



# Vaccine update



## NIN Conference

According to the World Health Organisation, vaccines, along with clean water, are the public health interventions that have had the greatest impact on the world's health.

The National Immunisation Network provides critical vaccine programme information regarding implementation, vaccine supply, training and related clinical matters. It is a mechanism for feedback on many issues and provides a regular clear channel for communication between all the screening and immunisation teams and stakeholders working across England in various health care settings.

The annual NIN conference is an important highlight in the Immunisation calendar providing an opportunity to meet each other face to face and share knowledge and experience. Read on for details of how to attend.

### CONTENTS

Sharing Best Practice for Improving Uptake in the Childhood Programme

HPV for MSM phased national rollout

Shortage of pneumococcal polysaccharide vaccine (PPV23)

Publication of the revised PHE National Minimum Standards and Core Curriculum for Immunisation Training for Registered Healthcare Practitioners

Vaccine coverage

Flu Vaccine Information and Availability 2017/18 for the children's national immunisation programme

Flu vaccines available for the children's programme

MMR vaccine ordering restriction

ViperaTab is changing presentation

Update on supply of Purified Protein Derivative PPD 10TU for Mantoux testing

Good Friday and Easter Monday Bank Holidays

Nimenrix pack size: Erratum and update

Vaccine supply for non routine programmes



## PHE National Immunisation Network Meeting

Monday 23 – Sunday 29 April 2018

### Booking open now!

**Welcome to all of our new readers and thank-you for subscribing to Vaccine Update. We would like to invite you to attend our immunisation conference in April.**

This two day meeting combines the well-established annual 'Scientific issues in immunisation' meeting with a second day focusing on the implementation issues relating to our national immunisation programme. This year's National Immunisation Network Meeting is being held in European Immunization Week which is being celebrated between 23–29 April 2018 in conjunction with other World Health Organization (WHO) regional initiatives and World Immunization Week. Our theme this year is Vaccines: our vaccination story in conjunction with the EIW annual theme 'Vaccines work!'. This will form the thematic spine for our two day event allowing us to explore immunisation at every stage of life and every age.

As well as presentations from world class epidemiologists and experts in immunisation from the UK, we look forward to welcoming Natasha Crowcroft, Chief of Applied Immunization research and evaluation, Public Health Ontario, Canada, as our keynote speaker.

We hope that by providing the science and rationale behind immunisation policy and decision-making, and by sharing experience and the latest and future developments, delegates will feel better equipped in their roles in this important public health work. This is a great opportunity to hear up-to-date information and network with colleagues from across the immunisation community.

The first day is open to everyone with an interest in the science behind the immunisation programme. The second day has been designed mainly for colleagues with a local leadership role in the commissioning, delivery and quality assurance of the immunisation programme.

All members of the Screening and Immunisation Teams (SITs) and Health Protection Teams (HPTs) with an interest and/or role in immunisation are encouraged to attend. We are hoping that at least one member of each SIT and HPT will be able to join us. In addition general registration is now open to all readers with an interest in immunisation. We anticipate that spaces will be taken up quickly and urge you to book a place as soon as possible as places are limited. Fees apply.



**Visit the meeting website to book now**

## Sharing Best Practice for Improving Uptake in the Childhood Programme

In October 2017 we asked teams who had achieved 95% uptake rates across the childhood immunisation programme to share initiatives that had helped increase uptake. Many thanks to all for your responses – we have been able to highlight a few for this article. This follows the publication of an updated Cochrane Review on 18 January showing that reminders and recall (of any type) increase the number of people receiving immunisations, seen at [weblink 1](#).

### Example from a schools-based provider

**Stockport Immunisation Team** administer HPV, Td/IPV and MenACWY immunisation in schools, and have achieved uptake above 95% for the past three years.



### The Stockport Immunisation Team:

(Left to right)

**Anthea Pimlott** – Clinical/Clerical Immunisation Support, **Vicky Riley** – Team Lead Immunisation Nurse, **Heather Doona** – Immunisation Staff Nurse, **Jo Farry** – Clinical/Clerical Immunisation Support.

Missing from the photo is **Mary Montgomery** – Immunisation Staff Nurse.

