HEALTH AND ADULTS
OVERVIEW AND SCRUTINY COMMITTEE
Monday 13th November 2013

PRESENT – Councillors *O`Keeffe* (Chair), Brookfield, Daley, Foster. D,. Humphrys, Hollings, Riley, and D Smith.

Co-optees *- none.*

Also Present –

Dr Jane Rossini	Public Health England (PHE), Cumbria and Lancashire Centre Director
Jane Cass	NHS England (NHSE), Head of Public Health Commissioning, Lancashire Area Team
Dr Shelagh Garnett	Screening & Immunisation Lead, Lancashire Area Team
Martin Samangaya	Screening & Immunisation Manager, Lancashire Area Team
Cllr Taylor	Lead Member for Health and Adult Services
Dominic Harrison	Director of Public Health Blackburn with Darwen Borough Council (BwD)
Dr Gifford Kerr	Consultant Public Health (Critical Friend BwD)
Dr Helen Lowey	Consultant Public Health (Critical Friend BwD)
Martin Eden	Link Chief Officer to the Committee
Heather Taylor	Senior Support Officer
Ben Aspinall	Scrutiny Manager
Linda Newsham	

RESOLUTIONS

16. Welcome and apologies

The Chair welcomed everyone to the meeting. Apologies were received from Councillors Groves, Khan, Sidat and Jacqueline Slater.

RESOLVED –

That apologies be noted from Cllrs Groves, Khan, Sidat and Jacqueline Slater be noted.

17. Minutes of the Health and Adults Overview and Scrutiny Committee meeting held on 11th September 2013

Members of the Committee agreed that the minutes of the Health and Adults Overview and Scrutiny Committee held on the 11th September 2013 be received as correct record with an amendment to Councillor Jamie Groves appearing as

present and having submitted apologies. Councillor Groves had been in attendance.

RESOLVED –

That with a change Cllr Groves attendance that the Minutes of the meeting of the Health and Adults Overview and Scrutiny Committee held on 11th September 2013 be agreed as a correct record.

18. Declarations of Interest in items on this Agenda

No Declarations of Interest were received.

19. An overview of North West Ambulance Service

The Committee received a presentation on North West Ambulance Service which highlighted the 999 Paramedic Emergency Service, Urgent Care, Patient Transport Service (Cheshire, Merseyside, Cumbria & Lancashire) and Major Incident Management.

The Committee were advised of the following key facts and figures:

- 7 million population over 5,400 square miles
- Employs approximately 5,000 staff
- Annual income of £260 million
- Three emergency control rooms
- 1.1 million 999 calls a year (900,000 emergency patient episodes)
- 1.2 million PTS journeys
- Covers the North West footprint – PCT clusters, 5 LATs with 33 CCGs, 28 provider trusts.

Key achievements

- One of the top performing ambulance trusts nationally despite activity increases
- Excellent CQC inspection
- Pathfinder and urgent care development
- Membership targets for FT achieved
- Established clinical leadership structure
- National innovation award for Patient Experience
- First ambulance service to get Gold IiP Award
- National recognition for Channel 4 series “999: What’s your emergency?”

Specifically relating to Blackburn with Darwen:

- 10 stations serve the East Lancashire area
- 132 Paramedics
- 113 Emergency Medical Technicians (1&2)
- 6 Rapid Response Vehicles (RRVs)
- 24 Emergency ambulances
- Between Oct '13 & Jan '14 an additional 9 Paramedics and 2 EMTs due to start in the sector
- 35 Patient Transport Service vehicles
- 57 Patient Transport Service staff.

Blackburn with Darwen Community Care

- Active community first responder teams in Blackburn, Darwen & Accrington
- Teams in Rishton & Great Harwood soon to be launched
- 7 new members being trained for Blackburn team
- Working with local schools to place defibrillators and provided training
- Defibrillators installed in all Blackburn & Accrington Asda stores
- Work with council to install defibrillators in Council sites
- Blackburn awarded British Heart Foundation's 'Heart Town' title.

Blackburn with Darwen initiative

- Diabetes pathway for Paramedics to refer patients to a specialist diabetes nurse
- Discussions with Bolton Careline with the aim of establishing a lifting service for falls patients
- Community care plans for patients with chronic disease – to avoid unnecessary trips to A&E
- Stroke, PPCI and specialist major trauma pathways.

The North West Ambulance Service concluded by advising the Committee of their application for Foundation status and of their Estates review and the work of #team999.

RESOLVED –

That North West Ambulance Service be thanked for their attendance and that the presentation be noted.

20. Vaccination and Immunisation uptake rates in Blackburn with Darwen:

Background

Following requests made earlier in the year for a expert panel of representative bodies to attend Committee to advise on the implementation of the new operating model, the Chair was delighted to welcome an expert panel from NHS England and Public Health England to the meeting.

