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Fieldwork on reducing differences in the uptake of immunisations (including targeted vaccines) in children and young people aged under 19 years

Report to the National Institute for Health and Clinical Excellence

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Abstract

This final report summarises a fieldwork evaluation of the draft recommendations developed on reducing differences in the uptake of immunisations (included targeted vaccines) in children and young people aged under 19 years. The report summarises findings from a series of workshops and interviews with key practitioners. It draws out key findings for the recommendations as a whole and for each individual recommendation.

The fieldwork focused on the content of the draft recommendations such as whether they were thought relevant and useful, factors affecting the feasibility in practice and potential impact of the recommendations.

Overall the findings suggested that the draft recommendations were received well and were both relevant and useful. They were well written and clear to understand. If the recommendations were all to be implemented fully they would increase the uptake of immunisations. However, there were concerns over resources as even though they were thought nothing new, no one PCT was currently doing it all and therefore, it was felt that they could not be fully implemented without additional resources. Practitioners also wanted more advice in the recommendations about how to reach certain groups of hard to reach children such as those that are very mobile and those not registered with the GP. Findings also indicated that as these were NICE recommendations they would hold a lot of weight. It was thought the recommendations would raise the profile of immunisation in GP surgeries and information systems were seen as integral to the success of all the recommendations.

E. Executive Summary

E.1 Introduction

The aim of the fieldwork was to get practitioners views on the content, feasibility and potential impact of the draft recommendations on reducing differences in the uptake of immunisations (including targeted vaccines) in children and young people aged under 19 years, including:

1. What were practitioner's views of the relevance and usefulness of the content and the wording of the draft recommendations?
2. What factors might affect the feasibility of the implementation of the draft recommendations?
3. What impact might the draft recommendations have on service provision and practice (by health and other agencies, for example schools)?
4. How well did the draft recommendations match with practitioner's experience?

E.2 Method

The fieldwork comprised three main activities:

1. Seven half-day workshops with practitioners such as directors of public health, immunisation coordinators, nurses, paediatricians and others.
2. Thirty telephone interviews – carried out with practice nurses and managers, community and neo-natal paediatricians, information systems managers within PCTs and one GP.
3. A content analysis of summaries to identify and summarise key themes of feedback.

The fieldwork took place from 5th May – 2nd June 2009.

E.3 Findings and conclusions

E.3.1 Overall findings

General findings

The overall findings from the fieldwork include:

- The draft recommendations were received well and thought to be well written;
- They were thought to be both relevant and useful to all practitioners apart from GPs and health visitors due to their reduced role in immunisation;
- If all recommendations were implemented they were thought to increase the uptake of immunisation in children and young people under the age of 19 years;
- To implement the recommendations additional resources would be required;
- There were several groups of hard to reach children not covered in the recommendations;
- Practitioners liked all the recommendations being in one document and felt as they were NICE recommendations they would hold a lot of weight;
- Thought they would raise the profile of immunisation in GP surgeries;
- Information systems were thought to be integral to the success of all the other recommendations.

Content and wording

The findings from the fieldwork on the content and wording of the recommendations include:

- The practitioners thought that the wording, the language (clear plain English) and the consistent formatting throughout the recommendations made the recommendations clear and easy to read.
- Practitioners suggested the ‘Who should take action’ section of the recommendations should be amended to reflect a lower level of involvement of GPs and health visitors. An option on ‘Who should take action’ section is to amend “GPs” to read “GP Practices”.
- The fieldwork found that there were several hard to reach groups that were not covered in the recommendations, such as children aged between 16 – 19 years old; Parents and children that suffer from mental health problems; and others. In addition it was indicated that practitioners wanted more advice on how to deal with children that were very mobile and would have liked to have seen more innovative ways of reaching hard to reach groups.
- There was some confusion from practitioners as to what the remit was of the recommendations and whether they included BCGs for example and HPV. Therefore, it is suggested that links are provided in the recommendations back to the overall guidance document that would clarify the remit of the recommendations and what vaccines are covered as part of them.
- Findings from the fieldwork revealed that there was no recommendation or advice in recommendations on waiting lists. Findings suggested that practitioners wanted to see advice on what is an appropriate size waiting list and what would be an appropriate length of time that children should remain on a waiting list.
- One of the areas missing from the recommendations was the education of parents and carers and the attitudes of parents and carers. The recommendations should also include advice on consulting with parents to explore the reasons why they are not having their children immunised.
- It was noted that the recommendations do not refer to Local Enhanced Services and it was felt that this can be a useful way of reaching vulnerable groups.
- Having alternative venues for immunisation may increase the opportunities to immunise children and therefore should be considered in the recommendations such as secure training homes, children’s centres and Libraries;

Impact of the draft recommendations

The findings from the fieldwork on the impact of the draft recommendations include:

- There was mixed feedback on the potential impact of the recommendations. On the one hand, feedback suggested that the recommendations were “nothing new” and that some of this was being carried out around the country by PCTs. However, to implement all of the recommendations additional resources in terms of both funding and additional staff would be required.
- Feedback did suggest that implementation of these recommendations may help in areas where immunisation uptake is lower.

Feasibility in practice of the draft recommendations

The findings from the fieldwork on feasibility of the draft recommendations include:

- Overall it was thought that the recommendations were feasible if there was sufficient resources and funding to implement them. However, it was felt that there is currently not sufficient resources and without additional resources these recommendations would not be able to be implemented fully;
- Findings consistently suggested that practitioners would benefit from implementation support with these recommendations. They noted that they would like practical examples of what has worked in different areas, case studies to assist with clarification and illustrate how to put the recommendations into practice.
- Findings also suggested that implementing all the recommendations in one go might not be feasible. However, suggestions were made of rolling the recommendations out over a period of a few years in order to place less of a demand on NHS resources. It was felt that this would make the recommendations more feasible to implement.
- It was reported that one of the main barriers to increasing uptake of immunisations was understanding the reasons why parents do not have their children immunised. Findings suggested that this was something that should be covered as part of the recommendations;
- One of the main factors that would affect the feasibility of successfully implementing of the recommendations was the information systems and the quality of the data. Practitioners generally felt that having an effective information system would be integral to the success of all the recommendations;

E.3.1 Recommendation specific findings

Recommendation 1: Immunisation Programmes

Overall this draft recommendation was:

- Considered easy to read, useful and relevant;
- Thought to be potentially useful to ensure that commissioners and practitioners were up to a certain standard and could also be a criterion to audit against;
- Clear about who the target population was, however, suggestions were made as to others that should be included, such as ‘all children’ and ‘guardians’;
- Lacking certain groups from the ‘who should take action’ section such as, practice nurses, school nurses, hostels and grand parents;
- Thought to be slightly unrealistic with regard to delivering immunisations in Accident and Emergency departments in hospitals;

The other main findings from recommendation 1 included:

- Collaborative working ensuring that data is shared consistently and at consistent times was thought to be key to the success of this recommendation;

- Alternative methods of engagement such as vaccinations at home were thought to be very important and were welcomed;
- Another key factor that could impact the feasibility of this recommendation was presenting information about immunisations via a range of mediums (visual, verbal and auditory) as well as through a range of media sources (TV, radio and posters) to help overcome language, literacy and cultural barriers.

Recommendation 2: Information systems

Overall this recommendation was:

- Well written and easy to understand;
- Useful, however, should recognise that currently there is not one system in place rather there are two main systems that are not always aligned;
- Thought to be the most important recommendation and integral to the success of all the other recommendations;
- Thought to be a lot of extra work to Practices if implemented;
- Considered to benefit from the inclusion of private providers and the recognition that private providers should report all vaccinations provided to the GPs;
- Thought could benefit from more information on how to implement this recommendation in particular how drop in centres can access child health records;
- Thought could benefit from information or advice on recording family risk factors;
- Thought could benefit from being extended to include information on how information that is recorded is used effectively.

Recommendations 3: Training

Overall this recommendation was:

- Thought to be very important and if implemented effectively would improve confidence in vaccination and increase the number of vaccines delivered;
- Considered a useful way of ensuring that all information about immunisations being disseminated by practitioners is up to date and correct;
- Thought relevant but that the target population of the recommendations should be extended to include:
  - Health protection unit staff;
  - Prison health care staff;
  - Walk in centre staff; and
  - Accident and Emergency staff.
- Thought could benefit from more detail on what members of staff should attend the training;
- Thought could benefit from examples of other training systems that have been successfully implemented.

The other main findings from recommendation 3 included:

- High quality training is required;
- Practitioners wanted more information on how to ensure good attendance at training events, including how to ensure that more experienced practitioners attend;
- Training that is provided should be innovative and flexible to ensure higher attendance. For example either running courses in the evening of making use of other technologies such as e-learning.

