PLC

SCIENTIFIC AND TECHNICAL ADVISORY CELL

(92nd Meeting)

(Business conducted via Microsoft Teams)

8th March 2022

PART A (Non-Exempt)

All members were present with the exception of Professor P. Bradley, Director of Public Health (Chair) and M. Clarke, Head of Public Health Intelligence, Strategic Policy, Planning and Performance Department, from whom apologies had been received.

Dr. I. Muscat, MBE, Consultant in Communicable Disease Control (Acting Chair)
Dr. G. Root, Independent Advisor, Epidemiology and Public Health
S. Petrie, Environmental Health Consultant
A. Khaldi, Interim Director, Public Health Policy, Strategic Policy, Planning and Performance Department
Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department
A. Noon, Associate Medical Director for Primary Prevention and Intervention
I. Cope, Director of Statistics and Analytics, Strategic Policy, Planning and Performance Department
E. Baker, Head of Vaccination Programme, Strategic Policy, Planning and Performance Department

In attendance -

Dr. E. Klaber, General Practitioner, Primary Care Body representative
C. Landon, Health and Community Services (item A1 only)
J. Lynch, Policy Principal, Strategic Policy, Planning and Performance
S. Martin, Chief Executive Officer, Influence at Work
R. Williams, Director, Testing and Tracing, Strategic Policy, Planning and Performance Department
L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department
K. Posner, Director of Policy and Planning, Children, Young People, Education and Skills Department (for a time)
S. White, Head of Communications, Public Health
P. Le Conte, Secretariat Officer, States Greffe

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

Intelligence overview, including Analytical Cell update and HCS activity.

A1. The Scientific and Technical Advisory Cell ('the Cell'), with reference to Minute No. A2 of its meeting of 1st March 2022, received a PowerPoint presentation, entitled 'STAC Monitoring Update', dated 8th March 2022, and heard from Dr. L. Daniels, Senior Informatics Analyst, Strategic Policy, Planning and Performance Department in connexion therewith.

The Cell was apprised of the current situation with regards to public health monitoring, noting that as at 7th March 2022, there were 2,115 active cases of COVID-19 recorded in the Island. The majority of cases were in adults aged 30 to 39 years, followed by those aged 40 to 49 years and 50 to 59 years.

Seeking healthcare was the most common reason for testing, accounting for 1,094 cases; 861 had been identified following positive Lateral Flow Tests ('LFTs'); and the remainder through various screening programmes. The age ranges, gender and vaccination status of the active cases were shown, with a further breakdown by age for active cases in those aged 18 and under.

Subsequent to changes in the testing approach, the number of daily PCR tests being undertaken had increased but was still fewer than 1,000 with actively seeking healthcare and workforce screening the main groups. An average of 280 cases per day had been identified over the previous 2 weeks. Having dropped to around 220 per day in February the numbers had returned to the levels experienced throughout January. The overall test positivity rate (measured as a 7-day rolling average) had increased to 45 per cent. It was recalled that the relatively high-test positivity rate was due in part to people coming forward for testing following a positive LFT result.

The 7-day case rate per 100,000 population had risen slightly with all age groups now aligned at a similar level. Those aged under 18 years were now the lowest group, whilst the rate for those aged over 60 years was now the highest, reflective of the situation in the hospital and care homes where high numbers were being reported.

The Cell reviewed the clinical status of cases in hospital since 28th June 2021 and noted that as at 7th March 2022, there were 49 patients in the Hospital.

Details were provided of the positive cases linked to schools, which had seen a gradual decrease over the course of February 2022. A total of 401 students and 83 staff had been reported with Covid in the last 10 days, which was lower than January but still significant.

A further 3 deaths had been recorded, bringing the total to 115, with 37 registered since the start of the 4th wave on 1st October 2021. It was noted that this was comparable to the second wave the previous Winter when 37 deaths had also been recorded. Further detail in the difference in recorded mortality trend between different waves was noted. In waves one and two a large spike in infections was matched by a corresponding spike in deaths. The current wave 4 was characterised by stubbornly high prevalence over a long period of time while the number of deaths climbed more gradually, suggesting a different pattern of mortality.

