NOT FOR PUBLICATION

JOINT COMMITTEE ON VACCINATION AND IMMUNISATION

Minutes of the meeting held on Friday 3 November 1989 in Room 83/84 Hannibal House at 10.30am

Present:

Members:	Professor A G M Campbell (Chairman)	
	Professor J E Banatvala	
	Dr M F H Bush	
	Professor J G Collee	
	Professor A M Geddes	
	Professor P Grob	
	Professor D Hale	
	Dr I Jones	
	Professor K Knowelden	
	Professor H P Lambert	
	Professor R J Levinsky	
	Dr J A MacFarlane	
	Professor D L Miller	
	Dr D Reid	
	Mrs R Roden	
	Dr G C Schild	
	Dr J B Selkon	
	Dr J W G Smith	
Secretariat:	Dr D M Salisbury	
	Mr L T Wilson	
Invited to attend:	Dr N T Begg	CDSC
	Dr K M Citron	BCG Sub-Committee
Observers:	Dr S N Donaldson	DHSS, NI
	Dr J K Richmond	WO
	Dr O A Thores	SHHD
	Mr J Huntington	HEA
Department of Health:	Dr G Lewis	
	Mr R L Cunningham	
	Dr A Fenton Lewis	
	Dr F Rotblat	
	Mr M A Noterman	
	Miss J Adaoui	
	Mr K O'Leary	

1. Apologies were received from Professors Crompton (who had replaced Dr Grundy as the Welsh Office nominee) Peckham and Smithells; from Dr Noble; and from Drs Bartlett (CDSC and Chambers (HEA). Mr J Huntington attended in Dr Chambers's place.

2. The Chairman said that Professor Knowelden was retiring from JCVI membership, and thanked him for the many years of service he had given to the Committee. Professor Grahame-Smith had resigned his membership due to pressure of other work. Dr Gwyneth Lewis (DH) and Dr Kay Richmond (WO observer) were welcomed to their first JCVI meeting.

3. The minutes of the meeting held on 21 April 1989 were agreed.

4. **Matters arising**

Page 2, bottom, confidentiality of research - Mr Wilson said that members' concern, particularly that of Professor Miller, had been put to the Department's Research Management Division, which would convey those views to the MRC.

Page 3, Item 2, "Public Health in England" - Mr Wilson referred to the note by the Department and to the copy of EL(89)P168 to Health Authorities etc (which immediately followed the Minutes for 21 April in the papers for this meeting), and said that copies of the Consultation Document to which the EL referred had been tabled for Members. Mrs Dennison in the Department would be grateful for (written) comments on the Document from JCVI members, by 31 January 1990.

Page 5, item 9, anaphylaxis - Dr Salisbury confirmed that he had examined reports to CSM of anaphylaxis following childhood vaccination in the period 1978 to 1989, and had made enquiries whether there had been in that time any reports of death in such circumstances to OPCS. In all that period, during which about 25 million childhood vaccinations had been given, no deaths were reported due to anaphylaxis. This information would be included in the new edition of the Memorandum.

Page 5, item 9, legal position on prescriptions - Mr Wilson acknowledged Dr MacFarlane's letter of 31 August clarifying this issue, and said that previous legal opinions had been referred to the Department's legal branch, with Dr MacFarlane's letter, for a consensus view. A reply was awaited, but it was hoped that a definitive statement would be available soon, possibly in time for the 1990 Memorandum.

Page 6, item 12.3, polio immunisation for unprotected adults - Mr Wilson said that the Committee's wish for deletion of the age limit (40) for an item of service fee had been passed to the appropriate officials and would be considered once the launch of the new GP contract was out of the way.

Page 7, item 16, vaccines against haemophilus B influenza - Professor Lambert asked about progress. Dr Salisbury referred to the CDVIP paper (JCVI(89)26) and said that another meeting of that Committee was due. Dr MacFarlane confirmed that funding had been obtained for an Oxford regional efficacy trial. Dr Smith said that research which could not be clearly identified as "original" could have difficulty in obtaining MRC

funds, and, in reply to a question from Dr Selkon, Dr Salisbury confirmed that the concordat between the Department of Health and the MRC, whereby each could re-direct and recommend projects to the other, still existed. Dr Smith said that the haemophilus working group within the PHLS co-operated fully with MRC and with Professor Moxon's group at Oxford.

