

JOINT COMMITTEE ON VACCINATION AND IMMUNISATION

DRAFT MINUTES OF THE MEETING held on 18 February 2009

Skipton House, 80 London Road,
London, SE1 8UG

Members

Professor Andrew Hall (Chair)
Professor Jonathan Friedland
Dr Christopher Verity
Dr Ray Borrow
Mrs Pauline MacDonald
Professor Claire-Anne Siegrist
Dr Gabrielle Laing

Dr Paul Jackson
Mrs Vivienne Parry
Dr Anthony Harnden
Mrs Anne McGowan
Dr Jennifer Harries
Dr Andrew Riordan

Ex-Officio

Dr Claire Cameron - HPS Scotland
Prof. David Hill – NATHNAC

Dr Stephen Inglis – NIBSC

Observers

Colonel Phil Bolton – MoD
Dr Darina O'Flannagan - Eire

Dr Linda Diggle – Jersey

Scottish executive

Dr Andrew Riley

Welsh assembly Government

Mrs Jenny Thorne

Dr Sara Hayes

Northern Ireland

Dr Lorraine Doherty

Invited to attend

Prof. Elizabeth Miller OBE - HPA
Mrs Joanne White - HPA

Dr Mary Ramsay - HPA

Department of Health

Professor David Salisbury CB (Medical Secretary)
Dr Karen Noakes (Scientific Secretary)
Dr Stephen Robinson (Scientific Secretary – minutes)

Ms Joanne Yarwood
Dr Emma Savage
Mr Guy Walker

Mr John Henderson
Dr John Licorish
Miss Rebecca Butterfield

MHRA

Dr Philip Bryan
Miss Jenny Wong

Dr Susie Seabroke

1. ANNOUNCEMENTS AND WELCOME

The Chairman welcomed all those present to the meeting. Apologies were received from the following members Prof. Alan Emond, Dr Syed Ahmed and Dr Richard Roberts.

Apologies had been received from the following Observers: Dr Lorraine Doherty, Wg Cdr. Andy Green, Dr Darina O'Flanagan.

The Chairman also welcomed Colonel Philip Bolton who was attending in place of Wing Commander Andy Green for today's meeting.

The Chair announced that Prof. Judith Breuer has been appointed to the Virologist post and her term will start in June.

The Chairman reminded members of the need to ensure their declarations of interest were up to date and to declare their interests relevant to each agenda item on the forms provided. All expenses should be claimed within one month of the meeting taking place.

The following additional papers were tabled:

- Wales COVER data
- Minutes of the pneumococcal subgroup
- JCVI statement on rotavirus vaccines

2. MINUTES OF THE LAST MEETING HELD ON 15 OCTOBER 2008

The following changes to the draft minutes were agreed:

The seventh paragraph of agenda item 13 should be amended to read 'At the last meeting JCVI made a statement that, on the basis of the available information (about the Hannah Poling case), it did not believe that a causal link had been established between vaccination, encephalopathy and onset of autism in children with mitochondrial dysfunction.'

The eighth paragraph of agenda item 13 should be amended to read 'UK data show no evidence of adverse impacts of vaccination on children with mitochondrial disorders.'

The secretariat was asked to make the above changes and remove the draft status heading from the minutes as they were now final. These would be updated on the JCVI website.

3. MATTERS ARISING

JCVI members had provided comments on a draft JCVI statement on rotavirus vaccines. A final version taking into account members' comments was circulated prior to the meeting.

Members discussed the importance of using the correct terminology when discussing cost-effectiveness so that it was clear to those commissioning vaccination services in the NHS.

The Department of Health reported that it had met with vaccine manufacturers recently to discuss JCVI's advice on rotavirus vaccines.

The committee accepted the statement and asked for it to be posted on the website.

4. NHS CONSTITUTION

The Department of Health gave a presentation outlining relevant sections of the NHS constitution, which was published on 21 January 2009. The constitution establishes the principles and values of the NHS in England.

The constitution contains a new right to vaccination:
'You have the right to receive the vaccinations that the Joint Committee on Vaccination and Immunisation recommend that you should receive under an NHS provided national immunisation programme.'

