JOINT COMMITTEE ON VACCINATION AND IMMUNISATION
Minutes of the meeting held on Friday, 2 November 2001
Held at BMA House

Attending:

Members:
Professor Michael Langman (Chairman)
Dr Barbara Bannister
Professor Keith Cartwright
Dr Jonathan Cohen
Dr David Goldblatt
Professor Paul Griffiths
Professor David Joynson
Professor Simon Kroll
Professor Neil McIntosh
Professor Lewis Ritchie
Dr Richard Smithson
Professor Brent Taylor

Ex officio:
Dr Ian Jones
Dr Geoffrey Schild

Observers:
Dr A. Croft (MoD)
Wg. CDR Andy Green (MoD)
Dr Arlene King (Bureau of Infectious Diseases, Ottawa, Canada)
Major Pauline McDonald (MoD)
Dr Angela Williams (MRC)
Dr Jan van Wijjngaarden (Ministry of Health, the Netherlands)

Invited to attend:
Dr Natasha Crowcroft (CDSC)
Dr David Elliman (Chair, London District Immunisation Co-ordinator's Group)
Dr Elizabeth Miller (CDSC)
Dr Mary Ramsay (CDSC)
Mrs Judith Moreton (Health Promotion England)

Department of Health
Dr David Salisbury (Medical Secretary)
Dr Jane Leese
Dr Hugh Nicholas
Nick Adkin (Administrative Secretary)
Mrs Loraine Gershon
Mrs Debby Webb
Dr Arlene Reynolds
Dr Karen Noakes

Robert Freeman (minutes)
Mrs Cl[illegible]ette Gyampoh
Mrs Josie Senior-St Juste
Miss Julia Falana

Medicines Control Agency
Dr Peter Arlett
Dr Phil Bryan
Dr Ragini Shivji

Scottish Executive:
Dr Elizabeth Stewart

National Assembly for Wales:
Dr Mike Simmons

DHSS Northern Ireland:
Dr Lorraine Doherty

1. ANNOUNCEMENTS AND WELCOME

1.1 The Chairman welcomed members to the meeting. Attending their first meeting were Judith Moreton (Health Promotion England, covering the work of Jo Yarwood); Dr Arlene King (Chief of the Immunisation Division, Bureau of Infectious Diseases, Laboratory Centre for Disease Control, Ottawa, Canada); Major (Dr) Pauline McDonald (MoD); and, Dr Karen Noakes (new Senior Scientific Officer with the Department of Health's Immunisation Team).

1.2 Invited to the meeting were Dr David Elliman, Chair of the London District Immunisation Co-ordinators' Group, and Dr Natasha Crowcroft (PHLS CDSC).

1.3 Apologies had been received from Drs Harling and Roworth from the Committee; Drs Walford, Griffin and Nicoll, ex-officio members; Dr O'Flanaghan (NDSC, Dublin); Mrs Jo Yarwood (HPE); Dr Tsang (MCA); and Dr O'Mahony, Mrs Carole Fry and Ed Davis (from the Department of Health).

The following papers were tabled:

Immunisation Coverage - Northern Ireland (JCVI(01)61), item 4.2;
Vaccine Associated Suspected Adverse Reactions (JCVI(01)65), item 4.6;
The impact of the MenC Vaccination Programme on unconfirmed meningococcal disease in England and Wales (JCVI(01)67), item 5.4(figures and tables);
Measles in London (JCVI(01)74), item 7.4.

The following items were available for members to take away:

'MMR - What parents want to know' video
'MMR - The Big Questions' video
MMR Information packs
CMO Letter 2001/5 "Current Vaccine and Immunisation Issues" (15 October 2001)
Pre-school immunisation information packs
DTaP Factsheet
New HPE childhood immunisation leaflets
'Health Information for Overseas Travel 2001' (Yellow Book)

2. MINUTES OF LAST MEETING HELD ON FRIDAY 4 MAY 2001 — JCVI(01)59

It was agreed that the wording of paragraph 3.4.2 of the minutes of the 4 May meeting was misleading. It was agreed to delete the first sentence of this paragraph, so that it reads:

3.4.2 It was noted that the FDA website devoted to this issue was very helpful.

Otherwise, ***the minutes were agreed as a true record of the meeting.***

3. MATTERS ARISING

3.1 Responses to JCVI advice at its last meeting

These were covered in the main body of the agenda.

