KS

SCIENTIFIC AND TECHNICAL ADVISORY CELL

(54th Meeting)

12th April 2021

(Meeting conducted via Microsoft Teams)

PART A (Non-Exempt)

All members were present, with the exception of R. Naylor, Chief Nurse, Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention, Dr. M. Garcia, Associate Medical Director for Mental Health and S. Skelton, Director of Strategy and Innovation, Strategic Policy, Planning and Performance Department.

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. S. Chapman, Associate Medical Director for Unscheduled Secondary Care
Dr. M. Patil, Associate Medical Director for Women and Children
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
S. Martin, Chief Executive Officer, Influence at Work
Dr. M. Doyle, Clinical Lead, Primary Care
B. Place, Head of Non-Clinical Support Services and PPE Cell (for item A6 only)
R. Johnson, Head of Policy, 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
M. Clarke, Principal Officer, Public Health Intelligence, Strategic Policy, Planning and Performance Department
R. Barnes, Operations Lead for the COVID-19 Vaccination Programme
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
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 29th 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 12th April 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 29th March 2021, received and noted a PowerPoint presentation, dated 12th April 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 9th April 2021, there had been 4 active cases of COVID-19 in Jersey, which brought the total number of positive cases since the start of the pandemic to 3,230. The active cases had been in direct contact with 42 individuals, who were self-isolating and the 14-day rate, per 100,000 population, had been 1.86. All of the active cases were asymptomatic, were aged between 40 and 59 years and had been identified as a result of arrivals testing. Two were male and 2 female. Since 12th February 2021, the number of daily average cases had remained below one and they were occurring only sporadically. During the week ending 9th April, approximately 1,000 tests had been undertaken on 4 days, the majority on arriving passengers and 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, although a positive case in a person aged under 18 years had been identified over the weekend of 10th / 11th April, which had increased the test positivity rate for that cohort.

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 11th April 2021 and was informed that there were currently no people in Hospital with COVID-19 and the 7-day admission rate, per 100,000 population, was zero, which aligned with the 7-day case rate. There had been no further deaths since the last meeting of the Cell and the figure, where COVID 19 had been referenced on the death certificate, remained at 69 since the start of the pandemic. 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 9th April 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 had increased slightly and, as aforementioned, there had been some active cases encountered at the borders.

During the week ending 4th April 2021, there had been 2,170 tests on inbound travellers, 3,940 as part of on-Island surveillance and 180 on people seeking healthcare. The weekly test positivity rate locally, as at that date (and also on 11th April), had remained at zero per cent and had decreased to 0.3 per cent in the UK. The local weekly testing rate, per 100,000 population, had reduced to 5,800 and in the UK had been 10,960, mindful that that jurisdiction included tests undertaken on Lateral Flow Devices ('LFDs').

The Cell was informed that attendance at Government primary schools, during the last week before the Easter holidays (week commencing 29th March), had averaged 97.4

per cent and 92.6 per cent at secondary schools. Absences related to COVID-19 in all settings had been 0.1 per cent 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 14,500 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 61 inconclusive results, which had been re-tested.

The Cell was presented with the provisional data, to 10th April 2021, in respect of COVID-19 vaccinations in Jersey, which was that approximately 70,000 doses had been administered, of which *circa* 45,090 had been first dose vaccinations and 25,140 second dose. Vaccine uptake in older Islanders continued at very high levels and, as at 7th April, approximately 100 per cent of those aged over 80 years had received their first dose (based on population figures from 2019) and 86 per cent their second, whilst 97 per cent of these aged between 75 and 79 years had received their first dose and 72 per cent their second, with those figures at 96 and 60 per cent respectively for those aged between 70 and 74 years. 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 4th April 2021 and was informed that most countries now averaged between 5 and 10 per cent, whereas approximately 52 per cent of those aged over 18 in Jersey had received at least one dose of the vaccine by 7th April.

