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SCIENTIFIC AND TECHNICAL ADVISORY CELL

(67th Meeting)

19th July 2021

PART A (Non-Exempt)

All members were present, with the exception of Mr. P. Armstrong, MBE, Medical Director (Chair), C. Folarin, Interim Director of Public Health Practice, R. Naylor, Chief Nurse, Dr. S. Chapman, Associate Medical Director for Unscheduled Secondary Care, Dr. M. Patil, Associate Medical Director for Women and Children, Dr. M. Garcia, Associate Medical Director for Mental Health, S. Skelton, Director of Strategy and Innovation, Strategic Policy, Planning and Performance Department and N. Vaughan, Chief Economic Advisor, from whom apologies had been received.

Professor P. Bradley, Director of Public Health (Acting 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
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

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
S. Martin, Chief Executive Officer, Influence at Work
S. O'Regan, Group Director of Education, Children, Young People, Education and Skills Department
Dr. M. Doyle, Clinical Lead, Primary Care
B. Sherrington, Head of Policy (Shielding Workstream) and Head of the Vaccine Programme, Strategic Policy, Planning and Performance Department
C. Keir, Head of Media and Stakeholder Relations, Office of the Chief Executive
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.

Monitoring metrics.

A1. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A3 of its meeting of 12th July 2021, received and noted a PowerPoint presentation, dated 19th July 2021, entitled 'STAC Monitoring Update', which had been prepared by the Principal Officer, Public Health Intelligence and the Senior Public Health Intelligence Analyst, Strategic Policy, Planning and Performance Department and heard from them in relation thereto.

The Cell was informed that, as at Friday 16th July 2021, there had been 2,053 active cases of COVID-19 in Jersey (which brought the total since the start of the pandemic to 5,724), who had been in direct contact with approximately 11,000 individuals. Of the active cases, 894 had sought healthcare on experiencing symptoms of the virus and 850 had been identified as direct contacts. The majority of the active cases were in people aged under 40 years and over two thirds were symptomatic. The Cell was advised that there had been some data quality issues with regard to the vaccination status of the active cases and in over 1,000 instances it had not been recorded. In excess of 4,000 tests had been undertaken on most days in the last week and on 16th July, 420 positive cases had been detected, which brought the average number of daily cases since the end of June to 148, albeit this figure was noted to fluctuate. When the inbound travel cases were removed, this number reduced slightly to 138. As at the same date, there had been 6 people in the Hospital with COVID-19, of which 3 had the virus as their primary health need, one of which had been in the Intensive Care Unit. As at Friday 9th July at least 208 of the 987 active cases had been in fully vaccinated individuals.

The Cell noted the test positivity rate by age groups and was informed that it was highest in the under 18s at 12 per cent and was approximately 11 per cent for those aged between 18 and 39 years, decreasing to 5 per cent for the 40 to 59 year cohort and around 2 per cent for those aged over 60 years. In light of the changing composition of those individuals being tested, the Independent Advisor - Epidemiology and Public Health, suggested that it would be useful to report on the test positivity rate of those seeking healthcare.

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')) and was informed that, as at 18th July, there had been 12 people in Hospital with the virus – 2 in the Intensive Care Unit ('ICU') - of which 7 had clinical COVID-19. There had sadly been a death from COVID-19 in the Hospital on 18th July of someone under the age of 50 years, with no underlying health conditions.

The Cell was provided with provisional information relating to the vaccination status of the positive cases, mindful of the aforementioned issues with regard to data quality, which were being addressed. It was noted that the 14-day case rate, per 100,000 population, for fully vaccinated individuals was currently 1,036, compared with 2,992 for those who were not fully vaccinated. Officers were asked if it would be possible to publish those figures, but expressed the wish to resolve certain data quality issues before so doing. The Cell was presented with a table that set out the vaccine status of the positive cases by age group and noted that the majority of cases in Islanders aged over 50 years were fully vaccinated, mindful of the wide coverage of the vaccine in that cohort and that most cases in young Islanders were in unvaccinated, or partially vaccinated, individuals.

