Dear Colleague

PNEUMOCOCCAL VACCINATION FOR THOSE AGED 65 AND OVER - 2003-04

INFLUENZA VACCINATION PROGRAMME - 2003-04

1. Our earlier CMO letter SEHD/CMO (2003) 4 (dated 6 March 2003) informed you of the new policy to offer pneumococcal vaccination to those people aged 65 and over, who have not previously been vaccinated, and set out the policy background.

2. This letter provides an update on arrangements for this year's influenza and pneumococcal vaccination programmes, specifically on:

- Plans for a centrally-generated letter to those aged 65 and over;
- GP vaccination payment arrangements;
- General plans for publicity and information materials.
- Updated at risk groups for pneumococcal vaccination and a new Green Book chapter;
- The need to order sufficient stocks of vaccine to reflect patient numbers and, in the case of influenza, to order vaccine for staff;
- Unchanged uptake targets for influenza vaccine;
- Unchanged at risk groups for influenza;
- Details of influenza vaccine composition in 2003-04.

3. For ease of reference, details specifically relating to the individual vaccination programmes are set out in Annex A (Pneumococcal) and Annex B (Influenza). More general issues that relate to both programmes are set out below.

Centrally-generated information letter

4. Recognising that maximising uptake of both vaccines is a challenging task, the Executive plans to issue a centrally generated information letter (signed by the Flu Co-ordinator in each NHS Board area). The aim of this letter will be to alert patients to the fact that they may be eligible to receive both influenza and pneumococcal vaccines in 2003-04 and that their GP practice will shortly be
contacting them about arrangements. The text of the letter will be cleared with Flu Co-ordinators, prior to being **issued between late September and mid October.** It will be issued to all of those who are, or who will reach, age 65 and over on or before 31 March 2004 using CHI patient lists. The text will be circulated in a subsequent CMO letter.

**GP patient lists**

5. To ensure that this central letter reaches only those patients who are eligible to come forward for one or both of these vaccines, it is therefore, once again, essential that CHI patient lists are as up to date as possible. This will have an impact on both the distribution of the central information letter and accuracy of the monitored uptake of vaccines.

**Additional funding**

6. As stated in the **CMO letter 2003 (6)** dated 24 April 2003, on arrangements for the Hib booster campaign, an additional £300,000 has been made available to boards to assist with the cost of the extra work required for the Hib booster, pneumococcal and influenza campaigns this year. This funding has now been allocated to Boards and should be ring-fenced and used to assist vaccination-related tasks only.

**GP vaccination payments**

7. As previously indicated, the Executive is committed to paying GPs for administering pneumococcal vaccine in 2003-04. To this end, we are currently in negotiation with the Scottish General Practitioners’ Committee (SGPC) on the level of payment to be applied. The Executive will also continue to make payments to GPs for the administration of influenza vaccine on the basis of previous arrangements. Information on the level of payments will be issued as soon as possible.

**Publicity - Influenza and Pneumococcal**

8. Arrangements for publicising these integrated campaigns are currently being developed. In outline, the key elements are as follows:

- **By 15 August, a PowerPoint education pack** will be e-mailed to Immunisation Co-ordinators to help them provide early information about the pneumococcal programme to colleagues who will be involved in the administration of the vaccine;

- **By 29 August, a factsheet for professionals (and patients, if appropriate) on pneumococcal vaccination** will be issued to colleagues;

- **In early September, TV and radio** will be used to raise awareness of the pneumococcal vaccination programme (because this is the first year in which pneumococcal is being offered routinely to those aged 65 and over);

- **By 10 September, a poster and separate leaflets - covering flu and pneumococcal vaccination** -will be issued to colleagues;

- **From mid-September, national press materials** will be used to raise awareness of the pneumococcal vaccination programme;
• **From early October, more general press and TV publicity** will signal the commencement of the vaccination programmes;

• All of the information materials will be available, **in advance**, on the Executive’s website: http://www.scotland.gov.uk/health/flu_pneumococcal

  Please note that this website is not live at present.