Recommendation 4 – Nurseries, schools, colleges of further education

Overall this recommendation was:

- Received positively;
- Useful as it would raise the status of immunisation in schools and colleges and provide more opportunities to reach those hard to reach children;
- Thought to be a bit aspirational;
- Out of date as some of the roles noted in the recommendation had changed;
- Thought could benefit from more clarity on some of the terminology, such as 'healthy child team';
- Thought could benefit from inclusion of up to date roles of health visitors;
- Relevant, however, could benefit from a few additions to the target population to include: siblings, those not in education and training, children in private schools and children schooled at home;
- Thought to benefit from amendments to 'who should take action' such as including, college nurses and university medical staff to ensure that the older children are catered for;
- Questioned on its feasibility of using schools as venues for immunisations, these include:
    - Complications with insurance,
    - Interruptions of the curriculum,
    - Lack of interest from the head teachers,
    - Issues of letting siblings into schools,
    - Lack of facilities in schools; and
    - Lack of time from the school nurse.
- Questioned on its feasibility of schools nurses checking the immunisation status of all children and young people when transferred from a different school or college;

The other main findings from recommendation 4 included:

- Additional resources would be required to implement this recommendation successfully;

- Quality and reliability of data was noted as pivotal to the success of this recommendation;
- This recommendation implies that there is a good working relationship between schools, health authorities and practitioners however findings suggested this was not the case and it was thought this would be difficult to implement with the current practice;
- The recommendation would need to make it clear that education authorities, schools and further education colleges need to share data with the PCTs and that this does not go against the Data Protection Act.

Recommendation 5 – Groups at increased risk of not being fully immunised

Overall this recommendation was:

- Received positively and was thought to be both relevant and useful;
- Thought to be lacking information on how to reach some hard to reach groups of children, especially those that are very mobile or those children not registered with a GP;
- Thought to benefit from including more innovative ways of reaching hard to reach groups. Suggestions included the use of media campaigns and also TV channels dedicated to foreign nationals and daytime TV for those not in employment;

The other main findings from recommendation 5 included:

- Walk in centres were considered good ways of reaching groups at increased risk of not being fully immunised. However, there were concerns about the cost of walk in centres;
- Offering transport to immunisation clinics may help to overcome the barrier of transport or the use of travelling buses;
- It was felt the recommendation should recognise that immigrants from EU and Non-EU countries have often have started immunisation schedules. However, this often differs from England together with differing names of the vaccinations, therefore, this can make it very difficult to determine when a child is due their next vaccination for example;
- It was thought that the recommendation should include instructions for health professionals on how they can constructively challenge parents that do not have their children immunised.

Recommendation 6 – Neonatal hepatitis B

Overall this recommendation was:

- Mainly received well however there were concerns that there was no mention of other vaccines such as BCG or HPV and therefore a reference back to the guidance document would be beneficial;

- Thought to benefit from the suggestion of an identified person responsible for the vaccination of babies at risk from Hepatitis B;
- Only relevant to certain groups of health care professionals who work with cases of Hepatitis B and generally there is a lack of knowledge about Hepatitis B in the health industry. Paediatricians and Health visitors were thought to be the most relevant groups to take action from this recommendation and were very positive of this issue being recognised;
- Considered less of a priority to many health professionals as there are so few cases of Hepatitis B each year, however, was recognised that due to the low priority some individuals can slip through and therefore this recommendation will help to ensure this does not happen;

The other main findings from recommendation 6 included:

- Suggestions were made to include Hepatitis B in children's 'red book.' However, there were concerns over confidentially and it was thought this needed to be clarified by the recommendation;
- Mothers affected with Hepatitis B are likely to come from foreign counties and there may well be language barriers and it was felt this was not covered in the recommendations and could affect the feasibility of successful implementing it.
- Mothers with Hepatitis B are often a mobile population and this was not addressed in the recommendation.

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1 INTRODUCTION

Greenstreet Berman Limited was commissioned by the National Institute for Health and Clinical Excellence to carryout fieldwork with practitioners to test draft recommendations on reducing differences in the uptake of immunisations (including targeted vaccines) in children and young people aged under 19 years.

The aim of the fieldwork was to get practitioners views on the content, feasibility and potential impact of the draft recommendations on reducing differences in the uptake of immunisations (including targeted vaccines) in children and young people aged under 19 years, including:

1. What were practitioner's views of the relevance and usefulness of the content and the wording of the draft recommendations?
2. What factors might affect the feasibility of the implementation of the draft recommendations?
3. What impact might the draft recommendations have on service provision and practice (by health and other agencies, for example schools)?
4. How well do the draft recommendations match with practitioner's experience?

1.1 A request for guidance from the Department of Health

The scope of the initial guidance came from a request by the Department of Health to:

"Produce public health intervention guidance on mechanisms to reduce inequalities in the uptake of immunisations amongst individuals under the age of 19 years (including targeted vaccines)."

NICE guidance is developed using the best available evidence and the expertise of the NHS and the wider public health community including NHS staff, healthcare professionals, parents and carers, industry and the academic world. Once NICE publishes public health guidance, health professionals and the organisations that employ them are expected to take it into account.

The NICE guidance on the reducing differences in the uptake of immunisations (included targeted vaccines) in children and young people aged under 19 years has been developed through a phased process, this included:

1. Drafting of a scope to identify the remit of the work.
2. Consultation to ensure relevance and usefulness of the scope.
3. Reviews of the relevant literature.
4. Consultation on the review to identify any missing evidence.
5. Public Health Interventions Advisory Committee (PHIAC) review of the evidence and drafting of the recommendations.
6. Practitioner consultation to evaluate the relevance, usefulness and implementability of the recommendations.

This fieldwork formed part of section 6. The findings from this fieldwork act as a source of evidence on the relevance, utility and implementability of the recommendations

NICE will provide tools to support implementation of the recommendations.

1.2 Target audience and populations covered

These draft recommendations are aimed at immunisation leads and immunisation coordinators in primary care trusts, strategic health authorities and health protection units, GPs, community and neonatal paediatricians, health visitors and nurses and professionals, commissioners and managers with a direct or indirect role in or responsibility for the immunisation of children and young people, including those with responsibility for the information systems and for recording immunisations. This includes those working within the NHS, local authorities, children's services, schools, colleges and workplaces, immigration services, young offender institutions, and the wider public, private, voluntary and community sectors.

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1.3 The draft recommendations

Six draft recommendations were developed as a result of the research. The draft recommendations covered six main areas including:

1. Immunisation programmes;
2. Information systems;
3. Training;
4. Nurseries, schools, colleges of further education;
5. Groups at increased risk of not being fully immunised; and
6. Neonatal hepatitis B

A copy of each draft recommendation is included in section 3.7 of this report.

1.4 This fieldwork

The findings from the fieldwork reported in this document form part of step 6 above. The objective of this fieldwork was to examine the relevance, utility and implementability of the draft recommendations with key practitioners. Findings from the fieldwork are considered by NICE to be an important source of evidence on the feasibility of implementation of the recommendations, and the conditions required for uptake and delivery.

The findings of the fieldwork reported in this document will be considered by NICE's Public Health Interventions Advisory Committee (PHIAC) in June 2009 and inform the final guidance, due to be issued in September 2009.

2 METHOD

2.1 Overview

The fieldwork comprised three main activities:

1. Seven half-day workshops with practitioners such as directors of public health, immunisation coordinators, heads of health protection, community and hospital based paediatricians, practice/school/prison nurses, GPs, Health Protection agency specialists/consultants including consultants in communicable diseases and consultants in public health.
2. Thirty telephone interviews – carried out with practice nurses and practice managers, community and neo-natal paediatricians, information systems managers within PCTs and one GP.
3. A content analysis of summaries to identify and summarise key themes of feedback. Section 3 of this report provides a synthesis of feedback from all parts of the fieldwork. The summaries of the workshops are provided in the appendices. The summaries of the telephone interviews are not available publicly in order to preserve the anonymity of the interview respondents.

All respondents received briefing materials and questions prior to the sessions, and were provided with summaries of their sessions for approval.

All workshops were scheduled for May 2009 in order to meet the project schedule. Telephone interviews with practitioners were conducted in May 2009 and the first two days of June 2009, again to comply with the project schedule.

The workshop topic guide was developed through close liaison with the team at NICE, to ensure that the key research questions were addressed. In development of the questions for the topic guide and telephone interview proforma reference, adherence was made to '*Methods for development of NICE public health guidance'* (2006).

The topic guide (Appendix C) was structured to ensure that practitioners had a comprehensive understanding of the background, aims and outcomes of the fieldwork. The topic guide was split into two main sections. The first section raised questions on the recommendations as a whole, and included questions in five main categories pre-agreed with the research team at NICE:

1. Content and wording of the recommendations;
2. Feasibility ;
3. Impact of the recommendations;
4. Barriers;
5. Inclusion of all groups under 19 years.

Each question under these main categories included prompts to give the facilitator the means to explore the subject in more detail.

The second section raised questions to be addressed to each recommendation in turn. This included questions on the wording, implementability, factors affecting feasibility, barriers, impact and more for each of the recommendations.

The telephone interview proforma was developed using the workshop topic guide as a basis.