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The Cell received the Analytical Cell summary which indicated that there had been approximately 838 additional cases over the weekend of 17th / 18th July, which were being analysed. The majority of cases were symptomatic and occurring in people under the age of 40 years, but there had been an uptick in instances of the virus in older Islanders. It was noted that the current 14-day case rate, per 100,000 population, was almost double the highest previous rate, which had been experienced in December 2020 and this was also the case for the number of known direct contacts. The Cell was cognisant that the virus was spreading exponentially and noted that the effective reproduction number (‘R_t number’) was currently approximately 1.7 and cases had doubled every 5 to 6 days during the preceding month. The Cell was provided with details of the numbers and locations of the active cases in people employed in the Health and Community Services Department, in community health and care settings and in the emergency services.

With regard to the schools, there had been 593 cases between half term and the 15th July (last day of term), of which 521 related to students and 72 to staff. Since 15th July a further 238 individuals had been contacted by the Covid Safe team. The Cell was informed that COVID-19 was now spreading widely within the community to the extent that it was no longer possible to identify a source for individual cases, or to identify distinct clusters. This growth in cases was translating into an increase in people failing to attend, or cancelling, their vaccine appointment with an uplift in cancellations because of people testing positive for the virus.

It was noted that, in Guernsey, the borders had re-opened on 1st July, at which point 70 per cent of adults had been fully vaccinated. Two weeks after 1st July, the 14-day case rate, per 100,000 population, in Guernsey had been 33. In Jersey, the restrictions on travel had eased from 28th May, at which juncture 50 per cent of adults had been fully vaccinated. Two weeks thereafter, the 14-day case rate had been 30, which was comparable.

The Cell was notified that technical issues had arisen with regard to the data from the COVID-19 Helpline, which was being reviewed and officers hoped that fuller data would be available for the next meeting. Over the last few weeks there had been an increase in the test positivity rate in arriving passengers, noted to be 0.73 per cent for the week commencing 5th July, but this was significantly lower than the in-Island rate. As at 11th July the test positivity rate had been 3.9 per cent which was higher than the UK rate of 3.1 per cent, but the local weekly testing rate, per 100,000 population, had far exceeded the UK (20,900 compared with 10,880) mindful that the latter included tests undertaken on Lateral Flow Devices (‘LFDs’). Of the local tests, 10,090 had been on arriving passengers, 11,140 as part of on-Island surveillance screening and 1,330 on people seeking healthcare as a consequence of experiencing symptoms of the virus. The overall test positivity rate on 18th July had been 7.03 per cent, which exceeded the upper limit recommended by the World Health Organisation (5 per cent) and when inbound travel was excluded, this figure increased to 11.76 per cent.

The Cell was informed that there were currently 50 people recorded in EMIS (the integrated healthcare IT system) as suffering from long Covid, of which 40 had post COVID-19 syndrome and 10 had ongoing symptomatic COVID-19. However, the code in EMIS had only been available since March 2021, so 50 was anticipated to be an underestimate.

The Cell was presented with the data, to 11th July 2021, in respect of COVID-19 vaccinations in Jersey, which demonstrated that 130,793 doses had been administered, of which 72,369 had been first dose vaccinations and 58,424 second dose, resulting in a vaccine rate, per 100 population, of 121.33. Provisional figures as at the date of the meeting were 135,371 total doses and a vaccine rate of 125.6. The Cell noted the percentage of the various age cohorts that had received their first and second doses of

the vaccine and that, across the adult population, this equated to 83 per cent having received their first dose and over two thirds (67 per cent) their second. There had been an uplift in both first and second cumulative doses.