During the week ending 6th March 2022, Jersey's testing rate, per 100,000 population, had been 4,500, compared to the United Kingdom ('UK') rate of 6,950, which included LFTs. The test positivity rate locally was 38 per cent compared to 5 per cent in the UK.

The Cell noted that 385 patients were currently recorded in the EMIS clinical IT system as suffering from 'Long Covid'. Women aged 40 to 49 years continued to be most affected. 19 patients had attended the newly established Long COVID clinic at the Hospital, and a further 76 patients had been referred.

The Cell was apprised of the results of social media sentiment analysis, noting general themes that included questioning why COVID-19 cases were increasing in the General Hospital and what the Government was doing to reduce those numbers. There was also reference to why the Government continued to post daily COVID-

19 updates when it was now 'just like a cold or flu'. The Chair questioned whether those 2 viewpoints were not diametrically opposed. The Cell was informed that they reflected a split in the community between those who were still concerned about COVID-19 and those who just wanted to live with it and move forward.

Details regarding the COVID-19 vaccine programme were shared and it was noted that as at 27th February 2022, 222,371 doses had been administered, of which 60,791 were third 'booster' doses, with high rates of coverage in older age groups and a slowing down in uptake rates across younger, eligible populations.

The Cell was informed that 10 episodes of flu-like illness had been reported in primary care during the week ending 6th March 2022. Overall, levels of flu-like illness were similar to those seen during the 2020/21 Winter season and significantly lower than in previous Winter seasons.

The Cell was apprised of the situation in the UK, noting that over the 7 days to 7th March 2022 (1st March 2022 for hospitalisation figures), cases had increased by 28.2 per cent, hospitalisations by 1.6 per cent and deaths had fallen by 5.5 per cent.

A graphical comparison of 14-day case rates per 100,000 population showed that Jersey's rate had increased to 2,978, and remained higher than that of Scotland (1,766), Northern Ireland (1,655), England (668) and Wales (336), though it was noted that this may be explained in part by Jersey's relatively high testing rate compared to those jurisdictions. The strong regional differences were noted with Scotland displaying a clear upward trend in the number of patients admitted to hospital at the moment, which would be monitored. The Cell was informed that 14-day case rates remained high across Europe.

The Cell was provided with an update on Hospital capacity, which confirmed that green status was being maintained with safe levels of staffing and care. On the day of the extant meeting there were 44 COVID-19 inpatients, mostly in the General Hospital but none in the ICU. There were 34 available beds and the hospital was at 83 per cent capacity. The challenge of patients who were medically fit for discharge but had nowhere to be discharged to continued and had been a contributory factor in the numbers climbing to 49. There were 62 Health and Community Services staff members with COVID-19 and 9 elective procedures had been rescheduled last week with a further 8 this week. Patients were being given new dates. Following Infection Prevention and Control ('IPAC') advice was inhibiting the ability to turnover beds due to the reluctance of care homes to accept patients still testing positive for COVID-19. It was a challenge to accommodate patients coming to the hospital for elective surgeries. There were 7 care homes closed due to the presence of COVID-19 cases.

A Cell member added that although COVID-19 was a large part of the infection control challenge, there was also norovirus and C. Difficile to consider. He also enquired whether there was any way of taking the data from the fourth wave and disassociating the Delta component from the Omicron and attributing the relative numbers to them both. In response, it was noted that with the exception of mortality and severe disease, the genomic sequencing was limited but officers undertook to consider what information could be made available.

