UK CMOs meeting on universal COVID-19 vaccination of 12-15year olds to make a decision on advice

Tuesday 7th September 2021

UK CMOS and DCMOs:

Frank Atherton, Michael McBride, Chris Whitty, Gregor Smith

Nicola Steedman, Jonathan Van Tam, Thomas Waite, Naresh Chada

Additional Attendees

Lucy Chappell- Department of Health and Social Care Chief Scientific Adviser

Wei Shen Lim- Chair of JCVI COVID-19 Immunisation

CMO England summarised the views of the independent leaders of the clinical and public health profession from across the UK. Both broad groups; public health experts and clinical experts from Royal Colleges concluded in favour of recommending universal COVID-19 vaccination of 12-15 year olds with an initial first dose of Pfizer vaccine.

This meeting is a frank discussion between colleagues on the evidence, with the intention of the four UK CMOs arriving at a joint decision on what advice to give to Ministers.

DCMO Scotland set out a degree of scepticism. Noting that we need to be persuaded that the intervention will have the impact on schools that we want. The modelling has a wide range of assumptions. And we need to account for the risk of myocarditis.

DCMO Northern Ireland explained that we have not had a mass vaccination programme like this, if it does go ahead. The alignment between JCVI and other medics has been key, and we should be wary of anything that might take us away from that. The focus of the vaccine programme so far has been to keep people out of hospital, so this is different and that will need to be communicated. The vaccination programme is becoming more and more complex. There are huge public health benefits to ensuring schools are as COVID secure as possible. The damage to children's education has been incalculable.

DCMO England set out that everyone is concerned about impact of pandemic on children, while noting that it doesn't follow that in future the impacts will be as great. The public health needle is toward vaccinating 12-15 year olds, but not as far over as for adults. The decisions of parents and children should be supported either way.

The JCVI Chair set out how they have tried in these meetings to represent the JCVI view as best as possible. Their view was that the process UK CMO's have followed is a fair process in terms of hearing the range of viewpoints.

CMO Northern Ireland explained that they were in favour of offering universal vaccination. Their strength of view moved as they listed to the expert views in the meetings we've had. They wished that the decision could have been made earlier in the year, but acknowledged that the evidence was not as strong then. Would not want to recommend against now, and look back at this as a missed opportunity to reduce impact on children of pandemic.

CMO Wales set out that the starting point for any decision is the purpose of the vaccination. Here it is less about direct harm, and more about loss of school and social activities and mental health. We

all agree that keeping schools open is really important. Need to consider the small but real risk of myocarditis, including the uncertainty. Need to consider overall vaccine confidence as well.

CMO Scotland appreciated the difficulty JCVI had faced up to this point in weighing the evidence. JCVI was clear that there was a marginal health benefit. Need to assure selves of impact on rest of COVID vaccine deployment, and be sure that a 12-15 universal programme will not impact on deployment of vaccines for immunosuppressed and boost

DCMO England agreed that boosters are clearly the priority here.

