

SCIENTIFIC AND TECHNICAL ADVISORY CELL

(70th Meeting)

(Business conducted via Microsoft Teams)

16th August 2021

**PART A (Non-Exempt)**

All members were present, with the exception of, Dr. C. Newman, Senior Policy Officer, Strategic Policy, Planning and Performance Department, N. Vaughan, Chief Economic Advisor, S. Martin, Chief Executive Officer, Influence at Work, and A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department, from whom apologies had been received.

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

In attendance -

Dr. L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department  
M. Clarke, Principal Officer, Public Health Intelligence, Strategic Policy, Planning and Performance Department  
J. Blazeby, Director General, Justice and Home Affairs Department  
B. Sherrington, Head of Policy (Shielding Workstream), Strategic Policy, Planning and Performance Department  
M. Rogers, Director General, Children, Young Persons and Education Service (CYPES) (for a time)  
K. Posner, Head of Office, CYPES (for a time)  
C. Maffia, Strategic Lead for Contact Tracing, Monitoring and Enforcement (for a time)  
J. Lynch, Principal Policy Officer Policy (for a time).  
C. Keir, Head of Media and Stakeholder Relations  
S. Nibbs, Specialist Secretariat Officer, States Greffe

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

Minutes

A1. The Scientific and Technical Advisory Cell ('the Cell'), reviewed the Minutes of the meeting held on 2nd August 2021. The Minutes were ratified, and it was noted that these would be provided to the Scrutiny Panel following the extant meeting.

Intelligence overview including Analytical Cell Update and HCS service activity.

A2. The Scientific Technical and Advisory Cell ('the Cell') reviewed a PowerPoint presentation, which had been prepared by M. Clarke, Principal Officer, Public Health Intelligence, Strategic Policy, Planning and Performance Department and Dr. L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department.

The Cell was advised that there had been 453 active COVID-19 cases in the Island as of Friday 13th August 2021 and arising from this figure were 1727 direct contacts. It was noted that the largest number of cases were being diagnosed in those aged between 10 and 19 years of age. 98 further cases had been identified through contact tracing and 234 cases via arrivals screening. A very small number of cases were evident in those of 60 years of age and over. More than 2000 tests per day were still being undertaken and an average of 46 cases per day were being diagnosed. A seven-day rate of 197 was noted, as was a fourteen-day rate of 516.

The weekly epidemiological graph was also reviewed. Contact tracing test positivity had reduced to five percent and the positivity rate of those seeking health care had reduced to fifteen percent. In contrast, there had been 136 positive tests at the border on 26th July, followed by 63 positive cases at the border at the beginning of August. As at Friday 13th August, it was noted that 16 patients were hospitalised with clinical COVID-19, which marked a decline in recent admissions. Two of these patients were being cared for in the Intensive Care Unit. Four positive COVID-19 cases had also been recorded within the Health and Community Services team. Within the care home community, numbers had reduced to five care home residents and four staff diagnosed as COVID-19 positive. One paramedic and one staff member from Jersey Hospice Care were also currently diagnosed with COVID-19.

A weekly updating report on the test positivity rate for COVID-19 confirmed that a ratio of 23,100 tests per 100,000 members of the population had been undertaken, with a positivity rate of 1.5 percent emerging. This compared favourably to the UK rate of 9,708 tests per 100,000 members of the population, with a test positivity rate of 3.7 percent. The Cell noted that the current '~R' Estimate was between 0.4 and 0.5.

In terms of Long COVID monitoring, it was noted that 136 patients had been recorded in in EMIS as suffering from Long COVID, an increase from 101 noted two weeks ago. Some patients had been listed as having both ongoing conditions, 64 patients having been registered with ongoing Long COVID symptoms.

COVID-19 vaccinations continued to increase, and the Cell noted that 144,896 total doses had now been given, which equalled 134.42 doses per 100 people in the population. Of the total number, 74,899 were first doses and 69,997 were second doses. Overall, 84 percent of the Island's eligible adult population had received their first dose and 74 percent had received their second dose of the vaccine. It was further noted that 100 percent vaccination of frontline Health and Community Services (HCS) workers had taken place.