And a new patient responsibility:
'You should participate in important public health programmes such as vaccination.'

All JCVI recommendations relating to national vaccination programmes, rather than travel vaccines or occupational health vaccines, must be shown to be cost-effective; and they must originate from an initial request by the Secretary of State to consider the issue.

The Secretariat clarified that JCVI would still be able to provide advice on areas outside of those specifically sought by the Secretary of State and that this advice would be minuted. For instance, the advice that additional cohorts of children should receive a Hib booster was made as a matter of equity rather than on the basis of cost-effectiveness.

The JCVI was pleased that recommendations from the committee would have the force of law behind it. The committee asked for clarification on the constitution including what exactly 'right' meant with respect to the right of a child to receive a vaccine when their parents were opposed to vaccination and how the constitution affected the recommendations of JCVI with respect to legal challenge.

5. JCVI BIENNIAL REPORT

Members were provided with a draft version of the JCVI biennial report. Members were asked to provide comments to the secretariat by Friday 27 February.

6. PNEUMOCOCCAL

The pneumococcal subgroup met on 15 January 2009 to provide advice to the committee on six areas of work. The chairman of the subgroup gave a summary of the advice to JCVI

- i) The impact of the pneumococcal conjugate vaccine (PCV) programme in vaccinated children and the herd immunity effects on the unvaccinated population.

The committee was impressed by the profound reduction in the pneumococcal disease in vaccinated individuals caused by the seven valencies that are in the conjugate vaccine. Serotype replacement has been seen across all ages, including 1, 7F and 19A but overall invasive pneumococcal disease is reduced in the vaccinated cohort. The committee noted that there has been a herd immunity effect, although this is not as large as that seen in the US. In the non-vaccinated age groups, however, the reduction of pneumococcal disease caused by the seven serotypes in the vaccine has been partially counter-balanced by serotype replacement.

- ii) The likely health benefits to be gained from introducing new higher valency pneumococcal conjugate vaccines to the childhood programme.

There are two new conjugate vaccines. The PCV 10-valent vaccine manufactured by GSK (which has recently received a positive opinion from the Committee for Medicinal Products for Human Use (CHMP) and is likely to be licensed shortly) is conjugated to protein-D, derived from non-typeable *Haemophilus influenzae* (ntHI). The PCV 13-valent vaccine manufactured by Wyeth (which is likely to seek licensure in late 2009 or early 2010) is conjugated to CRM197, the same conjugate used in the PCV7 currently used in the pneumococcal conjugate vaccine in the childhood immunisation programme.

The committee indicated that clinical trials of both new vaccines had not provided sufficient evidence for the committee to recommend that they could be used on a 2+1 schedule, as currently used for PCV7 in the UK. The committee advised that at present both vaccine might only be used on a 3+1 schedule until more data became available.

- iii) The effectiveness of the pneumococcal polysaccharide vaccine (PPV) in older adults.

The committee agreed with the subgroup that there was little population benefit from PPV vaccination in protecting individuals aged 65 years and over against IPD. Moreover, the increase in disease from serotypes covered by the PPV

vaccines but not in the PCV7 vaccine have not been mitigated by the PPV vaccination programme. The expected duration of vaccine effectiveness was less than had been anticipated when the programme was first introduced. At an individual level, PPV provides protection which lasts for about one year. Revaccination of individuals is not recommended as the risks of reactions outweigh the benefits of vaccination.

The committee discussed the issues around stopping the programme and several points were raised including: the logistics of stopping a programme if it were to be restarted a few years later should higher valency PCV vaccines be shown to be effective in older people, and whether there was benefit in stopping the programme and focusing resources on at risk groups only.

The committee asked the secretariat to prepare a paper for the next meeting outlining how many people enter a risk group by the time they are 65 years of age and vaccine uptake for people in risk groups aged 65 years versus all 65 years olds. The committee will then examine how this change in advice would affect people over 65 years of age.