CMO England set out that the JCVI position, which we took as read, is that JCVI's view is there is a marginal benefit in favour of vaccination, but that it was too small to recommend on that basis. JCVI did not say that the disbenefits outweighed the benefits, but that both were small and the benefits outweighed the disbenefits. We accept this JCVI advice.
The next question is whether it is likely on the wider issues that there is more benefit, more harm or no difference. Clearly the impact on education in areas on deprivation, is serious and will be lifelong. Parents cannot always home school children, and this is going to be very serious. Question is can the vaccination programme help them? Schooling is a central part of public health.
Next question is mental health. We've heard very powerful arguments that a lot of this is to do with uncertainty- with no structure to the disruption. This is cumulative, you do not reset the clock. Many children have reached a point where another occasion would cause severe problem. If vaccination would reduce school disruption this would provide us with a significant reason to add to JCVI's marginal view. Is that certain, likely or is it possible or unlikely? CMO England's view was it is not certain vaccine would do this, definitely not as a single entity. But do we think it is somewhere between possible and probable, CMO England's view is probable, will have significant impact on school disruption. Leaving aside reducing levels of worry, it is more likely than not that will have useful additional benefit in terms of reducing school disruption. Data and modelling does not say it will make overwhelming difference, this will make some difference.
If it is the case that Scotland epidemic has peaked and that is it in terms of surges. Or England in next short while. Can argue that school disruption is going to be limited. If think that COVID will surge, then this is a relevant question. That education central to public health has a certainty of 1. Probability that schooling is less disruption with a vaccination programme, is not 1 or 0. But it will reduce this, particularly in areas of greatest deprivation- those same towns that get the surges every time. Vaccination in schools is not going to increase the disruption. There is a large enough probability that will reduce impact on schooling and reduce mental health aspects, that it is worth adding in as a tool. Vaccination would need to go with wider statement that this is not a tool alone- all aimed at taking school disruption to a minimum.
The counter arguments include many of which are operational, which are an issue, but delivery teams have told us this is likely manageable. Because the benefit comes form largest number being offered, I would recommend universal vaccination of 12-15s.

DCMO Scotland agreed with this view. Data that quantifies the impact on school disruption is useful.

CMO England set out three levels of disruption where schools are disrupted.
1. Direct e.g. symptomatic people don't go to school
2. Clustered disease- some schools have no problems and others get hit in a big way. Superspreading event much less likely if children vaccinated.
3. Reduction in worry level amongst parents and teachers.
It is the former two we should account for in our decision. Headteachers and parents will make decisions on school attendance, regardless of what we or government says. Missives from London to

teachers do not ensure schools are kept open. Having less COVID is the best way to reduced COVID school closures.

DCMO England explained that JCVI had set out that there was uncertainty about the long term risks of myocarditis (for vaccination and from COVID). It may be that a COVID programme will lead to delays to flu programme, so would need to address this. Deprived areas will likely have lower levels of vaccination.

CMO England said that some areas of deprivation have very high uptake, so it is not always the case that they are correlated.

CMO Northern Ireland found the commentary by the Royal Colleges extremely compelling. We will see future waves. Children in receipt of free school meals 4 x more likely to be off isolating. Have spoken with headteacher who took half of people out of school due to an outbreak. There is a huge impact on schools, and they wished schools had not been closed for as long. Digital inequalities and educational inequalities have had massive impact on ability to home school. Regardless of decision on vaccine need to do considerable additional work on schools.

CMO Scotland said there was a marginal benefit on both counts. Suggested a neutral offer rather than a recommendation.

CMO Wales said we need to be sure that the marginal gain outweighs any disbenefit. Would not be in favour of an offer rather than a recommendation. Should be a recommendation either way.

JCVI Chair noted that opt-in offers can exacerbate inequalities more than recommendations.

CMO England set out how the UK CMOs had followed a process whereby they agreed to consult wide range of expert bodies. Having consulted them all of them were in favour of offering universal 12-15 vaccination. JCVI have said there is marginal health benefit. Children and parents want the option. Based on that we need to take two decisions; 1) what to recommend to ministers in terms of making vaccine available to 12-15s 2) what to recommend to 12-15 year olds and their parents.

CMO England noted that the UK CMOs views have clustered around a similar place. This is to recommend to ministers that we do make a universal offer of a single first dose of Pfizer to children 12-15, but that we are nuanced in the way we express that. We should make clear this was a far more balanced decision than previous advice from JCVI on the adult programme. The messaging to children and their parents will need to be well thought through.

ACTION: CMO England will draft a UKCMOs statement this evening- and circulate to UK CMOs for comment and amendment.

UK CMOs agreed that when advice goes to ministers, we should have a way to communicate on the same day- to ensure we can give a clear clinical message.

UK CMOs agreed that a clear informed consent programmed would be essential, and that clear communication of this also important.

