

KS

SCIENTIFIC AND TECHNICAL ADVISORY CELL

(60th Meeting)

24th May 2021

(Meeting conducted via Microsoft Teams)

PART A (Non-Exempt)

All members were present, with the exception of Mr. P. Armstrong, MBE, Medical Director (Chair), R. Sainsbury, Managing Director, Jersey General Hospital, R. Naylor, Chief Nurse, Dr. M. Patil, Associate Medical Director for Women and Children, 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.

Dr. I. Muscat, MBE, Consultant in Communicable Disease Control (Acting Chair)

C. Folarin, Interim Director of Public Health Practice

Dr. G. Root, Independent Advisor - Epidemiology and Public Health

Dr. A. Noon, Associate Medical Director for Primary Prevention and Intervention

Dr. S. Chapman, Associate Medical Director for Unscheduled Secondary Care

Dr. M. Garcia, Associate Medical Director for Mental Health

S. Petrie, Environmental Health Consultant

A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department

I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department

In attendance -

S. Martin, Chief Executive Officer, Influence at Work

Dr. M. Doyle, Clinical Lead, Primary Care

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

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

S. Nibbs, Temporary Secretariat Officer, States Greffe

K.L. Slack, Secretariat Officer, States Greffe

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

Minutes. A1. The Minutes of the meeting of the Scientific and Technical Advisory Cell, held on 17th May 2021, having previously been circulated were taken as read, subject to a minor deletion. Members were asked to provide any additional feedback thereon to the Secretariat Officer, States Greffe, by the end of 24th May 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 17th May 2021, received and noted a PowerPoint presentation, dated 24th May 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 the former in relation thereto.

The Cell was informed that, as at Friday 21st May 2021, there had been 4 active cases of COVID-19 in Jersey, all of which had been detected as a consequence of arrivals screening, as was the situation for all the confirmed positive cases over the previous 3 weeks. Three were asymptomatic and only one was experiencing symptoms of the virus and they had been in direct contact with 88 individuals. The 14-day case rate, per 100,000 population, was currently 3.71 and the 7-day case rate 1.86. The Cell noted a graph, which set out the daily incidences of non-seed cases, mapped against the dates of the introduction and relaxation of non-pharmaceutical interventions ('NPIs').

During the week ending 21st May, the number of tests had increased and had exceeded 1,500 on several days with the majority on arriving passengers and as part of the workforce screening programme. It was noted that there had been one community-related positive case during the week commencing 17th May, who had been a direct contact of an active cases, but there had been no COVID-19 positive hospital admissions in the last 7 days and no further deaths since the last meeting of the Cell. There had been no positive cases in fully vaccinated individuals since early March, albeit one recent positive case had received the first dose of the vaccine. The Cell agreed that consideration would need to be given to how best to manage those people who had received the first dose of the vaccine locally, but were unable to access the second, potentially due to being off-Island and noted that there was an agreement with the United Kingdom ('UK') that university students could receive their second dose in that jurisdiction if they had received the first in Jersey. With regard to the number of daily cases of COVID-19, the number of tests and the test positivity rates for various age groups, it was noted that the number of PCR tests for all cohorts, with the exception of those aged under 18 years, was relatively high, whilst the test positivity rate remained very low in all age groups.

The Cell was provided with further details of the active cases by the Interim Director of Public Health Practice, Chair of the Analytical Cell, who indicated that there had been some new cases over the weekend of 22nd / 23rd May, which were awaiting confirmation from serology tests.

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 21st May 2021 and was informed that the number of calls to the Covid Helpline continued at far lower levels than had been experienced in April. The volume of inbound travellers had increased since the Red / Amber / Green ('RAG') categorisation had been reintroduced for the Common Travel Area ('CTA') (excluding Eire) on 26th April. It was recalled that during the week ending 9th May 2021, there had been 4,160 tests on inbound travellers and the Cell noted that this figure had increased to 4,820 during the week ending 16th May with 4,290 tests as part of on-Island surveillance and 90 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, but the former had increased to 0.1 per cent as at 23rd May. During the week ending 16th

60th Meeting
24.05.21

May, the local weekly testing rate, per 100,000 population, had increased to 8,500 and in the UK it had been 9,086, mindful that that jurisdiction included tests undertaken on Lateral Flow Devices ('LFDs'), so the PCR testing levels in that jurisdiction were likely to be below Jersey's. With regard to the increasing numbers of arriving passengers and the cases being intercepted at the borders, it was queried whether these related to returning university students and it was agreed that it was important to understand the risk profile of the active cases that had come to light over the weekend, details of which would be circulated by the Chair of the Analytical Cell.