B. Sherrington, Head of Policy (Shielding Workstream), Strategic Policy, Planning and Performance Department advised that plans to vaccinate high health risk category children were in progress and were due to be presented to Ministers the next day at the Competent Authority Ministers meeting. A news release in connexion with the vaccination proposals would be distributed later during the week. P. Armstrong, MBE, Chair, thanked the Cell for its work on the paper regarding the vaccine strategy and its research in connexion with the

recommendations made by the Joint Committee on Vaccination and Immunisation ('JCVI').

Dr. G. Root, Independent Advisor - Epidemiology and Public Health, asked if any explanation could be attributed to the rise in infection for those aged 18 and expressed some concerns about the seeding of new infections. Ms. Clarke responded that this trend had only been noted immediately prior to the extant meeting and that the new data was currently being reviewed.

Ms. Clarke went on to present information regarding epidemiological modelling and daily cases of COVID-19. The Cell recalled that, in May 2021, modelling had been requested to support decisions to be made in connexion with the reconnection roadmap. Such models had used assumptions based on the best available evidence published at that time.

Dr. Daniels explained that there was a mixed picture regarding the use of modelling in the United Kingdom, with the most eminent data modelling teams there also appearing perplexed regarding an unexpected sharp decline in cases, which was then followed by a more recent uptick in cases. The latest ' $\sim R$ ' range estimate in England was 0.8 – 1.1. The latest COVID-19 infection growth rate range for England was noted as being minus 3 percent to plus 1 percent. Almost all trajectories had estimated a peak in late August or much later, however no epidemiological models had anticipated the shape of the viral trend observed during July 2021. In terms of trends elsewhere, the Cell reviewed such trends visible in terms of increasing numbers from the Netherlands, Portugal, France, Spain, and Israel. Some trends could indicate waning protection from the vaccine, although there was good vaccine coverage in most locations.

It was noted that actual infections had peaked sooner and at a much lower rate than the simple Susceptible-Exposed-Infectious-Removed (SEIR) model (used to describe the spread of the virus and compute the number of infected and deceased individuals) projections produced in Jersey.

The rapid spread of infection that had occurred during July 2021 appeared to have been following the highest  $\sim R$  rate scenario (when  $\sim R = 5$ ), which the Cell had reason to expect, given the high estimates of the natural  $\sim R$  of the Delta variant. It was recalled that the higher the  $\sim R$  rate, the more difficult it would be for the Island to reach 'herd immunity'. However, recently published evidence (from July 2021) had suggested that the rapid spread of Delta could be due, at least partly, to a shorter incubation period of between 3 and 4 days than the incubation period witnessed in its counterpart variants of concern, of between 5 and 6 days. The Cell noted that numerous factors were evident and had regard to a slide showing daily cases in Jersey since 1st June 2021, with mitigations, policy changes, and relevant external events included in the same. The Cell acknowledged that there were areas of high uncertainty around key parameters for modelling, which in turn led to uncertainty around any projections provided.

Possible factors contributing to the rapid increase in cases during July 2021, were considered to be the opening of schools until the end of the summer term (which translated as a high mixing of an unvaccinated cohort), relaxed social restrictions, the policy decision for direct contacts of positive cases not being required to isolate unless they themselves were tested as positive, and the shorter incubation period of the Delta variant, as discussed above.

In contrast, factors potentially contributing to an unexpected decline in cases during August 2021 (taking into account a two week time lag), had, it was thought, been due to schools closing for the term, the end of the Euro 2020 football

championships, the agreed delay in the Stage 7 reconnection strategy, personal mitigation factors such as the re-introduced use of masks, the increase of vaccine coverage, increased time spent outdoors and increased ventilation, the shorter incubation period of the Delta variant (meaning that those infected with COVID-19 were usually unwell for a shorter period of time) and the ‘export effect’ of Jersey residents travelling off-Island.

In summary, it was noted that any Autumn 2021 projections would have a high level of uncertainty attached to them, due to the lack of consensus amongst epidemiological experts and the demonstration that the model assumption for Summer 2021 had not played itself out as had been anticipated. It was noted that the output of research and modelling groups in the UK and further afield was being continually monitored, to ensure that the best evidence possible was incorporated. The Chair then invited comments and questions from the Cell regarding modelling scenarios and the contrast of such scenarios to the actual viral trends that had occurred.

