme.

A6. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A5 of its meeting of 29th March 2021, recalled that the vaccine programme was progressing locally in line with the recommendations of the Joint Committee on Vaccination and Immunisation ('JCVI') on the priority groups. The Cell received and noted a PowerPoint presentation, dated 10th May 2021, entitled 'COVID-19 Vaccination Programme. Report to STAC' and heard from the Head of Policy

(Shielding Workstream) and Head of the Vaccine Programme, Strategic Policy, Planning and Performance Department in respect thereof.

She reminded the Cell that the Medicines and Healthcare products Regulatory Agency ('MHRA') regulated medicines and medical devices, whereas the JCVI was an independent body, which provided advice to the United Kingdom ('UK') Government. The MHRA had undertaken a scientific review of safety concerns associated with the AstraZeneca COVID-19 Vaccine and had concluded that there were possible extremely rare blood clots linked thereto. However, the benefit of receiving the vaccine greatly outweighed the risk of experiencing an event and the AstraZeneca vaccine was still deemed to be safe, but was being monitored and had notified the JCVI that it may wish to consider its advice. The JCVI had accordingly issued a statement on 7th May 2021.

It was noted that in respect of the AstraZeneca vaccine to 30th April 2021, 28 million first doses had been given and the risk of an event associated therewith was 10.5 per million. For second doses, of the 6 million doses administered, 6 had resulted in a report of an incidence which were under evaluation. Accordingly, the events occurred extremely rarely.

The summary of the statement was that the high speed of deployment of the vaccine maximised benefit. It would be preferential to administer either the Pfizer or Moderna vaccine to unvaccinated adults aged between 30 and 39 years. However, the AstraZeneca vaccine should continue to be the preferred vaccine where there were logistical advantages and anyone who had received the AstraZeneca vaccine for their first dose, should also receive it for the second. Mindful that there was the potential for a third wave of infection towards the end of the Summer, any vaccine should be offered, rather than delaying vaccination. Vaccine confidence remained high.

The Cell was informed that this advice had the potential to delay the vaccination programme by one month and officers were working with the UK in respect of the risk and benefit and the likelihood of an adverse event. Whilst clotting occurred extremely rarely following vaccination, approximately one in 10 recipients would experience a sore arm, flu-type symptoms and tiredness. Less common reactions were diarrhoea and swelling under the armpit. It was noted that the MHRA would be working with all regulators internationally in respect of the vaccine.

The Cell noted the position and thanked the Head of Policy (Shielding Workstream) and Head of the Vaccine Programme for the update.

Matters for information.

A7. In association with Minute No. A2 of the current meeting, the Scientific and Technical Advisory Cell ('the Cell') received and noted the following –

- a weekly epidemiological report, dated 6th May 2021, which had been prepared by the Strategic Policy, Planning and Performance Department;
- statistics relating to deaths registered in Jersey, dated 7th May 2021, which had been compiled by the Office of the Superintendent Registrar; and
- a report on vaccination coverage by priority groups, dated 6th May 2021, which had been prepared by the Strategic Policy, Planning and Performance Department.

The Cell discussed agenda items for the next meeting of the Cell, which was due to be held on 17th May 2021, which included the status of children accompanying fully vaccinated travellers, an update on vaccination status verification, information on variants and large scale events.