

From The Chief Medical Officer:
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HSS(MD)31/2003

4th July 2003

To: All General Practitioners (for onward distribution to practice staff including practice nurses)
All Community Pharmacists
Directors of Public Health, HSS Boards
Directors of Nursing, HSS Boards
Medical Directors of HSS Trusts (for onward distributions to all Consultants)
Nursing Directors of HSS Trusts (for onward distribution to Community Nurses)
Directors of Pharmaceutical Services of HSS Boards
Directors of Pharmaceutical Services of HSS Trusts
Director of Pharmaceutical Services at CSA
Consultants in Communicable Disease Control in each HSSB
Directors of Pharmaceutical Services of each HSS Trust, HSSB and CSA
Regional Epidemiologist, CDSC
Chief Executives, HSS Boards and Trusts
GP Medical Advisers, HSS Boards

Dear Colleague

1. **INFLUENZA/PNEUMOCOCCAL IMMUNISATION PROGRAMME FOR WINTER 2003-2004**
2. **HIB CAMPAIGN**
3. **SARS**

The purpose of this letter is to (1) update you on the outcome of last years Influenza/Pneumococcal Immunisation Programme and also to outline arrangements for both immunisation programmes for 2003-2004. (2) Update you on the Hib Campaign. (3) Provide an update on SARS.

(1) INFLUENZA/PNEUMOCOCCAL

In 2002/2003 the communication arrangements for the Influenza Immunisation Programme changed somewhat to reflect the needs to promote immunisation update among the population aged less than 65 with an at risk medical condition. The Influenza Immunisation Programme was a great success. Once again an uptake rate of influenza immunisation in those aged 65 and over of 72% was achieved. A regional target of 60% uptake among those under 65 years of age and considered at risk was also set for 2002/2003. There were some difficulties agreeing a denominator population for monitoring this target, however having considered the national and local epidemiology, it was agreed that the denominator

population should be 10% of the practice population. Using this denominator an overall uptake rate for influenza immunisation in those aged under 65 of 55.8% was achieved. Many thanks to all those who were involved in delivering this very successful campaign, in particular those working in primary care and Trusts.

Outcome of Pneumococcal Immunisation of Over 65s in 2002/2003

During 2002 the JCVI made a recommendation that pneumococcal immunisation should be offered to all those aged 65 and over. DHSSPS identified funding to implement this policy during 2002/2003 and centrally purchased pneumococcal vaccine for immunisation of those aged 65 and over only. A total of 129,000 pneumococcal vaccines were purchased and of these 82,458 were administered to patients in the 65+ age group. Using historical data it is estimated that approximately 53% of the Northern Ireland population aged 65 and over have received pneumococcal vaccine since the year 2000.

Priorities For Action

The Influenza Immunisation Programme features again in Minister's Priorities for Action 2003/2004 (Circular: HSS(PPM)2/2003). The target for influenza immunisation among those aged 65 and over remains unchanged at 70%. In addition the target for influenza immunisation of 60% among those aged less than 65 with a clinical indication for influenza immunisation remains unchanged. No target has been set in relation to pneumococcal immunisation of those aged 65 and over.

Support for the Influenza/Pneumococcal Immunisation Programme 2003-2004

On the recommendation of the Regional Influenza/Pneumococcal Working Group, the Department will support the following initiatives to support the programme this year.

1. The supply of customised prepaid envelopes to GP Practices who wish to use their own patient invitation letters 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 2003. Unused envelopes must be returned to:

Mr Gerry Dorrian
Health Protection Team
Room C4.22 Castle Buildings
Stormont Estate
BELFAST BT4 3SQ
2. The look of the communications strategy – ie the 'Protection' theme – will remain unchanged for 2003-2004 to ensure consistency in the approach. However additional TV advertising will be sought for midway during the campaign. In addition, it is anticipated that radio advertising will also be used. As usual posters and leaflets will be circulated widely for use. A large poster will be made available to community pharmacies for window displays.

3. To support the delivery of pneumococcal immunisation in the over 65s the Department, in conjunction with the Health Promotion Agency, is currently developing a new pneumococcal leaflet which will be available and delivered to practices before the end of August 2003.

Action required by Boards, Trusts and Primary Care

Information on running a successful influenza immunisation programme is shown at **Annex 1**.

