Report to:	**TAMESIDE HEALTH AND WELLBEING BOARD**
Date:	28 June 2018
Executive Member Reporting Officer:	Gill Gibson, Director of Quality and Safeguarding Dr Anna Moloney, Consultant Public Health
Subject:	**HEALTH PROTECTION UPDATE: SEASONAL FLU IMMUNISATION PROGRAMME AND OUTBREAK CAPABILITIES PLAN**
Report Summary:	This report is in 2 sections the first of which is the annual seasonal flu programme performance update. A National Flu Immunisation Guidance letter has been issued for the 2018/19 season. The success of the seasonal flu programme is dependent on the collaboration of many stakeholders across the Greater Manchester and local health and social care system. The role of targeted communications is pivotal to the success of the flu campaign. The Tameside and Glossop CCG performance for the 2017/18 seasonal flu performance is summarised. The second section of the report discusses the Outbreak Capabilities Plan to assure Board that local stakeholders have robust arrangements for a range of outbreak scenarios.
Recommendations:	Health and Wellbeing Board to note and comment on: 1. Local performance for the 2017/18 seasonal flu programme plus the arrangements for the 2018/19 flu immunisation programme and the relationship between programme success and winter preparedness planning. 2. Local stakeholders have worked collaboratively to produce an Outbreak Capabilities Plan that details our response to a range of outbreak scenarios. It is important for participating organisations to support staff to engage in appropriate exercising to embed the multi-agency response to an outbreak and create familiarity over key tasks.
Links to Health and Wellbeing Strategy:	Health protection is a core foundation programme of the strategy. Seasonal flu immunisation is a national targeted immunisation programme. It makes an important contribution to the health of older people and vulnerable groups including those with long term conditions and those living in residential care.
Policy Implications:	It is a national programme commissioned by NHS England. The Local Authority has an oversight role in assuring the delivery of a high quality effective flu immunisation programme and in doing so will have due regard to principles 3 and 5 of the NHS constitution: Principle 3: The NHS aspires to the highest standards of

	excellence and professionalism Principle 5: The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
Financial Implications: (Authorised by the Section 151 Officer)	It is essential that the associated resource allocations are utilised effectively to ensure immunisation plans in are in place to reduce the impact of the related demand on health and social care services. The implementation of health protection and preventative strategies are also crucial to enable the locality to close the projected financial resource gap over the medium and longer term.
Legal Implications: (Authorised by the Borough Solicitor)	Local authorities have a statutory duty to have regard to the NHS Constitution (patients charter) when exercising their public health functions under the NHS Act 2006: https://www.gov.uk/government/publications/the-nhs-constitution-for-england In particular, this means that when making a decision relating to public health functions, a local authority must properly consider the Constitution and how it can be applied, in so far as it is relevant to the issue in question. The report author confirms compliance with the NHS constitution in undertaking this programme.
Risk Management:	National programme commissioned by NHS England.
Access to Information:	The background papers relating to this report can be inspected by contacting Dr Anna Moloney Telephone: 0161 342 2189 e-mail anna.moloney@tameside.gov.uk

1. PURPOSE

1.1 The first section of this report reflects on the local and comparative performance of the national flu immunisation programme which is commissioned by the National Health Service England (NHSE). It highlights arrangements for next year's flu immunisation programme in response to national guidance with the aim of maximising uptake in targeted populations. The prevention of seasonal flu is one of the factors that is considered part of NHS winter preparedness plans.

1.2 The second section of this report discusses local assurance with regard to outbreak management by the Outbreak Capabilities Plan.

2. PARTNERS' ROLES AND RESPONSIBILITIES: NATIONAL FLU IMMUNISATION PROPGRAMME

2.1 The successful implementation of the national flu plan is dependent on a range of organisations fulfilling their roles. These responsibilities are summarised below:

2.2 Department of Health (DH) – National programme policy decisions and oversight of the supply of antiviral vaccines. It holds NHSE and Public Health England (PHE) to account.

2.3 Public Health England – The Greater Manchester Screening and Immunisation Team (GMSIT) implement the national approach across the city region with the support of their named co-ordinators for each locality. They undertake surveillance and provide specialist advice to clinical providers.

2.4 NHSE - Commission the flu vaccination programme. This includes commissioning of the flu immunisation school provider that is currently delivered for Tameside by Intrahealth.

2.5 Local Authorities – Directors Public Health (DsPH) provide oversight and advocacy to ensure good access to flu vaccination. Public Health provide leadership with partners if required to respond to flu outbreaks.