3.2 Website/open minutes — JCVI(01)59(b)

A JCVI website was to be launched soon. It was intended that the website would include details of the Committee's terms of reference, membership, members' declared interests and the open minutes of committee meetings. The website would help in achieving the Committee's aim of being more open about its work. Since committee members' interests may attract public attention, members were asked to ensure that their Declarations of Interest were kept up to date and to send any outstanding returns to the Secretariat. The Chairman confirmed that, if a member was paid personally for work for a particular company, that should be declared as a personal interest. Members with personal interests in any particular issue may, because of the expertise they would have acquired, be asked questions during the course of a Committee discussion on that issue. They would not, however, have any involvement in any recommendations made by the Committee on that issue. Discussions about a generic product rather than about the product of a specific manufacturer would not stop a member's full participation in discussions.

3.3 'Immunisation against Infectious Disease'

The chapters for the new edition of 'Immunisation against infectious disease' (the Green Book) had been sent out to contributors. Half of these had now been returned. All the vaccine manufacturers had provided appropriate information. Copies of the new edition of 'Health Information for Overseas Travel' (the Yellow Book) were made available to members.

3.4 DTaP

Following the Committee's recommendation, DTaP vaccine was being introduced into the routine pre-school booster immunisation programme in England with effect from 5 November. The vaccine to start the programme had already been delivered, information for health care workers had been provided through a CMO letter and material for the public from HPE would be made available. Appropriate arrangements were also being made in Northern Ireland, Scotland and Wales. DT vaccine was still available from Farillon.

3.5 Meningococcal vaccine for Hajj pilgrims

3.5.1 The Committee had discussed meningococcus W135 at previous meetings. Although the Committee had recommended use of the quadrivalent ACWY vaccine in pilgrims last year, the vaccine had become generally available rather late and only about half of all pilgrims had been immunised with this vaccine. The Committee had recommended that a reserve stock be purchased by the Department and that the vaccine be more actively promoted during 2001. Both of these recommendations had been implemented. A publicity campaign to make pilgrims aware of the serious risk of meningitis and the need to have this vaccine was to be launched on 5 November. This advice was also included in the new edition of the Yellow Book. One member questioned whether increased reactogenicity would be expected in people who had recently had either conjugate meningococcal C or polysaccharide A&C vaccine. It was agreed that there was no reason to think this should be so, and no such reactions had been observed in studies. The MCA would, in future, follow-up Yellow Card reports where an individual had received the quadrivalent ACWY vaccine to clarify whether they had received meningitis C conjugate vaccine or polysaccharide A&C vaccine previously.

3.5.2 The schedule for young children was discussed. Previously 2 doses of the A&C vaccine had been recommended for children up to the age of 2 years. The quadrivalent vaccine is licensed from 35 months. It was agreed that unless more definitive advice was forthcoming, the same recommendation as for the A&C vaccine should be followed.

3.6 Options for the use of pneumococcal conjugate vaccines

This information is commercially sensitive.

3.6.1 The following declarations of interest were made by members:

Professors Kroll, Griffiths and Schild and Drs Jones, Goldblatt and Joynson: non-personal, non-specific;

Professor Cartwright: personal and specific

The Chairman agreed that all could remain for the discussion but that a personal specific interest prevented any participation except in answering questions. Non-specific, non-personal interests allowed full participation.

3.6.2 At its last meeting the Committee had discussed the potential use of conjugate pneumococcal vaccines. At that meeting the Committee had agreed that there was insufficient evidence on which to base a decision with regard to the vaccines' routine use in children. The Committee had agreed, however, that the vaccine should be used in those aged under 2 who were in the existing 'at risk' categories. This recommendation would be included in the revised Green Book. The vaccine manufacturer was eager for the vaccine to be used more widely, but the Committee agreed that there remained some difficult issues to be resolved before any final decisions on its more general use could be taken. These included the question of prioritising between MenC and pneumococcal vaccines and the time-tabling of multiple vaccines. Unlike meningitis C vaccine, for which there appeared to be evidence that two doses might be sufficient, there was no such data available at present for pneumococcal conjugate vaccine. Therefore, introducing pneumococcal vaccine at 2, 3 and 4 months of age would require three injections at each visit. The possible role of a booster and/or additional visits needed examining and the immunisation schedule would need rewriting. In addition to these difficulties, pneumococcal disease was less well known by the public and would thus require a major public information initiative. There remained the question of the role for the existing polysaccharide vaccines to cover a wider range of antigens in people who have conjugate vaccine. Concerns were also raised by members about the use of the new conjugate vaccine in those who had previously had the polysaccharide pneumococcal vaccine. There was little data on this, although US studies had showed no problem with vaccinating with conjugate vaccine after polysaccharide vaccine. Full information about this would be obtained for the Committee from CDC.