Health and Social Services Board should

- 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' by;
 - Working with GP practices to ensure all patients over 65 and all 'at risk' patients under 65 are identified and offered flu vaccine.
 - Aiding GP practices in their efforts to ensure those aged 65 and over, under 65s at risk, and patients with cochlear implants received pneumococcal vaccine if they have not had it already.
 - Supplying GPs with examples of good practice to encourage high uptake, personalised invitation letters were used successfully by many GP's last year and is an example of good practice in this area.
 - Providing additional support to practices where the targets for uptake may prove difficult to achieve.
 - Ensuring that arrangements are in place to monitor uptake of influenza immunisation in each practice and overall in the Board. This information will be used to contribute to the regional evaluation of influenza immunisation uptake.
 - Identify particular areas in their Board area with low uptake of influenza immunisation and work with local community pharmacists to develop initiatives to promote immunisation uptake in these areas.
 - Support primary care professionals in delivering the pneumococcal immunisation programme for the under 65s at risk and the over 65s.

GPs are asked to

- Update their register of those aged over 65 years of age.
- Identify their 'at risk' population aged less than 65 years (**see Annex 2**). This year the denominator to be used for influenza immunisation uptake monitoring purposes in this group is **10% of the existing practice population aged less than 65, based on CSA lists**.

- **It is essential that GPs have already determined their influenza vaccine requirements and placed orders with their local supplier. Those who have not done so should proceed to do so immediately.**
- Identify any patients aged 65 or over, those aged less than 65 with a risk factor, and patients with cochlear implants who have not already had pneumococcal immunisation and offer them pneumococcal vaccine.

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 and their Board area.

Residential and Nursing Homes

A recent study in Northern Ireland has indicated that the uptake of influenza immunisation in older patients in nursing and residential homes is lower than that of the general population of those aged over 65. Low uptake rates for influenza immunisation have been shown in those aged 85 or over. As these patients are particularly vulnerable given their age, any individual risk factors and also their residential environment, it is important that they are identified and offered influenza immunisation.

Vaccine Supplies

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 year's programme immediately

Enough flu 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 vaccine will be available should particular difficulties in supply arise. This supply may be accessed by contacting Dr Jill Mairs at Regional Pharmaceutical Procurement Centre (Tel 028 90552386). It should be noted that there will be limited contingency stock available and it must be assessed in exceptional circumstance only.

The latest information from the manufacturers is that vaccine should become available during the first week of October. Practices should therefore plan to start immunising patients from the week commencing Monday 13th October 2003. Details of the vaccine composition for this year area included in **Annex 3**.

Pneumococcal Vaccine:-

Pharmaceutical Branch, DHSSPS will be leading an audit examining all processes involved in pneumococcal vaccine distribution and administration in the 2002 campaign. 82,458 of 129,000 vaccines were administered to those aged over 65. In the meantime, from distribution records it seems approximately 20,000 doses of unused centrally purchased vaccine remain in the system from the 2002 campaign. This vaccine remains within its shelf life, it is therefore essential to try and identify where the excess vaccine may currently be stored.

****GPs, community and Trust pharmacists are asked to urgently review their vaccine stocks, determine how much unused centrally purchased vaccine they retain, establish whether cold chain has been maintained and then notify their local HSS Board CCDC/Immunisation Co-ordinator of any excess vaccine suitable for redistribution.**

GPs should also identify any patients aged 65 or over who have not yet received pneumococcal vaccine. It may be possible to access some supplies of centrally purchased vaccine left over from the 2002 campaign, for immunisation of over 65s only if there is enough available in local Board areas to redistribute. Otherwise it should be prescribed for individual patients on HS21 prescriptions in the usual way.

Funding

As in previous years the Department has recognised the importance of the influenza immunisation and has allocated specific resources for the delivery of the programme. The Department have agreed terms with the General Practitioners Committee (GPC) of the BMA for GPs to be reimbursed for influenza immunisation of patients aged 65 years and over and for immunisation of those aged under 65 with at risk medical conditions. This year GPs will receive an item of service payment at the B rate (£6.80) for immunisation of those aged 65 and over. An equivalent payment of £6.80 per patient will be made for immunisation of under 65s with a clinical indication and the Department will allocate funding to the Boards for this purpose. The Item of Service B Rate will also be paid for pneumococcal immunisation of over 65s, under 65s at risk, and patients with cochlear implants

In recognition of the value of the local development schemes to promote influenza immunisation which have been used by the Health and Social Services Boards in conjunction with GPs over the last few years the Department will continue to allocate specific funding for these schemes.