2.2 Recruitment of workshop delegates

All recruitment for the workshops was performed by Greenstreet Berman Limited. Key practitioners for the direct email were identified from:

- NICE's practitioner list (reducing differences in the uptake of immunisations[1]);
- An internet search of organisations using key terms such as PCT Directors of Public Health, Immunisation Co-ordinators, Health Visitors GPs, Practice Nurses, Community and Neonatal paediatricians, Sure Start, Consultants in Communicable Diseases and representatives from children's trusts and Directors of children's services.

A list of 850 individuals was developed covering London, South East, Midlands and North West England, with their names, organisations and email addresses, these included:

1. GPs;
2. Local authority children's services;
3. Representatives from children's trusts;
4. Primary Care Trust Directors of Public Health and Immunisation Coordinators;
5. Strategic Health Authority Directors of Public Health;
6. Practice Managers and Practice nurses;
7. Community and neonatal paediatricians;
8. Health Protection consultants and nurses including Consultants in Communicable Diseases;
9. Health Visitors.

They were contacted via an email to request the attendance of a representative of their organisation at one of the eight scheduled workshops (2 in London, 2 in Birmingham, 2 in Manchester and 2 in Brighton). The invitation outlined the purpose of the workshops, the scope of recommendations and who they are aimed at.

All individuals that booked onto a workshop were sent a copy of the draft recommendations included as part of the delegate's topic guide in advance of the workshops.

As noted in Table 1, 79 delegates attended the workshops. Due to the relatively low number of delegates in Brighton the afternoon session was cancelled.

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[1] http://www.gserve.nice.org.uk/guidance/index.jsp?action=download&o=38094

Table 1: Number of delegates per workshop

Workshop	Number of delegates that agreed to attend	Number of delegates that attended
London 19th September AM	20	**13**
London 19th September PM	17	**13**
Brighton 14th May AM	9	**8**
Manchester 21st May AM	17	**14**
Manchester 21st May PM	15	**15**
Birmingham 12th May AM	11	**11**
Birmingham 12th May PM	7	**5**
Total	96	**79**

2.3 Conducting the workshops

The seven workshops held in Birmingham, London, Brighton and Manchester ran for three hours each. There was one main facilitator running the workshop with a second facilitator that acted as a scribe in the plenary sessions, and a facilitator in the recommendation-specific review. All workshops sessions were recorded, consent for which was obtained from all delegates at the beginning of the workshop. The session consisted of:

- Introduction and housekeeping – 10 minutes;
- General review of the guidance as a whole – one hour;
- Tea break – 10 minutes;
- Recommendation specific review (in which the workshop broke into between two and three smaller groups with facilitators moving between groups to ensure adherence to the agenda, and each group discussing three recommendations each) – one hour and 15 minutes;
- Plenary appraisal and discussion of findings – 25 minutes;
- Evaluation of the workshop – five minutes.

In total 79 delegates attended the workshops. Although this was a lower figure than anticipated, the information gathered and the range of delegates and responses given was nevertheless enormously valuable to the fieldwork. The disciplines of delegates were all relevant and appropriate to the subject matter. Types of practitioners included directors of public health, immunisation coordinators, heads of health protection, community and hospital based paediatricians, practice/school/prison nurses, GPs, PCT specialists/consultants including consultants in communicable diseases and consultants in public health.

On completion of the workshops a summary was written up by the facilitators. This summary (Appendix B) was then forwarded to the delegates for any additional comments and approval.

Listed below is a summary of the evaluation worksheets that were received on completion of the four workshops. Delegates were asked to answer each question on a 10 point scale (1 = not at all/poor, 10 = definitely/excellent).

Table 2 Average evaluation score for workshops

Questions posed to the delegates included the following	Average score (max score 10)
Were the key points covered?	8
Did the workshop satisfy its objectives?	8
Was the length of the workshop adequate?	8
Please rate the standard of facilitation	8
Please rate the quality of written materials/visual aids	7.5

2.4 Recruitment and sampling of telephone interviews

A list of 546 contacts was developed by an internet search of pertinent organisations. In each case a name and telephone number was identified. The contacts were telephoned for the sake of explaining the purpose of the fieldwork, the scope of the recommendations and to request an interview. In total 546 practitioners were approached to take part in the telephone interviews, of these 30 agreed to take part and were interviewed. The types of practitioners that were approached included:

- GPs
- Community and neonatal paediatricians;
- Health Visitors;
- Practice Nurses and practice managers; and
- People within PCTs responsible for the information systems.

2.5 Conducting the telephone interviews

Practitioners were sent the interview proforma and a copy of the recommendations to read prior to the interview. Each interview lasted between 15 minutes and an hour. Respondents were required to comment on those recommendations that were relevant to them. Therefore, four main telephone proformas were developed, these included:

- One for GPs and Practice Nurses;
- One for Paediatricians;
- One for Health Visitors;
- One for Information system people within PCTs and Practice Managers.

On completion of the interviews a summary was written up by the interviewer and forwarded to the interviewee for any additional comments and for their approval.

2.6 Analysis and reporting of results

The findings from the fieldwork reports were analysed ‘by hand’ using thematic and content analysis techniques. A set of repeatable rules were used for the content analysis which included:

- The categories of themes of feedback, such as inclusion and integrating with other policies;
- The group that cited the theme and any other sub-categorisation, such as the size of the business or public/private sector organisations;
- The importance attached to each theme;
- A summary of feedback in each theme; and
- Examples to illustrate themes where provided.

Responses of the telephone interviews were compared with the workshops.

3 MAIN FINDINGS

3.1 Introduction

This section of the report provides the feedback on the recommendations as a whole, specifically:

- General reaction to the recommendations;
- Content and relevance of the recommendations;
- Impact of the recommendations;
- Feasibility of the recommendations;
- Compulsory immunisation.

The findings from the seven regional practitioner workshops together with the 30 telephone interviews with practitioners have been analysed and the key themes are highlighted in the following section. Overall the content analysis revealed that the findings from all types of practitioners were quite consistent and there were no major differences between the findings from the workshops and the telephone interviews.

3.2 General reaction to the recommendations

Practitioners were positive about the recommendations and liked the way that all the recommendations had been pulled together into one document. They thought that as these recommendations are from NICE they will hold a lot of weight. However, a small number of telephone interviewees seemed to think that this may hamper their successful implementation as they felt there were too many large and detailed guidance documents in circulation already from NICE covering other topics and consequently, they may not be prioritised and given serious consideration. Others had concerns that because these recommendations are not mandatory that relevant organisations[2] will not implement them, therefore some practitioners thought that they would have '*no teeth.*'

Practitioners also thought that these NICE recommendations would raise the profile of immunisation status in GP surgeries. They noted that at present, immunisation has quite low importance and that it is no longer GPs carrying out the immunisations but the practice nurses. It was stated by respondents that it should remain the role of the GP to administer vaccinations and not that of the school nurse for example, and in doing such it could result in further inaccuracies with immunisation records and greater demand for resources, personnel and training for those involved. However, the limited feedback from the GP interview revealed that GPs do not see the relevance of these recommendations to them as it is others such as practice nurses and the school nurses carrying out the immunisations.

Many of the practitioners consulted with as part of the fieldwork process felt that recommendation 2 was integral to the success of all the other recommendations.

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[2] Specific types of organisations were not detailed.

3.3 Content and relevance of the recommendation

Overall it was felt that the recommendations were useful and relevant to all of the practitioners that were consulted with as part of this fieldwork. However, it was felt less relevant to GPs and Health Visitors as discussed in more detail below. The findings on the content and wording of the recommendations are discussed below.

Wording of the recommendations

Overall, the findings suggested that the overall layout and formatting of the recommendations was good and that delegates like the consistent approach used throughout the six recommendations. The findings indicated that practitioners were positive towards the way the recommendations were written. They thought that they were clear, used simple English and were easy to follow because each recommendation was presented in the same format. A small number of practitioners felt that the recommendations could be improved with evidence based support for what they were proposing and that this addition may increase the likelihood of uptake among the different sources mentioned.

Whilst the practitioners thought that the recommendations were clear, they felt that there would be a wide spectrum of practitioners that would be using these recommendations and therefore abbreviations such as SHA or PCT should not be used as these may not be widely understood.

Breadth of the recommendations

It was apparent that there was confusion over which vaccinations were included in the recommendations and exactly what vaccinations were included. Questions were raised as to whether or not the BCG was included and also whether or not the HPV was included. Practitioners thought that the recommendations should be extended to cover HPV. The researchers felt that this maybe because the practitioners in the fieldwork were only presented with the draft recommendations and not the whole guidance document and that this may have been clarified in the guidance document.

Language

Some of the findings indicated that practitioners would have preferred the recommendations to use more forceful language. At present, the recommendations were considered '*too woolly'* and that if words such as 'should' are replaced with words such as 'must' then it was thought it may increase the likelihood that the recommendations are implemented successfully and taken on board by all practitioners that they are aimed at.

Layout of the recommendation

Suggestions were made on ways to present the recommendations to make them clearer. One suggestion from a practitioner was presenting the recommendations in matrix format that will diagrammatically show the links between the recommendations. However, in general the majority of the practitioners felt that they were happy with the layout and the format of the recommendations.