Page 7, item 18, Bovine Spongiform Encephalopathy and Creutzfeldt-Jakob Disease - Professor Collee reported that firm evidence still showed no certain cause for alarm, but there was quite a lot of speculative media material which did cause concern. The issue would not be finally resolved for some years. In reply to a question from Dr Smith about meat from animals infected but not exhibiting BSE, but which might have passed into the human food chain, Professor Collee said that the apparent relationship of scrapie and BSE was the only one identified so far, but the experts were looking also at similar conditions in mink and deer. The hope remained that cattle proved to be "dead-end hosts".

5. Vaccination and Immunisation Statistics 1988-89

5.1 England (JCVI(89)18) - Dr Salisbury said that it had not been possible to table the figures for England because the reporting year was the first to use Korner specifications, and there had been both late and inaccurate returns. Some were clearly aberrant and the assistance of the Immunisation Co-ordinators was being sought to clarify them.

5.2 Scotland JCVI(89)19) - Dr Thores tabled this paper and said that it contained validated figures from ISD. MMR had not been included because of the possibility of double-counting. Many Health Boards are still on manual systems. Dr Jones commented that the figures for Fife were seriously inaccurate. He had contacted ISD but the difficult was that they used birth cohorts and not the number of children actually living in the area. Fife's own calculations indicated 96% for Diph/Tet/Polio, 93 for MMR and 83 for pertussis. Dr Thores added that there was genuine concern about the future of GP returns with the advent of the new contracts.

5.3 Wales (JCVI)(89)20) - Dr Richmond said that the Welsh figures (tabled) still showed a considerable variation in uptake of pertussis. The old basis of return was still used in Wales; Korner had not yet been introduced.

5.4 Northern Ireland (JCVI(89)21) - Dr Donaldson pointed out that Diph/Tet/Polio uptake had risen by 3% and measles by 23%. There were some fears of double counting on MMR.

In response to an enquiry from the Chairman, it was confirmed that all countries except Scotland would eventually use Korner returns. Professor Collee said that the Committee should emphasise that it was of the utmost importance that compatibility and accuracy of immunisation statistics should be improved. Such accuracy was essential if the Committee were to pursue its aims. This view was unanimously endorsed. Mr Cunningham said that the Department would consider whether the

issue might be put to the NHS Management Executive; Dr Salisbury said that there had been discussions with the Child Health Computing Committee about ensuring accuracy down to GP level and, in answer to question from Dr MacFarlane, said that the list of duties of immunisation co-ordinators would be checked to confirm their responsibility on statistics. The British Research Marketing Bureau had been commissioned by the Department to interview all co-ordinators; the questionnaire included a question on checking statistics. If co-ordinators did check, there was generally a good uptake; if not, it was generally lower. The full results of the BMRB survey would be available for the Committee's next meeting.

6. Meeting of District Immunisation Co-ordinators from 25 lowest achieving DHAs : 20-22 September (JCVI(89)22)

Dr Salisbury, in commenting on the papers provided, emphasised that some of the most impressive improvements in uptake were coming from these lowest achieving DHAs. The greatest problems identified at the seminar were mobility of young families and inaccuracies in the recall systems leading to under-recording. The Department would try to pursue these problems through the management side, but individual districts must assume responsibility too. Dr Bush commended the proposal to approach management, saying that some co-ordinators were less well supported locally than others, and Mr Huntington said that the DH/HEA immunisation publicity plans for 1990 would be aimed at managers as well as professionals. On mobility, Dr Salisbury said that DH was discussion with DSS the possibility of inserting immunisation reminders with child benefit books following changes of address.

7. Childhood Immunisation Schedule JCVI(89)23

The Chairman asked Dr Salisbury to introduce this paper which reported the meeting of a Working Group held in 6 September at JCVI's request to consider an accelerated schedule of primary immunisation. The possibility of an imminent pertussis epidemic was an additional factor. Dr Salisbury referred particularly to the accompanying published WHO paper by Halsey and Galazka, the most important points of which were summarised at 4.4 to 4.6 of the Note (effectiveness of OPV begun at 4-6 weeks, antibody titres one year after DTP administered at one monthly or two monthly intervals, likely reduction of febrile reactions (very rare before six months), and likely increase in temporal association with SIDS). The recommendation before the Committee was for Diphtheria, Tetanus, Pertussis and oral polio vaccinations all to be given at two, three and four months.

Dr Begg outlined two studies already under way and a retrospective cohort study from Plymouth involving children in the previous whooping cough epidemic (out of 51 so far tested only two did not have adequate immunity at 4½ years), and the other a prospective cohort study in one DHA. No untoward adverse events had shown up in the first 20 children who had completed the accelerated schedule.