UK CMOs meeting with clinical experts from Royal Colleges as part of consideration of advice on universal COVID-19 vaccination of 12-15year olds

Tuesday 7th September 2021

UK CMOS and DCMOs:

Frank Atherton, Michael McBride, Chris Whitty, Nicola Steedman

Jonathan Van Tam, Thomas Waite, Naresh Chada

Royal Colleges

Helen Stokes-Lampard- President of the Academy of Medical Royal Colleges

Camilla Kingdom- President of the Royal College of Paediatrics and Child Health

Martin Marshall- Chair of Royal College of General Practitioners

Maggie Rae- President of the Faculty for Public Health

Elaine Lockhart- Chair of Child and Adolescent Mental Health Services Faculty, Royal College of Psychiatrists

Alastair Henderson- Chief Executive of the Academy of Medical Royal Colleges

Miles Mack- Chair of Scottish Academy

Mairi Stark- Scottish Officer, Royal College of Paediatrics and Child Health

Additional Attendees

Heather Payne- Consultant Paediatrician, Senior Medical Officer Welsh Government

Lucy Chappell- Department of Health and Social Care Chief Scientific Adviser

Wei Shen Lim- Chair of JCVI COVID-19 Immunisation

Note

JCVI recommended to Ministers that CMOs were consulted, and Ministers have accepted that advice. CMO England set out the question that the UK CMOs have been posed. The CMOs do not want to revisit the ground covered by MHRA and JCVI, but rather cover new ground if any. He recommended the decision is whether to give one dose of Pfizer to healthy 12-15 year olds or not.

The JCVI advice says *that the benefits from vaccination are marginally greater than the potential known harms but acknowledges that there is considerable uncertainty regarding the magnitude of the potential harms. The margin of benefit, based primarily on a health perspective, is considered too small to support advice on a universal programme of vaccination of otherwise healthy 12 to 15-year-old children at this time.*

UK CMOs will start from the position of MHRA and JCVI on individual child clinical benefit, and use JCVI and MHRA numbers. These will not be revisited. The UK CMOs will consider the wider issues that are relevant to the public health of children 12-15, including education, operational and mental health issues, as suggested by JCVI, and requested by Ministers. UK CMOs wanted, in addition to the papers circulated, and their wider knowledge of the impact of COVID on children, to get input from two expert groups; leaders in the public health profession and leaders from the relevant Royal

Colleges. This meeting is of the clinical experts from Royal Colleges, as representatives of their professions. The meetings will be noted by CMO England office.

The UK CMOs will not consider issues where vaccination of children might accrue benefits or disbenefits for adults, or other (under 12 or over 16) children and young people by vaccinating children 12-15. All benefits and disbenefits, direct or indirect, considered should be for children and young people 12-15 years. Political views are not relevant to this process and will not be taken into account.

When a statement from the UK CMOs is published it will say which bodies have been consulted in an advisory capacity, but not name individuals. Those consulted should state any Conflicts of Interest (CoI) before any interventions.

The Academy of Medical Royal Colleges set out that the Academy was very supportive of the JCVI decision making process and acknowledge that some would seek to frame this as JCVI and other clinical experts disagreeing, when this was not the case. They raised the importance of considering long COVID and how consent is done, as two of many important topics to discuss today.

The Royal College of Paediatrics and Child Health have thought very carefully about vaccination 12-15 year olds, and consulted widely, so represent a UK view. Paediatricians have seen significant rise in child mental health problems, including seeing those with eating disorders in acute paediatric beds. There is currently a large number of other viral infections, which impact on the ability to deliver child healthcare. They are also worried by unreported safeguarding concerns, which are very hard to work out the prevalence of. Community child health colleagues explained how referrals for safeguarding reduced during the start of the pandemic but now they are starting to see cases of a very serious and more significant nature than they are familiar with. Mental health and safeguarding concerns worry the College in terms of long-term impacts. They strongly believe that ensuring that children can attend school and be confident in attending school daily, and wider school activities, will have a positive impact not just on preventing new mental health problems but giving children from more deprived communities an education they have missed. Education is closely linked to life chances. Safeguarding in school makes a huge difference overall. The College have concerns around viewing vaccination as a simple solution, so are in favour of vaccinating, but only if part of a broader piece of work to keep children safely in school. This could include stopping school testing completely. Prioritisation of vaccination is important, and they do not want to see other school-based vaccination programmes suffer. The College has a programme called *voices of children*- about 1000 children who work with them, headlines messages from young people- they want the choice- but to be a genuine choice. Balanced conversation about reasons to do so and reasons not to do so. Have seen that experts have found it a hard decision to make and are aware of this. Passionately in favour of vaccination in general, and are supportive of offer in 12-15 for COVID. But see it as different to routine vaccination programmes.