Relevance to GPs

Although there was only one telephone interview with a GP conducted, their findings did support the findings that came out of the workshops (4 GPs attended the workshops). It was felt that GP's role in immunisations is minimal and that really it is the practice nurses and the school nurses that carryout the immunisations. Indeed, the low level of response from GPs was indicative of the finding that GPs do not have a major role in immunisation. Numerous attempts were made to solicit responses from GP with minimal success due to the perceived lack of relevance to GPs. The GP felt that in 'Who should take action' section of the recommendations this should read GP Practices only and not GPs. It was felt that GPs are part of a team now and due to many government targets and demands they have less time to spend on immunisations. Therefore, it was felt that these recommendations would have little impact on the role of GPs but perhaps could have a wider impact on the Practices in areas that are under performing on immunisation.

Role of Health Visitors

The role of health visitors in immunisations was discussed by many of the practitioners consulted. It was stated that health visitors are no longer carrying out immunisations and that due to a demand on their time; their priorities have changed more towards child protection. However, despite not carrying out immunisations, health visitors are still providing parents with information on immunisations. Practitioners noted that some health visitors have been missing their mandatory training on immunisation. It was felt that unless the role of health visitors changes the recommendations will need to reflect their reduced role in immunisations.

Furthermore, practitioners believed that the role of immunisation coordinators was underplayed within the recommendations and that their greater inclusion could help to alleviate the pressure o other health professionals.

Alternative venues for immunisations

Practitioners noted that the recommendations do not consider a number of different settings that can be used to deliver immunisations. Suggestions on alternative venues for immunisations included libraries and children's centres.

One of the practitioners saw no reason why vaccinations could not be provided in all of the locations that information is to be distributed, provided that appropriate procedures were in place and individuals are sufficiently trained.

Areas to be further developed in the recommendations

The findings from the workshops and the telephone interviews revealed that there were a few areas that could be further developed in the recommendations, these included:

Parent's attitudes towards immunisations

Practitioners noted that the recommendations did not include any information about education of parents. Three main issues were noted from practitioners on the knowledge of parents on immunisations:

- There are those parents that use misinformation as an excuse not to have their children immunised;
- Those parents that are not aware of the risks of not having their children immunised and;

- Those parents that research the immunisations themselves and therefore read all the possible side affects and risk associated with them and therefore opt out of having their children immunised.

As noted above the practitioners noted that there are a variety of reasons why parents do not have their children immunised. However, the recommendations do not cover trying to understand why this is. Practitioners suggested that there were ways that this could be done such as running focus groups with parents to try to get to the underlying reasons why they do not have their children immunised. Some practitioners noted that parents are involved strategic meetings (such as PCTs) so that their views are taken into consideration, and practice nurses noted speaking to parents and checking children's immunisation records when the parent alone visits the surgery for alternative reasons. Furthermore it was felt that the use of services outside of the health care setting, such as nurseries, to provide information and education to parents may be influential to parent's choice to have their children immunised because the information is coming from outside the health profession.

In addition, delegates felt that there were inconsistencies in the attitudes of health professionals towards immunisations and that their own personal beliefs about immunisations may impact on those that they are immunising. Therefore, it was noted that it was very good that one of the recommendations was about training of all staff even receptionists as it may help to eliminate some of the myths that are associated with particular vaccinations such as Measles Mumps and Rubella (MMR).

Waiting Lists

In two of the workshop, practitioners felt that the recommendations did not cover the issues relating to waiting list[3]. Practitioners wanted to see recommendations on how big waiting lists should be and also advice on how long a child or young person should have to wait for a vaccination. Apparently there is a lot of variation in the size of waiting lists; the examples given in workshops were between 300 and 2500 people on waiting lists.

Local enhanced Services

It was noted that the recommendations do not refer to Local Enhanced Services and it was felt that this can be a useful way of reaching vulnerable groups.

3.4 Impact of the recommendations

Although the findings indicated that most of these draft recommendations are already being implemented, no one PCT is doing everything. The practitioners noted that they felt the recommendations implied these recommendations could be implemented without further resources. When in reality, it was noted that additional resources would be required to implement all the recommendations.

[3] Practitioners did not discuss whether they all had waiting lists or how long children are having to wait.

It was felt that these recommendations were '*nothing new.'* Some felt that the recommendations did help to formalise what was already being done, highlighting what is lacking or in need of improvement/adaptation, and bring the things covered in to the forefront of focus. The practitioners also felt that these recommendations were not *'rocket science.'* However, in areas that were doing less it would have a large impact on practice.

Resources

Nearly all practitioners that were consulted with raised the concern of resources. Despite childhood immunisation being a tier 2 priority[4], practitioners did note that resources were an issue, in terms of both funding and staff. It was felt that they were already stretched and that these recommendations would add to that existing pressures. Practitioners felt that the recommendations assumed adequate resources when in reality they noted that this was not the case and that additional resources would be required to implement these recommendations. It was felt that if the recommendations were all implemented fully in one go then there was potential for staff and resources to be taken away from other key services and therefore may have an adverse affect on other services provided by the NHS.

3.5 Feasibility in practice

Overall it was apparent from the findings that the recommendations would be feasible if there were additional resources (both funding and staff) available to implement them. Other factors affecting the potential feasibility of these recommendations being implemented include the use of alternative venues, private providers, reaching hard to reach groups and how the recommendations are implemented. These are expanded below.

Private providers

Practitioners noted that private providers could potentially impact on how successful these recommendations are. Practitioners noted that they are not even aware of who the private providers are and private providers do not feedback information about immunisation status of a child to the GP. Practitioners expanded to say that private providers do not even feedback to the GP if a child has had an anaphylactic reaction to a vaccination.

Hard to reach groups

As a general point the practitioners felt that they wanted more information on how to target hard to reach groups of children that are for example very mobile, these typically are those children from travelling families, service/military families and children in care, who are perhaps less likely to be registered with a GP.

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[4] Childhood immunisation is a 'tier 2 Vital Sign' which means it is a NHS priority. As such, primary care trusts (PCTs) must set targets to improve vaccination uptake and agree these with their strategic health authorities (SHAs). The SHAs, with the help of the Department, monitor the PCTs against these targets.

Information Systems

Generally, all practitioners consulted with thought that the quality of information systems and data is integral to all of the recommendations. The findings suggested that if there is not an effective information system in place then the other recommendations will not be feasible. The quality of data, inconsistencies in data and differences in IT systems currently appeared to be one of the main barriers to implementing these recommendations. Practitioners noted that at present there are two main systems the Child Health Information System and the GP reporting system or Exeter system. These systems are different and do not always align with each other, delegates noted that they '*don't talk to each other*.' Practitioners noted that the recommendations do not currently note that there is not a robust system in place to allow information to be exchanged between different health settings, and that this can often result in long delays in obtaining up to date records from different PCTs, surgeries and geographical locations; something practitioners thought could be overcome with an overarching IT system.

Furthermore, it was noted that walk in centres at present do not have access to immunisation records of the primary care services, and that the provision of this would be beneficial to increasing uptake as potential barriers for parents, such as time and access problems, would be greatly reduced.

Implementation

The practitioners that attended the workshops thought that if they were to implement all the recommendations in one go, it could potentially have an adverse impact on other services as resources would be needed to support these recommendations. The workshop practitioners suggested that instead of recommendations being implemented all in one go, they are rolled out over a few years.

The general feedback was that the recommendations were useful however; many practitioners reported that they would like further information on how to implement these recommendations. They thought that the recommendations would benefit from links to case studies of examples of what has worked in other areas or examples of best practice to assist with clarification and illustrate how to put the recommendations into practice. Contrary to this, one telephone interviewee felt that it was good that the recommendations only provided general guidance because they could then be adopted and utilised differently by the different service providers.

Another suggestion to support the implementation of the recommendations was to present the recommendations as a matrix. It was felt that there was a lot of overlap in the recommendations and that a more visual and user friendly way of providing an overview of the recommendations would be by presenting the recommendations as a matrix. This matrix would indicate the links between all the recommendations.

To assist implementation it was suggested that PCTs could contact all organisations to determine whether they were aware of the recommendations and also to encourage them to implement the recommendations.

3.6 Compulsory immunisation

Mandatory in Schools

Several practitioners during the workshops and the telephone interviews discussed making immunisations mandatory entry requirements in to schools colleges and universities. During the workshops this topic created debate amongst practitioners as to whether it would be possible to implement this in England. America was used as an example as a country that had implemented this, however, it was not thought possible in this country as there were ethical issues and Primary and Secondary schools are currently mandatory for children to attend. Generally there were mixed views as to the feasibility of making immunisation mandatory in this country.

3.7 Recommendation specific feedback

3.7.1 Recommendation 1 – immunisation programmes

Who is the target population?

- Children and young people aged under 19, particularly those who may not have been immunised or have only been partially immunised.
- Parents and carers of children and young people aged under 19.

Who should take action?

