JOINT COMMITTEE ON VACCINATION AND IMMUNISATION

Minute of the JCVI COVID-19 sub-committee held 29 October 2020 08:00-11:00

Members

Prof Wei Shen Lim (Chair)
NR
NR
Prof Matt Keeling
NR
NR
NR
Prof Robert Dingwall
Prof Martin Williams
NR
NR
Dr Kevin Brown
NR
Dr Rebecca Cordery
NR
Prof Lucy Yardley
NR

Co-opted members

NR (Wales)
Dr Julie Yates (England)

Medical Advisor

Prof Jonathan Van Tam

Secretariat

NR
NR
NR
Dr Mary Ramsay
Dr Gayatri Amirthalingam

Invited experts/presenters

NR (PHE)
Ines Campos-Matos (PHE)

Invited observers from Devolved Administrations

NR (Scotland)

Other invited observers

Alex Hawkins-Drew (Guernsey)
Becky Sherrington (Jersey)
Jacqui Dunn (IoM)
NR (PHW)
Claire Cameron (HPS)
Marty Coleman (NI)
Luke Collet-Fenson (DHSC)
NR (DHSC)
Claire Vittery (DHSC)
NR (DHSC)
NR (MoD)
Tessa Walton (NHSE)
Amy Bowen (NHSE&I)
NR (NHSE)
NR (PHE)
NR (PHE)
NR (PHE)
NR (PHE)
NR (PHE)
Sema Mandal (PHE)
NR (PHE)
Professor Maria Zambon (PHE)

NR (PHE)
Margret Boyle (NI)
Charlotte Miller (DHSC)
Sharron Richards (Wales)

NR (BEIS)

Apologies

programme, but there was the potential for at least some impact on transmission. It was suggested that any offer would need to be caveated to ensure individuals understood the limitations in the evidence around the potential benefits regarding transmission. This was important to ensure such individuals did not undertake activity which increased their risk of exposure, under the potentially false assumption that they could not be infected and pass the infection on to vulnerable household members.

19. It was agreed that the immunosuppression risk group should include the additional examples of "individuals with systemic lupus erythematosus (SLE), rheumatoid arthritis (RA) and psoriasis who may require long term immunosuppressive treatments".

20. On the wording around Health and Social Care workers, Members were asked to comment by correspondence with the secretariat.

21. The Committee reviewed data on the risk of mortality in risk groups by age. While the increased absolute risk appeared to increase from around age 40 years, it was agreed that if there was no barrier to vaccine availability that all at-risk adults should be offered vaccine.

22. All advice would continue to depend on the necessary data on vaccine safety and efficacy being reviewed by the Committee.

III. Occupational risk for COVID-19

22. Priority groups down to age 50, along with adults under the age of 50 in a risk group had been outlined, and was described as Phase 1 of the programme, subject to sufficient vaccine availability.

23. PHE presented a paper entitled 'Considerations on occupational use of COVID-19 vaccines: evaluating risks of infection and death from SARS-CoV-2' to aid in consideration of whether there were occupations to be slotted into the priority groups, either above an age band or in phase 2; with the under 50s.

24. It was noted that there were 32.3 million workers with 33% designated as key workers; mostly health and social care workers. ONS had estimated the risk of particular occupations based on individual perception of risk. This included exposure and increased proximity to others at their workplace. Health and social care workers had prolonged exposure and increased proximity to disease.

25. Other professions such as bus drivers and bar staff may have high reported proximity to individuals, they may not have higher exposure to disease, as they have less exposure to sick people.

26. The REACT study estimated the community prevalence of SARS-CoV-2 and

had found that health and social care workers had a higher risk of infection. Other studies found 15.4% seropositivity in healthcare workers in May/June (Pillar 3) and 24.9% seropositivity in care home workers (VIVALDI 2)

27. A model constructed in the US estimated mortality by occupation within the UK and back calculated the infection rate by occupation in the US. The analysis indicated an increased risk of infection within the healthcare professional group, with moderate increases in other work forces represented.

28. With regard to mortality, the highest age standardised mortality rates were in those above the working age group. It was noted that in the working age population in males less than 50 the age standardised mortality rate is 3.4 and beyond 50 it increases markedly. In females the trend was similar, but the rates were lower.

29. Deaths due to occupation taken from the ONS website and PHE data indicated that in men the most significant mortality rates are attributed to process, plant and machine operators and similarly in women, but also in the caring professions. The age-related trend was also seen in different occupations, including healthcare workers.

30. Models of vaccination allocation by occupation were considered. In the US models, vaccine would be prioritised to older people and healthcare professionals, rather than all working people.

31. The paper concluded that – in addition to the age-based criterion vaccine could be considered for:

    a. those in occupations at very high risk of infection.

    b. those where there is a risk of onward transmission to vulnerable individuals

    c. to older members, or those with recognised comorbidity, of occupations at lower risk of infection.

Discussion

32. Having made a recommendation on healthcare professionals, discussions were on whether there were any professions to consider for prioritisation and whether they should be age stratified.

33. There was some support for a strategy of targeting occupational groups at risk and stratifying by age within the group. The difficulty of identification of and delivery to particular occupations and age groups within the occupation was raised; it was suggested that there could be public messaging about the occupation groups with higher than average risk for age, encouraging them to come forward for vaccination in Phase 2. It was noted that the absolute risk for occupations other than health and social care work was very low.