- Planning:** the scheduling of school immunisation sessions is agreed at least six months before the start of the academic year, and the ordering of vaccines and the planning of staffing is done at least half a term in advance. To make sure that sessions start on time, a taxi company collect the vaccines from the pharmacy and delivers to the school each day. The standard operating procedures (SOPs) that they have developed ensure consistency with delivery of vaccinations and in obtaining consent. A letter is included in the year 7 welcome pack to inform parents about vaccinations their child is eligible for during the school year. The team have built good working relationships with the schools, and say that this helps them to deliver a smoother service as school staff strive to return the consent forms from the tutors, and provide class lists.
- Consent:** forms are sent out two weeks before a planned session and returns are chased with the school. Children whose consent forms are still outstanding on the day of the session, are called in to the sessions and the team attempt to obtain verbal consent by telephone on the day. If a consent form states that a child is having the vaccination in general practice, this is verified with the practice, and where necessary contact is made with the parents to remind them and invite them to a catch-up clinic. The team uses Twitter to advertise school vaccination dates and to remind parents to return consent forms.
- Recall:** the team makes the most of opportunities in the school to catch up children who missed out. When vaccinating year 9s, they will call in year 8s who have missed their HPV vaccination. They call parents of children on the catch up lists, informing them of dates and dealing with queries. The team offer Saturday drop-in catch-up clinics three times a year for children who missed out in school sessions and invite them by letter (sent to their home).
- HPV specifically:** for the girl's HPV programme, the two doses are delivered during a single academic year, with at least six months between doses. Should anyone wish to view the following documents provided by the Stockport Immunisation Team please email us at [immunisation@phe.gov.uk](mailto:immunisation@phe.gov.uk): Letter to parents for the year 7 welcome pack, SOP on obtaining consent, SOP on delivery of vaccinations, Competency form, Risk assessment.

## Examples from General Practice

**Chiddenbrook Surgery in Crediton, Devon** managed to turn their below-target uptake levels around by implementing the following changes, and after two quarters haven't looked back.

- **Staff ownership:** they allocated a member of practice staff to be responsible for the childhood immunisation programme, and who, in addition to CHIS sending out invitations, took charge of booking appointments, calling parents to remind them, etc.
- **Call and recall:** they introduced a letter from the doctor to be sent to parents whose children were behind with their immunisations. They work together with the Health Visitor, enlisting their help with following up patients. They make sure their lists are clean and up to date.

**The Downland Practice in Chieveley, Berkshire** currently have a 97% uptake rate. Their best practice includes the following initiatives:

- **Call and recall:** EMIS searches in Population Reporting are date edited at the start of the month to identify patients to be invited the following month. Advance appointments are made in nurse Child Health Immunisation (CHI) clinics where possible. The previous month's search is run at the end of the month as a failsafe to identify any late registrations. Unregistered newborns are identified using the mother and baby discharges. Newly registered older children are flagged if they are due or behind in their immunisations.

Invitation letters are sent out with the relevant immunisation leaflets approximately two weeks prior. Twelve and sixteen week visits are arranged at the prior routine appointment. Non-attendees are recalled by letter and/or phone at least three times, after which the GP and Health Visitor are informed.

**Modality Diadem Medical Practice in Hull** have achieved levels of 98.8% in their 2-3 year olds, and 94.75% in their 5-6 year olds. They feel it is important to focus on the 2-3 year olds, because if they don't complete the routine schedule it will impact the target for 5-6 year olds.

- **Staff ownership:** the practice has a dedicated team member who oversees and monitors the immunisation programme in the practice, checks the immunisation status of all new registrations of children under five years old and ensures they are included in the programme.
- **Delivery:** the practice runs weekly baby clinics overseen by three practice nurses, and offer flexible general nurse appointments for parents, including evenings. They also liaise with the Health Visitors to help with hard to reach families.



### Modality Diadem Medical Practice Team:

(Left to right)

**June Holmes** – Practice Nurse,  
**Sue Thompson** – Practice Manager,  
**Rachel Barnes** – Practice Nurse,  
**Maureen Cox** – Senior Receptionist



**SSAFA Community Health Team** serving the British Forces at five British Military bases in Cyprus, put their excellent uptake levels down to the following:

- **Staff ownership:** staff are encouraged to take ownership of their clinics and are provided with rigorous training and supervised mentorship prior to starting a clinic. Childhood immunisations are provided by a variety of healthcare professionals including Health Visitors.
- **Checking immunisation status:** parents with children under 5 years of age who transfer to their caseload are seen by a Health Visitor who enters immunisation details from the Red Book into the GP records (DMICP), and schedules appointments for immunisations as needed.
- **Call, recall and reminders:** primary immunisation appointment dates are provided to parents at the primary birth visit by the Health Visitor, along with the immunisation leaflet. This provides an opportunity for discussions around immunisation, and further information such as when to give infant paracetamol. The routine appointment for immunisations at one year of age is arranged at the 10-12 month development assessment, and parents are advised on what vaccines to expect. Pre-school booster appointments are telephoned, emailed or posted to parents. Parents receive a reminder by text message the day before, and are telephoned on the day if they have not attended. Usually non-attendance is because a parent has forgotten.

