

Moving Forward

# The Bailiwick Blueprint



States of Guernsey  
Public Health Services

[gov.gg/coronavirus](https://www.gov.gg/coronavirus)



## Background?

As we move towards a Bailiwick that is living with COVID-19 as an endemic,<sup>1</sup> rather than a pandemic<sup>2</sup> virus, we need to consider what is required to balance the specific risk of infection with SARS-CoV-2, or a variant of this virus, with the broader considerations of the restrictions imposed during the pandemic on the wider health and wellbeing of Bailiwick residents. This includes the economic impact of the Pandemic, as well as the curtailment of the freedoms of islanders.

Of note to date is:

- ▶ Public health and social measures have been critical in limiting the transmission of COVID-19 in the Bailiwick and have reduced deaths associated with infection with this virus;
- ▶ The decision to adapt or lift these measures have been based on the local situational assessment relating to local transmission of the virus, the risk of imported infections and the capacity of the healthcare system to respond;
- ▶ The effect of public health and other measures on the general welfare of society and individuals have been considered as part of the Bailiwick's approach to the COVID-19 pandemic.

Assessing the level of transmission is key to assessing the overall COVID-19 situation and has therefore been central in guiding essential decisions to tailor control measures for the Bailiwick. Also important are categories of transmission. Table 1 illustrates the World Health Organisation (WHO) definitions for categories of transmission.<sup>3</sup> Consideration of these categories is central to the development of this Bailiwick Blueprint.

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<sup>1</sup> Endemic: An endemic disease may be found among particular people or in a certain area. Endemic diseases are not always present at high levels. They can be relatively rare.

<sup>2</sup> Pandemic: A pandemic is defined as "an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people.

<sup>3</sup> [https://apps.who.int/iris/bitstream/handle/10665/336374/WHO-2019-nCoV-Adjusting\\_PH\\_measures-2020.2](https://apps.who.int/iris/bitstream/handle/10665/336374/WHO-2019-nCoV-Adjusting_PH_measures-2020.2). [Accessed 4th March 2021]

Table 1: Definitions of categories of transmission

Definition of categories for transmission classification: <i>category name</i>	Definition Countries/territories/areas with:
No (active) cases	No new cases detected for at least 28 days (two times the maximum incubation period), in the presence of a robust surveillance system. This implies a near-zero risk of infection for the general population
Imported / Sporadic cases	Cases detected in the past 14 days are all imported or are all linked to imported/sporadic cases, and there are no clear signals of further locally acquired transmission. This implies minimal risk of infection for the general population
Clusters of cases	Cases detected in the past 14 days are predominantly limited to well-defined clusters that are not directly linked to imported cases, but which are all linked by time, geographic location <b>and</b> common exposures. It is assumed that there are a number of unidentified cases in the area. This implies a low risk of infection to others in the wider community if exposure to these clusters is avoided

The WHO recommends that when lifting public health measures, the capacity of the system to rapidly respond to any new increase in cases should be considered. The following should be in place:



Adequate health system capacity to detect, test and manage new cases.



Measures to minimise the risk of outbreaks in settings with vulnerable individuals. This requires identifying all major drivers of COVID-19 transmission (e.g. various types of closed settings) in the local context, with appropriate measures in place to maximise social distancing and minimise the risk of new outbreaks. Measures must be in place to reduce the risk of hospital transmission and outbreaks in settings such as care homes.

When developing this Bailiwick Blueprint, consideration has been specifically given to the WHO definitions of transmission scenarios.<sup>4</sup> These have a focus on both imported cases and Community Transmission (CT) and include:

- ▶ No (active) cases;
- ▶ Imported / Sporadic cases;
- ▶ Clusters of cases;
  - » CT1: Low incidence of locally acquired widely dispersed cases detected in the past 14 days ;
  - » CT2: Moderate incidence of locally acquired widely dispersed cases detected in the past 14 days;
  - » CT3: High incidence of locally acquired widely dispersed cases in the past 14 days;
  - » CT4: Very high incidence of locally acquired widely dispersed cases in the past 14 days.

Table 2 defines the parameters for levels of community transmission.

