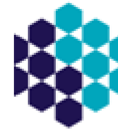
From the Acting Chief Medical Officer
Dr Ian Carson



Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

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HSS(MD)10/2006

To:
Chief Executives, HSS Boards and Trusts
Directors of Public Health, HSS Boards
Director of Nursing, HSS Boards
Directors of Pharmaceutical Services, HSS Boards/Trusts/CSA
GP Medical Advisers, HSS Boards
Consultants in Communicable Disease Control, HSS Boards
All Community Pharmacists
Medical Directors, HSS Trusts *(for onward distribution to all Consultants)*
Nursing Directors, HSS Trusts *(for onward distribution to all Community Nurses)*
All General Practitioners *(for onward distribution to practice staff including practice nurses)*
Regional Epidemiologist, CDSC (NI)
Dr P Jackson, Chair RACCDC Regional Immunisation Cte
Respiratory Physicians
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Our Ref: HSS(MD)10/2006
Date: 13th April 2006

Dear Colleague

CONTROL OF TUBERCULOSIS IN NORTHERN IRELAND - UPDATED GUIDANCE

The purpose of this communication is to update you on:

1. Changes to the BCG Immunisation Programme

2. Control of TB in Northern Ireland.

CHANGES TO THE BCG IMMUNISATION PROGRAMME

1. On 15th July 2005 a joint letter from the Chief Medical Officer, Chief Nursing Officer and Chief Pharmaceutical Officer (HSS(MD)25/2005) detailed changes to the BCG programme. A regional implementation group was established to develop operational guidance to the change in BCG policy, consider the implications for TB control and make appropriate recommendations.

2. The change to the BCG programme will involve an improved targeted neonatal and others at risk based programme and replaces the current school programme for older children. In practice this means that services should be in place to actively identify and vaccinate eligible infants as early in life as possible. Wherever possible, neonates eligible for BCG vaccination should be identified and vaccinated soon after birth, and ideally before discharge from hospital.

3. The contact, occupational and travel-related recommendations remain unchanged. Please refer to the revised TB chapter of “Immunisation against Infectious Disease” (the “Green Book”) for detailed information (http://www.dh.gov.uk/assetRoot/04/12/44/92/04124492.pdf). The new edition of the “Green Book” will be available shortly.

Neonatal Policy and Practice

4. **HSS Trusts** providing maternity services are required to ensure:

- a risk assessment is undertaken on all newborn infants to identify neonates:

  - whose parents or grandparents were born in a country with a TB incidence greater than 40/100,000 (for list of countries see Appendix 1);

  - or who will be living in such countries for more than one month;

  - or who are contacts of cases of respiratory TB (see recommended contact management advice – currently from the Joint Tuberculosis Committee of the British Thoracic Society 2000 and the National Institute of Clinical Excellence (NICE) guidance.)

  This will be undertaken using a common proforma (Appendix 2).

- mothers whose babies are deemed to be eligible for BCG to receive information on TB and BCG immunisation.

- at risk infants to be identified at the new born examination prior to discharge from hospital. The risk assessment outcome will be documented in the personal held child health record and the neonatal discharge form. BCG immunisation is to be offered to at risk infants prior to discharge, where possible. Immunisation details are to be entered on CHS3 (neonatal discharge form).

- each maternity unit identifies a small number of appropriately trained permanent staff to administer BCG vaccine to neonates.

- appropriate referral arrangements to services providing “mop up” BCG immunisation for at risk infants who have not been previously vaccinated. This will include those born at home, infants discharged before vaccination and other infants who have moved into the area (see later).

- appropriate record keeping.

BCG Vaccination for Older Infants and Children

5. Following the start of this new immunisation policy, there may be infants and older children with specific risk factors for TB who would previously have received their vaccination through the schools programme. Children should only be offered BCG vaccination whenever they are identified as having specific risk factors which predispose them to a higher risk of TB. Those without risk factors should not be offered BCG immunisation but parents should be advised of the current policy and given written information (see later).

6. **HSS Trusts** providing community/community child health/school health services should:

   - identify a small number of appropriately trained staff to administer BCG vaccine.