Methodology

In advance of the topic coming before Overview and Scrutiny, the Committee agreed that they would review the vaccinations and immunisations services for Blackburn with Darwen using a Collaborative Inquiry model: Most approaches to performance review or reform are top-down or expert-led reviews. As the Committee membership is entirely lay members in this field, as are the Lead and Executive Members, a collaborative approach of the Lead Member, Scrutiny Committee members supported by Critical Friends from the newly incorporated Public Health department was adopted.

This approach supported a five stage process of:

- Action research on the part of the Executive, the Committee and Critical Friends to the Inquiry; which on this occasion consisted of papers submitted in advance of the meeting that were scrutinised.
- An Inquiry meeting with attendance from Lead Member for Health and Adult Services, Health and Adults Overview and Scrutiny Committee, and Critical Friends; the Director of Public Health and two Public Health Consultants to consider both the briefing papers and the outcomes of a round table discussion with an expert panel.
- An evaluation session following the Inquiry, where participants would be asked for their thoughts views and opinions as to whether the questions asked had been answered satisfactorily, and what the next steps to test the outcomes of the Inquiry should be.
- Testing the findings.
- Outcome recommendations.

It should be noted that certain caveats were agreed in advance of the meeting: The Executive (or Lead) Member as Portfolio holder and decision maker was not attending to be scrutinised by the Committee, nor would be under any obligation or expectation to make decisions at the meeting. On this occasion the Lead Member having heard from an expert panel, (supported by Critical Friend experts from the Authority), heard the opinions and views of cross party Members from the Overview and Scrutiny Committee.

Dr Garnett led the Inquiry through the paperwork that had been circulated in advance with the agenda entitled “New arrangements for Immunisation and Screening Services in Lancashire.” She advised that with the local operating model having 66 pages describing how it would work there was some concern that the vaccination and immunisation system could be seen as having become

fragmented. She explained to the Inquiry that NHS England was actively trying to clarify how that setup was working.

As part of the discussion Dr Garnett referred to the briefing paper that had been sent to the Inquiry which outlined; the changes in the Health and Social Care Act 2012, the local arrangements, structures and responsibilities for immunisation; detailing the roles of NHS England (NHSE) Lancashire Area Team, Public Health England (PHE) Cumbria and Lancashire Centre, Local Authorities via their Director of Public Health (DPH), Clinical Commissioning Groups (CCGs) and service providers. Dr Garnett outlined the differences regarding commissioners and providers of established immunisation programmes and the key differences for commissioners and providers of new immunisation programmes and the governance arrangements thereof.

Additionally each of the ten questions supplied in advance from the Centre for Public Scrutiny guide: "Ten questions to ask if you're scrutinising …local immunisation services" was addressed in the briefing paper. To support these answers a presentation was also supplied expanding on some of these issues and offering an example of influenza to test the model.

In summation Dr Garnett advised that a series of tables describing immunisation performance nationally were included as appendices to the report. She concluded by explaining that on 1st April everything changed with the disappearance of PCTs and that from 1st April 2 key things had happened; with all those engaged at PCT level and SHA level in the delivery of vaccination and immunisation programs, with a decision to introduce 5 new immunisation programs, which had led to some concerns that some of the services could become fragmented.

Having completed the first half of the discussion the Inquiry chose to use the additional questions outlined in the Centre for Public Scrutiny (CfPS) guide to add further clarity to the answers they had received so far.

It should be noted that not all questions were asked, but are contained herein for completeness. Questions and answers (where applicable) are outlined as follows:

1. What are the local arrangements, structures and responsibilities for immunisation?

***1.2** Have the responsibilities of those involved been clearly defined?*
Who has responsibility for these arrangements? Is there an agreed mechanism for flagging up any concerns about an individual providers' performance, if necessary?

PHE advised that

- The Child Health Information System is the responsibility of NHS England. It is inherited and is not gold standard, however they are working towards change.

- They are working in partnership with primary care and CCGs and are supportive of Primary Care and GP colleagues.

1.3 *Are local immunisation providers aware of new structures and key contacts – has this been demonstrated to you?*

1.4 *How will regular reports be provided to the councils various bodies?*

1.5 *How is data about vaccinations collected, collated and reported both within the organisation and to national reporting/ recording/monitoring systems?*

The Inquiry were advised that

- Immunisations and screening was delivered on a local operating model.
- INFORM is run by the Department of Health and contains information that each provider supplies.
- Some GPs use EMIS and VISION 360: Patient's medical records at their registered practice, where GPs and their teams rely on the information daily to support their clinical decisions.
- They can use INFORM as a fairly good resource for collecting data about influenza immunisations but cannot use child immunisations which comes off the Child Health Information System.
- It was acknowledged that there are some problems with the Child Health Information System.
- General practice immunise children and complete forms and a copy of that goes to the Child Health Information System. Schools also complete forms for each child vaccinated, those forms are then fed into the Child Health Information System. The same happens in schools. It was explained that this is not the most robust database and that it was difficult to get the data from it.
- The East Lancashire Child Health Information System is very active for 0-5 year olds, but less reliable for children over that age.
- The system that issues the invites to attend a vaccination works well. But the recording and reporting for the system is not that good.
- On 1st April everything changed with the disappearance of PCTs, from 1st April – 2 key things were happening with all those engaged at PCT level and SHA level and a Decision to introduce 5 new immunisation programs – so there have been some concerns that some of the services would become fragmented.

