Hampshire and Isle of Wight (HIOW) Seasonal Influenza Evaluation Report

NHS England and NHS Improvement

HIOW Seasonal Influenza Evaluation Report

Season 2020-2021

Version number: 0.6 Draft

Report prepared by:

Lynn Davies - Screening and Immunisation Co-ordinator

Data prepared by:

Matthew Pickerill – Screening and Immunisation Co-ordinator

South, Central and West Commissioning Support Unit (SCW CSU)

Community Pharmacy South Central (CPSC)

Contents

Executive Summary

The purpose of this report is to provide an evaluation of the 2020-2021 flu campaign by reviewing four workstreams in the HIOW system.

The campaign was delivered during the Covid-19 pandemic with national lockdowns imposed. The school campaign was affected by school closures.

Overall, the campaign was successful, with improved uptake in clinical risk groups, and all areas achieving 75% and over for the 65 plus age group.

Some of the factors that led to this success were the flexibility to deliver vaccines in alternative ways, an increase in the number of vaccinators, the increased use of Information Technology (IT) and media for patients to book appointments, good communications and tools, and staff who showed commitment and flexibility.

Challenges and issues came from incompatible data collection systems across sectors, clinical risk groups still not being reached, a varied ease of booking appointments for patients, vaccine supply issues, teams working off site and school closures, national issues impacting locally, and patient perception of the vaccine.

Consideration for 2021/22

In the event of Covid-19 boosters being recommended the potential to co-ordinate delivery of this with the flu campaign should be explored.

Summary of recommendations:

- A single compatible data platform to collect and report on all data is needed.
- Support for General Practitioners (GPs) to improve patient access to booking appointments and vaccination clinics.
- The need to continue work to reach at risk groups.
- The numbers of staff and vaccinators to be increased again with a good skills mix.
- Vaccine ordering and supply issues needs resolution to be consistent and reliable.
- Information and communication tools to be improved and expanded.
- The impact of leadership at national and regional levels to be assessed to be improved and a full impact of key decisions e.g. call/recall service to be undertaken.

1. Introduction

The 2020-21 Influenza (flu) vaccination campaign was delivered during the peak of the Covid-19 pandemic with two national lockdowns occurring during the campaign. School were closed for over 50% of time during the campaign and approximately 93,515 individuals in the region were advised to shield by Department of Health and Social Care (DHSC)/Public Health England (PHE). The impact upon resources in all care sectors and for all care providers was significant. Despite these challenges vaccine uptake in the HIOW region was higher than the national average.

Scope

This evaluation will assess the impact and outcome of the delivery of the flu vaccination. The evaluation is formed from the summaries of four different work streams in the HIOW region and summaries of surveys undertaken by SCW CSU. The workstreams are:

1. Communications
2. Primary care and community (including Pharmacy – Central Pharmacy South Central (CPSC) group)
3. Secondary care
4. Schools

Summary of impact of Covid-19 on delivery of flu vaccine

- Social distancing and the impact on travel for shielders and other vulnerable groups led to alternative models for providers to administer vaccine.
- Resources were stretched across all sectors and disciplines. Community teams were reported to be less able to reach housebound patients due to the demands on their services.
- School closures impacted upon the school teams with inconsistent access to schools affecting how the programme could continue to be delivered.
- National communications for Covid-19 took priority, at times, over flu, leading to delay or cancellations in communications relating to flu.
- Some patients were reported to be initially reluctant to go out to access vaccination due to Covid-19. However, the pandemic appears to have increased demand for vaccination compared to previous years and some risk groups were noted by providers to be coming forward to receive vaccines. Maternity services noted women coming forward for flu vaccine as they were initially not eligible for the Covid-19 vaccine.
- Opportunistic vaccination lost for the homeless when some facilities closed due to Covid-19.
- Feedback from primary care that patients believed the Covid-19 vaccination would also protect them against flu or that flu vaccination was not needed this year due to social distancing measures.

Targets for 2020/21

Eligible Group	2019/20	2020/21
Over 65s	75%	75%
Under 65 at risk	55%	75%
2-3 year olds	50%	75%
Primary school aged children	65%	75%
Pregnant women	55%	75%

Eligibility

The following groups were eligible for flu vaccination in 2020/21:

- Aged 65 years and over
- Aged 6 months - 65 years at clinical risk (see below)
- Pregnant women
- 2 and 3-year olds
- Children in school years R to 7 (year 7 a new cohort for 2020/21)
- Health and Social Care Workers (HSCW)
- Those in long-stay residential care homes
- Carers and household contacts of anyone on the shielded patients list.
- Those aged 50-65yrs (eligible from December 1st, 2020)

Clinical Risk Groups (CRGs):

Priority groups for HIOW 2020/21 were:

- Chronic respiratory and liver disease
- Asplenia or dysfunctional spleen
- Immunosuppressed individuals
- Neurological conditions including Severe Learning Disability (SLD)
- BMI ≥ 40 with and without co-morbidity.