The Scottish Academy emphasised the important of the impact of the intervention in deciding what advice to give. It depends on how much vaccination will make a difference to the topics we are discussed.

The Royal College of General Practitioners have consulted widely across GPs, and there is a strong consensus in favour of vaccinating 12-15s. Again, they emphasised the importance of how the communication is done. They are very concerned about inequalities- which works in both ways- if we don't vaccinate then inequalities will be exacerbated, if we do and there is differential uptake then this will also exacerbate.

The Royal College of Psychiatrists set out how the impact on mental health is a shift in the curve for this age groups. Resilient children are now very affected by the isolation. The most disadvantaged have been most adversely affected. Those with conditions like ADHD and autism, have temporarily felt better with lower case levels, but are now having to go back to having a hard time. The College is much in favour of vaccination, as any tool we can use here is a benefit.

The Faculty of Public Health have been tracking non-direct medical effects for some time. They are on balance in favour of the vaccination programme, sharing the views of other colleagues on this. If the advice is to offer vaccination to 12-15s then should aim for good uptake. This issue is not just about the next few months, this is a long-term issue. Children cannot be missing school for another long period of time. Many children won't go back to school this week because they have already tested positive. Has to run alongside a general approach to children going back to school, with policy changes to improve this.

CMO England made the point that government pronouncements are not the only thing that schools take account of. They often close due to local decisions. DCMO England said that reducing transmission and encourage confidence in attending schools would impact on closures.

CMO Northern Ireland emphasises the important to children of predictability in structure and routine. The policy on testing was having a limited impact on that. They noted that what children were saying on vaccination was striking.

Chair of JCVI set out that vaccine effectiveness against infection from dose 1 for the Alpha variant was around 55-60%. For Delta about 50%. For transmission for Alpha the data would suggest around 45% and for Delta there was not solid data- but it would likely be lower- could be as low as 30%. With Delta the breakthrough in infection has the same level of viral load. They noted that an opt-in system can increase inequalities.

Chair of JCVI made the point that people often rank risk more highly than benefit. The JCVI set out that there was a marginal health benefit and suggested to government that UK CMOs could be consulted for wider health impacts. CMO reiterated that the clinical advice would be on health impacts, not on any other considerations.

CMO England made the point that transmission refers to people who are already infected passing the virus on. And noted that if someone is not infected then they cannot transmit. They noted that mass spreading events have caused a substantial amount of the disruption. Vaccination would decrease the likelihood of mass spreading events substantially.

Faculty for Public Health noted that at the worst point last year there were 500,00 children off school. Their view was that this could be repeated. Health is mental, physical and social. There is a benefit to school attendance, and child mental health, from vaccination. Even if the testing policy was stopped, there will be those with symptoms and it will be very hard to keep children at school. The DPHs build confidence in children and parents to attend school and are in favour of vaccination.

The Royal College of Psychiatrists noted that communications on getting children back to school, including through vaccination, should engage with teachers, communication with our education colleagues is very important.

The Royal College of Paediatrics and Child Health made the point that the 12-15 age group is quite a heterogenous group, with most parents making decision for 12-13. But for 14-15, particularly girls, many likely to be Gillick competent. Typically, parents encourage children to have vaccine, but it may be that parents are concerned, and children want the vaccine.

The Royal College of General Practitioners noted that for children the process will likely take longer that it does for adults. Information should be aimed at children and parents.