As at 7th April 2021, 98 per cent of care home residents had received their first dose of the vaccine and 89 per cent their second and in respect of staff employed in those *loci*, these figures were noted to be 95 and 85 per cent respectively. With regard to Islanders classed as 'clinically extremely vulnerable' 90 per cent had received their first dose and 53 per cent their second and for those at moderate risk, those figures were noted to be 77 and 42 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 informed that 1,484 people working in frontline health and social care positions had received their first vaccine, which was greater than the cohort size (this was because that population was 'fluid') and 74 per cent their second. Eighty five per cent of other workers in those settings had received their first dose and 56 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 no further active cases identified amongst those who had been vaccinated, but this was being kept under review.

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 6th April 2021, on a 7-day rolling basis. This demonstrated the continuing reduction in infection rates across much of that jurisdiction, although there were higher rates in Manchester and Birmingham than in other areas. 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. It was noted that only 11 per cent of England was Red and 45 per cent Green and there were increasing areas designated as Green in Scotland

and Wales and to a lesser extent Northern Ireland. The situation in Europe had worsened and 99 per cent of France was now Red (including some of the overseas territories) and all of Italy and Germany. With regard to the maps, which had been prepared by the ECDC, for weeks 12 to 13 (29th March to 5th April) when compared with the previous week, on 14-day case rates per 100,000 population, rising rates in Poland and France were noted, with some decreases in Italy. The Cell was informed that these would be kept under close review in light of the upcoming changes to the border policy.

The Cell received the most recent economic indicators report, which had been published by Statistics Jersey and noted that, as at the end of March 2021, 1,320 people had been registered as actively seeking work, which was far lower than in May 2020 and continued a downward trend. The number of Income Support claimants had also decreased. With regard to the number of vehicles using the overpass, during the week ending 28th March 2021, usage had been 49 per cent higher than the equivalent week one year earlier, when the Island had been in 'lockdown'. Bus usage had been 259 per cent higher than in the previous year, but was still far below the 2019 figures.

The Chief Economic Advisor informed the Cell that, substantively, the report was similar to March 2020 in that the economy had taken a 'structural hit', with the downgrade in the forecast having been driven by a sharper than expected fall in financial services profits in 2020. The forecast for 2021 was based on assumptions around the reconnection and, accordingly, the Fiscal Policy Panel had produced a 'high' and 'low' set of economic scenarios, mindful that there remained a range of potential outcomes. With regard to the visitor economy, the forecast was polarised. It was possible that there might be little travel outside the Common Travel Area in 2021, so people would holiday in Jersey, leading to an exceptional Summer season. Alternatively, if travel from the UK were to open more widely, the Island could find itself in fierce competition with countries in Southern Europe and experience a weak season. The Chief Economic Advisor informed the Cell that certainty around reconnection was important and helped to inform economic policy forecasting and planning. With respect to the co-funded payroll scheme ('CFPS'), it was noted that significant *tranches* of funding had been paid to hospitality businesses, which made a relatively low contribution to the economy of 4 per cent and 8 per cent employment. The construction industry had also received relatively large payments initially, but this had now reduced as work in that sector had increased. It was noted that the CFPS would continue until June for those businesses that could demonstrate lack of external demand, but there would then be a transition to normal working. The Cell was informed that the CFPS enabled businesses to claim money, subject to proven fall in takeover, but still continue to operate, which was preferable to the equivalent scheme in the UK, which did not facilitate continued working.

The Cell heard from the Managing Director, Jersey General Hospital, who indicated that the situation in respect of Islanders' mental health was being kept under review. In adult mental health settings there had been 2 months of lower occupancy, with fewer than 83 patients in Orchard House and acute adult admissions, per 100,000 registered population, having been below the National Health benchmark of 20 for the previous 2 months. However, pressure was being experienced in the Child and Adolescent Mental Health Service ('CAMHS'), where there had been a 3 per cent increase in caseload over the previous month and an increase during the year to-date of 20 per cent. It was noted that with regard to CAMHS this was reflective of a similar trend in the UK and other jurisdictions.

The Cell noted the position and thanked officers for the update

COVID-19 – 7-day and

A3. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of its meeting of 22nd March 2021, recalled that, as part of the Safer

14-day case notification rate comparison.

