

From the Chief Medical Officer
Dr Henrietta Campbell CB

HSS(MD)23/2004

To:

Chief Executives, Health & Social Services Boards and Trusts
Directors of Public Health, Health & Social Services Boards
Director of Nursing, Health & Social Services Boards
Directors of Pharmaceutical Services, Health & Social Services Boards
GP Medical Advisers, Health & Social Services Boards
Consultants in Communicable Disease Control, Health & Social Services Boards
All Community Pharmacists
Medical Directors, Health & Social Services Trusts (*for onward distribution to all Consultants*)
Nursing Directors, Health & Social Services Trusts (*for onward distribution to all Community Nurses*)
Directors of Pharmaceutical Services, Health & Social Services Trusts
Director of Pharmaceutical Services, CSA
All General Practitioners (*for onward distribution to practice staff including practice nurses*)
Regional Epidemiologist, CDSC (NI)

Castle Buildings
Stormont Estate
Belfast BT4 3SQ
Tel: 028 9052 0563
Fax: 028 9052 0574
Email: Henrietta.Campbell@dhsspsni.gov.uk

Your Ref:

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Dear Colleague

INFLUENZA/PNEUMOCOCCAL IMMUNISATION PROGRAMME FOR 2004/2005

The purpose of this letter is to inform you of the details for this year's Influenza/Pneumococcal Immunisation Programme and to update you on the new recommendations for pneumococcal immunisation. There is a major change to the arrangements for the delivery of influenza and pneumococcal immunisation this year resulting from the new GMS contract. Under the terms of the contract, the influenza and pneumococcal programmes will be delivered as a Directed Enhanced Service (DES), which will be commissioned by HSS Boards from primary medical services contractors. Formal Directions to Boards on the delivery of all Directed Enhanced Services, including the Influenza and Pneumococcal DES will issue from the Department shortly. In support of the forthcoming Directions, this letter sets out regional policy on influenza and pneumococcal immunisation for this coming year and provides guidance for Boards in commissioning these programmes and for those who will be involved in their delivery.

INFLUENZA IMMUNISATION PROGRAMME

2003/2004 Campaign

1. As in previous years the Influenza Immunisation Campaign in Northern Ireland during 2003/2004 was a huge success and thanks are due to all who contributed to the high uptake rates achieved in Northern Ireland. An uptake target of 70% was set for those aged 65 and over and this target was exceeded with an uptake of 73% in this age group. In the under 65 population with an at-risk medical condition an uptake target of 60% was set and this target was exceeded with an uptake rate of 64% being achieved. Northern Ireland currently has the highest rates of uptake for influenza immunisation in the UK.

Epidemiology of Influenza in Northern Ireland 2003/2004

2. CDSC (NI) undertake enhanced surveillance of influenza and influenza-like illness in Northern Ireland through a network of GP spotter practices, which are distributed across the province. The key features of influenza during 2003/2004 can be summarised as follows:
 - Influenza activity in Northern Ireland commenced in the first week of October 2003 – several months earlier than would normally be expected.
 - Infection was caused by the Fujian Strain of Influenza A H3N2.
 - The Fujian Strain predominated across the UK, Ireland and Europe during 2003/2004.
 - Rates of illness were highest in children under 4 years of age.

Arrangements for Influenza Immunisation Programme 2004/2005

3. Essentially the Influenza Immunisation Programme remains unchanged since 2003/2004. The uptake targets for Boards remain as:
 - 70% for people aged 65 and over
 - 60% for people under 65 with at-risk medical conditions

All those providing the service should develop a proactive and preventive approach to offering immunisation with the aims of maximising uptake in the interests of at-risk patients and of meeting any public health targets set.

Having considered the epidemiology of influenza in Northern Ireland and the rest of the UK during 2003/2004 we are asking this year that, in the delivery of the programme, particular attention is paid to the need to ensure that all children in the at-risk groups are offered influenza immunisation. In addition, the Joint Committee on Vaccination and Immunisation (JCVI) have recommended that all children who have previously been admitted to hospital for lower respiratory tract disease should be included in the risk groupings for influenza and hence be offered influenza immunisation (full details of the risk categories are included at Annex A). In children the recommended doses for influenza vaccine are as follows:

Children aged 4-12 years:

0.5ml im or deep sc, repeated 4-6 weeks later if receiving influenza vaccine for the first time

Children aged 6 months-3 years:

0.25ml im or deep sc, repeated 4-6 weeks later if receiving influenza vaccine for the first time.

