London-wide GP webinar – Measles | 21 February 2024

Questions and answers from the session.

For use by GPs and medical professionals.

The Q&A includes the following sections:

- Contact details
- Vaccine age/timeframe questions
- Rashes (vaccine and measles)
- Primary care management
    - Including staff vaccinations
- Measles case questions

Contact details

- Please provide the link to UKHSA's diagnostic guide so we can circulate amongst clinical colleagues in general practice?
  https://www.gov.uk/government/publications/national-measles-guidelines
  https://assets.publishing.service.gov.uk/media/653b77e5d10f35000d9a6a6c/UKHSA-12724-think-measles-HCW-poster.pdf

- How do we get in contact with the health protection team (HPT)?

  To notify the HPT of a suspected or confirmed case of measles, please use the London region notification of infectious diseases form and email this in when in hours (9 to 5pm, Monday to Friday). If out of hours or the likelihood of urgent actions needed for vulnerable contacts, please call the HPT. If in doubt, please call. Contact details for the HPT are here- https://www.gov.uk/health-protection-team

  There are three HPTs in London. The telephone number for all three teams is the same: 0300 303 0450 (for in and out of hours queries).

Vaccine age/timeframe questions

- **Contact**

- Is there a time frame in getting someone in for the MMR vaccine if they have been in contact with a confirmed case?

  Ideally within 72 hours (3 days), but you can give at any stage if asymptomatic.

  FROM NATIONAL MEASLES GUIDELINES- the limited evidence suggests that MMR may prevent disease, or reduce its severity, when administered soon after exposure (within 72 hours). Beyond this period, MMR should protect individuals from future measles exposures and provide

protection against mumps and rubella. Importantly, in outbreak-prone settings such as schools and nurseries, MMR should prevent tertiary transmission in those who have not already been significantly exposed.

- How early can we give first MMR if they are concerned a baby has been in contact or at nursery with cases of measles?

  See table – household contact gets human immunoglobulin (HNIG) – if outside household, from 6 months, but remember that any doses up to 12 months don't count, and they should still go on to receive two doses at the normal time afterwards. This is because maternal circulating IgG may affect the effectiveness of the live vaccine. Also note that, more often than not, the HPT will be aware of exposure at a nursery and will have sent a letter out to parents with the recommendation to seek vaccination in line with guidance below. If you are not sure that an exposure has occurred and you wish to confirm this, please contact the HPT. Any arrangements for HNIG must go through the HPT.

Table 5. Assessment and treatment of infants

Infants under 6 months	Assume susceptible and administer HNIG, ideally within 72 hours but up to 6 days, regardless of maternal status.	
Infants aged 6 to 8 months	For household exposure, administer HNIG, ideally within 72 hours but up to 6 days if necessary.	For exposures outside of the household, administer MMR, ideally within 72 hours.
Infants 9 months and older	Administer MMR vaccine, ideally within 72 hours of exposure.	

  - **Babies/children – bringing forward doses**

- If the parent requests bringing forward the second MMR, can we do this?

  Yes, as long as it's at least a month apart from the first dose. As per the green book (Page 9), a second dose is normally given before school entry but can be given from 18 months. Please refer to your PGD too.

- If we have administered MMR2 early as per parent request, we can consider that as part of the 1yr/pre-school booster vaccine and no need to repeat?

  If you give the second MMR vaccine early (between 15 months and 3 year 4 months) then you don't need to give a third dose. But please note that the second dose should not routinely be given below 18 months. Please refer to green book page, 9.

- If a child had a vaccine at 1 year old but no second vaccine and they are now 10+ years old, do you just give one vaccine or do they need two?

Just one dose.

- How soon can you give second dose after flu?

  Please refer to the flu green book, page 19. LAIV can also be given at the same time as other live or inactivated vaccines. Although it was previously recommended that, where vaccines cannot be administered simultaneously; a 4-week interval should be observed between live viral vaccines, JCVI have advised that no specific intervals need to be observed between LAIV and other live vaccines.

  This advice is also in the flu vaccination programme for flu healthcare practitioners. https://www.gov.uk/government/publications/flu-vaccination-programme-information-for-healthcare-practitioners/flu-vaccination-programme-2023-to-2024-information-for-healthcare-practitioners#vaccine-administration

  Inactivated flu – not live vaccine, don't need to wait.

    - **Adults**

- Is there an upper age limit for MMR vaccination?