- iv) The use of PPV in children who are in a clinical risk group and the efficacy of PPV following routine PCV vaccination in these children.

The committee agreed with the advice of the subgroup that at present there was no data to suggest a change to the current recommendation that children in clinical risk groups should receive PPV at two years of age. They did recommend that this should be at least six months after the final dose of PCV in order to avoid a potential attenuation of the PCV response.

- v) The use of PPV and PCV in clinical risk groups and whether the use of PCV may be extended in older individuals of some risk groups.

The committee reviewed a paper that had gathered all available evidence on the effectiveness of PPV or PCV in clinical risk groups. The committee noted that individuals in some of the clinical risk groups were on the borderline between recommendations for PPV or PCV; there was insufficient evidence to make a judgement and JCVI might want to reconsider this advice when PCV vaccines of greater valency were available.

The committee agreed with the advice of the subgroup that there should be a change in the recommendation for three risk groups: PCV should be offered to HIV infected people, individuals who receive bone marrow transplants and people who have chronic renal disease. HIV positive and those receiving bone marrow transplants should receive two doses of PCV with an interval of two months between doses (in line with the current advice for children aged 12 months to five years who are immunosuppressed). People who have chronic renal disease should receive two doses of PCV followed by a booster dose every five years.

- vi) The extended use of PPV in health care workers and people who are not

in clinical risk groups aged 15 to 65 years, in the event of an influenza pandemic.

The committee advised that PPV should be considered as a potential clinical countermeasure to pandemic influenza. There was evidence to show that PPV was effective in healthy adults against bacteraemic pneumonia but that protection was not long-lasting. The extent to which PPV vaccination would be beneficial in a pandemic was difficult to predict as the amount of pneumococcal disease following influenza infection varied between pandemics.

7. INFLUENZA

The Department of Health provided an update on the seasonal flu immunisation programme for 2008/09. The predominant influenza strain identified in 2008/09 was an H3N2 strain (representing about 90% of positively identified cases). The main other type in circulation was an H1N1 strain. There were concerns at the start of the influenza season that this strain may become the predominant type because it was found to be resistant to oseltamivir but its circulation was limited with the majority of resistant isolates being identified in the Avon area in specific outbreaks.

The peak incidence of influenza that occurred in December was the highest seen since 1999/2000. However, influenza activity this season was only a quarter of the peak incidence seen then. The highest influenza rates were found in working age adults.

Despite targeted radio advertising at younger individuals in clinical risk groups and an advertising campaign that focused on both the 65 and over risk group and younger at-risk individuals, flu vaccine uptake in England remained at 74% for those 65 years and over, and 46% for those under 65 years of age. This was close to the vaccine uptake figures seen in previous years. The Department reported that a new advertising campaign was planned for 2009/10 to try to further improve vaccine uptake figures.

The committee understood that vaccine uptake among health professionals working in acute trusts was low and similar to last year. The Committee raised its concern at the continuing low vaccine uptake among health professionals. A committee member noted that in Switzerland, facemasks are to be introduced during the flu season for those health professionals who refuse flu vaccination.

The Chair of the influenza subgroup summarised the conclusion reached at the subgroup meeting held in December 2008. The Committee agreed with the subgroup's advice that:

- no new evidence had become available on flu vaccine effectiveness in young children that supported a recommendation to offer universal vaccination to children;
- the vaccination of pregnant women was only likely to be cost-effective if there was evidence to suggest that vaccination in the late stages of

pregnancy reduced influenza in neonates. A paper had reported this but the study has been conducted in Bangladesh so may not be comparable to the UK and the study size was also small.

- It was difficult to define at what level of immunosuppression a patient could be considered to be at a greater risk of the serious consequences of influenza and should be offered flu vaccination. This decision was best made on an individual basis and left to the patient's clinician. The committee agreed that conditions such as Addison's Disease should be considered for flu vaccination on an individual basis. Similarly, patients who were survivors of polio could be considered to have a serious neurological condition depending on their current condition.

