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Date of issue: Wednesday, 9 January 2019

MEETING:	**HEALTH SCRUTINY PANEL** (Councillors A Sandhu (Chair), Smith (Vice Chair), Ali, Chaudhry, M Holledge, Matloob, Qaseem, Shah and Strutton) **NON-VOTING CO-OPTED MEMBERS** Healthwatch Representative Buckinghamshire Health and Adult Social Care Select Committee Representative
DATE AND TIME:	THURSDAY, 17TH JANUARY, 2019 AT 6.30 PM
VENUE:	VENUS SUITE 2, ST MARTINS PLACE, 51 BATH ROAD, SLOUGH, BERKSHIRE, SL1 3UF
DEMOCRATIC SERVICES OFFICER: **(for all enquiries)**	NICHOLAS PONTONE 01753 875120

NOTICE OF MEETING

You are requested to attend the above Meeting at the time and date indicated to deal with the business set out in the following agenda.

JOSIE WRAGG
Chief Executive

AGENDA

PART I

AGENDA ITEM	REPORT TITLE	PAGE	WARD
APOLOGIES FOR ABSENCE			
CONSTITUTIONAL MATTERS			
1.	Declarations of Interest	-	-

All Members who believe they have a Disclosable

AGENDA ITEM	REPORT TITLE	PAGE	WARD
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2.	Minutes of the Last Meeting held on 21st November 2018	1 - 6	-
3.	Action Progress Report	7 - 8	-
SCRUTINY ISSUES			
4.	Member Questions *(An opportunity for Panel Members to ask questions of the relevant Director/ Assistant Director, relating to pertinent, topical issues affecting their Directorate – maximum of 10 minutes allocated).*	-	-
5.	First Annual Report on Immunisations & Screening in Slough	9 - 66	All
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8.	Forward Work Programme	75 - 80	-
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10.	Date of Next Meeting – 25th March 2019	-	-

Press and Public

You are welcome to attend this meeting which is open to the press and public, as an observer. You will however be asked to leave before the Committee considers any items in the Part II agenda. Please contact the Democratic Services Officer shown above for further details.

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Health Scrutiny Panel – Meeting held on Wednesday, 21st November, 2018.

Present:- Councillors A Sandhu (Chair), Smith (Vice-Chair), Chaudhry, M Holledge, Matloob, Qaseem (from 6.46pm) and Shah

Non-Voting Co-optee – Colin Pill, Slough Healthwatch representative

Apologies for Absence:- Councillors Ali and Strutton

PART I

36. Declarations of Interest

No declarations were made.

37. Minutes of the Last Meeting held on 16th October 2018

Resolved – That the minutes of the last meeting held on 16th October 2018 be approved as a correct record.

38. Action Progress Report

The Panel noted the progress being made on the actions agreed at recent meetings. The Members visit to Respond and Lavender Court would be arranged in the new year. All other actions were either completed or ongoing.

Resolved – That details of the Action Progress Report be noted.

39. Member Questions

No questions from Members had been submitted.

40. Frimley Health and Care System Winter Planning 2018/19

The Commissioning Manager from East Berkshire Clinical Commissioning Group (CCG), Ben Cox, gave a presentation on the winter planning arrangements for the Frimley Health and Care system including details of system planning, implementation arrangements, governance and resilience arrangements for 2018/19.

The objective was to ensure the system was resilient through the winter period and could provide safe, effective and sustainable care for local people. An Urgent & Emergency Care Delivery Plan 2018/19 was in place and there were well established operational procedures between partners to increase resilience by managing discharges, capacity and flow to seek to meet the increased demands during this period. Specific actions included extended GP access from December, the promotion of NHS 111 online from January and additional staffing and capacity where appropriate. From February 2019 an additional 39 beds would be made available at Wexham Park Hospital in the

new accident and emergency block. The plans sought to learn from local experiences in previous years and good practice from elsewhere. Linkages were made to national campaigns and communication activity such as 'stay well this winter'.

(Councillor Qaseem joined the meeting)

Members raised a number of issues which are summarised as follows:

- Adverse weather – there was provision this year to receive forecasts from the Met Office to help predict and plan for bad weather as far as possible. Ensuring staff could get in to work during poor weather was a major issue and 4x4 vehicles and other measures were in place to mitigate this risk.

- GP access and capacity – there was increased primary care streaming at Wexham Park Hospital and there was 24 hour, 7 day a week provision at the GP Unit. The 39 new beds at A&E would be available from February and it wouldn't be possible to make them available earlier.

- Information and communication – Members emphasised the importance of a communications plan to make residents aware where best and when to access the most appropriate services, particularly extended hours for GPs. It was suggested that Healthwatch could assist with the dissemination of leaflets and posters.

- Flu jab – there was a good level of uptake from the flu jab this year, despite some issues with supplies. A high proportion of the healthcare workforce had received the jab and Members were encouraged to take up the offer.

The Panel was assured that winter planning was stronger this year and had been based on what had worked in previous years. However, it was expected that there would be pressures on the system due to the very high levels of demand but plans were in place to resolve issues as soon as possible. An escalation process was in place with the Integrated Care System Board if required.

Resolved – That the update on winter planning arrangements for the Frimley Health and Care system be noted.

41. Frimley Health and Care Integrated Care System

The Director of Adults and Communities updated on the progress being made to deliver the Frimley Health and Care Integrated Care System (ICS) and the 'Big Conversation' led by the CCG on the future of urgent care services.

The ICS draft operating plan was being drafted and would be circulated to the Panel when available. The ICS Chair, Sir Andrew Morris, would leave the role

in December and an independent chair and senior responsible officer would be appointed.

The 'Big Conversation' on urgent care had generated feedback from 2,300 people across East Berkshire of which circa 500 were from Slough. The responses were being reviewed and it was noted that a majority of people said they had wanted to see their GP first if they had an urgent care need. A revised timetable had been agreed by the CCG Governing Body with models for future delivery being developed through to May 2019. This would be followed by a shortlist of models and consultation if required. A decision on the service model was due in September 2019.

The new 10-year plan for the NHS was due to be published in the next few weeks and was expected to mark a shift towards prevention and early intervention. Members discussed the likely budget implications. The Green Paper on adult social care was due to be published at around the same time and was likely to set out a range of options for long term funding. It was agreed that summaries of the NHS Plan and Green Paper would be circulated following publication.

At the conclusion of the discussion, the update was noted.

Resolved – That the progress being made in developing the Frimley Health and Care ICS and 'Big Conversation' on urgent care be noted.

42. Air Quality and Health in Slough

The Public Health Programme Manager, Fatima Ndanusa, and the Technical Officer for Air Quality and Environmental Noise, Sophia Norfolk, introduced a report on the links between air quality and health in Slough that sought to provide further information on the key areas of concern previously raised by Members including:

- Slough's mortality rate attributable to air pollution;
- The causes of the mortality rate;
- The distribution of associated health conditions across the population;
- Any plans to review the action plan; and
- Future arrangements for air quality monitoring.

The Panel received information on the principle causes of air pollution that included proximity to the motorway network, cross boundary effects from London and the continent, incineration and electricity generation and emissions from airplane take-off at Heathrow and unburned jet fuel. In the latest figures from 2016, 6.2% of all cause adult mortality was attributed to particulate air pollution, which was higher than the national average of 5.3% and 5.5% in the South East. This equated to approximately 51 people in Slough, although it was noted that the mortality rate may be relatively higher because cardiovascular and respiratory health were already poor locally. There was strong evidence between air pollution and major diseases such as heart disease, stroke, lung cancer and childhood asthma.

Members discussed the work the Council was doing to address the issues of poor air quality including the recently agreed Low Emission Strategy (LES), the five Air Quality Management Areas and the transport strategy to encourage model shift away from cars. In terms of monitoring there was an extensive monitoring network already in Slough and the data was regularly published.

The Panel discussed a number of other issues including;

- The potential risks of exercising in areas of high air pollution. Air quality varied throughout the day and the AirTEXT service was available to people to provide information. Members felt this could be more widely publicised.

- The apparent disparity in the mortality rate in the report compared to that stated in the LES. It was agreed that the figure would be clarified.

- There was a high cost of poor air quality and it was considered that this was likely to be understated. It was noted that it was difficult to accurately quantify the local costs.

Councillor Smith made a number of comments about the air pollution attributable to Slough's proximity to Heathrow airport and was concerned about the impact of the proposed third runway. The associated increase in traffic movements in the Colnbrook and Poyle area were also a concern and proper mitigation in terms of the surface access transport plan would be required to protect local residents.

The Panel welcomed the information that had been provided and it was agreed that strong action needed to be taken to address the air quality problems in Slough. It was noted that the LES had recently been agreed and the detailed action plans emerging from the strategy with health implications were likely areas of future scrutiny that the Panel could add to its work programme. At the conclusion of the discussion, the report was noted.

Resolved – That the report be noted.

43. Forward Work Programme

The Panel considered the Work Programme for 2018/19 and confirmed the items for the next meeting as stated.

Resolved – That the Forward Work Programme be agreed.

44. Attendance Record 2018/19

Resolved – That the Members' Attendance Record for 2018/19 be noted.

45. Date of Next Meeting - 17th January 2019

The date of the next meeting of the Panel was confirmed as 17th January 2019.

Chair

(Note: The Meeting opened at 6.30 pm and closed at 8.07 pm)

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Health Scrutiny Panel – Actions Arising from Meetings

21st November 2018

Minute:	Action:	For:	Report Back To: Date:
40	That the Panel receive a summary of the NHS 10 Year Plan and the adult social care Green Paper when published.	Adult Social Care	December 2018

16th October 2018

Minute:	Action:	For:	Report Back To: Date:
27	Member visit to be arranged to Respond and Lavender Court (instead of Priors and Phoenix Day Centres which were undergoing refurbishment).	Adult Social Care	HSP Early 2019
29	**Resolved:** That the Panel support further engagement with and contribution from communities and residents, in particular with becoming more physically active.	Public Health	HSP Ongoing
30	The Panel requested further information on: • Number of dentists and availability of NHS dentists in Slough. • Any data available on the cost of tooth extractions in Slough.	Public Health	HSP Circulated by email 30th October 2018

31	**Resolved:** a) That the area of joint working between the Panel and Slough Wellbeing Board as detailed in paragraph 5.4 of the report be agreed. b) That the Panel ask the Wellbeing Board and partners to consider how to improve the provision and access to green spaces, including in new developments, allotments etc. to improve residents activity and wellbeing. c) That the Slough Wellbeing Board receive a report on the outcomes of the Disability Task & Finish Group at its meeting in May 2019.	Scrutiny Officer Wellbeing Board Wellbeing Board	HSP Ongoing HSP Ongoing Wellbeing Board 8th May 2019
32	The Panel requested further detail on the outcomes of concern/enquiries; the types of physical abuse reported and any relevant comparative data with previous years for types of abuse.	Safeguarding Adults Board	HSP 21st November 2018

SLOUGH BOROUGH COUNCIL

REPORT TO:	Health Scrutiny Panel
DATE:	17 January 2019
REPORT AUTHORS:	Jo Jefferies, Consultant in Public Health, Public Health Services for Berkshire Nisha Jayatilleke, Screening and Immunisation Lead, NHS England South Paula Jackson, Screening and Immunisation Lead, NHS England South
CONTACT OFFICER: **(For all Enquiries)**	Dr Liz Brutus - Service Lead Public Health (SBC) (01753) 875142
WARD(S):	All

PART I
FOR COMMENT & CONSIDERATION

FIRST ANNUAL REPORT ON IMMUNISATIONS & SCREENING IN SLOUGH

1. Purpose of Report

- To provide a summary of the current commissioning and provider arrangements for immunisations and screening programmes and the organisations involved
- Provide an update on immunisation and screening programme coverage in Slough
- Highlight recent successes and key opportunities to maximise programme coverage and uptake with a view to reducing health inequalities in this area.

2. Recommendations

The Panel is recommended to:

1. Consider the actions being taken to deliver the national programmes for immunisation and screening and their progress in tackling health inequalities in Slough.
2. Review the proposed Local Action Plan in 3 – 6 months to ensure it has actions tailored to the needs of Slough and relevant partners are addressing the relatively lower uptake and health inequalities in both immunisation and screening.
3. Request an Annual Report on Immunisation and Screening from NHS England every year.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3a. Slough Joint Wellbeing Strategy Priorities

The current programme is aimed at supporting local residents to improve their health and wellbeing through improved prevention and early detection as provided through

the national immunisation and screening programmes. In particular, this work supports the Joint Wellbeing Strategy priorities:

- Protecting vulnerable children
- Increasing life expectancy by focusing on inequalities

Data from the immunisation and screening activities contribute to further developing the base of the Joint Strategic Needs Assessment and understanding the needs and health inequalities of our population..

3b. **Five Year Plan Outcomes**

The primary outcomes where delivery will be enhanced by the paper are:

- Outcome 1: Slough children will grow up to be happy, healthy and successful
- Outcome 2: Our people will be healthier and manage their own care needs

4. **Other Implications**

(a) Financial

There are no financial implications directly resulting from the recommendations of this report and outlined activities are within the current budget and resources.

(b) Risk Management - None

There are no identified risks associated with the proposed actions.

(c) Human Rights Act and Other Legal Implications

There are no Human Rights Act implications to the content of this report

(d) Equalities Impact Assessment

The content of this report does not require an Equalities Impact Assessment.

5. **Supporting Information**

Context

5.1 NHS England is responsible for commissioning screening and immunisation programmes in England. Locally this is co-ordinated and managed across Thames Valley by the Public Health Commissioning team at NHS England, South East under an agreement known as Section 7a.

5.2 Historically, Slough has had some of the lowest uptake of screening and immunisation programmes in the South East of England, contributing to poor health in both adults and children and our health inequalities. Over the last 5 years, there have also been various changes in the organisation of the commissioning and delivery nationally. This combined annual report, for the first time, therefore outlines the picture of immunisations and screening in Slough, their current provision, the challenges and opportunities and future plans.

5.3 Panel Members may find it helpful to consider 'The Ten Questions to Consider If You're Scrutinising Local Immunisation Services'[1] which have relevance for both Immunisation and Screening. In view of Slough's focus on health inequalities, Question 10 is particularly relevant. (See Appendix.)

Executive summary of Immunisations and Screening Report

5.4 The full report is in the Appendix but summarised below.

5.5 NHS England has continued to commission the services set out under the Section 7A agreement to a high standard, offering continued protection to the public. Data and evidence demonstrates that public health protection remains world class and we have achieved real success. Increasing access to screening and immunisation programmes, contributes to the wider prevention agenda and the implementation of the Five Year Forward View.

5.6 Some of the recent successes that have benefitted the local population include programmes to increase uptake and improvements to data quality for closer monitoring of progress. Examples include the development of a GP toolkit with tips and advice for primary care colleagues to improve immunisation uptake for their patients. The toolkit is implemented in many practices across Slough. In addition, data on immunisations delivered in primary care are now auto-extracted from the clinical record and entered electronically on the Child Health Information System (CHIS) which is not only more efficient but has also improved the accuracy of the data. The LA, the school immunisation provider and NHS England have worked together to agree how they will address cultural and language barriers to further improve uptake in groups with lower historic vaccination rates.

5.7 As part of the Thames Valley Cancer Alliance GP Quality Improvement Scheme, there are initiatives in place to improve cancer screening coverage as well as the safe mobilisation of the Diabetic Eye Screening programme following a contract review.

5.8 Successful collaborative working has enabled improvements in some outcomes, however there is still opportunity to improve uptake of cancer screening programmes and childrens immunisations, particularly PCV (pneumococcal) booster, second dose MMR, and the Hib/MenC booster. It is important to have a thorough understanding of opportunities and challenges that need to be considered in Slough to be able to support families take up the offer for vaccination and to work collaboratively with stakeholders to improve vaccine uptake.

5.9 There are several new opportunities ahead to implement and embed changes that will further improve screening and immunisation services locally. These include the introduction of a new screening test in the bowel screening programme, incorporating HPV primary screening into the cervical screening programme and a new booster seasonal flu immunisation for people aged 65 and over.