Surveillance Arrangements

Each Board is asked to supply a minimum dataset on the uptake of influenza immunisation for regional monitoring purposes. The Department allocates funding to Boards to support the collection of this data through local development schemes and the payment this year will be £1.75 per patient. It is essential for practices 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 was circulating at an extremely low level within the province and therefore no major influenza outbreaks or increases in admissions due to influenza related illnesses. However, as in every other year, we must sustain our efforts to increase influenza immunisation uptake to avoid problems should we experience high levels of influenza virus.

(2) HIB CAMPAIGN

In April 2003 you received a communication from the DHSSPS regarding the arrangements for the extra dose of Hib Vaccine [HSS(MD)17/2003]. In this letter it was made clear that orders for Hib vaccine should match the scheduling of the Child Health System and that youngest children should be immunised first (Paragraph 6 and Annex 1, Paragraph 4 refer). This was due to the fact that the vaccine manufacturers were unable to supply the entire vaccine requirements for the UK at once. We appreciate this may have caused difficulties for practices but unfortunately the manufacture of the vaccine is beyond DHSSPS control. We are grateful to primary care and Trust colleagues for the support for this campaign to ensure all young children are immunised against Hib before the coming winter.

(3) SARS

Worldwide the transmission of SARS had abated, but all health authorities remain vigilant for the occurrence of SARS and potential spread to Europe. DHSSPS, in conjunction with the wider HPSS, are actively engaged in contingency planning for SARS to ensure that the HPSS is fully prepared in the event we start to see SARS cases here in Northern Ireland. The most up-to-date information about SARS is available at: www.dhsspsni.gov.uk/publichealth

For further information please contact:

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Regional Influenza & Pneumococcal Working Group

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Yours sincerely

Dr H Campbell
Chief Medical Officer

Dr N Morrow
Chief Pharmaceutical Officer

Ms J Hill
Chief Nursing Officer

cc Prescribing Advisers of HSS Boards
Directors of Primary Care of HSS Boards
Regional Drug and Poisons Information Service of Poisons
Dr Jill Mairs, Regional Procurement Pharmacist
Local Health & Social Care Groups – Chairs/Managers

ANNEX 1

Running a Successful Influenza Immunisation Programme

Over the last number of years lessons have been learned from the implementation of the influenza immunisation programme regionally and nationally. This has enabled the identification of good practice, which is relevant locally in the implementation of a successful programme. The following should act as a guide for those planning and delivering local programmes.

At HPSS Boards

- Boards should advise GP practices of the necessity to have ordered their influenza vaccine supply early. Consortia of practices, and practices in the same area should not make themselves dependant on vaccine from one manufacturer: influenza vaccine manufacture is to a tight timetable, and delays are not uncommon.
- Directly contacting people aged 65 years and over to inform them that they are recommended to have the vaccine demonstrated maximum benefit in achieving uptake targets. Experience shows that a personalised letter from GPs is the best way of achieving a high take-up. Last year this method was used successfully by a large number of GP practices here. Boards should commend this as good practice to local GP practices.
- Boards should work closely with GP Practices to share expertise. Additional support should be offered to those practices that may have difficulty organising their immunisation programme or achieving good uptake rates.
- Boards should identify areas of low uptake and explore the possibility of collaborative initiatives with local community pharmacists to promote influenza immunisation uptake.
- Before embarking on local advertising campaigns Boards should ensure that vaccine supplies are available at GP Practices; local advertising should emphasise that people will be immunised over a period of several weeks – there is no need to panic early in the programme
- The monitoring of the uptake rates is the responsibility of Boards. Each Board should ensure arrangements are in place to collect data from GPs which meets regional monitoring requirements. This year Boards are required to monitor uptake in the under 65 population ‘at risk’.

In General Practice

There is no single way to run a successful immunisation programme in General Practice. The following advice is directed mainly at general practitioners, practice nurses and practice managers and is based on published information both published and evidence from last years successful programme.