The Cell was shown 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 11th July 2021 and was informed that whilst 83 per cent of adults in Jersey had received their first dose, with a similar percentage in the UK, Malta (82.5 per cent) and the Netherlands (82.1 per cent), it was lower in certain neighbouring jurisdictions, such as France (67.1 per cent) and Eire (71.5 per cent). In Iceland, however, coverage of 90 per cent had been attained. In respect of the cumulative number of fully vaccinated adults across Europe, it was recalled that Jersey was at 67 per cent, which compared favourably with many other areas *inter alia* France (46.8 per cent) and Eire (56.5 per cent). As at 11th July, 99 per cent of frontline health and social workers had been fully vaccinated and 92 per cent of other workers in those settings. This had also been the case for 84 per cent of Islanders aged from 16 to 69 years deemed to be at high risk and 81 per cent of those at moderate risk. The Cell was shown a map, which had been produced by gov.uk, which showed the percentage of vaccinated adults to 17th July and noted that there was a degree of variability around the Midlands and the North West of England.

In terms of the 7-day case rate, per 100,000 population, in the UK, the Cell noted high rates in the North of England down to Birmingham. The Cell was presented with information on the RAG (Red / Amber / Green) status for the UK, Eire, France and Germany, at a regional level as at 20th July and noted that from that date, all of England and Northern Ireland would be Red and Scotland and Wales would be 97 and 95 per cent Red respectively. Almost half of Eire would be Red as at the same date and in France there would be a reduction to 43 per cent of areas classed as Green, whereas all of Germany remained Green for the third consecutive week. In relation to countries and areas not categorised at a regional level, there had been a slight increase (to 30 per cent) of areas designated as Red. With regard to the maps, which had been prepared by the ECDC, for weeks 26 to 27 (28th June to 5th July) when compared with the previous week, based on a 14-day case rate, rising instances in Spain and Portugal – and to a lesser extent France – were noted, whereas low case numbers were being experienced in much of Eastern Europe. On the basis that this uplift in cases in Spain was redolent of the commencement of the second wave of the virus, it would be kept under close review.

The Cell was informed that officers would continue to monitor the R_t number, which was indicative of the infection rate, the daily case rate trajectory and the number of admissions to the Hospital in developing short-term projections. Based on an estimate of the average R_t number at 1.7 (between 1.6 and 1.8), it was possible that a peak of 990 cases per day could arise in early August, but the Cell was informed that the current testing regime would be unlikely to have sufficient capacity to detect all positive cases should this arise. This would potentially be followed by a projected Hospital peak occupancy of 140 ten days later, but there was a high level of uncertainty in relation to these figures, due to the small numbers of current cases. It was noted that the percentage of cases resulting in hospitalisations in the UK was declining as more people were vaccinated and the rate in that jurisdiction was currently 2.4 per cent. It was hoped that Jersey's rate could be lower (one per cent) due to improved case detection, but the current pressures on the system made this less likely than had previously been anticipated.
Based on a 6-day doubling rate of cases and assuming one per cent of cases would require hospitalisation after 10 days, it was projected that by the end of July there could be 16,000 cumulative cases and approximately 50 people in the Hospital. Approximately half of the active cases were symptomatic, working-age, adults, which

could have a negative impact on key businesses, the Health and Community Services Department and impinge the vaccination programme as most infection was currently in partially vaccinated individuals, who would not be able to receive the next injection until 4 weeks had elapsed. It was estimated that a total of 37,000 infections could occur in the third wave, resulting in 4,600 individuals experiencing long Covid and 32 deaths, based on the most recent evidence from the UK that suggested just under one in 1,000 infected people would die.

In respect of the estimated quantum of admissions to the Hospital, based on one per cent of cases, the Cell was informed that the previously referenced UK definition was employed, *viz* 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. As a consequence, this included those individuals with non-clinical COVID-19. The Managing Director, Jersey General Hospital, opined that it would be helpful to run the anticipated data for those being admitted with COVID-19 as the primary cause as well as all admissions. He referenced the graph which had estimated that there would be 13 hospitalisations by 19th July and indicated that there were currently 7 in the Hospital with clinical COVID-19 as their primary health need, which was indicative of approximately 0.5 per cent of cases requiring hospitalisation.