Travel Policy, which had been implemented on 3rd July 2020, the Island categorised areas as Red / Amber / Green ('RAG'), based on their case rate, per 100,000 population, over the previous 14 days, which impacted the duration of the period of isolation for arrivals therefrom. It was further recalled that Competent Authority Ministers had agreed to reimplement the Safer Travel Policy on 26th April 2021 for the United Kingdom ('UK') and Crown Dependencies and from no earlier than 17th May for the rest of the world. The Cell was cognisant that the UK reported widely on 7-day rates, whereas the European Centre for Disease Prevention and Control ('ECDC'), which reported on the rest of the world, only provided 14-day case rate data.

The Cell accordingly received and noted a paper, dated 7th April 2021, entitled '7-day and 14-day case notification rate comparison', which had been prepared by the Principal Officer, Public Health Intelligence, Strategic Policy, Planning and Performance Department. She reminded the Cell that since the Safer Travel Policy had been introduced, the Public Health Intelligence Team had publicised weekly maps showing RAG ratings on a 14-day case basis and in advance of the aforementioned reconnection on 26th April, the Communications Team had been publishing maps on social media, which showed the current classifications ahead of the reimplantation. In order to prepare the weekly updates, the team undertook 750 risk assessments each week for regional areas and countries, using a wide range of different data sources. Whilst it would be relatively straightforward to 'translate' some of the case rates into 7-day rates, this was not the case for others, such as the ECDC.

The Cell was informed that the rationale for using a 14-day rate was that it mirrored the time period of the full infection curve, by which 99 per cent of cases would have developed an infection since exposure; any delay in reporting data, or provisional data, would have a reduced impact over a 14-day period; some laboratories did not report over weekends and testing numbers might drop over the same period; smaller time periods could lead to greater fluctuations in smaller geographic areas; and Islanders had become accustomed to the current RAG categorisation, noting that the thresholds would need to change if the decision was taken to move to reporting on a 7-day basis. In support of the move to a 7-day case notification rate was that a large proportion of non-resident travel to the Island came from the UK, where the 7-day rates were widely reported and understood and it would allow for more immediate responses to a change in rates and more rapid reclassification. The Principal Officer indicated to the Cell that any change to a 7-day case rate would have implications for the capacity within the Public Health Intelligence Team and the timeliness of announcements after the data had been processed *inter alia* because the ECDC maps would no longer be relevant and other sources of maps for the world would need to be identified and communicated.

The Cell was asked to consider whether there was scientific justification for moving to a 7-day case notification rate to assess risk in other jurisdictions for inbound travellers and whether it was advisable to move to a 7-day rate in the current context. The Independent Advisor – Epidemiology and Public Health, suggested that it would be sensible to move to a 7-day rate as it would provide an early warning system and be more sensitive for reclassification. However, if it proved operationally problematic, the 14-day rate could be retained, mindful that the greater the delay in reporting change, the less useful the system became. He indicated that there had been discussion in the UK press of the introduction of a RAG system in that jurisdiction and suggested using its data analysis, as it might be using 7-day rates for the rest of the world.

The Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, stated that he had found it challenging to locate the relevant information on the RAG categorisation on the gov.je website and suggested that with most visitors to the Island coming from the UK, if the decision was taken to retain the 14-day case notification rate, it would be important to make it easier for people to locate and understand the information, because a reduction in comprehension could translate

to a decline in compliance. The Consultant in Communicable Disease Control suggested that it might be helpful to produce both a 7-day and 14-day rate for the UK, to enable comparison with the rates in other places and to make it easier for travellers from that jurisdiction to understand the local system.

Having discussed the foregoing, the Cell was of the view that it would be very difficult to move away from a 14-day case rate for the rest of the world, but most Members favoured reporting on a 7-day case rate for the UK. Mindful that the UK would be introducing some form of RAG categorisation, they advocated waiting to see the basis for the classifications.

The Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, indicated that the Public Health Intelligence Team did not have the capacity to convert the 14-day rates for the rest of the world to a 7-day rate, but he was not opposed to reporting on a 7-day rate for the UK alone. That said, Islanders were familiar with the current, 14-day system and with the Safer Travel Policy due to be reintroduced in that jurisdiction on 26th April, he would endeavour to discover what the UK planned in respect of its RAG and then make a judgement call as to when and how to communicate any change to the policy, subject to the views of Ministers.

The Cell noted the position accordingly.

COVID-19 vaccination science and risk associated with travel.