**Monitoring**

9. The Scottish Centre for Infection and Environmental Health (SCIEH) will monitor influenza and pneumococcal vaccines uptake against actual incidence of these diseases. It will also, for influenza, as in previous years, provide the Executive with monthly data from October to December 2003, which will be distributed to Boards for information and action, as required.

**Further information**

10. Further information on the publicity materials and advertising, vaccination recording, any need to recall and dispose of vaccine, examples of good practice and answers to Frequently Asked Questions (FAQ) will follow in our next communication (in August/September).

11. We look forward to working together towards a successful joint campaign and are grateful for the hard work of all those involved.

Yours sincerely

DR E M ARMSTRONG  MISS ANNE JARVIE  MR BILL SCOTT
Chief Medical Officer  Chief Nursing Officer  Chief Pharmaceutical Officer
ANNEX A

PNEUMOCOCCAL

New Policy

1. As stated in our letter of 6 March, the new pneumococcal vaccination policy is to offer pneumococcal vaccine to all adults aged 65 and over who have not previously been vaccinated against pneumococcal disease. The cohort for 2003-04 should include all patients who are, or will be, 65 years and over by 31 March 2004. In future years, there will a more limited 'exercise' to offer vaccination to those reaching aged 65 in any particular year.

Policy Background

2. The Joint Committee on Vaccination and Immunisation (JCVI) reviewed all available evidence on pneumococcal polysaccharide vaccine in the general elderly population in 2002. They concluded that the best estimate of the overall efficacy of pneumococcal polysaccharide vaccine against invasive (bacteraemic) pneumococcal disease is around 50-70% in older age groups. Immunisation with polysaccharide vaccine would thus prevent a significant amount of the more severe pneumococcal infection. Based on this evidence JCVI recommended that the current UK policy be extended to include all people 65 years and over, to help prevent invasive pneumococcal disease in the older population. Current evidence suggests that the polysaccharide vaccine is not effective in protecting against non-bacteraemic pneumococcal pneumonia.

Vaccination uptake target

3. There is no formal uptake target for pneumococcal vaccination for those aged 65 and over, but an uptake figure which is broadly consistent with your influenza uptake figure would be a very welcome outcome and a considerable achievement given that a number of patients in the cohort will have previously been vaccinated against pneumococcal disease.

Current Policy At risk Groups for Pneumococcal Vaccination - New Green Book Chapter

4. Pneumococcal vaccine is already recommended for all those in whom pneumococcal infection is likely to be more common and/or serious. The at-risk groups, defined in paragraph 25.3 of the new pneumococcal chapter of Immunisation Against Infectious Disease 2003 (The Green Book revision of the chapter will be available from early August at www.doh.gov.uk/greenbook), are people with:

i. Asplenia or severe dysfunction of the spleen, including homozygous sickle cell disease and coeliac syndrome
ii. Chronic renal disease or nephrotic syndrome
iii. Chronic heart disease
iv. Chronic lung disease
v. Chronic liver disease including cirrhosis
vi. Diabetes mellitus
vii. Immunodeficiency or immunosuppression due to disease or treatment
viii. HIV infection at all stages.
ix. Cochlear implants
Orders for Pneumococcal Vaccine

5. As stated in our previous CMO letter of 6 March, the costs of providing the vaccine required for the pneumococcal vaccination campaign should be met from NHS Boards unified budgets that have been substantially increased this year.

6. A recent trawl of the level of pneumococcal vaccine ordered for 2003-04 reflected around 384,000 doses. Recognising that a proportion of the cohort has already been vaccinated against pneumococcal disease, this suggests that there may be a gap between orders and likely demand of around 57,000 doses.

7. Anecdotal feedback suggests that uncertainty around GP payments may be a factor. We would therefore reiterate that GPs will receive a payment for administering pneumococcal vaccine routinely to those aged 65 and over in 2003-04. We would, therefore, ask that all GPs, as a matter of urgency, establish the pneumococcal vaccine required for patients in the target group in their practices and ensure that their orders for vaccine are in line with those numbers. Can we remind you that you order vaccine through community pharmacists in the usual way.