Table 2: Levels of Community transmission<sup>5</sup>

Category name	Definition Countries/territories/areas with:
Community transmission - level 1 (CT1)	Low incidence of locally acquired, widely dispersed cases detected in the past 14 days, with many of the cases not linked to specific clusters; transmission may be focused in certain population sub-groups. Low risk of infection for the general population.
Community transmission - level 2 (CT2)	Moderate incidence of locally acquired, widely dispersed cases detected in the past 14 days; transmission less focused in certain population sub-groups. Moderate risk of infection for the general population.
Community transmission - level 3 (CT3)	High incidence of locally acquired, widely dispersed cases in the past 14 days; transmission widespread and not focused in population sub-groups. High risk of infection for the general population.
Community transmission - level 4 (CT4)	Very high incidence of locally acquired, widely dispersed cases in the past 14 days. Very high risk of infection for the general population

<sup>4</sup> [https://apps.who.int/iris/bitstream/handle/10665/336374/WHO-2019-nCoV-Adjusting\\_PH\\_measures-2020](https://apps.who.int/iris/bitstream/handle/10665/336374/WHO-2019-nCoV-Adjusting_PH_measures-2020). [Accessed 2nd March 2021].

<sup>5</sup> [https://apps.who.int/iris/bitstream/handle/10665/336374/WHO-2019-nCoV-Adjusting\\_PH\\_measures-2020](https://apps.who.int/iris/bitstream/handle/10665/336374/WHO-2019-nCoV-Adjusting_PH_measures-2020). [Accessed 2nd March 2021].

Table 3: Adapted from the WHO Guidance on the implementation of Public Health Measures for Situational Level 0<sup>6</sup>

Situational Level 0	Considerations for implementation of PHSM by Situational Level
<p>No known transmission of SARS-CoV-2 in the preceding 28 days. The health system and public health authorities are ready to respond, but there should be no restrictions on daily activities</p>	<p>At this level, the Bailiwick Surveillance Programme should ensure that any new case can be detected and managed as early as possible, but there should be no restrictions on daily activities. Authorities may consider implementing the following measures:</p> <ul style="list-style-type: none"> <li>▶ Continue strengthening COVID-19 preparedness and response, ensuring adequate stockpiles of medicines and medical equipment and that sufficient staff have been recruited and trained to handle anticipated surges in workload.</li> <li>▶ Individuals should apply basic individual precautionary measures and behaviours such as hand hygiene, cough etiquette, staying home / wearing a mask if unwell and voluntary physical distancing.</li> <li>▶ Robust surveillance should be in place to rapidly detect and investigate suspected cases and clusters and ensure public health measures such as isolation and quarantine are undertaken to reduce onward spread if cases are confirmed and contacts are traced.</li> <li>▶ Travel outside the area should be permitted with adherence to border restrictions based on the prevalence of infection in neighbouring jurisdictions. <ul style="list-style-type: none"> <li>• Clear information should be provided to the public about what to do if unwell and whom to contact for advice, testing and/or treatment.</li> <li>• Roll out of the vaccination programme to Priority Groups 1 – 9, as outlined by JCVI should be well-established.</li> </ul> </li> </ul>

<sup>6</sup> [https://apps.who.int/iris/bitstream/handle/10665/336374/WHO-2019-nCoV-Adjusting\\_PH\\_measures-2020](https://apps.who.int/iris/bitstream/handle/10665/336374/WHO-2019-nCoV-Adjusting_PH_measures-2020). [Accessed 2nd June 2021].



# The Bailiwick Context

As we progress from Stage 1 to 3, the most favourable measure from a virological point of view will be elimination. This is because our population will not yet be fully immunised by the proposed date of entry into Stage 3 on 22nd March 2021. Elimination is defined as 28 days with no new community cases of SARS-CoV-2 infection; virus free days in Stage 1 will count toward this. However, elimination is not a prerequisite for progression into Stage 3. Specifically, the required release trigger for progression between Stage 2 and Stage 3 in terms of cases is:



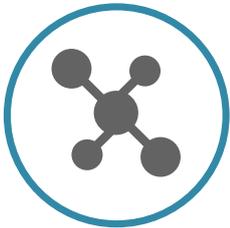
No concerning new cases (cases where the source of infection cannot be found, either through contact tracing or source tracing; or a case that has the potential to cause a super-spreading event) of unexplained community transmission for at least 14 days between Stages 2 and 3.

If we are still seeing cases of COVID-19, but are able to control these through our Test, Trace and Isolate Programme, we will be able to progress to Stage 3, but will be doing this in the face of viral suppression, rather than viral elimination.

