Dear Colleague

INFLUENZA IMMUNISATION

This letter provides further information and advice for all those involved in this year's influenza immunisation programme and follows on from our letter SEHD/CMO (2001) 9 issued on 26 March 2001.

Last year saw major changes in the influenza immunisation policy. In what is now seen as an important initiative in public health, influenza immunisation was offered for the first time, to all people aged 65 years and over. Also for the first time, health boards were set the target of achieving a 60% uptake of immunisation for this group. The programme for 2000-01 was a great success, achieving an overall national uptake of 63.5% in those aged 65 and over.

This year the policy, as set out in the 26 March letter, has not changed. However, building on last year's success, the target is to achieve a minimum 65% uptake in those aged 65 and over in all Health Board areas. In addition, we aim to improve uptake among people under 65 years of age who are in the risk groups recommended for immunisation (see Annex 1).

There will again be a national publicity programme, to be launched in late September, slightly later than last year, to allow for practices to have their flu programme arrangements and initial deliveries of vaccine in place first. The publicity will take account of comments received last year. In particular, it will stress to the public that the programme is delivered over a number of weeks, to avoid unrealistic expectations of what can be achieved at the start of the campaign. It would be extremely helpful if that key message could be conveyed consistently by every one dealing with enquiries from patients. Posters, leaflets and materials for General Practices, Community Pharmacists and health boards, to supplement their local materials, will be supplied in advance in the course of September. We would ask you to display these materials in a prominent position throughout the winter. You may also wish to take account of these dates in your local planning; from late-September patients should begin to be aware of the campaign. Publicity materials for 2001-02 will be placed on the SHOW website, in due course.
The Scottish General Practitioners’ Committee (SGPC) have agreed a revised incentive payment scheme for GPs. Details are being published separately.

Although local immunisation programmes worked well last year, we consider that it would be appropriate for health boards to nominate a “Flu Co-ordinator” to lead the programme in each board area. Such a role would appear to fall within the remit of the Immunisation Co-ordinator. It would be helpful if all boards could let Dr Stewart (see contact list) have details by e-mail of the person they have chosen for this role.

Local plans should already be well advanced. Practices should by now have ordered vaccine for their patients in the recommended risk groups (Annex 1) and should also be working on compiling registers as recommended in the letter SEHD/CMO (2001) 09. While the Executive plans to retain a small central contingency supply of the vaccine to meet any marginal mismatches between demand and supply, the importance of good local planning is self-evident.

Further information on running a campaign and answers to some commonly asked questions are contained in the annexes to this letter.

We look forward to working together towards another successful campaign.

Yours sincerely

pp DR E M ARMSTRONG
Chief Medical Officer

MISS ANNE JARVIE
Chief Nursing Officer

MR BILL SCOTT
Chief Pharmaceutical Officer
Annex 1

INFLUENZA IMMUNISATION POLICY and VACCINES FOR 2001/2002

National Policy

In line with advice already provided in the CMO letter of 26 March, national policy for 2000/2001 is that influenza immunisation should be offered to:

1. People of all ages in the following risk groups:

<table>
<thead>
<tr>
<th>Disease Category</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td><strong>Chronic respiratory disease, including asthma.</strong></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><strong>Chronic heart disease.</strong></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><strong>Chronic renal disease.</strong></td>
<td>Including nephrotic syndrome, chronic renal failure, renal transplantation.</td>
</tr>
<tr>
<td><strong>Diabetes.</strong></td>
<td>Diabetes mellitus requiring insulin or oral hypoglycaemic drugs.</td>
</tr>
<tr>
<td><strong>Immunosuppression.</strong></td>
<td>Due to disease or treatment, including systemic steroids equivalent to 20mg prednisolone daily for more than 2 weeks. <em>However, please note that some immunocompromised patients may have a suboptimal immunological response to vaccine</em></td>
</tr>
</tbody>
</table>

2. All aged 65 years and over.

3. Those living in long-stay residential and nursing homes or other long-stay facilities.

One of the contributors to the success of last year’s programme was the ability to identify the target population of people 65 years of age and over so that they could be invited to attend for immunisation. As previously requested in the March CMO letter, practices should compile and maintain an up to date list or register of those in the other clinical categories so that this year uptake can be improved in these groups. The BMA Vaccination and Immunisation Group has indicated its support for this recommendation.