Re-vaccination

8. Re-vaccination with polysaccharide vaccine is not currently recommended except for people whose antibody levels are likely to have declined more rapidly, eg those with no spleen, with splenic dysfunction or with nephrotic syndrome. In these circumstances, another dose should be given 5 years later. A few centres are able to measure antibody levels in cases where there is doubt about the need for re-vaccination. This should first be discussed with a local haematologist, however, as interpretation of the findings is not straightforward.

Presentation and storage

9. Pneumococcal polysaccharide vaccine is supplied in a single dose vial. You should therefore ensure that you have sufficient stocks of needles and syringes. It should be stored unopened at +2 to +8°C and not frozen. The vaccine is used as supplied: no dilution or reconstitution is necessary. It should be inspected before being given to check that it is clear, colourless and without suspended particles.

Dosage and Administration

10. A single dose of 0.5ml is given subcutaneously or intramuscularly preferably into the deltoid muscle or lateral aspect of the mid-thigh. Intradermal injection may cause a severe local reaction. The vaccine must not be given intravenously. If given at the same time as influenza vaccine it should be given in a different limb.

Pneumococcal Vaccines

11. There are two types of pneumococcal vaccine:

The 23-valent pneumococcal polysaccharide vaccine should be used for this vaccination programme. The vaccine is licensed for adults and children over the age of 2 years. It is a polyvalent vaccine containing 25 microgrammes of purified capsular polysaccharide from each of 23 capsular
types of pneumococcus which together account for about 96% of the pneumococcal isolates causing serious infection in the UK.

Please note:

The polysaccharide vaccine does not produce good immunity in very young children (under 2 years) and a separate pneumococcal conjugate vaccine is available for at risk children in this age group (CMO letters SEHD CMO (2002) 1 and SEHD (2002) 6. The 7-valent pneumococcal conjugate vaccine is currently only licensed for children under the age of 2 years.

**Pneumococcal Co-ordinators**

12. For the purposes of taking forward the pneumococcal vaccination programme in 2003-04, we shall assume, unless we hear to the contrary, that those acting within NHS Boards as Flu Co-ordinators, normally Immunisation Co-ordinators, will also co-ordinate issues relating to the pneumococcal vaccination programme this year - see also paragraph 14 on page 9 of this letter.
**INFLUENZA**

**Influenza at risk groups**

1. There has been no change to at risk groups for influenza vaccination for 2003-04. These are, however, set out in the table below as a reminder:

   a. All patients aged 65 and over;

   b. All patients over 6 months in the following at risk groups:

<table>
<thead>
<tr>
<th>Disease Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Those with chronic respiratory Disease, including asthma</td>
<td>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.</td>
</tr>
<tr>
<td>Those with chronic heart disease</td>
<td>This includes chronic ischaemic heart disease, congenital heart disease and hypertensive heart disease Requiring regular medication and follow-up (but excluding uncomplicated controlled hypertension), and chronic heart failure.</td>
</tr>
<tr>
<td>Chronic renal disease</td>
<td>Including nephrotic syndrome, chronic renal failure, renal transplantation.</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Diabetes mellitus requiring insulin or oral hypoglycaemic drugs.</td>
</tr>
<tr>
<td>Immunosuppression</td>
<td>Due to disease or treatment, including systemic steroids equivalent to 20mg prednisolone daily for more than 2 weeks. However, please note that some immunocompromised patients may have a suboptimal immunological response to vaccine.</td>
</tr>
</tbody>
</table>

   Hospitalisation for any of the above “at risk” conditions within the last year would also be an indication for influenza vaccine.

   c. Those living in long-stay residential and nursing home or other long-stay facilities, including long stay hospitals and prisons.

**Vaccination uptake target**

2. As stated in the 6 March letter, in an effort to maintain a realistic but stretching influenza uptake target, we agreed to **maintain the 70% target** for patients aged 65 and over for 2003-04. This is in line with the final uptake figures for influenza in 2002-03, which reflected a Scotland-wide average uptake approaching 70%. 10 NHS boards exceeded the 70% uptake target set for last year’s influenza campaign.

3. That is, of course, a significant achievement but we would encourage all of you to try to build upon previous uptake figures for your practice or area to ensure that uptake for flu increases again in 2003-04.
Orders for Influenza Vaccine

4. As stated in our previous CMO letter of 6 March, the costs of providing the vaccine required for the influenza vaccination campaign should, as in previous years, be met from NHS Boards unified budgets, which were substantially increased this year.

