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Dear Colleague

## SHORT CATCH-UP CAMPAIGN FOR MEASLES IMMUNISATION IN SCOTLAND 2013 – REDUCING THE RISK

1. The purpose of this letter is to inform you of a short catch-up measles immunisation campaign for children aged between 10 and 17 (the group currently most at risk of being infected by the virus and passing it on to others). This campaign is to provide a further opportunity for children in this age group to be protected if they have not already been immunised. This campaign follows on from that of September 2011 (see http://www.sehd.scot.nhs.uk/cmo/CMO(2011)12.pdf).

### Green Book Update – January 2013

2. Please see the latest link to the Green Book chapter for further information on measles immunisation https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147968/Green-Book-Chapter-21-v2_0.pdf

3. NHS Boards have been asked to begin the catchup campaign over the next few weeks. Vaccination will be offered to partially immunised or unimmunised children aged 10-17 either in school or via local GP practices depending upon NHS Board preferences for implementation. There are good reasons to offer vaccination in secondary school to this age group, both in terms of maintaining high uptake levels and addressing socio-economic disparities.

### Cross-Border Issues

4. Some NHS Boards will offer vaccination to those based on area of residence, while other NHS Boards will do so on basis of school attended. This means that some children could potentially be missed, for example by attending school in a neighbouring NHS Board area. Neighbouring NHS Boards should work together as necessary to reduce the risk of children being missed.

5. This programme will run in conjunction with the work already being undertaken by NHS Boards across Scotland to ensure that MMR vaccination status is checked when children attend for their S3 booster appointment at school, and

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SGHD/CMO(2013)7

**For Action**
NHS Board Chief Executives
NHS Board Immunisation Co-ordinators
NHS Board Medical Directors
NHS Board Nursing Directors
Directors of Public Health
Infectious Disease Consultants
Practice Nurses
Health Visitors
CPHMs
Scottish Prison Service
Scottish Ambulance Service

**For Information**
General Practitioners
Directors of Pharmacy
Consultant Paediatricians
Consultant Physicians
Health Protection Scotland
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**Further Enquiries**

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vaccination offered where appropriate. Depending on vaccine uptake, NHS Boards may be asked to repeat the catch-up for 10-17 year olds later in 2013. This will be reviewed over the summer and a further letter will be issued if necessary.

6. In line with existing guidance, NHS Boards should employ effective measles control strategies in the event of any cases or small outbreaks that emerge.

**Communications**

7. To support this short catch-up campaign, the Scottish Government will implement a national awareness raising campaign for measles including radio broadcasting, a public information leaflet and a Q&A document in partnership with NHS Health Scotland.

8. Materials will be made available to NHS Boards and GP practices no later than 24 May 2013. Timing of local radio broadcasts will be flexible according to local needs and will be discussed further with NHS Boards.

9. NHS Boards should ensure that, where the catch-up programme is to be run through schools, appropriate communications take place with schools and education authorities as early as possible.

**Current Risk of Measles in Scotland**

10. Currently in Scotland, MMR1 vaccination uptake rates in 5 year olds are very high, with reported rates reaching 96.9% in the last quarter (October – December 2012). These figures exceed the World Health Organisation target of 95%. MMR2 uptake rates are also high, reaching 91.8% in 5 year olds in the same period. Health Protection Scotland (HPS) undertook a risk assessment in 2011 and an overview is attached (Annex A). Average susceptibility rates (i.e. the estimated proportion of the population without immunity to measles) are relatively low in Scotland and are lower than those in England and Wales. However with the increase of cases in other parts of the UK, there are continued opportunities for measles to enter the population in Scotland with a consequent rise in the number of cases and small outbreaks. Subsequent, sustained large scale spread is considered unlikely.

11. There is a relatively high proportion of 10-17 year olds in Scotland who are unimmunised or partially immunised. These are the age groups who were offered MMR1 and 2 as infants during the years of unfounded controversy over the safety of the vaccine. Evidence from outbreaks in Wales and England has shown that it is in this age group where significant transmission is taking place with onward spread to others in the communities affected, especially to infants aged less than one year who are too young to receive MMR immunisation. The HPS risk assessment shows that there are likely to be some pockets of co-terminous small areas, particularly in urban areas, where susceptibility in those aged 10-17 year olds will be relatively high. Levels of susceptibility will have been lowered as a result of vaccinations carried out since the CMO letter sent in 2011. However more needs to be done to further reduce the risk of measles outbreaks. The impact of this campaign on the risk of measles and the need for further initiatives will be assessed by HPS.

**Children Aged Under 10 Years Old**

12. As current levels of uptake of MMR within the routine childhood immunisation programme in Scotland are very high, there is no evidence of significant increased

transmission of measles amongst young children. If current levels of uptake continue young children will continue to be at relatively low risk from measles. However those unimmunised or only partially immunised should be offered the vaccine whenever appropriate.

13. It is possible that parents of children who are part of the childhood vaccination programme, may seek advice from their GP surgery rather than awaiting call up through the normal programme. Such children should be offered the vaccination if appropriate.