During the week ending 23rd May 2021, attendance at the Government primary schools had been 97.3 per cent and in the secondary schools 76.8 per cent, mindful that the year 11 pupils were currently on study leave. The COVID-19 related absences in the secondary schools were noted to have increased to 7.7 per cent and there had been one positive case linked to the schools in May. 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 by the Principal Officer, Public Health Intelligence, that she had liaised with the Informatics Team, which had confirmed that some schools had only been submitting data on 'positive' tests. Of the 19,741 LFD tests which had been reported to-date, it remained the case 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 68 inconclusive results, which had been re-tested.

The Cell was presented with the data, to 16th May 2021, in respect of COVID-19 vaccinations in Jersey, which demonstrated that 97,366 doses had been administered, of which 57,124 had been first dose vaccinations and 40,242 second dose, resulting in a vaccine rate, per 100 population, of 90.32. The Cell was presented with the percentage of the various age cohorts that had received their first and second doses of the vaccine and noted that amongst Islanders aged over 18 years, 65 per cent had received their first dose and 46 per cent their second. Across the whole population, this equated to 53 per cent having received their first dose and over one third (37 per cent) their second. The Cell was presented with a new graph, which compared the administration of first and second doses with England, the Isle of Man, Wales and Scotland, which demonstrated that Jersey was performing on a par with or favourably to those jurisdictions. This was particularly noted to be the case for second dose vaccinations for Islanders aged between 60 and 64 years. With the focus on administering the second dose of the vaccine to those in priority groups one to 9, in addition to the first to the younger cohorts, 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 16th May 2021 and was informed that whilst 65 per cent of adults in Jersey had received their first dose, with a similar percentage in the UK, it averaged between 30 and 40 per cent in many European countries. In respect of the cumulative number of fully vaccinated adults across Europe, it was noted that Jersey had now attained 46 per cent, whereas most of Europe averaged between 10 and 15 per cent. As at 16th May 2021, 99 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 95 per cent respectively, mindful that this workforce fluctuated. With regard to Islanders classed as 'clinically extremely vulnerable' 91 per cent had received their first dose and 84 per cent their second and for those at moderate risk, those figures were noted to be 80 and 71 per cent respectively.

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. 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 90 per cent their second, whilst 93 per cent of other workers in those *loci* had received their first dose and 73 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 noted the distribution of the variants of concern ('VOCs') and variants under investigation ('VUIs'), prepared by the Sanger Institute and was informed that there had been a total of 3,424 confirmed cases of the B.1.617.2 VOC (known as 'the Indian VOC'), of which 2,111 cases had been identified since the most recent update, 50 days previously. That variant was distributed across the UK and a high number of cases in the North West of England and London were noted. The risk assessment for the Indian VOC, which had been prepared by Public Health England indicated that it appeared more transmissible than the wild type of COVID-19, but the magnitude of the change in transmissibility remained uncertain. Evidence of its impact on the effectiveness of the vaccine appeared moderate after the first dose, but low after the second. The secondary attack rate amongst contacts of cases that had not travelled, or were unknown, was noted to be approximately 8.1 per cent for the B.1.1.7 VOC ('Kent VOC') and 12.5 per cent for the Indian VOC.