Important here is that, at the time of writing (9th March 2021), the most vulnerable in our community have already been vaccinated against COVID-19. The protective efficacy of this vaccination programme, in terms of reducing both morbidity and mortality was seen during the second wave of infection, starting on 22nd January, 2021. For this reason, whilst elimination is preferable for progression into Stage 3, suppression is acceptable.

However, a specific concern relates to the size and gatherings, both indoors and outdoors, particularly in relation to a possible 'superspreading' event. For Stage 3, gatherings of over 100 people will be allowed, but only subject to a specific risk-assessment of the facilities and measures to prevent viral spreading. A record of people attending the event must also be kept.

As we progress beyond Stage 3 and remove or reduce border restrictions there needs to be an acceptance that SARS-CoV-2 is likely to become endemic. This will align with the completion of our vaccination programme. At this point in time the focus will switch to detecting Variants of Concern that either have enhanced morbidity and mortality or reduced vaccine sensitivity, or both.



## Key Inter-Dependencies

The Bailiwick Blueprint does not consider the exit from lockdown in a singular fashion. The key dependencies are illustrated in Figure 1.

Figure 1: Exit from Lockdown: Key Inter-dependencies





# Border Controls

The Bailiwick border controls are twofold. These include:

- ▶ Travel restrictions into the Bailiwick; and,
- ▶ Border restrictions on arrival into the Bailiwick, including a programme of testing and self-isolation.

Travel restrictions into the Bailiwick, and self-isolation and testing requirements for travellers entering the Bailiwick, have been a key aspect of the islands' response to the COVID-19 pandemic. Imposing a requirement for self-isolation on travellers means that the transmission of SARS-CoV-2 virus from infected individuals to the other islanders can be prevented.

Under successive regulations<sup>7</sup>, the Civil Contingencies Authority have taken proportionate and evidence-based steps to firstly reintroduce, and then gradually ease, and then re-impose, strict travel restrictions across the Bailiwick.

There are three considerations with regards to the future management of travel. These are:

- ▶ When non-essential travel can recommence.
- ▶ What border restrictions should be in place for arriving travellers when non-essential travel resumes. These could include:
  - » 14 days self-isolation with a Day of Arrival and Day 13 test, with 21 days self-isolation for those who decline testing;
  - » The reinstatement of testing and self-isolation requirements depending on the country or regional classification (or Variants of Concern that pose a specific risk to the Bailiwick), as indicated in Table 4;

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<sup>7</sup> The Emergency Powers (Coronavirus) (General Provision) (Bailiwick of Guernsey) Regulations, 2021 (as amended) and The Emergency Powers (Coronavirus) (General Provision) (Bailiwick of Guernsey) (No. 2) Regulations, 2021

- » An incremental approach, blending the above two options with a staggered approach linked to the roll out of the vaccination programme in the Bailiwick.

► When all border restrictions are removed or minimised (for example, the possible requirement for a vaccination passport and / or test on arrival into the Bailiwick).

**Table 4: Country / Regional classification (Category 1 – 4): Exit from Lockdown**

	<b>Category 1 (Air Bridge)</b>	<b>Category 2</b>	<b>Category 3</b>	<b>Category 4</b>
<b>Prevalence level of regions recently visited by a traveller entering Guernsey</b>	Equivalent to the Bailiwick of Guernsey and no community seeding	Less than 30 per 100,000 for 7 consecutive days	Between 30 to 100 per 100,000 for 7 consecutive days	More than 100 per 100,000 for 7 consecutive days
<b>Testing</b>	None required	Test on arrival (Day 1) and test on Day 7	Test on arrival (Day 1) and test on Day 7	Test on arrival (Day 1) and Day 13 with 21 days of self-isolation for people declining testing
<b>Self-isolation</b>	None required	Self-isolation until the receipt of a negative result on day 1 then passive follow-up until day 14	Self-isolation until the receipt of a negative result on Day 7 then passive follow-up until day 14	Self isolation for 14 days

It is recommended that the Bailiwick Blueprint aligns decreasing border restrictions, with decreasing prevalence of infection in our neighbouring jurisdictions and with an increasingly protected local population through vaccination. Border restrictions should also be linked to local monitoring of ‘Variants of Concern’ in countries and regions. The ultimate aim is for the removal of border restrictions (see table 5 below).