We hope you have found these initiatives insightful. If you would like further information, please email us at [immunisation@phe.gov.uk](mailto:immunisation@phe.gov.uk).

We are very grateful for the examples you sent into us and for the hard work that goes into providing immunisation programmes. Clear themes emerge through some of these cases, led by the need for careful planning, communication and good staff engagement.

**These few case studies exemplify the ambition that all of us share to ensure a more effective approach in improving the protection of the children we serve.**



### **SSAFA Community Health Team:**

**Clare Henderson** – Specialist Public Health Nurse (Health Visitor), Akrotiri (pictured)

Missing from this photo are **Rachel Thurlow** – Health Visitor (Akrotiri)

**Sharon Boyle** – Community Children's Nurse (Akrotiri)

**Sian Buttery** – Business Support Administrator (Akrotiri)

**Ceri Henderson** – Health Visitor (Dhekelia)

**Gail Higgins** – Community Children's Nurse (Dhekelia)

**Samantha Jobson** – Business Support Administrator (Dhekelia)

**Kerry Riley** – Health Visitor (Episkopi)

**Racheal Andrews** – Community Children's Nurse (Episkopi)

**David Twist** – Business Support Administrator (Episkopi)

**Helen Provan** – School Nurse

**Jennie MacPhee** – School Nurse;

**Victoria Critchley** – Bank Staff Nurse.

## HPV for MSM phased national rollout

We are very pleased to announce that the government has confirmed that a nationwide HPV vaccination programme will be introduced for men who have sex with men aged 45 years or younger attending GUM and HIV clinics in England. NHS England and Public Health England will work together to agree a programme for implementation starting from April 2018.

Human papillomavirus (HPV) is a virus transmitted through sexual contact, with over 100 different types of HPV. It is most commonly associated with causing cervical cancer in women. The Joint Committee on Vaccination and Immunisation (JCVI) have recognised the increasing evidence of the association between HPV infection and non-cervical cancers, as well as the burden from genital warts on men who have sex with men (MSM), who do not benefit from indirect protection from the girls programme.

A PHE vaccination pilot started in 42 specialist sexual health services clinics from June 2016, to assess the feasibility and cost-effectiveness of a national HPV vaccination programme for MSM delivered through this setting. This pilot was a success, see more at [weblink 5](#).

The government has therefore decided to proceed with a phased, nationwide rollout to protect men who have sex with men from some cancers that are caused by the HPV as well as genital warts. The programme is opportunistic, and patients attending GUM and HIV clinics will be offered the vaccine when it becomes available.

Public Health England

NHS

**HPV vaccination pilot**  
for men who have sex with men (MSM)

Are you a MSM and 45 years or younger?  
**Get your free HPV vaccine today**

Ask your clinic nurse or doctor for more details

Immunisation

Helping to protect everyone at every age

© Crown copyright 2017. 3204636B to 30K\_A06 2017 0912

**HPV for MSM poster**  
Product code: 3204636B

## Shortage of pneumococcal polysaccharide vaccine (PPV23) – recommendations on how to manage PPV23 immunisation during 2018

The supply constraints affecting PPV23 vaccine will have made it unlikely that practices have been able to offer the vaccine alongside influenza vaccine, to all eligible patients in lower priority groups e.g. healthy people aged 65 years and over. Supplies of PPV23 are likely to remain constrained for the foreseeable future. Practices should therefore plan, subject to vaccine supply to offer PPV23 to those eligible throughout the whole of 2018 rather than aligning immunisation to take place alongside the flu programme.

### **PPV23 continues to be recommended for:**

- individuals aged from 2 years or over in clinical risk groups
- all individuals aged 65 years and over

This will help to ensure demand for vaccine is more consistent across the year and that stock can be ordered in small quantities to cover the requirements each month, thus also reducing the risk of wastage.

If you are able to procure stock, the priority should be to offer vaccine to those newly diagnosed with conditions in the high and moderate priority groups (see the table below). When such individuals are first identified, if no vaccine is available, please ensure that their records are flagged in order to call them for a future appointment. Also ensure that other aspects of management are optimised and in place (for example antibiotic prophylaxis, or booster doses of PCV13) – as advised in relevant guidance, or by the specialist clinician caring for the patient. Opportunistic vaccination of those in the high and moderate priority groups who have not already been vaccinated, and booster doses for those with splenic dysfunction and chronic kidney disease is less urgent and can be planned when sufficient stock is available.

Please also note that national stocks of PCV13 (Prevenar13), or separately procured PCV10 (Synflorix), should not be used in place of PPV23 as herd immunity from the infant and toddler programme has reduced levels of infections in the elderly for the 13 (or 10) serotypes to very low levels, only PPV23 can provide any protection against the serotypes that now predominate in that age group.

