UK Health Security Agency

NHS

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Measles, mumps and rubella (MMR) vaccine for use in community measles outbreaks Patient Group Direction (PGD)

This PGD is for the administration of measles, mumps and rubella (MMR) vaccine to individuals born on or after 1 January 2020 to be offered **by exception**, who require urgent protection against a community measles outbreak in accordance with the national measles guidelines.

Children who have had up to 2 doses of MMR vaccine under this PGD remain eligible for MMRV appropriate to their age, under the national MMRV vaccination programme (see MMRV PGD).

This PGD is for use by registered healthcare practitioners identified in section 3, subject to any limitations to authorisation detailed in section 2.

Reference no:	MMR vaccine **(for use in community measles outbreaks)** PGD
Version no:	v1.0
Valid from:	1 May 2026
Review date:	30 September 2028
Expiry date:	31 March 2029

The UK Health Security Agency (UKHSA) has developed this PGD to facilitate the delivery of publicly funded immunisation in England in line with national recommendations.

Those using this PGD must ensure that it is organisationally authorised and signed in section 2 by an appropriate authorising person, relating to the class of person by whom the product is to be supplied, in accordance with Human Medicines Regulations 2012 (HMR2012)[1]. **The PGD is not legal or valid without signed authorisation in accordance with HMR2012 Schedule 16 Part 2.**

Authorising organisations must not alter, amend or add to the clinical content of this document (sections 4, 5 and 6); such action will invalidate the clinical sign-off with which it is provided. In addition, authorising organisations must not alter section 3 (characteristics of staff). **Sections 2 and 7 can be edited within the designated editable fields provided, but only for the purposes for which these sections are provided, namely the responsibilities and governance arrangements of the NHS commissioned organisation using the PGD. The fields in section 2 and 7 cannot be used to alter, amend or add to the clinical content. Such action will invalidate the UKHSA clinical content authorisation which is provided in accordance with the regulations. The legal validity of this PGD is contingent on those authorising sections 2 and 7 complying with the above.**

Operation of this PGD is the responsibility of commissioners and service providers. The final authorised copy of this PGD should be kept by the authorising organisation completing section 2 for 8 years after the PGD expires if the PGD relates to adults only and for 25 years after the PGD expires if the PGD relates to children only, or adults and children. Provider organisations adopting authorised versions of this PGD should also retain copies for the periods specified above.

Individual practitioners must be authorised by name, under the current version of this PGD before working according to it.

[1] This includes any relevant amendments to legislation

Practitioners and organisations must check that they are using the current version of the PGD. Amendments may become necessary prior to the published expiry date. Current versions of UKHSA PGD templates for authorisation can be found from: Immunisation patient group direction (PGD) templates.

Any concerns regarding the content of this PGD should be addressed to: immunisation@ukhsa.gov.uk.

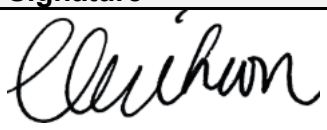
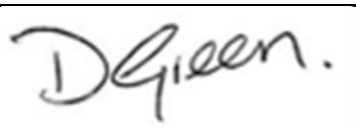
Enquiries relating to the availability of organisationally authorised PGDs and subsequent versions of this PGD should be directed to: england.swvast@nhs.net.

Change history

Version	Change details	Date
v1.0	New UKHSA MMR PGD to enable administration of MMR to individuals routinely eligible for the MMRV vaccine under limited circumstances and within the context of a community measles outbreak.	29 April 2026

1. PGD development

This PGD has been developed by the following health professionals on behalf of the UKHSA:

Developed by:	Name	Signature	Date
Pharmacist (Lead Author)	Christina Wilson Lead Pharmacist - Immunisation Programmes, UKHSA		27 April 2026
Doctor	Dr Hannah Emmett Consultant Medical Epidemiologist, Immunisation and Vaccine Preventable Diseases Division, UKHSA		27 April 2026
Registered Nurse (Chair of Expert Panel)	David Green Nurse Consultant for Immunisations, Immunisation Programmes, UKHSA		27 April 2026

This PGD has been peer reviewed by the UKHSA Immunisations PGD Expert Panel in accordance with the UKHSA PGD and Protocol Policy. It has been ratified by the UKHSA Medicines Governance Committee.