A4. The Scientific and Technical Advisory Cell ('the Cell') received and noted a PowerPoint presentation, dated 12th April 2021, entitled 'Vaccination science and risk to Islanders associated with travel', which had been prepared by the Principal Officer, Public Health Intelligence and the Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department and a report dated 31st March 2021, which had been prepared by the Scientific Pandemic Influenza Group on Modelling, Operational sub-group ('SPI-M-O'), entitled 'Summary of further modelling of easing restrictions – Roadmap Step 2', together with a report, dated 29th March 2021, which had been prepared by the European Centre for Disease Prevention and Control ('ECDC'), entitled 'Risk of SARS-CoV-2 transmission from newly-infected individuals with documented previous infection or vaccination'.

The Interim Director, Public Health Policy, informed the Cell that Competent Authority Ministers had expressed interest in a potential variation to the risk assessment at the border, based on vaccination status. Accordingly, work was underway to assess the potential policy options that could be implemented as an alternative to the Red / Amber / Green ('RAG') for fully vaccinated people (those who had received the second dose of an approved vaccine at least 2 weeks previously). It was noted that this might include a 'step down' where fully vaccinated arrivals from an Amber area, for example, would be treated as if they had arrived from an area designated as Green. There would be digital and operational solutions required to enable confirmation of the vaccine status of an individual, but the ethical and legal implications of conferring a benefit to Islanders, or visitors, on the basis of their medical status would require consideration. Any policy that might be introduced at the borders would need to be proportionate to the risk associated with any variation to the RAG and would require a close understanding of the scientific consensus on transmission risk of vaccinated travellers.

Key issues for the Cell to consider were what the science demonstrated in respect of the risk vaccinated arrivals posed to Islanders; whether the level of transmission risk for a vaccinated arrival could be quantified; the level of risk posed by new variants of COVID-19 in the short and long term and how the scientific evidence could be related to policy options. It was envisaged that the issue should be re-considered further by the Cell at its next meeting, once further analysis had been undertaken to understand any risks or opportunities.

The Principal Officer, Public Health Intelligence, informed the Cell that clinical trials and real world evidence showed that the Pfizer and AstraZeneca vaccines reduced the risk of becoming seriously ill, or dying, from COVID-19 by approximately 80 per cent. It was estimated that they led to a reduction of between 57 and 73 per cent in symptomatic infection. Accordingly, a reduction in transmission of the virus could be inferred from a reduction in symptomatic infection and evidence of reduced viral load in vaccinated individuals. It was not yet possible to assess whether immunity would wane as time elapsed and it was conceivable that yearly 'boosters' might be required and it was probable that protection could be compromised, both at an individual and population level, by vaccine resistant variants. It was recalled that the efficacy of the AstraZeneca vaccine against the South African Variant of Concern ('VOC') was reduced to 10 per cent and for Pfizer to 60 per cent.

It was noted from the SPI-M-O paper, that in preparing modelling, the London School of Hygiene and Tropical Medicine ('LSHTM') had assumed a 31 per cent reduction in the risk of infection from the AstraZeneca vaccine, whereas Imperial College assessed the second dose Pfizer vaccine as leading to a 94 per cent reduction and the figures from Warwick were between 65 and 85 per cent. The ECDC indicated that a study from Scotland suggested that vaccination of a household member reduced the risk of infection in susceptible household members by at least 30 per cent. There was evidence that vaccination significantly reduced viral load, although did not necessarily decrease transmission. It was recalled that the purpose of the vaccine was not to have a sterilising effect, but to reduce serious illness.

Analysis that had been undertaken to-date, demonstrated that assuming exposure to the virus at some point in the 14 days prior to travel, 60 per cent of infections would be detected by testing at day zero, 91 per cent by day zero and 5 testing and 99 per cent by testing at days zero, 5 and 10. However, of significance was when individuals became exposed relative to when they travelled. Group one individuals had been exposed before travel, group 2 were incubating the virus when travelling and group 3 had contracted the virus when travelling (most likely from a group one individual). The Cell was informed that if people had been exposed to the virus in the 3 days prior to arrival, just 3 per cent of active cases would be detected through the testing at day zero. As a consequence, short trips to the Island could pose a greater risk if the individual was released from isolation after providing a negative result from the day zero test.