Basis of the policy

The aim of influenza immunisation policy is to reduce serious illness and deaths from influenza. The targeted groups are those most likely to suffer complications or die from influenza.
Epidemiology of the disease

Every winter, mainly during a 6-8 week period, influenza causes acute respiratory illness affecting people of all ages. While for most people the illness is unpleasant, it is usually self-limiting and without complications. However, among older people and those with the risk conditions listed above, influenza carries an increased risk of serious illness and complications such as bronchitis and pneumonia, often resulting in admission to hospital. In addition to the distress caused by the illness itself, serious influenza-related illnesses put pressure on health, social care and other services usually at an already busy time of year.

Mortality

Influenza is an important contributor to the excess mortality that occurs every winter in the UK. Peaks of winter mortality follow closely the pattern of influenza activity, resulting in an estimated average of around 12,000 excess deaths each winter.

Efficacy of the vaccine

Influenza vaccines are effective in preventing, or ameliorating, influenza, including in the elderly. In UK studies, influenza vaccine has been shown to reduce complications, and reduce hospital admissions by as much as 60%, and mortality by around 40%, compared with matched controls.

What has changed this year?

- There has been no change in the targeted risk groups from last year.
- The main change is to improve on last year’s target uptake among people aged 65 years and over which was 60%. This year we want to see a steady improvement, with the overall minimum target increasing to 65% of people aged 65 years and over for this winter.
- Nominating a Flu Co-ordinator to lead the programme in each health board area.
- Last year’s successful publicity campaign has been developed further: adverts in local newspapers and on buses will help to target areas where uptake has been low in the past and a complimentary tissue pack will be given to pensioners when they draw their pension at the post office. In addition, a leaflet drop to every household in Scotland will provide information to the population as a whole, in order to also try to minimise unnecessary and avoidable calls on NHS resources.

Responsibility for meeting targets?

- Health boards and Primary Care Trusts (PCTs) continue to be charged with responsibility for achieving the uptake target.

Monitoring flu vaccine uptake

- SCIEH will continue to carry out flu vaccine uptake surveillance work for those aged 65 and over on behalf of the Executive, through the collation of monthly returns for October, November and December. Questionnaires will be issued by post - and electronically by e-mail - at the end of October, November and December, as was the case last year. It would be helpful if practices have uptake figures to hand in the first week of the following month ready to provide to SCIEH.
- As per last year, these monthly figures will be communicated to the Executive and to boards. It will be for the Flu Co-ordinators within boards to monitor the surveillance information provided.
and address any concerns that the national uptake target of 65% is not going to be met in their areas.

- In line with this year’s agreement for payments to GPs, all practices which provide this information will be able to claim interim payments for their flu immunisation work at the end of December, should they wish to do so.

Monitoring flu incidence

- In addition, through its sentinel computerised practices, which have linked laboratory testing, SCIEH will again monitor surveillance of flu incidence over the season and provide weekly reports to the Executive and health board flu co-ordinators from the end of week 40 onwards.

Influenza immunisation for health and social care staff

- As last year NHS employers should offer influenza immunisation to employees directly involved in patient care. Social care employers should consider similar action.

- Influenza immunisation is highly effective in preventing influenza in working age adults. In addition, it may reduce staff absenteeism and any resulting disruption to services during influenza outbreaks (at a time when demand on services is likely to be increased). It may also reduce the transmission of influenza to vulnerable patients, some of whom may have impaired immunity and thus reduced protection from any influenza vaccine they have received themselves.

- Responsibility for occupational influenza immunisation rests with the employer, and staff immunisation programmes should be arranged through Occupational Health Services or resourced alternatively through local arrangements. It is for individual organisations to determine their own programmes. Supplies of the vaccine for administration to health and local authority social care staff should be obtained through NHS Trusts. In addition to existing orders, Trust Chief Pharmacists may be able to draw down additional supplies, from a small centrally held reserve, available from the end of October. Staff should not be asked to approach their GP for their immunisation, unless they fall within one of the at risk groups.

- Health boards are asked to monitor with their Acute and Primary Care Trusts and local authority planning partners the number of staff in their target group who have been immunised and monitor the effectiveness of their programme in reducing influenza related absence. Last year, the numbers of staff receiving the vaccine varied enormously across the country but, on the whole, NHS staff uptake was low. Based on the lessons learned from last year, health boards should carry out positive local campaigns encouraging relevant staff to take up the vaccine. It is important to ensure that the Occupational Health Service is effectively resourced to deal with the extra pressures of these campaigns. As reports will be sought of staff uptake, records should be kept of the staff groups targeted and the numbers and proportion of these targeted staff who have been immunised.

Influenza vaccine composition for 2001/02

- Flu vaccine strains are recommended by the World Health Organisation 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.