Other risk groups

- Chronic heart and kidney disease.
- Diabetes
- Pregnant women.

Data analysis

A summary of the available data analysis has been included within the report. More extensive and detailed analysis is available in the accompanying data pack entitled Flu Data Analysis Pack 2020-21.

2. Uptake of vaccination

2.1 Overall summary

Uptake increased significantly in all Clinical Commissioning Groups (CCGs) with all groups achieving 75% and above for the over 65 age group, and improved uptake for the under 65s, and the 2-3-year olds.

There is no data to compare the uptake for 50-64 year old with no risk factors (eligibility from 01/12/20). However, approximately 179,907 individuals were vaccinated which accounts for 48.7% of the cohort.

Uptake for the SLD group is approximately 76% with all CCGs achieving over 70%. This is a new clinical risk group (CRG) reported for 20/21 and there is no comparison for previous years.

There is an increase in overall vaccination in pregnancy but there is a discrepancy between the figures reported via secondary care and uptake reported by general practices. A small audit has demonstrated that the data sent to GP practices is not always being input/uploaded to the individual patient record by the practice team.

Community pharmacy increased delivery by 69.9% overall compared with the 2019/20 season. Data about which groups were vaccinated by pharmacy is available in the data pack.

Health Care Workers (HCW) vaccine uptake showed an increase in all trusts except one. Data for this and for HSCW in CCGs is also included in the accompanying data pack.

Table 1 – summary of uptake in main eligible groups

Percentage Uptake of Flu Vaccine by Main Eligible Group
HIOW STP, January 2019/20 and 2020/21

	Over 65s			Under 65s			Pregnant Women		
CCG	**19/20**	**20/21**	**Difference**	**19/20**	**20/21**	**Difference**	**19/20**	**20/21**	**Difference**
NHS NORTH HAMPSHIRE CCG	74.2	84.1	+9.9	47.3	61.3	+14.0	45.9	51.1	+5.2
NHS FAREHAM AND GOSPORT CCG	76.1	85.6	+9.5	47.4	60.3	+12.9	45.7	48.8	+3.1
NHS ISLE OF WIGHT CCG	68.8	79.8	+11.0	42	54.1	+12.1	27.4	49	+21.6
NHS PORTSMOUTH CCG	72.7	82.2	+9.5	45.7	56.5	+10.8	33	51.4	+18.4
NHS SOUTH EASTERN HAMPSHIRE CCG	77.6	85.1	+7.5	52.6	61.8	+9.2	49.7	50.1	+0.4
NHS SOUTHAMPTON CCG	73.5	82	+8.5	46	53.3	+7.3	43.9	42.1	-1.8
NHS WEST HAMPSHIRE CCG	76.4	85.3	+8.9	49.9	62.8	+12.9	49.7	55.5	+5.8
HIOW STP	**74.9**	**84**	+9.1	**47.9**	**59.2**	+11.3	**43.6**	**50.7**	+7.1
South East Region	**72.7**	**81.8**	+9.1	**44.9**	**56.1**	+11.2	**44.9**	**47.4**	+2.5
England	**71.9**	**80.7**	+8.8	**43.6**	**52.4**	+8.8	**43.1**	**43.6**	+0.5

Source: ImmForm

Percentage Uptake of Flu Vaccine by Main Eligible Group						
HIOW STP, January 2019/20 and 2020/21						
	2 Year Olds			3 Year Olds		
CCG	19/20	20/21	Difference	19/20	20/21	Difference
NHS NORTH HAMPSHIRE CCG	47.7	66.1	+18.4	51.9	70	+18.1
NHS FAREHAM AND GOSPORT CCG	48.3	64.7	+16.4	51.1	68.5	+17.4
NHS ISLE OF WIGHT CCG	44.1	55.2	+11.1	40.1	56.9	+16.8
NHS PORTSMOUTH CCG	50.7	61.9	+11.2	51.8	63.9	+12.1
NHS SOUTH EASTERN HAMPSHIRE CCG	48.4	66.8	+18.4	50.9	70.2	+19.3
NHS SOUTHAMPTON CCG	45	55.3	+10.3	43	59.3	+16.3
NHS WEST HAMPSHIRE CCG	56.4	71.7	+15.3	57.8	74.3	+16.5
HIOW STP	**50.1**	**64.7**	+14.6	**51.3**	**67.9**	+16.6
South East Region	**47.1**	**62.3**	+15.2	**47.2**	**64.9**	+17.7
England	**41.7**	**55.1**	+13.4	**42.6**	**57.8**	+15.2
Source: ImmForm						