[1] The Ten Questions to Consider If You're Scrutinising Local Immunisation Services. Centre for Public Scrutiny. 2016. Available at: https://www.cfps.org.uk/10-questions-ask-youre-scrutinising-local-immunisation-services/

5.10 Governance and reporting arrangements are also being tightened. The Shared Public Health Team is scoping an annual Health Protection Report, drawing together key metrics and issues. The Terms of Reference of the Berkshire Health Protection Committee is also under review to ensure the committee fulfils its system assurance role, with partners providing assurance to the Strategic DPH and holding each other to account. In addition, NHS England is revising the quarterly Berkshire screening and immunisation dashboard to improve clarity and enable access for Public Health Consultants in each Local Authority.

5.11 The Report focuses on the commissioning and delivery of the screening and immunisation programmes but we also need to consider the wider determinants of health (including for example, income levels, education and skills, employment, housing and environmental factors). These affect both overall health and wellbeing and decision-making about health.

6. Comments of Other Committees

6.1 None

7. Conclusion

7.1 The national Screening and Immunisation programmes provide important opportunities for protecting health and wellbeing and preventing avoidable disease with cost-effective and evidence-based interventions. However, their uptake also acts as marker of health inequality in certain groups which we must be vigilant to.

7.2 Historically, Slough has had lower than average uptake of both screening and immunisations, reflecting a variety of issues including accessibility, acceptability and availability of interventions delivered by the system as well as individuals' beliefs and understanding of the programmes. Poor uptake of these programmes (and other health improvement activities) is also more likely in individuals and key groups in Slough who already experience the worst health outcomes with associated worsening impact on health inequalities. Social and environmental factors – the wider determinants of health – also affect our population's health and shape their individual health and wellbeing decisions on matters such as taking up invitations for screening and immunisation.

7.3 Through concerted local partnership working, there has been some encouraging progress in recent years however considerable challenges remain across the various immunisation and screening programmes in Slough. These challenges will benefit from the proposed national and local plans being developed and/or currently delivered. The programmes will also benefit from ongoing monitoring of their impact on Slough's health.

8. Appendices

1. Immunisation and Screening Programmes - an update for Slough. Dec 2018.

2. The Ten Questions to Consider If You're Scrutinising Local Immunisation Services. Centre for Public Scrutiny. 2016

APPENDIX A

TITLE: **Immunisation and Screening Programmes- an update for Slough**

DATE: December 2018

Report By: Jo Jefferies, Consultant in Public Health, Public Health Services for Berkshire
Nisha Jayatilleke, Screening and Immunisation Lead, NHS England South
Paula Jackson, Screening and Immunisation Lead, NHS England South

Purpose of Report:

- To provide a summary of the current commissioning and provider arrangements for immunisations and screening programmes and the organisations involved
- Provide an update on immunisation and screening programme coverage in Slough
- Highlight recent successes and key opportunities to maximise programme coverage and uptake with a view to reducing health inequalities in this area.

Executive Summary

NHS England has continued to commission the services set out under the Section 7A agreement to a high standard, offering continued protection to the public. Data and evidence demonstrates that public health protection remains world class and we have achieved real success. Increasing access to screening and immunisation programmes, contributes to the wider prevention agenda and the implementation of the Five Year Forward View.

Some of the recent successes that have benefitted the local population include programmes to increase uptake and improvements to data quality for closer monitoring of progress. Examples include the development of a GP toolkit with tips and advice for primary care colleagues to improve immunisation uptake for their patients. The toolkit is implemented in many practices across Slough. In addition, data on immunisations delivered in primary care are now auto-extracted from the clinical record and entered electronically on the Child Health Information System (CHIS) which is not only more efficient but has also improved the accuracy of the data. The LA, the school immunisation provider and NHS England have worked together to agree how they willaddress cultural and language barriers to further improve uptake in groups with lower historic vaccination rates. As part of the Thames Valley Cancer Alliance GP Quality Improvement Scheme, there are initiatives in place to improve cancer screening coverage as well as the safe mobilisation of the Diabetic Eye Screening programme following a contract review.

Successful collaborative working has enabled improvements in some outcomes, however there is still opportunity to improve uptake of cancer screening programmes and childrens immunisations, particularly PCV (pneumococcal) booster, second dose MMR, and the Hib/MenC booster. It is important to have a thorough understanding of opportunities and challenges that need to be considered in Slough to be able to support families take up the offer for vaccination and to work collaboratively with stakeholders to improve vaccine uptake.

There are several new opportunities ahead to implement and embed changes that will further improve screening and immunisation services locally. These include the introduction of a new screening test in the bowel screening programme, incorporating HPV primary screening into the cervical screening programme and a new booster seasonal flu immunisation for people aged 65 and over.

Governance and reporting arrangements are also being tightened, The Shared Public Health Team is scoping an annual Health Protection Report, drawing together key metrics and issues. The Terms of Reference of the Berkshire Health Protection Committee is also under review to ensure the committee fulfils its system assurance role, with partners providing assurance to the Strategic DPH and holding each other to account. In addition, NHS England is revising the quarterly Berkshire screening and immunisation dashboard to improve clarity and enable access for public health consultants in each Local Authority.

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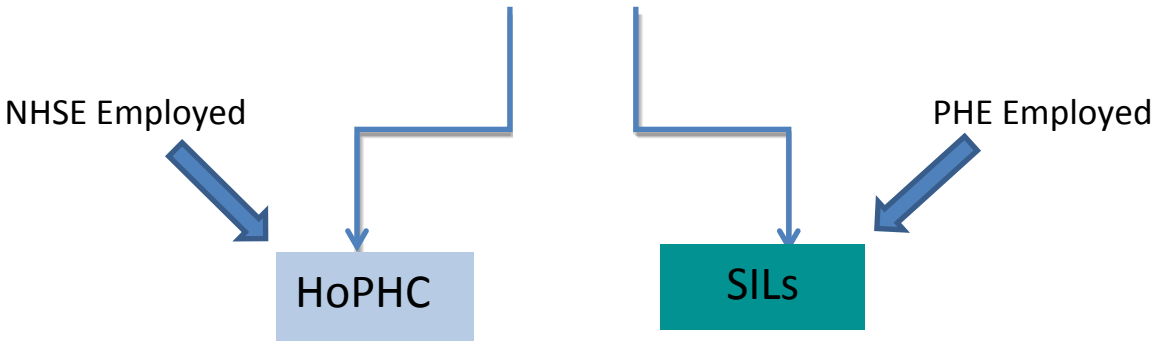
Background

Current commissioning and provider arrangements

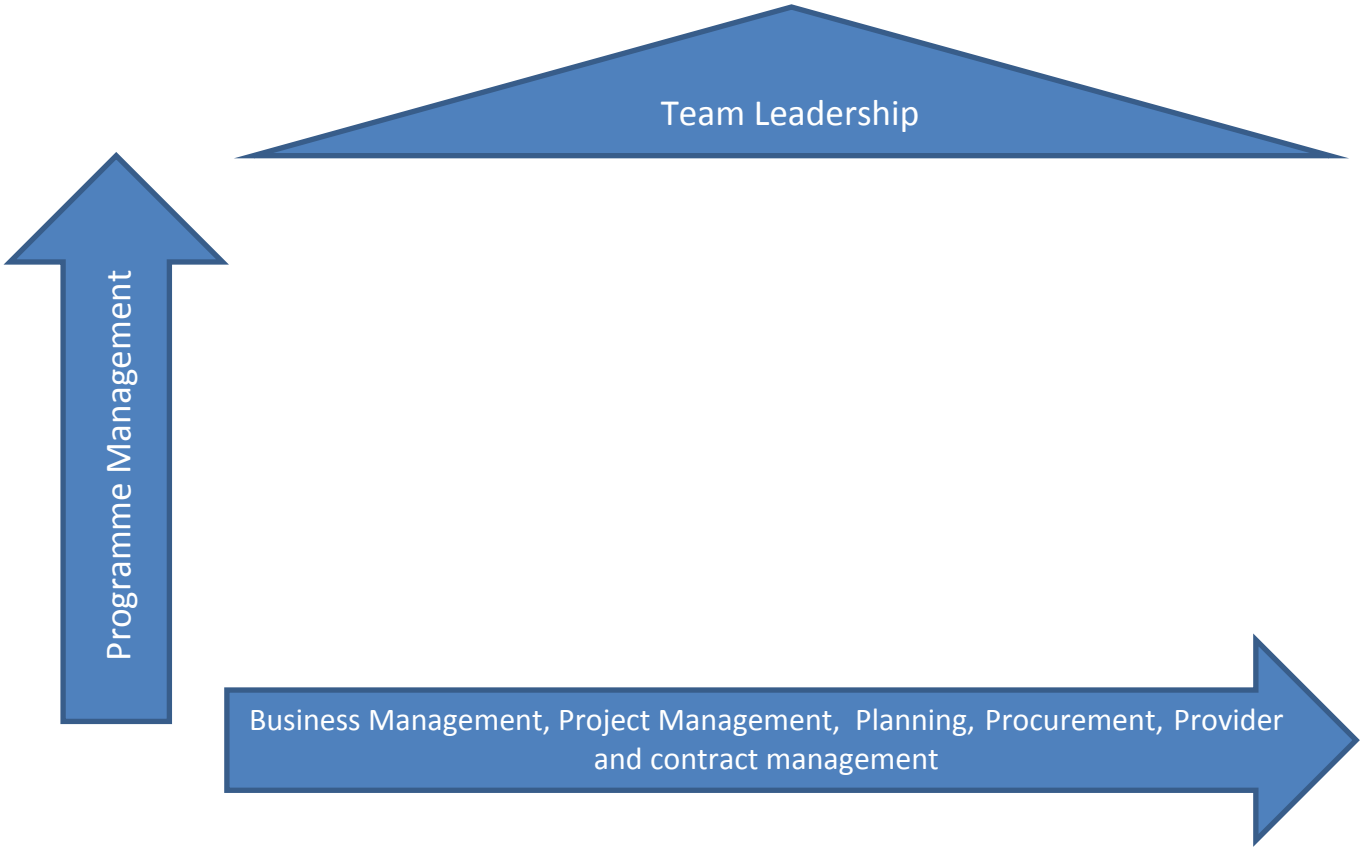
- NHS England is responsible for commissioning screening & immunisation programmes in England. Locally this is co-ordinated and managed across Thames Valley by the Public Health Commissioning team at NHS England, South East under an agreement known as Section 7a – see
-
- Figure 1 and Figure 2.
- GP Practices are the main providers of childhood immunisation for children under 5 years of age commissioned by NHS England and with a quality duty in CCGs.
- NHS Trusts are the main providers of NHS Screening Programmes
- Currently, the Berkshire Healthcare Foundation Trust School Immunisations Team is commissioned by NHSE to provide school aged immunisations in Berkshire. This is a different service than the School Nursing Services commissioned by Slough Borough Council
- Public Health England South East Health Protection Team is responsible for functions related to health protection reactive work, outbreak management etc. in which immunisations may be offered to protect healthy people who have been exposed to a particular infection.

Figure 1: Public Health and NHS England: Section 7a Operating Model



Local Office Public Health Commissioning Team

Figure 2: Public Health and NHS England: Section 7a Programme Management



Immunisation programmes

Immunisation is one of the most effective public heath interventions, the World Health Organisation states that “Only clean water (a human right) ranks as highly as vaccination in terms of the greatest impact on health globally”. The UK has a well-established and successful immunisation programme offered through the NHS. There is a need to ensure that as many people as possible are taking up the offer of vaccination to protect against disease.

Immunisation is more than the sum of its parts, as increasing the number of immunised people in a population reduces the opportunity for infection to pass from one person to another through the phenomenon known as ‘herd immunity’. When an immunisation programme against a disease begins, the number of people catching the disease goes down. As the threat decreases, it's important to keep vaccinating; otherwise the disease can start to spread again. If enough people in a community are vaccinated, it's harder for a disease to pass between people who have not been vaccinated. Herd immunity is particularly important for protecting people who can't get vaccinated because they're too ill or because they're having treatment that damages their immune system.

Childhood immunisation programmes

The UK Childhood Immunisation Schedule covers the recommended immunisations for children and young people aged 0 to 18 years. The schedule comprises the recommended universal or routine immunisations which are offered to all children and young people, as well as selective immunisations which are targeted to children at higher risk from certain diseases. The target of the national immunisation programme is for 95% of children to complete courses of the routine childhood immunisations at appropriate ages.

Table 1: UK Childhood Immunisation Programme as of November 2018

Age	Vaccines offered	Diseases protected against
Eight weeks old	Hexavalent vaccine (DtaP/IPV/Hib/HepB)	Diphtheria, tetanus, pertussis (whooping cough) polio, *Haemophilus influenzae* type B infections and hepatitis B
	MenB	Meningococcal group B infections
	Rotavirus	Rotavirus gastroenteritis
	PCV13	Pneumococcal infections (13 serotypes)
Twelve weeks old	Hexavalent vaccine (DtaP/IPV/Hib/HepB) – dose 2	Diphtheria, tetanus, pertussis (whooping cough) polio, *Haemophilus influenzae* type B infections and hepatitis B
	Rotavirus – dose 2	Rotavirus gastroenteritis
Sixteen weeks old	Hexavalent vaccine (DtaP/IPV/Hib/HepB) – dose 3	Diphtheria, tetanus, pertussis (whooping cough) polio, *Haemophilus influenzae* type B infections and hepatitis B
	MenB – dose 2	Meningococcal group B infections
	PCV13	Pneumococcal infections (13 serotypes)
One year old (on or after the child's first birthday)	Hib/MenC	*Haemophilus influenzae* type B infections and meningococcal group C infections
	PCV13 booster	Pneumococcal infections (13 serotypes)
	MMR	Measles, mumps and Rubella (German measles)
	Men B booster	Meningococcal group B infections
Children aged 2 and 3 and those in schools years reception to year 5*	Nasal flu vaccine (each year from September)	Seasonal influenza
Three years four months old or soon after	DtaP/IPV	Diphtheria, tetanus, pertussis and polio
	MMR – dose 2 (check first dose given)	Measles, mumps and Rubella (German measles)
Girls aged 12 to 13 years old	HPV (two doses, 6 to 24 months apart)	Cervical cancer caused by humans papillomavirus (HPV) types 16 and 18 and genital warts caused by types 6 and 11
Fourteen years old (school year 9)	Td/IPV (check MMR status)	Tetanus, diphtheria and polio
	Men ACWY	Meningococcal groups A, C, W and Y infections

All babies born on or after 1 August 2017 are offered protection against hepatitis B as part of the universal childhood immunisation programme in addition to continued protection against diphtheria, tetanus, pertussis, polio and Hib.The 6-in-1 vaccine (Dtap/IPV/Hib/HepB) is offered at 8, 12 and 16 weeks old. Babies are also vaccinated to protect against rotavirus (a common cause of diarrhoea and sickness, sometimes requiring hospitalisation) and Meningitis B (to protect from infection by meningococcal group B bacteria, which are responsible for more than 90% of meningococcal infections in young children).

Vaccines are offered at age 12-13 months and in the pre-school years including MMR (measles, mumps and rubella) and the pre-school booster. From 1st July 2016, the schedule for MenC vaccination changed. Babies have their first dose of the MenC vaccine at 12-13 months of age through the combination Hib/MenC vaccine. They then receive a booster dose at 13-14 years of age, as part of the MenACWY vaccine. From 1st August 2017 the combined infant vaccination (DTaP/IPV/Hib) changed to include Hepatitis B (DTaP/IPV/Hib/HepB) at 8 weeks, 16 weeks and at the pre-school booster given at 3 years 4 months.

The school-aged immunisation programme is primarily delivered in schools offering HPV to Year 8 or 9 girls as well as the fifth and final dose of tetanus, diphtheria and polio (Td/IPV) vaccine. Teenagers are offered the MenACWY vaccine to protect them against four different causes of meningitis and septicaemia. There is provision made to offer the full immunisation schedule to children who are home schooled or otherwise not in full-time education.

The COVER (Cover of Vaccination Evaluated Rapidly) programme evaluates childhood immunisation in England. PHE in collaboration with other agencies collates UK immunisation coverage data from child health information systems for children aged one, two and five years of age. COVER monitors immunisation coverage data for children in the United Kingdom who reach their first, second or fifth birthday during each evaluation quarter. This information is promptly fed back to local level, creating the opportunity to improve coverage and to detect changes in vaccine coverage quickly.