The Consultant in Communicable Disease Control indicated that it was encouraging to witness the *in vivo* data confirming that the second dose of the vaccine increased efficacy against the Indian VOC to around 81 per cent, compared with 87 per cent for the Kent VOC and 75 for the South African. Accordingly, the impact of the VOCs was primarily being experienced in relation to the efficacy of the first dose. Hospital admission rates from 1st February 2021 appeared to increase by 1.5 for the Kent VOC and 1.1 for the Indian, with higher death rates associated with the former. However, it was suggested that increased vaccination rates might have impacted the figures and the Indian VOC had only recently become apparent, so direct comparison between the two was not easily achievable. The Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, queried whether the Indian VOC was particularly located in those areas where there were large populations from the Indian sub-continent or whether it was more widespread. The Principal Officer, Public Health Intelligence, indicated that some research could be undertaken in this regard. The Independent Advisor – Epidemiology and Public Health, stated that it was positive to note that the transmissibility of the Indian VOC appeared lower than originally anticipated and questioned whether contextual factors had played a role in the over-estimation. He opined that there appeared to have been a falling away of the growth rate of that variant recently. The Principal Officer, Public Health Intelligence, suggested that there was a mixed picture, with some areas appearing to experience the dampening effects of surge testing and increased contact tracing, whilst active cases were increasing in others.

The Interim Director, Public Health Policy, agreed that the Indian variant did not appear to be following a clear pattern. There were high infection rates in areas such as Bolton but, as aforementioned, increased vaccination, surge testing and other NPIs appeared to be having an impact on the virus in other areas. As vaccination rates increased across the UK, especially with more urgent focus on the administration of second doses, this should bear down on the impact of the variant. With the proposed move in the local travel policy to national categorisation on 31st May, Scotland would be classified as

60th Meeting
24.05.21

Amber due to increased case rates (noted to be 70 per 100,000 population over the preceding 14 days) but England was ‘hovering’ around 41, with slight increases in certain Lower Tier Local Authority (‘LTLA’) areas, which designated it as Green. It was suggested that it would be interesting to see how the situation developed over the coming weeks.

The Consultant in Communicable Disease Control was encouraged by the impact of the second dose of the vaccine on the Indian VOC and opined that it had been a correct decision by the JCVI to reduce the interval between doses. It was envisaged that all in priority groups one to 9 would have been offered both doses by the end of May and the increased transmissibility of the Indian VOC was likely to be revised downwards from 50 per cent, potentially to 20 or 25 per cent, as anticipated by the Deputy Chief Medical Officer.

The Cell was shown a map of the classification of the CTA by LTLA that would apply from 25th May, based on the 14-day case rate, per 100,000 population and noted a small number of Red areas in England, which were being kept under review. 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 16th May 2021, which mirrored that situation. The Cell was presented with information on the RAG status for the UK, Eire and France, as at 25th May and it was noted that from that date, 81 per cent of England would be Green and 18 per cent Amber. In Scotland there would be an increase in Red areas, whilst all but 5 per cent of areas in Wales would remain Green and all of mainland France remained Red. The situation in Northern Ireland had slightly deteriorated with a reduction in Green areas and an increase in Amber. The Cell was informed that there had been an issue in respect of the data for Eire, which had not been produced, albeit it was recalled that a blanket Red categorisation would continue to apply to it. With regard to the maps, which had been prepared by the ECDC, for weeks 18 to 19 (10th to 17th May) when compared with the previous week, based on a 14-day case rate per 100,000 population, it was noted that case numbers were starting to decrease across France, Spain, Germany and Poland but remained high in Sweden and the Netherlands.

The Cell noted the position and thanked the Principal Officer, Public Health Intelligence, for the update.

Border policy
– request from
Senator L.J.
Farnham,
Deputy Chief
Minister.

A3. The Scientific and Technical Advisory Cell (‘the Cell’) received and noted an electronic mail message, which had been circulated by Senator L.J. Farnham, Deputy Chief Minister and Minister for Economic Development, Tourism, Sport and Culture in which he requested the Cell to examine the stated policy position from Guernsey in respect of the borders. The Cell was reminded that an announcement had been issued by the States of Guernsey to the effect that, from 1st July 2021, any arrivals from within the Common Travel Area (‘CTA’) would not be required to self-isolate, nor to undergo PCR testing.

The Cell noted that the Guernsey proposed border control strategy included a ‘Blue’ categorisation for arrivals from within the CTA, or for a fully vaccinated individual from a United Kingdom (‘UK’) green list country. A caveat had been issued to the Guernsey policy to the effect that the CTA included the UK, the Bailiwick of Guernsey, the Bailiwick of Jersey, the Isle of Man and the Republic of Ireland. Whilst it was currently the intention for all travellers from the CTA to be considered as ‘Blue’ when the new travel rules were introduced, the States of Guernsey might determine ahead of this that jurisdictions or regions within the CTA should be classified separately.