2.2 Clinical Risk Groups

There has been a significant increase in uptake amongst all risk groups. Some practices have commented that the pandemic has increased uptake for the flu vaccine for those potentially at increased risk from both Covid-19 and flu (asthma given as one example). Table 2 illustrates the improvements but that the 75% target is still not being reached indicating more needs to be undertaken to reach these groups. The BMI risk group with no co-morbidity has the lowest uptake – note the increase in the number of patients registered in this group.

Table 2 - Uptake in under 65 clinical at-risk groups

Flu Vaccine Uptake by Under 65 Clinical At-Risk Group									
HIOW STP 2019/20 and 2020/21									
Under 65 At-Risk Group	2019/20			2020/21			Differences		
	Register	Vaccinated	Uptake	Register	Vaccinated	Uptake	Register	Vaccinated	Uptake
Immunosuppression	13711	6471	47.2	16605	11317	68.2	+2894	+4846	+21.0
BMI>40, No Other Risk Group	7732	1591	20.6	23376	9252	39.6	+15644	+7661	+19.0
Chronic Heart Disease	30143	12742	42.3	37942	22872	60.3	+7799	+10130	+18.0
Asplenia/Splenic Dysfunction	9429	3777	40.1	9563	5241	54.8	+134	+1464	+14.7
Chronic Kidney Disease	8590	4459	51.9	8643	5716	66.1	+53	+1257	+14.2
Chronic Neurological Disease	28629	12875	45.0	27736	16266	58.6	-893	+3391	+13.6
Chronic Liver Disease	15218	6067	39.9	17219	9044	52.5	+2001	+2977	+12.6
Chronic Respiratory Disease	99993	52148	52.2	101075	64724	64	+1082	+12576	+11.8
Diabetes	44792	27832	62.1	44926	32611	72.6	+134	+4779	+10.5
Source: ImmForm									

2.3 Schools

School uptake improved in some areas but fell in other areas largely attributed to the schools being closed despite the team being available to go to the schools and utilising other venues. At the time of writing this report the schools have reopened but access is still proving to be an issue for various reasons related to Covid-19. This has been raised at a national level and is also impacting upon other immunisations in the national schedule.

Table 3 – School programme summary - - Note: Year 7 was a new cohort for 20/21 so no data to compare.

Flu Vaccine Uptake in the Schools Programmes by Year Group

HIOW STP 2019/20 and 2020/21

	Year R		Year 1		Year 2		Year 3		Year 4		Year 5		Year 6		Year 7	
Local Authority	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21	19/20	20/21
Portsmouth	70.0	73.6	75.7	72.1	75.3	72.6	71.1	70.8	70.0	66.0	67.7	69.9	67.0	63.0		63.9
Southampton	65.6	64.3	63.4	62.7	63.4	61.4	63.0	59.3	57.1	58.4	56.6	56.7	56.7	54.9		55.3
Isle of Wight	55.0	62.8	59.0	64.4	57.6	64.1	57.6	64.0	53.7	62.5	47.2	60.7	34.4	58.0		52.7
Hamsphire	78.6	77.5	78.4	78.3	77.4	76.8	75.4	75.8	74.8	74.7	72.0	73.4	70.4	71.9		67.6
HIOW	**74.5**	**74.7**	**75.0**	**74.6**	**74.3**	**73.5**	**72.4**	**72.4**	**70.7**	**70.9**	**68.1**	**70.0**	**65.7**	**67.8**		**64.7**

Source: ImmForm

Lower than 19/20

Higher than 19/20

3. Performance

This information was obtained from a combination of surveys and feedback from providers via each work stream.