8. POLIO

The committee was provided with a report commissioned by the Department which reviewed current UK activities on the laboratory containment of polioviruses and which had made recommendations on future activities to be carried out in order to complete the goals set out in the WHO's global action plan for the containment of polioviruses after eradication.

Laboratories are being encouraged to destroy any materials that may be contaminated with wild poliovirus and may be a potential source of reintroduction of the virus especially in a post eradication environment.

The committee was asked to consider the report and send any comments to the Secretariat.

The Secretariat also reported that a suspected imported polio case had been reported in south London in the last week. The case was later confirmed as being unrelated to poliovirus infection but it was a reminder of the need to remain vigilant.

9. HPV

The committee was informed that DH had announced that PCTs were encouraged to accelerate the HPV catch-up programme in England. This acceleration will enable the girls already identified for the catch-up programme to be offered protection earlier. At the end of January, the Department had provided further details to PCTs on this acceleration of the HPV programme. DH will be providing additional assistance to PCTs to support the extra work involved in accelerating the catch-up programme.

The committee was provided with an update on vaccine uptake.

Vaccine uptake in England

Vaccine uptake information is supplied by each of the 152 PCTs and provisional data is submitted monthly using the Health Protection Informatics (HPI) website. Annual coverage data will be collected in September 2009.

Approximately 83% of 12 to 13 year olds received their first dose of vaccine by the end of January; approximately 73% of 12 to 13 year olds in those PCTs have also received a second dose.

Approximately 32% of 17-18 year olds received their first dose.

The total number of doses administered so far is around 656,000.

46 PCTs achieved a first dose uptake of over 90% of 12 to 13 year olds, with a further 62 achieving over 80%. This means that 71% of PCTs have achieved over 80% first dose uptake amongst 12 to 13 year olds by the end of December 2008.

Vaccine uptake for first dose of HPV is expected to rise as the last of the PCTs finish their first dose cohorts.

The Department continues to support the HPV programme through a national advertising campaign. The next wave of advertising and PR will run in April and May this year and aims to remind girls and their mothers that the programme comprises of three doses and that all three vaccinations are needed for full protection. Post campaign research recently conducted among parents and girls suggests that both have been very positive about their HPV vaccination experience. There was evidence that some girls aged 17-18 years were delaying their vaccination with common reasons being low awareness of cervical cancer and the importance of HPV vaccination, concern about needles and the vaccination itself and the effort required to book an appointment.

Vaccine uptake in Scotland

The committee was informed that provisional first dose HPV vaccine uptake in Scotland was 92.5% and second dose uptake was 81.8% for girls aged 12 to 13 years (school year S2 in Scotland). Uptake for the other two school years (S5 and S6) for girls aged 15 to 17 years old is in the high 80%^s and for the second dose is mid to high 70%^s. Alternative community models are being used to target girls who are in the eligible cohorts and are out of the school system.

Vaccine uptake in Wales

The committee was informed that uptake for the first dose of HPV vaccines in girls in school year eight was 87.9%. Over half of all local health boards have a first dose uptake of over 90%. Provisional uptake of the second dose of HPV vaccine was 74.4%; because immunisation sessions and data entry are still in progress at the time of the meeting, this figure is expected to rise.

Vaccine uptake in Northern Ireland

The committee was informed that vaccine uptake at 30 November 2008 for Northern Ireland was 89% for the first dose and 67% for the second dose.

Vaccine safety

The MHRA provided an update on the proactive pharmacovigilance plan in place in the UK for Cervarix vaccine. The MHRA study yellow card reports on a daily

basis in order to assess the seriousness of each case and determine if follow-up is required. The findings are published each week on their website:
<http://www.mhra.gov.uk/hpvvaccine>

MHRA is working closely with colleagues in the Health Protection Agency in compiling information on reported serious adverse reactions and comparing them to expected background incidence rates (stratified by age, gender and season) using the general practice research database (GPRD). The data provide information on whether there is an increase in any adverse reaction over and above what would be expected within the population for that age group.

Using these background rates and estimates of vaccine exposure provided by DH, MHRA is performing observed versus expected analyses of any reported 'events of interest' on a continuous weekly basis.