1.6 *What has been done to try to ensure that recording and reporting systems, at primary care centres and at the PCT, are regularly reviewed to ensure they are as accurate as possible (new patients added and records updated and patients who have moved away removed, both as swiftly as possible)?*

The Inquiry was quoted an example of a measles outbreak: Where PHE? (check) were recommended to do a big push to deliver the MMR vaccine; it became clear Child Health Information System was not adequate: One of the drawbacks identified was that where an individual who has had an immunisation in practice

probably had the information in their notes, however it may not necessarily be the case that this information had been transferred to the child health system. NHSE advised that they were trying to improve the System: calls were being recorded, regularly reviewed alongside a regular review of the data.

It was put by the Inquiry that one of the best ways to get accurate data is to publish data. Therefore did the panel feel it would be useful to publish results based on GP practices on vaccinations & Immunisations, then people could see the performance?

Responding the Inquiry were advised that

- The data would need to be checked by GPs for accuracy with a right to correct any inaccuracies before such data was publicised.
- The approach was thought to be a good idea, but the panel cautioned that the system is not currently mature enough to support such a suggestion.
- It was stressed that PHE need to be as accurate as they can be with what they have currently got before they look to introduce new initiatives.

1.7 *Is there, or has consideration been given to, supplementing primary care and routine school nursing provision with outreach activities performed by a dedicated team?*

1.8 *If school nursing services are not supplying vaccinations (e.g. the 'school leavers' booster, missing vaccinations, HPV for girls aged 12-13), is the alternative provision achieving satisfactory results?*

2.0. *How is the local area performing against national standards for childhood immunisation?*

- It was explained to the Inquiry that this is NHSE responsibility.
- A brief summary was given.
- The Inquiry was signposted to the tables on pages 22 and 23 of the agenda.
- A brief mention of the governance structure screening and immunisation teams have was made.

2.1 *What activities are in place to ensure that as many young children as possible are fully immunised? Is enough being done to ensure that local children are leaving school with complete immunisation histories in line with national recommendations?*

- Reference was made to the MMR vaccination: It was suggested that many people paid privately for separate vaccinations as this service was unavailable on the NHS: Therefore accurate and up to date records would not be held of those who had received the injection, nor would there be an accurate picture of who was adequately covered in the locality: No mechanism appeared to be in place for private doctors to advise NHS doctors

that a child has been immunised. They system currently relies on an individual to do that.

- NHSE acknowledged this remained an issue and acknowledged they could only get that data from NHS GPs.

- When asked if there was a separate system for recording this data, the Inquiry were advised that there is no mechanism for private Doctors to confirm to GPs that they have given vaccinations.

2.2 *What activities are in place to ensure these figures are increased to meet WHO 'aspirational' targets?*

2.3 *What arrangements are there to try to ensure that local children leave school having completed vaccinations in line with national recommendations?*

2•7 What arrangements are there to identify patients who are resident within the area but are not registered with primary care providers?

2.9 Is enough being done to improve access to immunisation services, for instance, non-GP provision, Saturday clinics and/or opportunistic services?

2.10 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)?

2.11 Does the local Joint Strategic Needs Assessment [JSNA] reflect the importance of good immunisation uptake?

2•4 *Are efficient 'invitation/recall' systems in place within the PCT and schools to increase awareness of the 'school leavers' booster and to ensure good uptake at school vaccination clinics?*

The Inquiry was advised that there is and that is a standard approach.

2•5 Is there a satisfactory protocol in place to deal with issues of consent and have all service providers agreed to follow this (e.g. if teenagers attend sessions and a consent form cannot be found – see Consent in the Glossary)?
If the child is considered capable of consent they consent for themselves.

Additional questions were asked of specifically of the recent issues with pork gelatine in influenza sprays for children.

The Inquiry were advised that

- PHE and NHSE had both discussed this with Dept of Health and agreed a joint position on how we would present this to the public:

- There is always an assessment of risk and at this stage the risk assessment included a very clear statement that the product had been treated.
- There was sign up from community leaders from across a whole range of religious backgrounds and PHE / NHSE had worked closely with community leaders to achieve that joint statement and additionally offered people an alternative.
- PHE explained that there would be discussion on a case by case basis by the NHS and available local groups that would be affected by it, so that they are fully informed and fully understanding of the impact of the work that's being carried out.

It was stressed that in Blackburn some areas of the community would have a zero tolerance to pork product inclusion regardless of some teachings or religious guidance to the contrary.