3.1 Aspects contributing to success of the campaign.

Using different modes of delivery to increase access, space and numbers of appointments due to Covid-19.	• Hire of local community halls – drive though clinics (see Appendix 1). Able to see more patients in same clinic time due to more space and concentrated plan of delivery. Best performing surgeries adopted these approaches and have said they would do it again as so successful. • Weekend clinics to increase attendance options and focus on 'shielders only' for some clinics. • Varied venues gave patients with transport issue more choice. • Funded taxi an option for homeless/rough sleepers to get them to alternative venues. Key/support workers could accompany.
Vaccine and vaccinators and ability to delivery in primary, secondary, community care settings.	• More vaccinators - additional staff trained and employed to vaccinate patients and HSCW. Collaboration between Trusts to vaccinate each other's staff. Some Primary Care Networks (PCNs) working together. Increased access for staff in secondary care settings with Occupational Health (OH) follow up for those not been recorded as having been approached. • Skills mix included Band 4 nursing associates and support workers. • Clinical divisions including maternity vaccinating both in and outpatients. • More pharmacists able to vaccinate in community. • Schools – able to start early due to early vaccine supply. Significant for uptake in special schools. • QIVe was alternative for LAIV (due to porcine content). • Central stock of vaccine to supply teams.
Use of IT systems both for patients and providers.	• Online booking and use of texts with reply facility increased access for patients to arrange appts and took pressure off phone lines. Surgeries able to then focus on patients who had not booked. Best performing surgeries and pharmacies used one or both systems. • Sharing information on cohort uptake to focus efforts. Barcode system and colour coding by cohort adopted by some surgeries to upload from invites and monitor uptake – then able to focus on specific cohorts and recall weekly. • Use of master spread sheet in primary care to monitor vaccine uptake and support the ordering of vaccine. • E- consent for schools enables teams to transfer data and advise parents of vaccination outcome and give advice on side effects.

Communications	• Toolkits to support campaign were well received. • Weekly bulletins - feedback from CCGs and practices that these were well received. • Support with queries, and meetings and debrief between teams reported as gone very well. • Use of social media and positive patient feedback reported by providers to have helped campaign. • Use of parent mail in schools to promote/advise.
Commitment of staff	• Collaborative working across teams and Trusts. • Committed to vaccinating in all settings and extending usual roles to include this. • Flexible in how, when and where staff worked. Conditions were not easy at times (see Appendix 1). • Inventive approaches to increase uptake such as Peppa Pig nature trail for 2-3-year olds.

3.2 Challenges and issues

Data collection, inputting and sharing. Reported as an issue across all groups delivering vaccine.	• No single national system to capture and report on data. Multiple systems for collection and reporting – Foundry/NIVS/ IMMFORM/PharmOutcomes not all compatible and primary and secondary care often needed to report twice as unable to report out of NIVS. • There is potential missing data from inpatients, outpatients, and maternity. An audit has been undertaken for maternity which confirms this. Secondary care advise they have communicated vaccines given to GP but if not then input will not be included in data. Primary care reported confusion over what data was needed and that data recorded did not reflect true situation. • Many OH teams do not use any reporting system and rely on employees advising GP. Approx. 34,500 vaccines were administered to front-line HCW and more to non-front line HCW (Note: not all by OH). These will overlap with every risk group and ages from 16 upwards. Many employees aged over 65. • Schools team – paper consents were time consuming to upload daily if e-consent not used. • Some confusion across teams as to what data to upload and which codes to use.
Some clinical risk groups still not being reached	• Uptake has improved but outcomes still low for some groups especially liver, kidney, spleen, BMI ≥ 40. • The number of patients in the BMI ≥ 40 group with no risk factors has increased significantly and data extraction may need to be checked by ImmForm. (Increase of 15,644 from 19/20 noted in group). • School closures impacted on special schools as parents/carers often had limited transport options to access alternatives.