Expert Panel

Name	Designation
Dr Nicholas Aigbogun	Consultant in Communicable Disease Control, Yorkshire and Humber Health Protection Team, UKHSA
Jess Baldasera	Health Protection Practitioner, North East Health Protection Team, Regions Directorate, UKHSA
Helen Beynon	Clinical Advisor, Immunisation Clinical Advice Response Service (CARS), NHS England – London
Alison Campbell	Screening and Immunisation Coordinator, Clinical, NHS England – Midlands
Laura Craig	Lead Immunisation Nurse Specialist, Immunisation Programmes – UKHSA
Jane Freeguard	Deputy Director of Vaccination – Medicines and Pharmacy, NHS England
Rosie Furner	Advanced Specialist Pharmacist - Medicines Governance (Patient Group Directions and Medicines Mechanisms), NHS Specialist Pharmacist Services (SPS)
Ed Gardner	Advanced Paramedic Practitioner/Emergency Care Practitioner, Primary Care Based, Southborne Surgery
Shilan Ghafoor	Lead Medicines Governance Pharmacist, Medicines Governance, UKHSA
Michelle Jones	Principal Medicines Optimisation Pharmacist, NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board
Elizabeth Luckett	Senior Screening and Immunisation Manager, Screening and Immunisation Team – Kent and Medway, NHS England – South East
Dr Vanessa MacGregor	Consultant in Communicable Disease Control, East Midlands Health Protection Team, UKHSA
Lesley McFarlane	Lead Immunisation Nurse Specialist, Immunisation Programmes – UKHSA
Briony Mason	Vaccination Manager and Professional Midwifery Advocate, Vaccination and Screening, NHS England –West Midlands

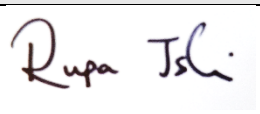
2. Organisational authorisation

The PGD is not legally valid until it has had the relevant organisational authorisation.

The fields in this section cannot be used to alter, amend or add to the clinical or other PGD content (sections 3 to 6 inclusive). Such action will invalidate the UKHSA clinical content authorisation which is provided in accordance with the regulations. See page one for full details.
It is the responsibility of the organisation that has legal authority to authorise the PGD, to ensure that all legal and governance requirements are met. The authorising body accepts governance responsibility for the appropriate use of the PGD.

NHS England (South West) authorises this PGD for use by the services or providers listed below:

Authorised for use by the following organisations and/or services
All NHS England commissioned immunisation services within • Bath & North East Somerset, Swindon, and Wiltshire • Bristol, North Somerset, and South Gloucestershire • Cornwall and the Isles of Scilly • Devon • Dorset • Gloucestershire • Somerset
Limitations to authorisation
This patient group direction (PGD) must only be used by the registered healthcare practitioners identified in Section 3 who have been named by their organisation to practice under it. The most recent in-date final version authorised by NHS England (South West) must be used. This PGD includes vaccination of individuals across the national immunisation programme. Users of this PGD should note that where they are commissioned to immunise certain groups this PGD does not constitute permission to offer immunisation beyond the groups they are commissioned to immunise.

Organisational approval (legal requirement)			
Role	**Name**	**Sign**	**Date**
Deputy Medical Director for Primary Care and Responsible Officer, South West Region, NHSE	Dr Rupa Joshi		18 May 2026

Additional signatories according to locally agreed policy			
Role	**Name**	**Sign**	**Date**

Local enquiries regarding the use of this PGD may be directed england.swvast@nhs.net.

Section 7 provides a practitioner authorisation sheet. Individual practitioners must be authorised by name to work to this PGD. Alternative practitioner authorisation sheets may be used where appropriate in

accordance with local policy but this should be an individual agreement or a multiple practitioner authorisation sheet as included at the end of this PGD.

3. Characteristics of staff

Qualifications and professional registration	**All practitioners should only administer vaccination where it is within their clinical scope of practice to do so. Practitioners must also fulfil the additional requirements and continued training requirements to ensure their competency is up to date, as outlined in the section below**. Practitioners working to this PGD must also be one of the following currently registered professionals who can legally supply and administer under a PGD: • nurses and midwives currently registered with the Nursing and Midwifery Council (NMC) • pharmacists and pharmacy technicians currently registered with the General Pharmaceutical Council (GPhC) (Note: this PGD is not relevant to privately provided community pharmacy services) • dieticians, occupational therapists, paramedics, physiotherapists and podiatrists currently registered with the Health and Care Professions Council (HCPC) Check section 2 (Limitations to authorisation) to confirm whether all practitioners listed above have organisational authorisation to work under this PGD.
Additional requirements	Additionally, practitioners: • must be authorised by name as an approved practitioner under the current terms of this PGD before working to it • must have undertaken appropriate training for working under PGDs for supply and administration of medicines • must be competent in the use of PGDs (see NICE Competency framework for health professionals using PGDs) • must be familiar with the vaccine product and alert to changes in the Summary of Product Characteristics (SPC), Immunisation Against Infectious Disease (the Green Book) and national and local immunisation programmes • must have undertaken training appropriate to this PGD as required by local policy and in line with the National Minimum Standards and Core Curriculum for Immunisation Training • must be competent to undertake immunisation and to discuss issues related to immunisation • must be competent in the handling and storage of vaccines and management of the cold chain • must be competent in the appropriate administration method for the vaccines listed in this PGD • must be competent in the recognition and management of anaphylaxis • must have access to the PGD and associated online resources • should fulfil any additional requirements defined by local policy **The individual practitioner must be authorised by name, under the current version of this PGD before working according to it.**
Continued training requirements (continued over page)	Practitioners must ensure they are up to date with relevant issues and clinical skills relating to immunisation and management of anaphylaxis, with evidence of appropriate Continued Professional Development (CPD). Practitioners should be constantly alert to any subsequent recommendations from the UKHSA, NHS England and other sources of medicines information. Note: the most current national recommendations should be followed but a Patient Specific Direction (PSD) may be required to administer the vaccine in