Immunisation programmes for young people and adults

Although the majority of vaccines in the immunisations programme are offered in childhood with the aim of conferring long lasting immunity, a number of vaccines are offered to young people and adults in order to protect them against infection, these are set out in Table 2.

Table 2: Immunisation programmes for young people and adults

Vaccine	Population offered the vaccine	Infection vaccine aims to prevent
Pneumococcal vaccine	All people aged 65 and over	Pneumococcal disease.

Annual flu vaccine	• People aged 65 and over
	• People aged under 65 in a clinical risk group
	• Pregnant women
	• Carers and household contacts of immunocompromised individuals
	  • Social Care and hospice staff
	  • people living in long-stay residential care homes or other long-stay care facilities
	  • School aged children in reception to year 5
	  • 2 and 3 year old children
		Seasonal influenza

Shingles vaccine	Routine cohort people aged 70 (see details below) The shingles vaccination programme started on 1st September 2013. The programme offers routine vaccinations to people aged 70 years old along with a catch-up immunisation programme for people aged 79 years. Anyone who has previously been eligible remains eligible until their 80th birthday. The link attached shows eligibility for 2018/19: https://www.gov.uk/government/publications/shingles-vaccination-eligibility-poster	Shingles (caused by the varicella-zoster virus which also causes chicken pox) https://www.gov.uk/government/collections/shingles-vaccination-programme
Pertussis Vaccine	All pregnant women	Whooping cough in newborn infants

Additional vaccines are also recommended for people with specific health conditions (see The Routine Immunisation Schedule).

Population Screening

Screening is the process of identifying healthy people who may have an increased chance of a disease or condition. Screening aims to identify the individuals most at risk of a disease so that they can be offered information, further tests and early treatment.

Table 3: NHS National Screening Programmes

Screening Programme	Population offered the screen	Aim of programme
Bowel Cancer (**faecal occult blood test** (FOBT) checks for occult (hidden) blood in the stool. Bowel Scope	Men and women aged 60 to 74 One off test offered at age 55. This programme is currently being rolled out and is not yet available to the entire population	Reduce illness and deaths from bowel cancer Prevent the development of bowel cancer by removing pre-cancerous polyps
Breast Cancer	Women aged 50 -70	Reduce illness and deaths from breast cancer in women aged 50 to 70
Cervical	Women aged 25 to 64	Reduce illness and deaths from cervical cancer in women through identifying pre-cancerous changes
Abdominal Aortic Aneurysm (AAA)	One off test for men in their 65th year	Reduce AAA related deaths among men aged 65 to 74
Diabetic eye screening	All people with type 1 and type 2 diabetes aged 12 or over who are not already under the care of an opthalmologist for diabetic retinopathy	Reduce sight loss due to diabetic retinopathy
Antenatal screening	All pregnant women- Infectious Diseases in Pregnancy screening Sickle cell and thalassaemia Down's, Edwards' and Patau's syndromes Physical abnormalities (mid-pregnancy scan) Eye problems in women with diabetes	Screening tests are offered during pregnancy to try to find any health problems that could affect the woman or the baby. The tests – ultrasound scans, blood tests and a questionnaire – can help make choices about care or treatment during pregnancy or after baby is born. A dating ultrasound scan, offered at around 8 to 14 weeks' pregnancy, is the most accurate way to work out the baby's due date. A mid-pregnancy ultrasound scan, offered around 18 to 21 weeks' pregnancy, looks for physical abnormalities in the baby.
Newborn screening	All Heart, eyes, hips and testes (physical examination) Hearing loss Blood spot	Screening offered so that baby can be given appropriate treatment as quickly as possible if needed

Current Performance- national immunisation programmes

Childhood immunisation programmes

Annual immunisation uptake statistics for children aged up to five years in Slough, compared England uptake for 2016-17 and 2017-18 is shown in Table 4. In Slough, across all indicators except DTaP/IPV booster, there have been improvements from 2016/17 to 2017/18. However uptake of MMR1, Hib/MenC and the PCV booster remains lower than the England figure and below 90%. Uptake of all vaccines by five years has improved in 2017-18 compared with the previous year but remains substantially below target for MMR2, meaning that around 1 in 5 children in Slough are not adequately protected against measles at a time when incidence has increased in England[1]. Some of the improvements are directly due to data quality improvements both at GP practices and within Child Health Information System. As part of the data quality improvement activity, the reporting for DTaP/IPV booster in 2017/18 was standardised to align to national COVER reporting criteria which means only children who received the vaccination between age 3 years and 4 months and 5 years is included.

Table 4: Childhood Immunisation (0-5 years) Uptake 2016-17 and 2017-18

			2016-17 England	2017-18 England	2016-17 Slough	2017-18 Slough
Age 1	DTaP/IPV/Hib	% immunised	93.4	93.1	90.8%	93.7%
	PCV	% immunised	93.5	93.1	90.8%	93.8%
	Rotavirus (1)	% immunised	89.6	90.1	87.9%	91.2%
Age 2	DTaP/IPV/Hib primary	% immunised	95.1	95.1	94.1%	95.2%
	MMR 1st dose	% immunised	91.6	91.2	84.8%	87.1%
	Hib/ MenC	% immunised	91.5	91.2	85.6%	87.2%
	PCV booster	% immunised	91.5	91	84.6%	87.3%
Age 5	DTaP/IPV/Hib primary	% immunised	95.6	95.6	93.3%	97.7%
	DTaP/IPV booster	% immunised	86.2	85.6	77.7%	75.1%
	MMR 1st dose	% immunised	95	94.9	91.1%	94%
	MMR 1st and 2nd dose	% immunised	87.6	87.2	79.0%	81.1%
	Hib/ MenC booster	% immunised	92.6	92.4	90.3%	91.4%

Data Source: NHS Digital (2017 and 2018): Childhood Vaccination Coverage Statistics, England

Prior to Q2 of 2017-18, children who received the vaccination for DTaP/IPV booster from 3 years of age were included in the COVER data. The dip in performance for the DTaP/IPV booster at age 5 years may be explained by the fact NHS England changed the 5 year COVER parameters for DTaP/IPV as of Q2 2017-18 to standardise reporting parameters with national guidance and to align with local practice. The

[1] *Laboratory confirmed cases of measles, rubella and mumps, England: April to June 2018, PHE*

impact of this change was a perceived difference in performance as there were 270 children in Slough who received the vaccination aged between 3 years and 3 years 4 months which would not be included in the COVER parameters. To address this, the CHIS Provider is now sending invitations at age 3 years and 4 months to ensure timely vaccination.

Schools-aged immunisation programme

In England, the recommendation from September 2014 was to offer the first (priming) HPV vaccine dose to females in Year 8 and the second dose 12 months later in Year 9 (aged 13 to 14 years), as this would reduce the number of immunisation sessions required in schools. In Berkshire, the school immunisation Provider, Berkshire Healthcare NHS Foundation Trust, with effect from September 2017- autumn term deliver to this model to facilitate expanded delivery of the seasonal childhood flu programme across most of the autumn term.

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. The Berkshire Healthcare Foundation Trust School Immunisations Team delivers Td/IPV tetanus and diphtheria and polio combined vaccine and (since January 2018) also deliver the MenACWY (meningitis vaccine) to students in school Year 9.

The School Immunisation Team have also been offering a catch up MMR programme to all year 9 students who missed one or more doses as an infant, during 2017-18, 979 students were vaccinated with MMR as part of this programme. The catch up programme is being run alongside the delivery of MenACWY and Td/IPV in secondary schools. This reduces the time students are absent from education and minimise disruption to lessons while improving efficiency and maintaining high uptake. From April 2018, a check is taking place in school year 2 to identify children with incomplete or missing MMR and this will be offered in school.

Table 5: HPV, Men/ACWY and Td/IPV vaccine uptake in school-aged children 2016-17

			England 2016-17	**South East 2016-17**	**Slough 2016-17**
Girls aged 12 to 13 (Year 8)	HPV 1st dose	Cohort	299,198	26,290	1,177
		Number of children immunised	260,959	21,288	1,046
		% immunised	87.2%	81%	88.9%
Girls aged 13 to 14 (Year 9)	HPV 2nd dose	Cohort	289,499	25,697	916
		Number of children immunised	240,590	20,120	834
		% immunised	83.1%	78.3%	91.0%
School Year 9 in 2016/17 (13-14 year olds) born between 1 September 2002 - 31 August 2003)	Td/IPV and Men/ACWY	Number of 13-14 year olds	463,477	52,805	1,976
	Td/IPV	Number of children immunised	384,564	42,751	1,804
		% immunised	83%	81%	91.3%
	Men/ACWY	Number of children immunised	402,942	43,225	1,789
		% immunised	83.6%	81.9%	90.5%

Data source: NHS Digital (2017)

The school-aged immunisation programme for HPV performs similarly or better than England in Slough. In 2017-18 uptake of HPV is approaching the 90% objective in Year 8 and achieved the objective in year 9, comparing well with 83% nationally.

The Trust is changing HPV vaccination delivery schedule to 12 months/ 2 academic terms, HPV 1 was delivered to Year 8 students during summer 2018 and HPV 2 will be delivered to Year 9 students in summer 2019. A few schools will remain on the 6 month schedule, including pupil referral units.

Over the past year, the school nursing team has reported a number of instances of anti-vaccine information being circulated among parents across Berkshire LA areas, primarily through social media. This has the potential to undermine the performance of the service and has been recognised as an area of action by commissioners and local stakeholders.

Young people and adult Immunisation Coverage

Table 5: Shingles Vaccination Coverage, Slough CCG May 2018

	Percent coverage	
	Slough	**England**
Shingles: coverage for routine cohort since 2013	32.2%	41%
Shingles: coverage for the catch up cohort since 2013	35.9%	42%

Data Source: https://www.gov.uk/government/publications/herpes-zoster-shingles-immunisation-programme-2013-to-2014-provisional-vaccine-coverage-data

Table 6: Pneumococcal Vaccination Coverage, all GP registered patients aged 65 and over Slough CCG

	Received the Pneumococcal (PPV) vaccine between 1st April 2017 and 31st March 2018 inclusive
Slough	67.6%
England	69.5%

Data Source: Pneumococcal Vaccine Coverage Monitoring Programme England - data to end March 2018, PHE

Table 7: Annual pre-natal Pertussis Vaccination Coverage, Slough CCG between 2015-16 and 2017-18

	2015-2016	2016-2017	2017-2018
Slough	43%	51.3%*	49.1%*
England	58.2%	66%*	71.9%*

Data Source: Immform /Prenatal Pertussis Vaccine Coverage monitoring programme.
*Please note NOV 2016- No data received from one large IT supplier for Thames Valley and APRIL-JUNE 2017- No data received nationally from IT supplier

Table 8: Seasonal Flu Vaccination Coverage, Slough CCG 2017-18

Eligible group	National Ambition	% uptake Slough	% uptake England
2yr olds	40%	26.3%	42.8 %
3yr olds	40%	28.1%	44.2%
Pregnant women	55%	35.9%	47.2 %
Under 65s at risk	55%	47.5%	48.9 %
65 and over	75%	69.9%	72.6 %
School based programme			
Reception	40%	53.5%	62.6%
Year 1	40%	45.2%	61%
Year 2	40%	46.8%	60.4%
Year 3	40%	43.2%	57.6%
Year 4	40%	42%	55.8%

Data source: Seasonal flu vaccine uptake in gp-patients winter 2017 to 2018 and Seasonal flu vaccine uptake in-children of primary school age winter 2017 to 2018

Current Performance- national screening programmes

Screening data is subject to a time lag as invitees are given a period of time to respond to an invitation in order to improve participation in the programme and maximise uptake. Episodes therefore close some time after an invitation is issued and data is not available until this period has ended, which varies for each programme.

Coverage of screening programmes for young people and adults

Table 9: Cancer Screening Coverage 2017

finition	National Targets		Latest published data		
			Slough	South East	England
BREAST: % of the eligible population (50-70) have been screened in the last 3 years	70%	80%	68.7%	76.9%	75.4%
BOWEL: % of the eligible population (60-74) have been screened in the last 2.5 years	52%	60%	44%	61%	59.6
CERVICAL: % of the eligible population (25-64) have been screened in the last 3.5 /5.5 years	75%	80%	66.4%	73.2%	72%

Data source: Public Health England; Public Health Outcomes Framework
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

Table 10: Non-Cancer Screening Uptake

Programme	2016/17	
	National	Local
Berkshire Diabetic Eye Screening: Uptake of Routine Screening	82.4%	74.4%
Thames Valley AAA Screening: Proportion of eligible men offered screening who accept the offer	81.1%	79.3%

Data Sources: https://www.gov.uk/government/publications/diabetic-eye-screening-2016-to-2017-data
https://www.gov.uk/government/publications/abdominal-aortic-aneurysm-screening-2016-to-2017-data

Coverage of antenatal and newborn screening programmes

Table 11: Antenatal and newborn screening programmes delivered at Wexham Park (Frimley Hospitals Trust) 2017/18 Q2- 2018/19 Q1

	2017/18 Q2	2017/18 Q3	2017/18 Q4	2018/19 Q1
Infectious Diseases Screening				
HIV testing coverage	100.0	99.8	99.9	99.9
Hep B testing coverage	100.0	99.8	99.9	100.0
Syphilis testing coverage	100.0	99.8	99.9	100.0
Fetal Anomaly Screening				
Fetal anomaly screening(18+0 to 20+6 fetal anomaly ultrasound)-Coverage	100.0	101.4	99.8	100.0
Sickle Cell & Thalessaemia Screening				
Antenatal sickle cell and thalassaemia screening – coverage	100.0	99.8	99.9	100.0
Newborn Bloodspot Screening				
Newborn blood spot screening – coverage	97.9	98.9	98.9	92.6
Newborn blood spot screening – coverage (Movers In)	93.8	93.1	90.5	86.5
Newborn Hearing Screening				
Newborn hearing screening – coverage	99.5	99.3	99.7	99.7
Newborn and Infant Physical Examination Screening				
Newborn and Infant Physical Examination – coverage (newborn)	98.0	98.7	98.8	99.5

Data source: https://www.gov.uk/government/collections/nhs-population-screening-programmes-kpi-reports

Assurance arrangements

NHS England Public Health Commissioning Team provide assurance to the Strategic Director of Public Health through the quarterly Berkshire Health Protection Committee that work is progressing to maintain and improve uptake of immunisations and screening across Berkshire.

The Public Health Consultant in Slough is informed of performance and progress on all immunisation and screening programmes through the sharing of published key screening and immunisations indicators as part of the suite of JSNA data updates prepared by the Shared Public Health Team and of progress on regional initiatives via the monthly Shared Team Highlight Report presented at consultant meetings. The Slough consultant is a key stakeholder in local initiatives to improve uptake. An annual flu report collates data on flu activity and vaccine uptake is provided by the Berkshire Shared Public Health Team.

The Strategic Director of Public Health may seek additional assurance from NHS England or other stakeholders as regards the performance of local health protection programmes, including screening and immunisation.

Recent key Successes

- Immunisation data delivered in primary care are now auto-extracted and entered electronically on Child Health Information System (CHIS), improving efficiency and accuracy of data. NHS England procured a new larger CHIS system across the entirety of Thames valley to reduce variation and issues with children registered around county borders.
- Development of a GP toolkit to improve immunisation uptake with tips and advice for primary care colleagues. The toolkit is implemented in many practices across Slough.
- Joint working between LA, school immunisation providers and NHS England to agree actions to address cultural and language barriers to improve uptake rates.
- Thames Valley Cancer Alliance GP Quality Improvement Scheme; to improve cancer screening coverage.
- There has been a procurement of the diabetic eye screening programme in Berkshire, with the new contract awarded to Health Intelligence. The new provider began offering screening in Q1 2018-19 and patient feedback so far has been positive. Performance data for the new provider will be published next quarter.
- Slough Borough Council Public Health Team launched the #IamVaccinated campaign in 2018. This is the new face of the teams drive to increase vaccination rates within the local community. The campaign focuses on the personal reasons people get vaccinated and aims to dispel myths. It is not vaccine specific, but initially focussed on Flu, HPV and MMR.
- East Berkshire CCG has worked with Macmillan and other key partners to implement the Slough Bowel Cancer Screening Project. This aims to support GP practices to improve uptake and to raise awareness of bowel cancer and its signs and symptoms through community education. To date there have been 67 events and conversations with over 1800 people. 14 out of 16 practices have improved their screening uptake since the project began.