PHE explained that

- At every level individual or child, are informed that the programme is there and that information is available for both the parent and the practitioner;
- Guidance for practitioners is to always explain the risks and benefits of giving or not receiving the vaccination and to be transparent about the information.
- It can be a very personal discussion with the individual – as there could be all sorts of caring responsibilities –
- All of which would need to be taken into consideration.
- However, in conclusion it was stated that there were probably some things that NHSE could do with their primary care providers to alert them to the fact that there is this new vaccine and to bear that in mind when having conversations with parents prior to the administration of the vaccine.

It was pointed out to the Inquiry that

- DHE discussed these issues at a national level .
- Always assessment of risk which is given to the public.
- A very clear statement - sign up from community leaders and offered alternative.

Again it was raised by the Inquiry that in some sections of the local Muslim community people are advised to throw away any thing if in doubt. It was also asked of the panel to explain in more depth what happened regarding individual consent?

PHE explained that

- At every level it was the patients decision to accept the offer, and
- That individuals were informed of the programme available, and
- That there was guidance to be followed by practitioners, explaining both the risks and benefits of immunisation.

2•6 Assuming monitoring procedures identify concerns about an individual providers' performance, what arrangements are in place to correct any problems

(e.g. providing advice and support to such 'less well performing' providers, contract review and modification, alternative provision of services etc)?

NHS England explained
- Yes - can do with providers…
- GP underachieving – there are the same levers as previously available

However regarding formal disciplinary action resulting in dismissal,
- Would not wish for matters to get to that stage;
- Would wish to work with CCG colleagues and
- That there were things they would need to consider as update supportive way.

3.4 What specific measures are in place to ensure that those older people in congregate settings, such as long-stay residential care homes, are suitably immunised?

One member of the Inquiry; explaining that his grandmother was 94 and in residential care asked, how assurances could be given that people in residential care receive the vaccinations they require. He explained that his grandmother still gets the letter advising her she requires the vaccination but cannot read the letter as she has dementia and being in a residential care home she is unable to attend the GP surgery.

He was advised that
- GPs are responsible for ensuring people in residential care receive vaccinations they require.
- Some CCGs commissioned district nurses to deliver their vaccinations & immunisations program (although GPs still hold the responsibility).
- Sometimes there were different models in different areas: In some areas district nurses who will go into residential care homes and vaccinate whilst they are in there visiting the patients.
- It was re-emphasised that the GP still has a responsibility to offer the vaccination to people even if the patient is in a residential care home.

2•7 What arrangements are there to identify patients who are resident within the area but are not registered with primary care providers?

PHE advised that
- They had inherited procedures that were already in place before, so they had not done anything to alter them.
- Mostly if people are registered that's how systems are set up.
- That there were systems in place to register travelling communities.
- That in farming communities there were specific services available.

2•8 How are local GPs being encouraged and/or incentivised to achieve higher coverage?

Some members of the Inquiry revisited the question (2.6) as to whether a GP would be dismissed if they did not meet performance indicators.

- They were advised that there are a number of levers NHSE could use and that they would not wish to get to a stage where that level of disciplinary action was necessary, and that they we would want to be working with their CCG colleagues to look at how CCGs can support their colleagues to improve vaccination rates.
- It was highlighted that this is not something that has been tested out yet as this is the first time this particular programme has been embarked upon. But there are things that need to be considered to improve uptake in particular practices.
- NHSE advised that they do not have any current data on which to benchmark performance.

A member of the Inquiry asked what were the "carrots and what are the sticks"? Commenting that there seemed to be no clear accountability.

- Dr Kerr as Critical Friend to the review explained that the "carrots and sticks" have not particularly changed since the 1st April and that GPs and other providers know the financial penalties.

NHSE advised that

- Getting a practice to vaccinate on behalf of another is a delicate relationship with the patient. Wouldn't particularly stop a practice from vaccinating purely based on update levels. However performance was being reviewed due to mistakes or poor practice that was a different matter where formal disciplinary procedures would be followed.
- Ideally if a practice was underperforming the solutions would be to commission another practice to deliver on their behalf however there always remains a delicate balance between the GP and patient relationship.
- He was not aware of a practice being stopped from practicing purely because of low performance in uptake levels.
- Regarding the flu programme, there was active commissioning of alternative providers to improve uptake, with a number of different bodies who can now influence and improve performance encouraging uptake across the system.
- NHSE advised that they were tightening up on if a practice did not immunise they no longer get their points – this had changed recently. They explained that they have removed the incentive payment across the whole of Lancashire, and that they were getting smarter and tightening up on all practices.
- It was suggested that possibly GPs may not holding accessible clinics – that the practice had to get individuals to physically come through the door, and that there were different pieces of work that needed to go on to encourage take-up: Offering a different venue was not always the solution people sometimes would not turn up to that either.

2.9 Is enough being done to improve access to immunisation services, for instance, non-GP provision, Saturday clinics and/or opportunistic services?

PHE advised that

- Enough is being done for flu
- Rolled out pilot last year for flu commissioned community pharmacies…..
- Anyone who wanted to take up the offer could now do this:
- That gives people a wider choice; open at weekend and evenings.

