



Public Health
England

Protecting and improving the nation's health

Workforce planning and models of delivery toolkit

Extension of the national flu immunisation
programme to children



Section A: Background and Introduction

Background

In 2012 the Joint Committee on Vaccination and Immunisation (JCVI) recommended that the routine annual flu vaccination programme is extended to children aged two years to under 17 years of age.

Vaccinating children each year not only protects them but aims to reduce transmission across all age groups, protecting those who are at increased risk of becoming seriously ill from the virus in our communities, lessening levels of flu overall and reducing the burden across the population.

Due to the scale of the extension of the programme to children, a phased approach to implementation began in 2013-14, with 2-3 year olds being offered immunisation in general practice, and 4-11 year old children in seven areas being offered vaccination through pilot programmes, mainly in primary schools (phase 1). One of these pilots chose a community model using pharmacists and general practices due to their rural location.

In 2014-15 all two-, three- and four-year-olds were offered vaccination, the primary school age pilots continued and 16 areas also tested delivery to years 7 and 8 in secondary schools.

In 2015-16, phase 2 of the extension will begin with immunisation extending nationally to children of school years 1 and 2 age. It is likely that these children will be immunised predominantly in primary school settings.

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Further details on the extension of the national flu immunisation programme can be found in the Annual Flu Letter <https://www.gov.uk/government/publications/flu-plan-2015-to-2016>

Extension beyond 2015/16

The intention for the future is to extend upwards through the older age cohorts. These plans will be subject to annual review by JCVI.

Key facts on flu

General

Flu is an acute viral infection of the respiratory tract (nose, mouth, throat, bronchial tubes and lungs). It is a highly infectious illness which spreads rapidly in closed communities and even people with mild or no symptoms can infect others.

Flu is caught through droplets of saliva that spread when an infected person coughs or sneezes. These droplets can then be breathed in by other people or they can be picked up by touching surfaces where the droplets have landed.

Flu is characterised by a fever, chills, headache, muscle and joint pain and fatigue. For most healthy people, flu symptoms can make you feel so exhausted and unwell that you have to stay in bed and rest until you get better.

Flu immunisation is one of the most effective ways to prevent flu and so reduce the potential harm it can cause.

The most likely viruses that will cause flu each year are identified in advance of the flu season in the UK and vaccines are then made to provide protection against these strains as closely as possible.

Those who are eligible to receive the flu vaccination for free, are recommended to do so as early as possible from October, before flu starts circulating in the community.

Aims of the toolkit

This toolkit is aimed at School Nursing Immunisation teams, Community Teams, and local NHS England teams (local healthcare teams) who are planning the resourcing and delivery of the extension of the national flu immunisation to children. It aims to:

- outline approaches to delivery and different models used
- inform your workforce and resource planning for the programme
- provide key data on staffing required
- capture and share some of the learning from the pilot programme

Approaches to delivery will vary according to local need and it is for local NHS England teams and providers to develop a model that meets local population needs. Consideration needs to be given to workforce planning and training to ensure delivery can be achieved.

Workforce planning and the national planning cycle

Health Education England (HEE) provides leadership for the education and training system. It ensures that the shape and skills of the future health and public health workforce evolve to sustain high quality outcomes for patients in the face of demographic and technological change.

HEE operates on a model that is service-provider led; seeking workforce demand forecasts from employers on an annual basis. Employers provide these to their Local Education and Training Board (LETB), who will use this information when determining where and when to invest in education or training programmes.

Service providers need to ensure that the workforce requirements of their chosen delivery model are reflected in their demand forecast submission to the LETB. There are 13 LETBs across England.

Further information about LETBs, including their contact details, and HEE's workforce planning guidance can be found on HEE's website – www.hee.nhs.uk

Extending the national flu immunisation programme to children in 2015-16

Phase 2 of the extension offers vaccination to all children of school years 1 and 2 age in England.