Key Opportunities

- A new test known as FIT (Faecal Immunochemical Test) is being introduced into the national bowel screening programme in April 2019. This test will replace the guaiac faecal occult blood test (gFOBt). The new test is more sensitive and because it is easier for participants to use improves uptake in screening, particularly in deprived groups. This is likely to improve uptake of bowel cancer screening in Slough.
- From December 2019 all cervical smear tests will be tested using HPV primary testing following a national procurement process. Evidence shows that HPV testing is a better way to identify women at risk of developing cervical cancer than cytology (looking at cells under a microscope). The test will increase the number of women correctly identified as being at risk of developing cancer of the cervix. This new service will also alleviate the poor performance nationally to the 14 day turnaround time key performance indicator.
- NHSE commissioned a pilot project from the South Central and West Commissioning Support Unit CHIS to send a letter to parents in Berkshire providing information about the benefits and practicalities about vaccinating their 2 and 3 year old children against flu. It is hoped that this will increase the uptake of the vaccine in this age cohort.

- The 2018/19 seasonal flu programme includes a new booster vaccine for people aged 65 and over. Research indicates that the new adjuvant vaccine (aTIV) is both more clinically and cost-effective than the non adjuvanted vaccines previously offered to this age group. It is anticipated that this will contribute towards reducing flu related morbidity and mortality among older people.

Next Steps

- Key partners will work together to develop a local action plan for Slough to improve uptake of screening and immunisation programmes
- The Shared Public Health Team will scope production of an annual Health Protection Report, drawing together key metrics and issues
- The Terms of Reference of the Berkshire Health Protection Committee are under review reviewed to ensure the committee fulfills itssystem assurance role, with partners providing assurance to the Strategic DPH and holding each other to account
- NHS England are reviewing the presentation of the quarterly Berkshire Screening and Immunisation Dashboard to improve clarity and enable wider sharing to public health consultants in each borough.

Centre for Public Scrutiny

sanofi pasteur MSD
vaccines for life

10 Questions To Ask If You're Scrutinising...
...Local Immunisation Services

Third edition, April 2016

The Centre for Public Scrutiny

The Centre for Public Scrutiny (CfPS), an independent charity, is the leading national organisation for ideas, thinking and the application of policy and practice to promote transparent, inclusive and accountable public services. We support individuals, organisations and communities to put our principles into practice in the design, delivery and monitoring of public services in ways that build knowledge, skills and trust so that effective solutions are identified together by decision-makers, practitioners and service users.

This guide on the scrutiny of immunisation provision is one of a series by CfPS designed to help Health Overview and Scrutiny Committees (HOSCs) carry out their scrutiny work around various health, healthcare and social care topics.

The guide identifies ten key question areas and their detailed questions, which can be used by the HOSC to scope out a wide review or to concentrate on an area of particular interest or bearing; this is important if local needs are to be identified and areas are to provide an effective response.

Other guides in the series include:

- Child and Adolescent Mental Health Services
- Services for people with dementia
- Adult social care
- Reducing unintentional injury in the under 15s
- Preventing cardiovascular disease
- Men's health
- Service for Looked After Children

THIS SCRUTINY GUIDE HAS BEEN PRODUCED AS A COLLABORATION BETWEEN THE CENTRE FOR PUBLIC SCRUTINY AND SANOFI PASTEUR MSD; THE GUIDE WAS COMMISSIONED AND FUNDED BY SANOFI PASTEUR MSD, WHO HAVE CONTRIBUTED TO AND REVIEWED THE CONTENT. THE GUIDE IS PRIMARILY INTENDED FOR HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEMBERS AND ASSOCIATED STAKEHOLDERS.

Acknowledgements

The following authors have co-authored this third edition of the guide:

- Helen Donovan - Specialist Nurse in Immunisation and Health Protection, Professional Lead for Public Health Nursing, Royal College of Nursing
- Dr Tim Davies – Consultant Lead for Screening and Immunisation, NHS England

With acknowledgment and thanks to the co-authors of the original guide and second edition:

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CONTENTS

FOREWORD

Asking well-informed questions about immunisation is an essential component of effective scrutiny. This publication provides the material and framework to enable members and officers to explore the complex and multifaceted topic in a clear and accessible way. As the authors have identified, immunisation is one of the great success stories of modern public health with a strong evidence base of successful interventions.

However, there are also specific challenges for the layperson as they engage with some of the more specialist and technical elements. The situation on the ground is increasingly complex with a wide range of approaches to commissioning and provision. At times this can appear inconsistent and liable to change. As a result there is significant variation across the country in terms of uptake and impact. Understanding who holds local responsibility for immunisation is critical. Local authorities are well placed to bring together networks and use their influence and leadership to build stakeholder approaches to mapping and understanding the system.

The immunisation of young children between 0 and 5 years old provides the foundations for lifelong immunity and helps to protect the most vulnerable members of our communities. It is essential that scrutiny committees understand the positive impacts of infant programmes and the reasons for any patterns of low take-up. But it is also important to consider the significance of a life course approach to immunisation for other groups such as young people, adults and older people as well as the broader issues of diversity and health inequalities. Scrutiny offers the opportunity to assess some of the wider, more holistic aspects of immunisation and share learning with other local authority functions in areas such as early years, housing, education and communications. Listening and understanding the experiences of children, young people and families can also ensure that scrutiny reviews take account of local voices and perspectives – placing them at the core of a review.

10 Questions to ask if you're scrutinising local immunisation services will be of great benefit to scrutiny committees, health and wellbeing boards and other local partnerships that want to understand more about the factors that drive effective and inclusive immunisation programmes. The Centre for Public Scrutiny looks forward to seeing how local committees use this resource to lead effective reviews.

Lord Kerslake,
Chair of the Centre for Public Scrutiny

INTRODUCTION

Nowhere has public health achieved more success than in the protection against infectious disease. Over the centuries improved living standards, sanitation, hygiene and nutrition have all been contributory factors. After clean water, vaccination is recognised as one the most effective public health interventions for saving lives and promoting good health. It is seen as the most cost-effective activity undertaken by healthcare professionals and is a critical element of preventive health care around the world. [1]

Immunisation is the process whereby a person is made immune or resistant to an infectious disease. This is achieved through vaccination but also when an individual has the disease naturally. Vaccination is the term used when a vaccine is introduced into the body to invoke an immune response. Vaccines are products developed to immunise against a specific disease. The terms vaccination and immunisation are used interchangeably.

BACKGROUND

In the United Kingdom, vaccine policy is advised by the Joint Committee on Vaccination and Immunisation (JCVI). The success of immunisation policy in the UK relies on vaccines protecting the individual from the specific disease. It is also dependent on achieving high uptake of the vaccines across the population, which thereby minimises the spread of infections. The UK is successful in this and although it is not compulsory for anyone to receive vaccines, the uptake for most vaccinations is high and vaccine-preventable disease is now relatively rare in the UK. The programmes rely on a complex process of policy decision, contract development and implementation to ensure access is equitable. This includes vaccine procurement and appropriate training and support for staff involved.

Vaccines are routinely given across the life course to those at most risk of contracting serious illnesses, including;

- Children between 0 and 5 years of age receive the majority of routine vaccinations.
- School-aged children require certain vaccines; some as boosters which will prolong the longevity of the immunity acquired and some deemed best to be given to teenagers.
- Adults require vaccines depending on age and if they have underlying medical conditions.
- Travellers will also be recommended some vaccines depending on where they are going.
- Some vaccines are recommended for certain occupational groups. This is to protect the individual who is at an increased risk of exposure. It is also to protect the wider public from any subsequent spread of infection.

HOW TO USE THIS GUIDE

This third edition of the guide is intended to be used as a tool to provide local authority councillors and others involved in Health Overview and Scrutiny Committees (HOSCs) and Health and Wellbeing Boards (HWBs), with useful background information about immunisation and a series of questions that may be helpful to consider when scrutinising the effectiveness of local services.

The right to receive the vaccinations that the JCVI recommends under an NHS-provided national immunisation programme is enshrined in the NHS constitution. [2] The effectiveness of the programme is dependent on the uptake of the specific vaccine being high and equitable across the eligible population. This requires close scrutiny of all the elements of the programme and the role of the local authority is to make sure the needs of their population are being met. This scrutiny falls broadly into three main groups:

- Vaccines for children aged 5 and under
- Vaccines for school-aged children
- Vaccines for adults.

This '10 Questions' guide is designed to give an overview of the rationale and policy for immunisation. It provides a basis to discuss the specific issues relating to each of these groups and how to make sure services are equitable across the population so that uptake is maximised.

Immunisation is very effective at reducing the incidence of infectious disease. The graphic below from Public Health England (PHE) demonstrates how once very common and potentially fatal infections are now very rarely seen in the UK following the introduction of vaccination.

Source PHE : https://publichealthmatters.blog.gov.uk/2015/11/12/phe-data-week-immunisation-in-numbers-5-fascinating-facts/

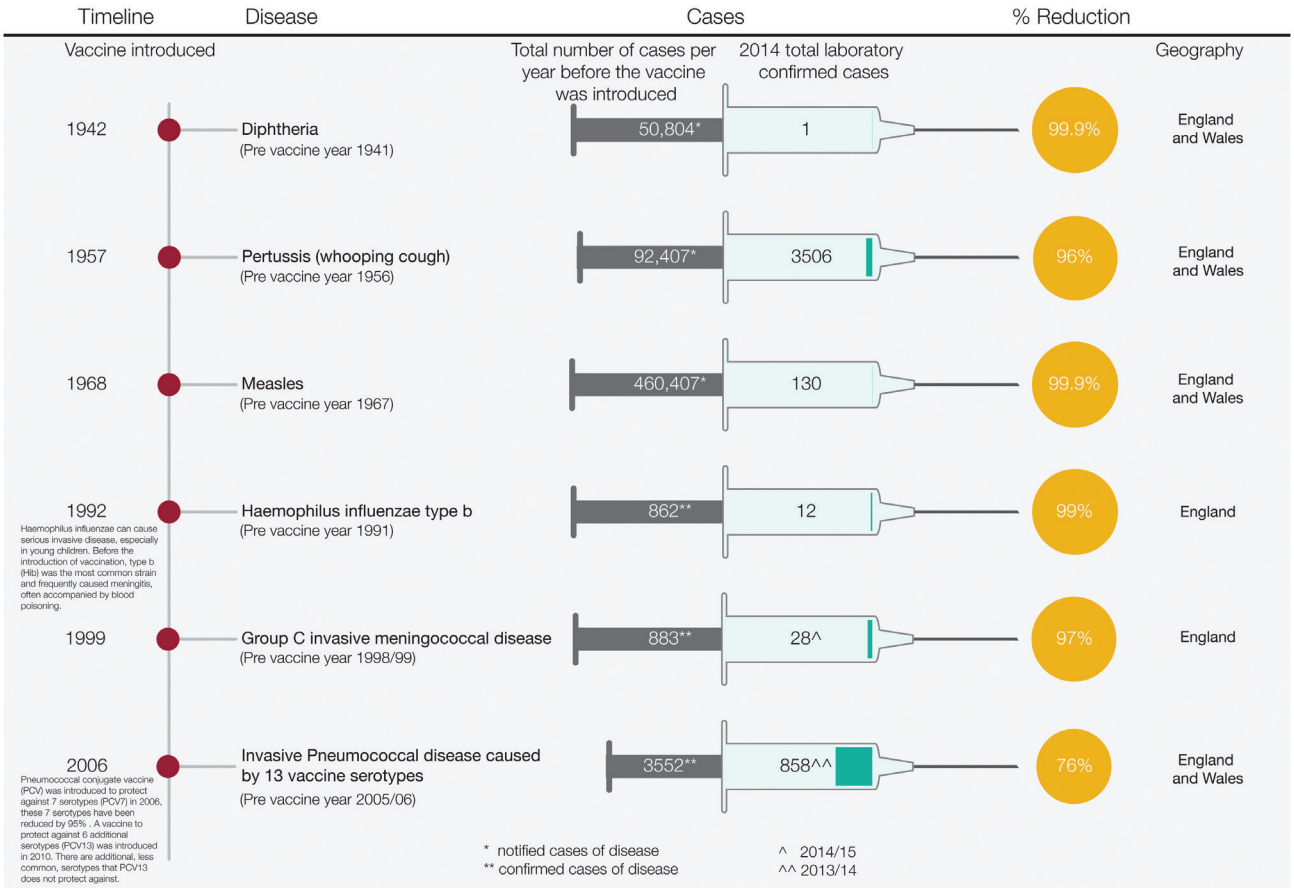


Image reproduced with permission from PHE.

A glossary of technical and medical terms can be found at the end of the document along with a Useful Links section to provide you with further resources should you wish to know more.

10 QUESTIONS TO CONSIDER WHEN SCRUTINISING LOCAL IMMUNISATION SERVICES

These questions are designed to give background and context for HOSCs and HWBs to consider and explore to ensure local immunisation services are effective and responsive.

1. Why is immunisation important and how is policy for vaccination decided in the UK?

Background and policy context

Immunisation is a proven tool for controlling and eliminating infectious diseases and the World Health Organisation (WHO) have estimated it to avert between two and three million deaths globally each year. [3] The primary aim of vaccination is to protect the individual. However, because vaccinated individuals are less likely to be a source of infection to others the risk to those not protected by vaccination being exposed to infection is reduced, this is a concept known as 'herd immunity' (or 'community immunity'). It is, however, important to note that not all diseases can be eradicated. Infections such as tetanus can only be kept at bay by protection of the individual. Tetanus spores are present in soil or manure and can be introduced into the body through a puncture wound, burn or scratch so protection against tetanus is individual.

Vaccine policy in the United Kingdom is advised by the JCVI, whose remit is;

"To advise UK health departments on immunisations for the prevention of infections and/or disease following due consideration of the evidence on the burden of disease, on vaccine safety and efficacy and on the impact and cost effectiveness of immunisation strategies. To consider and identify factors for the successful and effective implementation of immunisation strategies. To identify important knowledge gaps relating to immunisations or immunisation programmes where further research and/or surveillance should be considered."

The JCVI has no statutory responsibility to provide advice to ministers in Scotland or Northern Ireland. However, health departments from these countries may choose to accept the Committee's advice or recommendations. UK health departments are made aware of all JCVI advice through their designated observers who attend JCVI and sub-committee meetings and receive committee papers.

Decisions on the national vaccination programmes are taken after scrutiny of available evidence and literature both published and unpublished, alongside analysis of epidemiological data of disease incidence and consideration of the economic and health benefits of specific vaccinations and the benefit of making changes to the schedule.

The NHS delivery of immunisation programmes is good and uptake rates in the UK are generally very high. The key reasons for this are:

- A right to be immunised, free of charge, is enshrined under the NHS Constitution and as such vaccines for the NHS programme are provided free of charge to patients.
- The COVER programme (Cover of Vaccine Evaluated Rapidly); [4] since 1987 this programme has improved coverage by collecting, analysing and publishing data on vaccine uptake at local level in a consistent way across the country enabling changes in vaccine coverage to be detected quickly.
- The ongoing surveillance of all immunisation programmes to ensure maximum benefit to the individual as well as safety and cost-effectiveness through the JCVI.
- The continued high priority given by the government to the national childhood immunisation programme. With a commitment within NHS England and PHE structures that supports the effective delivery of immunisation programmes.

- Regular updates and information via tripartite (Department of Health (DH), PHE and NHS England) communications.
- Requirements for training and updates at a local level. PHE have developed a core curriculum and national minimum standards as well as a range of training resources. [5] There is a joint RCN and PHE training guidance resource [6] and a framework to asses staff competence in the workplace. [7]
- The regular updating of national policy guidance in the online resource, 'Immunisation against infectious disease' ('The Green Book' [8]).
- Publicity and information materials to support the programmes, including leaflets and factsheets developed by the immunisation team at PHE and made available via NHS Choices and the government website.