Another Cell member questioned what support could be offered to the Hospital and care sector. He recalled how the Cell had discussed the concept of de-escalation for the general public and the various arms of Government. Whilst the policy and strategy set by the Competent Authority Ministers was nuanced and the removal of legal restrictions was the right decision, people had heard the de-escalation message but not necessarily heard and understood the caveat that it was still necessary to

protect Health, the care sector and schools in particular. The result had been the spiking cases in Hospital and some visitors behaving obstructively in terms of the refusal to wear masks. For everyone engaged in Hospital or care homes the continued use of Personal Protective Equipment ('PPE') and Lateral Flow Tests ('LFT') was appropriate. He queried to what extent the de-escalation announcements in Jersey and also the UK could explain what was happening. He also asked what the source of infection had been in the Hospital. Levels of clinical COVID-19 were still manageable, but seemed high by Jersey standards over the course of the pandemic and this needed to be monitored. He added that the process of clarification of public health policy in terms of discharge with COVID-19 had been complicated, but accepted by representatives of the care sector. A fit for discharge cohort of 49 seemed quite large and it was suggested that efforts with the media needed to be redoubled.

Another Cell member suggested that it could soon be necessary to give consideration to how Omicron was managed in terms of infection control measures. The approach could possibly follow that taken with influenza and then it could be examined as to whether management within the hospital and care homes was proportionate to the risks. He also questioned whether wave 4 could be divided into 3 phases, the first Delta, the second a mixture of Delta and Omicron and the third/current Omicron. He added that taking the 14-day case rates and making comparisons could be very misleading given the role of LFTs and who was being tested. He was not convinced of the usefulness of the reports which could give the wrong impression.

There was a discussion in relation to the COVID-19 mortality rate and whether more people were dying in a year than would have been expected from influenza. It was estimated that during the 5 years prior to the COVID-19 pandemic there had been between 15 and 30 influenza deaths but this was an estimate due to the lack of testing for influenza. The number of deaths from COVID-19 was expected to exceed that normal annual level even with the vaccination. It was also stated that patients who died in the community or care homes from respiratory illness would not have been tested for influenza and their death certificates would not mention influenza which meant it was difficult to compare the data. A member of the Cell suggested that he was of the impression that in Jersey and globally, influenza rates were estimated based on excessive cardio-respiratory deaths during influenza season. Many occurred some considerable time after influenza had been acquired and even if a PCR test was undertaken the virus would not be found. It was suggested that a check was made on how influenza death rates were calculated due to the limitations of testing, not just in terms of availability but also when they were applied.

In summary, the Acting Chair suggested that the statistics indicated an increase in infection numbers and a shift in the age groups with predominantly the older adults being affected more than children. That was a move in the wrong direction in terms of potential severity, but they were the cohorts with the highest vaccination rates. The de-escalation message needed to be revisited with the appropriate caveat emphasizing de-escalation in a measured fashion while protecting vulnerable individuals and patients through a number of appropriate methodologies such as infection control precautions and the need to acknowledge that the testing system was different to the UK so the numbers were not comparable. However, the number of cases per 100,000 population over a 14-day period revealed an interesting uptick for Jersey while the trajectory for the other devolved nations was downwards or at worst had plateaued. It was acknowledged that part of the burden on the hospital was the difficulty in discharging back to the community for a variety of reasons, one that had not been mentioned earlier was that care homes were partly governed by having to act within the parameters defined by insurance companies.

The Cell noted the position and thanked Dr. Daniels for the update.

Asymptomatic Testing.

A2. The Scientific and Technical Advisory Cell ('the Cell'), noted a report entitled 'Asymptomatic Testing Beyond De-Escalation' compiled by the Public Health: COVID-19 Response Team and heard from Dr. C. Newman, Principal Policy Officer, Strategic Policy, Planning and Performance Department, in connexion therewith.

The Cell was informed that there had not yet been a sustained decline in cases, case rates remained significantly high in the general population, including prevalence in the Under-18s. The majority of cases in schools were asymptomatic, while it was estimated that more than half of cases had been identified by the use of Lateral Flow Tests ('LFTs') with most children reporting 2 to 3 symptoms. Although it was difficult to formally assess the uptake and compliance, there was some suggestion of ongoing use of LFTs based on registration numbers for the schools' testing programme. There was no evidence that the use of LFTs was causing any additional harm – the vast majority of staff and student cases identified by LFTs were symptomatic and likely to require time off school as they were unwell.