# The COVID-19 Vaccination Programme

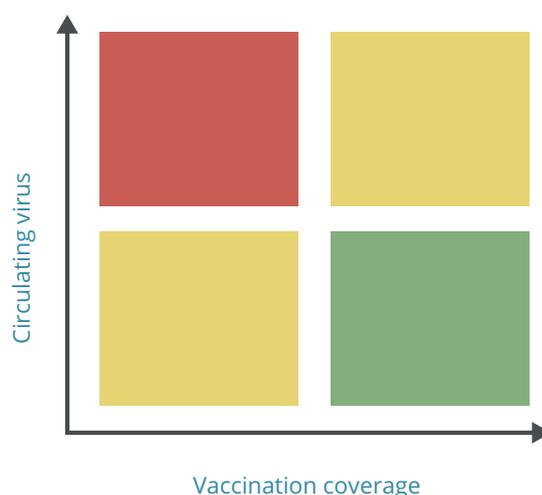
The Bailiwick of Guernsey is currently implementing the largest vaccination programme in the islands' history. Two vaccines are currently in use (Pfizer/BioNTech and AstraZeneca) and a third (Moderna) will soon be available for use locally. The Bailiwick is using the priority groups currently outlined by the Joint Committee on Vaccination and Immunisation (JCVI), an independent advisory body to the UK Government. This uses primarily an age-based strategy, together with vaccination of the clinically vulnerable or 'at risk' groups.

Phase 1 of the vaccination programme will vaccinate all of the Priority Groups 1 – 9 (all over 50s, clinically extremely vulnerable and 'at risk' groups). It is anticipated that the first dose of this will be given to all eligible islanders by the end of April 2021, with the second dose by the beginning to the middle of July 2021.

Phase 2 of the programme will focus on the vaccination of all eligible islanders (over 16 or over 18 – age still to be determined) and will start in May 2021, vaccine supplies allowing. Vaccination of children under 16 years of age remains under review.

Figure 2 illustrates the critical interaction with regard to the risk rating of the amount of circulating virus in relation to increasing rates of vaccination. The most favourable position is that of low circulating virus and high vaccination rates (illustrated in green). An intermediate risk assessment (illustrated in amber) is high vaccination rates with high amounts of circulating virus, or low vaccination rates with low circulating virus. The highest risk situation (illustrated in red) is high circulating virus with low vaccination rates.

Figure 2: Circulating virus versus increasing vaccination



It is recommended that decreasing border and internal restrictions (which pose a risk for increased circulating virus) are therefore aligned to an increasingly vaccinated population.



## Non-Pharmaceutical interventions (NPIs) – The future in Stage 3 and beyond?

As part of considering the exit from lockdown, the role of NPIs and their use in the Bailiwick have been assessed. NPIs applied so far during this pandemic have included border restrictions, school closures, remote working and quarantine. It is worth noting that estimates of the effect of NPIs on reducing transmissions of SARS-CoV-2 are approximate and the combined effect of multiple measures implemented together are not robustly quantified. Internationally NPIs have generally been scaled up over time in response to the magnitude of the outbreak in each respective country in line with worsening outbreaks.

While the precise effect of each intervention can only be estimated these measures have been shown to be effective at reducing the transmission of pandemic influenza and were implemented on the assumption that they would also be applicable to COVID-19.<sup>8</sup>

The ECDC specifically recommends a cautious approach to relaxing NPIs. Furthermore, the ECDC recommends that 'in light of the evidence of substantially higher transmissibility of the new variants of concern, national authorities should rather be ready to enforce even stricter measures, communicating and engaging with the population to encourage compliance. In general, contact tracing should be reinforced, and its scope widened in relation to cases suspected to be infected with new variants.'<sup>9</sup>

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<sup>8</sup> Neil M Ferguson, Daniel Laydon, Gemma Nedjati-Gilani et al. Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand. Imperial College London (16-03-2020), doi: <https://doi.org/10.25561/77482>.

<sup>9</sup> <https://www.ecdc.europa.eu/en/current-risk-assessment-novel-coronavirus-situation>. [Accessed 7th February 2021]

Further information of the need to specifically consider viral variants comes from the minutes of the seventy-fourth SAGE meeting on COVID-19, 22nd December 2020, where it was noted 'there is high confidence that this variant is spreading faster than other SARS-CoV-2 virus variants currently circulating in the UK, based on several different analyses. The cause (or causes) of that faster spread are unclear, but evidence is consistent with an increase in transmissibility being a factor.' It was also noted that 'There is also some evidence that the variant is more likely to transmit within households.' New and emerging evidence, such as the emergence of viral variants, needs to be integrated into consideration of the exit framework.<sup>10</sup> With regard to mitigation measures SAGE noted that 'existing mitigation measures (e.g. social distancing, ventilation, hand hygiene and mask usage) remain important, but given the increase in risk associated with the new variant, a commensurate strengthening in the measures taken (rather than a need for different measures) may be needed (i.e. greater use of all these mitigations).'