- Flu vaccines currently contain versions of three flu viruses: Influenza A (H3N2), Influenza A (H1N1) and Influenza B. This year's recommended vaccine strains are:
• an A/New Caledonia/20/99(H1N1)-like virus
• an A/Moscow/10/99 (H3N2)-like virus*
• a B/Sichuan/379/99-like virus**

*The widely used vaccine strain A/Panama/2007/99, is an A/Moscow/10/99-like virus
** B/Johannesburg/5/99 and B/Victoria/504/2000 are B/Sichuan/379/99-like viruses, which have been used for vaccine production.
In recent years the strains in the vaccine have been a very good match with circulating strains and have offered good protection.

Vaccine suppliers

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</td>
<td>Split virus</td>
<td>0800 085 5511</td>
</tr>
<tr>
<td></td>
<td>(split virion) BP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evans Vaccines</td>
<td>Fluvirin</td>
<td>Surface Antigen</td>
<td>08457 451500</td>
</tr>
<tr>
<td>Glaxo SmithKline</td>
<td>Fluarix</td>
<td>Split virus</td>
<td>0808 100 2228</td>
</tr>
<tr>
<td>Solvay</td>
<td>Influvac</td>
<td>Surface Antigen</td>
<td>0800 358 7468</td>
</tr>
<tr>
<td>Wyeth</td>
<td>Begrivac</td>
<td>Split virion</td>
<td>01628 604377</td>
</tr>
</tbody>
</table>
ANNEX 2

Examples of good practice in running a successful Influenza Immunisation Programme

Experience of last year’s flu campaign reflected some good examples of best practice. Some of these are set out below for the benefit of all involved in taking forward this programme:

• 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 in all target groups - both age and non-age related;

• Health boards, PCTs and flu co-ordinators should work with GP Practices and community pharmacists to produce action plans for achieving targets;

• Health Boards, Trusts and practices should ensure that vaccine supplies are available from community pharmacies before launching local advertising programmes or initiating call and recall systems; 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;

• As well as a flu co-ordinator at health board level, practices should consider the benefit of nominating a lead person to take charge of the campaign at practice level;

• Ensure the register you have compiled of those patients for whom immunisation is recommended is up to date. If you do not have a register you should compile one from computer generated age/sex data – or obtain a list from your PCT/health board or Practitioner Services Division. For those outwith the age-related at risk groups, registers can be compiled from Chronic Disease Management Programmes; patient or prescription records; or as patients are seen throughout the year.

• 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 community pharmacist or supplier for staggered deliveries if you think storage space will be a problem.

• 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.

• If you store information on your practice computer, ensure all staff enter the same READ code to indicate influenza immunisation has been given. The correct code is 65E.. - note that the two dots after 65E are important for this purpose.

• Order sufficient vaccine for your needs. Confirm orders well in advance. Some manufacturers will take part of the order as provisional, to be confirmed during the campaign;

• Involve all the key players, including practice nurses, practice receptionists and managers, district nurses, health visitors and local pharmacists. Try to draw on any experiences learned from previous campaigns employed in your practice. Try to ensure, in particular, that every one dealing with enquiries from patients is well-briefed and primed early in the campaign, in order
that they can provide accurate information to the public on, for example, those in the at risk
groups, the timing of vaccination clinics in their surgery and how to get an appointment for
vaccination.

- Posters, leaflets and materials for General Practices, Community Pharmacists and health boards
to supplement their local materials will be supplied in the course of September. We suggest that
you display these materials in prominent positions throughout the winter.

- Consider how your PCT or health board can help, for example, with advertising, protocol
development, notifying patients or in sharing resources with other practices for running
immunisation clinics and provision of assistance from community nursing staff. Ensure local
community pharmacists are kept informed and are invited to support the programme.

- 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?

- 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.

- 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, immunisation of those outside the target
groups may lead to shortages of vaccine for the high risk groups.

- 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.

- 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 tell them of
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).
ANNEX 3

INFLUENZA IMMUNISATION: SOME COMMONLY ASKED QUESTIONS ON THE POLICY

Q. What has changed this year?
A. We aim to improve the uptake of vaccine in all the at risk groups; and a minimum target of 65% uptake has been set for immunising people aged 65 years and over. The policy is explained in more detail in the text of this CMO letter and Annex 1.

Q. What does the target apply to?
A. The target is for PCTs and health boards to achieve a minimum 65% uptake of immunisation in those aged 65 years and over registered in their areas.

Q. Are targets being set for the other risk groups?
A. No, but we have recommended that GPs compile at-risk registers of their patients as part of good practice.

Q. Can GPs give influenza vaccine outside the recommended risk groups?
A. The final decision as to who is recommended influenza vaccine is for the patient's doctor, but those in the targeted groups are the ones whose health is most at risk and these should be given priority. Those under 65 and not in an at-risk group should not expect flu immunisation to be provided by the NHS.