The Cell was provided with hypothetical estimate of seeding rate, based on travel volumes from Summer 2020 and assuming a test efficacy of 100 per cent. Based on 10,000 travellers per week, which had been peak weekly travel during Summer 2020, an estimated 2 to 4 seed cases could be experienced each week. With the assumption that vaccinated individuals were between 50 and 90 per cent less likely to be infected and that they were offered an afore-referenced 'step down' rating and a similar spread of arrivals from RAG areas, between none and 4 seed cases could be experienced weekly, based on 10,000 arrivals. However, this could increase to between zero and 7 if more people travelled to and from Red and Amber areas, encouraged so to do by the 'step down' policy. Accordingly, it was mooted that this could be avoided by introducing a 'hard cap' on particularly high risk areas. As an example, where the 14-day case rate, per 100,000 population, exceeded 240, arrivals would be treated as Red, regardless of their vaccination status.

It was recalled that the public would be likely to modify their behaviour as case rates increased and the Government would introduce restrictions to reduce the risk. However, with an effective reproduction number (R_t) of 1.6 and some mitigations in place, one seed case per week could take 6 months to give rise to 30 cases per day. However, with minimal internal mitigations in place and an R_t of 3.0, it was possible that one seed case per week could lead to 30 cases per day in under 3 weeks. If vaccination reduced the risk of becoming infected by between 50 and 90 per cent and

travellers continued to arrive from areas designated as Green, then stepping down that categorisation for vaccinated individuals was unlikely to result in a substantial increase in seeding risk for the Island. However, there was limited evidence (from real world studies) for infection and transmission risk in vaccinated individuals and the stepping down of the categorisation was likely to encourage travel from areas posing a greater risk and the proportion of travellers from Red and Amber regions was likely to increase. Hence the proposed mitigation through means of the introduction of a 'hard cap'. It was noted that officers from the Public Health Intelligence Team were due to work on modelling in the event of the introduction of a 'hard cap' 14-day case rate of 240 cases per 100,000 population.

The Consultant in Communicable Disease Control indicated that although not everyone would develop sterilising immunity, the more people in Jersey who were vaccinated, the less susceptible the Island would be to transmission and protection gained would be a function of the vaccine on travellers as well as non-travellers. He made reference to aforementioned research from Scotland, in respect of household members of healthcare workers and stated that this should not be underestimated, as they would have been potentially exposed to infection outside the household, as well as inside. However, the VOCs were problematic and the ECDC paper had summarised some reduction in efficacy of the vaccine in respect of the VOC. This, combined with the volume of incoming travellers, was a cause for concern. It was complex to quantify the validity of the protection afforded by the vaccine in respect of the VOCs. He suggested that there might be merit in adopting a blanket approach and, for example, indicating that if a fully vaccinated person had travelled from an area where the South African VOC was present, they might be deemed to be only half, rather than fully, protected.

The Independent Advisor – Epidemiology and Public Health agreed and suggested that if a territory had a VOC of sufficient concern, any arrivals would have to quarantine. However, in his view, the key question, that was not being posed to the Cell, was the risk of severe disease and he opined that until consensus could be reached on that subject, some other questions became redundant. He was in favour of the introduction of a 'hard cap' for certain Red areas, but suggested that the system could be simplified further by not requiring any fully vaccinated individuals, who had arrived from a Green or Amber area, to quarantine at all, but to treat Red arrivals in a different way. He did not believe that this would significantly increase the risk posed at the borders and would simplify the system. He reminded the Cell that the risk of transmission of the virus would decrease over the Summer and supported the introduction of a vaccine certificate system, which would encourage uptake amongst people wishing to be able to travel, thereby affording further protection to the Island.

The Interim Director, Public Health Policy, indicated that the requirement for a vaccine certificate at the borders would afford the opportunity to permit people to enter the Island based on evidence and science, rather than their current travel declarations, which it was not possible to verify and could vary in accuracy. It might be necessary to operate a selective regional approach, based on prevalent VOCs and being more stringent in respect thereof. It was noted that surge testing was currently underway in Wandsworth, where a significant cluster of the South African VOC had been detected.