So, we progress out of lockdown into the post-pandemic world with the positive impact of an increasingly vaccinated local population, but with the knowledge of the concern with regard to the emergence of Variants of Concern. For this reason we need to consider what NPIs we should retain.

It is therefore advised that the following measures are retained as we exit out of lockdown

- ▶ Some border restrictions, as outlined below;
- ▶ Optional face covering wearing in enclosed spaces;
- ▶ Sanitisers available on entry into public spaces;
- ▶ Social distancing encouraged in public spaces – possible with the retention of 'markers' to remind people;
- ▶ A strong adherence to respiratory and hand hygiene becomes the new normal;
- ▶ A 'stay at home if you are unwell' message is strongly endorsed and supported by the general population, but specifically by employers.

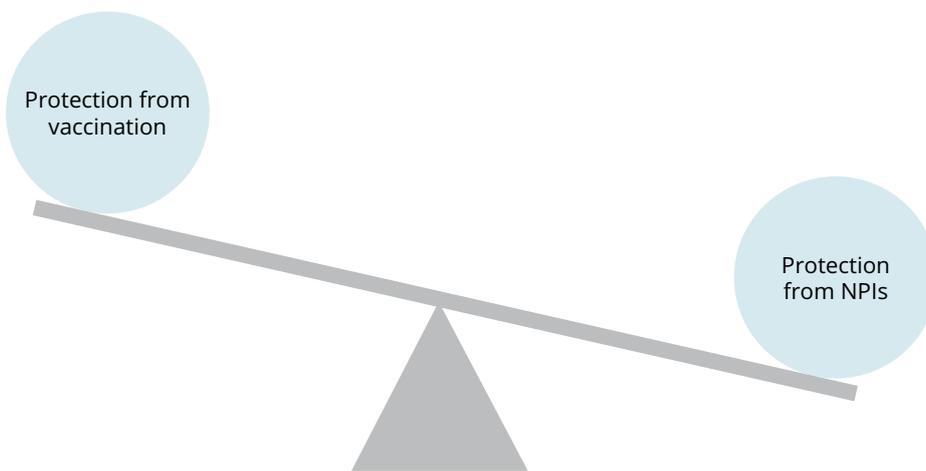
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<sup>10</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/948606/s0991-sage-meeting-74-covid-19.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/948606/s0991-sage-meeting-74-covid-19.pdf). [Accessed 19th January 2020].

In the longer term there needs to be a consideration of what measures should become part of our daily lives.

Figure 3 illustrates the concept of a tipping point between vaccination and the use of NPIs. At present, much of the protection in the Bailiwick is afforded by NPIs, including restrictions in schools, border measures, social distancing and the mandatory use of face coverings. As the vaccination programme progresses it is expected that this will change and most of the protection of islanders will be afforded by the vaccination programme.

Figure 3: The Tipping Point: Non-Pharmaceutical Interventions versus Vaccination



## Testing strategy

There are three arms to the testing strategy. These include:

- ▶ Testing of symptomatic people, and, if positive, their contacts;
- ▶ Surge / cohort testing around cases or areas in which cases of COVID-19 have been identified;
- ▶ Surveillance, based on workplace / individual characteristics to detect asymptomatic infections.

All of these components of the testing strategy are key to the Bailiwick Blueprint. Testing of symptomatic people will remain part of the management algorithm for the foreseeable future, together with surge testing around cases or areas of concern.

**It is recommended that the wider population-based surveillance programme should remain in place until the first phase of the vaccination programme is completed with all of the over 50s, together with the clinically extremely vulnerable and 'at risk' groups having been vaccinated.**

**After that, and dependent of a risk assessment of prevailing conditions, it is likely that the surveillance programme will be scaled down with a possible move to other methodologies, for example sewage surveillance.**



## Sequencing for Variants of Concern

The rapid identification of Variants of Concern will enhance our ability to detect these in 'real time'. Currently it can take more than two weeks for us to obtain this information if samples are sent to the UK.