2.6 Clinical Commissioning Groups (CCGs) – Provide quality assurance and improvement of primary care services delivering the flu plan. Commissioning of flu immunisation for pregnant women is via the GM maternity services specification.

2.7 GP Practices are responsible for vaccine ordering for their eligible practice population and issuing patient invitations. Practices can prescribe antiviral medication according to Department of Health (DH) policy. They also facilitate flu vaccination of their own staff as an employer.

2.8 Pharmacists can choose to deliver the national flu vaccination specification where all eligible adults can choose to receive their vaccination by a participating pharmacist.

2.9 NHS and Social Care Employers - Management of flu vaccination for frontline staff.

3. NATIONAL GUIDANCE

3.1 A National guidance letter was issued in March 2018 for the 2018/19 flu immunisation programme and the key elements are highlighted below.

3.2 There has been one change in the programmes eligibility criteria with the extension of the school based programme to include children in year 5. Therefore the groups eligible for the 2018/19 programme are:

- Those aged 65 year or over (delivered by GP practices, pharmacists)
- Those aged under 65 in a clinical at risk group (delivered by GP practices, pharmacists)
- Pregnant women (delivered by midwives, GP practices, pharmacists)
- All 2 and 3 year olds (delivered by GP practice)
- Children in reception class and Year 1, 2 ,3, 4 and 5 (delivered by Intrahealth)
- Frontline health and social care workers (delivered by employer)
- People living in long stay residential care homes or other long stay facilities (delivered by GPs)
- Carers (delivered by GPs, pharmacists)

3.3 The national targets and interim ambitions are the unchanged for 2018/19 with the exception of the preschool programme where it is now set at 48% and for the school programme it is also increased to 65%; both targets having been increased from a 40% lower limit that was set during the 2017/18 season.

3.4 Flu vaccination of preschool and school aged cohorts is important for their own protection and also to reduce the risk of transmission in communities.

3.5 NHSE issued an enhanced service specification in late November 2017 for the vaccination of care home workers by a registered residential/nursing home or registered domiciliary care provider. Therefore GP practices and participating pharmacists could choose whether to sign up. In addition, locally we ran an adjunct to this national scheme via primary care offering vaccination to staff working in care homes or if a home care worker through the ICFT occupational health service vaccination flu clinics. We are awaiting a decision by NHSE whether these staff groups will be included in the national programme for the 2018/19 season.

3.6 Flu is one of the factors that the health and social care system considers as part of its winter preparedness plans. Risks to programme success are mainly related to vaccine effectiveness, disruption to supply networks or a change in the predicted circulating flu strains. Risk mitigation plans are prepared by PHE, NHSE and DH. Local surge and outbreaks plans would need to be activated if there were extra cases placing pressure on care locally.

4. VACCINES AND FLU STRAINS

4.1 The predominant flu strains that circulated during 2017/18 were Flu A (H3N2) and Flu B. All the vaccine offered to children and adults covered the Flu A (H3N2) strain. People over the age of 65 are slightly more likely to catch the Flu A H3N2 strain. Children in eligible groups received a quadrivalent vaccine as this group are more likely to be affected by Flu B. Protection against the Flu B strain “Yamagata” which circulated in 2017/18 was contained in the quadrivalent vaccine but not in the 2017/18 trivalent vaccine. However, children who had been immunised would have provided indirect protection to the adult population as they often pass on flu to other family members.

4.2 For the forthcoming flu season the Joint Committee on Vaccination and Immunisation (JCVI) has concluded that an adjuvanted trivalent vaccine (aTIV) is more effective and highly cost effective in those aged 65 and over compared to the vaccine used in the 2017/18 season for adults. JCVI also recommended that adult at risk groups under 65 receive the quadrivalent vaccine which will offer protection against 2 strains of Flu B rather than one seen in the trivalent vaccine. On average use of the quadrivalent vaccine is likely to lead to reduced activity in terms of GP consultations and hospitalisations. The aTIV vaccine will be delivered to providers in phases for the 18/19 only; this is to ensure the availability of the vaccine is

equitably distributed nationally. Therefore providers will need to prioritise within their over 65 population at the start of the flu season to protect the most vulnerable individuals.