### Priority groups for Pneumococcal polysaccharide 23-valent vaccine (PPV23)

Clinical risk group	Examples (decision based on clinical judgement)
<b>High priority</b>	
Asplenia or dysfunction of the spleen	This also includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction.
Immunosuppression	<p>Due to disease or treatment, including patients undergoing chemotherapy leading to immunosuppression, bone marrow transplant, asplenia or splenic dysfunction, HIV infection at all stages, multiple myeloma or genetic disorders affecting the immune system (e.g. IRAK-4, NEMO, complement deficiency)</p> <p>Individuals on or likely to be on systemic steroids for more than a month at a dose equivalent to prednisolone at 20mg or more per day (any age), or for children under 20kg, a dose of 1mg or more per kg per day.</p>
Individuals with cerebrospinal fluid leaks	This includes leakage of cerebrospinal fluid such as following trauma or major skull surgery.
Individuals with cochlear implants	It is important that immunisation does not delay the cochlear implantation.
<b>Moderate priority</b>	
Chronic respiratory disease	This includes chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema; and such conditions as bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Children with respiratory conditions caused by aspiration, or a neurological disease (e.g. cerebral palsy) with a risk of aspiration. Asthma is not an indication, unless so severe as to require continuous or frequently repeated use of systemic steroids (as defined in Immunosuppression above).
Chronic heart disease	This includes those requiring regular medication and/or follow-up for ischaemic heart disease, congenital heart disease, hypertension with cardiac complications, and chronic heart failure.
Chronic kidney disease	Nephrotic syndrome, chronic kidney disease at stages 4 and 5 and those on kidney dialysis or with kidney transplantation.
Chronic liver disease	This includes cirrhosis, biliary atresia and chronic hepatitis.
Diabetes	Diabetes mellitus requiring insulin or oral hypoglycaemic drugs. This does not include diabetes that is diet controlled.
<b>Low priority</b>	
Healthy aged 65 years and over	



## Publication of the revised PHE National Minimum Standards and Core Curriculum for Immunisation Training for Registered Healthcare Practitioners

Following contributions and consultation with professional organisations, training providers, immunisation experts and immunisation practitioners across a wide range of service areas, the 'National Minimum Standards and Core Curriculum for Immunisation Training for Registered Healthcare Practitioners' ([weblink 7](#)) have been extensively revised from the original 2005 version and published together as one document on the PHE immunisation webpage at [weblink 10](#).

In order to ensure the ongoing delivery of a high quality, safe and effective immunisation programme that achieves high uptake, it is important that all practitioners involved in immunisation have a high level of knowledge and are confident in immunisation policy and procedures.

To gain this, they need to receive comprehensive foundation training, regular updates, supervision and support. The aim of these national standards is to describe the training that should be given to all practitioners engaging in any aspect of immunisation so that they are able to confidently, competently and effectively promote and administer vaccinations.

**Everyone involved in immunisation is encouraged to read these revised training standards and to make use of the 'Competency Assessment Tool' contained in Appendix A of this document.**

## Vaccine coverage

### **Evaluation of vaccine coverage of the herpes zoster (shingles) vaccination programme in England, from September 2017 to January 2018.**

This PHE report presents the evaluation of vaccine coverage of the herpes zoster (shingles) vaccination programme in England, from September 2017 to January 2018. Since April 2017, eligibility criteria have changed and patients can be offered the shingles vaccine as soon as they reach the eligible age (70 for the routine programme or 78 years for the catch up), and remain eligible until their 80th birthday – see [weblink 9](#).

Provisional cumulative vaccine coverage estimates up to the end of January 2018 show 34.6% coverage for the 70 year old routine cohort and 34.8% coverage for the 78 year old catch-up cohort. Compared with January 2017, coverage is 5.3% lower for the routine and 5.5% lower for the catch-up cohort.

However, by the end of January 2018, 4.6% of those aged 69 years old on 1st September 2017 had received shingles vaccine (compared to 0.7% of 69 year olds at the end of January 2017) and 5.4% of those aged 77 years old on 1st September 2017 had received vaccine (compared to 1.4% of 77 year olds at the end of January 2017).

Most of these individuals will have received the vaccine under the revised eligibility criteria, being offered it as they reached their 70th birthday between 1st September and 31st January 2018. It is therefore likely that part of the decrease in coverage evaluated in January 2018 is a data artefact related to the change in eligibility criteria. Nevertheless, coverage has decreased compared with the same point in time last year and GPs are urged to continue to offer vaccinations to eligible cohorts as per current guidance, to improve protection in these age groups.

The full report and associated data tables can be found at [weblink 12](#).