Continued training requirements (continued)	line with updated recommendations that are outside the criteria specified in this PGD.

4. Clinical condition or situation to which this PGD applies

Clinical condition or situation to which this PGD applies	Immunisation of individuals from the age of 12 months for the prevention of measles during a community outbreak in line with the national measles guidelines, when the individual is ordinarily eligible for the MMRV vaccine and the recommendation for use is in line with specific advice from UKHSA Health Protection Teams (HPTs)
Criteria for inclusion	Any child born on or after 1 January 2020 should routinely be given MMRV if they are un- or under-vaccinated against measles. Any child born on or before 31 December 2019 should be given MMR if they are un- or under-vaccinated against measles. However, in an outbreak, UKHSA may recommend flexibility in the choice of vaccine option given in order to manage vaccine supply, ensure timely protection against measles, and take account of local circumstances. An outbreak includes both an outbreak confined to a setting, for example a school, and a period of increased community transmission in which there may be increased demand among previously unvaccinated individuals. See also special considerations and additional information – situations where this PGD should be used instead of the MMRV PGD **Criteria:** Individuals who are unvaccinated, incompletely vaccinated or have an unknown MMRV/MMR vaccination status with a date of birth (DOB) on or after 1 January 2020 **and**: (i) the individual is 12 months of age and over at the time of presentation (use the MMR PGD if they are currently 6 months to under 12 months old) **and** (ii) the individual is identified as requiring protection as part of a measles outbreak and in line with the national measles guidance **and** (iii) the recommendation to use MMR outside of recommended guidance is in line with specific advice from the UKHSA Health Protection Teams **Children who have 2 doses of MMR vaccine under this PGD remain eligible for MMRV appropriate to their age under the national MMRV programme. See the MMRV PGD.**
Criteria for exclusion[2] (continued over page)	Individuals for whom no valid consent has been received (or for whom a best-interests decision in accordance with the Mental Capacity Act 2005, has not been obtained). For further information on consent, see chapter 2 of the Green Book). Several resources are available to inform consent (see written information to be given to individual, parent or carer section). Individuals who: • are aged under 12 months at the time of presentation or born on or before 31 December 2019.The MMR PGD already enables these groups to be offered the MMR vaccine in a measles outbreak

[2] Exclusion under the PGD does not necessarily mean the medication is contraindicated, but it would be outside its remit and another form of authorisation will be required

Criteria for exclusion[3] (continued)	• have had a confirmed anaphylactic reaction to a previous dose of any measles, mumps or rubella containing vaccine or to any components of the vaccine. These may include neomycin or gelatine (refer to relevant SPC) • have a primary or acquired immunodeficiency state (see the Green Book chapter 6 for more detail) • are on current or recent high dose immunosuppressive or biological therapy (see the Green Book chapter 6 for more detail) • have received a live varicella-containing or yellow fever vaccine in the preceding 4 weeks, unless protection against measles is rapidly required (see drug interactions) • have received blood products, such as immunoglobulins, in the preceding 3 months, unless protection against measles is rapidly required (see drug interactions) • are awaiting reading of a tuberculin (Mantoux) skin test, unless protection against measles is rapidly required (see drug interactions) • are suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for immunisation) • have already received 2 doses of MMR-containing vaccine (including MMRV) at an appropriate age to be considered effective (see also special considerations and additional information– early vaccination due to travel, outbreak or contact with a probable or confirmed case of measles)
Cautions including any relevant action to be taken (continued over page)	Facilities for management of anaphylaxis should be available at all vaccination sites (see chapter 8 of the Green Book and advice issued by the Resuscitation Council UK). Individuals who are immunosuppressed or who are living with HIV, but who are not contraindicated to receive this live vaccine (see the Green Book chapter 6) may not make a full antibody response and revaccination upon cessation of treatment or clinical recovery may be required. This should be discussed with the appropriate specialist and the repeat dose administered under a PSD. If idiopathic thrombocytopenic purpura (ITP) has occurred within 6 weeks of the first dose of MMR, then blood should be taken and tested for measles antibodies before a second dose is given. Serum should be sent to the UKHSA Virus Reference Department, which offers free, specialised serological testing for such children. If the results suggest a lack of immunity against measles, then a second dose of MMR is recommended. The presence of a neurological condition is not a contraindication to immunisation but if there is evidence of current neurological deterioration, deferral of vaccination may be considered, to avoid incorrect attribution of any change in the underlying condition. The risk of such deferral should be balanced against the risk of the preventable infection, and vaccination should be promptly given once the diagnosis or the expected course of the condition (or both) becomes clear.There will be very few occasions when deferral of immunisation is required. Deferral leaves the child unprotected and so the period of deferral should be minimised, with immunisation commencing as soon as possible. If a specialist recommends deferral, this should be clearly communicated to the individual's primary care provider, who must be informed as soon as the child is fit for immunisation. Children