The Independent Advisor - Epidemiology and Public Health, suggested that it would be useful to compare the severe disease case rates in those who were fully vaccinated and not, as he was concerned that the public would not be sufficiently convinced of the protection afforded by the vaccine based on the current data. He opined that the UK's 'worst case outcome' of 100,000 daily cases (which would be analogous to 2,100 locally) rendered the local, higher, estimates somewhat implausible. The Senior Public Health Intelligence Analyst indicated that overall rates in the UK were increasing, although they were plateauing in Scotland. She informed the Cell that the models were based on the epidemiology of the virus and did not take into account changes in people's behaviour as the case numbers increased, so it was difficult to determine whether they were plausible. The Cell was reminded that the systems were struggling with the high volumes of cases, which made it impossible to undertake backwards tracing and analysis of clusters, which led to uncertainty.

The Clinical Lead, Primary Care, indicated that when discussing those who were fully vaccinated and not, it was important to be cognisant that within the former group there would be individuals who had become infected with the virus and had subsequently received both doses of the vaccine, who would have the highest level of immunity. There would also be one or 2 per cent of the population who did not have a good response to the virus, perhaps due to medication that they had been prescribed, which could lead to a drop in efficacy of the vaccine of up to two thirds. In respect of the 524 active cases in fully vaccinated individuals, he suggested that it would be helpful to know if the infection had occurred in high risk individuals, or was across the piece.

The Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, indicated that a meeting of the Competent Authority Ministers was due to take place on the evening of 19th July and Ministers would wish to have a clear understanding of the capacity within the Hospital to manage clinical Covid admissions over the coming weeks, including *inter alia* bed capacity, oxygen availability, staff levels and the number of beds within the ICU, particularly if the aforementioned estimate of 50 admissions was attained. The Director General, Health and Community Services Department, indicated that the Hospital was currently at 60 per cent occupancy and she was relatively confident that the Department would be able to absorb any pressures, as it had not exceeded 80 per cent occupancy at its busiest time. She noted, however, that there could be challenges around staffing if they were required to self-isolate. This view was shared by the Managing Director, who indicated that the Hospital was well prepared and had had bed sequencing models in place throughout the

pandemic. Occupancy was reviewed on a daily basis and rarely exceeded 70 per cent. There were currently 127 beds in the Hospital with a further 35 expansion beds available and oxygen consumption was below 25 per cent, notwithstanding that the operating theatres were in use. The Interim Director, Public Health Policy, suggested that Ministers would wish to be apprised of the point at which clinical Covid would become problematic for the Hospital and the Associate Medical Director for Primary Prevention and Intervention emphasised the importance of including the staffing issues that would be associated with any additional beds.

The Managing Director indicated he would prepare a briefing note on the preparedness of the Hospital for the meeting of the Competent Authority Ministers.

COVID-19 – latest research.

A2. The Scientific and Technical Advisory Cell ('the Cell') received and noted a PowerPoint presentation, dated 19th July 2021, entitled 'Summary of latest research', which had been prepared by the Principal Officer, Public Health Intelligence and the Senior Public Health Intelligence Analyst, Strategic Policy, Planning and Performance Department and heard from them in connexion therewith.

The Cell was informed that the latest research by the Scientific Pandemic Influenza Group on Modelling, Operational sub-group (SPI-M-O) showed that the effective reproduction number (R_t number) was estimated at between 1.2 and 1.5 in England, that the link between cases and hospitalisations had been weakened but not broken and the prevalence of the virus was likely to remain high for at least the remainder of the Summer. Modelled waves were smaller than previous iterations, linked to the 4 week delay to the Stage 4 reconnection in England, which had enabled approximately 4 million additional vaccines to be deployed. The modelled scenarios were caveated, due primarily to uncertainties around anticipated behavioural change after the lifting of all COVID-19 restrictions in England on 19th July and most had hospital admission peaks were lower than had been estimated in January, but a resurgence was not discounted and in almost all scenarios, the peak in deaths was lower than previously modelled.