The policy proposal was:

1. To continue to recommend the current testing regimes until at least 31st March 2022, including pre-attendance daily testing for those attending Early Years and Educational Settings;

2. For a reduction in testing frequency to take place after 31st March 2021, provided there had been a sustained decline in cases, indicating a drop in overall prevalence. Should there be a marked reduction in cases in those aged 18 years or under, before an overall reduction in population prevalence, consideration could be given to a decrease in asymptomatic testing for this group alone (likely to twice per week initially);

3. That any reduction in testing regimes should also consider the rates of hospitalisation (especially in children), numbers of Long COVID cases, vaccination uptake rates, and the timing of the introduction of vaccination for children under 12 years; and,

4. To develop an understanding of staff and student views on testing by working with colleagues in CYPES to make best use of forums already established.

Cell members were asked to consider and advise on the proposed approach to the use of asymptomatic testing beyond the de-escalation phase, with a particular focus on the testing of those aged 18 years and under. It was suggested that testing for Under-18s and more generally, including health and care settings, should be discussed separately.

A Cell member opined that he would have expected Omicron to have gone through the whole school population by now. He suggested that if the majority of school aged children were taking daily pre-attendance LFTs he would have expected far more positive cases. The fact that the majority of cases were symptomatic suggested people were using LFTs when a child developed one or more symptoms and they thought it may be COVID-19. Rather than continue with mass asymptomatic testing of the school population on a daily basis, a policy change should be recommended to test students who were symptomatic. He added that, anecdotally, he believed that parents and students had already shifted in that direction and were not testing daily and the policy needed to catch up with that rather than continue in its present form. Another member stated that it should be possible to establish how many people had

registered for LFT kits, but he agreed that many of the population had decided to take LFT tests if they had a cough or a cold and felt unwell.

The views on testing would be explored with colleagues in Children, Young People, Education and Skills to make the best use of forums already established. The thrust of the report was such that, with the consent of schools and headteachers, the consensus was to move to less regular LFTs once case rates had decreased sufficiently. Given what had happened elsewhere in response to de-escalation, it was important to keep infection out of schools due to the uncertainty in relation to natural immunity. He proposed airing on the side of caution and keeping the current regime in place and once the general prevalence had dropped the Island would be in a better position to reduce the guidance to testing twice a week. Once the infection spread through the population of children it would then spread among the older age categories and while mortality was low as a percentage of overall numbers it was preferable to remove such measures when in a stronger position of lower prevalence, which it was hoped would be seen over the next few months.

A Cell observer questioned whether people should be encouraged to think about the set of symptoms and the guidance to take themselves out of an environment where they could be sharing an illness with someone else. COVID-19 would not just disappear, with similar waves likely in future. At some stage the population needed to behave appropriately in response to the symptoms they were experiencing. If a patient tested negative for COVID-19 it did not necessarily mean they should carry on as normal, this was taking the responsibility away from patients when they had an illness.

The Cell was reminded that schools had agreed to introduce High Efficiency Particulate Air ('HEPA') filters which it was hoped would help remove transmission of respiratory viruses. It was suggested that this could be factored into the decision-making in relation to changing the LFT recommendation in schools. A representative of CYPES confirmed that the department had taken delivery of the units and that they were being distributed on a risk basis. He also suggested that further discussions would be held and that a stepped approach was preferable with testing retained as de-escalation continued towards the Easter Holidays with change to be instigated for the Summer Term.

A Cell member commented that it was necessary to get to the point where people were behaving responsibly and when symptomatic they took the appropriate steps. There was a risk of losing the audience with a mass screening programme for all school-aged children, which probably very few parents were adhering to unless they were symptomatic. There was a danger of the population not engaging with a public health policy. After March this testing should reduce to twice per week otherwise it reduced the credibility of the overall approach Jersey was taking.

The valid points that had been made were acknowledged and it was noted that it was only 3 weeks until the end of March and there was some flexibility about when the reduction to 2 LFTs per week could begin. Concern was expressed that if the reduction was introduced at an earlier date it would be another message about not testing when some people were already failing to adhere to the recommendation to continue to take an LFT test before visiting the hospital.