2.10 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)?

PHE advised that

- Yes advice is available and promoted
- Those giving the vaccinations all have to go through accredited training and are trained beforehand.

3.1 With respect to seasonal influenza vaccination of over 65s, how well is the area performing both in absolute terms and in comparison to neighbouring and/or similar areas?

3.2 With respect to pneumococcal vaccination of over 65s, how well is the area performing both in absolute terms and in comparison to neighbouring and/or similar areas?

NHSE explained that

- 65+ overall uptake was 59% over 65 (target was 75%)
- At risk groups 40%
- Hoping community pharmacists will offer.
- Did not currently have comparative data…would have it next year.

3.3 What is being done to improve uptake of both seasonal influenza and pneumococcal in the area?

3.4 What specific measures are in place to ensure that those older people in congregate settings, such as long-stay residential care homes, are suitably immunised?

- Take up for 65 & over …overall 59% been immunised.
- Target is national 75%.
- The at risk groups is lower at 40% hence the community pharmacies to support.
- Don't currently have comparisons to other areas.
- Last year 76% on a par with others and at risk groups was 56% and healthcare workers at 40% - as good as the rest –
- 45% already in general hospital, but not so high in general practice

3.5 Does the area's JSNA reflect the importance of maximising immunisation uptake for older people?

4.1 The WHO aim is to achieve 75% seasonal flu vaccine uptake in people aged 65 years and over; what is the % coverage rate for the area, and what activities are in place to ensure that this figure is increased?

- Already exceeded that target.

4.2 The EU has adopted a Council Recommendation to achieve a seasonal flu vaccination uptake of at least 75% for those under 65 with clinical conditions, and pregnant women; for these two specific 'at risk' groups, what are the % coverage rates for the area, and what activities are in place to ensure that these figures is increased?

The Inquiry asked at what stage in the pregnancy did NHSE / PHE encourage vaccination?

- They were advised that it would be any trimester / any time during the pregnancy.

4.3 The DoH 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?

A member asked how industrial employers could encourage the take-up of vaccination by their employees.

PHE advised that

- The DPH team would be asking businesses if they have business continuity plans in place.
- This would be part of the Healthy Work Programme.
- Don't currently have a national programme for healthy adults - local public health team largely there to provide assurance.
- Health at work is a priority in the Health and Wellbeing Strategy, however it remained a moot point who would fund it – probably CCGs.

4.5 With respect to seasonal flu vaccination of people aged 6 months to 65 years who have an underlying medical condition, how well is the area performing both in absolute terms and in comparison to neighbouring and/or similar areas?
4.6 Does the area monitor the vaccination of staff and people living in long-stay residential care homes or other long-stay care facilities?
If yes, is the uptake satisfactory or are there plans in place to enable uptake to be increased?
4.7 Are there local initiatives in place to encourage pharmacists to offer vaccinations to those in 'at risk' groups who might not otherwise avail themselves of flu vaccination at their GP's surgery?

4.5 4.6 & 4.7 Inquiry considered to have been answered already.

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

Having responded, one of the Inquiry asked - if less than 50% of Healthcare workers were not having flu vaccinations, had any research been undertaken as to why people refuse to have individual protection? The outcome being to promote wider protection.

- It was explained that in the past there had been a view to let individuals think about individual protection as opposed to promoting the people they were in contact with and their role in protecting the population.
- It was stressed that there was a possibility that the current data and how this is collected did not reflect the people who get vaccinations elsewhere.

Inquiry asked NHSE if they monitor take up from their staff, and could it be made mandatory for NHS staff to be immunised to give that extra degree of protection to the most vulnerable.

NHSE advised
- This is happening a little in hospitals where they are expected to show that there staff are being immunised.
- Possibility that when contracts are renewed that it could be changed to include this requirement but would require legal advice.

PHLA advised that
- Since PHLA came back as a Council function this had been looked at but there was an issue as to who in the workforce PHLA would want to target in the workforce for the vaccination.
- This is not the same as concentrating on crucial services. There are issues there that PHLA would have to look at and a leadership role for the Council to lead by example and consider including such a clause in contracts with the independent sector. Working towards that for next year.

5.2 What **initiatives are in place to immunise social care staff, as well as frontline healthcare staff?**
NHSE advised that
- Carers on a register (those in receipt of an allowance) – we know who and where they are, the issue would be there are many more who are not identified.

PHE advised that
- There was a real role to work closely with PH LA to work closely to include more carers.
- They explained that they have not got as good data as they would like and that it was an area they themselves would like to improve.

A question was asked to clarify if it were the case that in the NHS employers were not allowed under HR legislation to ask staff what their vaccination status is?

It was confirmed that it was correct and currently considered to be against an individuals human rights, and that this was acknowledged as a risk.

The Inquiry seeking to consider safety in future, posed the question, whether central government some be lobbied to find a workaround this situation in order to prioritise and protect the patient.