Individual cases of adverse reactions are placed into one of five categories; i.e. injection-site reactions; allergic reactions; 'psychogenic' events; 'other recognised' reactions; and 'suspected adverse reactions not currently recognised'. There have been several clusters of convulsions, loss of diabetic control and lymphadenopathy. There have also been two cases of Guillain Barré syndrome and one case of Bell's Palsy. Taking into account the number of vaccine doses that have been administered so far these cases are not likely to be linked to the vaccination as they fall within expected rates for these conditions.

The MHRA noted that, to date, no significant new safety issues have been identified during worldwide use of Cervarix and no new undesirable effects have been added to the Summary of Product Characteristics (SPC) since licensure.

The committee felt that this process was open, helpful, and balanced and would help to reassure people that the safety aspects were being carefully monitored.

10. MEASLES

The committee was provided with an update on measles and the MMR catch-up campaign, which was launched by the DH in August 2008. This campaign is aimed at children aged from 13 months to 18 years who have received either no doses of MMR vaccine or are only partially immunised. This campaign was launched in response to the rising numbers of measles cases in the country. Data were provided showing the number of measles cases in England and Wales up to the end of November 2008.

The committee was informed that there were an additional 113 cases in December 2008 bringing the end of year figure to 1348 cases of measles in England and Wales in 2008.

In addition to the routine data which are collected through COVER, the Department is currently piloting a new collection of MMR vaccine uptake data through automated extraction from GP records via the Health Protection Informatics (HPI) website. Around 50% of all GP practices are currently

supplying these data. They are being collected to measure trends in MMR uptake in response to the MMR catch-up campaign and are not intended to be used as an absolute measure of vaccine uptake. The results are likely to under-report vaccine uptake as not all GP practices automatically update immunisation records when patients move between practices.

The committee was informed that since September there has been an increase of 1.8% in the number of children who have received two doses of MMR. DH intends to carry out further analysis in the near future as it is currently too early to reach any conclusions.

DH is also supporting the measles catchup campaign with a managed communications approach. A new web site 'landing page' for measles and MMR vaccine has been developed (<http://www.nhs.uk/measles>). A public relations campaign will start next month and will use media partnerships, online, and radio marketing. The committee was also informed that the London Strategic Health Authority have commissioned the London Social Marketing Unit to provide a more vigorous approach addressing London's particular problems.

The committee was informed that Scotland, which has had high MMR vaccine uptake for a number of years, has no plans for a specific MMR vaccine campaign. Instead, they are using a more targeted approach using leaflets that convey the 'it's never too late' approach.

Wales informed the committee that they had recently had a mumps outbreak and as a consequence ran an MMR campaign. They have no specific plans for a more extensive campaign.

Northern Ireland, like England, is conducting a targeted MMR catchup campaign.

The committee was informed that the US Court of Federal Claims has been considering three cases relating to claims that MMR vaccine and thiomersal containing vaccines are linked to autism and has found that there is no association between vaccines and autism.

11. US national strategic vaccine draft plan

The committee was asked by the US Department of Health and Human Services to comment on the draft US national strategic vaccine plan. The chair asked members to send their comments to the Secretariat and these will be compiled and sent to the DHHS.

The committee welcomed the chance to review the plan and suggested that a similar forward looking plan for the UK would be welcome. The Chair noted that the committee already receive a horizon scanning paper each year, which looks at future vaccines and their development.

12. VACCINE COVERAGE

The committee was presented with a report on vaccine coverage for England, Scotland, Wales and Northern Ireland.

England

England reported vaccine coverage for the period of July to September 2008. Children who reached their first birthday in the quarter (born January to March 2007) were the fifth quarterly birth cohort recorded by COVER to have been scheduled to receive their primary vaccinations in accordance with the new schedule introduced on 4th September 2006. In England, coverage at 12 months for all vaccines remained similar to the previous quarter; 91% of children had received their primary course of DTaP/IPV/Hib, and 91% had received primary courses of MenC and PCV vaccines.