   - establish services and referral arrangements for Mantoux testing and BCG immunisation including “mop up” services for at risk neonates born at home or discharged from hospital before immunisation.

   - as part of the “primary visit” by health visitors to newborns and “movement in” of preschool children review risk assessment and BCG status. Where at risk infants are identified, they and any siblings should be referred, as appropriate, for BCG immunisation.

   - ensure all children aged four years are assessed for TB risk factors as part of existing “school readiness” arrangements (see Appendix 3). This will identify at risk children who have moved into the area. The outcome of the risk assessment and, if BCG administered, should be recorded on the Child Health System. It should be noted that a tuberculin skin test is not necessary prior to vaccination for all children under 6 years of age provided that:

     - they have not stayed for more than one month in a country with high incidence rates

     - there is no history of contact with a person with known respiratory TB

     - there are no general contraindications as detailed in the “green” book.

- ensure parents are provided with appropriate information on TB and BCG immunisation.

- undertake a risk assessment in Form 1 (school year 8) to identify those at risk who did not receive BCG earlier including those who have moved into the locality, as part of existing school entry arrangements.

- establish arrangements within the school health system to identify at risk children who have moved into the local area/school.

The risk assessments undertaken at age 4 years and in Form 1 would be time limited as in future those at risk would be identified in the antenatal/post natal period and through new arrangements in general practice (see later). This will be kept under review.

Tuberculin PPD

7. Supplies of Tuberculin PPD for both Heaf and Mantoux testing are currently unavailable from Chiron Vaccines Evans (the sole supplier of UK Licensed PPD).

   Consequently, until further notice, all Tuberculin PPD testing will be by the Mantoux intradermal method using an alternative Tuberculin product manufactured by the Statens Serum Institute (SSI) in Denmark.

   The UK Medicines and Healthcare Products Regulatory Agency has licensed the import of this product into the UK and the Department of Health has approved its use for tuberculin testing.

   Strictly speaking, however, this product remains unlicensed in the UK and its use must be on the authority of a doctor for individually named patients on his/her own responsibility. In the context of the arrangements for Tuberculin PPD testing it is the doctor's responsibility to authorise the supply and administration and ideally in the form of a Patient Specific Direction (PSD) which could cover multiple (named) patients. This is the primary authority but where such a PSD is in existence an Extended Formulary Nurse Prescriber (EFNP) can administer or give directions for administration of Tuberculin PPD.

   Where Tuberculin PPD is to be administered by a person acting in accordance with the directions of an EFNP, the directions must be for a named patient and the arrangements should be documented for each patient. An example proforma is attached at Appendix 4. It includes the facility for an EFNP to give directions to another person(s) to administer.

   In summary, this unlicensed product must be ordered by a doctor for use for his individual patients on his direct responsibility. But it can be administered to those patients by an EFNP, or by a person acting under the directions of a doctor or an EFNP. The doctor remains responsible for the decision to give the unlicensed product for the individual concerned.

CONTROL OF TB IN NORTHERN IRELAND

Epidemiology

8. While the annual incidence rate of TB in Northern Ireland (4/100,000) is considerably less than in England, Wales and the Republic of Ireland there has been a rise in recent years with 84 cases provisionally reported in 2004. Notifications of pulmonary TB have particularly increased. This increase has been noted among the indigenous population as well as an increase in those now living in Northern Ireland but who were born outside the UK. Increased population movement to and from countries with high incidence rates of TB will result in further increases in TB in Northern Ireland. This highlights the need for Boards and Trusts to maintain and develop existing services for TB prevention and control in accordance with relevant professional standards and consistent with local assessed needs.

Action Required on TB Control

9. **HSS Boards** should:

- ensure appropriate arrangements and resources are in place:

    - to enable the prompt notification of individuals suspected of having TB
    - for patients to be managed by a clinician experienced in TB and in accordance with relevant professional guidance
    - to provide directly observed therapy when clinically appropriate
    - to enable early identification, assessment and management of contacts
    - for others requiring tuberculin skin testing and BCG immunisation.