3.6.3 ***The Committee agreed that, pending further evidence, the plain polysaccharide vaccine should be used for those needing repeat doses of pneumococcal vaccine. The Committee agreed that more information to answer the questions raised above was required before further recommendations could be made. The Committee requested a paper addressing these issues for the next meeting.***

3.7 Chairman's report on special advisory groups

3.7.1 There had been three meetings of specially convened JCVI sub-groups to discuss smallpox, anthrax, plague and botulism in the light of the current international situation. They had looked at recommendations for vaccines, antibiotics policies and delivery strategies. The meetings had helped to clarify many issues. This information was sensitive, no minutes had been taken but advice had been provided to Ministers and published on the PHLS website. The sub-groups had emphasised the need for information for the public and frontline workers.

3.7.2 The issue of advice to the profession and public on bioterrorist threats was raised. Members with concerns were asked to let the PHLS know if they had suggestions for improving any aspects of their published advice.

4. COVERAGE AND OTHER REPORTS

4.1 Cover Report and Immunisation Statistics JCVI(01)60

In England, MMR vaccine uptake had fallen slightly again reflecting the major wave of adverse media publicity in January 2001, although the figures may be artificially low because of the data collection requirements for the now routine MenC vaccine. There had also been a very small fall in uptake of other antigens at 12 months. It was noted that the situation in London was particularly poor with uptake being 10 to 20 percentage points lower than the rest of the country. Reported MMR uptake was particularly low in London, although there were undoubtedly some data collection problems (see agenda item 7.4, below).

4.2 Immunisation Coverage - Northern Ireland JCVI(01)61

Uptake of the primary vaccines remained high in Northern Ireland although MMR uptake had seen a slight drop (uptake at 24 months had fallen by 5 percentage points but was still at 90%). A number of local initiatives were in place to reverse this. The DTaP programme would start by the end of the year and extending the use of meningitis C vaccine to those up to age 24 was also under consideration. The meningitis C vaccine had reduced cases by 90% during 2001 over the previous year.

4.3 Immunisation Coverage - Wales JCVI(01)62

The situation in Wales was similar to that in other parts of the UK outside London. Dr Andrew Wakefield had addressed the National Assembly of Wales on MMR but his presentation did not appear to have gained much media attention.

4.4 Immunisation Coverage - Scotland JCVI(01)63

MMR remained the main problem in Scotland and uptake had dropped by 3 percentage points. One Health Board was tracking parents' refusals to see what reasons were being given. The Wales "Myth Buster" pack had been adapted for use in Scotland. Uptake of meningitis C vaccine was good.

4.5 Health Promotion (England) JCVI(01)64

Health Promotion England had published its new MMR Pack in July and feedback from the field had been positive, especially with regard to the parents' and health professionals' videos. Coinciding with the introduction of DTaP vaccine for pre-school immunisation, a new information pack was being issued containing a revised general Guide to Childhood Immunisation, a new leaflet for pre-school immunisation, a DTaP factsheet and a new poster. Work was also going into development of a replacement for the existing TV advert. New leaflets for school leavers and about BCG were being prepared, as were quick reference guides. All parts of the immunisation programme were, therefore, now covered by updated parents' information leaflets.