14. We appreciate the work being undertaken currently by Public Health Teams, GP practice staff and Health Visiting Teams. This work ensures our high uptake rates are maintained. Uptake of childhood vaccines in Scotland, including MMR, continue to be higher than average for the UK

**Babies Under One Year – Travel**

15. Healthcare professionals are reminded that in some circumstances the recommendations regarding vaccines in the Green Book chapters may differ from those in the Summary of Product Characteristics (SPC) for a particular vaccine. When this occurs, the recommendations in the Green Book are based on current expert advice received from the Joint Committee on Vaccination and Immunisation (JCVI) **and should be followed**.

16. Please see advice contained in the Green Book which recommends that infants from 6 months of age travelling to measles endemic areas or to an area where there is a current outbreak should receive MMR. As the response to MMR in infants is sub-optimal where the vaccine has been given before one year of age, immunisation with 2 further doses of MMR should be given at the recommended ages. Children who are travelling who have received one dose of MMR at the routine age should have the timing of the second dose brought forward to at least one month after the first. If the child is under 18 months of age and the second dose is given within 3 months of the first dose, then the routine pre-school dose (a third dose) should be given in order to ensure full protection.

17. Both the currently available brands of MMR vaccine are recommended in their marketing authorisations for use from 9 months of age and therefore any use in children younger than 9 months would constitute an ‘off label’ use of a licensed medicine. GPs may wish to refer to guidance from the BMA for further clarification.

18. As is normally the case, it will be the prescriber who takes responsibility for the use of the vaccine in this group of patients.

**Young People Aged 16 & 17 Years Old**

19. If advice is sought by a person who is aged 16 years or over and who is concerned or unsure about their vaccination status, they should be offered the vaccination if clinically appropriate.

20. MMR vaccine can be given to individuals of any age, but those born before 1970 are highly likely to have been exposed to measles as children (measles vaccination was introduced in 1968) and it is estimated that around 99% are immune. The decision on when to vaccinate adults needs to be taken into consideration, the past vaccination history, the likelihood of an individual remaining susceptible and the future risk of exposure and disease.

21. If unsure of status, offer vaccination (cost of vaccination outweighs costs of trying to track down status – perhaps if a child have moved from school to school over the last few years), as a 3rd dose in a person aged 16 years or over is safe.

**Contraindications and Special Considerations**

22. Almost all individuals can be safely vaccinated with all vaccines. In very few individuals, vaccination is contraindicated or should be deferred. Where there is doubt, rather than withholding vaccine, advice should be sought from an appropriate consultant paediatrician or physician, the immunisation co-ordinator or consultant in health protection. Please refer to the relevant Chapter in the Green Book for further information https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147824/Green-Book-Chapter-6-v2_0.pdf

**Availability of Vaccine**

23. We have been advised that there is no concern around the availability of MMR vaccine. Vaccine should be ordered in the usual way from NHS board vaccine holding centres. Holding centres will order vaccine via ImmForm.

**Process for Call Up**

24. Call up letters for children aged 10-17 who have been identified as being partially immunised or unimmunised will be issued from the NHS Board and this letter will advise on how to make an appointment to be vaccinated. Any NHS Board introducing the catch-up through secondary schools will liaise directly with the school authorities to put arrangements in place. NHS Boards will also call up on behalf of GP practices.

**Vaccination of Healthcare Staff**

25. Hospital staff are at increased risk of coming into contact with cases and some staff may not be vaccinated (or vaccination status may not be known). The resulting control measures might include ward closures or the need for enforced staff absences. As with all vaccinations available to frontline healthcare staff, the importance of staff ensuring that they are protected and that they protect patients in their care must be emphasised. This is especially important for those caring for neonatal and paediatric patients and the immunocompromised as well as any staff working out of hours. In the first instance healthcare workers should contact Occupational Health about vaccination.

26. Staff born after 1 January 1970 are strongly advised to have MMR unless they are certain they have previously had 2 doses of MMR, definitely had measles (such as documented laboratory confirmed) or have had a blood test in Occupational Health confirming immunity. If there is any doubt, staff should have 2 doses of MMR (having MMR if a person is immune, carries no risk).

27. The MMR vaccine cannot be given to pregnant women or administered to women trying to get pregnant. Healthcare workers should not try to get pregnant until one month after the vaccine has been given.

28. It is equally important that the vaccination status of staff is known and recorded by Occupational Health so that the response to any hospital outbreak of a vaccine preventable disease can be well-informed and timely.

29. Given the importance of this catch-up campaign, GP practices can use NHS vaccine supplies to vaccinate their own staff for the purposes of this campaign.

**GP Contractual Arrangements**

30. Under the GP contractual arrangements, GP practices are obliged to administer the MMR vaccine to the target groups specified in Annex J of the General Medical Services Contract Statement of Financial Entitlements. This includes individuals aged under 16; women who may become pregnant, but are not pregnant, and are sero-negative; and male staff working in antenatal clinics who are sero-negative.

31. For patients outside these arrangements an enhanced service will be appropriate and NHS Boards are requested to put this in place in conjunction with their Local Medical Committee (LMC), where it is required, through a Local Enhanced Service (LES) agreement. This will cover vaccinations for individuals aged 16 years and over.