  No

- We have received queries from older patients (over 50yrs) who are unsure of their vaccination status (likely on LG records) and would like to be vaccinated. Can this happen?

  Yes.

- How do we say no (you're at low risk) to the elderly?

  Epidemiology and serosurveillance shows us that the vast majority have IgG from childhood illness and in outbreaks we tend not to see cases in this age group.

- If a patient has rubella immunity does that cover measles?

  Not necessarily - see chart for who should be protected. Clear evidence for measles protection is 2 doses of MMR or a positive measles IgG.

Table 3a. Group A: individuals who should develop and maintain adequate antibody from past exposure or vaccination

Age and history of measles exposure or vaccination		Recommendation
All ages	Previous measles IgG positive	Assume immune – do not give IVIG
Born before 1970	Positive history of measles infection	Assume immune – do not give IVIG
	No history of measles infection	Rapid IgG test and issue if negative or equivocal If not possible to test within 6 days of exposure, assume immune – do not give IVIG
Born between 1970 and 1990	Positive history of measles infection or vaccination	Rapid IgG test and give IVIG if negative or equivocal If not possible to test within 6 days of exposure, assume immune – do not give IVIG
	No history of measles infection or vaccination	Rapid IgG test and give if negative or equivocal If not possible to test within 6 days of exposure, give IVIG
Born after 1990	History of 2 measles containing vaccines	Rapid IgG test and give if negative or equivocal If not possible to test within 6 days of exposure, assume immune – do not give IVIG
	History of one measles containing vaccine	Rapid IgG test and give if negative or equivocal If not possible to test within 6 days of exposure, give IVIG
	Unvaccinated	Give IVIG

- **Pregnancy**

- A child from abroad with no MMR protection after 12 months old. The mother is currently pregnant. Can the child be vaccinated knowing that MMR is a live vaccine?

  Yes

- Which months of pregnancy woman can take MMR if needed?

  MMR is not recommended in pregnancy. Refer to green book page 11 and page 12. There is no evidence that rubella-containing vaccines are teratogenic. However, as a precaution, MMR vaccine should not be given to women known to be pregnant. When MMR vaccine is given to adult women, they should be advised to guard against pregnancy for one month.

Schools programme

- Are NHSE considering sending HCPs into schools to talk to parents re MMR uptake?

  SAIS providers are visiting schools to provide vaccinations.

- **Immunosuppressed patients**

- As green book states that the MMR vaccine is contraindicated in immunosuppressed patients, are there any scenarios where we would vaccinate this cohort of patients (with advice from specialist and under a PSD)?

  No – information is being given to specialists in hospital to manage this.

Rashes (vaccine and measles)

- MMR can also cause a rash and fever so do we assume post exposure it's infection?

  Yes, from an infection prevention control perspective – they should isolate for four days after the rash to break transmission cycle. They should also be reported to the HPT.

Primary care management

- **Infection prevention control (IPC)**

- Do we need to clean the room down if we see a case of measles?

  Yes, a terminal clean should be performed (i.e. removal of all healthcare waste and decontamination of all reusable equipment, surfaces, the environment with detergent and disinfectant). This should be performed after any required fallow (resting) time which is subject to local risk assessment. Cleaning products would be a neutral detergent followed by a disinfectant (or a combined product). Typically, a product with 1000ppm available chlorine is recommended but other locally approved products can be used provided there is evidence from the manufacturer that it is suitable for the purpose and organism. Wear PPE when cleaning.

  https://www.england.nhs.uk/long-read/guidance-for-risk-assessment-and-infection-prevention-and-control-measures-for-measles-in-healthcare-settings/

- If we see a patient with measles and the next patient is a pregnant woman, is there a risk of seeing her in the same room?

  After seeing a patient with suspected or confirmed measles in a room, the room needs a terminal clean as per guidance after a fallow (resting) time – this is the time taken for airborne particles to settle onto surfaces and be removed and diluted in the air by ventilation. The amount of time needed will vary and is subject to local risk assessment as it will be dependent on the number of air changes (ACH) in a room through ventilation, the size of the room and the duration of time the patient with suspected or confirmed measles has been in there. As most GP practice settings have natural rather than mechanical ventilation, the number of ACH isn't known and it is difficult to calculate the fallow time. It may be useful to consider the survival time of measles virus in the environment in your local risk assessments for this - the virus can remain active in the air or on surfaces for up to two hours.

- Is it good to have air conditioning on in the room?