Dr Smith said the Group had been impressed in particular by the view that the correct (imprecise) schedule did not help in obtaining maximum uptake. The child problem, it felt, was in deciding whether to start at 2 or 3 months. The USA and Canada started at 2 months with no apparent problems and a reduction in febrile convulsions. He was persuaded by the arguments for an accelerated programme starting at 2 months, but monitoring of immunity would be important.

Professor Miller said that Dr Begg's report of "slippage" in the cohort study was not necessarily adverse, but the doubt remained that adherence to a strict schedule might have produced a different result. He felt uneasy about being asked to decide on a change in advance of UK studies, but agreed that the evidence from the USa and Canada was impressive. He was not entirely happy with some of Galazka's conclusions. The reason for the current schedule was that it produced a better antibody response. He begged to differ with paragraph 4.6 of the notes. The peak incidence of afebrile convulsions was at 6 months and there was a risk of associated neurological events. However, Phase III of the MRC Acellular Pertussis Vaccine Study was due to start soon and he therefore hoped that the Committee would reach a decision at this meeting.

Dr Selkon sought an adequate definition of "date of birth" relation to premature babies, and Professor Hull replied that a study had already been competed; there was no reason of a pre-term infants to be managed differently. The Chairman confirmed that many nurses vaccinated babies before they left neonatal intensive care units. Professor Collee felt that the points mentioned by Professor Miller needed to be considered carefully and referred to ARVI's insistence on a precise definition of cot deaths.

Professor Grob said that the proposed schedule would meet with approval from the RCGP it fitted in well with paediatric surveillance. The Committee would need to consider how to time its introduction.

Professor Lambert asked about the need to give a fourth dose of vaccine at 18 months if an early schedule applied (as in the US), but Dr Smith said that vaccines were less potent when a fourth dose was recommended. The present vaccines were more reliably potent and there was good evidence that a three dose schedule conferred immunity. Dr Bush said that if the Committee agreed a new schedule it would have to be sure it would apply for some years; furthermore, he felt that the new schedule would have to be recommended formally to apply from a pre-determined date. Dr Salisbury agreed and said that those responsible for computers would be consulted.

Dr Schild shared Professor Lambert's concern on the shortened schedule. Diphtheria and tetanus vaccines seemed secure, but he was less certain about pertussis. Dr MacFarlane said that the first check on the child health surveillance progress was recommended at six to eight weeks of age, and this check could be made to coincide advantageously with the first vaccination. There was general agreement that an 8 week, 12 week and 16 week recommendation for vaccinations would fit in best with computer requirements, and the child health check could coincide with

the first one at 8 weeks. Concern was expressed by several members about the likely future introduction of a haemophilus influenza vaccine and the optimal age for such a conjugate vaccine and Professor Levinsky said that it will be necessary to demonstrate that it was adequately immunogenic if given at 2, 3 and 4 months. Mrs Roden supported the proposed change, but asked that the parents' views be borne in mind. Professors Geddes, Banatvala and Knowelden also expressed support. Dr Thores urged for an adequate lead-in time and Dr Rotblat asked for the manufacturers to be alerted early. The Chairman put the proposal formally to the Committee who agreed without dissent to the schedule for diphtheria, tetanus, pertussis and oral polio vaccinations being adjusted to 8, 12 and 16 weeks. The points made on early warnings, adequate lead-in time, a specific starting date and close surveillance of the new schedule in early years would all be taken on board.

8. **Memorandum "Immunisation against Infectious Disease" JCVI(89)24**

A complete draft of the proposed 1990 edition was tabled for Members. Dr Salisbury went through the main changes, including the new schedule just agreed, the unequivocal reference to anaphylaxis, the expanded references to immunoglobulins, the recasting (with the help of Professor Miller) of the Adverse Reactions passage in the Whooping Cough chapter, the "promotion" and rewriting of the MMR chapter, a compete revisions to the Tuberculosis chapter (Dr Fenton Lewis) and new chapters on Varicella/Herpes Zoster and Meningococcal infections. Dr Salisbury asked Members to comment in writing on the draft by 24 November so that the new edition could be released as early as possible in 1990. The Chairman congratulated Dr Salisbury on the effort put into improving an already greatly improved handbook.

