JOINT COMMITTEE ON VACCINATION AND IMMUNISATION

Minutes of the meeting held on Friday 3 May 1991 in Room 63/4 Hannibal House at 10.30 am.

Present.

Members:	Professor A G M Campbell (Chairman)	
	Professor J E Banatvala	
	Dr M F H Bush	
	Professor J G Collee	
	Professor G Crompton	
	Professor A Geddes	
	Professor P Grob	
	Dr I Jones	
	Professor H P Lambert	
	Professor D L Miller	
	Professor C Peckham	
	Mrs D Roden	
	Dr J B Selkon	
	Dr J W G Smith	
Secretariat:	Dr D M Salisbury	MED MCD
	Mr L T Wilson	CMP3
Invited to attend:	Dr N T Begg	CDSC
Observers:	Dr A Greer	DHSSNI
	Dr J Ludlow	WO
	Dr O A Thores	SOHHD
	Dr N Cumberland	MOD
	Dr D Reid	CD(S)C
	Dr B Cooke	HEA
Department of Health:	Dr F Rotblat	MCA
	Dr J Hilton	MED MCD
	Dr J Leese	MED MCD
	Mrs S Philogene	NUR
	Mr K O'Leary	CMP3
	Mr R Freeman	CMP3
	Miss J St Juste	CMP3

1. Apologies were received from Professor Breckenridge, Dr MacFarlane and Professor Levinsky; from Dr Lewis and Dr Rubery, Mr Hale and Mr Sharpe (all DH).

2. Announcements:

The Chairman informed members of Professor Hull's resignation and thanked him for his many years' service to the committee, and welcomed Dr Leese, successor to Dr Milner as the Department of Health Senior Medical Officer responsible mainly for influenza and tuberculosis.

3. Minutes of the last meeting.

The minutes of 2 November 1990 were agreed subject to the following amendments:

9.4 para 3 line 4
Amend " Dr Rotblat said" to "Dr Smith thought"
9.4 para 3 line 5
Amend "would" to "might".

4. Matters arising.

Professor Peckham said that for national studies, having to obtain ethical approval in every district was the problem. Professor Banatvala agreed.

Items 8 and 9.4 Professor Miller drew attention to delays in issuing product licences for acellular vaccines and urged the committee to express its concern. Dr Smith said that it was a major task for a company to put forward an application and suggested that, in the case of Hib vaccine, companies may be waiting for the conclusions of Dr Begg's study which may show that one vaccine is preferred over the others, and that it might be feasible to introduce a mechanism for easing the method of applying for licences. Dr Rotblat said that to date MCA had received only one application for Hib vaccine which had been through all the processes and would be approved soon. If the other companies were to wait until the results of the study appeared there would be no possibility of processing licences on time.

Dr Selkon asked how companies might be advised that DH would like to see them submit their applications. Dr Salisbury replied that he wrote to all the vaccine manufacturing companies in November 1990 immediately following the JCVI meeting, and he stressed that the Department had done everything possible, formal and informal, to keep the manufacturers in the picture.

Item 6. The Chairman confirmed that district immunisation co - ordinators would be seen primarily as purchasers of services, but would also have responsibility for ensuring that the services were provided. Mr Wilson said that the information sheet distributed at the co -ordinators meeting, could be quoted.

Item 5.4 The Chairman informed the committee that the department wrote to the Republic of Ireland Health Department in November 1990 asking if they wished to send a representative to future meetings of JCVI. There had been no response. The chairman asked Dr Greer to take informal soundings, and Mr Wilson said that he would send the Dublin Health Department a set of the committee's papers.

The Chairman reminded members that it was important to note the dates of meetings and make a commitment to attend for an all day meeting. Mr Wilson informed the committee that the 1992 meetings would be held on 1 May and 6 November.