Questions to ask/consider?

An effective immunisation programme should encompass key 'Quality Criteria' - these were previously defined by the Health Protection Agency (HPA) in 2012; the HPA is now part of PHE. [9]

1) How is information and advice on changes and amendments to the schedule cascaded to services delivering vaccination?
2) Is immunisation a high priority area locally and does the local Joint Strategic Needs Assessments (JSNA) reflect the importance of maximising immunisation uptake across the life course for adults and children and is it updated to reflect new vaccines added into the national programme?
3) Is vaccination available easily and actively offered to those who need it and the service designed to make sure that every opportunity is taken to make sure those eligible are assessed and offered vaccination appropriately.
4) Are there call and recall systems in place in primary care and are staff alerted to the fact that a patient is due a vaccine?
5) Are there effective documentation and record keeping processes to ensure accurate information is available on population coverage and that the individual has a lifelong record?
6) Are vaccine related incidents reported and managed appropriately and are lessons learnt and disseminated.
7) Are there effective mechanisms to ensure vaccines are transported and stored appropriately so that vaccines given are of optimum quality?
8) Is training available for staff? The vaccine programmes are complex; training and access to support should be available for anyone involved in immunisation. All staff need to know where and how to access this.
9) Is there effective coordination so that all the elements of the immunisation programme are appropriately aligned and accountable?

2. Why is it important to scrutinise immunisation?

Background and policy context

Systematic review of vaccination uptake has been a key requirement for many years, to enable close analysis of pockets of poor uptake in order to support prediction of potential problems and implementation of early measures to mitigate these. The Public Health Outcomes Framework (PHOF), 'Improving outcomes and supporting transparency' [10] includes immunisation coverage rates as a continued outcome measure for reporting with the addition of the requirement to report on the uptake for targeted vaccinations and those given to teenagers and adults in a similar way to routine childhood vaccinations.

The PHOF Data Tool (under Indicator 3.03) enables individual local authorities to "compare and contrast" data, across a spectrum of immunisation indicators, against neighbouring authorities within the region and against an England average. [11]

The NHS England commissioning, Immunisation and Screening National Delivery Framework and Local Operating Model 12 sets out the arrangements for delivery and governance of immunisation and screening programmes and, importantly, who is responsible for the various aspects of immunisation.

NHS England/Public Health England

NHS England local offices are responsible for commissioning the national immunisation services locally and for providing system leadership to all those involved. Each NHS England local office has one or more public health commissioning teams made up of both NHS England-employed staff and public health professionals who are employed by PHE but are "embedded" within NHS England in order to provide public health leadership and expertise for these programmes.

Contracts to provide immunisation services are held with a range of providers;

- General practices for immunisations given in primary care (this includes vaccines given to children up to 5 years old and others)
- Community providers for immunisations that are given in a school setting (for example the childhood flu and the teenage vaccines).
- Contracts may also be held with community pharmacists (for example for flu vaccine) and sometimes with maternity services for the vaccines given to women who are pregnant (whooping cough and flu).

The NHS England teams will offer help and support to immunisation providers as well as monitoring uptake and taking action where uptake could be improved whilst acknowledging that immunisation is also a choice for parents and patients.

NHS England also holds contracts with the local provider of the Child Health Information System (CHIS). The CHIS should keep a record of every child's immunisation status and is the source for the childhood immunisation uptake data.

Clinical commissioning groups (CCGs)

CCGs have a responsibility for the quality of primary care services provided by the general practices within their organisation. CCGs are encouraged to see immunisation uptake rates as a marker for good quality primary care. Many CCGs include measures such as flu immunisation uptake and MMR uptake as quality measures in a "balanced scorecard" approach to quality.

Local Authority Director of Public Health (DPH)

The DPH has an assurance function. They need to assure themselves that the arrangements for immunisation are fit for purpose and are delivering service of high quality. Many local authorities exercise this responsibility via a health protection board as a sub-group of their health and wellbeing board.

Relationships between the local providers and commissioners and the HOSC and HWB are crucial in making sure the links between the various elements are transparent.

Increasingly the discussion about immunisation has expanded to recognise that immunisation is not only important in reducing preventable illness but also in minimising the consequences of infection for those with chronic conditions. For example, seasonal flu immunisation prevents not only excess winter deaths but reduces both hospitalisation and winter pressures on accident and emergency departments and it may, in turn, reduce nursing costs and residential home placements.

Immunisation should not always be a subject of scrutiny in isolation. When HOSCs are considering other topics, immunisation pathways should be included in the review. For example, a scrutiny of local maternity services could include a review of the provision of pertussis vaccination or of hepatitis B immunisation for at-risk neonates and, similarly, a review of support for older or vulnerable adults with long term conditions could consider how well they are protected through seasonal flu immunisation programmes.

Questions to ask/consider?

1) Is it clear who is responsible for commissioning immunisations within the NHS England local office?

2) Are providers of immunisation services (general practices and school-aged immunisation providers) clear who is responsible for commissioning and system management of immunisation services locally?

3) What are the reporting mechanisms within NHS England locally to show that immunisation performance is being given sufficient importance?

4) What systems does the DPH have in place to provide themselves with the assurance they need that immunisation services locally are fit for purpose?

5) Are practice level immunisation rates used by CCGs as a quality measure of general practice in their area?

3. How do you know which vaccines are available on the NHS?

Background and policy context

The routine schedule constantly evolves as research identifies better use of the vaccines currently available and as new vaccines become available. The schedule is developed to ensure that the most cost-effective programme is in place to protect the public from vaccine-preventable illness. Some vaccines are recommended for everyone whereas others are only recommended for those at greatest risk of developing severe disease or at particular risk of infection.

The timeline below shows when vaccines were introduced into the UK schedule.

Source PHE : https://www.gov.uk/government/publications/vaccination-timeline

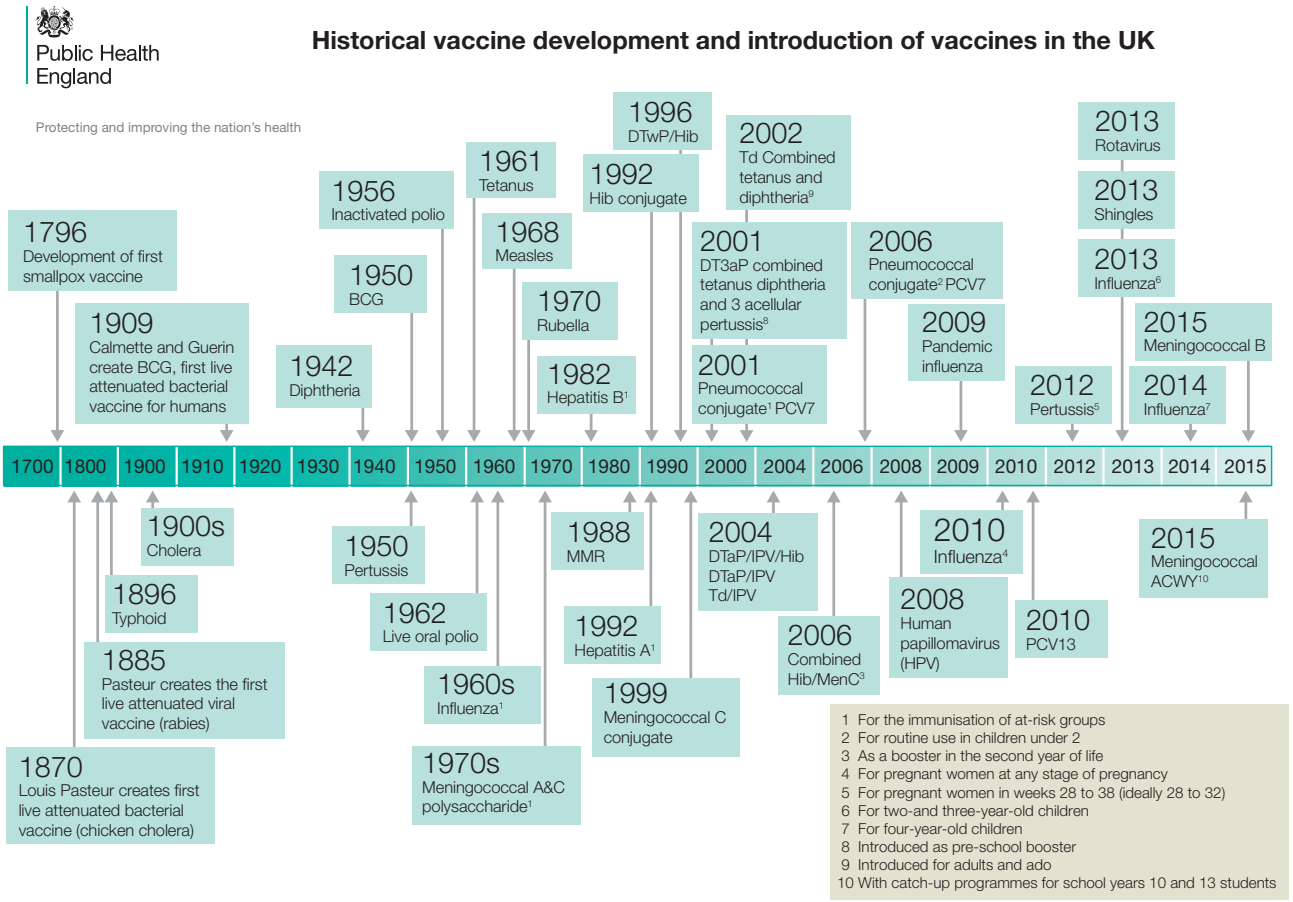


Image reproduced with permission from PHE.

The current complete routine schedule is available from PHE. [13] The detail behind it is presented in the DH publication 'Immunisation against infectious disease', [8] the Green Book which is regularly updated and only available on-line.

Childhood vaccines (under 5 years) are given to protect against the following diseases;

- rotavirus
- diphtheria
- tetanus
- polio
- meningococcal serogroup B (Men B)
- pertussis (whooping cough)
- haemophilus influenzae type b (Hib)

- meningococcal serogroup C (Men C)
- pneumococcal disease
- measles
- mumps
- rubella
- influenza
- hepatitis B } For babies identified as being at risk.
- BCG for tuberculosis } For those in defined high risk groups

School-aged vaccines are given to protect against the following diseases;

- tetanus
- diphtheria
- polio
- meningococcal serogroups ACWY (Men ACWY)
- human papilloma virus (HPV); in girls
- influenza

Adult vaccines are given to protect against the following diseases;

- shingles
- pneumococcal disease
- influenza
- pertussis; vaccine given in pregnancy to protect the new-born infant.

This guidance covers vaccines given as part of national immunisation programmes to protect the public's health. Certain vaccines are given for specific clinical need to those with particular health problems; these are not monitored for uptake as part of wider public health scrutiny.

It is important to note that the schedule will continue to change and evolve with the development of new vaccines and with ongoing evidence from surveillance of diseases. Changes are often widely reported in the press and sometimes cause some anxiety amongst the public and also in staff delivering the services.

The schedule may change to make sure individuals are protected against infections for as long as possible, for example, introducing a booster of pertussis (whopping cough) vaccine to teenagers and changing the schedule for meningococcal vaccination. HPV vaccination for boys may be recommended in due course, if it can be shown to be cost effective. These decisions are for the JCVI to make.

Questions to ask/consider?

1) Are staff locally aware of how to access the current schedule and where to look when things change?

2) Are staff locally aware of the local commissioning arrangements and who to contact for advice and support?

3) Are publicity campaign materials available? These are generally developed nationally and can be useful in raising awareness but there is also a need to ensure that professionals receive appropriate training to promote immunisation and support children, parents and adults taking up the offer to protect themselves.

4. How does your local authority know what the uptake of particular vaccines is in the local population?

Background and policy context

Data is key to understanding how successful local immunisation programmes are in protecting local people from preventable diseases through vaccination.

Different immunisations are reported through different data collection pathways, most of which involve an element of time delay between the immunisation being administered and recorded at a local level and the immunisation being reflected in local authority statistics. Data and reports for England on the coverage of vaccinations offered under the national immunisation programmes are available from PHE. [4]

Immunisation data for seasonal flu is the timeliest, collated via GP practice systems. Routine childhood immunisations are reported through the COVER system. The delay on this can be up to 18 months as the data is extracted based on the age of the child, not the chronology of the immunisation. For example, a child who is appropriately immunised at 12 months old with MMR will not be reflected in the statistics until they reach 24 months and are included in the 2 year old data cohort.

Despite various initiatives over the years there continues to be a wide variation of uptake to immunisation programmes across the country. Every effort should be made to ensure that all those eligible are offered immunisation. Some vaccines continue to be indicated even if they are not given at the ideal time. This would include vaccines such as MMR and tetanus. Some other vaccines may not continue to be indicated if the child has exceeded the aged where the risk is highest. This would apply to rotavirus and to childhood pneumococcal vaccines for example.

Questions to ask /consider?

1) What activities are in place to ensure these figures are increased to meet WHO “aspirational” targets?

The PHOF Data Tool [11] (under Indicator 3.03) enables an individual authority to “compare and contrast” data, across a spectrum of immunisation indicators, against their neighbouring authorities within the region and against an England average. Comparisons with ONS-defined peer authorities can be a very useful way of using this sort of data as this helps to lessen the impact of population factors (such as deprivation) and increase the impact of service differences. The following highlight the key areas to look at.

Children aged 0-5

2) What is the uptake of 2 doses of MMR vaccine in children at 5 years of age? WHO Europe has a regional goal to eliminate measles and rubella disease. [14] To achieve this, there is a recommendation of 95% coverage of two doses of measles-containing vaccine.

3) What are the uptake rates across the programme; 12 months – primary immunisation, 2 years – child immunisation course and 5 years – completed primary immunisations and boosters?

4) How is the local area performing against national standards for childhood immunisation? How well is the area performing both in absolute terms and in comparison to neighbouring/ peer authorities and to national rates?

5) Is practice level data fed back to practices on a regular basis? Do practices know how well they are doing in comparison to national targets and to neighbouring practices?

School-aged children

6) What is the uptake for HPV vaccine and how well is the area performing both in absolute terms and in comparison to neighbouring/peer authorities and to national rates?

7) What is the uptake for the teenage booster vaccine and how well is the area performing both in absolute terms and in comparison to neighbouring/peer authorities and to national rates?

8) What is the uptake for the Meningococcal ACWY vaccine, given as part of the teenage booster, and how does this compare to neighbouring/peer authorities and to national rates?

9) What is the uptake for the influenza vaccine given to school-aged children and how well is the area performing both in absolute terms and in comparison to neighbouring/peer authorities and to national rates?

Adult vaccines

10) What is the uptake locally for the seasonal flu vaccine and how does this compare to neighbouring and/or similar areas?

- in those aged 65 and over,
- in those in clinical at-risk groups,
- in pregnant women,
- in carers in receipt of an allowance
- in local health and social care staff

11) What is the uptake for the adult pneumococcal vaccination and how well is the area performing both in absolute terms and in comparison to neighbouring/peer authorities and to national rates?

12) What is the uptake for the shingles vaccination and how well the area is performing both in absolute terms and in comparison to neighbouring /peer authorities and to national rates?

13) What is the uptake for the pertussis vaccination in pregnancy and how well is the area performing both in absolute terms and in comparison to neighbouring /peer authorities and to national rates.