The deltoid muscle is the recommended site for adults and older children. For infants and young children the preferred site is the anterolateral aspect of the thigh.

Influenza Vaccine Composition 2004/2005

4. Following detailed analysis of the epidemiology of flu viruses internationally the WHO have made their recommendations on the strains of influenza virus to be included in the components for the 2004/2005 vaccine in the Northern Hemisphere (details of these are included at Annex B)

Publicity

5. In view of the need to ensure that at-risk children are offered influenza immunisation a new publicity campaign is being developed and will be launched in October 2004. This includes the development of a new information leaflet, supplies of which will be distributed in advance of the launch of the Influenza Immunisation Programme.
6. The supply of customised prepaid envelopes to GP Practices who wish to use their own patient invitation letters will continue this year. These envelopes have been given a new look to ensure that patients realise they contain important information about influenza immunisation. These envelopes will be delivered directly to GP practices by the end of August 2004. Unused envelopes must be returned to:

Mr Gerry Dorrian
Health Protection Team
Room C4.22 Castle Buildings
Stormont Estate
BELFAST BT4 3SQ

Funding

7. Boards have already received funding for the influenza immunisation of the under 65s and over 65s as part of their allocated share of the GMS Contract financial envelope. Further resources will be allocated to Boards in the latter part of August from the Department's Health Protection budget for the provision of additional support for Trusts (paragraph 8 refers) and for the payment of a data collection fee (paragraph 17 refers). Resources will also be made available to Boards to support community pharmacies in promoting the influenza immunisation campaign.

Trusts

8. The Department will again allocate resources to Boards to support the delivery of the Influenza Immunisation Programme. This will include provision of additional Trust support for the delivery of the programme.

Influenza Immunisation Among Healthcare Workers

9. There is evidence that healthcare workers can spread influenza virus to patients in their care. Unvaccinated healthcare workers can be a key cause of outbreaks in healthcare settings such as GP practices, hospitals, long-term and residential care facilities, and other healthcare settings. It is thus important that Trusts work to increase the uptake of the influenza immunisation among healthcare staff in whom uptake rates in previous years have been extremely low indeed. Responsibility for occupational influenza immunisation rests with the employer and it should be provided through an occupational health service. It is up to individual trusts/employers to determine their own programme and fund the immunisation of their staff. Employers are recommended to keep records of staff immunised and monitor the effectiveness of their programme. Details of strategies which may be employed to increase influenza immunisation uptake among healthcare workers are included in Annex C.

Immunisation Against Infectious Disease (The Green Book)

10. A revised Influenza Chapter for the book 'Immunisation Against Infectious Disease' (The Green Book) with details of the current recommendations is available at <http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/GreenBook/fs/en>

Vaccine Supplies

11. Influenza Vaccine

All practices, which have not already done so, should inform their local supplier (most often a community pharmacist) of their estimated need for this years programme immediately.

Enough influenza vaccine is expected to be available for the recommended risk groups. However, if demand is higher than expected and firm orders have not been placed in advance shortages could occur. As an additional safeguard to ensure adequacy of supplies GPs are asked to follow a generic prescribing policy i.e. influenza vaccine rather than a specific brand.

A contingency supply of influenza vaccine will be available should particular difficulties in supply arise. This supply may be accessed by contacting Dr Jill Mairs at the Regional Pharmaceutical Procurement Service (Tel: 028 9055 2386). It should be noted that there will be limited contingency stock available and it must be accessed in exceptional circumstances only.

12. Pneumococcal Vaccines

Community supplies of pneumococcal vaccines should be prescribed for individual patients on HS 21.

23-valent pneumococcal polysaccharide vaccine (Pneumovax II)

Community and hospital pharmacies may source supplies of 23-valent pneumococcal polysaccharide vaccine (Pneumovax II) manufactured by Aventis Pasteur through local wholesalers or direct from Aventis Pasteur (Tel: 0800 085 5511).