Dr. G. Root opined that it was very important to look beyond the models provided and to review the plausibility of such epidemiological models in relation to Jersey. He recalled that the Cell had previously highlighted the peak caseload for Jersey, noting that this would be more than twice the volume of that modelled by teams in the UK. Dr. Root expressed the view that the Cell “needed to look at elsewhere, and see what was plausible”, based on the Cell’s experience, and to review other models that might be available.

Dr. I. Muscat MBE, Consultant in Communicable Disease Control, was of the view that previous models had indicated both hospitalisations and ICU admissions, and therefore an idea of the same had been outlined, but, on reflection, it was not clear from either the Scientific Pandemic Influenza Group on Modelling (‘SPI-M-O’) or local epidemiological models that the levels on infection that were apparent in Jersey would be evident as first modelled.

**COVID-19  
Strategy –  
Autumn 2021:  
Forwards and  
backwards  
contact  
tracing.**

A3. The Scientific and Technical Advisory Cell (‘The Cell’) received a presentation from C. Maffia, Strategic Lead for Contact Tracing, Monitoring and Enforcement, regarding forwards and backwards contact tracing.

Ms. Maffia explained that there had been a request from Ministers to review the value of backward contact tracing. The Cell recalled that, from September 2020, the Covid Safe (Contact Tracing) team had introduced ‘backward contract tracing’, in order to ascertain the activities of each positive individual over the previous ten days, in order to both identify Direct Contacts and to identify the source of the infection. This approach had assisted in identifying a number of COVID-19 ‘clusters’ and instances of community transmission, and had enabled a tactical approach to be taken, to reduce the risk of further onward transmission and to identify other possible positive individuals who had not been named as part of the initial contact tracing.

The Cell noted that, during July 2021, the Covid Safe team had been inundated with an unexpectedly high workload, due to an exponential increase in the number of positive COVID-19 cases. The team had therefore re-prioritised, to focus on telephoning positive cases and ensuring their isolation; the team had also paused backward contact tracing, instead identifying Direct Contacts during the previous three days. As demand had reduced during early August 2021, the team had returned to a more fully operational status.

It was noted that at least one Minister had recently requested that backward contact

tracing be reviewed and possibly removed in due course, and for the Covid Safe team to focus solely on forward contact tracing, which would encourage direct contacts of a positive individual to follow public health guidance during their infectious period. At the present time, there had been no requests to change the use of the Covid Application Trax.je, (a tracing App used on mobile telephones and other portable devices).

In order to present a number of options for consideration, Ms. Maffia set out the original and existing positions of Governments for whom backward contact tracing was included in the range of measures to reduce the risk of Covid. The paper presented also considered recommendations from the World Health Organisation (WHO), the European Centre for Disease Prevention and Control (ECDC) and Centres for Disease Control and Prevention (CDC).

The Cell was requested to review the use of backward contact tracing in the context of other jurisdictions. Views were sought as to whether the Covid Safe Team should continue with this approach or focus solely on forward contact tracing. The Cell recalled that in terms of existing and original practice, backward contact tracing had been agreed as the appropriate way forward in Autumn 2020. The principle of backward contact tracing was to identify 'who infected the infected.' It was noted that this approach assisted with reducing onward transmission, helped to reduce case numbers more swiftly and aided Government in reducing case numbers back to lower levels. The Covid Safe team had utilised this approach during the second wave of COVID-19, which found that case numbers had rapidly reduced after the initial surge. The Cell was further requested to consider the future for contact tracing mechanisms, in particular:

- Considering the current position and options arising therefrom;
- Identifying additional risks and benefits;
- Providing its views regarding a possible preferred option for contact tracing in Jersey.

The Cell noted that there were four options available for its consideration:

- (a) to continue the existing practice of forward and backward contact tracing in conjunction with the COVID-19 mobile application;
- (b) to cease backward contact tracing and focus solely on forward contact tracing and the COVID-19 application;
- (c) to cease people-based contact tracing and focus on App use only; and
- (d) to introduce a two-tier approach dependent on the vaccination status of the individual in conjunction with use of the App.

Following receipt of the presentation, the Cell was requested to consider the options available to it. The Cell sought Ms. Maffia's opinion in connexion with what the most appropriate option would be to follow and she explained her view that the backward contact tracing options had been extremely helpful previously.