The Consultant in Communicable Disease Control, Acting Chair of the Cell, indicated that this caveat was the equivalent to the ‘emergency brake’ that had been approved by the Competent Authority Ministers locally, which would enable a more specific approach to be taken to certain smaller regions in the event of escalating risk. Important

to the thinking in Guernsey was to have sufficient fully vaccinated individuals to enable them to open the borders without the threat of the health service being overwhelmed by an influx of active cases. He suggested that the Cell's role was to consider the relative risks associated with such a policy from an epidemiological and scientific perspective mindful that the Competent Authority Ministers would ultimately be responsible for reaching the decisions. The Cell would need to determine the risk of inbound infection, the vaccination rates both locally and elsewhere in the CTA, the potential for seeding and the risk posed by any seeding, mindful that those most at risk would have been offered both doses of the vaccine by 1st July.

The Interim Director, Public Health Policy, reminded the Cell that officers had focused on policy leading up to 28th May at which point the CTA would be categorised at a larger scale and status certification introduced. It was a legitimate question to ask whether Jersey should have a future date, like Guernsey, at which Ministers could indicate that they would be minded to move to a more 'connected' position, somewhat akin to 'living with the virus'. However, officers would need to assemble the evidence to present Ministers with a range of options, which could include adhering to the policy that had been set from 31st May, adopting something akin to the Guernsey model, or introducing a hybrid approach where a more open regime could be introduced at a later juncture for fully vaccinated passengers. At the current time he favoured continuing with PCR testing for arrivals at day zero for fully vaccinated individuals, but in the event that no active cases were detected after a month, it could potentially be possible to consider removing the requirement for testing.

The Independent Advisor – Epidemiology and Public Health, indicated that the key issue was the risk of severe disease. He suggested that Jersey was close to attaining 'herd immunity' and opined that any seeding of cases was unlikely to lead to severe cases of COVID-19. It would be possible to undertake further modelling, but this would still raise issues around the level of risk that Ministers were willing to take. Cognisant that assumptions and knowledge of the disease and vaccine changed over time, he felt that multiple scenarios would be required. The Consultant in Communicable Disease Control emphasised the importance of affording officers sufficient time to undertake modelling and risk assessments and develop a range of options for Ministers, *inter alia* if Jersey were to decide to adopt the same policy as Guernsey on 1st July, or delay until 1st August, by which time more people would have been fully vaccinated.

The Cell was reminded that testing arriving travellers enabled officers to have a clear picture of what was happening at the borders, which would be lost if that requirement was removed. The Consultant in Communicable Disease Control indicated that information such as this should be included in the summary for Ministers, to sight them on what would be gained and lost by adopting a similar policy to Guernsey. Mindful that 31st May was a Bank Holiday and the Cell was not due to meet during that week, it was agreed that proposals should be drawn up and circulated to members of the Cell in order for views to be recorded by way of an electronic mail meeting.

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

Covid Status Certification.

A4. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A4 of its meeting of 17th May 2021, recalled that it had discussed Covid Status Certification ('CSC') and specifically for children and young people accompanying fully vaccinated adults, mindful that the latter were to be afforded a 'green light' on arrival from areas categorised as Green or Amber and whilst they would undergo a PCR test at the border, would not be required to self-isolate. These changes to the Safer Travel Policy had been agreed by Competent Authority Ministers at their meeting of 23rd April.