Children reaching their second birthday in the quarter (born July to September 2006) were the fourth quarterly birth cohort recorded by COVER to be offered the new booster doses of Hib/MenC and PCV. Coverage at 24 months in England was 84% and 81% respectively, similar to the previous quarter. Coverage for MMR at 24 months has increased slightly from the last quarter to 83.4%.

Coverage at five years was up on the last quarter to 79% for the pre-school booster, 89.2% for MMR1 and 77.9% for MMR2.

Neonatal hepatitis B coverage was 61% for three doses measured at 12 months and was 51% for four doses by 24 months.

Scotland

The coverage of DTaP/IPV/Hib is 98% for children aged 24 months of age. Coverage for two doses of MenC is 96%. Coverage for booster doses for Hib/MenC and PCV by 24 months of age is 90.6% and 93.0% respectively. Coverage for MMR at 24 months is 92.3%. At five years old, MMR1 coverage is 95.4% and MMR2 is 87.4%

Wales

Uptake of the DTaP/IPV/Hib, MenC immunisation and pneumococcal conjugate vaccine (PCV) at 1 year of age have all reached the target of 95% this quarter. Uptake of the first dose of MMR in children aged two years remained at 88.4%, varying between local health boards from 84.3% to 94.6%. Uptake of the second MMR by five years of age continued to increase and now stands at 82.3% with local health board variation from 77.1% to 90.2%. Uptake of pre-school booster in five year old children increased to 87.7%.

Northern Ireland

The uptake of three doses of DTaP/IPV/Hib in children aged 12 months is 96.70% and of the first dose of MMR in children aged 24 months at 90.1% with coverage of first dose of MMR in children aged five years at 95.90%.

Compared with results for the quarter ended June 2008, uptake of three doses of DTaP/IPV/Hib3 and MenC at 12 months has increased by 0.2% to 97.60%; PCV

coverage has increased by 1.4% to 96.60%.

At 24 months, uptake of MMR1 has increased by 1.3% to 90.1%. Coverage of three doses of DTaP/IPV/Hib has decreased by 0.2% to 97.6%. Uptake of MenC has decreased by 1.4% to 95.3%. Coverage of the PCV booster has increased by 9.6% to 88.9% and Hib/MenC has increased by 15.6% to 85.8%.

By age five years, uptake of three doses of DTaP/Hib/ IPV shows an increase of 0.7% to 97.4%. Uptake of MenC has increased by 0.9% to 95.1%. MMR1 uptake has increased by 0.6% to 95.9%; MMR2 remains the same as last quarter at 88.9%. Coverage of DTaP/IPV has decreased by 0.4 % to 97.4%.

13. ARTICLES FOR INFORMATION

The following articles were presented to the committee for information:

- Poland GA and Schaffner W. Immunisation Guidelines for Adult Patients: An annual update and a challenge. 2009. *Ann Intern Med* 150(1):53-55.
- Advisory Committee on Immunisation Practices. 2009. Recommended Adult Immunisation Schedule: United States, 2009. *Ann Intern Med* 150(1):40-44.
- Smith JC, Snider DE and Pickering LK. 2009. Immunisation policy development in the United States: The role of the Advisory Committee on Immunisation Practices. *Ann Intern Med* 150(1):45-49.
- Kang LW, Crawford N, Tang MLK *et al.*, 2008. Hypersensitivity reactions to human papillomavirus vaccine in Australian schoolgirls: retrospective cohort study. *BMJ* 337:a2642 doi:10.1136/bmj.a2642.
- McIntyre PB, Brotherton JML, Burgess MA *et al.*, 2009. Hypersensitivity to HPV vaccine. More data from Australia on sensitivity to HPV vaccine. *BMJ* 338:b26
- Muscat M, Bang H, Wohlfahrt J *et al.*, 2009. Measles in Europe: an epidemiological assessment. *The Lancet*.
- Kremer JR and Muller CP 2009. Measles in Europe – there is room for improvement. *The Lancet*
- Stowe J, Andrews N, Taylor B *et al.*, 2009. No evidence of an increase of bacterial and viral infections following Measles, Mumps and Rubella vaccine. *Vaccine*
- Erlewyn-Lajeunesse M, Manek R, Lingam R *et al.*, 2008. Anaphylaxis following single component measles and rubella immunisation. *Arch Dis Child* 93:974-975.