J. Blazeby, Director General, Justice and Home Affairs Department, thanked Ms. Maffia for the report and update and noted the issues arising from ten days backward tracing and the subsequent change of time frame to five-day contact tracing. Dr. G. Root, Independent Advisor - Epidemiology and Public Health stated that the actual purpose of contact tracing had to be considered, and that the Cell needed to ensure that its response to COVID-19 remained proportionate.

Professor P. Bradley, Director of Public Health, commented that there was a need to understand the impact of the changes proposed and where transmission occurred in the community.

Professor Bradley pointed out that there was the possibility of another wave of COVID-19 infection and the population needed to be able to make choices and consider what the purpose of the tracing activity was. Dr. I. Muscat, MBE, Consultant in Communicable Disease Control, having asked if Ms. Maffia was aware of any jurisdictions where backwards tracing had been withdrawn, was advised that she had not found any such jurisdictions during her research, although Singapore was considering still performing contact tracing but not reporting the same on a daily basis. Dr. Muscat, MBE considered whether or not there would also be a fourth wave of the COVID-19 virus, but caveated this by reminding those present that booster vaccinations were soon to be put in place.

Ms. Maffia considered that the need to re-examine the extant contact tracing system was due to the need to move away from the ill-health associated with COVID-19 and to instead move towards business continuity.

Dr. Root advised that he was of the view that Jersey had one of the most advanced contact tracing systems in existence in the Western world and, from an epidemiological perspective, he noted that Jersey enjoyed high vaccination coverage, but acknowledged that it appeared that Delta was effective at being able to challenge the vaccinations system. That said, those who did become infected post-vaccination were usually largely mildly symptomatic or asymptomatic. Although Dr. Root was supportive of the option to scale back the extant system, he wished to consider how difficult it would be to scale up once again if there was a further variant of concern which was identified. The Director General, Justice and Home Affairs Department, expressed the view that this could be done. Ms. Maffia explained that a key element was retaining the skilled staff within the contact tracing team. For example, the team had previously been able to take on 40 staff members in a short period of time and there was then an intensive three-day training course, including shadowing experienced team members, but experience was always favourable and of course this needed to be established.

Dr. Muscat, MBE, enquired whether, given the relatively small numbers, those in authority would be able to flex the team as may be necessary. Ms. Maffia confirmed that this had been possible, with a mixture of fixed term and zero-hour contracts in place for numerous individuals and she advised that the team was still seeing quite high case numbers and agreed with Dr. Muscat, MBE that it was “sensible” to maintain a flexible team. Dr. Muscat, MBE asked whether it was a reasonable compromise to put contact tracing back to three days, rather than five or ten days, on the basis that COVID-19 usually incubated for three days. Ms. Maffia explained that the focus of the team was also upon events, this in conjunction with the testing policy. Dr. Muscat, MBE expressed the view that five days backward was more likely to capture the virus, describing it as “not an unreasonable halfway house” and he considered it could be seen as “over courageous” to stop contact tracing. Mr. P. Armstrong, MBE, Medical Director (Chair) confirmed that he felt he had heard the argument for maintaining the backward tracing and supporting team due to concerns about future variants potentially arising.

Dr. Root reminded those present of the need to bear in mind how long would be required should the need to scale up the Contact Tracing (‘CT’) team become apparent, should future variants of concern be identified, before such variants risked becoming seeded in Jersey. Ms. Maffia highlighted the rather high levels of attrition in the CT teams as individuals within those teams went on to secure other jobs in within the Government of Jersey. She also emphasised that the CT teams had been able to retain some excellent people, but they were usually only able to be retained on three-month contracts, or failing this, via zero-hours contracts.

The Chair summarised that the CT function and the backward tracing functions did

need to be maintained and that the Cell should, therefore, be advising Ministers accordingly. R. Sainsbury, Managing Director, Jersey General Hospital, expressed the view that additional oversight of this function was required beyond the Cell's viewpoint.

S. Petrie, Environmental Health Consultant, proposed that a review on what activities the CT teams undertook, and how they did this, would be appropriate. J. Blazeby, Director General, Justice and Home Affairs Department suggested that Ms. Maffia could therefore revert to the Competent Authority Ministers at their next meeting with a proposal that five-day backward testing was retained.