Q. Can a GP charge the patient for an immunisation if they are outside the risk groups?
A. A GP cannot charge a patient on his or a partner’s NHS list for a flu immunisation.

Q. Will GPs be required to immunise health and social care workers on their lists?
A. Immunisation of health, social care or other occupational groups is a matter for the employer through their occupational health service. A GP may be contracted to provide this service outside his or her General Medical Services contract. If a GP immunises a healthcare worker on his list he cannot charge the worker.

Q. Should primary care staff be immunised?
A. NHS independent contractors eligible for occupational health services and Community Pharmacists, should liaise with local Trusts to discuss arrangements for them and their staff.

Q. Should a GP immunise staff in residential and nursing homes?
A. As for healthcare workers, it is the responsibility of the employer to make any arrangements.

Q. Will sufficient vaccine be available?
A. Enough vaccine is available for the recommended at risk groups. However, if demand is higher than expected and firm orders have not been placed in advance, shortages could occur.

Q. Should pneumococcal vaccine be given at the same time as flu vaccine?
A. Some of the at risk groups recommended for pneumococcal vaccine are the same as for flu vaccine, but pneumococcal vaccine is not recommended for everyone over 65. Pneumococcal vaccine is also usually given once only and inadvertent early re-immunisation may cause adverse reactions, whereas flu vaccine has to be given every year. As long as the appropriate checks are made, pneumococcal vaccine can conveniently be given at the same time as flu vaccine - but at a different site.

Q. Should vaccine be administered to elderly people who cannot give their own consent?
A. A doctor may prescribe influenza vaccine for one of his patients where they are unable to give their own consent if he believes it to be in the patient’s best interests. Each case should be judged on its own merits. It is good practice to discuss the issue with relatives, unless the patient, whilst competent, indicated that he/she did not want information shared with relatives or with a particular relative. Part V of the Adults with Incapacity (Scotland) Act 2000 will, when commenced, put in place new procedures for providing treatment to such patients.

Q. Treatment of influenza.
A. One anti-viral drug (amantadine) has been available for treating flu for a long time. Others are either recently developed (zanamivir) or are in development. These drugs may help shorten the symptoms of flu (or in the case of amantadine help prevent the spread) but only by about a day on average. The message clearly remains that for the at risk groups, prevention is better than cure. CMO letter- SEHD/CMO(2000)10 issued on 8 December, which provided guidance on the issue of zanamivir (Relenza), is still current. It is worth noting that since this guidance was issued there has been national guidance on Patient Group Directions (PGDs) and any local schemes developed should comply with the guidance on PGDs.

QUESTIONS SOMETIMES ASKED BY PATIENTS

Q. Flu is not so bad/I’ve had flu in the past and survived/I’m pretty fit for my age. Why do I need a flu vaccine?
A. Because flu is more than just a heavy cold and though not usually serious in younger people, as you get older it can really knock you out.

Q. I had a flu vaccine before and I still got flu.
A. It probably wasn’t flu. There are many other respiratory infections around every winter - flu is just one of them, but it is usually worse than the others and there is a vaccine to prevent it. Unfortunately the flu vaccine won’t prevent the other infections, but it will stop you getting flu.

Q. I had a flu vaccine before and it gave me flu.
A. It can’t. There is no active virus in a flu vaccine so it can’t cause flu. You could have had one of the other viruses referred to above. Or very occasionally you could have caught flu before the vaccination took effect. Vaccinations are given before the flu season usually starts, but occasionally influenza appears earlier than expected.

Q. I had a flu vaccine before and it made me ill.
A. Flu vaccine can cause some discomfort and swelling at the site of the injection. On rare occasions a flu immunisation can produce a temperature and aching muscles, sometimes with joint pains, beginning a few hours after the injection and lasting up to 2 days. Other reactions are very rare. If you had a serious reaction, however, you should discuss with your GP whether you should have the vaccine again.

Q. What other reactions can flu vaccines cause?
A. In people who have a severe hypersensitivity to hens’ eggs the vaccine may cause a reaction. Neurological symptoms - called the Guillain Barré syndrome - have been reported very rarely after influenza immunisation. This is estimated to occur once for every one million doses given.

Q. I can’t eat eggs. Should I have the vaccine?
A. Food intolerance alone is not a contra-indication to having the vaccine.
Q. Will I have to pay for the vaccine?
A. No - unless you choose to go to a private doctor or clinic.

Q. I heard you can now treat flu.
A. One antiviral drug has been available for treating flu for a long time, others are either recently licensed or in development. They may shorten the symptoms of flu but only by about a day.