### **Second annual vaccine coverage report for the schools based meningococcal ACWY (MenACWY) adolescent vaccination programmes in England, 2016/17**

Annual vaccine coverage estimates have been published for the schools based meningococcal ACWY (MenACWY) adolescent vaccination programme in England for the school year 2016/17. MenACWY immunisation was added to the national immunisation programme in August 2015 following advice from the Joint Committee on Vaccination and Immunisation (JCVI) in response to the rising number of meningococcal W (MenW) cases.

In 2015/16, the first academic year of the MenACWY schools vaccination programme, two groups of adolescents were offered the vaccine in schools: approximately half of adolescents in Years 9 and 10 as part of the routine programme, and adolescents in year 11 as part of the catch-up campaign.

In 2016/17, the MenACWY vaccine was offered in schools to two groups as part of the routine programme: approximately half of adolescents in year 10 and 11 (who were in years 9 and 10 in 2015/16 and were not offered the vaccine), and adolescents in Year 9 in the majority of local authorities. The results show 124 of 152 local authorities (82%) offered MenACWY routinely in Year 9 (those born 1 September 2002 to 31 August 2003) through the schools based programme in 2016/17, and coverage evaluated up to the end of August 2017 was 83.6%, compared with 84.1% reported for Year 9 in 2015/16. The remaining LAs offered the MenACWY vaccine either through year 10, or through general practice.

Coverage at the end of August 2017 for the first cohorts to be routinely offered MenACWY vaccine in schools from September 2015 (those born 1 September 2000 to 31 August 2001 (Year 11 in 2016/17) and those born 1 September 2001 to 31 August 2002 (Year 10 in 2016/17)) was 79.0% and 82.5% respectively.

Coverage at the end of August 2017 for Year 12 in 2016/17 (those born 1 September 1999 to 31 August 2000) and offered MenACWY in schools in most LAs in 2015/16 as part of a catch-up campaign, was 71.4%. All cohorts remain eligible for vaccination until the age of 25.

The full report and associated data tables can be found at [weblink 2](#).

### **Second annual vaccine coverage report for the schools based Td/IPV (school leaver booster) adolescent vaccination programmes in England, 2016/17**

The school leaver booster is the fifth dose of tetanus, diphtheria and polio (Td/IPV) vaccine in the routine immunisation schedule and completes the course, providing long-term protection against all three diseases. Despite these antigens being offered to adolescents for decades, 2015/16 was the first pilot year of national vaccine coverage data collection for Td/IPV.

This is the second vaccine coverage report for the Td/IPV schools based immunisation programme in England and presents updated data for school year 10 and new data for school year 9 in 2016/17. Coverage of the Td/IPV booster vaccine up to the end of August 2017 for those born 1 September 2001 to 31 August 2002 (Year 10 in 2016/17) was 81.7%.

Coverage of the Td/IPV booster vaccine up to the end of August 2017 for those born 1 September 2002 to 31 August 2003 (Year 9 in 2016/17) evaluated from school based programmes was 83.0%, similar to coverage achieved in year 9 in 2015/16 (83.5%).

The full report and associated data tables can be found at [weblink 3](#).

### **Preliminary vaccine coverage estimates for the meningococcal B (MenB) immunisation programme for England, update from August to December 2017**

This sixth early assessment of infant MenB vaccine coverage at six months of age, just two months after the second dose is scheduled indicates that the vaccine has continued to be well accepted and implemented.

High completed primary course coverage similar to that previously reported was achieved between August and December 2017, remaining around 88% by six months of age. By 12 months of age 93% of infants have completed a two dose course indicating around 5% receive the second dose after six months of age.

This report also presents the third estimates of MenB booster coverage at 18 months of age for the routine cohorts, showing a similarly high proportion of children, around 87% of the routine cohorts, are continuing to receive their booster dose within five to six months of the vaccine being scheduled.

The full report and associated data tables can be found at [weblink 4](#).

## Training

Places still  
available

### Fundamentals of Immunisation

12 and 13 March 2018,  
UCL Great Ormond Street Institute of Child Health  
30 Guilford Street, London WC1N 1EH

~ Course fee: £150 ~

Programme and booking information available at [weblink 11](#)

Public Health England and UCL Great Ormond Street Institute of Child Health are running a Fundamentals of Immunisation course in March. This annually held, two day intense theoretical course is designed for those new to a role in immunisation and is most suited to those who give or advise on a range of different vaccines. The course comprises a series of lectures from national immunisation experts and will provide delegates with up-to-the-minute information on the range of topics included in PHE's 'Core Curriculum for Immunisation Training'. A basic level of prior immunisation knowledge and familiarity with the Green Book (Immunisation against infectious disease) will be assumed.