5. Why and when should children aged 0-5 years receive vaccinations?

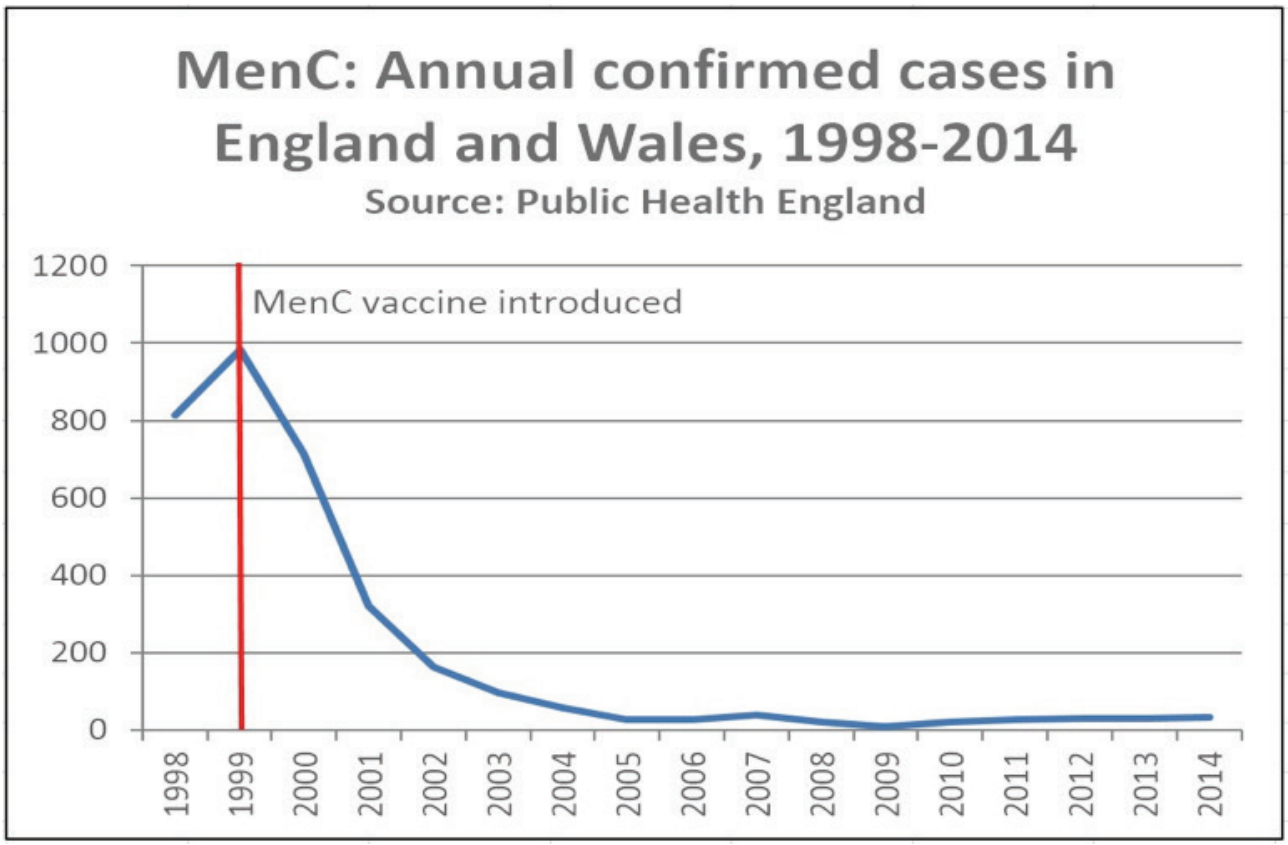
Background and policy context

The childhood immunisation programme in the United Kingdom (UK) protects young people against a wide number of infectious diseases, such as measles, polio, diphtheria and pertussis (whooping cough). What has been forgotten is how, in the past, large numbers of children either died or were left with permanent damage to their health and wellbeing because of these infections and their complications. The success of the immunisation programme can reduce the perception of the severity of these diseases both with the public and amongst health professionals.

The immunisation programme is an essential part of protecting children's health. Low vaccine uptake puts children at risk, particularly in view of recent outbreaks of measles, mumps and pertussis.

As examples, it is worth noting that:

- Before the introduction of MMR vaccine in 1988, approximately 1,200 people across England and Wales were admitted to hospital each year because of mumps. [8]
- Since 2000, the Meningitis C vaccination programme has prevented over 9,000 cases of serious disease and more than 1,000 deaths. There have been only 2 deaths in children and young people under 20 in the last 5 years, compared to 78 deaths the year before the vaccine was introduced. [8]



- Before the introduction of the haemophilus influenzae type b (Hib) vaccination in 1997, one in every 600 children developed Hib meningitis or other serious forms of disease before their fifth birthday. Today, there are only a handful of cases in young children. [8]

Vaccines should be given as soon as a child reaches the age at which the vaccine is indicated. Generally young infants are most at risk and therefore the majority of vaccines are given in infancy and childhood.

The schedule is complex, with boosters and repeat doses recommended during the child's life to complete the programme and maximise protection.

Where children are born in other countries they should be offered relevant vaccinations to bring them into line with the UK schedule as quickly as possible. Wherever possible the vaccines should be given together to minimise the number of appointments the child needs to attend.

Guidance on this is clearly detailed in the Green Book [8] and in a specific PHE resource vaccination of individuals with uncertain or incomplete immunisation status. [15]

Questions to ask/consider?

1) What structure is in place to achieve oversight, monitoring and coordination of services (e.g. a local strategy and/or implementation committee)? Are the responsibilities of those involved clearly defined?

2) What arrangements are in place to provide appropriate, regular reports to the local authority, CCG, Children's Trust Board, HWBs etc. about local providers' performance?

3) Are local immunisation providers aware of new structures, sources of expertise and key contacts?

4) The majority of vaccines at this age are given in primary care, are the mechanisms between primary care and the local CHIS system robust to ensure accurate data transfer so the figures reported are correct?

5) Who is responsible for inviting children for their routine immunisations? If it is general practices do we know that every practice is actively inviting children at the correct time for each vaccine? If invitations come from the child health information system are we sure their registers are complete and that they are calling children at the correct time?

6) Do we know if any practices have waiting lists for routine childhood immunisations?

7) Do the local systems enable opportunistic and catch-up vaccination?

8) Many practices have fixed immunisation clinics, for example, every Tuesday morning. Are practices able to offer appointments at other times if parents are unable to attend the fixed clinic?

6. Why and when should school-aged children receive vaccinations?

Background and policy context

Vaccines given to school-aged children are part of the wider schedule, giving boosters for certain vaccines given first in early childhood and infancy or specific vaccines recommended to be given at this age. The timing of when to give vaccines is often a balance between when the disease is most likely to be contracted and the age when the vaccine would be most effective. Vaccines are given in early childhood to provide timely protection at a time when they are most vulnerable. As the immune system matures through childhood and into teenage years, boosters of vaccines given in early childhood prolong the longevity of the protection, thus ensuring that protection against these infections lasts through to adulthood.

The meningococcal ACWY vaccine which is given alongside the teenage booster for diphtheria, tetanus and polio will enhance the protection against the meningococcal C serotype, from the vaccines given to children in early childhood, and add protection against A, W and Y serotypes. Vaccines are also given to school-aged children because this is the most appropriate age; for example the HPV vaccine which protects against cervical cancer and is given to teenage girls before the age when they are likely to become infected. The influenza vaccine for children is given in primary care settings to those in early childhood and then normally in school as children gets older.

In terms of access it makes sense to give vaccines at a venue where children already are. This helps improve uptake and makes it as easy as possible for individual children to be able to benefit, preventing additional appointments out of school and potential time out from the school day.

It is important that records of vaccines given at school are shared with each child's GP so that their patient records are kept up to date. The information also needs to be recorded on the CHIS system. For vaccines given in primary schools, written parental consent is always sought in advance and vaccines will not be given without this being available. For children in secondary schools written consent is normally sought in advance involving both the parent/guardian and the young person. On occasions, if a young person wishes to receive a vaccine and is considered to be 'Gillick' competent, a vaccine may be given in the absence of parental consent. [16]

The process for school-based vaccination requires close liaison between the service providing the vaccination (often but not always the school nursing service), the schools, parents or guardians and the children or young people themselves.

It needs to consist of a process for advising parents and guardians and the school staff and gaining consent. It requires administration for the vaccination sessions, arranging appropriate times in liaison with the school to avoid for example school examinations. School-based vaccination sessions also need to consider the practicalities of providing a clinical health procedure in school such as maintaining infection control, having a process for transporting vaccines so that they stay at the correct temperature, this normally requires the use of appropriate medical cool boxes. It also needs to consider the disposal of needles and syringes, so having appropriate sharps disposal.

The school-based sessions, as well as at school entry at reception and year 7 or whenever the child joins the school, are good opportunities to check on the child's immunisation history and can serve as a useful reminder to parents or guardians. Similarly school trips can be helpful in checking the child is fully protected. For many vaccines it will still not be too late if the child has previously missed out and parents or guardians can be advised to go to their GP surgery. Given the complexity it may be appropriate, depending on the staff and service available, to think of what other health promotion could be built in around these sessions.

Questions to ask/consider?

1) Are vaccines for school-aged children given in a school setting or by general practice?

2) If not given in school how is the access for children ensured so they do not have to miss too much school. For example, is there provision for evening and weekend clinics?

3) If given in schools, are all schools included (e.g. academies, public schools, independent schools, special schools etc)?

4) Are there any schools that do not allow immunisation sessions within the school? If so, what arrangements are in place to offer the children a service?

5) How are those not at school on the day offered a service, for example those who are sick, are home educated or attend pupil referral centres?

6) If children miss the opportunities in school can these vaccines be given in general practice, if necessary?

7) Are health screens used to check on immunisation history at school entry or for school trips?

8) Do schools use health promotion opportunities on, for example, school admission documentation on which vaccines children should have received with advice on where to go?

9) Do local services support young people to check they are fully immunised before leaving school?

7. Why and when should adults receive vaccinations?

Background and policy context

Immunisation is often seen as the domain of children, however, immunisation should be seen as a necessary intervention across all stages of life, as part of a life course approach.

Analysis from Age UK, [17] demonstrate that the population is ageing rapidly. There are currently approximately 15 million people over 60 years of age and the projections estimate that this will rise to 20 million over 60 by 2020. By 2040, 24.2% of the UK population will be aged 65 or over and the number of people who are over 85 will more than double. Evidence demonstrates that older people are at greater risk of morbidity and mortality from vaccine-preventable diseases. Research from the University of Birmingham has identified several reasons why vaccination is increasingly important within older age groups: [18]

- Older people may be at increased risk of serious illness or death resulting from certain common infections.
- Immune function decreases with age, leading to increased susceptibility to more severe and frequent infections.
- Older people may not have received immunisations in younger years and newer vaccines may not have been available to them when they were children.
- Boosters may be recommended for immunity that decreases with age.

As well as the increase of co-morbidities, increasing frailty and moving to institutional living, where infections are more easily transmitted, may also be contributing factors.

Adults require protection against vaccine-preventable disease when travelling – this increasingly includes those "Visiting Friends and Relatives" (VFR) as well as trips for business or holiday. While many of the vaccines recommended for travel are not covered by the NHS, it does provide an opportunity to make sure adults are up to date with the routine scheduled vaccinations.

The Best Practice Guide 'Vaccination programmes in older people' from the UK British Geriatric Society [19] recommends greater emphasis on vaccination in older people. It is recognised that while the immune response to vaccines is less than in younger people there is good evidence that they can significantly reduce the impact of infectious illnesses and therefore should be actively promoted. There has also been a call for a life course approach to vaccination by the International Longevity Centre UK [20] as an essential part of preventative health care across the population.

There is similar recognition from the EU that the older population is not properly protected from vaccine-preventable disease. [21] The WHO recommends that where national flu vaccination policies exist, strategies should be established and implemented to increase vaccination coverage of all people at high risk, including the elderly and persons with underlying diseases, with the goal of attaining vaccination coverage of the elderly population of at least 75% as well as in those under 65 years of age with clinical risks and for pregnant women and to also encourage healthcare workers to take up the vaccination. [22]

Herpes Zoster (shingles) vaccine is recommended for those aged 70 with a phased 'catch up' so that those up to 79 are offered the vaccine.

Vaccinations offered in pregnancy through the maternal vaccination programme include influenza, given during the flu season as pregnant women are at higher risk of complications that can threaten both mother and baby. Maternal vaccination also helps protect babies during the first few months of life when pertussis (whooping cough) can be a very serious illness.

Some vaccines are recommended for specific occupations to protect the staff but also the public from inadvertent cross infection. These include; health and social care staff, environmental health staff, laboratory technicians etc. These vaccines are the responsibility of the employer to provide and are not part of NHS provision. Apart from monitoring of the uptake for seasonal flu vaccination in health and social care staff, occupational health vaccination is not part of the NHS and as such detailed description of occupational health vaccination is not included in this guidance.

Whilst the UK is well ahead of most countries of the EU, with uptake of seasonal flu vaccination for the over 65 year olds at just below the WHO target of 75%, the uptake in certain groups remains inadequate, for example, frontline health and social care workers (HCW). 4

Questions to ask/consider?

1) What specific measures are in place to ensure that those older people who are living together in settings, such as long-stay residential care homes, are suitably immunised?

2) How are local services delivering immunisation to pregnant women? Are vaccinations available via midwifery services?

3) The Department of Health recommends that every employer has ambitious flu immunisation programmes for frontline health and social care workers to significantly improve upon their uptake; what is the % coverage rate for front line HCW staff in local primary and secondary care settings, and what activities are in place to ensure that this figure is increased? What initiatives are in place to ensure high coverage of HCW flu vaccination uptake?

4) Is there any local data relating to seasonal flu vaccination of frontline social care staff? If yes, how well is the area performing? If not, are there any plans to gather this important data in future?

8. Are sufficient measures being taken to ensure that local people are adequately protected from vaccine-preventable illnesses whilst abroad "Visiting Friends and Relatives" (VFR)?

Background and policy context

Travel, whether for leisure or business purposes or in order to visit friends and relatives, has steadily increased from the 1980s until now. Provision of travel vaccines as part of NHS core responsibilities is limited to diphtheria, polio and tetanus as a combined booster, typhoid, hepatitis A and cholera. [23] Other vaccinations for travel purposes may entail payment and not all primary care providers will wish to provide a service.

There are instances of mandatory vaccination for travellers. For example, Saudi Arabian authorities require those undertaking pilgrimage to Mecca to have certain vaccinations and vaccination against Yellow Fever (YF) is still required for travellers to many YF endemic countries or for entry into other countries for travellers arriving from YF endemic countries. General information on immunisation, travel advice and health risks when travelling overseas, can be found at the NaTHNaC (National Travel Health Network and Centre) website. [24]

Few of the health hazards associated with travel outside the UK are preventable by vaccination, however, those that can be prevented by vaccination can be very serious and potentially fatal.

Attendance for vaccination also offers the opportunity for the practitioner to offer additional travel health advice, particularly around malaria, food and waterborne illness such as salmonella and typhoid as well as HIV and other sexually transmitted diseases.

Questions to ask/consider?

1) Have there been any initiatives to make information available to members of ethnic minority communities about the need to seek health protection advice and services for those VFR travellers?

2) Do all practices actively promote travel advice and vaccination in their surgeries?

3) What means are taken to ensure that comprehensive education and awareness information is made available for those VFR, in order to promote correct messaging and encourage immunisation?

4) Do local pharmacies offer advice on protecting health when travelling abroad?

5) From a wider perspective, how much engagement takes place with religious community leaders to ensure that health protection messages around the benefits of immunisation are properly communicated and in turn cascaded out to their communities?

9. What policies are in place for the two childhood programmes that are offered to specific at-risk groups?

Background and policy context

There are two childhood immunisation programmes that are not universally offered to all but are offered to those at specific risk. These are the programmes for BGC vaccine for tuberculosis (TB) and hepatitis B vaccine to babies born to mothers who are infected with the hepatitis B virus.

BCG vaccine for tuberculosis

BCG vaccine used to be given to all children in their teenage years to help prevent TB in young adults. This strategy was ceased in 2005 due to a continuous decline in TB in the indigenous UK population and was replaced by a targeted approach. BCG should now be offered to the following groups: [8]

- All infants (aged 0 to 12 months) living in areas of the UK where the annual incidence of TB is 40/100,000 or greater
- All infants (aged 0 to 12 months) with a parent or grandparent who was born in a country where the annual incidence of TB is 40/100,000
- Children older than 12 months who have not been previously vaccinated, with a parent or grandparent who was born in a country where the annual incidence of TB is 40/100,000.

BCG is a difficult vaccine to give and most people who give other childhood vaccines are not trained to give BCG vaccine. It is important that staff who do give BCG vaccine are adequately trained in the specific technique.

The vaccine is shown to have varying efficacy. It is most effective at preventing the most severe forms of the disease, such as TB meningitis, in young children and this is the reason it is given in this context. It has limited effect on pulmonary disease which tends to affect older people.