- Gauthier A, Breuer J, Carrington D et al., 2008. Epidemiology and cost of herpes zoster and post-herpetic neuralgia in the United Kingdom. *Epidemiol. Infect.* 137, 38-47.
- Van Hoek AJ, Gay N, Melegaro A et al., 2009. Estimating the cost-effectiveness of vaccination against herpes zoster in England and Wales. *Vaccine*.
- Lu PJ, Euler GL, Jumaan AO et al., 2008. Herpes zoster vaccination among adults aged 60 years or older in the United States, 2007: Uptake of the first new vaccine to target seniors. *Vaccine*.
- Gillet Y, Steri GC, Behre U et al., 2009. Immunogenicity and safety of measles-mumps-rubella-varicella (MMRV) vaccine followed by one dose of varicella vaccine in children aged 15 months-2 years or 2-6 years primed with measles-mumps-rubella (MMR) vaccine. *Vaccine* 27:446-453.
- Pace D, Snape M, Westcar S et al., 2008. A novel combined Hib-MenC-TT glycoconjugate vaccine as a booster dose for toddlers: a phase 3 open randomised controlled trial. *Arch Dis Child* 93:963-970

The committee noted that the Pace *et. al.*, paper showed that the booster response with a tetanus toxoid-conjugated Hib-MenC-TT vaccine (Menitorix) was greater when children were primed with MenC-TT (NeisVac-C) compared with those primed with CRM-conjugated vaccine (Menjugate or Meningitec).

The HPA has conducted clinical trials with MenC vaccines using CRM-conjugated primary vaccines and tetanus toxoid-conjugated boosters and has followed such vaccinated children for two years. These studies have looked at the effects of a reduced MenC vaccination schedule in the first year of life (1 dose compared to 2 doses) and has also looked at the response to the concomitant administration of Hib-MenC (Menitorix) and PCV (Prevenar) at 12 months given at the same time as MMR vaccine.

ACTION: The Chair asked Prof. Elizabeth Miller to prepare a paper for the June meeting summarising the findings and all the available evidence on this issue.

- Southern J, Borrow R, Andrews N et al. (2008) Immunogenicity of a reduced schedule of meningococcal group C conjugate vaccine given concomitantly with a 7-valent pneumococcal conjugate vaccine and a combination DTaP5/Hib/IPV vaccine in healthy UK infants. *Clin Vaccine Immunol.*
- Jackson LA, Jacobson RM, Reisinger KS et al. (2008) A Randomized Trial to Determine the Tolerability and Immunogenicity of a Quadrivalent Meningococcal Glycoconjugate Vaccine in Healthy Adolescents. *Pediatr Infect Dis J.* 28(2):1-6

- Ginsberg J, Mohebbi MH, Patel RS *et al.*, 2008. Detecting influenza epidemic using search engine query data. *Nature*.
- Jordan RE and Hawker JI. 2008. Influenza vaccine in the over 65s. *BMJ* 337:a2545
- Hall H, 2008. Flu vaccine in the over 65s- a proper RCT is needed. *BMJ* 337:A2924
- Mayfield MP. Universal BCG in the UK again? 2008. *BMJ* 337:A3101
- Davies PDO. Why universal BCG in the UK was deemed not necessary. 2009 *BMJ* 338:B192
- Meeting of the immunization Strategic Advisory Group of Experts, November 2008 – conclusions and recommendations. *Wkly Epidemiol Rec.* 2009. 84(1-2):1-16

14. ANY OTHER BUSINESS

HPV immunisation for girls aged 18 to 25 years

The committee had previously concluded that a ‘catch up’ vaccination of all women aged 18 to 25 years was not cost-effective at the vaccine price considered. However, the committee recognised that the vaccine could benefit some individual women aged 18 and over who were at risk of new HPV infection by the vaccine types. The committee asked that the Department to consider this further and explore mechanisms of meeting such requests.