9. **ARVI Committee - Minutes of meeting 6 October 1989 (JCVI(89)25**

With this item was taken Item 11.3 : Report on Adverse Events Associated with MMR JCVI(89)30. Professor Collee said that the 6 October meeting, which spent much of its time on MMR, justified the existence of ARVI, although he regretted the absence of so many of its members. Although the Committee needed to be strengthened considerably those present on 6 October represented a wide spectrum of experience. The preliminary conclusion on neurological reactions at paragraph 5.2 would need to be reviewed as time went by and the estimate of risk in 5.2.3 would be viewed with reservation. The statement referred to in 5.2.4 (at Annex A) was produced at SHHD's request as the Procurator Fiscal was involved in the case. Professor Collee expressed gratitude to NIBSC for the progress it had achieved in developing techniques to identify wild and vaccine virus strains. Dr Schild reported that NIBSC was now able to distinguish clearly the wild strains from each of the two vaccines, and isolates from the CSF clearly showed Urabe i all three cases believed to be associated with vaccine - although it should not be assumed that Jeryl-Lynn is not capable of the same result. Professor Collee added that no

mumps vaccine could be said to be void of risk. Dr Schild said NIBSC would be happy to continue analysing samples and Dr Smith and Dr Begg agreed to prepare an appropriate note for "Communicable Disease Reports" issued by CDSC.

Professor Hull expressed concern about the detail of the information provide by ARVI for JCVI and said he would like to see a synoptic statement giving more precise information, an indication of the framework on which ARVI based decisions. Professor Collee replied that to provide additional material on which ARVI reached conclusions would add considerably to the papers already distributed to JCVI; those who attended on 6 October had spent as long in committee as could reasonably be expected, an he wished for record his thanks to Dr Salisbury who had prepared so much of the ground for ARVI outstandingly well. The Chairman thanked Professor Collee who had now relinquished the ARVI chairmanship and said that this report reinforced the importance of ARVI's continued existence.

11. MRC CDVIP JCVI(89) 26 and MRC CMV Research

The minutes of the CDVIP meeting of 15 November 1988 were for information. Dr Smith reported good scientific progress on Respiratory Syncytial Virus (RSV) vaccine research and congratulated Professor Miller and colleagues on the work on acellular pertussis vaccine. New hepatitis A vaccines were on the horizon. The two registers Leeds and Great Ormond Street, monitoring cases of CRS had been amalgamated at the latter location in the change of Dr Helen Holzel. Following the closure of the common cold research unit there was at present no human volunteer facility. Dr Schild added that the proposed clinical trail of the herpes simplex (Skinner) vaccine would not now take place. The news of a vaccine against AIDS was now more optimistic. Studies with monkeys had shown evidence o vaccine effectiveness in similar viruses. The paper on MRC CMV Research (numbered JCVI(89)27) was not available and would be provided later. CMV had been brought to the public attention through BBC1's Watchdog programme.

11.1 MMR - Report on Notifications and Vaccine Distribution JCVI(89)28

Dr Salisbury said that notifications of measles were very low - the lowest half year on record had just been recorded. The major proof of the success of MMR would be in 1990 when a measles epidemic was due. The graph circulated showed a continuing divergence between distribution of vaccine and number of children in the recommended cohorts. There was a flattening of the distribution in August because NIBSC failed one batch.

11.2 MMR - Report on COVER programme (JCVI(89)28

Dr Begg said the paper was an early look at coverage, and referred to the graph comparing measles and MMR at 15 months for children born in July to December 1986 and 1987 respectively. The low figures probably reflected late vaccination and late recording of vaccination.

11.3 MMR adverse Events (JCVI(89)30 was taken with item 9

11.2 Measles immunity - correspondence from Dr McConnell JCVI(89)31

Professor Banatvala said that there was no evidence or the efficacy of measles vaccine wearing off and Dr Begg pointed out that coverage in the US was less than in the UK. Dr Salisbury said that the US presented a situation of great complexity since so many children were only vaccinated immediately before school entry; epidemiological arguments for recommending a measle booster at age 12 were not present in the UK. Coverage in Denmark, where a booster was recommend at age 13-14 was only 50-60 per cent.