PHE advised that

- More could be done to encourage staff take up of vaccinations.
- On every (vaccination) program they are able to close loopholes.
- That employment in the NHS had a standard set of protocols.
- Some individuals may choose not to receive a vaccination because of potential side effects.
- That it always remained individual choice.
- That there still remained an opportunity to take up preventative measures.
- That they would never set 100% target as it would be unattainable.
- A good rate of return would be 75% who take up offer: 75% suppresses activity.
- Same issue for nursing / residential care home staff.
- That there was a higher rate vaccination rate of patients and residents of nursing and residential care homes than of staff in either setting. This remained a real patient risk issue and a national as opposed to localised problem.

There was a suggestion that current recordings of staff taking up the offer of vaccinations, employers have a record as a survey goes out to general practices.

- NHSE - For many of the reasons above NHSE could not guarantee that all nursing staff nursing patients are vaccinated.

One member of the Inquiry asked if a requirement might be explored for staff dealing with the most vulnerable patients that there was a requirement to have been vaccinated and to consider the possibility of everyone in an at risk work environment being mandated to have been immunised.

PHE In response explained that

- Having had the vaccination it could give the individual a health issue.
- Although it depended from person to person, what PHE normally say for a vaccination to go into circulation is that possible side effects are mild minimised and minor.
- There is a central monitor from the regulatory agency where a yellow card system is in place to flag up where negative effects are observed.

5.3 What initiatives are in place to immunise student nurses?

5.4 Are there suitable opportunities for HCWs to easily access immunisation services?

5.5 Do all local Trusts contract with an Occupational Health service to advise on and/or supply vaccination and monitoring of staff with respect to influenza, hepatitis B, MMR, Varicella (protects against chicken pox) and BCG?

PHE advised that

- They work closely with Public Health colleagues and specific communities.
- Do we have an emergency programme in place.
- Over 65s - we have an international surveillance programme on flu. All strains.
- Piece of discreet work PHE and colleagues at WHO – track flu and watch which strains are getting active, devise a vaccine, immunise. Ongoing monitoring – feeds into their annual flu plan.
- If it becomes high risk and pandemic they would introduce a mass vaccination flu programme.
- Some of the issues from 1974 were to do with overcrowding and to do with poor working conditions that have been picked up through the health and safety executive- although not popular it did improve workplaces significantly.

6.1 What arrangements are in place to provide hepatitis B vaccination to children born to carrier mothers? If children are not receiving a complete course, are there monitoring and failsafe arrangements that will identify them and ensure they are offered vaccination?

NHSE explained that

- At antenatal clinics all women screened and if found to be positive, both the unit and the GP would be informed.
- A plan is when a child is born they would receive their first vaccination in hospital sand their second in GP practice.

6.2 What is the uptake of the neonatal BCG programme in the area? Are there arrangements for call and recall to centres where the vaccinations are delivered?

6.3 Have the necessary links been made between secondary care services (maternity, paediatric, etc), PCT data collection and monitoring services and primary care providers to ensure the appropriate children are identified and vaccinations are provided and recorded/reported? Are all parties working to agreed protocols?

6.4 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?

PHE advised that

- They scan for various diseases and
    - Notify the Health Protection Unit (used to be Health Protection Agency) who would
    - Identify contacts the individual had had,

    - Find them,
    - Speak to them
    - Send them to a relevant service to do a risk assessment
    - If in need of treatment offer treatment
    - Also manage communications around that and ensure that all other relevant agencies were in place.
- When people present with a problem that is given a diagnosis and scanned for infection this is notified to the Health Protection Agency – that part of the system has not changed.
- If people need any treatment at any stage we would ensure they are passed into treatment services.
- If there were an outbreak PHE would manage the communications around that and support the agencies involved to put measures in place to stop that happening again.

The Chair of the Inquiry explained to the Panel that he had read in the paper that there was a possible outbreak of Polio in Syria, and that people coming into Britain could bring the disease with them.

The Inquiry was advised by PHE that
- Polio is a very safe vaccine.
- PHE have been tracking this very closely and are aware that there was an issue with what is termed flaccid paralysis.
- Have really good polio coverage in the UK: that the vulnerable and general population is already protected.
- Polio uptake is very strong.

NHSE also advised that an alert had already been sent out to providers.

7. The incidence of vaccine-preventable diseases is often higher in the more deprived sections of the population; is enough being done to ensure these deprived communities are being engaged and fully able to access immunisation services?

Who is now and how in the timeframes are they going to set about reviewing and improving these and IRO Q7 is there a particular emphasis for deprived sections of these services.

7.1 Can the Scrutiny Inquiry be reassured (a) that providers of health services regularly review their arrangements to assess who is at increased risk of vaccine-preventable diseases such as hepatitis A & B, measles, TB etc and (b) that providers are making efforts to offer appropriate advice and services to those groups?

7.2 Has the PCT considered whether adequate provision already exists or whether additional measures/services should be provided?