It was queried whether it would be possible to employ the exposure notification App to act as a form of vaccine certification and it was noted that the Emergency Medicine and Digital Health Specialist was working with officers from Modernisation and Digital on the development of some form of certification, but it was not thought that the exposure notification App would be the appropriate gateway, because it was designed to retain confidentiality, whereas the certification would require the presentation of personal details.

In summary, the risk posed by vaccinated arrivals would reduce, but would vary by

vaccine and there was support in the Cell for the introduction of a form of vaccine certification. It was complex to quantify the level of transmission risk for a vaccinated arrival at the ports and whatever steps were taken there would be an element of 'leakage'. There was some knowledge in respect of the VOCs, but their future transmissibility and the severity of disease that they caused was unknown. The Cell was supportive of the introduction of a 'hard stop' for countries where there were VOCs or other concerns and a simple, but robust, way of identifying them by sub-region or regional Covid status was required for the border.

The Interim Director, Public Health Policy, informed the Cell that he would incorporate the views expressed and re-present a proposal to the next meeting. In the meantime, if any members of the Cell wished to provide further views, he welcomed their input.

Impact of vaccination on severe disease risk.

A5. The Scientific and Technical Advisory Cell ('the Cell') recalled that it had previously questioned the impact that vaccination would have on the risk of severe disease in vaccinated individuals and accordingly received and noted a PowerPoint presentation, dated 12th April 2021, entitled 'Impact of Vaccination on Severe Disease Risk – Work to date', which had been prepared by the Principal Officer, Public Health Intelligence and the Senior Informatics Analyst, Strategic Policy, Planning and Performance Department and initially heard from the latter in relation thereto.

As referenced at Minute No. A4 of the current meeting, there was evidence that the COVID-19 vaccine reduced the risk of infection by between 31 and 94 per cent and that it provided strong protection against symptomatic disease and hospitalisation, reducing the risk of the same by between 50 and 98 per cent, based on data from clinical trials. In the preparation of the modelling, the Cell was informed that an optimistic 95 per cent vaccine efficacy had been used. It was recalled that the risk of severe disease was age dependent and, extrapolating the modelling prepared by the Scientific Pandemic Influenza Group on Modelling, Operational sub-group ('SPI-M-O') to Jersey, the average risk of hospitalisation across the population was estimated to be 3.1 per cent and the risk of death 1.1 per cent. During the second wave of the pandemic (from 1st October 2020), there had been 42 hospitalisations, which equated to a 1.5 per cent risk and 37 deaths, a 1.3 per cent risk. The risk distribution had been age dependent in Jersey, however, the small local sample size meant that the risk distribution appeared to differ slightly.

Based on a 95 per cent efficacy of the vaccine 3 weeks after receiving the first dose, it was envisaged that, by 20th April 2021, the average risk of hospitalisation across Jersey would reduce significantly to 0.88 per cent and death to 0.14 per cent. In a hypothetical third wave, with mitigations in place to keep case numbers below 3,000, such as the closure of hospitality and restrictions on household mixing, if the cases attained 2,800 (as in the second wave), the vaccination of the most vulnerable would result in fewer hospitalisations and deaths. It was estimated that there would be between 9 and 25 people admitted to Hospital (as opposed to 47 in the second wave) and between 4 and 5 deaths (as opposed to 37). However, 16,000 direct contacts would still be required to isolate and a similar number of Islanders would be affected by the impacts of non-pharmaceutical interventions ('NPIs') and Long COVID, which impacted one in 7. With fewer internal mitigations in place and case numbers up to 10,000 this would increase the instances of severe disease and death, despite vaccine protection and half the population would be affected as direct contacts but the NPIs would be moderate for everyone, rather than restrictive.

The most recent SPI-M-O modelling report from 5th April demonstrated that the academic teams from both Warwick and Imperial College predicted a third wave of the virus towards the end of late Summer, early Autumn. The models had a reduced peak than from previous estimates due to a higher revised estimate of vaccine uptake and vaccine efficacy. Contained within the report was the observation that it was

noteworthy that the resurgence in hospital admissions was accompanied by a very large numbers of infections, with daily incidence levels of 100,000, which demonstrated the changing relationship between infections and serious outcomes.