- Boards should therefore ensure NICE recommendations on diagnosis, management, prevention and control are included in the commissioning process and used as a basis for multidisciplinary audit

- Advise general practitioners of the countries with high incidence rates of TB (Appendix 1) and local arrangements for:

    - referral of patients suspected to have TB
    - tuberculin testing/BCG immunisation
    - assessment of those recently arriving in or returning to the UK from high incidence countries

Recently arrived immigrants

10. Those arriving in the UK from non EC countries and intending to stay more than six months are assessed by Port Health staff and this assessment is often completed by local public health staff. However this process is incomplete, forwarding addresses are often missing and these arrangements do not apply to those travelling within the EC. It is important that new entrants are made aware of how to access health and personal social services, particularly registration with a general practitioner. For some, English may not be their first language and therefore information on TB and accessing services should be made available in appropriate languages. New entrant assessment for TB should be incorporated within a larger health programme for new entrants, linked to local services.

11. New entrants should be identified for TB assessment from:

    - port of arrival reports from Port Health departments
    - new registrations within primary care
    - entry to education or university
    - links with statutory and voluntary groups working with new entrants.

12. **HSS Boards** should review services to those immigrating to Northern Ireland. This would include considering outreach services and how best to engage with ethnic communities and their representatives to enable registration with GPs and assessment for TB acknowledging associated language, knowledge and cultural issues. Boards should consider introducing Local Enhanced Service schemes as a means to improve access by minority ethnic communities to services.

Primary Care

13. Opportunities exist when new patients register with a general practice to assess their risk factors for TB. **General Practitioners** are requested to ensure that staff are aware of the local arrangements for TB assessment/referral and obtaining advice. Practices should notify their local health visitor of all new registrations of children.

Travel Health

14. Current guidance is that BCG immunisation is recommended for those unvaccinated tuberculin-negative individuals aged under 35 years who are gong to live or work with local people for more than one month in countries with a high incidence of TB (Appendix 1).

    HSS Boards should ensure there is local access to tuberculin testing and BCG immunisation for travel health purposes and these arrangements are widely known.

Hostels for the Homeless

15. Those who are homeless and disadvantaged are at an increased risk of TB. **HSS Boards** should ensure that those working with the homeless, for example, GPs, social services and voluntary agencies receive information on TB and how individuals suspected of having TB can be referred for investigation.

Prisons and Young Offenders Centres

16. Healthcare workers providing care for prisoners and detainees should be aware of the signs and symptoms of active TB. TB risk assessment should be included in the reception screen for all new prisoners. **Prison medical services** should ensure appropriate liaison with CsCDC and clinical colleagues to ensure continuity of care and follow up.

Training

17. **HSS Boards** support HSS Trusts to ensure appropriate training programmes have been established and delivered locally to provide a core of staff in hospital and community proficient in tuberculin testing and BCG administration.

Audit/Evaluation

18. Minor changes are being made to the Child Health System to accommodate the changes to the BCG programme and to facilitate record keeping. It is recommended that Boards in conjunction with CDSC (NI) develop appropriate monitoring indices regarding coverage of the risk assessments and BCG uptake. This information should be presented annually to DHSSPS.

Public and Professional Information

19. The Health Promotion Agency for Northern Ireland has produced three publications:

    - TB - the disease, its treatment and prevention (for general use)
    - TB - factsheet for healthcare workers (and for those wishing additional information)
    - BCG and your baby – protecting babies against TB

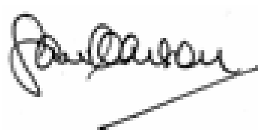
20. Packs for professionals, containing a copy of the factsheet and a sample of each of the public leaflets, will be sent directly to all GPs and to Child Health Managers/Directors of Nursing to forward to the relevant health professionals in community Trusts. Consultants in Communicable Disease Control will receive supplies to forward to Paediatricians, Obstetricians and Midwives in acute Trusts in their Board areas.

21. Limited supplies of the public leaflets will be sent directly to GP surgeries and maternity units with small numbers for use by health visitors or school health being sent via Child Health Managers/Directors of Nursing. Pharmacies and medical officers in prisons will be sent small quantities of the TB leaflet. Additional supplies of both the public leaflets will be available from the Central Health Promotion Resource Services in each Board area.