Please note that Pneumovax II is not recommended for children under 2 years of age.

7-valent pneumococcal polysaccharide conjugate vaccine (Prevenar)

Community and hospital pharmacies may source supplies of 7-valent pneumococcal polysaccharide vaccine (Prevenar) manufactured by Wyeth through Farillon (Tel: 01708 379 000).

PNEUMOCOCCAL IMMUNISATION PROGRAMME

13. Since 2002 all those aged 65 and over in Northern Ireland have been offered pneumococcal immunisation. To date it is estimated that approximately 58% of the Northern Ireland population aged 65+ have received pneumococcal immunisation. During 2004/2005 Boards should continue to target those aged over 65 who have still not received pneumococcal immunisation and they should be offered pneumococcal polysaccharide vaccine. An allocation will be made to Boards from the Department's Health Protection budget in the latter part of August to fund the delivery of this part of the Directed Enhanced Service.
14. There are changes to the age at which pneumococcal conjugate vaccine is recommended and the at-risk groups recommended to receive pneumococcal vaccination (these are included at Annex D).

Action required by Boards and Trusts

15. Health and Social Services Boards should

- Commission the influenza and pneumococcal immunisation programme as a Directed Enhanced Service in line with the forthcoming Departmental Directions and the influenza and pneumococcal immunisation policy set out in this letter. Boards should ensure that appropriate data collection processes are in place to meet the surveillance requirements of CDSCNI and DHSSPS.
- Identify a Board co-ordinator with overall responsibility for influenza and pneumococcal immunisation.
- Support primary care professionals in delivering the influenza immunisation programme and attaining the 70% uptake target in over 65's and the 60% uptake target in under 65's 'at risk'.

16. Action required of Trusts

- Trusts will need to make arrangements for the influenza immunisation of all staff.
- Trusts should begin to make arrangements for the provision of Trust nursing support to support the delivery of the influenza and pneumococcal immunisation programme in their Board area.

17. Surveillance Arrangements

Each Board is asked to supply a minimum dataset on the uptake of influenza immunisation for regional monitoring purposes. The Department has previously allocated funding to Boards to support the collection of this data through local development schemes and this funding will continue for the 2004/05 programme. The payment this year will be £1.75 per patient. It is essential for Boards to supply this information in the required format by the agreed deadlines. Specific arrangements for surveillance will be issued by Consultants in Communicable Disease Control at Health & Social Services Boards at a later date.

In order to ensure that uptake rates for influenza immunisation remain high, a similar level of effort to last year is required by all those involved in delivering the programme. Last year influenza virus arrived early in the province highlighting the need for early implementation of the influenza immunisation programme. The occurrence of human cases of highly pathogenic avian influenza in South East Asia this year has also raised international concerns about future influenza epidemics. As in every other year, sustained effort is required to achieve high levels of influenza immunisation uptake.

For further information please contact:

Dr Lorraine Doherty (Medical Issues) lorraine.doherty@dhsspsni.gov.uk
Senior Medical Officer/Consultant Epidemiologist Tel: 028 90 520717
& Chair of Regional Influenza & Pneumococcal Working Group

Dr Norman Morrow (Pharmaceutical Issues) norman.morrow@dhsspsni.gov.uk
Chief Pharmaceutical Officer Tel: 028 90 523219

Dr Carolyn Mason (Nursing Issues) carolyn.mason@dhsspsni.gov.uk
Tel: 028 90 520795

Yours sincerely

Dr H Campbell
Chief Medical Officer

Dr N Morrow
Chief Pharmaceutical Officer

Ms J Hill
Chief Nursing Officer

cc: Dr Jim Livingstone, Director Primary Care DHSSPS
Mr Gerry Dorrian, Deputy Principal, Health Protection Team, DHSSPS
Mrs Beatrice Major, Deputy Principal, GMS Contract Unit, DHSSPS
Prescribing Advisers, Health & Social Services Boards
Directors of Primary Care, Health & Social Services Boards
Regional Drug and Poisons Information Service
Dr Jill Mairs, Regional Procurement Pharmacist
Local Health & Social Care Groups – Chairs/Managers
Dr Philip McClements, NI Prison Service
Dr Brian Dunn, Chair, GPC, BMA
Universities Student Health Services
Occupational Health Departments Boards/ Trusts
NICS Occupational Health Service

This letter is available at www.dhsspsni.gov.uk and also on the DHSSPS Extranet which can be accessed directly at <http://extranet.dhsspsni.gov.uk> or by going through the HPSS Web at <http://www.n-i.nhs.uk> and clicking on DHSSPS.