1. Preliminary Planning

Plan your campaign early -

- ❖ Nominate a lead person to take charge of organisation.
- ❖ Compile a **register** or list of those patients for whom immunisation is recommended, from computer, age/sex, chronic disease management, patient or prescription records, or as patients are seen during the year. The computer search strategies supplied by DHSS&PS last year may help in this respect. GP Medical Advisers at Boards may also be able to provide advice on the best way of compiling your register.

The list generated by your search should be kept to record information on when a patient is immunised and should be used for future campaigns. It may be useful to flag or mark patient records in some way.

Make plans for immunising:

- Vulnerable/homebound patients
- Residential home patients

- ❖ Order sufficient vaccine for your needs. Confirm orders well in advance.

Decide upon the best strategy for your practice -

- ❖ Involve all the key players. These include practice nurses, practice receptionists and managers, district nurses, health visitors and local pharmacists. Try to draw on any experiences learnt from previous campaigns employed in your practice.
- ❖ Consider how patients will be offered immunisation. The use of a personalised invitation letter has been shown to be effective. Prepaid customised envelopes will be supplied by DHSSPS to support this approach.
- ❖ Decide what approach your practice will take to delivering immunisation, e.g. individual appointments, immunisation clinics.
- ❖ Determine in advance how patient consent will be obtained and how records will be kept.

Immunisation clinics -

Consider the logistics of special clinics. Where and when will they be held? Should they be held at lunchtimes, evenings or Saturday mornings when the surgery is not busy with routine work, or in other places? What staffing resources and training will be needed? Remember staff will not be able to carry out normal duties during flu immunisation sessions.

Storing vaccines -

Ensure you have, or have access to, adequate refrigeration facilities (see Immunisation against Infectious Disease 1996, chapter 4). Flu vaccines must be stored at 2-8 °C and must not be frozen or they will lose potency. Develop procedures to avoid disasters such as fridge doors being left open or power supplies being disconnected and for the refrigeration of vaccines in transit to any other settings where immunisation may take place. Consider asking your supplier for sensible staggered deliveries if you think storage space will be a problem. Check to see if manufacturers are offering guaranteed delivery dates.

Review appointments -

Where feasible consider timing review appointments for patients in the target groups, routine elderly health checks or visits to housebound patients, nursing or care homes to coincide with your immunisation campaign.

Target the targeted -

It is appreciated that the 'worried well' will continue to ask for flu immunisations. Whilst GPs retain the final say as to who is to be offered vaccine, excessive immunisation of those outside the target groups may lead to shortages of vaccine for the high-risk groups.

2. Informing patients

Role of DHSS&PS -

The Department will be running an advertising campaign, including TV and radio, from early October, and will supply resource material including leaflets and posters from end of August.

Local publicity -

Publicise your own arrangements within your practice, including clinic times and how to make an appointment. Your Health Board may also be organising local publicity.

Practice staff -

Encourage staff to remind patients in the target groups about the need for immunisation, on home visits or when they collect repeat prescriptions, for example. Stickers as reminders on notes may help.

Making contact -

Telephone or write to patients in the risk groups advising them to have a flu immunisation and informing them of the arrangements. Make sure they know when to call for an appointment. Consider generating a list of patients whom you have already informed about your vaccination arrangements.

Personal contact -

Patients are most likely to take up flu immunisation if their doctor, nurse or pharmacist recommends it. The best form of publicity and the best way to achieve a high uptake, is a personal recommendation, or personalised letter, from the GP.

Advice for patients about flu vaccine -

When giving vaccinations, remember to tell people what the vaccine can do (give substantial protection against influenza, which can be a nasty illness and take some time to recover from in people in the recommended risk groups) and what it will **not** do (cause flu; protect against the many, mainly less serious, respiratory infections that circulate each winter)!. Also any adverse reactions they might expect (temporary soreness at the injection site, and, uncommonly, elevated temperature and muscle aches lasting up to 48 hours following immunisation, but much less than the symptoms caused by flu itself).

3. Recording Information

The vaccine given, batch number, person giving the injection and site of injection if more than one vaccine is given at the same visit must be recorded in the patient's record. Agree a consistent way of doing this in the practice. A system of reporting any adverse reactions should also be in place.