The committee was informed that DH is considering these options and will provide advice when they are able to.

Hepatitis B immunisation – providing hepatitis B antigen as part of a combined vaccine

A committee member asked whether there is a timescale for when additional modelling could be carried out to look at the benefits of vaccination with a combined diphtheria, tetanus, acellular pertussis, inactivated poliovirus, Hib, Hepatitis (DTaP/IPV/Hib/HepB) vaccine. Previous concerns had been brought to the committee that such a product provides protection against Hepatitis B but is not as effective at protecting against Hib compared with the vaccine currently in the schedule (Pediace).

The secretariat informed the committee that the hepatitis B cost-effectiveness analysis is currently being independently peer-reviewed and the topic will be on the agenda for the June meeting. The committee agreed to discuss this issue further at the June meeting.

Committee processes

Discussions with vaccine manufacturers

The committee members were asked for their views on whether vaccine manufacturers could present their data to the committee or subgroups of the committee. Members agreed that the data they receive from vaccine manufacturers in written form has provided the information needed for it to make recommendations. Therefore, the committee agreed that vaccine manufacturers should not be asked to present their data at JCVI or sub-group meetings.

The Chair asked for it to be noted that this recommendation overrides a former recommendation minuted under item 10 of the October 2007 meeting.

Committee openness

The committee discussed the issues around providing greater openness and ways in which the committee could provide greater access to the public. Other committees have developed methods of providing open meetings including holding closed and open parts of a meeting, one open meeting a year and web-broadcasting of meetings.

ACTION: The committee asked the secretariat to provide a paper and to circulate it before the June meeting. The paper should outline the different processes that could be adopted and the pros and cons (including costs) of implementing the various processes.

15. DATES OF FUTURE MEETINGS

Wednesday 17 June 2009 (confirmed)
Wednesday 14 October 2009 (confirmed)
Wednesday 3 February 2010 (provisional)

ANNEX: DECLARATIONS OF INTEREST

Item (6): Pneumococcal vaccines

Dr Ray Borrow	Personal non-specific (GSK and Wyeth) Non-personal non-specific (Sanofi Pasteur)
Mrs Pauline MacDonald	Non-personal non-specific (GSK and Sanofi Pasteur)
Prof. Claire-Anne Siegrist	Personal non-specific (GSK); Non-personal non-specific (GSK and Sanofi Pasteur)
Dr Anthony Harnden	Non-personal specific (GSK)
Dr Andrew Riordan	Non-personal non-specific (GSK and Sanofi Pasteur)

Item (7): Influenza vaccines

Dr Ray Borrow	Personal non-specific (GSK and Wyeth) Non-personal non-specific (Sanofi Pasteur)
Mrs Pauline MacDonald	Non-personal non-specific (GSK and Sanofi Pasteur)
Prof. Claire-Anne Siegrist	Personal non-specific (GSK); Non-personal non-specific (GSK and Sanofi Pasteur)
Dr Anthony Harnden	Non-personal specific (GSK)
Dr Andrew Riordan	Non-personal non-specific (GSK and Sanofi Pasteur)

Item (9): HPV vaccines

Dr Ray Borrow	Non-personal specific (Sanofi Pasteur)
Mrs Pauline MacDonald	Personal non-specific (GSK and Sanofi Pasteur)
Prof. Claire-Anne Siegrist	Personal non-specific (GSK); Non-personal non-specific (GSK and Sanofi Pasteur)
Dr Anthony Harnden	Non-personal specific (GSK)
Dr Andrew Riordan	Non-personal non-specific (GSK and Sanofi Pasteur)

Item (13): Hepatitis B (hexavaccine)

Dr Ray Borrow	Personal non-specific (GSK)
Prof. Claire-Anne Siegrist	Personal non-specific (GSK); Non-personal non-specific (GSK)
Dr Anthony Harnden	Non-personal specific (GSK)
Dr Andrew Riordan	Non-personal non-specific (GSK and Sanofi Pasteur)