CMO England noted the importance of the medical profession explaining the clinical rationale for a universal programme of 12-15 vaccination if that was the decision.

As a summary:

- If the UK CMOs recommend universal 12-15 vaccination they should do in context of supporting any movement that keeps children in schools and keeps education predictable.
- It cannot be claimed that vaccination here is a compete answer. It is instead an additional tool, particularly in areas of deprivation. It is part of the wider approach to keeping children in school.
- A part of any recommendation to vaccinate would be to keep schools open, based on preventing spread of the virus. If recommend, then will recommended wide uptake. Clear that consent process should be informed.
- Key to ensure children are not stigmatised for not getting vaccinated or getting vaccinated.

The view from the Royal College clinical experts representing their professions was that taking into account the factors discussed, there were in favour of allowing the opportunity for 12-15 year old children to be vaccinated.

UK CMOs meeting with senior leaders and experts in public health as part of consideration of advice on universal COVID-19 vaccination of 12-15year olds

Monday 6th September 2021

Attendees

UK CMOs and DCMOs:

Frank Atherton, Michael McBride, Nicola Steedman, Chris Whitty, Jonathan Van Tam, Thomas Waite, Naresh Chada

Association of the Directors of Public Health:

Jim McManus Acting President of the ADPH, Ben Wealthy ADPH Head of Policy and Communications, Ivan Browne, Director of Public Health for Leicester City Council, Ruth Tennant Director of Public Health for Solihull.

PHE Regional Directors:

Alison Barnett, Debbie Stark, Peter Kelly, Andrew Furber

Additional attendees:

Giri Shankar Director of Health Protection Wales, Graham Foster Director of Public Health NHS Forth Valley, Nicholas Phin Director of Public Health Science at Public Health Scotland, Lucy Chappell DHSC CSA, Wei Shen Lim Chair of JCVI COVID-19 Immunisation.

Minute

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UK CMOs will start from the position of MHRA and JCVI on individual child clinical benefit, and use JCVI and MHRA numbers. These will not be revisited. The UK CMOs will consider the wider issues that are relevant to the public health of children 12-15, including education, operational and mental health issues, as suggested by JCVI, and requested by Ministers. UK CMOs wanted, in addition to the papers circulated, and their wider knowledge of the impact of COVID on children, to get input from two expert groups; leaders in the public health profession and leaders from the relevant Royal Colleges. This meeting is of the public health profession. The meetings will be noted by CMO England office.

The UK CMOs will not consider issues where vaccination of children might accrue benefits or disbenefits for adults, or other (under 12 or over 16) children and young people by vaccinating children 12-15. All benefits and disbenefits, direct or indirect, considered should be for children and

young people 12-15 years. Political views are not relevant to this process and will not be taken into account.

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The acting ADPH President set out the view of consulted members:

- Disruption of education can have mental health impact on life change progression, education attainment, and mental health.
- Keeping schools open is essential to avoiding this
- Currently a significant wave of infection is likely.
- Schools have had significant levels of disruption when there has been a large amount of infection.
- A vaccination programme would also cause some disruption.
- Areas of enduring transmission in their experience adds additional risk for children. And many areas of enduring transmission are deprived areas.
- Children's mental health has been significantly impacted, particularly for those who are more in need of social contact.

Individual DPHs made additional points. One explained that in their local area there is a high level of support for 12-15 universal vaccination. But emphasized the importance of the messaging. The area is very busy currently in terms of use of education helplines, questions on risks in school, children that are COVID positive, and there is an ask for additional tools such as vaccine. Another outlined the impact on emotional wellbeing in children, including anecdotal evidence that repeated periods of self-isolation are hard to sustain. Some children are well able to cope with the first or second time but struggle in later isolations. Some school closures have been due to teachers being in isolation rather than children. There was also strong support from public health professionals in their region to do universal 12-15 vaccination. They noted that schools in deprived areas been particularly hit by outbreaks. The counterpoint is that vaccination take up is also likely to be lower in deprived areas.