12.1 Whooping cough - article by Dr A H Griffith in Vaccine etc JCVI(89)32

Note : At Professor Miller's request, this item was taken after item 8 in the Agenda)

Professor Miller referred to the two other papers which accompanied Dr Griffiths and formed JCVI (89)32 - the response from the NCES team to Dr Griffiths article, which would be published in Vaccine for December 1989, and the paper they had given toe the Fifth International Symposium on Pertussis in September 1988 in Copenhagen. He said these papers spoke for themselves; the NCES had spent a long and intensive period on the study and had been unable to reach a conclusion on risks. Professor Hull referred to the question raised by Griffith in relation to JCVI. The Judge's conclusions, which were contrary to JCVI's long-standing views on risk; were equally based on over interpretation of data. Should a degree of risk appear at all in the Memorandum? What the NCES had shown, was that if the vaccine led to acute neurological reaction it did so very rarely. Professor Miller, agreed and Professor Hull said that he would like to see the advice modified on the lines of:-

> "All but one of the children in the study identified as having suffering associated reactions recovered. Clearly the conclusion cannot be reached from this study that the vaccine causes permanent brain damage."

Dr Bush agreed that the statistical data of attributable risk should be removed, but felt that the judgment should not be accepted unreservedly.

Dr Salisbury said that if the public was given a risk ratio - any ratio - they would still see it as a scientifically proven risk. It was therefore preferable not to use insecure figures if possible but to stress the benefits from vaccination. He asked members to consider the revised passage on adverse reactions in the draft Memorandum, which had been prepared with Professor Miller.

12.2 Whooping Cough Notifications JCVI(89)33

The five week moving average graph prepared by Dr Salisbury showed notifications so far running at well before the level of the previous comparable epidemic year (1985).

13. **Influenza Pandemic Plan JCVI(89)34**

Dr Smith said that this plan was not finalised, but that a draft should be available later in the year. It could be activated if a pandemic arose but there was no such prediction at present.

14. **Cholera and Typhoid Vaccination - Recommendations for Travel JCVI(89)35**

Dr Fenton Lewis referred to the booklets distributed which gave the current advice, and to the tabled paper, and he asked Members to comment in writing.

15. **Pneumococcal vaccine JCVI(89)36 and 37**

Professor Collee said that uncertainty surrounded the recommendations for pneumococcal vaccine, particularly in relation to the elderly. Dr Selkon felt that JCVI should seek to make a firm statement on the matter; more data would be provided for the next meeting. Dr Rotblat confirmed that the vaccine was licensed in the UK and she was surprised, therefore, that what MSD had told Dr Fedson.

16. **BCG vaccine supply and figure of schools' programme JCVI(89)38 and 29**

Dr Citron presented the minutes of the two BCG Sub-Committee meetings on 27 June and 9 August. The Sub-Committee had considered the importance of the high risk groups and the effect of postponement of the schools programme on deaths from tuberculosis. It had also concluded that there was no suitable alternative vaccine. The second letter from the Department had been sent at the end of October, and it was now reasonable to conclude that sample supplies would be available again by June 1990. The next Sub-Committee meeting on 29 November was the one which would consider the future of the schools programme. The Chairman agreed that this topic would be a major item at JCVI's May 1990 meeting.

Dr Citron drew attention to two further points - Dr Lunn's study of keloid scars, noted in the June minutes, showed that most were due to incorrect site of vaccination; and, in reply to a question from Dr Jones, said that the (small) company producing disposable plastics heads seemed reluctant to proceed because of doubt surrounding the future of the schools' programme.

Dr Bartlett's paper on tuberculosis infections for the CMOs Central Health Monitoring Unit was drawn to the Committee's attention.

17. **Meningococcal Vaccines**

Two A and C vaccines had been licensed; there had been just five reports of local adverse reactions. Dr Salisbury had prepared a chapter for the new Memorandum.

18. **Storage of vaccines JCVI(89)40**

Dr Hunter's article was noted. Dr Salisbury said there would be a section on storage in the new Memorandum.

19. **WHO EPI report JCVI(89)41**

Dr Salisbury said that the Global Advisory Group had met in October. Over two-thirds of the worlds' children were now protected by vaccination by the age of 12 months. WHO now recommended counties with high rates of early fatality from measles to use high-potency vaccine at the age of 6 months, but all such vaccine would be provided in the first instance by UNICEF. Nevertheless, the use of such high-potency vaccines promised early protection against measles and may need to be consider at some point. Professor Banatvala said the MRC Sub-Committee would pick this up.

20. **Any other business**

The Chairman said that the Joint Working Group of the BPA and JCVI had met in late October. The BPA also favoured the proposed new vaccination schedule.

Dr Rotblat said that a licence variation application for using paracetamol as treatment for pyrexia had been turned down.

Dr Thores spoke of the risk to the MMR programme of adverse publicity and said that vigilance by all was essential.

21. **Meetings in 1990**

The Committee's meetings in 1990 will be on Friday 4 May and Friday 2 November.