5. MONITORING

5.1 Monitoring involved immunisers recording activity on the national IMMform system from 1st September until the official end of flu season March 2018. Practices are notified of any flu vaccinations administered by third parties such as local pharmacists, midwives and Intrahealth, the school programme provider. Throughout the flu season PHE publish a weekly flu report detailing levels of circulating flu strains.

5.2 Public Health England has provided summary data for the 2017/18 season across the North West. Laboratory detections (PHE NW laboratory data): from week 27 2017 to week 15 2018 found there for both influenza A and B, this was the highest number of detections seen since the 2010/11 season. In the North West most outbreaks were reported by care homes (87%). 61% of outbreaks were confirmed as Flu A and 42% confirmed as Flu B (4% of confirmed outbreaks had both A and B identified). Locally we had one confirmed flu outbreak in a care home.

6. COMMUNICATIONS AND PROMOTION

6.1 Excellent communications are pivotal to the successful promotion of the seasonal flu programme. The 2017/18 season delivered a comprehensive campaign locally and in partnership with GM Health and Social Care Partnership. The national "Stay Well this Winter" campaign was the overarching link to our communications plan that encompassed press releases, articles in the Citizen, a taxi wrap, bus adverts and banners as well as using social media, through all available channels. Messages were sent to convey the universal importance of good respiratory etiquette when coughing and sneezing; and target information to at risk groups. In addition, local flu clinic timings were advertised. The content was adapted to reflect the issues arising from the flu teleconferences held with stakeholders, as the season progressed. The local communications campaign has been reviewed and an updated communication plan is in progress for the forthcoming season.

6.2 Flu campaign material and training resources can be accessed on https://www.gov.uk/government/collections/annual-flu-programme

7. PERFORMANCE

7.1 Within GM there were 1,217,028 people eligible for the influenza (flu) vaccine in 2017/18 across the GM Health and Social Care Partnership (GMHSCP) area (according to provisional data), an increase of 82,646 people from the 2016/17 eligible cohort. GMHSCP was the highest ranked area (out of 25) in uptake among those individuals in at risk groups aged 6 months to 65 years, and the second highest performing amongst all pregnant women, and for those aged 65 or over. There has been significant improvement in the average (mean) uptake of the vaccine in school aged children across GM in comparison to 2016/17, with over 10% improvement demonstrated across all eligible age cohorts in all 10 GMHSCP Local Authorities (LAs).

7.2 Table 1 compares the Tameside and Glossop CCG performance for 2017/18 against our uptake position in 2016/17 with GM and national comparators (England). We achieved higher uptake in all risk groups compared to the GM and national average. We have improved our performance position locally for the over 65 age group and 2 and 3 year olds. The latter group was a key focus of our campaign. Our local position in 2017/18 has dipped for

pregnant women and under 65 clinical at risk groups and this has been discussed with stakeholders.

Table 1: Comparative National /GM ranking and flu vaccination uptake for 2016/17 and 2017/18

	2016/17	2017/18	Target/Ambition	National and GM uptake 2017/18	Tameside and Glossop CCG 2017/18 % uptake (2016/17 in brackets)
For those aged 65 or over					
National Rank*	18	29	75%	72.6%	75.9% (74.4%)
GM Rank	4	4		75.4%	
Clinical at risk groups aged 6 months to 65 yrs					
National Rank	11	11	55%	48.9%	54.7% (55.8%)
GM Rank	4	3		52.4%	
Pregnant Women					
National Rank	11	45	55%	47.2%	52.7% (54.4%)
GM Rank	2	4		52.1%	
2 year olds					
National Rank	144	92	40% -65%	42.8%	44.8% (38.5%)
GM Rank	6	4		43.5%	
3 year olds					
National Rank	92	99	40%-65%	44.2%	46.1% (43.7%)
GM Rank	6	4		45.1%	

• National ranking is out of 209 CCGs Data Source: HSCP.

7.3 **Tameside Schools Flu Programme Performance (Ambition 40%-65%)**
Tameside's local performance for the school based programme compares favourably to the GM and national average, as shown in Table 2. There has been a significant improvement in 2017/18 especially with children of reception age where the setting for delivery changed to schools. Glossop schools uptake is reported with Derbyshire data.

Table 2: Tameside schools performance 2017/18 and 2016/17 with comparative GM and national data.