Neonatal hepatitis B vaccine

All women who are pregnant are offered a blood test to see if they are infected with hepatitis B virus. It is not uncommon for people to become chronically infected with the hepatitis B virus and this poses a threat to the baby if the mother is infected in this way. If babies contract hepatitis B from their infected mother then 90% will themselves become chronically infected with the risk of serious liver disease later in life including cirrhosis and liver cancer.

Babies born to mothers who are known to be hepatitis B positive should be offered a course of hepatitis B vaccine with doses given at birth, 1 month, 2 months and 12 months, so four doses in all. The children should also be tested at 12 months to check whether they have become infected with hepatitis B. It is very important that these children receive all four doses of the vaccine in a timely manner. [8]

Questions to ask/consider

1) What BCG policy currently applies in the local authority area and why? Are all neonates offered BCG because it is a high prevalence area or is it offered only to those with a parent or grandparent from a high prevalence country?

2) If it is a targeted approach is there a clear and written pathway describing who assesses the need and who is responsible for giving the vaccine?

3) If eligible babies get discharged from hospital without receiving BCG vaccine what are the follow up and fail-safe processes to ensure that the child is offered the vaccine?

4) What data is available on the number of babies born in the area who are eligible for BCG vaccine and the number of these babies who received a BCG vaccine?

5) Is there a clear and written pathway for identifying babies born to mothers who are hepatitis B positive? Does this clearly identify the necessary communication required between maternity services, health visitors, general practice and child health information departments?

6) Who is responsible for scheduling each immunisation appointment and what are the failsafe procedures to ensure that children are not lost to the system?

7) What data is available on the number of babies born to hepatitis B positive mothers and the completeness of each eligible child's immunisation status?

8) Who is responsible for undertaking the blood test for each eligible child at 12 months and what proportion of these tests are completed?

10. How do you know vaccination is easily accessible to everyone in the population?

Background and policy context

Immunisation provides clear protection for the health of the individual; systematic and unjustified differences in immunisation rates between population groups should be viewed as an avoidable inequality in health.

For most immunisation programmes improving uptake impacts on the herd immunity. Reducing inequalities in uptake therefore also improves the overall effectiveness of immunisation and its health benefits.

There is a moral justification for reaching out to as many of those who can benefit from immunisation as possible. If some groups are systematically 'not reached' then services need to work hard to ensure that their offer is set out, or tailored, in the right way, so that the benefits of immunisation are clearly expressed and understood by the intended recipient groups.

The local JSNA may include case studies of inequalities in vaccinations and immunisations.

NICE guidance, [25] demonstrates the evidence which shows that the following groups are more likely to be at risk of not being fully immunised:

- Those who have missed previous vaccinations (whether as a result of parental choice or otherwise)
- looked-after children
- those with physical or learning disabilities
- children of teenage or lone parents
- those not registered with a GP
- younger children from large families
- children who are hospitalised or have a chronic illness
- those from some minority ethnic groups
- those from non-English speaking families
- vulnerable children, such as those whose families are travellers, asylum seekers or are homeless

Patient reminders and recall systems are also shown to be effective in developed countries such as the UK. [26]

Although population level coverage is presented in the PHOF national benchmarking tool, [7] coverage of vaccinations can be compared to other local authorities. The area statistics are not broken down by important inequalities groups. Therefore, monitoring uptake is not possible but HOSCs should consider how accessible and available the services are across the population.

Infectious diseases contribute to health inequalities. The burden of disease falls disproportionately on disadvantaged groups such as older people, the homeless and the chronically ill. [27] These vulnerable groups are also those most likely to be at risk of not being fully immunised.

The scrutiny needs to focus on what arrangements are there to identify patients who are resident within the area but are not registered with primary care providers. Although most people are registered with primary care providers, there are certain recognised groups who are known to fail to engage with services, including vaccination services. Those groups include the homeless, drug and

alcohol abuse clients, asylum seekers (either through fear of detection if staying illegally or through ignorance/lack of information about access to health services), traveller communities, those with learning difficulties, looked-after children, children excluded from school and young offenders.

Questions to ask/consider?

1) Has an equity audit been undertaken to understand different uptake of immunisation in different population groups?

2) Given the importance of repeated failure to attend immunisation appointments as a warning sign in several high profile child protection cases, how does the local immunisation programme integrate its safeguarding responsibilities around children who repeatedly do not attend immunisation appointments?

3) How are local GPs being encouraged and/or incentivised to achieve higher coverage?

4) How are the local GP practices being monitored and supported to ensure that 'early years' immunisations are optimised?

5) Are opportunities optimised to immunise immigrants from developing countries? And are translated materials or translator access available for immunisation appointments?

6) Is advice about vaccinations available and/or promoted at pharmacies, libraries, community centres, retail outlets, etc. (i.e. places other than those where vaccinations are given)?

7) Is enough being done to ensure people are fully able to access immunisation services? For example, weekend clinics and/or opportunistic services?

8) Is vaccination advised at other opportunities e.g. A&E, Outpatients, Developmental Assessments and Child Health Reviews, so that every opportunity is taken to identify unprotected individuals and advise on vaccination?

9) Can the Scrutiny Committee be reassured that providers;

- regularly review their arrangements to assess who is at increased risk of vaccine-preventable diseases?
- are making efforts to offer appropriate advice and services to the most vulnerable groups?

10) If there are homeless hostels or gypsy and traveller sites in the area, how is the immunisation programme making specific outreach and engagement efforts to provide services in these locations?

11) What arrangements/agreements are in place for dealing with single cases or outbreaks of communicable disease for which vaccination of contacts may be required? Does any agreement/ plan identify resources that can be mobilised, as required?

USEFUL LINKS

Inside Government – Gov.uk website

'The Green Book' ('Immunisation against infectious disease') has the latest information on vaccines and vaccination procedures for all the vaccine-preventable infectious diseases that may occur in the UK.

Available From:
https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

The complete immunisation schedule can be found at:

https://www.gov.uk/government/publications/the-complete-routine-immunisation-schedule

There are also other general and specific resources on vaccination including; training resources, Q&A documents, leaflets and posters.

Available From: https://www.gov.uk/government/collections/immunisation

PHE Vaccine uptake guidance and the latest coverage data

Vaccine coverage data reports for England of vaccinations offered under the national immunisation programme for;

- influenza,
- human papillomavirus (HPV),
- rotavirus,
- pertussis (whooping cough) for pregnant women
- shingles
- COVER data programme which evaluates childhood immunisation in England.

Available from: https://www.gov.uk/government/collections/vaccine-uptake

Health and Social Care Information Centre (HSCIC)

NHS Information Centre (for Health and Social Care) publishes uptake statistics on an annual basis which looks at the number of children who are immunised against childhood diseases by their first, second and fifth birthdays, those people over the age of 65 immunised against influenza and immunisation against tuberculosis (BCG).

Available from: http://www.hscic.gov.uk/searchcatalogue?productid=18810&topics=1%2fPublic+health%2fHealth+protection&sort=Relevance&size=10&page=1#top

Public Health Outcomes Framework

The Public Health Outcomes Framework, part of 'Healthy lives, healthy people: Improving outcomes and supporting transparency' sets out desired outcomes and indicators to provide an understanding of how well local public health is being improved and protected.

Available from: http://www.phoutcomes.info/

The indicators for 'population vaccination coverage' are under the health protection section covers all vaccination programmes across the life course.

Available from: http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000043

The on-line framework is set out as an interactive tool which enables an individual local authority to "compare and contrast" (across a spectrum of immunisation indicators) their performance against their neighbouring authorities within the region and against an England average:

NHS Choices

Set up as a first-line for information for the public and includes a comprehensive section on immunisations recommended across the life course. It includes which vaccinations are offered to all on the NHS, at what age, and the optional vaccinations for those considered at-risk.

Available from:
http://www.nhs.uk/Conditions/vaccinations/Pages/vaccination-schedule-age-checklist.aspx

NICE

PH21; reducing differences in the uptake of immunisations (issued September 2009, reviewed March 2013): Provides guidance on differences in the uptake of immunisations (including targeted vaccines) in people younger than 19 years. The guidance aims to increase immunisation uptake among those aged under 19 years from groups where uptake is low. It also aims to ensure babies born to mothers infected with hepatitis B are immunised.

Available from: http://www.nice.org.uk/PH21

Key Operational Documents

NHS England work closely with the DH in commissioning a number of public health services, including immunisation. Key documents that underpin these services are:

- The NHS Public Health Functions Agreement (Section 7a services), which is the annual agreement between the Secretary of State for Health and NHS England for these services. NHS England has a specific role to commission specific public health services set out in this agreement and DH is the overall steward of the system. The document includes links to specific services agreements for the various programmes
- The Immunisation and Screening National Delivery Framework and Local Operating Model sets out the national, regional, and local operational and governance arrangements for national screening and immunisation programmes in England.

These two documents are available from:
https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-2015-to-2016

and https://www.england.nhs.uk/commissioning/pub-hlth-res/

GLOSSARY

Consent: Consent is legally required before a vaccine is given. Where vaccines are given to those under 18 the consent is usually sought from the parent or guardian. However, those aged 16 /17 are generally deemed able to consent without their parents express permission. Younger children can sometimes consent. 'Gillick competent' is the term used in medical law to decide whether a child, of 16 years or younger, is able to consent to his or her own medical treatment, without the need for parental permission or knowledge is (see the NSPCC website for further information on Gillick competence).

Diphtheria: Diphtheria is an upper respiratory tract illness caused by the bacterium Corynebacterium diphtheriae. It is a contagious disease spread by direct physical contact or breathing the aerosolised secretions of infected individuals.

'The Green Book': The Green Book is the popular name for the document 'Immunisation against infectious disease'; this is the policy document on the principles, practices and procedures of immunisation in the UK. The document provides details of the diseases, how they are spread and the history of vaccination. It is only available on line and can be found at: https://www.gov.uk/government/organisations/public-health-england/series/immunisation-against-infectious-disease-the-green-book

Hepatitis A: Hepatitis A is an acute infectious disease of the liver caused by the hepatitis A virus, usually spread through the faecal-oral route; transmitted person-to-person by ingestion of contaminated food or water or through direct contact with an infectious person (The Green Book, section 17).

Hepatitis B: Hepatitis B is an infectious inflammatory illness of the liver caused by the hepatitis B virus (HBV); the virus can be transmitted by exposure to infectious blood or body fluids such as semen and vaginal fluids, and also from mother to child around the time of birth (The Green Book, section 18).

Herd immunity: Herd or community immunity describes a form of immunity that occurs when the immunisation of a significant portion of a population provides a measure of protection for individuals who have not been vaccinated or developed immunity.

Human papillomavirus (HPV): While the majority of the nearly 200 known types of human papillomavirus (HPV) cause no symptoms in most people, some types can cause warts, while others can – in a minority of cases – lead to cancers of the cervix, vulva, vagina, and anus in women or cancers of the anus and penis in men. The virus can also cause head and neck cancers (The Green Book, section 18a).

Immunisation: Immunisation is the process by which an individual's immune system becomes fortified against an agent (known as the antigen).

Immunocompromised: A term used to describe the state in which a person's immune system is weakened or absent. This can be as a result of underlying disease or condition (e.g. HIV/AIDS, pregnancy) or as a result of treatment (e.g. chemotherapy, radiotherapy).

Influenza: Commonly known as flu, a viral infection that affects mainly the nose, throat, airways and, occasionally, the lungs. The influenza virus is transmitted easily from person to person via droplets and small particles produced when infected people cough or sneeze. Influenza tends to spread rapidly in seasonal epidemics

Joint Committee on Vaccination and Immunisation (JCVI): The Joint Committee on Vaccination and Immunisation (JCVI) is an independent expert advisory committee that advises Ministers on matters relating to the provision of vaccination and immunisation services. JCVI gives advice to Ministers based on the best evidence reflecting current good practice and/or expert opinion. The process

involves a robust, transparent, and systematic appraisal of all the available evidence from a wide range of sources. Members of the committee are appointed on merit by the Appointments Commission.

Measles: Measles (sometimes known as English Measles) is a highly contagious infection of the respiratory system caused by a virus, and spread though contact with fluids from an infected person's nose and mouth, either directly or through aerosol transmission.

Meningococcal disease: Caused by the bacterium, neisseria meningitidis, also known as meningococcus, there are 12 known different serotypes of which groups A, B and C account for about 90% of meningococcal disease. Recently there have been increasing numbers of cases attributed to the Y and W135 strains. Many people "carry" meningococci without suffering any harm, but meningococcal disease is uncommon. When it occurs, however, it is very serious and can cause meningitis and/or septicaemia. Even with the best treatment about 10% of cases will die; and a high proportion of the survivors will have long-term damage

Mumps: A viral disease caused by the mumps virus. Before vaccination, it was a common childhood disease worldwide. Painful swelling of the salivary glands (classically the parotid gland) is the most typical presentation a rash may also occur. The symptoms are generally self-limiting and not severe in children but can lead to complications in teenagers and adults.

Pertussis (whooping cough): Is highly contagious bacterial disease caused by Bordetella pertussis. Symptoms are initially mild, and then develop into severe coughing fits, which produce the characteristic high-pitched “whoop” sound in infected babies and children when they inhale air after coughing. The coughing stage lasts for approximately six weeks before subsiding

Poliomyelitis: Often referred to as polio or infantile paralysis, is an acute viral, infectious disease spread from person to person, primarily via the faecal-oral route

Rotavirus: Is highly infectious virus which causes gastroenteritis, characterised with fever and diarrhoea and vomiting. Prior to vaccination nearly all children under five would have at least one episode of rotavirus gastroenteritis.

Rubella: A disease caused by the rubella virus, and often referred to as "German measles". Usually mild symptoms and attacks can pass unnoticed or last one to three days. Children recover more quickly than adults. Infection of the mother by rubella virus during the first 16 weeks pregnancy can disrupt the development of the baby and cause a wide range of significant health problems

Shingles (Herpes zoster): Shingles is caused by the reactivation of the virus that causes chickenpox. Once a person has had chickenpox, the varicella zoster virus (VZV) lies dormant in the nerves and can re-emerge at a later stage as shingles. Shingles, characterized by a rash of blisters, can be very painful but is seldom life-threatening. Shingles is most common in people over age 60 or in those with a weak immune system

Tetanus: Caused by the Clostridium tetani bacteria and often referred to as "lockjaw", tetanus infection generally occurs through wound contamination and often involves a cut or deep puncture wound. As the infection progresses, muscle spasms develop in the jaw (hence the name “lockjaw”) and elsewhere in the body.

Tuberculosis: Tuberculosis (TB) is a contagious bacterial infection which usually attacks the lungs but can also affect other parts of the body. It is spread through the air when people who have an active TB infection cough, sneeze, or otherwise transmit their saliva through the air

Typhoid: A highly contagious bacterial disease transmitted by the ingestion of food or water contaminated with the faeces of an infected person, which contain the bacterium, Salmonella typhii.

Varicella (chickenpox): A highly contagious illness caused by primary infection with varicella zoster virus (VZV). It usually starts with a skin rash mainly on the torso and head and becomes itchy, raw

pockmarks, which mostly heal without scarring. Chickenpox is an airborne disease spread easily through coughing or sneezing of ill individuals or through direct contact with secretions from the rash. There are very limited rationale for vaccination against varicella for chicken pox in the UK.

Visiting Friends and Relatives (VFR): "Visiting Friends and Relatives" or "VFR" travel is travel involving a visit whereby either (or both) the purpose of the trip or the type of accommodation involves visiting friends and/or relatives.

World Health Organization, (WHO): The World Health Organization (WHO) is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends. In the 21st century, health is a shared responsibility, involving equitable access to essential care and collective defence against transnational threats.

Yellow fever: Yellow fever is an acute viral haemorrhagic disease; the virus is transmitted by the bite of female mosquitoes (the yellow fever mosquito, Aedes aegypti, and other species) and is found in tropical and subtropical areas in South America and Africa, but not in Asia. The only known hosts of the virus are primates and several species of mosquito (The Green Book, section 35).