	• Individuals with a Learning Disability (LD) can be at increased risk. Only data on SLD is included on ImmForm. Therefore, potentially more individuals at risk not being identified and captured by data.
Systems not consistent for booking appointments.	• Some surgeries did not have online booking or text messaging. Feedback from surgeries not using this was that this would potentially have increased uptake and saved time/phone traffic and that it should be funded. • Responses in patient feedback survey (see Appendix 2) reported that 42 had been unable to book appointments or did not know how to.
Vaccine delivery/ delays/shortages	• Some confusion on which vaccine to order. • Erratic or late vaccine supply and no 'bulk' delivery. Often difficult to get reliable information. • Clinics cancelled at short notice due to supply and unable to plan. Frustrating for staff and patients and missed patients if not rebooked. Patient feedback survey highlighted this as reason for not having vaccination (see Appendix 2). • Secondary care - ordered for maternity and staff so delay in approaching other cohorts. • School teams report that Movianto unable to give delivery slot and are advised 0800-1800 and not told if delivery is then not coming. This affected multiple sites. • Schools: delay in QIVe availability meant no immediate alternative to LAIV and needed to make parents more aware there was an alternative (see Appendix 2).
Working 'off-site'	• Increased costs due to building hire. • Poor internet and unable to support multiple laptops led to having to input after clinic. • Transportation of equipment and setting up clinics was time consuming and physically problematic. Some venues were not completely suitable due to access/parking etc. • Varied access for school vaccination team to schools when shut. Schools reported to be concerned regarding possible Covid-19 contact from outside school and this also meant paper consents were not welcome by schools (worried re contamination). • Schools teams noted to be exhausted due to the increase in cohorts and the expectations on the team.
National and regional involvement impacting on local delivery.	• Delays in some sign off at national level impacted at regional and local level. Covid-19 taking priority led to cancellation of some planned flu comms. • Delay in service specification being released. • Practices wanted earlier clarification which cohorts would be included. Additions late in campaign caused issues with

	vaccine supply and patient phone traffic increased in 50-64 age group. • Comments that providers would like information before they hear it on BBC news and have patients calling. • All teams would have liked more time to prepare or receive material. • Call and recall letters sent late and were not reflecting current situation – led to confused and upset patients and parents, increased phone traffic and demand on teams. Comments made through primary care survey was that the letters wasted time and money and control of this was wanted at a local level. • Some flu leads in secondary care felt they needed more support due to being unfamiliar with programme • Delays in funding being released or confirmed for additional resources. Led to uncertainty as to whether could commit to some planned initiatives. • Information on care homes was delayed and unreliable – feedback was better uptake would have been achieved with accurate timely information for community teams.
Patient preference, concern and understanding about the vaccine, and how to access.	• See Appendix 2. Patients gave reasons for not being vaccinated as their personal preference, concern regarding side effects and how it would affect a health condition, vaccine ingredients and safety, language barriers, lack of time. Indicates the messages regarding vaccination need to continue to be reinforced. The porcine content of the LAIV was an issue in some cases and alternatives were offered depending on age. • Some practices with patients of diverse ethnicity reported problems with language and explaining/educating about flu. • Employee vouchers were not clear as to where vaccine could be obtained. These were offered to some HSCW and by larger employers such as Portsmouth City Council.
Communication	• Some videos would not play. • Some materials not received in timely manner. • Voluntary sector may benefit from different materials. • Covid-19 often took priority over Flu communications. • School team felt the campaign was aimed at adults and not at their cohorts.

3.3 Summary of issues identified as impacting on lower performing areas

3.3.1 General aspects noted to have affected campaign

- Closure of school and some homeless facilities as noted above.

- An initial comparison based on their own feedback could be made between surgeries that had performed well and those that had not. This generally demonstrated that the surgeries achieving better uptake had used online booking, texts, and alternative venues and had addressed the delivery of the campaign as needing to be different this year. The difference in uptake between the highest and lowest 25% of practices is demonstrated in table 4 indicating that this gap has narrowed in some groups there is still a significant difference in uptake.

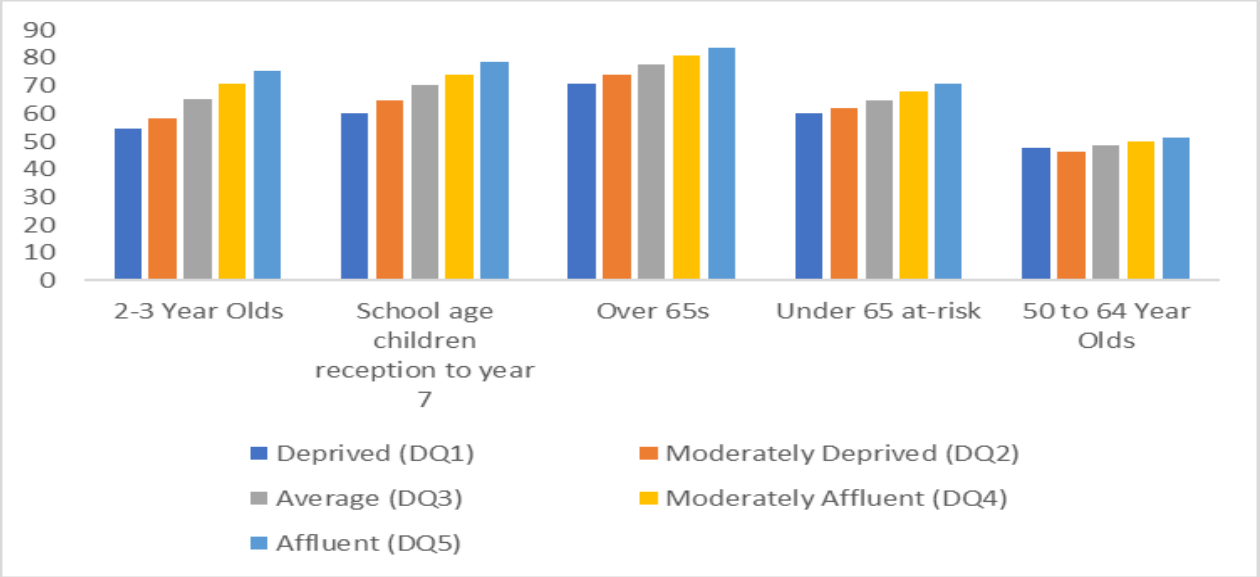
Table 4 – Difference in uptake between highest and lowest 25% of practices.