## Vaccine Supply Update

### Flu Vaccine Information and Availability 2017/18 for the children's national immunisation programme

#### Expiry dates for Fluenz Tetra®

PHE is now issuing the final batch of Fluenz Tetra® (JK2516C) for the 2017/18 season. This batch will continue to be issued until 8 March or until stocks are exhausted (whichever is soonest). Please note this batch expires on 15 March 2018.

#### All other batches have now expired

Please ensure that the expiry date is always checked before use and that any expired stock is disposed of in line with local policies. Please record any stock that is disposed of due to expiry before use through the ImmForm Stock Incident page.

Batch	Expiry date	Batch	Expiry date	Batch	Expiry date
JH2616	26-Dec-17	JJ2069	04-Jan-18	JJ2838	23-Jan-18
JH2617	27-Dec-17	JJ2071	09-Jan-18	JK2516	29-Jan-18
JH2618	28-Dec-17	JJ2609	10-Jan-18	JK2516B	13-Feb-18
JH2619	02-Jan-18	JJ2612	15-Jan-18	JK2516C	15-Mar-18
JH3127	04-Jan-18	JJ2837	15-Jan-18		

## Flu vaccines available for the children's programme

The following vaccines remain available to order by providers of the children's national flu programme via the ImmForm website:

Vaccine	Manufacturer
Inactivated influenza vaccine (split virion) BP	Sanofi Pasteur
Fluarix Tetra	GSK

### Providing a second dose of flu vaccine after all Fluenz Tetra® has expired

In the event that you still need to give a second dose of flu vaccine four weeks after the first dose (for example, for children in clinical risk groups aged two to under nine years who have not received influenza vaccine before), then it is safe and effective to give inactivated vaccine as a second dose.

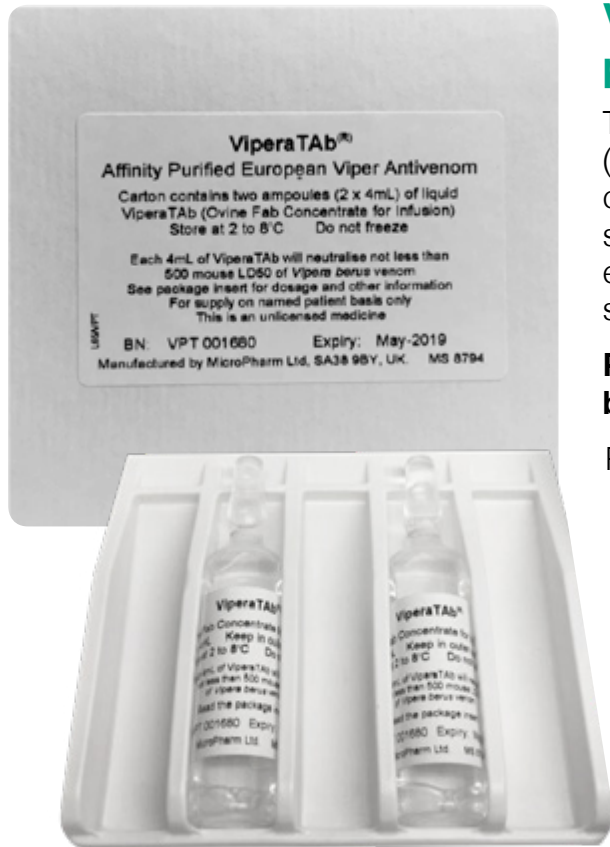
### Reporting any remaining unused Flu Vaccine ordered for the Children's Flu Programme

As the vaccination period for flu enters the final stage, it is important to remember that any vaccine that has expired, or remains otherwise unused at the end of the season, is recorded on ImmForm, using the Stock Incident page. This is to ensure that all stock is accounted for and supports efforts across the system to reduce the level of vaccine which may go unused at the end of the season. Please ensure that you select the appropriate reason (i.e. 'expired before use' or 'cold chain failure') when recording the disposal of any stock.

## MMR vaccine ordering restriction

There are currently 2 vaccines available to order for the MMR programme, M-M-RvaxPro® and Priorix®. Orders for Priorix® are currently capped at 6 packs per order per week for accounts in England and Wales. Controls are also in place for Scottish customers. The alternative MMR vaccine, M-M-RvaxPro®, remains available to order without restriction. If you require further assistance regarding these ordering controls, please contact the ImmForm Helpdesk at [helpdesk@immform.org.uk](mailto:helpdesk@immform.org.uk).





## ViperaTab is changing presentation

The presentation of ViperaTab (supplied to treat the bite of the common Adder) will be changing shortly from two glass vials, to two easy-snap glass ampoules (please see images to the left).