There remained a number of key uncertainties, which included the number of confirmed cases and people's willingness to be tested and capacity to do so. Further, the precise values for the effectiveness of the vaccines with the Delta variant could not be determined from observational studies, noting that small differences in efficacy could have a significant impact on hospitalisations and there was insufficient data on the exact number of unvaccinated people. Moreover, the proportion of the population which had previously been infected with COVID-19 could not be precisely determined, but this influenced the extent to which the epidemic could grow before herd immunity was attained.

The Cell noted that, in the Academy of Medical Sciences' report entitled 'COVID-19: Preparing for the future', it was concluded that in order to prepare for the Winter period and beyond, the priorities over the Summer had to be to maximise the speed and uptake of COVID-19 vaccination, to increase the ability of those with COVID-19 to self-isolate, to boost capacity in the National Health Service and to provide clear guidance about precautions that individuals and organisations could take to protect themselves and others, particularly the most vulnerable.

In respect of in-hospital complications associated with COVID-19, these were noted to include renal, respiratory and cardiovascular and arose in around half of hospitalised patients, most notably in older or male patients, although 55 per cent were in previously healthy patients under the age of 60 years. It had been concluded that the complications associated with COVID-19 were likely to cause a substantial strain on health and social care in the coming years.

The Cell noted the position accordingly.

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COVID-19 infection rates – short term options for intervention.

A3. The Scientific and Technical Advisory Cell ('the Cell') received a PowerPoint presentation, dated 19th July 2021, which had been prepared by the Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department and heard from him in relation thereto.

He indicated that an informal meeting of the Competent Authorities had been held on 16th July 2021, at which Ministers had discussed the increasing COVID-19 case rates, mindful that the fast speed of rising infection could create significant demand beyond the capacity of the Island to manage, leading to high numbers of Islanders self-isolating, of which many would be working adults potentially employed in critical sectors. This could also result in possibly unmanageable hospital occupancy numbers and there was uncertainty in respect of the anticipated 'peak' of the infection rate. The Cell was reminded that the short term objectives of Ministers were to shield the vaccination programme, to reduce severe disease and to protect key services and infrastructure and, cognisant that there would be a time lag of approximately 2 weeks between active cases leading to severe disease and a similar time delay for interventions to impact case numbers, clear advice and decisions were required during the current week to try to slow the spread of the virus. It was acknowledged by Ministers that more measures would be required and the advice of the Cell, in conjunction with Public Health, was required on a number of potential issues, including accelerating the gap between doses of the COVID-19 vaccine, the wearing of masks and isolation requirements.

The Cell received 3 potential options for its consideration and noted that, for all, continued optimisation of vaccination was required *inter alia* by ongoing behavioural science focus on encouraging vaccination in younger Islanders, 'walk in' vaccination centres, if considered feasible and effective and shortening the dosage interval subject to clinical advice. Likewise, for all options, the reduction of harms caused by self-isolation would require consideration, including guidance to ensure wellbeing, such as spending time outdoors.

The options were noted to be as follows –

<u>Option 1 - continue to encourage self-mitigation</u>

- encouraging direct contacts to self-isolate, particularly within households;
- continuation of guidance to work from home and wear masks and encouraging good practice on distancing and undertaking lower risk behaviour;
- strong shielding messages to reduce hospitalisation;
- business continuity messages as a consequence of an increase in the number of Islanders in self-isolation; and
- provision of ventilation advice, in light of a developing evidence base.

However, it was suggested that this option could result in a high risk of a continued exponential rise in infections and unmanageable hospitalisations.

<u>Option 2 – stronger package of enforceable measures</u>

- mandatory masks in indoor public places;
- two metre physical distancing in public places;
- closure of indoor physical activity as a consequence of distancing requirements;
- reduction in the size of gatherings to 10, including tables at restaurants;
- re-introduction of legislation relating to self-isolation for direct contacts within the same household; and
- strong shielding guidance to reduce hospitalisations.

It was noted that these measures would need to be sufficiently robust to slow the spread of the Delta variant, which had a natural reproduction number of 7.