[3] Exclusion under the PGD does not necessarily mean the medication is contraindicated, but it would be outside its remit and another form of authorisation will be required

Cautions including any relevant action to be taken (continued)	with a personal or close family history of seizures should still be given the MMR vaccine. Priorix® contains 334 micrograms of phenylalanine per 0.5ml dose. MMRVAXPRO® also contains a source of phenylalanine. Though phenylalanine may be harmful to individuals with phenylketonuria (PKU), such individuals (or their parent or carer) will be well versed as to the amounts of phenylalanine tolerable in their diet. The National Society for Phenylketonuria (NSPKU) advise the amount of phenylalanine contained in vaccines is negligible and therefore strongly advise individuals with PKU to take up the offer of immunisation. Syncope (fainting) can occur following, or even before any vaccination especially in adolescents as a psychogenic response to the needle injection. This can be accompanied by several neurological signs such as transient visual disturbance, paraesthesia and tonic-clonic limb movements during recovery. It is important that procedures are in place to avoid injury from faints.
Action to be taken if the individual is excluded (continued over page)	Individuals who have had a confirmed anaphylactic reaction to a previous dose of MMR vaccine or any components of the vaccine should be referred to a clinician for specialist advice and appropriate management. The existing MMR PGD already outlines provision for those with a DOB on or before 31 December 2019, including for post-exposure protection from measles. The existing MMR PGD already has provision for administering the vaccine to at-risk individuals between 6 and 12 months of age and the dose should instead be administered under the MMR PGD. For children aged between 9 and 12 months requiring measles protection and where MMR is unavailable, MMRV can be administered under the MMRV PGD. Individuals who have a primary or acquired immunodeficiency state or who are currently, or were recently on high dose immunosuppressive or biological therapy (see chapter 6) should consult the appropriate specialist regarding the individual's immune status and suitability for receiving live MMR vaccine. Where administration of MMR is advised, a PSD will be required. Further information to guide suitability of the MMR vaccine for individuals living with HIV is available in Table 1, in the measles chapter of the Green Book. Individuals who have been immunised against varicella (live vaccine),or yellow fever within the last 4 weeks, or received blood products in the preceding 3 months, and do not require rapid protection against measles, mumps or rubella should defer immunisation until the appropriate minimum interval has been observed (see drug interactions section). Individuals who are awaiting reading of a tuberculin (Mantoux) test should delay MMR vaccination until the skin test has been read, unless protection against measles is urgently required. In case of postponement due to acute severe febrile illness, advise when the individual can be vaccinated and ensure another appointment is arranged at the earliest opportunity. Seek appropriate advice from the local Screening and Immunisation Team, local Health Protection Team or the individual's clinician as appropriate. The risk to the individual of not being immunised must be taken into account. Document the reason for exclusion and any action taken in the individual's clinical records.

Action to be taken if the individual is excluded (continued)	Inform or refer to the GP or a prescriber as appropriate.
Action to be taken if the individual, parent or carer declines treatment	Advise the individual, parent or carer about the protective effects of the vaccine, the risks of infection and the potential complications of disease. Document the advice given and the decision reached. Inform or refer to the GP or a prescriber as appropriate.
Arrangements for referral for medical advice	As per local policy