**Please note that ampoules should be handled and opened with care.**

Please see the patient information leaflet in each pack for more information on use of the new ampoules. For a limited time, customers placing orders for ViperaTab will receive either the existing presentation or the new presentation until we have exhausted stocks of the older presentation.

## Update on supply of Purified Protein Derivative PPD 10TU for Mantoux testing

Purified Protein Derivative PPD 10TU for Mantoux testing will soon no longer be available to order through ImmForm as incoming supply has come to an end. Ordering of PPD 10TU will continue on ImmForm until the remaining stocks are used up. This will not impact on routine Mantoux testing and PPD 2TU/0.1ml will continue to be available to order through ImmForm.

In the UK, the standard concentration of Purified Protein Derivative (PPD) 2TU/0.1ml is used for routine Mantoux testing to identify latent TB infection among contacts of active TB cases, migrants and in individuals prior to immunosuppressive therapy. The higher concentration of 10 TU/0.1 ml is only used in rare circumstances, for example where the first Mantoux test (PPD 2TU) is negative (less than 5 mm in diameter) and a retest is considered appropriate for clinical purposes e.g. in immunocompromised patients/contacts (Green Book page 404 at [weblink 8](#)).

PHE is currently reviewing the evidence for the use of PPD10TU and will be issuing information in the near future on possible appropriate alternatives.

## Good Friday and Easter Monday Bank Holidays

Due to the Easter Bank Holidays, there will not be any deliveries or order processing by Movianto UK on Friday 30 March and Monday 2 April 2018. Please see the table below for revised order and delivery dates.

Customers with a standard delivery day of Friday should be aware that after 23 March, your next available delivery day will be the 6 April 2018.

Customers with a standard delivery day of Monday should be aware that after 26 March, your next available delivery day will be the 9 April 2018.

You are reminded to be prepared for the break in deliveries and to order accordingly. Please make sure you have sufficient room in your fridge for any additional vaccine you wish to stock over this holiday period, bearing in mind the recommendation that only two to four weeks of vaccine stock be held at any one time.

Delivery date	Order cut-off date	Order cut-off time
Friday 23 March	Wednesday 21 March	11:55 AM
Monday 26 March	Thursday 22 March	11:55 AM
Tuesday 27 March	Friday 23 March	11:55 AM
Wednesday 28 March	Monday 26 March	11:55 AM
Thursday 29 March	Tuesday 27 March	11:55 AM
Friday 30 March	<b>CLOSED – NO DELIVERIES</b>	
Monday 2 April	<b>CLOSED – NO DELIVERIES</b>	
Tuesday 3 April	Wednesday 28 March	11:55 AM
Wednesday 4 April	Thursday 29 March	11:55 AM
Thursday 5 April	Tuesday 3 April	11:55 AM
Friday 6 April	Wednesday 4 April	11:55 AM
Monday 9 April	Thursday 5 April	11:55 AM

## Nimenrix pack size: Erratum and update

The pack sizes outlined in the March 2017 edition of Vaccine Update for Nimenrix were incorrect. The Nimenrix packs currently being distributed by PHE have the following dimensions: Width 50mm x Breadth 28mm x Length 178mm. Later in 2018 PHE will start issuing vaccine in packs with the following dimensions: Width 57mm x Breadth 27mm x Length 135mm and further details will appear in Vaccine update closer to the time.

## Vaccine supply for non routine programmes

### HEPATITIS A VACCINE

#### Adult

- **GSK:** Supplies of Havrix PFS singles, PFS packs of 10 and vials in singles are available. Please note, there may not be sufficient stock in each presentation to accommodate demand, therefore you may not be able to access supply of some presentations
- **Sanofi Pasteur:** Limited supplies of Avaxim are available. It is likely that there will be order restrictions in place.
- **MSD:** VAQTA Adult is currently unavailable and there will be intermittent supplies during 2018.

#### Paediatric

- **GSK:** Havrix Paediatric singles and packs of 10 will experience supply constraints until spring 2018
- **MSD:** VAQTA Paediatric is currently available with supplies expected throughout 2018.

### HEPATITIS B VACCINE

All Hepatitis B monovalent and combination hepatitis A/B vaccines are currently under supply management. While priority groups 1-3 (in the PHE temporary recommendations) will continue to have access to Hepatitis B monovalent vaccines, availability for priority group 4 patients is anticipated to commence in a phased approach from spring 2018. Further details will be available in March at [weblink 6](#).