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National Policy

National policy for 2004/05 is that influenza immunisation should be offered to:

- (i) All those aged 65 years and over;
- (ii) All those aged over 6 months in the following clinical risk groups:

Clinical risk category	Examples (decision based on clinical judgement)
<i>Chronic respiratory disease, including asthma</i>	This includes chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema, bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis, asthma requiring continuous or repeated use of inhaled or systemic steroids or with previous exacerbations requiring hospital admission, children who have previously been admitted to hospital for lower respiratory tract disease.
<i>Chronic heart disease</i>	This includes those requiring regular medication and/or follow-up for ischaemic heart disease, congenital heart disease, hypertensive heart disease (excluding uncomplicated controlled hypertension) and chronic heart failure.
<i>Chronic renal disease</i>	Including nephrotic syndrome, chronic renal failure, renal transplantation.
<i>Diabetes</i>	Diabetes mellitus requiring insulin or oral hypoglycaemic drugs.
<i>Immunosuppression</i>	Immunosuppression due to disease or treatment, including asplenia or splenic dysfunction, and also including those on or likely to be on systemic steroids for more than a month at a dose equivalent to prednisolone at 20mg or more per day (any age) or for children under 20kgs a dose of 1mg or more per kg per day. HIV infection at all stages. <i>However, some immunocompromised patients may have a suboptimal immunological response to the vaccine</i>

- (iii) those living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality (this does not include prisons, young offender institutions, university halls of residence etc).

Influenza vaccine composition for 2004/05

Flu vaccine strains are recommended by the World Health Organisation (WHO) following careful mapping of flu viruses as they travel the world. This monitoring is continuous and allows experts to make predictions of which strains are most likely to cause influenza outbreaks in the northern hemisphere in the coming winter.

The strains of influenza virus recommended by WHO to be included in the components for the 2004/05 vaccine are:

- an A/New Caledonia/20/99(H1N1)-like virus
- an A/Fujian/411/2002(H3N2)-like virus*
- an B/Shanghai/361/2002-like virus**

* The currently used vaccine virus is A/Wyoming/3/2003. A/Kumamoto/102/2002 is also available as a vaccine virus

** Candidate vaccine viruses include B/Shanghai/361/2002 and B/Jilin/20/2003 which is a B/Shanghai/361/2002-like virus

STRATEGIES WHICH MAY BE EMPLOYED TO INCREASE INFLUENZA IMMUNISATION UPTAKE AMONG HEALTHCARE WORKERS

Trusts should be working now to develop policies and approaches to support influenza immunisation for healthcare workers in their employment. Trusts need to communicate with staff the fact that influenza immunisation is important to healthcare worker and patient safety alike. A variety of approaches may be used to help increase immunisation uptake rates among healthcare workers:

1. Chief Executives/Senior Management – need to become strong advocates of influenza immunisation among healthcare workers/employees in order to achieve better infection control, reduced absenteeism, and cost saving/effectiveness.
2. Influenza vaccination needs to be made convenient for employees by offering vaccine clinics at various times and by taking vaccine directly to healthcare workers.
3. Trusts should remind healthcare workers that DHSSPS recommends influenza immunisation annually.
4. Healthcare workers need to be informed that:
 - Influenza vaccine does not cause influenza
 - Influenza virus is easily transmitted putting them, their patients, their families and others at risk.