It was agreed that the CT teams needed to maintain their flexibility to scale up and down as required, and that it was not the appropriate time for such teams to be disbanded. Mr. Blazeby agreed that the CT team should not, and would not, be disbanded.

Testing  
Strategy  
Update

A4. The Scientific and Technical Advisory Cell ('The Cell') received a presentation prepared and delivered by J. Lynch, Principal Policy Officer, entitled 'Testing Strategy Update'. Mr. Lynch apprised the Cell that the need to re-consider the Island's extant testing strategy followed on from a shift in emphasis from the Government of Jersey's suppression strategy to a system of mitigation centred around the concept of Test, Trace and Isolate ('TTI').

It was recalled that the Government had, to date, pursued a robust COVID-19 strategy. Key features of the same had included a suppression strategy (as opposed to an elimination strategy) which had and continued to use non-pharmaceutical interventions (NPIs) including the use of face coverings.

Given the protection afforded by the successful COVID-19 vaccination programme and the move to a mitigation-led approach, the Cell was asked to advise upon the proposal to begin to reduce and simplify the testing programmes as outlined within the presentation, in order that a framework could begin to be developed, to enable an exit from the current testing strategy over the next six to nine months.

The Cell noted the following matters in connexion with proposed changes to the testing strategy:

- there would be an emphasis away from a mandated testing regime to one of personal responsibility and choice;
- it was intended that there would be reduced levels of intrusion through self-administration (of testing) and self-reporting;
- there would be a progressive risk-based deconstruction of the extensive PCR testing regime as part of the move from pandemic to endemic phases; and
- it was intended that there would be improved access to optional lateral flow testing ('LFT') for vigilance screening purposes.

The Cell further noted that there were currently four testing programmes in place within the Island, each covering active case control, safe places (such as care homes and residential homes), inbound travel and community testing functions.

Testing the exit framework was discussed, with the Cell noting that the withdrawal of testing was likely to commence with community testing, then safe places (protecting vulnerable and enclosed populations and preserving vital services), followed by inbound travel testing, and then finally phasing out active case control.

It was noted that the cost of Government-provided tests and the expense of same was a factor for this proposed approach.

It was explained to the Cell that proposed initial changes would take the form of a move to twice weekly lateral flow testing (LFT) (such testing to take place at home) for all secondary school students and staff working in educational and early years settings. It was further suggested that there would be a transition away from once or twice weekly PCR testing to twice weekly LFT at home for the majority of on-Island staff mitigation testing, and that this would be the case within both Safe Places and Community Testing programmes. Furthermore, an offer would be made of daily LFTs for ten days to all direct contacts of any COVID-19 positive cases, this being dependent on the supply and availability of such test packs.

I. Cope, Interim Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department, questioned the merits of using PCR tests, rather than lateral flow tests, when visiting vulnerable people in care homes. Concern was also expressed regarding how, and where, results of such testing would be recorded. Mr. Lynch confirmed that the “direction of travel” in terms of testing was towards that seen in the UK; either the collection or ordering of ten LF tests at one time. However, it was noted that, in care homes, for example, PCR tests were preferred by those working in that sector.

It was averred that the Government needed to move from a model based on vigilance to one based on surveillance. Dr. G. Root, Independent Advisor - Epidemiology and Public Health, expressed the view that the Government of Jersey needed to “mitigate the risk of tomorrow, rather than to mitigate the risk of today.” Dr. Root asked the Cell to consider how difficult it would be to scale up testing in the future, if necessary. Dr. Root further expressed the viewpoint that not many businesses would wish to keep testing for their staff due to the ability for such testing to interrupt business continuity. He also expressed his uncertainty of the rationale for retaining the testing of inbound travellers at the airport as it was, suggesting instead that it might be more sensible to take tests from a sample of travellers. However, this viewpoint was given with a caveat that, in the future, any testing regime might need to be increased once more.