A Cell member expressed concern at the possible conflicting message of the removal of mandatory isolation (Minute No. A3 of this meeting refers) while still asking some people to take LFT tests if symptomatic or asymptomatic and if positive then take a PCR test. If the latter was positive then it would only result in a recommendation to isolate, which he felt caused a tension that was difficult to reconcile.

In summary, the Acting Chair noted that the Cell was in agreement that a controlled and measured de-escalation was the sensible way forward. The general philosophy required the protection of vulnerable individuals and places and the general view, although not unanimous in every detail, was that the change in LFT testing in schools was dependent on the prevalence and an estimate of immunity. It was difficult to give clear direction to people other than to continue using LFTs and as time progressed decide whether to decrease the overall frequency of LFTs or target those who were symptomatic. This decision could be taken according to prevalence and an estimate of immunity and the measured effects of any other interventions that may have been taken.

The Cell noted the position and thanked Dr. Newman for the update.

Suspension of mandatory isolation.

A3. The Scientific and Technical Advisory Cell ('the Cell'), noted a report entitled 'Confirmed COVID-19 Cases – End of Mandatory Isolation Requirement', prepared by the Principal Policy Officer, Public Health, and heard from Mr. J. Lynch, Policy Principal, Strategic Policy, Planning and Performance in connexion therewith.

The Cell was reminded that within the range of de-escalation measures announced on 28th January 2022, Competent Authority Ministers approved the removal of the legal requirement to isolate following a positive PCR test by the 31st March 2022. That was the last remaining enforceable legal requirement under the COVID-19 restrictions. This was in step with many comparable jurisdictions. England removed the requirement on 27th February 2022, Guernsey on 17th February and both Wales and the Isle of Man had signalled the removal on 31st March 2022. In all cases, legal requirements would or had been replaced with strong guidance recommending positive cases continued to isolate for varying periods of time in the interests of reducing onward transmission.

STAC members were asked to consider and advise on:

- The proposed approach for positive cases following the end of the mandatory isolation requirement; and,

- The risk associated with the timing of a change from mandatory to strongly recommended arrangements should prevalence of COVID-19 continue to be high at the time of any such change.

Mr. Lynch mentioned the messaging and communications so that the population continued to take the right precautions once the legal lever had been removed. The removal of the legal requirement to isolate would increase the importance of resourcing to ensure people had the best opportunity to follow guidance and isolate. The proposal was that support measures were framed within a 3-point approach:

1. Information provision: The COVID-19 helpline would remain active as a point of contact for isolating people, as would the COVID Safe Team, whose role would move from compliance monitoring to support. Direct written communication with positive cases would continue for the immediate future, providing information on support available, isolation periods and emergency/medical support;

2. Practical and Psychological Support: The ConnectMe service would remain active offering practical support to positive cases and onward referral to specialist services. Again, the Helpline and Covid Safe Team would continue to act as an available point of contact for referral to support.

3. Financial Support: The Government had consistently provided financial support to those unable to work due to mandatory isolation requirements; the importance of maintaining that support (whether directly from government or through employers) would remain within a non-mandated arrangement.

There would be no change to stay at home recommendations, with the exception of a proposed simplification of the release point after isolation regardless of vaccination status. This would apply the pre-existing arrangements for fully vaccinated individuals to all cases and bring Jersey in line with the English Government approach to non-mandatory guidance. Some organisations or employers could choose to apply enhanced or more stringent requirements under their own operational policies, in particular within Health and Care settings. Consideration would be given to an enhanced return to work after a positive test policy and enhanced requirements for visitors following a positive test. The proposal was that schools and early years settings fell under standard guidance. Under Children, Young People, Education and Skills ('CYPES') department policy children would be able to return to school once they had completed the recommended isolation policy.

A Cell member suggested that it was extremely challenging to get people to adhere to a policy when it became strongly recommended rather than mandatory, he believed that people who were symptomatic would isolate until they started to feel better. He queried whether there was any way of simplifying the recommendations still further. A Cell observer stated that it was important to meet the challenge of maintaining good levels of adherence when the law fell away.