- Commissioners, managers and coordinators of children's services in primary care trusts (PCTs), children's trusts, Sure Start children's centres and services run by family nurse partnerships.
- Health professionals responsible for children's immunisation services, including directors of public health, paediatricians, GPs and health visitors.
- Immunisation coordinators and others who work in immunisation services in strategic health authorities (SHAs), PCTs and GP practices.
- Health protection specialists and immunisation leads in health protection units (HPUs).

What action should they take?

Ensure the Department of Health's (DH) guidance and recommendations on immunisation are disseminated and implemented. This includes adopting a multifaceted, coordinated programme across different settings to increase timely immunisation among groups with low or partial uptake. The programme should form part of the local child health strategy and should include the following actions:

- Monitor vaccination status as part of a wider assessment of children and young people's health.
- Ensure an identified healthcare professional in the GP practice is responsible for implementing the local childhood immunisation programme.
- Provide parents, carers and young people with tailored information, advice and support to ensure they know about the recommended routine childhood vaccinations and the benefits and

risks. This includes detail on the infections they prevent. Information should be provided in alternative formats for example, to help those whose first language is not English.

- Ensure parents and carers have an opportunity to discuss any concerns they might have. This could either be in person or by telephone with a GP, health visitor, school nurse or practice nurse.
- Send tailored reminders and recall invitations when a child does not attend vaccination appointments. Reminder invitations could be delivered by text message, telephone or letter.
- Improve access to immunisation services for example, by extending clinic times, reducing waiting times and ensuring waiting areas are child-friendly.
- Check immunisation status at every appropriate opportunity whether in primary care (for example, as part of a healthy child development review), hospital in- or outpatient and accident and emergency departments, walk-in centres or minor injuries units. Use the personal child health record (PCHR) as appropriate. Discuss outstanding vaccinations with the parent, carer and young person. Where parents or carers have expressed views about immunisation and this is documented, these appointments should be used as an opportunity to have a further discussion. If appropriate, offer vaccinations by trained staff before they leave the hospital. In such cases, notify the child or young person's GP so that the GP records can be updated.
- Consider offering vaccinations at home for children whose parents and carers have not responded to reminders, recall invitations or appointments for immunisation.

The feedback received for this recommendation was on the whole positive. The recommendation was described as being "easy to read, relevant and useful to have at hand" (Manchester workshop am, 21/05/09) and it was felt that this recommendation would be a useful tool in ensuing commissioners and practitioners up to a certain standard and also be a criterion to audit against. It was felt that much of the recommendation was already in place, but to expand further would require additional resources. There were some suggestions for alterations to this recommendation specific to the wording and content of the recommendation and also covering some of the key themes and points within the recommendation.

Content and wording

Generally feedback on the content and wording of the recommendation was positive, although there were a number of points for clarification including:

- Clarity on what is meant by "tailored reminders";
- Provision of an identified healthcare professional seems like a lot of work and a bit "nebulous" (Manchester workshop pm, 21/05/09) and this could just be a lead GP;
- "Local childhood immunisation programme" should in fact be "National";
- Within bullet point 7 the section beginning "Where parents or carers have expressed views…" should be moved and included as part of bullet point 4;
- Replace "Consider" in bullet point 8 with "Offer" or "Provide a service";

- More clarity on what the "family nurse partnerships" are and clarify that they are a pilot scheme;
- Amend "healthcare professional in the GP practice is "responsible" to "healthcare professional in the GP practice is accountable";
- Avoid using abbreviations such as SHA and PCT as the broad spectrum of readers may not understand these abbreviations.

Practitioners put forward additional groups to be included in the target population and they felt that these should include "all children" as well as "guardians." A number of suggestions for inclusions in the "who should take action" section were adding in practice nurses, school nurses, hostels where women with children may be living and also grandparents.

Feasibility and implementation

Effective collaborative working would be key to the successful implementation of this recommendation such as providing data at consistent times. Practitioners felt that extending clinic times would be useful although practices would need to be mindful to match practice schedules to patient needs and this may be resource intensive. To improve access to immunisation services they need to be both accessible and flexible, therefore rather than extending clinic times it was suggested that flexible services are offered.

One of the main concerns with this recommendation was how realistic it was to deliver immunisations to children and young people within Accident and Emergency departments in hospitals. They would not have access to the information and IT systems, it would very costly, they would require appropriate training to deliver immunisations and they are more than likely to be focusing on treating the reason for hospital visit rather than ensuring immunisations are delivered. Practitioners suggested that it may be more effective to invest resources in training professionals to chase and visit patients that have not been immunised. It was felt to be important to include alternative methods of engagement such as vaccinations at home which is mentioned in this recommendation.

A massive importance was placed on ensuring that those that administer vaccinations are competent and that in the case where there are not competent personnel available, that GP surgeries and clinics are signposted to.

There were questions raised as to providing published information in different languages as in many cases this information is not utilised, certain members of these communities are unable to read and so other forms of presenting the information need to be considered also. Some information may need to re-conceptualised for certain groups, for example the Jewish community are uncomfortable with frank discussions of sensitive subjects. There was positive feedback on the recommendation stating that parents and carers have the opportunity to discuss concerns with practitioners, however they questioned how in reality this would be managed and resourced. Practitioners felt that ensuring that parents were educated would breakdown barriers and some suggestions included hard hitting poster and advertising campaigns, Department of Health media education campaign and National Immunisation Day. It was believed presenting information via a range of mediums (visual, verbal and auditory) as well as through a range of media sources (TV radio, posters) would help to overcome language, literacy and cultural barriers.

Impact

Suggestions were put forward to use community facilities for vaccinations for those not registered with GPs. Additionally, using Paediatric Unit for immunisations was put forward and as well as this, including an immunisation check within discharge plans, "if in doubt give" (Manchester workshop pm, 21/05/09).). This was contradictory of another delegate who was reluctant o give immunisations in a situation of ambiguity, for fear of re-administering vaccinations which may have already been given.

A key point raised for this recommendation was the need for an immunisation co-ordinator or someone with a dedicated role to deliver the recommendation and be responsible for this; it was felt that this should be clearly placed with one person. This point was supported by both the telephone consultation and workshop practitioner consultation. A further point was that the success of this recommendation would rely heavily on quality data collected at consistent points in time; a lot of work may need to be invested to achieve this. Finally, it was suggested to make this recommendation successful that it would be helpful to prioritise sections of the recommendation to aid implementation.

3.7.2 Recommendation 2 – Information systems

Who is the target population?

- Children and young people aged under 19, particularly those who may not have been immunised or have only been partially immunised.
- Parents and carers of children and young people aged under 19.

Who should take action?

- Those responsible for information services within SHAs, PCTs, acute trusts and GP practices.
- SHA and PCT immunisation coordinators, directors of public health and community paediatricians.
- Health protection specialists and immunisation leads in HPUs.
- GPs, nurses and health visitors.
- Independent and private sector providers of immunisation services.

What action should they take?

- Ensure there is a clear system within GP practices, PCTs and SHAs for recording and maintaining accurate information on the vaccination status of all children. The same data should be used for cover of vaccination evaluated rapidly (COVER) and GP childhood immunisation target reporting. It should be possible to identify patients from this data.
- Ensure information systems can record vaccinations carried out by private providers on children and young people who live in the SHA, PCT or practice area.
- Private providers should report all vaccinations carried out on children and young people to the relevant GP practice or PCT so they can be recorded on the appropriate information system.
- Record the factors which make it less likely that a child or young person will be up-to-date with vaccinations. For example, note if children and young people are looked after, have special needs or have any contraindications to vaccination. Also note if the parents or carers have expressed their views on vaccination.
- Regularly update and maintain the databases for recording children and young people's immunisation status. Follow-up on any missing data to ensure up-to-date vaccination coverage data are available to all healthcare professionals.
- Record administered vaccinations in the personal child health record (PCHR or 'Red book').
- Use recorded information to inform local immunisation needs assessments and support delivery of an immunisation programme for children and young people.

Recommendation 2 was seen to be the most important recommendation and would be key to the underlying success of all other recommendations. Therefore, it was suggested that this recommendation should be prioritised and the first to be implemented.

Content and wording

It was reported that the recommendation was well written, using simple language and easily understood.

One of the main benefits of this recommendation reported was the inclusion of private providers and the recognition that these providers should report all vaccinations provided to the relevant GP. It was reported that currently there is no exchange of information from private providers and GPs, resulting in a child's immunisation history to be unable to be determined. Moreover it was highlighted that drop in centres are also unable to access health records to determine the information necessary to immunise. However, practitioners also reported that more information on how this action could be implemented should be included in the recommendation.

Practitioners noted that the recommendation should include more information on coding family risk factors in the information system. Findings suggested that data held on the information system needs to be coded to identify family issues such as if parents are drug users, or if the children are in care etc.