The Cell accordingly received and noted a PowerPoint presentation, dated 24th May

2021, entitled ‘STAC. COVID Status Certification (CSC) Update’, which had been prepared by the Senior Policy Officer, Strategic Policy, Planning and Performance Department and heard from her in relation thereto. She reminded the Cell of the definition of a fully vaccinated individual *viz* someone who had received 2 doses of a vaccine approved by the Medicines and Healthcare products Regulatory Agency (‘MHRA’) at least 2 weeks previously and indicated that with proof of this status from within the Common Travel Area (‘CTA’), such individuals could be permitted a proportionate reduction in testing and isolation requirements. Anyone arriving from an area designated as Red (where the 14-day case rate exceeded 120 per 100,000 population, or which was on the UK ‘red list’, or where an ‘emergency brake’ had been applied due to the presence of variants of concern (‘VOCs’) or high case rates) would continue to be required to undergo testing at days zero, 5 and 10 and to self-isolate until they received a negative result from the latter test. This would apply whether or not the individual was fully vaccinated. However, fully vaccinated arrivals from areas designated as Amber or Green would be given a ‘green light’ and would be tested only on arrival, with no requirement to self-isolate. Those who were not fully vaccinated and arrived from an Amber area would be subject to the 3 tests, with release at a day 5 negative result, whereas arrivals from Green areas would be tested at days zero and 8 with the requirement to self-isolate until a day zero negative test. Those under the age of 18 years arriving from Green or Amber areas would be afforded a blanket green classification.

In order to deliver the CSC project, the Cell was informed that there were 7 core requirements, as follows –

- evidence of fully vaccinated status for those vaccinated in Jersey;
- verification of fully vaccinated status at the border for those vaccinated in Jersey;
- verification of fully vaccinated status at the border for those vaccinated in the CTA;
- evidence of COVID Status Certification for those vaccinated and tested in Jersey;
- verification of COVID Status Certification for those vaccinated and tested in Jersey;
- verification of COVID Status Certification for those vaccinated and tested in the CTA;
- verification of COVID Status Certification for those vaccinated and tested in the rest of the world.

Phase one would deliver the first 3 requirements by 28th May 2021 and the remainder would be delivered in the second phase.

Evidence of fully vaccinated status for those who had received the vaccine in Jersey would be furnished by means of a paper COVID Status Certificate, produced with security features that provided an equivalent level of security to the NHS England document, including foil artwork for the logo, fluorescent ink behind the vaccine dose information, microtext in the margins and a unique reference number. All Islanders who had received both doses of the vaccine by 28th May would receive their certificates between 1st and 10th June as part of an initial bulk mail distribution, supported by the Customer and Local Services Department’s Covid Helpline team.

This would be preceded by a targeted communications campaign, encouraging people to ensure that the Government held the correct address for them, providing them with the option to opt out and explaining the circumstances in which the certificates might be required. Following the initial bulk mailing of the certificates, the programme would automatically distribute them to individuals as they became eligible. Work was underway with the UK Government and Department for Trade to ensure that the Jersey certificates were recognised by international destinations as the equivalent of an NHS England certificate.

Verification of fully vaccinated status at the border for those vaccinated in Jersey could be achieved when completing the pre-travel registration form by entering a Social Security JY number, or in the case of an individual who had been vaccinated locally but did not have the same, by providing name and date of birth and the certificate would not be required. Verification of fully vaccinated status at the border for those vaccinated in the CTA would primarily be handled through the pre-travel registration form. Passengers would complete an honesty declaration, declare that they were fully vaccinated and provide details of where they had been vaccinated, on which dates and the type of vaccine received. It was noted that the wording and format of the form had been developed in conjunction with the Behavioural Science team to encourage honesty. Subject to the aforementioned criteria being met, the passenger would provisionally be considered as fully vaccinated for the purposes of calculating their Red / Amber / Green ('RAG') status. On arrival at the border, officers would manually review of an agreed set of vaccination documents from other jurisdictions and the Cell was informed that these varied by location and that some evidence might not be available by 28th May. Accordingly, Competent Authority Ministers had agreed that, for a limited period of time, the vaccination appointment cards, or PDFs of General Practitioner records would be accepted from travellers originating from jurisdictions that did not yet have access to more secure evidence.

For the second phase of the CSC development, COVID-19 test results and vaccination status would be included into what was anticipated to be a digital solution with a QR code to enable international automatic verification. Work would be undertaken with the UK Government to avail the Island of the secure QR code generation service proposed for the Devolved Nations and Crown Dependencies. There would be the protentional for bilateral agreements in advance of an international solution for verification being agreed and once the latter was achieved, this would permit the verification of the CSC in line with European Union and World Health Organisation standards.

