To: SofS, PS(VP)

From: Name Redacted
Clearance: **Helen Beazer, Deputy Director, COVID-19 Vaccine Deployment Directorate**
Date: **10 February 2022**
Copy: Name Redacted **(SofS)**
Name Redacted **(PS(VP))**
Private Office Submissions Copy List

Expansion of the COVID-19 Vaccination programme

Issue	The Joint Committee on Vaccination and Immunisation (JCVI) has provided updated advice on children and young people aged five to eleven (CYP) (Annex A). This submission sets out the policy advice for COVID-19 vaccines deployment based on the JCVI advice. This update covers primary COVID-19 vaccination in children aged five to eleven years old.
Date a response is needed by **Reason**	**Urgent** Response requested ahead of a potential announcement on Friday 11 February.
Recommendation	We recommend that you: • **Accept** the JCVI advice to offer COVID-19 vaccination to all children aged five to eleven not included in previous advice. • **Agree** the statutory products for primary COVID-19 vaccination of children aged five to eleven (Annex B - Annex E) and **note** that a PAC Select Committee letter and impact statement will follow. • **Agree** proposed timing of publication on 11 February and handling arrangements in paras 27-35.

Background

1. On 16 December 2021, JCVI provided formal advice to offer COVID-19 vaccination to children aged five to eleven who were either classed as at-risk or who were household contacts of the immunosuppressed.

2. You accepted this advice conditionally as to be operationalised in mid-January given the drive behind the adult booster programme, and to coincide with when we had paediatric Pfizer supply available. Consequently, deployment of COVID-19 vaccination to children aged five to eleven classed as either at risk as set out in the UK Health Security Agency (UKHSA) Green Book or who are household contacts of the immunosuppressed began on w/c 31 January 2022 in England.

to August which will see completion of the Not Relevant contracted order. We are therefore well positioned to supply the commencement of this campaign and the 12 week interval being recommended.

Operational considerations – NHSE/I

9. To help stimulate demand, build confidence in the process and to allow parents to plan, we would anticipate that the programme launches at the start of the Easter Holidays. We would primarily utilise assured community pharmacy-led sites and some vaccination centres.

10. The deployment programme will need approximately 5 weeks to plan to stand this cohort up looking at the best way to make the offer to non at risk five to eleven year olds, bearing in mind the tone of the guidance from JCVI. We will be happy to provide further details in due course.

DA considerations and UK alignment (Matt DiClemente)

11. Devolved Administrations (DAs) are sent advice from the JCVI as part of their observer roles on the Committee. The DA Senior Responsible Officers for the COVID-19 vaccination programme have indicated they are planning to advise their Ministers to follow the updated advice on COVID-19 vaccine doses for children aged five to eleven.

12. DHSC officials will keep DA officials updated around plans for publishing the advice and operationalising it in England. Once communications products are cleared, these will be circulated across Government, to the Crown Dependencies and the Overseas Territories to inform rollout.

Impact Statement to assess cost effectiveness of offering vaccination to children aged five to eleven covered by JCVI advice

(i) Costs

13. *For costs, the finance team's estimates are used for budgetary purposes, whereas analysts independently estimate expected total costs based on HMT Green Book principles. The estimates are slightly different for this reason. Analysts estimate that for a 2 dose schedule for all remaining five to eleven year olds covered by JCVI advice, the total costs will be £91 million to £220 million in vaccine costs and £168 million to £388 million in deployment costs, giving a total cost of £259 million to £607 million. The costs of vaccinating this cohort are expected to be relatively high compared to previous cohorts; the paediatric formula purchase costs are not significantly cheaper than the adult formula (despite it being a third of a dose), and the deployment costs are expected to be higher due to the complexities of administering an injection vaccine to young children who require accompaniment to a vaccination centre and parental consent.*

(ii) Benefits and cost effectiveness

14. Vaccinating this cohort is unlikely to provide any significant benefits against the current Omicron wave. By the time this cohort is vaccinated, Omicron infection levels are expected to be much lower, and the majority of children aged five to eleven will have been infected with Omicron, a previous variant, or both. The benefits of vaccinating this cohort are likely to be against a future wave. It is not currently possible to say with any certainty what this wave will look like, when it is likely to peak, or what the characteristics of any new variant will be. If the future

wave is more severe, with a more severe and transmissible variant the benefits of vaccinating five to eleven year olds are likely to be greater – providing that the vaccine effectiveness continues to be high – compared to a less severe wave.

15. For this policy to be cost effective, a future wave of infections would need to come about while vaccine effectiveness in children is still high with characteristics such as a COVID-19 variant much more severe in children, or a variant which the vaccine provides very high protection against infection and onward transmission for children but otherwise has high transmission in the wider population. Other scenarios that are more consistent with waves of infections seen so far (lower severity in children and a moderate impact on onward transmission) would not be cost-effective even where vaccine costs are treated as sunk costs. There are, however, wider health benefits from COVID-19 vaccines in preventing disruption from COVID-19 to non-COVID-19 healthcare, which are not taken into account here.

16. An alternative policy, with cost-effectiveness in mind, would be to postpone a decision to deploy these vaccines until a heightened threat is identified, although this approach may mean there is never an opportunity to deploy to this group, either due to time constraints or as the priority for vaccine deployment at a time of high threat is likely to be older age groups.

17. **Although vaccination of this cohort at this point is unlikely, under most scenarios, to be cost-effective, our analysis is not an impediment to accepting any part of JCVI's advice should you decide to take a strongly precautionary approach, recognising the risks associated with some possible scenarios of COVID-19.**

Finance Name Redacted

18. The maximum cost for a primary course for at risk 5-11s and expanding boosters to eligible children and young people is £420m, consisting of c£240m for deployment and £180m for vaccine usage[1]. This is only an initial estimate and will have to be fully costed and submitted as a business case to HMT.

19. The vaccine deployment programme has been treated as a single programme with multiple phases, with HMT funding the deployment on a rolling basis. This expansion is not affordable from within the current SR settlement (which was based on one boost for over 50s) and the department may well need to push for additional funding at the appropriate point. We may also need additional funding to procure and consume the vaccines, as paediatric vaccines are not included in the SR settlement.

20. HMT requirement is that CST approves the announcement on the expansion of the vaccination programme to 5 to 11 year olds not at risk to avoid spending on these groups being deemed as irregular. We are working with HMT to get this approval ahead of the announcement.

Legal Risk

[1] We have used 2.8m population compared to 2.6m in the impact assessment to reflect NHSE's assessment of the population and ensure they have adequate funding for deployment.