The rapid detection of Variants of Concern will inform our Public Health response, allowing for a more targeted approach if restrictions are required. Specifically we also want to be able to rapidly detect Variants of Concern with increased virulence, but particularly those that the currently available vaccines are less likely afford a protective efficacy against infection.

In addition, the rapid detection of Variants of Concern will inform contact tracing measures, as well as provide case linking to allow for a better understanding of any spread of the virus in the Bailiwick.

The implementation of this is both technically feasible and is likely to be cost-effective as it may prevent unnecessary restrictions having to be put

in place, the most extreme of which is another lockdown.

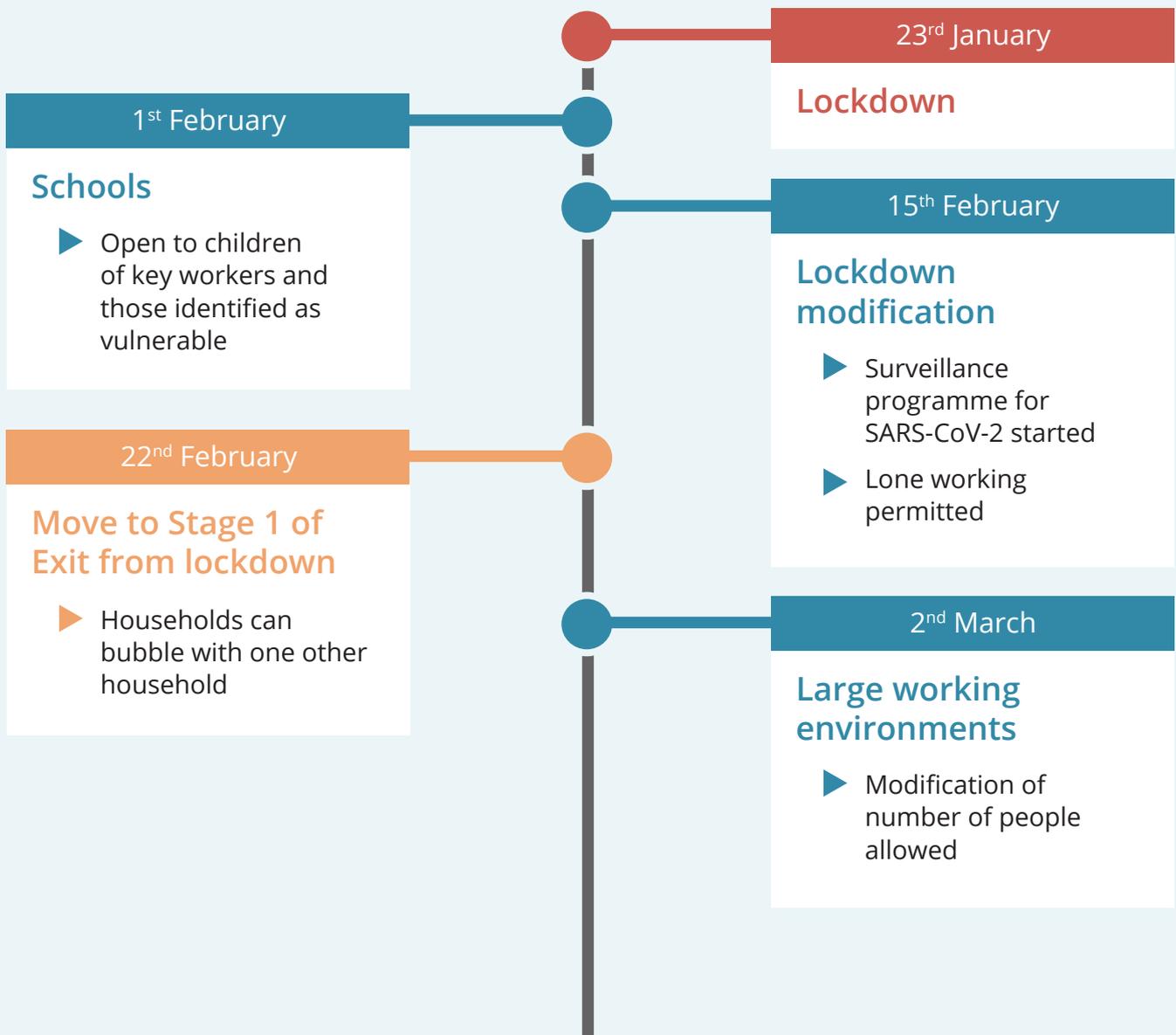
It is therefore recommended that:

- ▶ That a local capacity for sequencing and identification of Variants of Concern is developed.
- ▶ That this is used to inform the Public Health response as we transition from SARS-CV-2 being a pandemic to an endemic virus.