NHSE explained that

- They are responsible for the commissioning of those services.
- Throughout the year we need to address more equitable access and more coverage
- Currently they have taken on a lot of inherited protocols and acknowledged some areas where improvements
- NHSE focus was to ensure that they had safe transition of those services.
- Now in process of need to look at equitable access as they move through to the commissioning cycle,
- Data and its availability had been a real challenge, although it was now starting to come through.
- They are starting to draw some of these things together in terms of what they want to do differently next financial year to be able to improve their updated coverage and address those underserved and harder to reach groups.
- It was explained that travelling communities and Looked After Children were two areas they have a better understanding of their access to healthcare.

8.1 What arrangements are in place to vaccinate patients in all NHS settings including hospital wards, clinics, walk-in-centres, accident and emergency departments, and prison health centres?

A member of the Inquiry asked for an update on flu vaccinations for health care workers and whether there was there a Business continuity plan to keep the hospital running:

NHSE advised
- Business Continuity Plan – Hospital Trusts have to have a plan in place to cover these risks and NHSE have to assure that plan.
- Flu vaccinations have started again this year there is a real impetus to improve this.
- To date nationally there has been variable performance: Some Trusts do extremely well others don't. The role of NHSE this year is to support those who don't. This winter might be more troublesome than previous ones.
- They were concerned that the most vulnerable people receive a vaccine, but where they cannot have the vaccine it was imperative that staff were vaccinated so they cannot transmit the virus. – it is viral transmission that is the real problem looking much wider - not just looking at the NHS but the adult and children social care systems too - that bit is not as well developed.
- This year flu vaccination only started a month ago, East Lancashire in the first 4 weeks vaccinated 45% of their staff. The hope next month was for a higher figure. It was stressed that this is not a bad percentage in comparison to some other areas.

Acting as Critical Friend to the Inquiry Dr Kerr emphasised that
- The flu vaccination program only lasts 6-8 weeks, and
- That if local teams on the ground were going to support the delivery of that particular campaign programme then real time live data was needed to understand how the program is going to establish whether one group or another is doing particularly well.

NHSE acknowledged that

- The new system had not lent itself to availability of live data and acknowledged that this was an issue.
- They further explained that if they did have the data, they would share it.
- Concluding this point is was explained that NHS England drives forward the best plan available and that there was a strong plan through the NHS to monitor uptake.

8.4 Is appropriate equipment available to manage complications of vaccination in all NHS settings?

Members were informed that

- Immunisers are given training, and that
- They could be reassured that training was happening.
- Adrenaline and access to a telephone were the most important practical things: If any complications arose the first thing to do would be to give adrenaline.

9.1 Are arrangements in place with local providers to provide reviews of health care needs, including vaccinations, of people newly registering (whether this is first registration after immigration or registration after moving from another provider in the UK)?

9.2 Are local providers assessed with respect to services they provide to, and assessments they make for, individuals registering with them?

9.3 Has the HPA chart 'Vaccination of Individuals with Uncertain or Incomplete Vaccination Status' been recommended or supplied to providers of immunisation services, especially primary care providers?

9.4 Has the HPA advice about migrant immunisation been recommended or supplied to service providers?

A member of the Inquiry asked the basic question of who's in charge of what people have had?

The Inquiry were advised that

- There are clear protocols from the Health Protection Agency; for people coming in from overseas the protocols direct you down a process and assist you to complete the forms.
- Yes there are protocols in place yes they are followed and yes any updates are communicated to immunisers.
- If in doubt practitioners follow an algorithm that helps them complete dosage and protocols.

This was followed up with the question; if someone moves house – does anyone make sure that migrants sign up with a doctor's surgery?

NHSE advised

- Family Health Services are advised that people have arrived in their area and will send a letter - but not legal requirement.
- This is an area for collaboration between the local Public Health team and Public Health England: Getting information and growing intelligence of the areas where people are unlikely to be vaccinated.
- Often migrant workers are young and healthy and do not access health care proactively, only when they need services.
- Preventative work is not currently done - possibly the CCG could commission this.
- Local knowledge of growing communities is important.
- For children it is quite easy to pick up where they have or have not been immunised when they start school it is picked up there, however with young adults, although there are enough prompts there is a gap.

One member of the Inquiry stressed the importance of it not just being migrants, but the indigenous population.

NHSE explained that they

- Continue to provide the programs …
- Are reviewing how they use those assets in the community to improve GP Registration
- That vaccinations were available.
- In Blackburn there are 30 GP practices trying to work together to link with 4 zones to deliver more localised services. Discussions are at an early stage.
- It was felt that a group of people working together sharing local intelligence collaboratively will make systems more responsive.

An Inquiry member asked what facilities were in place to protect people when going abroad.

PHE advised that

- There is a section in the Green book which advises very clearly which vaccines to be offered up front.
- That is a well established program.
- Where people come back with anything unusual there are alert systems in place when people become unwell.
- Alerts can from blood tests.
- PHE would be alerted from screened blood & serology tests.