C. Keir, Head of Media and Stakeholder Relations, opined that, taking into account both public interest and political considerations, it would be “very difficult” to remove testing at the airport and ports at the present time, as arguably this regime was what provided both incoming passengers and Jersey residents with the most reassurance. Mr. P. Armstrong, MBE, Medical Director (Chair) noted this viewpoint and confirmed that the Cell would repeat its advice to Competent Authority Ministers (‘CAM’) that the function of the Cell was to provide public health advice, rather than political guidance. Dr. I. Muscat, MBE, Consultant in Communicable Disease Control expressed the view that carrying on testing at the border would enable both the Cell and the Government of Jersey to maintain an oversight of any incoming COVID-19 variants of concern, as border tests were either sequenced or tested for genotypes. The Chair confirmed that the Cell supported the order in which the testing amendments were proposed. Mr. Lynch thanked those present for their feedback.



educational establishments safely.

The Cell noted the various proposals made in the presentation, including the proposal to provide all teaching staff with the opportunity to receive PCR testing prior to the start of the Autumn term, expanding the use of optional lateral flow devices (LFD) as part of the wider test, trace and isolate (TTI) strategy, and a less restrictive policy on isolation.

Core to the proposals would be CYPES maintaining the attendance policy that Direct Contacts of COVID-19 infected individuals should not attend education settings until they had received their own negative PCR test result.

Continuing existing mitigations known to protect education settings, such as children remaining in class-focused and/or year focused 'bubbles', mask wearing in communal areas of schools, as well as physical distancing measures, (with a view to relaxing such measures if rates in education settings over the Autumn term should this prove possible), were considered.

The Cell also considered supporting existing mitigations, such as the ventilation of classrooms and other school areas, as well as encouraging the vaccination of those working in education settings against both COVID-19 and influenza.

K. Posner, Head of Office, CYPES, advised the Cell that the Minister for Education had committed to reverting back to the public with appropriate proposals by Monday 23rd August 2021. The Cell's view was therefore sought, given that a large unvaccinated population would again be attending school on a daily basis. The Cell noted that extended cleaning regimes and control on visitors to school premises would continue to be applied. M. Rogers, Director General CYPES assured the Cell that the CYPES team was trying to do everything within reason to ensure that every child could attend school, every day.

Professor P. Bradley, Director of Public Health opined that the objectives had been well set out and that a key factor was the Cell's confidence in the measures proposed. The proposal was noted as a fairly cautious one and would require constant review. Professor Bradley considered it was important to consider what was happening epidemiologically, and also requested a suggested timeline of mitigations, so that the Cell could track progress against this.

Dr. G. Root, Independent Advisor - Epidemiology and Public Health opined that much of the proposed measures were "highly politicised, rather than scientific in nature." Dr. Root did not believe that schools were very different environments to those with any other high level of usage and daily occupation. It was questioned whether the risk to teachers, in all likelihood, was not that much higher than other occupations. Dr. Root urged the Cell and CYPES to be careful not to "ratchet up" the perception of risk against actual risk. The clear message to teachers, it was opined, was that if they wished to be fully protected as possible against the virus, then they should ensure that they were vaccinated. It was also agreed that as much ventilation as possible in school buildings was also preferable.

Dr. I. Muscat, MBE, Consultant in Communicable Disease Control agreed that it should be borne in mind that the vast majority of children would not be vaccinated at the present time. Teachers, parents and students needed to have confidence regarding their return to school in the Autumn term. Dr. Muscat. MBE reminded the Cell to bear in mind that there were approximately 15,000 school-aged children and therefore at least 30,000 parents and care givers to also take into account. Dr. Root countered that there could be further harm to children if their education was impacted in a negative way. He expressed the view that the way to keep the

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schools open was to ensure that parents were vaccinated. It was understood that a multi-dimensional approach would be preferable and that children, parents and teachers should be educated on the relatively low probability of infection.

Professor Bradley stated that such an approach would need to go beyond epidemiology and be considered from the perspective of behavioural science.

Mr. Posner confirmed to the Cell that the reason that protective 'bubbles' were due to remain in place in schools was to ensure that effective contact tracing could still be carried out. The Director General, CYPES acknowledged the importance of vaccination and the issues that could arise around staff regarding infection. Dr. Muscat, MBE warned those present that the risk of Delta variant rates rising this Winter would have to be understood and anticipated. Therefore, having in place the measures discussed above to assist schools in re-opening was important. Mr. P. Armstrong, MBE, Medical Director (Chair) concluded that it was necessary to keep the situation concerning the commencement of the Autumn term and ongoing precautionary measures under continuous review, but to reiterate that children were generally at a low risk of developing serious and lasting symptoms from COVID-19.

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