5. Given the well-established nature of the annual influenza vaccination programme, we expect that local plans are well advanced for the order and delivery of influenza vaccine for those aged 65 and over and those under 65 and at risk. Feedback from vaccine manufacturers suggested that by end June a total of around 848,000 doses of influenza vaccine had been ordered. GP practices will wish to check their patient numbers in at risk groups against the vaccine orders they have placed to ensure that they have ordered sufficient vaccine for all of their patients in the various at risk categories.

Vaccination against influenza for health and social care staff

6. Vaccine orders should, as previously, take account of your local plans for occupational health vaccination programmes for health and social care staff.

7. This is particularly relevant this year, given the recent SARS epidemic. The World Health Organisation's (WHO) recommends that health care workers (especially those who might care for a patient suffering from SARS) are vaccinated against influenza.

8. Responsibility for occupational influenza vaccination rests with the employer, and staff vaccination programmes should be arranged through Occupational Health Services or resourced alternatively through local arrangements. Last year, the numbers of staff receiving the vaccine varied enormously across the country but, on the whole, uptake was low. Based on the lessons learned, NHS Boards should initiate positive local campaigns encouraging relevant staff to be vaccinated. As reports of staff uptake will be sought, records should be kept of the staff groups targeted and the numbers and proportion of the targeted staff who have been vaccinated. For the avoidance of doubt, this means that NHS organisations and Local Authority Social Work Departments will be responsible for making their own arrangements for vaccination, including ordering supplies of vaccine.

Influenza vaccine composition for 2003-04

9. Influenza vaccine strains are recommended by the World Health Organisation following careful mapping of influenza 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.

10. The strains of influenza virus recommended by WHO to be included in the components for the 2003/04 vaccine are:

- 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
11. The H1N1 and H3N2 components are unchanged from the current vaccine and are considered to provide good protection against the new influenza A H1N2 subtype.

12. In recent years the strains in the vaccine have been a very good match with circulating strains and have offered good protection.

**Vaccine suppliers**

13. The following manufacturers have indicated they will be supplying the UK market during the coming season:

<table>
<thead>
<tr>
<th>Manufacturer</th>
<th>Name of Product</th>
<th>Vaccine Type</th>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aventis Pasteur MSD</td>
<td>Inactivated influenza (split virion) BP</td>
<td>Split virus</td>
<td>0800 085 5511</td>
</tr>
<tr>
<td>Evans Vaccines/ Powderject</td>
<td>Fluvirin*</td>
<td>Surface antigen</td>
<td>08457 451 500</td>
</tr>
<tr>
<td></td>
<td>Generic brand*</td>
<td>Surface antigen</td>
<td></td>
</tr>
<tr>
<td>Glaxo SmithKline</td>
<td>Fluarix*</td>
<td>Split virus</td>
<td>0808 100 2228</td>
</tr>
<tr>
<td>Solvay Healthcare</td>
<td>Influvac*</td>
<td>Surface antigen</td>
<td>0800 358 7468</td>
</tr>
<tr>
<td>Wyeth Vaccines</td>
<td>Begrivac</td>
<td>Split virus</td>
<td>01708 330225</td>
</tr>
<tr>
<td></td>
<td>Agrippal*</td>
<td>Surface antigen</td>
<td></td>
</tr>
<tr>
<td>MASTA (distributor)</td>
<td># Inflexal V</td>
<td>Virosome adjuvated surface antigen</td>
<td>0113 238 7555</td>
</tr>
<tr>
<td></td>
<td>MASTAFLU*</td>
<td>Surface antigen</td>
<td></td>
</tr>
</tbody>
</table>

*Studies have shown that this vaccine may offer increased protection in older age groups (80+ years) (Vaccine 1997; 15:1675-9, Lancet 1994;344:160-3).

* Contains thiomersal

**Flu Co-ordinators**

14. NHS board nominated “Flu Co-ordinators” should advise Dr Stewart (see contact details on page 1) if last year’s contact details have changed.