Members of the Cell exchanged personal experiences of issues linked to the NHS England letters and App, which the Senior Policy Officer undertook to discuss with colleagues.

The Cell noted the position and thanked the Senior Policy Officer for the presentation.

Exit testing
feasibility.

A5. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A1 of its meeting of 4th May 2021, recalled that in light of the forthcoming change to the testing regime for arrivals from Green areas, who were not fully vaccinated - which required them to undergo tests at days zero and 8, rather than zero, 5 and 10 - it had been suggested that the potential to introduce departure tests should be explored, with a view to identifying any positive cases who were incubating infection on arrival, evaded the day zero test and left the Island before the day 8 test.

The Cell received and noted a paper, dated 17th May 2021, entitled 'Departure Testing Feasibility Analysis', which had been prepared by the Senior Policy Officer, Strategic Policy, Planning and Performance Department and heard from him in relation thereto. He indicated that he had liaised with the various operational leads in order to discuss

60th Meeting
24.05.21

the proposals and after analysis it emerged that pre-departure testing would probably only identify one additional case every 5 to 12 weeks depending on the volume of travellers and the off-Island prevalence of the virus. However, it would require new testing facilities at the airport and harbour, with the attendant costs and resource implications. There would also be potential legal challenges in respect of the enforceability of such testing.

In conclusion, it was felt that the costs of the policy proposal would outweigh the public health benefits. The Cell noted the position, thanked the Senior Policy Officer for the useful work that he had undertaken and agreed with the conclusions reached.

Management
of fully
vaccinated
direct contacts.

A6. The Scientific and Technical Advisory Cell ('the Cell') received a background paper, dated 24th May 2021, entitled 'Management of fully vaccinated direct contacts' and a PowerPoint presentation of the same name and date, which had been prepared by the Senior Policy Officer, Strategic Policy, Planning and Performance Department and heard from her in relation thereto. The Cell was informed that no decisions were required at the current time and the aim of the presentation was to provide an introduction to the topic and for the Cell to discuss potential future policy options for further development.

The Cell was cognisant that fully vaccinated individuals were those who had received 2 doses of a vaccine approved by the Medicines and Healthcare products Regulatory Agency ('MHRA') at least 2 weeks previously. Direct contacts were people who had spent more than 15 minutes within 2 metres or less of an active case, without personal protective equipment ('PPE') and they were currently required to self-isolate and undergo tests at days zero, 5 and 10, with release after a day 10 negative result. On 21st April, the European Centre for Disease Prevention and Control ('ECDC') had recommended that direct contacts were at higher risk of contracting and transmitting COVID-19 than others in the community and that risk assessments should be undertaken on a case-by-case basis. On 13th May the Centre for Disease Control and Prevention ('CDC') had provided an update to its recommendations for non-healthcare settings, which were that asymptomatic direct contacts did not need to isolate following a known exposure, but non-pharmaceutical interventions ('NPIs'), including mask wearing, 2 metre physical distancing and hand washing, should be maintained during travel. The advice from Public Health England, which had remained unchanged during the pandemic was that direct contacts should self-isolate irrespective of their vaccination status.

It was possible to introduce a more nuanced risk stratification for the management of direct contacts than was currently in place. Direct contacts who were not fully vaccinated, had no travel history and where there was no link to a variant of concern ('VOC') could continue to be managed as at present. In the event of likely contact with a VOC due to the travel history, or confirmed by sequencing, an individual could be assessed as a 'direct contact plus' and the isolation period could potentially be lengthened whilst awaiting sequencing. However, a fully vaccinated individual, or someone wearing full PPE could be exempted from isolation.

The Cell noted that there was currently very low prevalence and transmission of COVID-19 on-Island, the positivity rate was below 0.1 per cent and no known VOCs were circulating. The positivity rate amongst travellers was between 0.1 and 0.3 per cent and they posed the additional risk of carrying a VOC. The positivity rate amongst direct contacts was between 4 and 8 per cent, with the potential risk of carrying a VOC if they were direct contacts of travellers. There was a reduction in the risk of infection of between 63 and 85 per cent for fully vaccinated individuals. The current risk posed by arriving travellers from areas designated as Red was more than 120 per 100,000, whereas the risk posed by direct contacts was greater, at more than 2,000 per 100,000.