It was suggested by the Inquiry that paying for vaccinations will put people off having them. Many people in Blackburn with Darwen go to sub tropical climates and that there have been several cases where people not paying for vaccinations came back to the borough with infectious diseases. In the past Environmental Health used to pick this up, was that still the case? Who does it now, and how can PHE encourage more people to get vaccinated when there is a cost implication?

PHE advised that

- Health protection agency would do the contact tracing / PHE contact tracing depends on what the contact organism as to whether or not Environmental Health would be involved.

Another member of the Inquiry explained that she had been to Gambia and had not allowed to enter the country without vaccinations. Could people come to Britain without checks?

PHE advised

- Yes – however sexually transmitted diseases and Tuberculosis were the most likely infections people bring into the country – both of which have well established programs to be dealt with efficiently and effectively.

A question was asked whether pregnant women being checked for rubella and are they given booster dosage.

NHSE advised

- Ante natal all routinely are given rubella.
- MMR - the first dosage is the lifetime vaccination and protects approximately 90% the second dosage covers the remaining 10% is given to those who don't develop immunity after first dosage.
- Since 1988 MMR clinical evidence that 90% of the population receive lifetime coverage from 1 dose without booster. The Booster covers the remaining 10%.

PHE advised that

- For those who may be at risk PHE would look to protect mum and advise mum, although they would not vaccinate pregnant women with rubella.
- A pregnant mother who is at risk of rubella is highly dependent on everyone around her to have been vaccinated in order to keep her baby safe, which is why there is such a drive and focus to meet vaccination targets.

The Inquiry asked if anyone had done a cost benefit analysis on travel vaccines.
The Panel advised that

- No, not on travel vaccines.
- Analysis is done on a population based program.
- Travel vaccines were there to protect individuals, which is partly why there was an expectation for individuals to pay for them.

The Inquiry asked a question relating to governance explaining that having read the briefing paper he didn't get a clear sense of governance, and the new structure appeared to be more a series of "nudges" rather than clear accountability.

PHE explained that

- The paper attempts to describe accountability from the top.

- The first half of the paper explained the shared accountability DOH NHSE & PHE and describes tripartheid letters and the model a bit deeper.
- The second half of the paper talked about the local model which was a bit clearer and talked about accountability:
- For the immunisations program accountability is with NHS England Chief Executive who are responsible for commissioning.
- However the responsibility for ensuring people remain safe and appropriately cared for remains a shared responsibility.
- Programs that are commissioned are NHSE responsibility.
- However some of the pathways remain unclear and too distributed, with some real challenges in the system.

The Inquiry felt that at this point
- The structure and accountability still remained confusing, opaque and without clear accountability and
- That there remained no clarity at to where thresholds and levels were for individual GPs and
- That the "sticks and carrots" were not strong enough.

In conclusion the Panel commented that organisations needed to continue to work together – if the system fragmented there would be real issues.

NHSE offered to come back to the Inquiry and give a presentation and discussion on Screening.

Next steps

The Inquiry agreed for the questions asked of the expert Panel to be e-mailed to them so that they could individually consider whether they felt they had received satisfactory responses. Returns would then be collated and shared. Interim recommendations would be formally agreed at the next meeting along with suggested next steps to test the findings.

Having completed the Inquiry members returned to Committee business as detailed in the Agenda.

RESOLVED –

1. That the expert panel be thanked for their attendance

2. That members of the Inquiry return their responses for collation

3. That at the next meeting of the Committee a further follow up challenge session with Members be run and recommendations be formulated for circulation to relevant bodies.

21. Committees work programme

Due to the lateness of the hour, the Scrutiny Manager very briefly outlined to the Committee outstanding highlights from their work programme.

The Scrutiny Manager very briefly advised the Committee that everything in the work programme was going to plan, however there had been some difficulties in engaging external partners in a Peer review and the sharing of best practice. The Committee were assured this is being prioritised, and efforts were being made to engage three local authorities who are leaders in their field with Health and Well being.

Executive Member Health and Adult Social Care – H&WBB Strategy
The Executive Member for Health and Adults Social Care would be invited back to the January meeting to update the Committee on the implementation work of the Health and Well Being Board Strategy.

Health – Keogh Review
The Scrutiny Manager advised that the Trust Development Authority (TDA) had been contacted and a request had been made to advice the authority once a date was known for the second risk summit in relation to the Keogh review. The Committee agreed that there was little point holding an Inquiry until the second risk summit has taken place. A progress update would be brought to the January meeting.

Public Health inclusion:

The Committee have previously received a breakdown of the 55 Public Health contracts that have become a Council responsibility; and a demonstration of how those services are being promoted and embedded into the main function of the Council; should receive a progress update of contracts and an explanation of how the services have been promoted and embedded. The Committee are looking to conclude this topic from January – May 2014.

RESOLVED –

That progress on the Committee work programme as outlined above be noted.

Signed……

Chair of the meeting at which the Minutes were signed

Date……