It was suggested that the recommendation needs to make a clear reference to the issue that currently there are multiple information systems in place that do not align with one another. For example, it was often reported that GPs' systems do not link up to the Child Health system. These systems also have different coding structures that can make recording data difficult. This makes it very difficult to track what immunisations children have received, especially as many parents can not remember and the 'red books' are often lost, although it was noted that parent's utilisation of these was improving gradually. Therefore, it was reported that the recommendation should state that there should be one central information system in place where all child immunisations are recorded and used by all practices and health care professionals. For example, it was stated that,

"…there should be one universal system that everyone uses. At present there are so many systems that need to be updated. However, if there was one National system this would be really beneficial." (Workshop 7, Manchester)

Feasibility and implementation

Although this recommendation was seen to be very important it was reported to add a lot of extra work to practices if it was to be implemented. For example, systems constantly need to be maintained and people who are trained to use it, therefore a specific staff group would be required to implement it. It was stated that,

"..this recommendation would require people who have a high understanding of technology to implement it and there needs to be better resource sharing across sectors." (Workshop 3, Brighton)

It was also suggested that information systems have huge cost implications and that specific funds would need to be assigned to improve IT systems. It was stated from a workshop that,

"…having specific funding for IT provisions for immunisation would be an effective facilitator to improve the current system." (Workshop 2, Birmingham)

Impact

It was reported by some practitioners that at present there is a lack of understanding of how to effectively use the information that is entered into information systems. Therefore, it was suggested that the recommendation could benefit from being extended to include information on what should be done with data that is recorded to ensure it is used effectively.

Furthermore, it was mentioned that this increasing reliance on IT systems may impact on the accuracy of information obtained due to risk of human error and the decreasing amount of 'paper recordings' means that it is increasingly difficult to look back and cross check information.

3.7.3 Recommendation 3 – Training

Who is the target population?

Those who advise on and provide vaccination and immunisation services. including:

- GPs, health visitors, practice nurses, community nurses (including school nurses), midwives, nurses working in neonatal care and nursery nurses
- PCT immunisation coordinators and HPU immunisation leads
- hospital and community paediatricians and pharmacists
- public health professionals
- NHS health trainers
- support staff including clinic clerks and receptionists.

Who should take action?

- Professional bodies, skills councils and other organisations responsible for setting competencies and developing continuing professional development programmes for health professionals.
- HPUs.
- PCTs and SHAs.
- Private and independent sector providers of immunisation services for children and young people aged under 19.

What action should they take?

- Ensure all staff involved in immunisation services are appropriately trained. Training should be tailored to individual needs to ensure staff have the necessary skills (for example, communication skills) and knowledge to fulfil their immunisation role.
- Health professionals who deliver vaccinations should have received training that complies with the 'National minimum standard for immunisation training' (Health Protection Agency et al. 2005a[5]).

[5] www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1204100464376

- Professional bodies should ensure health professionals working with children and young people have the appropriate knowledge and skills to give advice on the core topics defined in the Health Protection Agency's 'Core curriculum for immunisation training' (Health Protection Agency et al. 2005b[6]).

Recommendation 3 received mixed feedback from the practitioners. They had a number of key amendments to the recommendation and some stated that it lacked *"weight"* to it; however others felt it was *"very important"* (Brighton workshop, 14/05/09) and that if implemented effectively that it would improve confidence in vaccinators and also increase the number of vaccines delivered. They felt it that it was good that the recommendation referenced the national standard and that it would also ensure that the information that is being disseminated by practitioners is up to date and correct. One practitioner from the telephone consultation felt that training should be made "*a priority for PCTs so that commissioners have to take it on board*" (Paediatrician telephone interviewee) and believed that with appropriate and sufficient training would help "*ensure opportunities to immunise young people don't get missed*" (Paediatrician telephone interviewee).

Content and wording

Practitioners identified a number of key groups that were not included in the target population that they felt needed including: Health Protection Unit Staff, Prison Health Care Staff, Walk in Centre Staff and Accident and Emergency Staff. Generally it was raised that this recommendation would benefit from more detail on which members of staff should attend the training, for example should receptionists from GP surgeries attend training?

Feasibility and implementation

Practitioners identified a variety of factors that would affect the feasibility of implementation of the recommendation. Some key issues that were raised were the quality of the training delivered and the expertise to deliver adequate training. Practitioner experience supported these points as higher quality training had helped reduce incidents. Another key issue that was raised was the importance of attendance at training events and also ensuring that experienced practitioners (where some feel they may not need extra training) attend training, this needed to be more clearly covered within the recommendation. Suggestions to overcome this issue included utilising professional bodies to endorse and enforce training to ensure attendance from staff.

[6] www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1204100466949?p=1153846674367

Delivery of training was a key area that was raised and ensuring that "new and innovative" (London workshop, 19/05/09) ways to deliver the recommendations were achieved. Suggestions included flexibility in the timing of training sessions to ensure that all personnel could attend. One example given by a practitioner was providing evening training for Pharmacists as they are often unable to attend training in working hours (London workshop, 19/05/09). Other suggestions included utilising other media such as e-learning and e-training to ensure that training needs are being met. Practitioners felt that providing examples of other training systems that have been successfully implemented would be very useful and also giving details of the cost to carry out these schemes be included also. The practitioners raised the importance of refresher training and they felt that this could be *"very worthwhile"* (Birmingham workshop, 12/05/09).

The issues of cost and funding of this recommendation would be key to its success. The importance here of commissioner's awareness of the recommendation was stressed and it was suggested that several practices could be given assistance to implement the recommendation and this would *"get the ball rolling"* (Brighton workshop, 14/05/09). It was then suggested that those practices could then be used as case studies and the lessons learnt shared with other practices.

There was concern from practitioners that this recommendation would take time to implement and that that this could take time away from actual delivery of immunisation. This could confound the existing shortage of staff in this area.

A key barrier to the implementation of this recommendation reported by numerous practitioners is the lack of suitably qualified and experienced trainers and the lack of training courses available to attend. Another area of concern was that nursery staff in particular may need increased effort to ensure delivery of the right message. It was felt that they may not be fully educated on immunisations and therefore at times providing parents with incorrect information. It was suggested that Nursery staff be provided with up to date information and educated on immunisations. Generally practitioners felt that more details on how to successfully implement this recommendation would be very useful.

Impact

It was felt by practitioners that this recommendation needs to cover training for the variety of settings that immunisations can be delivered in and for any additional venues included within other recommendations. For example in recommendation one, it suggest that accident and emergency departments should be checking immunisation status, this would require those staff to be trained to advise on immunisation also.

It was reported that it could take a long time to train every member of staff on all of the information needed to be covered within the training. Suggestions were raised to tier the training dependent on the grade of the member of staff and therefore all staff could be given appropriate training for their grade in an effective time frame. It was noted here that there is a vast variation of skills in front line practitioners and that this recommendation may help to standardise skill sets across the workforce.

Suggestions for further development of this recommendation included measuring the impact of training to ensure that it is effective and fit for purpose for all those that deliver vaccines. It was also suggested that more needed to be included on training needs and reflective tools such as feedback forms which could be utilised to understand why professionals do not or are unable to take up training.

3.7.4 Recommendation 4 – nurseries, schools, colleges of further education

Who is the target population?

- Children and young people aged under 19 attending nurseries, schools and colleges, particularly those who may not have been immunised or have only been partially immunised.
- Parents and carers of children and young people aged under 19.

Who should take action?

- PCT directors of public health, immunisation coordinators and community paediatricians.
- Community nurses including health visitors, school nurses and those involved in family nurse partnerships.
- Head teachers, school governors, heads of further education colleges.
- Nursery, pre-school and early years providers.
- Managers, nurses and early years support staff in Sure Start children's centres and children's services.

What action should they take?

- The Healthy Child team (led by a health visitor working with the local GP) should be able to check each child's immunisation record, including the personal child health record (PHCR), when they join a nursery, start pre-school education and school. They should do this in conjunction with staff at the nursery, Sure Start children's centre or school.
- School and community nurses, working with the local GP and school, should check the vaccination status of children and young people when they transfer to a new school or to college. Working with the PCT, they should also advise students, parents and carers about the tetanus, diphtheria and polio booster dose. This is recommended between the ages of 13 and 18 (that is, before leaving school).
- School nurses should provide children and young people who are not up-to-date with immunisations with advice and information. They should offer vaccinations to help them catch up with the recommended immunisation cover (for example, where necessary, offer them MMR).
- Explain to students, parents and carers why immunisation is important. Encourage children and young people who have not completed the recommended vaccination schedule to be vaccinated. Vaccinations can be given by the school nurse or their GP. Provide parents and carers with information in an appropriate language and format.

Encourage schools to become venues for vaccination of children and siblings, as part of their extended school role.

Generally there was positive feedback on this recommendation from the practitioners and this was echoed by the feedback from the telephone consultation. They expressed that they were *"really pleased with the recommendation"* (Manchester workshop am, 21/05/09) particularly that it was raising immunisation status in schools and colleges and that it would give more opportunities for uptake for hard to reach individuals. However, delegates did feel that there would be some challenges to implementing this recommendation and described it as a *"bit aspirational"* (Manchester workshop am, 21/05/09) and *"framed in the old style NHS"* (Manchester workshop pm, 21/05/09) as many of the roles quoted had changed. There were also questions raised as to who would be responsible for the implementation of this recommendation, as with all the recommendations it is important that this is clear within this recommendation.