5. Description of treatment

Name, strength and formulation of drug	Measles, mumps and rubella vaccine (live): • Priorix®, powder and solvent for solution for injection in a pre-filled syringe • MMRVAXPRO®, powder and solvent for suspension for injection in a pre-filled syringe
Legal category	Prescription only medicine (POM)
Black triangle▼	No
Off-label use	The vaccine should be stored according to the conditions detailed in the storage section below. However, in the event of inadvertent or unavoidable deviations of these conditions, refer to Vaccine Incident Guidance. Where vaccines are assessed in accordance with these guidelines as appropriate for continued use, this would constitute off-label administration under this PGD. Where a vaccine is recommended off-label consider, as part of the consent process, informing the individual, parent or carer that the vaccine is being offered in accordance with national guidance but outside of product licence.
Route and method of administration (continued over page)	The vaccine must be reconstituted in accordance with the manufacturer's instructions prior to administration. The deltoid muscle of the upper arm may be used in individuals over one year of age. When administering at the same time as other vaccines, care should be taken to ensure that the appropriate route of injection is used for all vaccinations. The vaccines should be given at separate sites, preferably in different limbs. If given in the same limb, they should be given at least 2.5cm apart. The site at which each vaccine was given should be noted in the individual's records. Individuals with bleeding disorders may be vaccinated intramuscularly if, in the opinion of a clinician familiar with the individual's bleeding risk, vaccines or similar small volume intramuscular injections can be administered with reasonable safety by this route. If the individual receives medication or other treatment to reduce bleeding, for example treatment for haemophilia, intramuscular vaccination can be scheduled shortly after such medication or treatment is administered. Individuals on stable anticoagulation therapy, including individuals on warfarin who are up to date with their scheduled INR testing and whose latest INR was below the upper threshold of their therapeutic range, can receive intramuscular vaccination. A fine needle (equal to 23 gauge or finer calibre such as 25 gauge) should be used for the vaccination, followed by firm pressure applied to the site (without rubbing) for at least 2 minutes. The individual or carer should be informed about the risk of haematoma from the injection. Both Priorix® and MMRVAXPRO® are licensed to be given by either the intramuscular or subcutaneous route. A healthcare professional may determine the subcutaneous route is the preferred route of administration for an individual with a bleeding disorder. Note fewer injection site reactions were reported with the intramuscular route compared with the subcutaneous route following administration of MMRVAXPRO®. The vaccine should be visually inspected for foreign particulate matter and other variation of expected appearance prior to preparation and

Route and method of administration (continued)	administration. Should either occur, do not administer the dose and discard the vaccine in accordance with local procedures. Upon reconstitution, Priorix® is a clear peach to fuchsia pink solution. MMRVAXPRO® forms a clear yellow liquid. The vaccine SPC provides further guidance on preparation and administration.
Dose and frequency of administration	Single 0.5ml dose per administration. In cases of post-exposure vaccination, the dose should ideally be given within 3 days of exposure to maximise vaccine efficacy. Where the MMR vaccine has been given within 3 months of a blood transfusion, or within 4 weeks of a live vaccine, the dose will need to be repeated and this PGD may be used to administer this dose. See the drug interactions section for more information. **Doses given under this PGD should not be counted towards the 2 dose MMRV offer** for children with a DOB on or after 1 January 2020. See the MMRV eligibility tables and vaccination of individuals with uncertain or incomplete immunisation status for further information. The MMRV vaccine should be offered when it is due according to the national schedule. There should be a minimum 4 week interval between the MMRV vaccine and any MMR dose that has been given for protection in an outbreak situation.
Duration of treatment	Up to 2 doses of 0.5ml at the recommended interval (see dose and frequency of administration above). Doses given within 4 weeks of previous yellow fever, live varicella-containing vaccine or within 3 months of receiving blood products will need to be repeated (see drug interactions and dose and frequency of administration sections).
Quantity to be supplied and administered	Single 0.5ml dose per administration.
Supplies	Centrally purchased vaccines for the national immunisation programme for the NHS can only be ordered via ImmForm. Vaccines for use for the national immunisation programme are provided free of charge. National stock may also be used for catch-up vaccination of individuals of any age. Protocols for the ordering, storage and handling of vaccines should be followed to prevent vaccine wastage (see the Green Book chapter 3).
Storage (continued over page)	Store between +2°C to +8°C. Store in original packaging in order to protect from light. Do not freeze. After reconstitution, the vaccine should be administered promptly or stored between +2°C to +8°C and used within 8 hours of reconstitution. If not used after this time, the vaccine must be discarded. In the event of an inadvertent or unavoidable deviation of these conditions, vaccines that have been stored outside the conditions stated above should be quarantined and risk assessed for suitability of continued off-label use or appropriate disposal. Refer to Vaccine Incident Guidance. Contact the vaccine manufacturer where more specific advice is required about managing a temperature excursion.

