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Meningitis Research Foundation

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To the secretariat and members of the JCVI,

We are writing in response to your minute of the meeting on 4th October 2017 to express concerns we have about the process that has been followed in reaching the decision to move from a 2+1 to a 1+1 pneumococcal vaccination dosing schedule.

We understand that there are numerous potential benefits of moving to a 1+1 pneumococcal vaccination schedule. We favour changes that simplify the routine infant immunisation programme and make it easier for parents to protect their children. We also appreciate that the change would save the NHS money which could be spent on making improvements to health and that the information gathered from a UK 1+1 programme could help inform other countries' immunisation schedules and reduce the overall cost of preventing pneumococcal disease globally.

Despite these benefits, we are concerned that there are identified risks associated with the reduced schedule which could lead to increases in disease, disability and death caused by invasive pneumococcal disease (IPD) in the UK.

We think the process of decision making in this instance needs to be more transparent and in line with JCVI's own code of practice. The code (page 24) explains how 'major changes to or discontinuation of an existing immunisation programme' should include a 'public call for evidence from interested parties issued to gather evidence from stakeholders'. Particularly in light of the known risks of amending the programme, we would expect the JCVI to call for evidence from interested parties, according to this code of practice before any recommendation is finalised. This could build a better common understanding and buy-in to any final decision.

A key issue is that this decision appears to be being taken without identified mechanisms in place to reintroduce the vaccine in the event that there is resurgence in disease. Under current guidelines, we understand that once a dose is removed, the decision to reintroduce it would have to be based on an incremental cost effectiveness analysis of adding one vaccine dose rather than the cost effectiveness of the programme as a whole. Disease levels would therefore have to dramatically increase, to the point where public health control of IPD is compromised, to warrant reintroducing an isolated dose on the basis of cost effectiveness, despite the three dose programme as whole being cost effective.

The following areas of risk are known and we think they should be more widely consulted on:

- The risk of an immediate increase in IPD in infants aged between 3 and 12 months as result of the reduced protection from a single vaccine dose at 3 months. This is particularly relevant for serotype 19A[1].
- The risk of an increase in vaccine type IPD amongst older age groups as a result of a potential increase in carriage of vaccine type bacteria in young infants[1].

- The risk arising from reduced immune response post booster to four of the vaccine serotypes, namely 6A, 6B, 18C and 23F. In the absence of data about how these reduced responses will affect carriage, it is unclear how this reduction would affect herd protection against these serotypes[1]. There is a risk that we could lose herd protection and see marked increases in IPD caused by these serotypes amongst all ages in the long term.
- The risk of geographically patchy protection resulting in pockets of IPD resurgence in areas of low booster uptake. Although uptake of the booster pneumococcal dose by 24 months of age is at 91.5% in 2016/17 on average across the UK this is still below the 95% coverage target. More concerning is that in some areas of London such as Westminster, uptake of the booster dose is very low at 67.7%[2]. The success of a 1+1 PCV schedule relies on the timely provision of a booster dose and the schedule's ability to sustain indirect protection[1].

All of these issues warrant wider stakeholder consultation and engagement before a final decision is made.

We need to address questions from our members and the public, so we intend to tell them we have written to the JCVI. We intend to publish this letter along with a statement voicing our concerns about the way in which this decision was reached on our website.

As described on page 18 of the JCVI code of practice, we are formally requesting the JCVI to consider and respond to the issues we are raising in this letter. We ask you to consider these issues with a degree of urgency as we are aware that decisions about the schedule may be imminent.

We look forward to hearing from you.

Yours sincerely,

Vinny Smith

Chief Executive
Meningitis Research Foundation

1. Goldblatt, D., et al., *Pneumococcal conjugate vaccine 13 delivered as one primary and one booster dose (1 + 1) compared with two primary doses and a booster (2 + 1) in UK infants: a multicentre, parallel group randomised controlled trial.* Lancet Infect Dis, 2017.
2. NHS Digital. *Childhood vaccination coverage statistics*. 2017; Available from: https://app.powerbi.com/view?r=eyJrIjoiYTRjZjY2ZDEtNmFhMi00ZWI5LWE2NDAtOWM0OTYzY2JhZWIzIiwidCI6IjgwN2YyZjMwLWNhOGMtNDE5Zi1hMTc5LTVjNGZjN2E0YmY2YiIsImMiOjN9.