Decide how you will collect and store information on immunisations given. To monitor overall uptake, Health Boards will require information on progress of your campaign, for people on your list aged 65 and over, at the end of October, the end of November and a final tally at the end of the campaign. An additional requirement this year is to monitor uptake of immunisation in those aged less than 65 with an 'at risk' medical condition. Your local Board will inform you of the information requirements and arrangements for collection; this will usually require completion of a standard form which may also be used for claiming payment.

Who should do it? -

Nominate key personnel to be responsible for collecting information.

Recording data on your computer -

If you store information on your practice computer, ensure all staff enter the same READ code to indicate influenza vaccine has been given e.g. "Influenza vaccination 65E".

ANNEX 2

Influenza and Pneumococcal Immunisation Policy for 2003/2004

National Policy

National policy for 2003/2004 is that influenza immunisation should be offered to :

1 People of all ages in the following risk groups:

Risk Group	Conditions Included
Chronic respiratory disease, including asthma	<ul style="list-style-type: none"> <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Interstitial lung fibrosis <input type="checkbox"/> Pneumoconiosis <input type="checkbox"/> Asthma <u>requiring continuous or repeated use of inhaled or systemic steroids or with previous exacerbations requiring hospital admission.</u>
Chronic heart disease	<ul style="list-style-type: none"> <input type="checkbox"/> Chronic ischaemic heart disease <input type="checkbox"/> Congenital heart disease <input type="checkbox"/> Hypertensive heart disease requiring regular medication and follow-up (but <u>excluding uncomplicated controlled hypertension</u>) <input type="checkbox"/> Chronic heart failure
Chronic renal disease	<ul style="list-style-type: none"> <input type="checkbox"/> Nephrotic syndrome <input type="checkbox"/> Chronic renal failure <input type="checkbox"/> Renal transplantation
Diabetes	<ul style="list-style-type: none"> <input type="checkbox"/> Diabetes mellitus <u>requiring insulin or oral hypoglycaemic drugs</u>
Immunosuppression	<p>Due to disease or treatment, including systemic steroids equivalent to 20mg prednisolone daily for more than 2 weeks. Note – some immunocompromised patients may have a suboptimal immunological response to vaccine.</p>

National policy for 2003/2004 is that pneumococcal immunisation should be offered to :

Risk Group	Conditions Included
<p>All those of any age group in whom pneumococcal infection is likely to be more common or dangerous</p> <p>Note: patients aged less than 2 years should be offered pneumococcal conjugate vaccine.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Asplenia or severe dysfunction of the spleen, including homozygous sickle cell disease and coeliac syndrome. <input type="checkbox"/> Chronic renal disease or nephrotic syndrome. <input type="checkbox"/> Immunodeficiency or immunosuppression due to disease or treatment, including HIV infection at all stages. <input type="checkbox"/> Chronic heart disease. <input type="checkbox"/> Chronic lung disease. <input type="checkbox"/> Chronic liver disease including cirrhosis. <input type="checkbox"/> Diabetes mellitus. <input type="checkbox"/> Cochlear Implants.
All patients aged 65 and over who have not previously received pneumococcal vaccine.	

ANNEX 3

Influenza Vaccine Composition for 2002/03

On 28 February 2003, WHO published a recommendation on the composition of influenza vaccine for use in the 2003/2004 influenza season. Because of insufficient data, a decision on the A(H3N2) component was deferred. Additional data has since confirmed that in haemagglutination-inhibition (HI) tests an increasing proportion of recent virus isolates was distinguishable from A/Panama/2007/99 and similar to A/Fujian/411/2002. However, since there is no A/Fujian/411/2002-like virus, isolated in embryonated eggs, suitable as a vaccine candidate and since many recent isolates are antigenically closely related to A/Panama/2007/99, it is recommended that the A(H3N2) component of vaccines to be used in the 2003/2004 season contain an A/Moscow/10/99 (H3N2)-like virus.

Accordingly, it is recommended that the vaccines used in the 2003/2004 season (northern hemisphere winter) contain the following:

- An A/New Caledonia/20/99(H1N1)-like virus
- An A/Moscow/10/99(H3N2)-like virus*
- A B/Hong Kong/330/2001-like virus**

*The widely used vaccine strain is A/Panama/2007/99

**Currently used vaccine strains include B/Shandong/7/97, B/Hong Kong/330/2001, B/Hong Kong/1434/2002