Disposal	Follow local clinical waste policy and standard operating procedures to ensure safe and secure waste disposal. Equipment used for immunisation, including used vials, ampoules, or discharged vaccines in a syringe or applicator, should be disposed of safely in a UN-approved puncture-resistant sharps box, according to local waste disposal arrangements and NHS England guidance (HTM 07-01): safe and sustainable management of healthcare waste.
Drug interactions	The immunological response may be diminished in those receiving immunosuppressive treatment. Vaccination is recommended even if the antibody response may be limited (see criteria for exclusion). MMR vaccine may be given at the same time as inactivated vaccines or at any interval before or after. MMR may attenuate the response to other live vaccines (see Table 11.4: Recommended time intervals when giving more than one live attenuated vaccine, in chapter 11 of the Green Book). Where protection against measles is required rapidly, other live vaccines and MMR should be given at any interval. The response may be suboptimal if yellow fever and MMR vaccines are co-administered or given within a 4 week interval; an additional dose of MMR should be given. If live varicella-containing vaccines are not co-administered at the same time as MMR, a 4 week minimum interval should be observed or consideration be given to administering an additional dose of MMR. If protection against measles is urgently required, then the benefit of protection from the vaccine outweighs the potential interference with a tuberculin (Mantoux) test. In this circumstance, the individual interpreting the negative tuberculin test should be made aware of the recent MMR vaccination when considering how to manage that individual. When MMR is given within 3 months of receiving blood products, such as immunoglobulin, the response to the measles component may be reduced. This is because such blood products may contain significant levels of measles-specific antibody, which could then prevent vaccine virus replication. Where possible, MMR should be given at least one month before or deferred until 3 months after receipt of such products. If immediate measles protection is required in someone who has recently received a blood product, MMR vaccine should still be given. To confer longer-term protection, MMR should be repeated after 3 months. A detailed list of drug interactions associated with the MMR vaccine is available from the product's SPC.
Identification and management of adverse reactions (continued over page)	Adverse reactions are attributed to effective replication of the vaccine viruses, with subsequent mild illness. Events due to the measles component occur 6 to 11 days after vaccination. Events due to the mumps and rubella components usually occur 2 to 3 weeks after vaccination but may occur up to 6 weeks after vaccination. Individuals with vaccine-associated symptoms are not infectious to others. The most common adverse reactions are fever and injection site reactions including pain, swelling and erythema. Rash is also commonly reported. Malaise, fever or a rash (or a combination of these) most commonly occur about a week after immunisation, lasting around 2 to 3 days. Upper respiratory tract infection was commonly reported in clinical trial data for Priorix®.

Identification and management of adverse reactions (continued)	Adverse reactions are less common after a second dose of MMRVAXPRO® vaccine than after the first dose; incidence and severity of adverse reactions following a second dose with Priorix® are broadly similar. Hypersensitivity reactions and anaphylaxis can occur but are very rare **Rare and more serious events** Febrile seizures, generally considered benign and short lived are the most commonly reported neurological event following measles immunisation. The rate of febrile seizures following MMR vaccination is lower than that following infection with measles disease and the absolute risk of febrile seizures remains low. Arthropathy (arthralgia or arthritis) has also been reported to occur rarely after MMR immunisation, probably due to the rubella component. If it is caused by the vaccine, it should occur between 14 and 21 days after immunisation. Where it occurs at other times, it is highly unlikely to have been caused by vaccination. The incidence rate is higher and the reaction more marked in adult females, though such reactions are generally well tolerated. ITP has occurred rarely following MMR vaccination, usually within 6 weeks of the first dose and resolves spontaneously. The risk of developing ITP after MMR vaccine is much less than the risk of developing it after infection with wild measles or rubella virus (see cautions). Further details on adverse reactions following MMR vaccine can be found in the Green Book chapters on measles, mumps and rubella. A detailed list of adverse reactions is available from the product's SPC.
Reporting procedure of adverse reactions	Healthcare professionals and individuals, parents or carers are encouraged to report suspected adverse reactions to the Medicines and Healthcare products Regulatory Agency (MHRA) using the Yellow Card reporting scheme or by searching for MHRA Yellow Card in the Google Play or Apple App Store. Any adverse reaction to a vaccine should be documented in the individual's record and the individual's GP should be informed
Written information to be given to individual, parent or carer	Offer the marketing authorisation holder's patient information leaflet (PIL) provided with the vaccine. For resources in accessible formats and alternative languages, please visit Find Public Health resources. Where applicable, inform the individual, parent or carer that large print, Braille or audio CD PILs may be available from emc accessibility by providing the medicine name and product code number, as listed on the product's SPC. Immunisation promotional material may be provided as appropriate: • MMR for all • have you had your MMR vaccines? • measles- protect yourself, protect others • think measles - it's not just a kids problem • measles: information for schools and healthcare centres • measles outbreak resources
Advice and follow up treatment (continued over page)	Inform the individual, parent or carer of possible side effects and their management. Advise about likely timing of and subsequent management of a fever. The individual, parent or carer should be advised to seek medical advice in the event of an adverse reaction and report this via the Yellow Card