4.6 Vaccine Associated Suspected Adverse Reactions JCVI(01)65

4.6.1 This paper provided an update on the number of claims for vaccine damage payments made to the Department for Work and Pensions' Vaccine Damage Payments Unit. There had been a significant fall in the number of claims made between April 1999 and March 2000. The number of claims had then increased between April 2000 and March 2001. Many of the claims in 2000/01 were for autistic spectrum disorder and the majority of these cited MMR vaccine. 75% of the ASD cases were in males. It was noted that the number of claims for vaccine damage was not the same as the number of awards made. Only one claim for damage caused by any vaccine had been successful during the previous 12 months (a claim for a 44 year old male who developed transverse myelitis and radiculopathy a week after receiving tetanus, polio and typhoid vaccines). The recent average was less than 5 successful claims a year. The Department of Health was provided with information on about 85% of all claims; this information was only made available with parental (or patient, where appropriate) consent. Whilst the Vaccine Damage Payments Panel knew of Department of Health policy, they were independent of the Department. A Panel's membership was generally not in the public domain but it did include a medical assessor.

4.6.2 It was noted that, following the US Institute of Medicine's report on MMR and autism, the US vaccine damage payments scheme had decided that claims of autism linked with MMR would not be added to its list of conditions receiving automatic payment.

5. THE MENINGOCOCCAL GROUP C IMMUNISATION PROGRAMME

5.1 Update on Meningitis C

The meningitis C immunisation programme was running well and the catch-up had been completed some time ago. The vaccine was now being used in Ireland, Spain, parts of Canada and other parts of Europe were looking at its potential use as well. The Netherlands was to introduce the vaccine from September 2002.

5.2 Progress on introduction of vaccine for 20-24 year old individuals

A cost benefit analysis had been undertaken on the use of the meningitis C vaccine in people aged 20 to 24 years. This analysis had come out in favour of the vaccine, and recommendations had been made to Ministers accordingly. Practical matters, such as payments for GPs and information requirements, were still being worked out. The problem of targeting those aged 20 to 24 - particularly males, who rarely visited their GP - was acknowledged.

5.3 Update on the meningococcal C conjugate vaccination programme efficacy in England and Wales JCVI(01)66

5.3.1 The meningococcal group C conjugate vaccine had had a big impact on meningococcal Group C disease. Vaccine failures had been few, efficacy estimates remained high and the levels of individual protection were also high. This winter will be of especial importance in providing evidence of protection in children who had received routine infant MenC

vaccination, who were now one year of age or more and had not had a booster dose. There was encouraging evidence of the vaccine providing herd immunity, a significant indirect benefit. There was no evidence that there had been serotype switching from Group C to Group B. This winter's meningococcal season would provide more data.

5.3.2 There had been a small increase in Group B meningococcal disease in people under 20 years of age.

5.3.3 It was noted that the sequence type causing the problems with increases in meningococcal C disease was the same as that in the W135 meningococcal disease, showing that there was a theoretical hazard of a sero-group shift. A large genetic review was being undertaken and ***the Committee endorsed the fundamental importance of this continuing surveillance programme.***

5.4 The impact of the MenC Vaccination Programme on unconfirmed meningococcal disease in England and Wales **JCVI(01)67**

5.4.1 This paper provided data on meningococcal cases where the grouping had not been confirmed. Before the introduction of meningitis C vaccine, it had been estimated that there were 5,000 confirmed cases of meningococcal C disease every five years which would be prevented by the vaccine. The cause of unconfirmed cases of meningococcal disease had now been looked at more closely, and it had been found that more cases of Group C disease had occurred prior to the introduction of the vaccine than had originally been thought. 1998 surveillance data identified 1,000 cases of meningococcal C per annum but this study suggested there might have been as many as 1,000 cases of meningococcal C in the first six months of that year alone. This data suggested that the impact of the meningococcal C immunisation programme may have been even greater than thought so far, with a 77% reduction of disease in all age groups.

5.4.2 The relationship between meningococcal C vaccine and Sudden Infant Death Syndrome (SIDS) was discussed. Sound data on whether the introduction of MenC vaccine had reduced SIDS through reducing meningococcal Group C disease were not available. Members expressed concerns about the shortage of paediatric pathologists and the subsequent use of adult pathologists for child autopsies when cases of SIDS were being investigated. This could impair proper recognition of the cause of death in babies.

5.4.3 . The MCA had brought an expert panel together which had concluded that no cases of SIDS were likely to have been caused by the vaccine. The MCA offered to make this paper available to the Committee and the Committee asked to see the paper at its next meeting.