## The Next Steps

The timeline below illustrates the Bailiwick Blueprint, mapping the path to the easing of restrictions in the Bailiwick.



8<sup>th</sup> March

## Move to Stage 2 of Exit from lockdown

- ▶ Gathering size limits depending on indoors / outdoors, four household bubbles
- ▶ Restaurants / bars open with mitigations
- ▶ Retail shops open with mitigations
- ▶ Further modifications for construction / business
- ▶ Lifestyle and treatments with mitigations

8<sup>nd</sup> March

## Schools / Colleges

- ▶ Schools and colleges open to all pupils with restrictions

22<sup>nd</sup> March

## Non-essential travel

- ▶ Non-essential travel allowed with all people entering the Bailiwick subject to a mandatory 14 days of self-isolation

## Hotels / guest accommodation

- ▶ Hotels may open for all guests arriving from outside of the Bailiwick with travellers subject to the border controls in place, as well as for staycations

## Travel passport

- ▶ Review of the role of travel passports with implementation as soon as national or international guidance becomes available

22<sup>nd</sup> March

## Move to Stage 3 of Exit from Lockdown

- ▶ The Bailiwick Bubble recommences with no restrictions on inter-island travel.
- ▶ All internal restrictions lifted, but some non-pharmaceutical interventions remain advised, e.g. face coverings, hand and respiratory hygiene.
- ▶ School reopen under Business as Usual Plus guidance
- ▶ Gatherings of over 100 people allowed with a specific risk assessment and a record of people attending.

30<sup>th</sup> April

## Travel

- ▶ Non-essential travel allowed with the reimplementation of regional / country prevalence restrictions in relation to testing and self-isolation on arrival. This coincides with the anticipated completion of the administration of the first dose of vaccine for Priority Groups 1 – 9 in Phase 1 of the COVID-19 vaccination programme

Specific information on Variants of

- ▶ Concern in the originating country means that there may be travel restrictions in place for a country / jurisdiction irrespective of the prevalence of infection. This will be determined by Public Health concerns.

## Gatherings

- ▶ All restrictions on gathering size removed

May - July

## Vaccination Programme progress

- ▶ Phase 1 of the vaccination programme complete
- ▶ Phase 2 of the vaccination programme starts and all eligible population have at least one dose of vaccine

## Local detection of Variants of Concern

- ▶ The development and implementation of a local sequencing capacity to detect variants of concerns

1<sup>st</sup> July or later

### Future Measures

- ▶ Borders re-open completely with no country or regional variations, subject to Phase 1 of the vaccination programme being completed (1st and 2nd dose) and the first dose of Phase 2 of the programme has been delivered to eligible islanders. A single test at the border, or pre-travel, may be retained, depending on Public Health concerns.
- ▶ Move is dependent on vaccines remaining effective against predominant circulating variants.
- ▶ Contact tracing process re-focussed to meet emerging needs, to include case isolation and a focus on Variants of Concern and household contacts.
- ▶ Possible testing on arrival, dependent on concerns with regard to control and emergence of vaccine-resistant strains of the virus.
- ▶ Possible use of travel passports as a condition of entry into the Bailiwick.
- ▶ If required, and depending of external Public Health threats, this testing and restrictions at the borders may be periodically implemented.

In addition to the chronological order of lifting restrictions, the Bailiwick Blueprint needs to consider the transition of COVID-19 as a pandemic disease to an endemic disease. This needs to take into account the inter-linking facets of prevalence, vaccination, healthcare requirements and the impact on population-based morbidity and mortality. Future planning needs to build on lesson learned from this pandemic and how we manage SARS-CoV-2 as an endemic virus. Some of these are illustrated in Figure 4 – see below.

**Of paramount importance is the fact that this timeline is based on a 'best-case' scenario and might not be achieved in the face of sub-optimal suppression of the virus or other emerging matters of Public Health concern. This could include the circulation of vaccine-resistant variants in neighbouring jurisdictions.**

Figure 4: Considerations of the transit from a pandemic virus to an endemic virus