Advice and follow up treatment (continued)	reporting scheme. When administration is postponed, advise the individual, parent or carer when to return for vaccination. Advise the individual, parent or carer when the subsequent dose(s) of MMRV vaccine are due, as vaccination under this PGD does not afford the individual immunity against chickenpox. The dose of MMRV should be scheduled at least 4 weeks after the dose of MMR vaccine was given.
Special considerations and additional information (continued over page)	Ensure there is immediate access to adrenaline (epinephrine) 1 in 1000 injection and access to a telephone at the time of vaccination. **Situations where this PGD should be used, instead of the MMRV PGD** It is a condition of use for this PGD that offering the MMR vaccine outside of recommended guidance is only advised following a discussion with the local HPT when a measles outbreak has occurred. Examples of situations where this PGD may be used include (but is not limited to): (i) the increased demand upon the MMRV supply chain means that urgent vaccination with the MMR vaccine is required to safeguard against the immediate public health risk posed by the measles outbreak (ii) the demographic of the community to be protected against the outbreak is not known in advance (for example, in a Traveller community) and individuals risk being lost to follow up through the MMRV vaccine not being immediately available at the time of the visit (iii) an unimmunised child risks being lost to follow-up or left unprotected where the parents of that child have not consented to the MMRV vaccine **Children who receive MMR under this PGD remain eligible for MMRV and must still be called and recalled for their MMRV vaccination offer. Any doses given under this PGD should therefore be discounted and the child should be vaccinated under the MMRV PGD according to their ongoing eligibility.** **Post exposure** Antibody responses to the rubella and mumps components of MMR vaccine do not develop soon enough to provide effective prophylaxis after exposure to these infections. However, as vaccine-induced measles antibody develops more rapidly than that following natural infection, MMR vaccine should be used to protect susceptible contacts from suspected measles. To be effective against this exposure, vaccine must be administered very promptly and ideally within 3 days. Even where it is too late to provide effective post-exposure prophylaxis with MMR, the vaccine can provide protection against future exposure to all 3 infections. Therefore, contact with suspected measles, mumps or rubella provides a good opportunity to offer MMR vaccine to previously unvaccinated individuals. If the individual is already incubating measles, mumps or rubella, MMR vaccination will not exacerbate the symptoms. In these circumstances, individuals should be advised that a measles, mumps or rubella-like illness occurring shortly after vaccination is likely to be due to natural infection.

Special considerations and additional information (continued)	Immunoglobulin may be indicated for contacts of measles who are infants, immunosuppressed or pregnant. Provision of immunoglobulin is not covered by this PGD (see national measles guidelines for eligibility). **Egg allergy and porcine content** Data suggests that anaphylactic reactions to MMR vaccine are not associated with hypersensitivity to egg antigens. All children with egg allergy should receive the MMR vaccination as a routine procedure in primary care. MMRVAXPRO® (Sanofi Pasteur MSD) contains porcine gelatine. Priorix® (GSK) does not contain porcine gelatine and can be offered as an alternative to MMRVAXPRO®. Health professionals should be aware of the need to order Priorix® when running clinics for relevant communities (see vaccines and porcine gelatine leaflet). **Early vaccination outside of recommended schedules due to travel, outbreak or contact with a probable or confirmed case of measles** For individuals aged 12 months and over, a second dose of MMR-containing vaccine should be given. For those still on the routine schedule, this should be given when due according to the schedule unless there is a reason to give it earlier. For individuals who did not complete their 2 dose course according to the schedule, the second dose should be given a minimum of 4 weeks after the first dose. Where a child needs to receive 2 doses under 18 months of age, a 3 month interval should preferably be left between doses. If this is not possible, a further routine dose should be given from 18 months of age (as MMRV), in order to ensure full protection and avoid interference from maternal antibodies. Individuals aged 18 months and over who have not received MMR or MMRV vaccines, or who received a dose of measles-containing vaccine before the age of one should receive 2 doses of MMR-containing vaccine at least one month apart. MMR vaccine is recommended when protection against measles, mumps or rubella (or a combination of the 3) is required. MMR vaccine can be given irrespective of a history of measles, mumps or rubella infection or vaccination. There are no ill effects from vaccinating those who are already immune. If there is doubt about an individual's MMR immune status, MMR vaccine should still be given. Children coming from abroad may not have been immunised against measles, mumps and rubella. Unless there is a reliable history of appropriate immunisation, individuals should be assumed to be unimmunised. See chapter 11 for more information. Children with chronic conditions such as cystic fibrosis, congenital heart or kidney disease, failure to thrive or Down's syndrome are at particular risk from measles infection and should be immunised with MMR vaccine without delay.
Records (continued over page)	The practitioner must ensure the following is recorded: • that valid informed consent was given or a decision to vaccinate was made in the individual's best interests in accordance with the Mental Capacity Act 2005 • name of individual, address, date of birth and GP with whom the individual is registered (or record where an individual is not registered with a GP) • name of immuniser • name and brand of vaccine • date of administration • dose, form and route of administration of vaccine • quantity administered