	2017/2018						2016/2017			
Local Authority	**Reception**	**Year 1**	**Year 2**	**Year 3**	**Year 4**		***Reception**	**Year 1**	**Year 2**	**Year 3**
Tameside	68.6%	65.4%	63.9%	63.7%	60.2%		27.7%	56.6%	54.1%	50%
GM	63.2%	61.2%	60.8%	58.1%	56.9%		32.3%	51.9%	50.2%	47.5%
England	62.6%	60.9%	60.3%	57.5%	55.7%		33.9%	57.6%	55.3%	53.3%

*Reception age children were immunised by primary care in 2016/2017

7.4 **Frontline HealthCare Workers**

ICFT undertook a proactive campaign for staff vaccination with the quadrivalent vaccine. NHSE has published a 2 year CQUIN covering 17/18 and 18/19 which includes an indicator to improve the uptake of flu vaccinations for frontline healthcare staff within providers. The CQUIN target for 2017/18 (Year 1) was 70% and it is rising to 75% in the second year. The ICFT reported 67% which but fell short of the 70% CQUIN target in year 1. The ICFT were short 94 staff (out of a denominator of 2874) to hit the 70 % target. Uptake varied across staff groups. ICFT have reflected on the outcome and are using the learning from the 2017/18 campaign to devise their implementation plan for 2018/19.

7.5 **Performance improvement**

An annual flu debrief occurs at the conclusion of the season when PHE performance reports are released to localities. The essence of action for all stakeholders involved is effective continuous communication to promote awareness of the vaccination among at risk groups, their carers and frontline health and social care staff. Primary care colleagues have received information on performance at a practice, neighbourhood and locality level. A key strategy is to continue to improve the uptake in children as this will not only protect them but reduce the circulation of flu in families and the wider community. The earlier the vaccinations for children are delivered will facilitate a reduced risk of flu spreading. We will continue to improve our overall performance across all age groups. It needs to be noted that denominator populations are increasing for adults hence providers are working harder to deliver more vaccinations for an equivalent uptake. The National Institute for Clinical Effectiveness (NICE) is working on guidance for increasing uptake in and is expected to be published in July 2018. The local Flu Working Group will use the guidance to assess local arrangements.

8. GOVERNANCE

8.1 The Tameside Health Protection Group oversees the co-ordination of the local seasonal flu campaign. In addition the Flu Working Group holds a monthly teleconference/meeting with a wider range of stakeholders, including Public Health England to update on performance, national and local communications and agree key actions as the season unfolds. It also meets to hold an annual flu debrief which occurred in March 2018. Our first meeting of the 2018/19 season is in June 2018 as we enter the preparation phase. The GM SIT has also held its annual debrief with local flu leads in May 2018.

9. OUTBREAK CAPABILITIES PLAN

9.1 Maintaining and improving the health of our communities is at the heart of Health Protection and ensuring an effective response to outbreaks of disease is a crucial part of this. Whilst the response to outbreaks isn't new and our local health economy routinely demonstrates that it has effective arrangements in place, it is important that we review our arrangements with the organisations and people who need to work together, cognisant of each other's roles and responsibilities for a range of scenarios.

9.2 The Outbreak Capabilities Plan (OCP) plan has been developed to ensure clarity on operational roles and responsibilities for each responding organisation in the event of an outbreak. It is intended to act as a companion to the GM Multi-agency Outbreak Plan, providing operational detail helping responders quickly provide an effective and coordinated approach to outbreaks of communicable disease. It is important for participating organisations to support staff to engage in appropriate exercising to embed the multi-agency response to an outbreak and create familiarity over key tasks.

9.3 Responsibility for managing outbreaks is shared by all the organisations who are members of the Outbreak Control Team (OCT). This responsibility includes the provision of sufficient

financial and other resources necessary to bring the outbreak to a successful conclusion. The great majority of incidents and outbreaks are dealt with as part of normal service provision, and may not impact greatly on routine services or require an OCT to be convened. On occasion, outbreaks are of such magnitude that there may be significant implications for routine services and additional resources are required. In this instance the Director of Public Health may declare a major outbreak / incident and therefore the major incident plans of organisations affected will be invoked as appropriate.

9.4 The Tameside OCP has been to the Health Protection Group and the Tameside and Glossop Health Emergency Resilience Group (HERG). It has been forwarded to Civil Contingencies Resilience Unit (CCRU) as part of their suite of plans to ensure we have a resilient city region. The Local Heath Resilience Partnership (LHRP) has oversight of all the OCPs from the GM 10 boroughs.

9.5 As the OCP contains confidential information, queries should be addressed to the report author.

10. RECOMMENDATIONS

10.1 As set out on the front of the report.