#### Adult

- **GSK:** Engerix B PFS singles are available
- **GSK:** Engerix B PFS packs of 10 are available
- **GSK:** Very limited supplies of Engerix B vials are available
- **GSK:** Fendrix is available
- **MSD:** Limited supplies of HBVAXPRO 10µg are available. Supplies are expected to be restricted throughout 2018
- **MSD:** Limited supplies of HBVAXPRO 40µg are available. Supplies are expected to be restricted throughout 2018

#### Paediatric

- **GSK:** Engerix B Paediatric singles are available
- **MSD:** Limited supplies of HBVAXPRO 5µg are available. Supplies are expected to be restricted throughout 2018

### COMBINED HEPATITIS A & B VACCINE

- **GSK:** Twinrix Adult and Paediatric presentations are available
- **GSK:** Ambirix is available

### COMBINED HEPATITIS A & TYPHOID VACCINE

- **GSK:** GSK is discontinuing Hepatyrix vaccine that has been under constrained supply for several years due to challenges associated with its manufacturing
- **Sanofi Pasteur:** Viatim is currently unavailable

**TYPHOID VACCINE:**

- **GSK:** GSK is discontinuing Typherix vaccine that has been under constrained supply for several years due to challenges associated with its manufacturing
- **Sanofi Pasteur:** Typhim is available to order without restrictions
- **PaxVax:** Vivotif is available

**RABIES VACCINE**

- **GSK:** limited supplies of Rabipur are available due to increased demand. Supply is being prioritised to hospitals and GPs for use in notified post-exposure cases only
- **Sanofi Pasteur:** Limited supplies of Rabies BP are available. It is likely that there will be order restrictions in place  
There is no impact on the National Immunisation Programme

**PPV (Pneumococcal Polysaccharide Vaccine)**

- **MSD:** Stock is currently available and additional replenishment is planned for April and May 2018

**VARICELLA ZOSTER VACCINE**

- **GSK:** Varilrix is currently available
- **MSD:** VARIVAX is currently available
- **MSD:** ZOSTAVAX is currently available

**DIPHTHERIA, TETANUS AND POLIOMYELITIS (inactivated) VACCINE**

- **Sanofi Pasteur:** Limited supplies of Revaxis are available. There are likely to be order restrictions in place for travellers  
There is no impact on the National Immunisation Programme

**MMR**

- **MSD:** currently have no MMR stocks available for private market sales and do not currently have dates for further replenishment
- There is no impact on the National Immunisation Programme. It should be noted that central MMR vaccine stock can be used to catch-up anyone of any age. Occupational Health Departments who are having difficulty obtaining MMR stock from manufacturers should contact the PHE vaccine supply team on [vaccine.supply@phe.gov.uk](mailto:vaccine.supply@phe.gov.uk)

**HUMAN PAPILLOMAVIRUS VACCINE**

- **MSD:** Stocks of GARDASIL are available for private market sales and for the National Immunisation Programme.
- **MSD:** Gardasil-9 is currently available

**MenACWY VACCINE**

- **GSK:** Menveo, is anticipated to be unavailable in the UK from February 2018  
Supply to improve in late 2018 and for supply to return to normal by 2019
- **Pfizer:** Nimenrix is currently available for private sales. There is no impact on the National Immunisation Programme

## Weblinks

- weblink 1 <http://www.evidentlycochrane.net/boosting-vaccination-rates-with-reminders/>
- weblink 2 <https://www.gov.uk/government/publications/meningococcal-acwy-immunisation-programme-vaccine-coverage-estimates>
- weblink 3 <https://www.gov.uk/government/publications/school-leaver-booster-tdipv-vaccine-coverage-estimates>
- weblink 4 <https://www.gov.uk/government/publications/meningococcal-b-immunisation-programme-vaccine-coverage-estimates>
- weblink 5 <https://www.gov.uk/government/publications/hpv-vaccination-for-men-who-have-sex-with-men-year-1-pilot>
- weblink 6 <https://www.gov.uk/government/publications/hepatitis-b-vaccine-recommendations-during-supply-constraints>
- weblink 7 <https://www.gov.uk/government/publications/national-minimum-standards-and-core-curriculum-for-immunisation-training-for-registered-healthcare-practitioners>
- weblink 8 <https://www.gov.uk/government/publications/tuberculosis-the-green-book-chapter-32>
- weblink 9 <https://www.gov.uk/government/publications/vaccine-update-issue-261-april-2017>
- weblink 10 <https://www.gov.uk/government/collections/immunisation#immunisation-training-resources-for-healthcare-professionals>
- weblink 11 <https://onlinestore.ucl.ac.uk/conferences-and-events/faculty-of-population-health-sciences-c09/ucl-great-ormond-street-institute-of-child-health-d13/d13-fundamentals-of-immunisation-2018>
- weblink 12 <https://www.gov.uk/government/publications/herpes-zoster-shingles-immunisation-programme-2013-to-2014-provisional-vaccine-coverage-data>