Records (continued)	• batch number and expiry date • anatomical site of vaccination • advice given, including advice given if the individual is excluded or declines immunisation • details of any adverse drug reactions and actions taken • supplied via PGD Records should be signed and dated (or password-controlled on e-records). All records should be clear, legible and contemporaneous. This information should be recorded in the individual's GP record. Where vaccine is administered outside the GP setting, appropriate health records should be kept and the individual's GP informed. Notify the local Child Health Information Systems (CHIS) team using the appropriate documentation or pathway as required by any local or contractual arrangement. PGD use should be audited as part of an organisation's medicines audit programme. An audit tool is available from NHS Specialist Pharmacy Services (SPS).

6. Key references

Key references	MMR vaccine • Immunisation Against Infectious Disease: the Green Book chapters on measles, mumps and rubella, Chapter 6 and Chapter 11 • Introduction of a routine varicella (MMRV) vaccination programme (NHS system letter), published 31 October 2025 https://www.gov.uk/government/publications/introduction-of-a-routine-varicella-mmrv-vaccination-programme • Summary of Product Characteristics for Priorix®, GlaxoSmithKline, last updated 2 January 2026 www.medicines.org.uk/emc/medicine/2054 • Summary of Product Characteristics for MMRVAXPRO®, MSD Ltd, last updated 5 January 2026 www.medicines.org.uk/emc/medicine/20968 • MSD Medical Information, Personal communication (via email), 13 December 2023 • UKHSA National measles guidelines, last updated 2 April 2026 https://www.gov.uk/government/publications/national-measles-guidelines • Vaccination of individuals with uncertain or incomplete immunisation status, UKHSA www.gov.uk/government/publications/vaccination-of-individuals-with-uncertain-or-incomplete-immunisation-status • The National Society for Phenylketonuria (NSPKU) Medical Advisory Panel: Vaccines and PKU, issued 2 October 2024 https://nspku.org/download/vaccines-and-pku/ **General** • NHSE Health Technical Memorandum 07-01: safe and sustainable management of healthcare waste, updated 7 March 2023 www.england.nhs.uk/publication/management-and-disposal-of-healthcare-waste-htm-07-01/ • National Minimum Standards and Core Curriculum for Immunisation Training www.gov.uk/government/publications/national-minimum-standards-and-core-curriculum-for-immunisation-training-for-registered-healthcare-practitioners • NICE Medicines Practice Guideline 2 (MPG2): Patient Group Directions, last updated March 2017 www.nice.org.uk/guidance/mpg2 • NICE MPG2 Patient group directions: competency framework for health professionals using patient group directions, updated January 2018 www.nice.org.uk/guidance/mpg2/resources • UKHSA Immunisation Collection www.gov.uk/government/collections/immunisation • Vaccine Incident Guidance, last updated July 2022 www.gov.uk/government/publications/vaccine-incident-guidance-responding-to-vaccine-errors

7. Practitioner authorisation sheet

MMR vaccine for use in community measles outbreaks PGD v1.0
Valid from: 1 May 2026 Expiry: 31 March 2029

Before signing this PGD, check that the document has had the necessary authorisations in section 2. Without these, this PGD is not lawfully valid.

Practitioner

By signing this PGD, you are indicating that you agree to its contents and that you will work within it. PGDs do not remove inherent professional obligations or accountability.

It is the responsibility of each professional to practice only within the bounds of their own competence and professional code of conduct.

I confirm that I have read and understood the content of this PGD and that I am willing and competent to work to it within my professional code of conduct.			
Name	Designation	Signature	Date

Authorising manager

I confirm that the practitioners named above have declared themselves suitably trained and competent to work under this PGD. I give authorisation on behalf of **insert name of organisation** for the above named healthcare professionals who have signed the PGD to work under it.			
Name	Designation	Signature	Date

Note to authorising manager

Score through unused rows in the list of practitioners to prevent practitioner additions post managerial authorisation.

This authorisation sheet should be retained to serve as a record of those practitioners authorised to work under this PGD.