5. Secretary of State's Health Strategy

The Chairman reminded members that the extract provided for information was part of a larger document and was confidential. Dr Salisbury said that the document reflected views on future uptake targets as discussed at the last JCVI meeting.

6. Immunisation Uptake Statistics - latest position.

6.1

Dr Salisbury presented paper JCVI/91/2 giving information on immunisation performance by DHA up to 1 April 1990. From April 1990 data taken from the quarterly returns to the COVER programme had been added to the tables. He said it was encouraging to see that the number of DHAs who had reached 90% by 1 April 1990 had increased considerably by February 1991.

a. Dr Salisbury presented JCVI/91/3 with its associated graph giving the national uptake for England. He said that all of the annual returns had been validated, and that incorrect reports were returned to DHAs. From April 1990 data was taken from the COVER programme.

b. The committee noted JCVI/91/4. Dr Salisbury said it was exciting to see the doubling of the number of districts achieving the target for measles uptake and how many DHAs were getting pertussis uptake to exceed 90%. 36 DHAs reached or exceeded the 90% target for all seven antigens.

6.2

The committee noted JCVI/91/5 and Dr Salisbury pointed out that NE Thames, NW Thames and West Midlands RHA had the lowest uptake rates for 1989/90, due to either poor performance or poor reporting, or both.

6.3

Dr Salisbury presented JCVI91/6 and said that each region was analysed by district and by antigen. He drew members' attention to Mersey RHA who had shown the greatest improvement and in particular to Liverpool, South Sefton and St Helen's DHAs who had gone from being the worst performing districts to being among the best district figures.

Professor Banatvala asked whether the lessons learned in Mersey RHA were being translated to other regions. Dr Salisbury said that information was shared between co - ordinators at their meetings and immunisation was well covered in the annual regional reviews.

Scotland.

Dr Thores said that uptake figures had increased but he was concerned about the possibility of pertussis uptake rates in inner cities falling off; it had not occurred so far but still

needed watching.

Wales.

Dr Ludlow said that there had been a noted increase in uptake figures in Wales.

Northern Ireland.

Dr Greer said that she was encouraged to see that figures were improving and would have figures at the next meeting for 1990 - 91.

6.4 COVER report

Dr Begg said that CDSC had introduced measurement of coverage by 12 months of age to monitor the impact of the new schedule. Evidence from North West Thames already showed that coverage of children at 12 months seemed to be identical to coverage at 18 months in the old schedule. National information would be available later in May.

7. Report of meeting of District Immunisation Co - ordinators

7.1

The Chairman highlighted Dr Baxter's paper "Pertussis Immunisation in Children with Neurological Disorders" and said that if this article was published the committee could refer to it in the next edition of "Immunisation Against Infectious Disease". Dr Bush asked if it was possible to emphasise that Hib was a vaccine against a wide range of paediatric haemophilus invasive disease. The Chairman said that this was recognised by the Hib implementation group, and publicity material would cover the point.

8. Measles, mumps and rubella

8.1 The first two years

Dr Salisbury presented JCVI/91/9 with its associated graphs and said that after the first two years of MMR vaccine, there had been a major impact on the three target diseases. He said that there had been a great improvement in most of the country, from 8 districts reaching 90 per cent before MMR to 118 in February 1991, but West Midlands and London districts still had problems. Professor Miller said that even with low incidence rates and high uptake rates there were still cases of indigenous measles and asked whether consideration should be given to the introduction of a two dose measles schedule. Dr Salisbury referred to the Czech experience which had not altered the situation and informed the committee that he had been asked by the USA to do a

presentation at their summer conference on the success of the UK immunisation programme. There was concern in the US about their programme with little current national uptake data available. He was also discussing measles strategy with an accredited group of modellers. Dr Jones suggested a study on ring immunisation, and Dr Smith said the success of MMR underlined the importance of surveillance, including antibody levels. Professor Peckham said that as children reported to the CRS survey no longer included the deaf, the position might "flatten" out, but Dr Salisbury said that the reduction in terminations was still gratifying. Dr Salisbury also raised the question of surveying measles incidence by saliva samples and Drs Smith and Begg said that PHLS was studying its feasibility.