Content and wording

There were a number of points that were specifically raised on the content and wording of the recommendation including:

- More clarity on who the "healthy child team" are and what they comprise of;
- Clarifying that "a health visitor working with the local GP", however health visitors are not linked to GPs anymore but to the geographical area;
- Whether health visitors work with nurseries and therefore whether it was appropriate to include this?

Some specific points related to amendments to the target population included incorporating siblings, ensuring that the needs of those not in education and training are catered for and ensuring that children at private schools and schooled at home are catered for in this recommendation.

Specific points that relate to the amendments to the "who should take action" section included the addition of college nurses and university medical staff to ensure that the needs of older children and young people are catered for. There was also a suggestion to start to use own consent for older children and young people rather than relying on parental consent. In fact there were propositions put forward for two separate based models for this recommendation, one primary care based and one school based.

Feasibility and implementation

Practitioners questioned the feasibility of using schools as venues for immunisation from many perspectives including complications with insurance, the potential disruption to the curriculum, issues with allowing the siblings into schools, lack of interest from head teachers and lack of facility to facilitate immunisation and lack of time on the part of the school nurse. Suggestions included leaving this section of the recommendation in as part of the extended school role and promoting the potential benefits to the headmaster so that the school view themselves as enhancing the health of the community and not just as an education provider.

Questions were raised as to whether it was a feasible expectation for school nurses to check the immunisation status of all children and young people when being transferred to a new school or college, they were concerned about how records would be kept up to date. The importance of the reliability of the data was raised here and that this would be pivotal to the success of this recommendation. Resources to check records and administrative support would need to be revised for this recommendation to be successfully implemented.

Some of the significant challenges to implementing this recommendation include resourcing and increasing the already stretched workload of school nurses. Also it would need to be made clearer to education authorities, schools and further education colleges that they need to share data with PCTs and that this is not against the Data Protection Act as often this has been misinterpreted. Practitioners felt that this recommendation would rely on the nurseries being pro-active and did not feel that this would work in practice. They felt that as a minimum this needed to be an Ofsted requirement. The issue of providing information in appropriate language and format was discussed and it was felt that it should be the responsibility of the Department of Health to provide that information nationally and not rely on local level to implement this.

Impact

Practitioners that attended the workshops did question the lack of attendance of education based practitioners and speculated whether this was a reflection of their commitment to the recommendations as a whole and this specific recommendation. The schools' (and head teachers') willingness to be involved in the recommendations would be a key part of the success of this recommendation and building partnerships would be very important. A practitioner from the telephone consultation stated that *"getting schools to buy into it may be difficult."* (Paediatrician telephone interview) Suggestions to link immunisation with Personal Social Health and Religious Education lessons could be helpful and also installing a *"champion"* (Birmingham workshop am, 12/05/09) to maintain a good relationship between health and education authorities. Further to this the importance of the Department of Health working with other government departments such as the Department for Schools, Children and Families would need to be strengthened to promote immunisation. Some practitioners felt that this recommendation implies that there is a good working relationship between schools and health authorities and practitioners (including GP's); however this recommendation would be difficult to implement on current practices.

The frequent shortage of both school nurses and administration staff to deliver vaccinations (particularly at present with the extra burden of the HPV) may confound the opportunity to utilise schools for vaccine delivery. Also practitioners reported that many schools' nursing services had stopped providing immunisations and therefore job descriptions may need to be re-written to include this. Suggestions for an additional vaccination team that could be utilised to work with the school nurse with specific immunisation responsibilities were raised. Other ideas included that part of the existing guidance for obesity in children required a check at reception and Year 6 and that this could be a good opportunity to tie in immunisation checks also.

3.7.5 Recommendation 5 – Groups at increased risk of not being fully immunised

Who is the target population?

- Children and young people aged under 19 from groups at risk of not being immunised or only partially immunised.
- Parents and carers of these children and young people.

Who should take action?

- Commissioners, managers and coordinators of children's services in PCTs, children's trusts and Sure Start children's centres.
- Health professionals responsible for children's immunisation services, including directors of public health, paediatricians, GPs, health visitors and those involved in family nurse partnerships.
- Immunisation coordinators and others who work in immunisation services in SHAs, PCTs and GP practices.
- Health professionals who have contact with children and young people aged under 19.

What action should they take?

- Improve access for those with transport, language or communication difficulties, and those with physical or mental disabilities. For example, provide walk-in vaccination clinics, services offering extended hours and mobile or outreach services.
- Provide accurate, up-to-date written information on the benefits of childhood immunisation against vaccine-preventable diseases, tailored for different communities and groups, according to local circumstances. For example, offer translation services and provide information in multiple languages. Consider using pharmacies, retail outlets, libraries and local community venues to promote and disseminate the information.
- Health professionals should check the immunisation history of asylum seekers when they arrive in the country. Discuss outstanding vaccinations with the parent, carer and young person and offer appropriate ones, administered by trained staff.
- Prison health services should check the immunisation history of young offenders. They should discuss outstanding vaccinations with the parent, carer and young person and offer appropriate ones, administered by trained staff.
- Offer looked after children vaccinations during their annual health plan review or via school-based immunisation programmes.

Recommendation 5 received positive feedback as it was felt that action needs to be taken to reach those at risk of not being fully immunised.

Content and wording

It was suggested that some of the wording and content of the recommendation could be improved. For example, the use of the phrase 'asylum seekers' in the recommendation should be replaced by *'all immigrants,'* as it is not only asylum seekers who are at risk of not being fully immunised and the immunisation history of all immigrants entering the UK should be checked. It was also suggested that it should be the responsibility of port officials to check the immunisation status of asylum seekers and checking their immunisation history should be completed as part of the asylum application process.

It was reported that the use of 'prison health services' in the recommendation should be replaced with *'Youth Offending Teams.'* This is due to not all areas having prison services, but all areas have Youth Offending Teams. It was also stated that,

"…at present there are no guidelines and/or requirements for youth offenders and this needed to be addressed." (Workshop 6, Manchester)

Practitioners thought that the recommendation could have included examples of different venues included:

- Secure training homes;
- Young offender's institutes.

It was felt that young offenders are vulnerable children that are frequently not included and therefore these recommendations should consider them.

There were several groups of children that it was felt were not covered in this recommendation. These included:

- Children aged between 16 – 19 years old;

- Service/military families – this was because it was felt that this group of children would be very mobile and therefore there would be issues related to keeping their data up to date and making sure their data is transferred to different areas;
- Those children immunised privately – it was noted that information from private providers is not being fed back into the GP even if children have anaphylactic reactions to certain vaccinations these are still not being fed back to the GP;
- Parents and children that suffer from Mental health problems – it was felt that this group were not mentioned in the recommendations however they are a group that are very vulnerable and should be considered;
- Disaffected white – it was felt that the white workless class are a large group that are hard to reach and this group was not covered in the recommendations;
- Children over five years – it was felt that children over five are a difficult group to target and that practitioners noted that they would have liked to have seen more in the recommendations on how to reach this group;
- Those children not attending school – it was felt that there was not enough in the recommendations that included children not attending school for a variety of reasons such as:
  - Those children excluded from school;
  - Those children educated at home.
- Children in care – although the recommendations do talk about children in care, it was felt that there was not enough in the recommendations that deal with children such as those that are very mobile as there are problems with their data being transferred;
- Travellers – this was another group that it was felt was not covered in the recommendations and as noted with other groups, this group was felt to be very mobile and they are often not registered with a GP surgery and therefore, they are very difficult to keep track of.
- Children of Immigrants– These families were considered as being likely to return to their country of origin, and often for long periods of time, and as a result, immunisation records are inaccurate upon their return.

As a general point the practitioners felt that they wanted more information on how to target the groups of children that are very mobile, these typically are those children from travelling families, service/military families and children in care, who are perhaps less likely to be registered with a GP.

Feasibility and implementation

Suggesting walk-in clinics and mobile or outreach services was reported to be a good way identified by the recommendation at reaching groups at increased risk of not being fully immunised. However, it was also reported that walk-in clinics can be very costly which could affect some practices implementing this. It was suggested that this action could be extended to clinics during school holidays or clinics set up in shopping centres. Offering transport to clinics was also suggested as a method that could be included in the recommendation. For example, in order to overcome any barriers to implementing the recommendation and reaching these groups it was stated that,

"Perhaps the use of a travelling bus to reach all different areas and people e.g. outside libraries and supermarkets." (Telephone Interview, Practice Nurse).

There were some issues that were reported needed to be considered by the recommendation. For example, immigrants from EU and Non-EU countries have often already started an immunisation schedule. However, this schedule differs from that of the UK's. Names of immunisations are also often different in these countries. This can make it very difficult to know what a child has been immunised for and when they are scheduled to have their next vaccination.

It was also reported that many health care professionals do not challenge those parents who do not have their child immunised. Therefore, the recommendation should cover instructions on how health care professionals can do this in a constructive way.