32. In addition, GP practices are entitled to charge for the administration of MMR vaccine when it is given for the purposes of travel, but have discretion not to do so. NHS Boards will wish to liaise with their GP practices and LMC to agree local arrangements in relation to the administration of the vaccine.

33. We ask NHS Boards to ensure that practice attached staff are appropriately engaged in assisting practices to deliver immunisations.

**Action**

34. NHS Boards are asked to note the arrangements outlined in this letter for the ongoing vaccination of those groups susceptible to measles, including this short catch-up campaign.

35. In particular NHS Boards are asked to ensure action is taken forward to ensure as many children as possible have received 2 doses of MMR by the time they leave secondary school, and the school-booster point at S3 should be used to check MMR status.

36. NHS staff are asked to ensure they are vaccinated against any vaccine preventable diseases particularly hepatitis B, influenza, measles, mumps, rubella and varicella. Occupational Health departments should ensure vaccination status of staff is known.

*Harry Burns* *Ros Moore* *Bill Scott*

**SIR HARRY BURNS**
**Chief Medical Officer**

**ROS MOORE**
**Chief Nursing Officer**

**PROFESSOR BILL SCOTT**
**Chief Pharmaceutical Officer**

**ANNEX A**

## An Assessment of the Risk of Measles Transmission in Scotland 2011 – Key Points

1. Overall measles is well controlled in Scotland. To be accredited by WHO as having achieved the elimination of measles, the annual incidence of measles must remain below one case per million (i.e. in Scotland, less than 5 cases per year). In the period 2000 to 2009, the average annual number of laboratory confirmed cases of measles in Scotland was 12.7. In 6 of the 10 years, it was less than 5.

2. Estimated levels of susceptibility to measles in 2-9 year olds are now lower than those recommended by WHO for attaining elimination. This is largely due to efforts at increasing and sustaining levels of uptake of MMR1 and 2. This year there have been only 2 cases of measles in children of this age - one was imported and the other was exposed to a case from England. There is no evidence of any transmission occurring at these ages in Scotland. In terms of pockets of susceptibility, at 2-4 years only 3.7% of all children live in datazones with average levels of susceptibility above the elimination level and at 5-9 years, only 10.7%.

3. However the situation is different in older children. For 10-14 years of age, the level of susceptibility for Scotland as a whole is 10% and for 15-17 years, 9.6%, both above elimination levels. There is now evidence of transmission in those aged more than 15 years. These levels of susceptibility are due to;

- The impact of adverse publicity on the uptake of MMR in the late 90s especially on children currently aged around 8-12 years who are now in school. These have higher levels of susceptibility although still well below those necessary to sustain on-going transmission. As older adolescents, they will mix and travel more, with a greater chance of them being exposed to the virus. This may lead to an increase in measles outbreaks at this age.

- The resurgence of measles in Western Europe in older adolescents and young adults. This is due to the pattern of introduction of measles control measures in different countries in the late 1980s and early 1990s. This has given rise to an accumulation of susceptibles in the population at levels sufficient to sustain measles outbreaks. For reasons of work, leisure and education, population mixing across Europe is relatively high at this age.

4. In looking at how to reduce measles susceptibility, broadly, there are three cohorts to be considered:

- **Children aged 2-9**. Uptake of MMR1 and MMR2 is currently very high in Scotland and accordingly we are not seeing any evidence of spread of disease in this group. We are achieving target susceptibility rates for elimination of measles.

- **Children aged 10-17**. Within this group are those children who were eligible for childhood vaccination during the Wakefield episode and amongst whom uptake dipped. Susceptibility is known to be higher than is desirable for measles elimination – but not high enough for sustained spread of disease, and indeed we are not seeing any significant transmissions amongst this group. However the concern is that once this cohort move out of school and are mixing more generally measles could re-emerge.

- **Adolescents/young adults aged 18-25**. There is no centrally held information on vaccine uptake rates amongst this group (the current childhood vaccination information system was introduced in 1995 and holds no data on vaccinations from before this point). This age group is where many of the measles cases in Europe are also being seen. Susceptibility of those aged 18-25 years is likely to be higher than that recommended by WHO for measles elimination

5. In light of this data, and when considered against the high likelihood of measles entering Scotland in the future (through travel and contact with other parts of the UK and Europe), Scotland is likely to remain at intermediate risk of measles with sporadic cases appearing and small clusters mainly affecting those ages 18-24 years, but without consequent widespread transmission in the population.

6. If current levels of MMR1 and 2 uptake persist amongst infants, those aged between 2 and 10 years will continue to be at a very low risk of being infected with measles. Certain groups with lower uptake of vaccine (such as travelling communities) will continue to be at risk. The risk in healthcare settings could increase. Babies under one year of age (who are not eligible for the vaccine), especially those who are born to unimmunised parents, will be at risk.

7. Any movement from intermediate risk of measles to low risk of measles (i.e. elimination) will largely depend on maintaining current coverage of MMR1 and MMR2 in children and **reducing levels of susceptibility in those aged 10-17 years by supplementary immunisation activities**.