There were underlying factors known to impact the threat posed by COVID-19 which still applied in the context of vaccination *viz* older Islanders remained more vulnerable, the risk posed by VOCs was not fully understood, the type of vaccine received, the duration of immunity following vaccination was unknown and the use of non-pharmaceutical interventions ('NPIs'). There was the risk of inequality arising before all eligible Islanders over the age of 18 had been offered both doses of the vaccine, which was anticipated to be by mid-August, subject to supply.

The Cell was presented with potential future policy options. If the current policy position for management of direct contacts was retained, this would align with the current Public Health England guidance and be consistent across all groups. It would be possible to remove the requirement to self-isolate for direct contacts who were fully vaccinated, which would reflect the CDC guidance but pose a greater risk to the Island and delays in sequencing samples and obtaining travel manifests could lead to the introduction of more transmissible variants. Alternatively, fully vaccinated direct contacts could have their isolation period reduced to 5 days, with the requirement to produce a negative day 5 test for 'release' from isolation.

It was proposed that the aforementioned NPIs during travel should be maintained irrespective of the passengers' vaccination status. Verification of vaccination status would follow the work on COVID Status Certification (as referenced at Minute No. A4 of the current meeting) and the level of proof of vaccination required and enforcement by the Contact Tracing Monitoring Enforcement Team would require further consideration. Given the unknown length of immunity afforded by the vaccine, a review date for the policy would need to be set.

The Consultant in Communicable Disease Control and Acting Chair indicated that if the Island was prepared to accept the degree of risk posed by not requiring fully vaccinated direct contacts to self-isolate (noted to be 2,000 per 100,000 over 14 days) this would have a 'domino effect' on other mitigating factors and would potentially signal an acceptance that fully vaccinated arrivals from areas designated as Red did not pose a risk. He reminded the Cell that the paper related to the vaccination status of the potential recipient of the virus, but the status of the donor was also relevant as in fully vaccinated individuals the level of transmissibility was reduced by 50 per cent. He emphasised the importance of the duration of the validity of any vaccination certification and the applicability of immunity to new variants of the virus, which had to be taken into account. He reminded the Cell that contact tracing was not specific to COVID-19 and was undertaken in respect of STIs, TB and MRSA as it was evident that contacts had a higher risk of infection than others in the community. He opined that, from a risk perspective, this should be one of the last things to be removed and if it was, other NPIs would have to be rethought.

The Independent Consultant – Epidemiology and Public Health, agreed that the risk of a fully vaccinated person transmitting the virus was lower than for someone who was unvaccinated. However, it might take them longer to seroconvert, which could impact the release option at day 5. He indicated that if a policy were adopted whereby fully vaccinated individuals were not required to self-isolate if identified as direct contacts, this could encourage vaccination uptake. He suggested that the policy would be time limited, as once a certain level of vaccination coverage was attained, the risk of severe disease would be so low that it would cease to be a policy consideration.

The Interim Director, Public Health Policy, suggested that at some point large scale contact tracing would not be undertaken in the way that it currently was. Although the CDC had published revised advice in respect of direct contacts, the advice from Public Health England and the ECDC was pending and it would be helpful for the Cell to have sight thereof. The trace and isolate system was the last line of defence for the Island, so it was important to consider the matter carefully and as greater connectivity was

60th Meeting
24.05.21

achieved, so the number of active cases was likely to increase, which would build on this point. He indicated his support for the direction of travel contained within the paper.

The Cell thanked the Senior Policy Officer for the very interesting and important work and noted the position.

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 20th May 2021, which had been prepared by the Strategic Policy, Planning and Performance Department;
- statistics relating to deaths registered in Jersey, dated 20th May 2021, which had been compiled by the Office of the Superintendent Registrar; and
- a report on vaccination coverage by priority groups, dated 20th May 2021, which had been prepared by the Strategic Policy, Planning and Performance Department.

It was noted that Monday 31st May was a Bank Holiday, so the next formal meeting of the Cell would take place on 7th June.