6. THIOMERSAL

6.1 Immunization Safety Review Committee: Thimerosal-Containing Vaccines and Neurodevelopmental Disorders — JCVI(01)68

6.2 Thimerosal-Containing Vaccines and Neurodevelopmental Disorders — JCVI(01)69

The US Institute of Medicine (IOM) had been commissioned by the CDC to provide reports on "emerging vaccine concerns". The IOM had used its standard categorisation in reporting - broadly, either the "evidence was sufficient to support an association" or that "the evidence was sufficient to reject an association" or the middle ground. The IOM review on thiomersal had concluded that, although it was biologically plausible that thiomersal could cause a neurodevelopmental adverse outcome, there was no evidence from any studies to show that it actually did. The IOM therefore concluded that "although the hypothesis that exposure to thiomersal-containing vaccines could be associated with neurodevelopmental disorders is not established and rests on indirect and incomplete information, primarily from analogies with methylmercury and levels of maximum mercury exposure from vaccines given in children, the hypothesis is biologically plausible". There had been little interest in the report in the UK.

6.3 Possible neuodevelopmental effects of thiomersal in childhood vaccines — JCVI(01)70

6.3.1 The conclusions of the Committee on Safety of Medicine's meeting, which had followed a very detailed discussion, had been quoted in the CMO letter issued on 15 October. The CSM had expressed some concerns about the limitations of the US study data available to it but had concluded that the preliminary results provided no coherent evidence of harm from thiomersal. They also felt that an extrapolation from methyl mercury to ethyl mercury (as contained in thiomersal) was not necessarily justified. Although CSM would continue to keep this issue under review, it had been reassured by what it had seen and had confirmed its view that there was no evidence that thiomersal was harmful.

6.3.2 A PHLS study, funded by WHO, was to be undertaken using the GPRD database. This would be done in close collaboration with Dr Chen's group at CDC in the USA. The analysis plan had been agreed and account taken of the differences between the codings in the GPRD and the standard ICD codes. Although the GPRD did not give exact dates of birth for all children, information was available on 120,000 children who had had recorded medical events from which a date of birth could be confidently extrapolated. A further study looking at the ALSPAC cohort (children born in Avon in 1991 and 1992) was also being undertaken by PHLS with Department of Health funding. This data was now ready for formal analysis and the results would be presented to JCVI.

6.3.3 In the US, many doctors still had thiomersal containing vaccines available. The IOM had called for withdrawal and replacement of thiomersal containing vaccines. This was contrary to the USA's Advisory Committee on Immunisation Practices (ACIP) recommendation which had been for progressive change. These confusing views together with public and professional concerns had resulted in people delaying hepatitis B

immunisation (hepatitis B vaccine contains thiomersal). ACIP's view was that a transition to thiomersal free vaccines should not involve active withdrawal of thiomersal containing vaccines.

6.3.4 The Committee was reassured by evidence that mercury exposure in the UK programme was very low. It confirmed its view that the available evidence did not indicate any hazard from the presence of thiomersal in vaccines but said that, because of the background evidence that mercury exposure could present a risk, thiomersal should nevertheless be withdrawn from vaccines whenever possible, provided equally safe and efficacious thiomersal-free products were available.

6.4 Progress on Future Supplies

This report was for the Committee's information. Although DTwP vaccines were generally more efficacious than DTaP vaccine, the five component DTaP vaccine had efficacy to match a good quality DTwP. This vaccine was currently only available in Canada, but it may become available in the UK within about a year subject to licensing. DTaP vaccines are thiomersal free. It was also pointed out that the Canadian vaccine used an aluminium phosphate adjuvant that did not interfere with the efficacy of the Hib component of the combined vaccine. The Committee also noted that the vaccine was produced in combination with Hib and IPV and that its availability would provide an opportunity for the JCVI to consider future options on OPV. The Department was discussing supply of the vaccine with the manufacturers.

7. MMR

The following declarations of interest were made by members:

Professor Ritchie, Dr Cohen: personal, non-specific;
Dr Goldblatt: personal, non-specific;
Professor Griffiths: non-personal, non-specific

The Chairman noted that those with personal interests could only answer questions but those with non-personal interests could take a full part.