Pneumococcal Immunisation

Changes to the age at which pneumococcal conjugate vaccine is recommended and risk groups recommended to receive pneumococcal vaccination

1. At risk children under 5 years of age

The Joint Committee on vaccination and Immunisation (JCVI) has recommended that pneumococcal conjugate vaccine should now be recommended for at risk children under five years of age according to the following schedule:

- Infants who commence pneumococcal immunisation at less than six months of age should be given three doses of pneumococcal conjugate vaccine from 2 months of age with an interval of one month between doses. A fourth dose should be given after the first birthday.
- Infants who commence immunisation aged seven to eleven months of age should be given two doses of pneumococcal conjugate vaccine with an interval of one month between doses. A third dose should be given after the first birthday, and at least one month after the second dose.
- Children who commence immunisation aged 12 to 60 months should have two doses of pneumococcal conjugate vaccine with an interval of two months between doses.

All children in the above groups also need to be given the 23-valent polysaccharide vaccine (Pneumovax II) to cover the wider range of serotypes. A single dose of 23-valent polysaccharide vaccine should be given after their second birthday and at least two months after the final dose of conjugate vaccine.

At risk children under 5 years of age who have already received 23-valent pneumococcal vaccine should receive two doses of conjugate vaccine (Prevenar) as above, at least two months after the polysaccharide vaccine.

Pneumococcal conjugate vaccine (Prevenar) is not currently recommended for those commencing immunisation at age 5 years and over.

2. Changes to the clinical risk groups recommended for pneumococcal immunisation

In addition to the above advice, the risk groups recommended to receive pneumococcal vaccine have been revised by JCVI to include new risk groups and to clarify existing risk groups. The new advice is summarised in Table A.

Children under 5 years of age who have previously had invasive pneumococcal disease such as pneumococcal meningitis or bacteraemia are now recommended to receive pneumococcal vaccination. This is being recommended as these children may have an unrecognised condition such as congenital asplenia that may make them more susceptible to pneumococcal infection.

TABLE A**Pneumococcal vaccine is recommended for:**

- All those aged 65 years and over;
- All those aged over 2 months in the following clinical risk groups:

Clinical risk category	<i>Examples (decision based on clinical judgement)</i>
asplenia or dysfunction of the spleen,	This also includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction.
<i>Chronic respiratory disease, including asthma</i>	This includes chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema, bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis, asthma requiring continuous or repeated use of inhaled or systemic steroids or with previous exacerbations requiring hospital admission. Children who have previously been admitted to hospital for lower respiratory tract disease.
<i>Chronic heart disease</i>	This includes those requiring regular medication and/or follow-up for ischaemic heart disease, congenital heart disease, hypertensive heart disease (excluding uncomplicated controlled hypertension) and chronic heart failure.
<i>Chronic renal disease</i>	Including nephrotic syndrome, chronic renal failure, renal transplantation.
<i>Chronic liver disease</i>	including cirrhosis
<i>Diabetes</i>	Diabetes mellitus requiring insulin or oral hypoglycaemic drugs.
<i>Immunosuppression</i>	Due to disease or treatment and also including systemic steroids (equivalent to prednisolone 1 mg/kg/day for a child, or 20mg daily for an adult, for more than 2 weeks). HIV infection at all stages. <i>However, some immunocompromised patients may have a suboptimal immunological response to the vaccine</i>
Individuals with cochlear implants	
Individuals with CSF shunts *	Including other conditions where leakage of CSF can occur
Children under 5 years of age who have previously had invasive pneumococcal disease *	eg children who have previously had pneumococcal meningitis or pneumococcal bacteraemia.

* New risk group category

3. **Recommendations of the DHSSPS Medicines Governance Team in relation to Pneumococcal Immunisation for those Aged 65 and Over**

The majority of people will be vaccinated in the community setting, however the situation may arise where a patient will be vaccinated in hospital.

A single vaccination offers protection against pneumococcal infection for up to ten years and re-immunisation after this time is only advised for selected patients, e.g. asplenic patients. **Re-vaccination within 3 years of a previous injection may cause severe reactions in some subjects.**

To reduce the risk of severe reactions, the Medicines Governance Team recommends that:

- Prior to pneumococcal vaccination within a hospital, confirmation should be sought that the patient has not received this vaccine within the last 3 years – either in the primary or secondary care setting.
- The patients General Practitioner should be informed if a patient is vaccinated during a hospital admission.
- A record of the date of vaccination must be made in the hospital notes.