Option 3 – circuit break

- closure of non-essential retail and hospitality;
- advice to remain at home, except for outdoor exercise, medical and care-related activity, essential shopping and essential work; and
- masks and closures as per option 2.

It was envisaged that this option would reduce the risk of severe disease impacts, including hospitalisation. However, it would be an extreme step to take, but could be of short duration (3 to 4 weeks).

Noting that Competent Authority Ministers wished to receive advice on whether to shorten the time period between first and second doses of the COVID-19 vaccine, the Cell heard from the Head of Policy (Shielding Workstream) and Head of the Vaccine Programme, Strategic Policy, Planning and Performance Department. She reminded the Cell that the aim was for 80 per cent of the population to be fully vaccinated by mid-August and the programme was currently on track to achieve this goal. Of those 87,140 individuals within the Joint Committee on Vaccination and Immunisation ('JCVI') priority groups one to 12, 84 per cent had received their first dose and 71 per cent both. During the current week, 5,000 vaccinations would be administered, but approximately 14,000 eligible Islanders had not yet received their first dose. Advice from the JCVI was that the optimum interval between vaccine doses was 8 weeks and the Cell was informed that, to-date, the gap had generally been between 5 and 12 weeks, based on appointments and the availability of the vaccine, but this could be reduced to 4 weeks in order to make more appointments available for second dose vaccinations.

The Cell was informed that the Head of the Vaccine Programme had been working closely with the behavioural scientists to encourage Islanders to book their vaccines, which included cards at all pharmacies, which were sent out with prescriptions. The 'time is running out' campaign was ongoing and Islanders were encouraged to take photos relating to their vaccination and post them on social media. Various videos and posts related to pregnancy and breast feeding had been prepared and specific vaccination sessions for farm workers – with interpreters available – had been organised. As to whether 'walk in' or 'pop up' vaccination centres would be viable, it was noted that the current venue at Fort Regent was working well, enabling the vaccine to be delivered quickly and efficiently and the programme could be hindered if a walk in centre were to be established whilst demand outstripped supply. However, if demand were to diminish, a walk in centre could be organised and this was being kept under review on a weekly basis.

The Director General, Health and Community Services Department, referenced the situation in Guernsey and 'freedom day' in the United Kingdom ('UK') and queried why, if only 14,000 people remained unvaccinated, the whole population of the Island would potentially be asked to accept restrictions, rather than advising the vulnerable to shield. The Consultant in Communicable Disease Control suggested that the high case numbers and extrapolation therefrom were indicative that a stable, endemic, relationship with COVID-19 had not yet been attained and it was behaving as an epidemic. Accordingly, it was reasonable to introduce measures to enable key businesses and infrastructure to continue to function, for the health service to cope with routine business – in addition to demands related to the virus – and for the vaccination programme to continue to roll out before a 'booster' became available in September.

The Director of Public Health indicated that Guernsey tested symptomatic individuals, people attending the Accident and Emergency Department and hospital admissions for COVID-19. Due to the lack of wider testing, the figures from that Island were probably an underestimate, but there was nothing to indicate that, at the current juncture, it was experiencing similarly high case numbers to Jersey. However, that was to be expected, as Guernsey had only recently opened its borders and it did not mean that a similar

situation would not arise there in the future.

The Independent Advisor – Epidemiology and Public Health agreed that passive surveillance was being undertaken in Guernsey, but opined that Jersey was moving to that situation, due to the lack of capacity in the system as a consequence of the high case numbers. He indicated that, as referenced at Minute No. A1 of the current meeting, the Jersey model estimated a peak of 990 cases per day, which would be the equivalent of 610,000 in the UK, but their worst case scenario only estimated 200,000 daily cases, so he suggested that careful consideration was required, which should include comparison with other places. He did not believe that the model factored in the increasing vaccination coverage, or those who had been infected by the virus and were, as a consequence, no longer susceptible. He stated that the slides produced by the Interim Director, Public Health Policy, referenced the Hospital being unable to cope with case numbers, but this view had not been borne out by the Managing Director thereof. He further opined that transmission might reduce now that the schools were closed and people were spending more time outdoors. He strongly supported heightened advice on shielding being provided.