8.2 Communicable Disease Report - Rubella Surveillance

The committeee noted JVCI/91/10. Professor Peckham said that the problem of higher incidence of congenital rubella in Asians was being addressed. Dr Smith referred to the new style CD reports, which aim to include more review material.

8.3 MMR adverse events - BPSU Surveillance

Dr Begg presented JCVI/91/11 with graphs. The reports of possible mumps vaccine meningo - encephalitis, after analysis, showed an estimated incidence of 4.2 cases per million if definite reports were taken, and 14.5 if "probable" were included as well. Professor Banatvala said that overall results were very encouraging but the data would need to be held in readiness in case the Japanese data raised problems. Dr Salisbury said that an article on the Japan experience had appeared in "Vaccine", but was well balanced. Professor Miller raised a question about the completeness of reporting. Dr Begg said that CDSC were happy that the reporting level was high. This was echoed by Dr Smith who was reassured by the data and the very highly effective reporting system. The Chairman added that if the Japanese problems had occurred in the UK, the reporting system would have brought them to light.

8.4 Correspondence SOHHD - Rubella Immunisation

Dr Thores raised the question of later immunisation in Scandinavia but Dr Salisbury said those individuals had not been immunised at a younger age. Professor Banatvala said that studies had shown that protection was still present at 15 and 21 years, and now they were looking at 26 years after immunisation. The Chairman asked Dr Salisbury to reply to the letter.

9. Pertussis

9.1 Notifications 1985 - 1991

The committee noted JCVI/91/13. Dr Salisbury commented that "epidemic" years were now little different from inter - epidemic years.

10. Poliomyelitis

10.1 WHO requirements for certification of elimination

Dr Salisbury presented JCVI/91/14 to the committee, setting out WHO plans to move towards global elimination of polio. WHO had not yet stipulated formal criteria for national certification of elimination but guidance was expected later in the year. He said that the UK did not have good reporting of flaccid paralysis and in order to prove the absence of paralytic poliomyelitis in the UK, active surveillance was necessary. A protocol had been written for flaccid paralysis to be added to the BPSU scheme and surveillance would start in July. The UK would be the first of the European and developed countries to do this. Dr Salisbury also raised the problem of environmental surveillance and asked for members' views. Dr Smith felt that sequencing of stool samples would be expensive and unnecessary and that a small survey of UK sewage would satisfy WHO. Dr Selkon agreed. Professor Collee stated that it was important to ensure that such surveillance used random samples. Dr Smith said PHLS would consider the question of sewage and environmental surveillance. Early guidance from WHO would be helpful. JCVI/91/15, JCVI/91/16 and JCVI/91/17 were all presented to the committee for information, and discussed under 10.1 above.

11. Hib Implementation Group

The minutes of the two Hib Implementation Group meetings, provided for the Committee, showed that some good progress had been made. The group had considered surveillance, responses amongst ethnic minority groups (with a study in NE Thames), materials necessary for professionals (with help from Dr J James, a GP in Bristol), the presentation and supply of the vaccines, US recommendations and a draft UK schedule. NIBSC had some encouraging news on mixing Hib with DTP and, in one case, MMR. Funding applications were in hand.

The Chairman drew attention to the recommendations that successive injections with Hib should be with the same manufacturer's vaccine, and to make all forms of invasive haemophilus disease notifiable. Dr Rotblat reported about progress on licensing. One company at least would gain a licence in 1991. Dr Begg raised the problem of bearing product liability if vaccines were mixed, and it was agreed that the Department might have to consider this .

12. Cold Chain

Dr Salisbury presented JCVI/91/20. After some anxiety was expressed about the cold chain, this study was set up to examine the postal method for vaccine distribution in this country. Results were encouraging and a further study could now look elsewhere in the chain, at district and wholesalers level.