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SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel **DATE:** 17th January 2019

CONTACT OFFICER: Geoff Dennis, Head of Adult and Older Adult Mental health Services
(For all Enquiries): 01753 690 950

Wards: All

PART I
FOR COMMENT & CONSIDERATION

MENTAL HEALTH: REVIEW OF HOPE COLLEGE AND MENTAL HEALTH SERVICES

1. Purpose of Report

To provide the Slough Health Scrutiny Board with a progress report on Hope College and other Mental Health Service developments.

2. Recommendation/Proposed Action

2.1 The Board is requested to note and comment on any aspects of the report.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Council's Five Year Plan

3a. Slough Joint Wellbeing Strategy Priorities

The work of mental health supports the following priorities of the Wellbeing Strategy:

1. Increasing life expectancy by focusing on inequalities
2. Improving mental health and wellbeing
3. Reduction of loneliness and social isolation in the Borough

3b. Joint Strategic Needs Assessment (JSNA)

The campaign uses data and intelligence from the JSNA and Public Health Berkshire colleagues to tell the mental health story of Slough, including:

- the demography of Slough
- the differing needs of communities in Slough
- the services currently available to Slough residents

3c. Council's Five Year Plan Outcomes

The campaign contributes to the delivery of each of the following 2018 - 2023 Five Year Plan outcomes:

1. Slough children will grow up to be happy, healthy and successful
2. Our people will be healthier and manage their own care needs

4. **Other Implications**

(a) **Financial** – No financial implications arise from this report.

(b) **Risk Management** - There are no immediate risks to be considered.

(c) **Human Rights Act and Other Legal Implications** – No human rights implications arise.

(d) **Equalities Impact Assessment** – There are no equality issues arising from this report.

(e) **Workforce** – No work force implications arise from this report.

5. **Summary**

This report provides the Board with:

a) Opportunity to review Mental Health Services development in particular Hope College

b) Review the schedule of forthcoming activity and events planned for Spring 2019;

c) *Consider next steps.*

6. **Supporting Information**

Background

Over the last five years, Slough Mental Health Services have been developing an innovative and comprehensive pathway for the population of Slough, by creating Hope Recovery College. The college has continued to grow throughout 2018, and is developing an even broader range of interventions/ courses for our students.

The main principal behind the college is co-production and relational practice where we design courses alongside our students. We are developing a 'whole-town' approach and this approach includes many other services such as;

Sport in Mind	ASSiST	In-voice
Art Beyond Belief	EMBRACE	CVS
Hope House	Supported Living Providers	P3
Musicians	Resource Productions	Kehorne Ltd

These services work alongside our Peer Mentors and Social Prescribers who have been developing services across health, social care, the voluntary sector, and supported living providers.

This creates a synergy between all parts of the system and of itself creates opportunity for people in services, which support independence and personal agency, to build preventative approaches which in turn build social cohesion, resilience and well-being. The approach we have developed challenges the health deficit model and utilises a positive community asset-based methodology. This normalises people's troubled experience, and is not specific to any particular population of mental health service users. Recently, it has been so successful that the graduate 'peer mentors' are now gaining employment within the system as social prescribers.

Recent activity – events

Each year Slough Mental Health Services including Hope College actively promotes World Mental Health Day. In October 2018, Slough Mental Health Services hosted an event at The Curve which included nineteen local providers in with information stalls for the public. One hundred and fifty people came along to support the event and to learn about mental health and wellbeing. People from the community were invited to take the opportunity to come along and take a look at the various stalls with information on the local services that continue to promote good mental health and wellbeing for the community of Slough.

On the 12 October, in conjunction with World Mental Health Day, Slough Mental Health Services held a Stronger Together conference. This conference marked the launch of the #NotAlone campaign which aims to raise awareness about the importance of looking after your mental health. The event also showcased the work of students from Hope College, including artwork put together in partnership with the Slough charity Art Beyond Belief. Students were encouraged to find their artistic voice and explore their own creativity in a number of different mediums, including painting, poetry and spoken word, digital software, photography and more. Other students presented research projects on varying topics including, loneliness and isolation, bullying, cyberbullying, depression, mental wellbeing in the workplace and dealing with mental illness from a minority background.

Attendees heard from a range of speakers who shared moving accounts of their personal journeys in mental health and how to access services in Slough, as well as the opportunity to mentor others, and which had helped them to address their own situations.

On 14 December 2018, the Hope College hosted an open morning at the Arbour Vale Sports Centre. Over one hundred service users, carers, students and members of the public attended this event. This event gave people an opportunity to take a look at the courses and workshops the college will be running during the Jan- March 2019 term, a chance to meet the courses facilitators and Peer Mentors and to enrol on to the new courses.

Hope College continue to focus on promotion of the college events and was widely promoted on BBC Radio Berkshire throughout the day. This included a live interview on BBC radio Berkshire, with the 'Drive time' programme interviewing Geoff Dennis Head of Mental Health Services for Slough, about Hope College and how it benefits people and helps to alleviate loneliness and Isolation and promote wellbeing for all.

Next steps – 2019 expansion

1) A bespoke website particular to Mental Health is currently being developed to support the campaign in the year ahead.
2) Enabling Environment strategy across all supported living providers.
3) Green Care (Growing Better Lives). The development of a green space at the Windmill Centre including utilising the Yurt.
4) An Oxford University Doctoral Clinical Psychologist is undertaking a research project on The Slough Model, (Hope College, ASSiST and EMBRACE).
5) We are implementing a co produced action research project focusing on Loneliness and Isolation and Being and Belonging. This is being commissioned over the next few months.
6) Expansion of Peer Mentors working at Prospect Park Hospital. 'Ward Embrace' is where senior peers of the Embrace group are engaging with Slough patients on the ward and to help them transition back into the Community.

7. Comments of Other Committees

7. This report has not been shared with any other committees.

8. Conclusion

8.1 The report provides the Health Scrutiny Board with an opportunity to review the effectiveness of the service to date and consider how members can best support the next phase of development. It is important for the Board to note, the synergy between the different campaigns that the Council are currently promoting are all designed to work cohesively with the intervention stated in this report.

SLOUGH BOROUGH COUNCIL

REPORT TO: Health Scrutiny Panel **DATE:** 17 January 2019

CONTACT OFFICER: Alan Sinclair – Director of Adults and Communities
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WARD(S): All

PART I
FOR COMMENT & CONSIDERATION

FRIMLEY HEALTH AND CARE INTEGRATED CARE SYSTEM: DRAFT OPERATIONAL PLAN 2019/20

1. Purpose of Report

This report provides Health Scrutiny Panel with an update on:

a) The progress being made to develop a single system Operational Plan for 2019/20 for the Frimley Health and Care Integrated Care System (ICS); and
b) The arrangements that are being put in place to develop a new operating model for Continuing Health Care (CHC) and Section 117 aftercare across East Berkshire.

2. Recommendation(s)/Proposed Action

Health Scrutiny Panel is recommended to note this report and the progress being made in developing a single system Operational Plan for 2019/20 and comment on any aspect of this Plan.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3a. Slough Joint Wellbeing Strategy Priorities

The priorities in the ICS reflect the need to improve the health and wellbeing of the population. The ICS will focus on those priorities that can be delivered across the system and local areas will continue to address their own local priorities. Slough's Joint Strategic Needs Assessment (JSNA) has informed the work of the ICS.

The ICS supports the delivery of several of the current Slough Wellbeing Board's strategic priorities including:

- Protecting vulnerable children and young people
- Improving healthy life expectancy
- Improving mental health and wellbeing

3b. Five Year Plan Outcomes

The ICS will also support the delivery of the following Five Year Plan outcomes:

- Slough children will grow up to be happy, healthy and successful
- Our people will be healthier and manage their own care needs

4. **Other Implications**

(a) Financial - One of the aims of the ICS is to bring financial balance to the Frimley footprint by 2020 – across health and social care. There are significant financial pressures facing all parts of the system and the 2019/20 Operational Plan will set out how some of these pressures will be managed. Any future investment from the NHS in local systems will come via the ICS process.

(b) Risk Management - There are no recommendations arising from this report.

(c) Human Rights Act and Other Legal Implications - No legal implications have been identified at this point.

(d) Equalities Impact Assessment - These are being undertaken by service deliverers as STP programmes become operative.

5. **Supporting Information**

Single system Operational Plan for 2019/20 for the Frimley Health and Care Integrated Care System

5.1 Local Authorities and local health organisations are working together as the Frimley Health and Care System to provide a joined up health, care and wellbeing system.

5.2 Frimley Health and Care are required to produce a single system Operational Plan for 2019/20 reflecting the development of the Integrated Care System (ICS), partnership working and including system, organisational and local place-based priorities for submission to NHSE/I by 11 April 2019.

5.3 The Operational Plan 2019/20 should describe the collective priorities and actions for the Providers, Commissioners and Local Authorities that make up the Frimley system and outline how Frimley Health and Care will deliver the overall vision of improved integration driving quality health and care improvements across the Frimley ICS. It will be set within a 12 month planning improvement journey in order to inform and support the delivery of multi-year plans - within the context of the longer term national 10 year plan.

5.4 By aligning the key assumptions on income, expenditure, activity and workforce between partners, Frimley Health and Care will ensure that the plan is built upon a firm platform of financial stability.

Recent activity

5.5 In order to develop the Operational Plan, Frimley Health and Care are refreshing the 2018/19 Operational Plan in line with national planning guidance.

5.6 A workshop was held with ICS partners and wider stakeholders (including the ICS Board, Alliance and health and wellbeing boards, as well as internal partners governance structures) in November 2018 to identify how they could work together to make the best use of the Frimley £ and bring the system to financial sustainability.

5.7 The outcome of this workshop was a first draft of the 2019/20 Frimley Health and Care Operational Plan which was circulated to partners for review and comment with a deadline of 14 December to respond.

5.8 Health Scrutiny Panel members were sent a copy of this 104 page document to review on 2 January 2019.

5.9 Feedback from the first phase of consultation is currently being analysed. A second draft of the Operational Plan will be circulated to partners and wider stakeholders on 15 January 2019 with a deadline of 8 February for further comments.

5.10 The NHS Long Term Plan was published 7 January 2019. The ICS Operating Plan will need to take of any additional priorities arising from this document.

A new operating model for Continuing Health Care and Section 117 aftercare across East Berkshire

5.11 A report is being taken to Cabinet on 21 January 2019 proposing a number of changes to the way Continuing Health Care (CHC) functions are currently delivered. It is proposed that from 1 April 2019 the following functions will transfer from the Clinical Commissioning Group (CCG) to Slough Borough Council's Commissioning and Transformation Service: Commissioning, Placement, Procurement and Contract Monitoring.

6. Comments of Other Committees

6.1 The draft Operational Plan will be considered by Slough Wellbeing Board on 14 January 2019 and by the Health and Social Care Partnership Board on the 29 January 2019.

7. Conclusion

7.1 The meeting provides an opportunity for the exchange of views and thoughts on the current draft of the Operational Plan before the second phase of the consultation gets under way

7.2 Panel members may also wish to consider how to add value to the implementation of the ICS throughout 2019/20 and how they can best contribute to its progress.

8. Appendices attached

None

9. Background documents

1 - Frimley Health and Care Integrated Care System: Draft Operational Plan 2019/20 (previously circulated)

2 - NHS Long Term Plan to tackle major killer conditions and save up to half a million lives https://www.england.nhs.uk/2019/01/long-term-plan/

3 - Proposal for an Integrated and Delegated Continuing Health Care Service across East Berkshire – paper presented to System leaders 20th November 2018

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SLOUGH BOROUGH COUNCIL

REPORT TO:	Health Scrutiny Panel	**DATE:**	17th January 2019
CONTACT OFFICER: **(For all Enquiries)**	Dean Tyler, Service Lead (01753) 875847		
WARDS:	All		

PART I
FOR COMMENT & DECISION

HEALTH SCRUTINY PANEL – 2018/19 WORK PROGRAMME

1. Purpose of Report

1.1 For the Health Scrutiny Panel (HSP) to identify priorities and topics for its Work Programme for the 2018/19 municipal year.

2. Recommendations/Proposed Action

2.1 That the HSP:

1) identify the major issues it would like to cover in the 2018/19 municipal year; and

2) agree, where possible, timing for specific agenda items during the 2018/19 municipal year.

3. The Slough Joint Wellbeing Strategy, the JSNA and the Five Year Plan

3.1 The Council's decision-making and the effective scrutiny of it underpins the delivery of all the Joint Slough Wellbeing Strategy priorities. The HSP, alongside the Overview and Scrutiny Committee and the other 2 Scrutiny Panels combine to meet the local authority's statutory requirement to provide public transparency and accountability, ensuring the best outcomes for the residents of Slough.

3.2 The work of HSP also reflects the following priority of the Five Year Plan:

- Our people will become healthier and will manage their own health, care and support needs.
- Our children and young people will have the best start in life and opportunities to give them positive lives

3.3 Overview and Scrutiny is a process by which decision-makers are accountable to local people, via their elected representatives for improving outcomes relating to all priorities for the Borough and its residents. Scrutiny seeks to influence those who make decisions by considering the major issues affecting the Borough and making recommendations about how services can be improved.

4. Supporting Information

4.1 The purpose of scrutiny is to hold those that make decisions to account and help Slough's residents by suggesting improvements that the Council or its partners could make.

4.2 Prioritising issues is difficult. The scrutiny function has limited support resources, and therefore it is important that the work scrutiny chooses to do adds value.

4.3 There are three key elements that make up the responsibilities of the scrutiny function:

- provide transparency and public accountability for key documents relating to the financial management and performance of the Council;
- scrutinise significant proposals which are scheduled for, or have been taken as, a Cabinet/Officer delegated decision; and
- strategic shaping of service improvements relating to the Cabinet Portfolios of Finance & Strategy and Performance & Accountability

4.4 In considering what the HSP should look at under points two and three above, Members are invited to consider the following questions:

- *To what extent does this issue impact on the lives of Slough's residents?*
- *Is this issue strategic and pertinent across the Borough?*
- *What difference will it make if HSP looks at this issue?*

5. Suggested Topics

5.1 It is generally recommended that a Scrutiny Committee should aim to look at no more than 3 or 4 items in any one meeting. This limited number can prove challenging, but does allow the Committee to delve down into specific subject areas and fully scrutinise the work that is being undertaken.

5.2 This will be a continuous process, and flexibility and responsiveness vital to success. It is important not to over-pack the Committee's agenda at the start of the year, which will not allow the flexibility for the Committee to adapt to take into consideration issues that have arisen during the year.

6. Conclusion

6.1 The scrutiny function plays a key role in ensuring the transparency and accountability of the Council's financial and performance management, and strategic direction. The proposals contained within this report highlight some of the key elements which the Committee must or may wish to scrutinise over the coming municipal year.

6.2 This report is intended to provide the HSP with information and guidance on how best to organise its work programme for the 2018/19 municipal year. As previously stated, this is an ongoing process and there will be flexibility to amend the programme as the year progresses, however, it is important that the Committee organises its priorities at the start of the year.

7. **Appendices Attached**

A - Draft Work Programme for 2018/19 Municipal Year

8. **Background Papers**

None.

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Appendix A

HEALTH SCRUTINY PANEL
WORK PROGRAMME 2018/2019

Meeting Date
17 January 2019
• Recovery Colleges • Immunisations • ICS update
25 March 2019
• Budget • Disability Task & Finish Group – final report • Oral Health • Autism Hub • Wellbeing Board – Annual Report

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MEMBERS' ATTENDANCE RECORD 2018/19

HEALTH SCRUTINY PANEL

COUNCILLOR	28/06	11/09	16/10	21/11	17/01	25/03
Ali	P	P	P	Ap		
Chaudhry	P	P	P	P		
M Holledge	P	P	P	P		
Matloob	P	P	P	P		
Qaseem	P* (from 6.37pm)	P* (from 6.35pm)	P	P* (from 6.46pm)		
A.Sandhu	P	P	P* (until 7.19pm)	P		
Shah	P* (from 6.59pm)	P	Ap	P		
Smith	Ap	P	P	P		
Strutton	P* (until 7.29pm)	P	P	Ap		

P = Present for whole meeting
P* = Present for part of meeting
Ap = Apologies given
Ab = Absent, no apologies given

(Ext - Extraordinary)

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