Gap in Uptake between Highest and Lowest Performing 25% of Practices HIOW STP 2016/17, 2019/20 and 2020/21					
Eligible Group	2020-21	2019-20	2016-17	Change in Gap 19/20 to 20/21	Change in Gap 16/17 to 20/21
Over 65s	8.8	11.3	11.4	-2.5	-2.6
Under 65s	17.4	14.4	18.5	+3.0	-1.1
Pregnant Women	24.3	28.5	23	-4.2	+1.3
2 Year Olds	26.2	28.5	33	-2.3	-6.8
3 Year Olds	25	27.9	32	-2.9	-7.0
Source: ImmForm					

3.3.2 Areas of deprivation

Some of the surgeries that had lower uptake were in areas identified as being deprived. See Table 5 for the relationship between vaccine uptake and deprivation. Closure of some facilities led to missed opportunity to vaccinate the homeless. Data indicates that those in less affluent areas are less likely to come forward for vaccination.

Table 5 – Relationship between vaccination uptake and areas of deprivation.

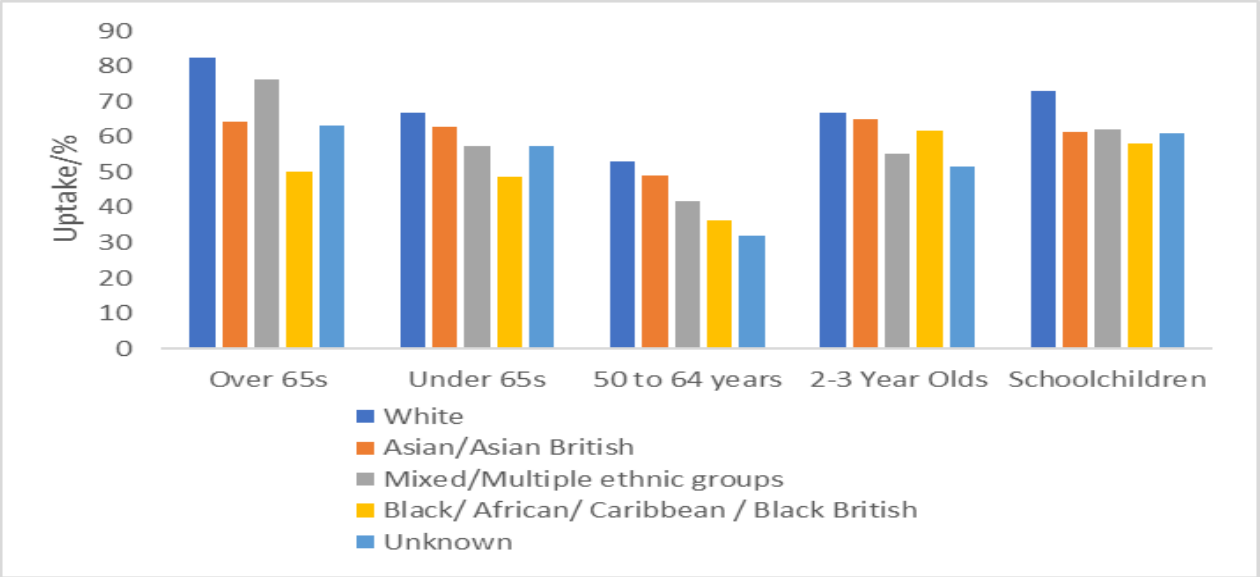


Source: South, Central and West CSU

3.3.3 Ethnicity

- Similarly, data indicates there is a correlation between vaccine uptake and ethnicity. The data shows, however, that this is less variable in school aged children. Whilst ethnicity alone does not increase the risk of complications from flu – it is relevant if any co-morbidity is present and has a direct link to Covid-19 risk. Further data on this is available – see accompanying data pack

Table 6 – Relationship between ethnicity and vaccine uptake.