One of the Regional Directors set out that the benefits of the vaccination programme will be less than would have been the case given the changes to the policies on self-isolation. But remained confident that DPHs in their area would support universal vaccination of 12-15 year olds as there has been a devastating impact on the education of young people.

The Scottish DPH representative agreed that children have had an extremely disrupted time. In Scotland they are only doing a small amount of close contact tracing. But currently 10% on children are on average off school. And they share the experience that some children have had multiple isolations. It was their view that anything we can do to help with this is important. It is important to consider not just schools but the full range of out of school clubs, which are also important to child development and wellbeing. There was a consensus view from colleagues of the Scottish DPH representative that children should not be denied access to the vaccine since JCVI have said on balance there is a marginal benefit on health risk/benefit.

It was generally agreed that school closure is a hard area to get robust models, as there is such uncertainty around relevant factors e.g. the case rate, the local and parental reaction to high rates in schools.

It was agreed that vaccination will not stop the disruption, but that few would suggest it will make no difference. The key question is how much difference will it make.

One of the Regional Directors noted the potential impact of a high profile serious adverse reaction in a child, and the potential impact of that on other childhood vaccination programme.

Another Regional Director emphasised the need to have very clear messaging to parents.

NI public health representation explained how they have seen high transmission spilling into schools, which has caused significant disruption. It would be key to set out the benefit of the intervention, ensure that operational impacts on other programmes are accounted for and noted a concern around uptake, which has so far dropped as go down the ages.

Some public health views in Scotland are that the focus should by on the at-risk groups of 12-15, and a concern that a universal programme might slow down provision to the at-risk groups.

One of the DCMOs set out that the mental health impact can be partly down to the general impact of lockdown as well as specific isolation. Other infections can mimic COVID-19 and parents will be unsure which it is when children have symptoms.

The Chair of the JCVI set out a view on the impact on transmission of vaccination. For the Delta variant there is data that suggests one dose can reduce infection by 55%. For the Alpha variant one dose reduces transmission in those infected by up to a further 50%. We do not have data on the additional effect on transmission of one dose for Delta on those infected, but it is likely to be lower, with an possible estimate of around 30%.

One of the DPHs noted that COVD goes up in community and school at the same time and there is a worry that the areas that have had high rates before, some of which are deprived areas, will get high rates this time as well. There was a concern that the current playbook of mitigations would not prevent this sufficiently.

DHSC CSA made the point that there will likely be multiple waves of infection so this is not just about this school term but will carry on going through the school age population into winter. It was agreed that the UK CMOs should not make decisions made on the basis that high case rates will be over shortly or indeed this term. Needs to be based on potential high case rates continuing until at least next spring.

As a summary, the points in favour of universal vaccination for 12-15 year olds included:

- If vaccination could reduce educational disruption that would reduce the very negative impact on children and their development. This is not just educational attainment, but public health in the broader sense. If vaccination reduced this disruption to a reasonable degree then this would be good for public health.
- When schools have high infection rates they do so in waves. Children are in isolation and parents withdraw children, and this all happens at same time. This is very difficult to model.
- Impacts on mental health are potentially significant
- In terms of to what extent are we confident that vaccination would lead to a reduced impact on education, it is likely it would to some degree. It will not solve the problem but will have some impact. UK CMOs will need to look at the size of benefit quite carefully.

As a summary the points not in favour of universal vaccination for 12-15 year olds included:

- Impacts on both operational and confidence issues on other vaccine programmes.

- Vaccination programme will provide some disruption in the school. Structured rather than unstructured, but disruption.
- The most disadvantaged are impacted most by disruption from COVID, but getting high uptake will also be harder.

The view from public health colleagues in attendance in England was that in their local situation the public health view, taking those educational factors into consideration, and everybody supportive of JCVI, was in favour of allowing parents the opportunity for their children to be vaccinated.

Public health colleagues in Scotland were had a more balanced view, with emphasis on 12-15 at risk, although DPH views were on balance in favour.