7.1 No Evidence for a New Variant of MMR-Induced Autism JCVI(01)71

This study by Dr Eric Fombonne (since published) was a good pre- and post-MMR vaccination study of autistic children, especially focusing on those with regressive features. The study had found no change in incidence of regressive autism resulting from the introduction of MMR and had concluded that there was no evidence for a new syndrome linking bowel disease with autistic spectrum disorder as suggested by Dr Wakefield. The study therefore answered the specific hypotheses that appeared to have been put forward by Dr Wakefield, although, as the paper explained, these hypotheses were sometimes difficult to nail down. ***The Committee agreed that this data from Dr Fombonne was persuasive and indicated that the frequency of regressive autism appeared not to have increased.***

7.2 Report on Childhood Immunisation JCVI(01)72

This report from the Irish Parliament which concluded that MMR vaccination was not associated with autism was noted.

7.3 Scottish Executive Press Release on MMR JCVI(01)73

As requested by the Scottish Parliament's Health and Community Care Committee, an Expert Group on MMR had been set up by the Scottish Executive. The Group was working in the context of the JCVI being the UK's advisory body on immunisation matters. The Group had a lay chairman and its membership included representatives from autistic support groups and consumer groups as well as two members of JCVI. The Group was currently at the evidence collecting stage, and had heard reports from CSM/MCA, Dr Wakefield, Dr Ken Aitken and parent groups. The Group's report would be available some time early in the New Year.

7.4 Measles in London JCVI(01)74

This agenda item was taken after item 4.1

7.4.1 Dr David Elliman, Chair of the London District Immunisation Co-ordinators Group updated the Committee on a study in London looking at the accuracy of immunisation uptake data collection (last reported at the JCVI meeting held in January 2001).

7.4.2 Low MMR uptake, sufficient to cause outbreaks of measles in children age 5 when they started primary school, had been identified as a major concern in London. This study had reanalysed the MMR uptake data for those children born between 1 July and 30 September 1995 to see how much low uptake was real or was the result of poor data collection. The outcome of this study was that Health Authority uptake rates had been revised upwards, by an average of 6 percentage points. However, Dr Elliman raised caution in taking these figures at face value, as methodological problems mean they were upper figures. Even so, the revised figures still suggested that only a little over 80% of the population in the areas of London that undertook this analysis had had MMR. On the issue of real susceptibility to measles, it was noted that, although PHLS ran a serological surveillance programme for measles, data was difficult to obtain in London.

7.4.3 Solutions to the problems of data accuracy in London had been put forward. One suggestion was that the COVER and GP target data should be linked to encourage more reliable data collection. GPs were more effective in making their returns for the target payments but not so effective for the COVER returns because there were no financial incentives; GPs needed to be informed as to why the COVER data was collected.

7.4.4 The Committee expressed concerns about future arrangements for immunisation services once Health Authorities ceased to exist. It was felt that Primary Care Trusts would become more involved in leading on immunisation and the Committee agreed that they should be reminded of the importance of immunisation work. Officials were aware of the changing roles of CCDCs, Immunisation Co-ordinators and also of the potential impact of

the forthcoming CMO's Communicable Disease Strategy and the need to maintain a clear focus f[illegible]mmunisation.

7.4.5 The Committee was told that the ongoing changes to the NHS structure might provide an opportunity to improve the Child Health Computer System (CHCS). The CHCS had been in place since the 1970s and was in need of updating. These improvements should include enabling it to incorporate such data as vaccine supply, delivery, uptake monitoring, target payments and ADR monitoring. Also, the National Service Framework for Children might provide further opportunities to improve immunisation delivery. The Committee, however, acknowledged the need for caution in making whole-scale changes to the CHCS as it had served the NHS well, if slowly. ***The Committee emphasised the need to improve estimates of coverage, and thanked Dr Elliman for his analysis and constructive suggestions.***

8. BCG

TB in Leicester **JCVI(01)75**

The recent outbreak of tuberculosis in Leicester had been large and explosive. Most of the children affected had been Asian and had been immunised before school age. The study of the outbreak had estimated BCG vaccine efficacy at 42% (with a very wide confidence interval encompassing zero) in protecting against disease in this population; this was disappointingly low, but the nature of the outbreak was also unusual. It was noted that other studies had shown the efficacy of BCG to vary widely. As part of the ongoing work following this outbreak, Leicester was now routinely skin testing all children in the affected schools, whether or not they had been previously immunised, as their years became eligible for the schools BCG programme. The information from the Leicester outbreak would be part of the data to be considered when the JCVI next looked at the future of the BCG immunisation programme. A PHLS cost/benefit study was also being undertaken.