The Senior Public Health Intelligence Analyst, Strategic Policy, Planning and Performance Department, conceded that the model was not dynamic, but it was predicated upon 55 per cent of the population being protected by the vaccine, which was the current situation, noting that there were marginal gains in reducing the risk of mortality and severe disease through vaccination. Officers had evidence that the infection rates locally were outstripping the whole of the UK, so she suggested it was sensible to be open to the possibility that that trend might continue.

With regard to the advice on shielding, the Head of Policy (Shielding Workstream) and Head of the Vaccine Programme, indicated that care was required to ensure the advice was based on evidence because of the potential impact on people's income and mental health of shielding and it was agreed that this required further discussion outside the meeting with the Interim Director, Public Health Policy and the Consultant in Communicable Disease Control to ensure that it was appropriate.

The Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, indicated that when the Cell had advised on the relaxation of restrictions, it had been recognised that case numbers would rise, but he and others had been surprised by the speed of the increase, which was impacting the wider economy, was causing disruption to public services and was of increasing concern. Accordingly, decisive action was required, so he favoured either option 2 or 3.

The Consultant in Communicable Disease Control reminded the Cell that when Guernsey had opened its borders on 1st July, the level of vaccination coverage in that Island's population had been higher than when Jersey had relaxed measures at the borders. As a consequence, it should not be presumed that the *status quo* would remain in that jurisdiction. In respect of those individuals who had been infected by COVID-19, he suggested that they would remain immune for a period of between 3 and 6 months and were included within the modelling as 'recovered'. With regard to the interval between doses of the vaccine, it was true that a longer interval afforded a more robust immune response, but where there was a lot of infection in the community, it was preferable to deliver the second dose rather than await the optimum interval and a gap of 4 weeks would be appropriate in those circumstances. He indicated that the majority of second doses were currently being administered to younger Islanders, whose immune systems were younger, thereby resulting in a better response.

The Clinical Lead, Primary Care, stated that it was reassuring to hear from the Director General, Health and Community Services Department and the Managing Director of the Hospital that they anticipated secondary care being able to cope with the current

wave of infection. However, he indicated that, in primary care, there was evidence of significant pressures and General Practitioners were testing positive for the virus and then being required to isolate for 14 days.

The Director of Public Health summarised that the Cell favoured reducing the interval between vaccine doses to 4 weeks, but had varying views on the 3 options for Ministers and, accordingly, he suggested that option 2 would be representative of the range of opinions. The Interim Director, Public Health Policy, suggested that Ministers would need to be aware that there was a risk posed and he acknowledged the differing views that had been expressed on that risk, which would be communicated to them. He thanked the members of the Cell for their input.

France.

A4. The Scientific and Technical Advisory Cell ('the Cell') was informed that the presence of the Beta variant of COVID-19 in France had prompted the United Kingdom ('UK') Government to introduce an 'Amber plus' policy in respect of arrivals from that jurisdiction. This would require arriving passengers to self-isolate for 10 days on return, even if they were fully vaccinated.

The Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, indicated that the Public Health Intelligence team was undertaking research to ascertain whether the Beta variant was circulating at worrying levels in mainland France. It was possible that the variant was prevalent in some of the French overseas territories, such as La Réunion, rather than mainland France itself and that the data had been assimilated from the whole of France, including its overseas islands, thereby resulting in a somewhat misleading picture. In the event that the Beta variant was present in high levels in the overseas territories, restrictions could be placed on travel from those individual islands, as necessary.

He informed the Cell that the intention was to adopt a holding position with regard to France until the aforementioned research had been undertaken and the Cell agreed that this would be appropriate. It was suggested that the steps taken by the UK Government had potentially been for political reasons, following France's declaration that it was concerned about the Delta variant from the UK.

The Cell noted the position accordingly.