The practitioners revealed that a number of delegates felt that there was an opportunity to link immunisations with acceptance into universities, colleges and schools; it was mentioned that in other countries (one example given being the US), children are not allowed to attend education facilities unless they have been fully immunised. Practitioners were able to recognise that this may not be possible to enforce in this country particularly among primary and secondary schools, to which attendance is mandatory.

Impact

It was reported that the recommendation could benefit from incorporating more innovative ways of reaching hard to reach groups as at present many of the actions stated by the recommendation are not new and are already being carried out. For example, providing information in different languages has already been carried out by many practices. However, this has not proved very successful due to many parents being illiterate or unable to read their own language. Therefore, it was suggested that actions such as using pictorial or symbolic information should be included in the recommendation. It was also suggested that translation leaflets need to be re-designed and this should be the responsibility of the Department of Health.

It was reported that:

"..if used correctly the media could be a facilitator and used for a communication campaign." (Workshop 2, Birmingham)

For example, advertising on TV channels dedicated to foreign nationals would be a useful way of reaching these groups. Using the media was also suggested to help reach those who do not work, a group referred to as the *'British workless class.'* It was suggested that advertising one day time on television would be an effective way to reach this group.

Promoting partnership working was another method reported that should be covered in the recommendation in order to help reach these groups.

There were many groups that were reported needed to be covered by the recommendation as they are not currently mentioned. These groups include:

- Travellers – this was a group reported to be very hard to reach;
- Those children not in schools – ways to reach these children needs to be considered as they will not be covered by school nursing immunisation programmes;
- Not in employment or education (NEET) groups;
- Socially deprived – this group was reported to be one of the worst groups not to take up immunisations;
- Resistant parents – those who do not take up immunisations due to fear of adverse reactions;
- Idle parents – those who would take up immunisations if they were very easily accessed but would not go out of their way to get their child immunised;
- Non-believers in traditional medicine and institutions such as schools; and
- Special needs schools.

3.7.6 Recommendation 6 – Neonatal hepatitis B

Who is the target population?

- Children born to mothers who are hepatitis B-positive.
- Parents and carers of children who are hepatitis B-positive.

Who should take action?

- GPs, health visitors, midwives, neonatal and community paediatricians, nursery and neonatal nurses, support workers and those involved in family nurse partnerships.
- PCT directors of public health and immunisation coordinators.
- Managers and family health and support teams in children's services
- Managers, health professionals and early years support staff in Sure Start children's centres.

What action should they take?

- Develop and implement a clear process for the local neonatal hepatitis B vaccination programme. It should ensure that antenatal, postnatal, neonatal paediatric, primary care and community support teams communicate effectively. Babies born to hepatitis B-positive mothers should be given the first dose promptly, whether delivered in hospital or the community. They should also receive all other recommended doses at the right time.
- Consider having an identified person responsible for vaccination of babies at risk of hepatitis B.

- Health professionals should record the mother's hepatitis B status in the personal child health record (PCHR) as soon as possible after birth (and before the neonatal period ends (that is, 28 days after birth).
- Health professionals should provide information, advice and support to parents and carers to prevent the transmission of hepatitis B. In addition, they should emphasise the importance of ensuring babies complete the recommended vaccination course at the right time.

Recommendation 6 received mixed feedback from the practitioners.

Content and wording

One of the main issues regarding this recommendation reported by the practitioners was that there is no mention of other targeted vaccinations such as the BCG or the HPV vaccine and there was confusion as to why the hepatitis B vaccine was singled out. Although it was explained that other targeted vaccinations were referred to in the guidance document, it was thought that a small reference to these was needed in the recommendation itself.

The recommendation was reported to benefit from suggesting that there should be an identified person responsible for the vaccination of babies at risk from hepatitis B. It was reported that an immunisation co-ordinator should be responsible for following up all those babies at risk and ensuring they have received all doses of the vaccine. It was suggested that only one person should provide all doses of the vaccine to babies and that the recommendation should state that all vaccines should be provided in the same location, whether that is the hospital or at GP surgeries.

Feasibility and implementation

It was thought that this recommendation was only relevant to a certain group of health care professionals who work with these cases and there is not a great deal of knowledge of hepatitis B immunisations for children held by all people working in the health industry. Health visitors and paediatricians were thought to be the group most relevant for this recommendation and many health visitors expressed their positivity at this issue being recognised by the recommendations. Practitioners also reported that many health care professionals would not place this recommendation as a high priority due to there being so few cases per practice, although it was mentioned that because the recommendation has such a small target group, these individuals can easily "*slip thorough the net*" and hence the introduction of the recommendation should help to ensure that this does not happen. Therefore, it was suggested that this recommendation should narrow down a specific group of professionals who work in this area that should be responsible for implementing this recommendation. This would improve the probability of this recommendation being implemented.

The practitioners reported that this recommendation should suggest having the hepatitis B vaccine included in the child's 'red book.' For example, having a page in the book to alert clinicians of the hepatitis B vaccines that a child has had or having a page that alerts clinicians that the mother of the child is hepatitis B positive. This was thought to help ensure that all 'at risk' babies are dealt with appropriately. Related to this issue however, was the issue of confidentiality. It was questioned as to whether the mother and child's hepatitis B status should be protected and therefore not recorded. This is an issue that was felt needed to be clarified by the recommendation.

Impact

It was reported that there are some issues that this recommendation does not address. For example, practitioners reported that those mothers who are affected by hepatitis B are more likely to come from foreign countries and language barriers are often apparent. Therefore, practitioners suggested that the recommendation should suggest ways in which to overcome these barriers and suitable methods of communication to inform these mothers of the immunisation and issues surrounding it. Related to this issue, the practitioners also reported those affected by hepatitis B are often a mobile population, which is not addressed by the recommendation. Therefore, the recommendation should include clearer instruction on how to track these people in order to provide the vaccine to the children. This is a particularly important issue as the vaccine has to be provided on several occasions. Therefore, it is important to track those infants in need of the immunisation to ensure they have received all the doses required.

It was also reported by the practitioners that the recommendation does not include information on fathers and siblings that are also affected by hepatitis B. It was reported that it would be relevant to include these in the recommendation due to issues such as horizontal translation. For example, it was stated in a workshop that horizontal transmission of partners and other family members would *"potentially be dealt with by other teams and the management of this could be a challenge."* (Workshop 1, Birmingham)

Other issues that were reported needing to be covered by the recommendation were educating midwives on hepatitis B and ensuring they ask the parents of their hepatitis B status. Additionally, the continual review of alternative approaches to the hepatitis B vaccination should be covered by the recommendation. It was reported that the recommendation should refer to

"the universal approach and the partial universal approach where hepatitis B vaccines are provided to those groups who currently receive the BCG vaccine (i.e. those from high risk countries)." (Workshop 1, Birmingham)

4 CONCLUSIONS

4.1 General reaction to draft recommendations

- The draft recommendations were received well and thought to be well written;
- They were thought to be both relevant and useful to all practitioners apart from GPs and health visitors due to their reduced role in immunisation;
- If all recommendations were implemented they were thought to increase the uptake of immunisation in children and young people under the age of 19 years;
- To implement the recommendations additional resources would be required;
- There were several groups of hard to reach children not covered in the recommendations.
- Practitioners liked all the recommendations being in one document and felt as they were NICE recommendations they would hold a lot of weight;
- Thought they would raise the profile of immunisation in GP surgeries;
- Information systems were thought to be integral to the success of all the other recommendations.

4.2 Content and wording

In terms of content and wording the practitioners thought that the wording, the language (clear plain English) and the consistent formatting throughout the recommendations made them clear and easy to read. There were suggested amendments to the recommendations such as amending who should take action section (e.g. GPs and health visitors). There needs to be further clarification on the remit of the recommendations. There were some areas that could be further developed in the recommendations. These included waiting lists, alternative venues and parent and carers attitudes towards immunisations.

4.3 Feasibility of the draft recommendations

In terms of the feasibility in practice overall it was thought that the recommendations were feasible if there were sufficient resources and funding to implement them. However, it was felt that there are currently not sufficient resources and without additional resources, these recommendations would not be able to be implemented fully.

Findings consistency indicated that practitioners would benefit from implementation support with these recommendations (e.g. practical examples and case studies). Suggestions were made of rolling the recommendations out over a period of a few years in order to place less of a demand on NNHS resources. It was felt that this would make the recommendations more feasible to implement.

One of the main factors that would affect the feasibility of successfully implementing of the recommendations was the information systems and the quality of the data. Practitioners generally felt that having an effective information system would be integral to the success of all the recommendations.

4.4 Impact of the draft recommendations

There was mixed feedback on the potential impact of the recommendations. On the one hand, feedback suggested that the recommendations were “nothing new” and that some of this was being carried out around the country by PCTs. However, to implement all of the recommendations additional resources in terms of both funding and additional staff would be required.

Feedback did suggest that implementation of these recommendations may help in areas where immunisation uptake is lower;

For a summary of recommendation specific findings please see the Executive Summary.