Source: South, Central and West CSU

4. Recommendations

No	Recommendation	Must/Should/ Could	Responsible	Support
1	**Covid-19 vaccination**			
1.1	Consideration to be given to a combined national campaign of delivery in the event of Covid-19 boosters being required.	Should	National	Region/System
1.2	Provide early clarification on the ongoing Covid-19 vaccine programme	Must	National	
1.3	Analysis and comparison between the Covid-19 vaccination campaign and flu to look for common themes that could improve the flu uptake.	Should	System	PHCT/System
2	**Data collection and recording**			
2.1	Develop and confirm as soon as possible a single, nationally compatible, comprehensive platform for collecting and reporting data for all points of care and to work across all teams to report into GP IT systems. Note: Pharmoutcomes works well for pharmacy and is recommended to continue. To include methods for capturing data from maternity and inpatients in any setting	Must	National	Region
2.2	Provide clear guidance on the data to be input and the processes for inputting for providers	Must	National	Region/PHCT
2.3	Ensure occupational health providers gain consent for data to be captured and transferred into the single national system, such as to match up with the GP record (i.e. using NHS number)	Should	National	Regional HCW team
2.4	Cleanse data streams to ensure patient information is accurate, adding or removing information where there are changes to health. For example, if a woman is no longer pregnant.	Must	General practices	CCGs
2.5	Use electronic methods for capturing consent as standard in school aged immunisation teams to ease data collection.	Must	School providers	
2.6	Reporting of uptake in those with LD should include all LD not just SLD.	Must	National/ImmForm	
2.7	Data on ImmForm for denominators for BMI ≥ 40 (no risks) group needs to be validated.	Should	National /ImmForm	

2.8	Promote recording and coding of active declines to enable analysis	Should	CCGs/LMC/LPC	PHCT
3	**System Capacity**			
3.1	GP practices to implement text invitation/response and reminder options and use on-line booking as a tool to increase uptake and reduce administrative burden.	Should	GP practices	CCGs to provide support and funding if required (factor into budgeting)
3.2	Renew the licence for on-line booking before it runs out at the end of the year, and ensure it is set up to incorporate the flu programme	Should	National	CCGs/ Region
3.3	Support GP practices and pharmacies to look at using alternative venues again to increase capacity and access at the start of the flu campaign. Support with costs, and collaboration between surgeries and pharmacies at PCN level	Could	CCGs	Local Authorities
3.4	In light of the extended schools' immunisation programme planned for the 2021/22 flu season, the team will need support from Department of Education (D of E) to ensure consistent access to schools. Wider availability with drop-in and after school sessions are likely to increase uptake.	Must	National	Local Authorities
3.5	Better links with GP/pharmacy in low uptake areas, supported by data.	Must	PHCT/LPC	
3.6	Review of contracts and Patient Group Directive (PGD) so care home staff can be vaccinated as well as patients	Must	National	MHRA
4	**Reaching at risk groups**			
4.1	Clinical champions in primary and secondary care to be recruited now to address areas and risk groups that are not achieving target.	Must	CCG/Trusts	PHCT
4.2	Work with voluntary sector to reach some groups.	Should	Local Authority/CCG/PCN	NHSE/I Comms
4.3	Identify/map existing services that work with at risk groups e.g. smoking cessation, cardiac rehabilitation etc	Should	CCG/LA/LPC	PHCT/Spec comm
4.4	Identification of other studies from other areas to look at reaching at risk cohorts.	Should	National	PHCT