9. INFLUENZA

9.1 Implementation of the 2001/2002 immunisation programme in England

Preliminary information from the RCGP showed influenza vaccine uptake so far this year (one month into a two and a half-month campaign) to be 45% in people aged 65 and over, against this year's target of 65%. In 2000, influenza infection had been at low levels, relatively mild and, at least latterly, mainly due to influenza B. It was not possible therefore to draw conclusions about the degree to which influenza immunisation had contributed to the low excess winter mortality observed last year. However, the general evidence for the policy was clear: overall, influenza immunisation does reduce hospital admissions and deaths in the targeted risk groups. The evidence base for the cost effectiveness of the vaccine's use in health care workers was less obvious; the Department had issued a call for research proposals in this field.

9.2 Implementation of the 2001/2002 immunisation programme in Scotland

The influenza immunisation programme in Scotland was being run as last year, although there were now influenza immunisation co-ordinators in place. In 2000, some Health Boards had failed to reach the 60% uptake target. This year local advertising was being used to increase uptake. One Health Board had unilaterally introduced pneumococcal vaccine for all over 65 year olds. The Scottish Executive would come to the JCVI for further advice on this issue.

9.3 Implementation of the 2001/2002 immunisation programme in Wales

The programme was going well in Wales with no evidence of vaccine shortages. Uptake data was not yet available.

9.4 Implementation of the 2001/2002 immunisation programme in Northern Ireland — JCVI(01)76a

A 70% uptake target for those aged 65 and over had been introduced for the 2001 campaign. Additional support had been provided for primary care, including provision of pre-paid envelopes for GPs to use when inviting patients for immunisation. GP fees for immunising at risk patients under age 65 had been raised last year and this had led to increased take-up in these groups.

9.5 New influenza vaccines and 9.6 Cold Adapted Influenza Vaccine — JCVI(01)76b

9.6.1 This report was presented as an 'horizon scanning' exercise.

9.6.2 Although live, intranasal influenza vaccines were not licensed, the Committee needed to be aware of their existence and of their potential. Work on live intranasal influenza vaccines had started in the 1960s. However, there were practical problems with this development as clinical trials were necessary every time the vaccine make-up was changed, ie every year. A Belgian intranasal influenza vaccine had been introduced in 1975 but had been withdrawn after two years because of the difficulty in performing clinical studies every year. The FDA in the USA had recently concluded that, although its efficacy was acceptable, there were safety concerns. It was agreed that more attention needed to be given to the possible effects in immuno-compromised individuals. Although using a vaccine to interrupt influenza transmission may be useful, the Committee felt that we should be cautious and that it might be useful if this were considered further.

9.6.3 In another development, the Committee was advised that the ACIP had discussed whether children should be considered a risk group for influenza and that they were moving towards recommending influenza vaccine for all children under age two. It was noted that Japan had had compulsory influenza immunisation in children. This programme had been ended but increases in deaths in high risk adults had then occurred suggesting that children with influenza were creating a risk for those adults.

10. VACCINE SUPPLY JCVI(01)77

This information was noted.

11. HEPATITIS

11.1 Improving Hepatitis B Vaccine Uptake JCVI(01)78

11.1.1 The support of the Committee was sought for the strategies outlined in the paper for increasing uptake of hepatitis B vaccine. ***It was agreed that the three targets set out in the paper were reasonable and the Committee accepted the recommendations.*** The targets agreed were:

- by the end of 2003, all homosexual and bisexual men attending GUM clinics should be offered hepatitis B immunisation at their first visit;
- expected uptake of the first dose of the vaccine, in those not previously immunised, to reach 80% by the end of 2004 and 90% by the end of 2006;
- expected uptake of the three doses of vaccine, in those not previously immunised, within one of the recommended regimens to reach 50% by the end of 2004 and 70% by the end of 2006.