22. HSS Boards will need some of these for the local arrangements they establish for referrals for tuberculin skin testing and BCG immunisation and they will need some of the TB leaflets for sending to hostels for the homeless.

23. Translations of the public leaflets and the risk assessment questions in a number of languages will be available for health professionals to download for patients as PDFs from the DHSSPS website www.dhsspsni.gov.uk/phealth

Yours sincerely



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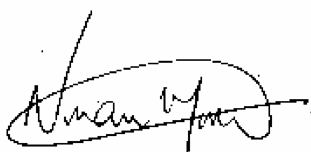

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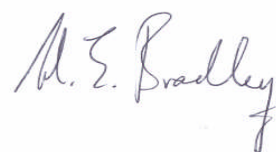

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Chief Nursing Officer

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Local Health & Social Care Groups – Chairs/Managers
Dr B Dunn, Chair, GPC, BMA
Dr B Gaffney, Chief Executive, HPA NI
Mr P Maguire, Information Office, DHSSPS
Ms C Baxter, Information Office, DHSSPS
Members of the RACCDC Regional Immunisation Committee

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.

APPENDIX 1

TUBERCULOSIS INCIDENCE RATES BY COUNTRY

See attached information **or** link to Health Protection Agency's website at: http://www.hpa.org.uk/infections/topics_az/tb/epidemiology/who_table1.htm

APPENDIX 2

NEWBORN RISK ASSESSMENT

1 Were any of the infant's parents or grandparents born outside Ireland and UK? Yes/No

If yes, state country/countries of birth*

2 Will the infant be living outside Ireland and UK for more than one month? Yes/No

If yes, state country/countries*

3 Does anyone in the household/family circle have TB at present or is suspected of having TB or had TB in the past 5 years **? Yes/No

If yes, give details.

4. Is BCG required? Yes/No

* Doctor/nurse/midwife must review the current information of TB incidence and recommendations for use of BCG vaccine (see HPA website http://www.hpa.org.uk/infections/topics_az/tb/epidemiology/who_table1.htm). BCG should be offered where the country recorded has an incidence of TB of 40/100,000 or greater. This includes most of Eastern Europe, Asia, Africa, Indian sub continent, Central and South America and Portugal (Dec 2005), except where the mother is HIV positive when specialist advice is required.

**see recommended contact management advice

APPENDIX 3

CHILD RISK ASSESSMENT

1	Has the child had a BCG vaccination? If no, or not sure, please complete following questions:	Yes/No
2	Were any of the child's parents or grandparents born outside Ireland and UK? If yes, state country/countries*	Yes/No
3	Will the child be living outside Ireland and UK for more than one month? If yes, state country/countries*	Yes/No
4	Was the child born or lived outside Ireland or UK, for 3 months or more? If yes, state country/countries*	Yes/No
5.	Does anyone in the household/family circle have TB at present or is suspected of having TB or had TB in the past 5 years **? If yes, give details.	Yes/No
6.	Is BCG required?	Yes/No

* Doctor/nurse must review the current information of TB incidence (see HPA website). BCG should be offered where country recorded has incidence of TB of 40/100,000 or greater. This includes most of Eastern Europe, Asia, Africa, Indian sub continent, Central and South America and Portugal (Dec 2005)

**see recommended contact management advice

PATIENT SPECIFIC DIRECTION FOR ADMINISTRATION OF TUBERCULIN PPD (SSI) FOR MANTOUX TESTING

The below named patients are eligible for routine Mantoux testing by intradermal injection of Tuberculin PPD (SSI) 2 TU per 0.1ml (20 units in 1 ml) and Tuberculin PPD (SSI) 10TU/0.1ml.
The higher concentration 10TU/0.1ml may be used for a second test if the first test (2 TU per 0.1 ml) is negative (less than approx. 6mm in diameter) and a retest is considered appropriate.

Patient's Name	**Address**	**Age (if appropriate)**

SAMPLE

Signature of prescribing doctor Date:

Signature of EFNP* Date:

Work Address	

*Required where an EFNP is giving directions to other named person(s) to administer.