4.5	LD groups – combine flu vaccination with Covid-19 vaccination and address the 18-25 cohort that are in education or training through their colleges with visits by team of vaccinators.	Should	PHCT	SHFT/PCCG (LD teams)
4.6	Contact LD care/group home managers pro-actively to inform/educate about the importance of flu vaccination for their clients.	Must	SHFT (LD leads)/CCGs	PHCT
4.7	Uptake amongst LD to be promoted as a priority for LD partnership boards	Should	System	CCGs/LA
4.8	BMI ≥ 40 – flu vaccination advice and promotion to link in with any national campaigns on obesity.	Should	National	Local Authorities/CCG
4.9	Further assessment into areas of deprivation and uptake in ethnic groups needed, linked to the work already done by the Covid programme, including engagement with community leaders.	Must	Covid	STP Covid inequalities workstream
5	**Staffing**			
5.1	Develop a protocol-driven approach to staffing in the flu programme in line with the Covid programme	Must	National	MHRA
5.2	Employ additional staff or use those employed for Covid-19 vaccination to increase vaccinator availability.	Could	Providers	System
5.3	Managers to ensure wellbeing checks on staff at regular intervals to look at resilience and how they are coping especially those working in offsite locations.	Should	Providers	System
6	**Vaccine supply**			
6.1	Primary care providers and other existing providers to ensure adequate stock is ordered to achieve the uptake ambitions (or at least the same uptake as in the previous year)	Must	GP practices, pharmacies, acute providers	PHCT/CCGs
6.2	Acute providers to ensure adequate stock is ordered to enable vaccination of identified priority groups (kidney, liver, immuno-supressed)	Should	Acute providers	
6.3	National team to ensure that vaccine supply is consistent, reliable and timely	Must	National	
6.4	Develop a central vaccine supply to provide back up for areas where stocks run low/demand is higher than expected	Should	National	

6.5	Review and improve the school delivery service (Movianto) to meet the needs of the teams.	Must	National	
6.6	Explore self-administration of the LAIV	Could	SAI providers	PHCT
6.7	Employee vouchers need to be clearer as to where staff can access vaccine.	Must	NHS EI/CCG/LA	LPC/GPs
7	**Information and Education**			
7.1	Continue to educate on risks of flu and why vaccination is important	Must	National	Region/System
7.2	Carry out further analysis of which languages and what information needs be included in translations	Must	National	Region
7.3	Develop a plan of action that aims to reach areas of deprivation and ethnic group, in collaboration with the Covid programme	Must	Region/System	
7.4	Provide more information for patients on the difference between the vaccines and why both the Covid and flu vaccinations are needed	Must	National	Region
8	**Communication**			
8.1	Develop a local communications campaign which is ready to go at the start of the flu season, (without waiting for national materials/campaign), and provide materials to practices before the season starts, building on the 20-21 GP communications toolkit	Must	Region	System
8.2	Ensure that material provided including videos are in accessible formats and are reviewed for usefulness.	Could	National/Regional	PHCT
8.3	Develop a suite of podcasts to address concerns and encourage uptake, using clinical and patient champions (along the lines of the LMC podcast)	Could	System	PHCT
8.4	Engage with the voluntary sector to identify what materials they need to support the flu programme	Should	National	Region
8.5	Develop more targeted communications for schools including information regarding an alternative vaccine due to porcine products	Should	National	Region
8.6	Put arrangements in place that enable a 'fleet of foot' response to issues that arise e.g. national announcements that raise expectations that practices cannot fulfil	Must	Region	PHCT

9	Leadership			
9.1	Prompt sign off at national level and no delay in starting campaign	Must	National	
9.2	Early and final clarification on what cohorts and data and coding is required included	Must	National	
9.3	Timely decisions and release of funding to support initiatives and resources	Must	National	
9.4	National call and recall letters to be reviewed with a view to control of this at a local level by providers	Should	National	
9.5	Planning and timing of call recall letters to be shared with local systems and providers ahead of time	Must	National	Region
9.6	Improve the call recall system so that only those that have not been vaccinated receive a letter (timeliness of data flow), and to ensure that people are able to opt out	Must	National	
9.7	Secondary care – more support at local level for flu leads who are unfamiliar with programme	Should	Regional	PHCT
9.8	Equal emphasis and resources given to flu vaccination campaign and Covid-19 vaccination.	MUST	National	Region

NB: The following recommendations have been actioned; 6.1,6.2,6.5.

Appendices

Appendix 1

Twyford practice drive through model

Twyford Practice (West Hants CCG) drive through at local village hall.

Demonstrates the set up and conditions staff were working in.

Appendix 2 - reasons given for not having the vaccine

Patient responses to why they had not had vaccine in HIOW – undertaken as part of a wider survey in South East. The 754 responses collated below are from the 16-65 age group considered to be at risk. Demonstrates a range of service provision issues and patient perceptions.

Note – the survey closed Jan 2021 and some patients will potentially have had vaccinations after their response.

Data from: SCW CSU

Table 7 – Patient responses on why they did not have the vaccination.