The Cell was shown an analysis from other jurisdictions *viz* Israel, Brazil, the Isle of Man and Guernsey, which demonstrated that moderate vaccine coverage reduced hospitalisation and deaths arising from outbreaks, but did not prevent the wave of itself, nor the need for lockdowns. Wider vaccine coverage, which exceeded 60 per cent, helped to mitigate outbreaks and the need for severe NPIs. Wider vaccine coverage appeared to improve the outlook in terms of suppressing outbreaks and delaying further waves until there was more widespread vaccine coverage would help to maximise the benefits provided by the vaccine. The situation in other places would be kept under review, but it was noted that Jersey was amongst the world's leading jurisdictions with regard to vaccine roll-out speed.

The Consultant in Communicable Disease Control indicated that there had been some criticism of SPI-M-O for suggesting that a third wave might occur in the Summer, on the basis that seasonality and behavioural change had not been taken into account. It was more likely to occur in the Autumn, by which time more people would have been vaccinated, but the variants of concern ('VOC') would have made inroads, noting that this was not factored into the modelling. If the virus spread amongst the unvaccinated population, it would ultimately impact the elderly and this would need to be considered with regard to the Care Homes. The Cell was informed that deployment of a Vitamin D supplement had been introduced on the basis of recommendations made by the National Institute for Health and Care Excellence ('NICE').

The Independent Advisor – Epidemiology and Public Health, thanked officers for their well-considered paper. However, he suggested that comparisons with other jurisdictions could be problematic as Chile, for example, was a very different place from Jersey, had a high degree of population mobility and was vaccinating its people using a different vaccine. In respect of the modelling for severe disease, he queried whether the impact of the vaccine on transmission was being factored in, as that could replace the NPIs. He made reference to the University College London ('UCL') model, which contained different assumptions from the models prepared by Warwick and Imperial College, was more optimistic and factored in seasonality. The Senior Informatics Analyst indicated that the UCL model had not been specifically included, but was assumed on the basis of an effective reproduction number (R_t) of 1.6 and low mitigations.

On a related note, the Chair of the Cell asked how many people locally were suffering with Long COVID as he did not have the impression that many were being treated in secondary care. The Clinical Lead, Primary Care, indicated that there were a few, primarily amongst younger, rather than older age groups and they were suffering with various symptoms, *inter alia* fatigue and 'brain fog'. They were being coded in primary care to develop a data set and he reminded the Cell that it was only now that 12 weeks had elapsed since the peak of cases in the second wave of the virus.

The Cell thanked officers for the interesting and informative briefing, the contents of which they noted accordingly.

Personal Protective Equipment Stock.

A6. The Scientific and Technical Advisory Cell ('the Cell') recalled that it had previously been provided with a paper, entitled 'PPE Demand & Supply 2020/2021 – 90 Worst Case v 45 Day Worst Case PPE Stockholding', which had been prepared by the Head of Non-Clinical Support Services and PPE Cell, which was taken as read and which proposed the reduction in the amount of Personal Protective Equipment ('PPE') that should be held on Island from 90 days' 'worst case scenario' down to 45.

The Cell further recalled that, in June 2020, the Council of Ministers had mandated that there should be 90 days' availability of all PPE stock, based on the peak of the epidemic curve and following certain assumptions, *inter alia* that up to half the population contracted COVID-19 and became symptomatic and that the 180 COVID 19 beds in the Hospital were in use, together with up to 180 beds in the Nightingale Wing.

The Cell was informed that the supply chain was more robust, both towards Europe and the rest of the world, than it had been in Summer 2020, so it would be possible to re-stock to 90 days' supply if required. Daily analytics were undertaken of the PPE and these were formally reviewed twice weekly, so in the event of an uptick in cases as Autumn approached, further stock could be sourced.

The Cell unanimously supported the proposed reduction in the stock of PPE from 90 days to 45 days.

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 1st April 2021, which had been prepared by the Strategic Policy, Planning and Performance Department;
- statistics relating to deaths registered in Jersey, dated 9th April 2021, which had been compiled by the Office of the Superintendent Registrar;
- a report on vaccination coverage by priority groups, dated 8th April 2021, which had been prepared by the Strategic Policy, Planning and Performance Department; and
- economic indicators for March 2021, which had been prepared by Statistics Jersey.