  Stand-alone air conditioning units recirculate air, can increase the risk of cross infection and should not be used in clinical areas. Other mechanical ventilation used in healthcare premises should meet the guidance set out in HTM 03-01: NHS England » Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises

- With the 21 days exclusion can staff use an isolated room to work?

  No, staff should not attend the workplace during their exclusion period. The HPT can advise on when staff should be excluded from and if any actions are possible (e.g. checking of immunity post exposure) to avoid exclusion.

- How do we organise FFP3 fit mask testing in primary care?

  You could approach your local ICB IPC lead in the first instance to see if there are any local arrangements within your system. Otherwise, Fit2Fit has the network of accredited RPE fit test providers and trainers to contact: https://www.fit2fit.org/

- There will be a cost to this so it may be worth considering fit testing with other practices together or as a PCN, and/or a 'train the trainer' system (members of staff train up to be fit testers) to ensure resilience.

- N.B. Fit testing must be on the specific brand(s) of mask being used and it is recommended that staff are re-fit tested at least every two years.

  - **Staff vaccination**

- Can GPs vaccinate their staff or do they need to go to their registered GP?

  Practices are advised to recommend that staff attend their registered practice to access the MMR vaccine. If vaccination history is unclear, it is usually recommended that staff have a course of MMR vaccine rather than testing for immunity unless this is the express wish of the member of staff.

  NHSE have sent out the following communication to practices. Please note, however, that CNSGP have advised that practices would not be indemnified if administering the vaccine to staff under INT for occupational health purposes. The BMA are seeking further clarification on this point.

Sent on behalf of NHS England Vaccination, Policy and Contracts Team

In light of the national measles outbreak and urgency to support rapid uptake of the MMR vaccine, we are permitting practices to administer MMR vaccines to their eligible staff who are registered with another practice under INT (immediately necessary treatment). Please note this is a time limited arrangement until 31 March 2024 in light of the on-going national incident and only applies to MMR vaccinations.

An item of service fee cannot be claimed for the administration of MMR vaccines to staff registered with another practice. However, indemnity cover will be provided through CNSGP and nationally supplied MMR stock can be used to vaccinate eligible staff. Staff must be strongly encouraged to inform their registered practice that they have received an MMR vaccine, requesting it be included in their medical record.

- Pragmatically, if staff have no history of MMR or measles, do we just give 1 MMR as a preventative measure? (rather than a course of 2)

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Satisfactory evidence of protection for healthcare staff includes documentation of having received 2 or more doses of measles containing vaccine and/or a positive measles IgG antibody test. Therefore, two doses are recommended. The second dose can be given after a month interval (at least one month).

  - or do we look at immunity blood testing, if so who processes these tests?
    It may be difficult to access immunity testing and it is advised that instead of looking at the level of immunity, even in those who think they had measles as a child, two doses of MMR should be given to ensure they are protected. The MMR is a very safe vaccine and can be used safely even if the person does have immunity from natural illness or previous vaccination. There are no negative effects from vaccinating people who are already immune

- What do we do if staff do not want the vaccine?

  There is no requirement to mandate the vaccination of staff. We would strongly encourage staff members to be vaccinated so that they can keep their patients and family members who may be vulnerable safe.

  However, if it is not possible for practice to vaccinate staff (preferable) or to check their immunity, practices should identify non vaccinated staff, and ensure that they are not exposed to potential measles cases – whether they are clinical or non-clinical members of the team.

  Please ensure you are actively risk assessing your staff so you are aware of your staff's risk profile

- Who is responsible for carrying out the immunisation - employer (GP practice) or patients GP?

  The employer is responsible for ensuring that patient-facing staff have the appropriate vaccinations for their role. Further information is available on this CQC mythbuster:

  https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-37-immunisation-healthcare-staff and in the Green Book. https://assets.publishing.service.gov.uk/media/5a7abc09e5274a319e77a5b9/Green-Book-Chapter-12.pdf

  However, as the MMR vaccine is available to adults with incomplete vaccination history on the NHS (as per eligibility guidelines), it is generally recommended that staff access the vaccine from their registered practice.

  - **Patient questions**

- Can you provide the vaccine if the parent doesn't have their red book?

The GP record is the central record of a child's immunisation history. If a parent does not have their red book, please use the opportunity to vaccinate the child and enter it on to the GP record. The red book can be updated at a later date.

Measles case questions

- Is there any guidance for urgent care centres?

  The measles IPC guidance for urgent care centres is the same as for GP practices.

- What cream we can give for the rash?

  No need to give anything