Another Cell observer questioned what the evidence base was for taking LFTs after 5 days in regard to release from isolation, whether any work had been carried out in regards to symptoms as he was beginning to see the behaviour described by the previous member among some patients. He agreed that if patients were asked to do something realistic they would comply, but if the recommendation was too obstructive or ambitious it could be fully dropped. It was important to find an acceptable compromise.

The presenter of the report responded that the evidence base offered strong confidence that multiple LFTs and the symptom check formula worked best, but the symptomatic check plus 2 LFTs gave a strong level of confidence. The natural progression to the normalisation of arrangements, particularly when testing had fallen away, was a challenge being faced by UK colleagues and it was known that 2 negative LFTs 24 hours apart plus no symptoms was a good indicator to return to normal levels of activity.

Another Cell observer made the analogy with patients on antibiotics who were told to complete the course but stopped after several days when they felt better even when it was stressed that it was important not just for the individual but for society as a whole to complete the course. He also reiterated the importance of ensuring financial support remained in place for employees who completed the recommended isolation period.

A Cell member accepted the antibiotics comparison, but stressed that just because the population was acting in a particular manner, steps should not necessarily be taken to legitimise that behaviour. The public had the right to the correct information and advice and should be urged to pay attention to and follow those recommendations. It was important not to give legitimacy to ignoring the advice if they were feeling well after 3 days. Another Cell member countered that the issue was that the evidence was not clear cut. The graph of infectiousness was a curve of

continuous decline and it was a question of at what point to draw the line for the acceptable level of risk. This decision was described as grey rather than black and white. Individuals with COVID-19 were most infectious prior to being symptomatic and in the first few days thereafter. Beyond that it was not clear cut. It was important that the guidance given was adhered to and that if it was based around symptoms that may be more likely, which could have a greater public health impact.

A Cell observer returned to the antibiotics analogy and suggested that from a prescribing point of view it was sometimes beneficial to offer the second-best option, for example a course of 2 tablets daily rather than the optimum 5 tablets a day, in order to increase the chances of the medication regimen being completed. Patients were more likely to adhere to reasonable steps rather than if too much was asked of them. Another observer stated that the communication of the removal of mandatory isolation was important as there was a risk of unintended consequences in terms of behaviour. Once the legal requirement was removed the main element to emphasise was that it was the socially appropriate behaviour to continue to isolate and that support remained in place to assist people in doing the right thing.

Another member stated that the discussion had been useful but highly speculative. He suggested it was the role of the Cell to review data and evidence to reach consensus if possible. There was a risk of forgetting that 5 days plus 2 negative LFTs was already a significant compromise position borne out of the wider politics of COVID-19. Scientists had stated that a 10-day period in isolation was appropriate and the 5 days plus 2 negative LFTs was acceptable. It was the right conversation at the wrong time in the context of the residual high rates of COVID-19 infection and alarming levels in the General Hospital and now was not the right time to take what would be almost a speculative decision on a radical new position. The member supported the guidance as set out in the report but if the infection rates remained stubbornly high at the end of March or continued even longer his view may have been different.

Another Cell member suggested that it was necessary to utilise data and evidence to indicate what a step down position from 5 days plus 2 negative LFT tests 24 hours apart would look like against the additional risk it could pose. Until consensus was reached on that, and a report should be brought in relatively short order, the default position as outlined in the report by Mr. Lynch should be adopted. There was clearly an appetite to consider what the next stage would involve and evidence needed to be applied to that decision rather than seeking consensus based on feeling and intuition. It was proposed to bring a report back on the infection levels of Omicron at different stages and that piece of work would inform a different position to be adopted in due course.

Mr. Lynch explained that the balance of risk had seen day 10 chosen over the enhanced guidance of 11 to 14 days in isolation. The position now arrived at was considered proportional as it combined the best known combination of minimum isolation at the front end with symptom checking and multiple LFTs. He added that the overarching principle for de-escalation was a clear evidence base and information to make decisions and that was the guidance public health should be providing. It was that information which had informed the policy position. He added that the future approach should be tied to LFT provision which would have to be watched closely.