13. Hepatitis

Professor Banatvala presented the minutes from recent meetings of the Advisory Group on Hepatitis and pointed to the finding that selective ante - natal screening failed to detect all carrier mothers, detailed information was being gathered and it was likely that the AGH would be putting recommendations on universal screening to the November meeting of JCVI. Information on local immunisation policies for health care workers was also being gathered; some (encouraging) information was already available on medical and dental students. The existing recommendations on hepatitis B infected health care workers had been reviewed and draft revised guidelines were in an advanced stage of preparation (copy included with the papers). Dr Selkon said that the cost of a course of hepatitis B immunisation was too high and asked whether the department could arrange a UK central contract and thus bring down the cost of the vaccine. Professor Banatvala agreed. Dr Salisbury said he knew the cost of the vaccine was negotiable.

Dr Selkon asked whether there should be testing of hospital staff for hepatitis C. Professor Banatvala said that the UK was still in the early stages of serological assays and these issues would be clarified in time when more information was available. Professor Banatvala said that Advisory Group he would keep hepatitis B mutants under review.

13.3 Correspondence from SOHHD - guidance on hepatitis b risk in "sewage workers

The committee agreed the reply put before them.

14 Influenza

Dr Smith spoke to the minutes of the Influenza sub - group and supporting papers. The group had considered whether to recommend universal immunisation for all over 65 (or 75), but by a large majority, with only two members dissenting, had decided against because:

such a policy had not been proved to work elsewhere;

the existing UK policy was not applied as effectively as it should;

there remained lingering doubts in the vaccine's efficacy;

GPs had the right to decide which patients were at risk.

A survey of GPs had indicated that they would like more information on the vaccines. A meeting with CMO on 1 May had accepted this advice, and the Committee endorsed it. This year's advice to GPs would be revised and made more positive. Professor Grob said that an item of service fee for influenza immunisations might encourage more GPs to take it seriously, and other members agreed. The Department undertook to consider this.

Other points raised included the conflicting recommendations on use of the vaccines in the under 4s (to be pursued by the Department), advice on use of amantadine (still being considered within the Department), and the EEC paper JCVI/91/25, which Dr Smith said was self - explanatory. The sub - group intended to continue to use WHO recommendations.

15. BCG

15.1 Disposable Head Heaf Gun - Progress Report

Dr Leese presented JCVI/91/25. She said that there had been a lot of concern about techniques used in sterilising the heaf gun for heaf testing. The results of clinical tests of the new disposable heaf gun head would be available next month and if they were satisfactory the new head would be recommended for use without the need for a larger trial. An example was circulated to members; the disposable heads were likely to cost 7p each.

16. Typhoid and Cholera

16.1 Dr Leese presented JCVI/91/27 which asked the committee to review their decision not to recommend the intradermal route for cholera and typhoid vaccination. Dr Smith gave his support to a change on the lines of the US guidelines. The Chairman suggested that the advice in the green book could be relaxed next time. This was accepted by the committee, which also agreed Dr Selkon's suggested wording "Second and subsequent doses may be given by the intradermal route". Dr Rotblat said that there were two new typhoid vaccines, including one oral, not yet licensed.

16.2 Cholera Vaccination for Foreign Travel

Dr Leese presented JCVI/91/27 which asked the committee to reconsider the advice given in the Green Book. She said that the WHO recommendation was that vaccination was not needed for travel abroad unless the country required a cholera certificate. The committee agreed to bring the Green Book into line with these recommendations.

17. WHO European Advisory Group - Report of 1991 meeting

JCVI/91/29 was provided for information.

18. WHO Global Advisory Group - Report of main recommendations of 1990 meeting

JCVI/91/30 was provided for information.

19. Any other Business

There was none.

20. Future Meetings

1 November 1991, 1 May and 6 November 1992.