11.1.2 The Committee also discussed the use of combined hepatitis A and B vaccine. There was little cost difference between the vaccines in their separate presentations and when in combination, but a combined A plus B vaccine may not be particularly cost effective given the low incidence of symptomatic hepatitis A infection in the UK.

11.2 Immunisation of Children against Hepatitis A For Travel Prophylaxis JCVI(01)79

11.2.1 The paper did not give a true picture of the burden of hepatitis A disease in children. It was felt that hepatitis A was neither a very rare disease nor a trivial illness in children. It was also under-reported in the UK. Although the disease was most unlikely to be life-threatening, there were a small number of children under 5 admitted to hospital with the disease annually and there may be enough serious illness in children to justify a recommendation for the vaccine for certain groups. As for concerns about children passing the virus on to adults, it was noted that the infectious dose was very small.

11.2.2 The Committee agreed that children travelling to highly endemic areas should, after discussion, be offered the vaccine. Beyond this, the Committee agreed that they needed more data on both the safety and efficacy of the vaccine and the morbidity of hepatitis A in children together with information on the transmission of infection in the population. ***Although the Committee felt that it could not make any firm recommendations without data, it was minded to recommend hepatitis A vaccine for children travelling to highly endemic areas, provided the vaccine was shown to be safe.***

failures, the level of antibodies resulting from immunisation, vaccine use in pregnant women and antibody testing in vaccinated and unvaccinated peoples.

12.7 Members were asked to write in with their views on the draft Green Book chapter as quickly as possible. It was agreed that, if there were general agreement, the chapter could be rewritten. If there were concerns, it should be considered by a small group from the Committee and then brought back to the Committee's next meeting. If there was a substantial disagreement, the chapter's finalisation would have to be delayed. ***The Committee agreed that, when available, the vaccine should be recommended for susceptible health care workers. However, there was insufficient information for it to make any recommendations for the vaccine's wider use and more data was requested for the next meeting, especially on the epidemiology of the disease. The Committee further agreed that a subgroup should be established to consider this issue and Professor Griffiths and Drs Ritchie, Kroll and Miller undertook to be part of the subgroup.***

13. ARTICLES FOR INFORMATION JCVI(01)81

MMR vaccine – a parents' dilemma (New Scientist, 3 February 2001)

MMR and autism: further evidence against a causal association (C P Farrington, E Miller, B Taylor); Vaccine 19 (2001): 3632-3635

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The natural history of autistic syndrome in British children exposed to MMR (W Spitzer, K Aitken et al); Adverse Drug Reactions and Toxicological Review 2001, 20(3): 160-163

Detection of persistent measles virus infection in Crohn's disease: current status of experimental work (Ghosh, Armitage et al); Gut 2001; 48: 748-752

Vaccination against mumps, measles and rubella: is there a case for deepening the debate? (T Heller et al); BMJ 2001; 323: 838-840; plus electronic responses to this article

Effectiveness of a single dose of acellular pertussis vaccine to prevent pertussis in children primed with pertussis whole cell vaccine (G De Serres, R Shadmani et al); Vaccine 19 (2001): 3004-3008

Immunogenicity and reactogenicity of acellular diphtheria/tetanus/pertussis vaccine givenas a pre-school booster: effect of simultaneous administration of MMR (E Miller, P Waight et al); Vaccine 19 (2001): 3904-3911

Reactogenicity of DTPa-HBV/Hib vaccine administered as a single injection vs DTPa-HBV and Hib vaccines administered simultaneously at separate sites, to infants at 2, 4 and 6 months of age (F Omenaca, R Dal-Re et al); Vaccine 19 (2001): 4260-4266

Effectiveness of a Mass Immunization Campaign Against Serogroup C Meningococcal Disease in Quebec (P De Wals et al); JAMA, January 10 2001; Vol. 285, No. 2: 177-181

As Assessment of Thiomersal Use in Childhood Vaccines (L K Ball, R Ball et al); Pediatrics, Vol. 107, No. 5, May 2001: 1147-1154

14. ANY OTHER BUSINESS

15. DATES OF FUTURE JCVI MEETINGS

Friday 25 January 2002
Friday 3 May 2002
Friday 1 November 2002