In summary, the Acting Chair suggested that COVID-19 infection remained high in Jersey, although the disease itself was significantly less virulent. The Cell supported continued LFT usage to reduce the absolute number of cases in circulation as part of the measured de-escalation strategy. The universal release time from isolation for those who had received a positive PCR test had been discussed at the extant meeting

and at 5 days was the same as the previous period for the fully vaccinated (it had previously been 7 days for the unvaccinated). This was to be followed by 2 negative LFT tests 24 hours apart based on the majority reduction in infectivity from the PCR positive date based on published studies and LFTs as the measure of infectivity. Once LFT negative, even though there would still be some infection in the respiratory tract the levels were not considered an infection risk. A question about the compromise of taking an LFT on day 5 or whether it was preferable to start taking LFTs when asymptomatic or symptoms had reduced significantly was a difficult call as there was a lack of evidence of a significant overall reduction of infectiousness if symptoms had reduced on day 3 compared to taking an LFT on day 5. There had been a theme across STAC meetings of concern that the de-escalation was rushed. A time-driven and symptom-driven clearance from recommended isolation was appropriate and as the number of infections decreased the move could be made to a symptom-driven release. Whilst not unanimous agreement, the majority view was to adopt the proposed recommendation for time-based release from isolation initially with more work to be undertaken as the Island moved towards a different approach, to be decided under the measured philosophy of de-escalation. He added that it was reasonable to remember the uptick in infection rates which had an effect on people despite the reduction in severe disease. Some people were unwell and unable to work and if infectious could transmit COVID-19 and that would contribute towards absolute numbers remaining high. Despite severe disease and mortality being low compared to what had been seen previously, the overall numbers could not be dismissed.

The Cell noted the position and thanked Mr. Lynch for the update.

Vaccine update.

A4. The Scientific and Technical Advisory Cell ('the Cell') with reference to Minute No. A6 of its meeting of 1st March 2022, received a presentation, dated 3rd March 2022, entitled 'Vaccination Coverage by Priority Groups', which had been prepared by Ms. E. Baker, Head of Vaccination Programme, Strategic Policy, Planning and Performance Department and heard from her in connexion therewith.

The Cell noted that Evergreen Over-18s continued to attend for primary doses while the uptake among 12 to 17 year olds had improved. The programme to revisit the schools had been due to be completed at the end of the week of the meeting, but several had requested the visit be rescheduled. A debrief was planned upon completion of the programme. An 'Ask the Expert' event had been held dealing with questions from young people. There had been a 33 per cent uptake among the 'At Risk' 5 to 11 cohort which was in line with other jurisdictions. Plans were being made to deliver the second doses. Discussions were in progress with the Children's Commissioner and communications team prior to the roll out of the Universal 5 to 11 cohort programme. The Spring Booster (fourth dose) for Over 75s and the Over 12 immunosuppressed was due to commence at the end of the week of the extant meeting.

In response to a question from the Acting Chair about the sentiment surrounding vaccination, Ms. S. White, Head of Communications, Public Health, responded that there had been little posted as current promotional activity was focused on attracting walk-ins. She explained that this was likely to change when the Spring Booster announcement was published on Thursday 10th March 2022. In general, those commenting had been supportive of vaccination although the sentiment throughout the previous 2 months suggested people were getting vaccinated when they felt they needed to and not when their next vaccination was due.

The Spring Booster campaign was scheduled to begin on Tuesday 15th March 2022 with the Universal 5 to 11 programme coinciding with the start of the school Easter Holidays. Plans for publicity for the latter would be developed after the launch of

the former. The Acting Chair expressed the view that it would be preferable to delay the promotion of the Universal 5 to 11 programme for as long as possible to allow the focus to be on the Spring Booster. This was to avoid any confusion and possible negative sentiment after the announcement of the Universal 5 to 11 vaccinations having an impact on the Spring Booster programme.

There being no further business to discuss, the meeting was concluded at 3.50pm.