In addition, children that were offered vaccination through primary school pilots in 2014/15 will continue to be offered flu vaccination in 2015/16.

There should be an offer of immunisation to all eligible children (“100% offer”). A minimum uptake of 40 per cent has been shown to be achievable in pilots conducted to date. As a minimum there is an expectation that uptake levels between 40—60 per cent would be attained, whatever model of delivery is used.

Section B: Overarching Activities to Support Delivery

This section details key activities that need to be planned and resourced, regardless of the model of delivery. Pilot teams report that these tasks took longer than anticipated. These are:

- engagement with schools, parents, children and other stakeholders
- preparation and communication materials
- managing the consent process and eligibility / suitability
- general administration requirements of the programme

Engagement with Schools, Parents, Children and other Stakeholders

Working with education settings

Early engagement with schools about their involvement in the programme will be important in gaining schools' participation, as well as ensuring sufficient lead-in time is given to schools.

The national flu immunisation programme is likely to provide many benefits for schools including:

- reduced school absences of children suffering from flu
- reduced transmission of flu to other children and staff in the school
- potential reduction in staff absences from flu and flu related illnesses, therefore reduced temporary staffing costs

Activity to promote improved health and wellbeing of pupils also contributes to whole-school health and wellbeing policies and OFSTED outcomes. The link to the OFSTED Framework can be found here https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/389974/The_framework_for_school_inspection.pdf

Schools' involvement in the programme is part of a partnership approach to supporting the health and well-being of the school-aged child population. Information has been produced for schools participating in the programme and can be found at <https://www.gov.uk/government/publications/flu-immunisation-for-primary-school-children-advice-for-headteachers>

Issues to consider:

- primary schools may be familiar with the delivery of elements of the Healthy Child Programme, for example the National Child Measuring Programme, but less familiar with an immunisation session offered in a primary school so preparations need to start early in the calendar year
- a timely start to engagement with schools will help to build subsequent partnership working for future delivery
- for those schools joining the programme for the first time an early meeting is recommended with key school leads. Evidence from South Tyneside NHS Foundation Trust suggests that perceived impact on schools was less likely where a pre-meet had been undertaken with the school

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- In some areas termly head teachers forums can be used to communicate details of the local programme. This is a useful opportunity to describe the benefits of the programme, the cohort involved, their involvement, roles and responsibilities and facilities needed. One area that developed a comprehensive electronic communication pack for schools outlining key issues found this beneficial. This included:

- a letter to the head teacher
- scheduled immunisation dates
- checklist for schools
- frequently Asked Questions
- PHE statement regarding the vaccine and porcine gelatine
- contact sheet for the immunisation team
- examples of consent forms

The dialogue with schools is likely to be ongoing. Once involvement is agreed, some areas developed a local agreement to ensure clarity around roles and responsibilities, what the local healthcare team will be providing and the support – such as school staff potentially acting as runners on the immunisation day or despatch of invitation letters through the satchel drop – that may be needed from schools themselves. An example of a Local Agreement agreed between a provider and a local school can be found in Appendix 1. The aim is to minimise the impact on schools and how you best achieve this will be negotiated locally.

School staff might also have queries or concerns that need to be explored. For example, some staff voiced concerns over terms such as ‘live vaccine’ and local communication needs to be based on national messaging for the programme and consistent.

Attendance at assemblies

Planning can also include a member of the local healthcare team attending relevant assemblies and school roadshows to talk to the children and the school community about being immunised against flu. There is a wealth of **age-appropriate material** available to ensure these sessions can be fun, engaging and informative, such as videos aimed at primary school age children www.healthforkids.co.uk/staying-healthy/stopping-flu, produced by colleagues in Leicestershire and Rutland, websites (www.healthforkids.co.uk), flu badges and stickers for children that have been immunised.

Engaging with other stakeholders

Teams may need to contact the local authority to identify children who may be home educated or otherwise not likely to be offered the vaccine through a school based programme. The provider’s contract will determine whether home educated children are to be included in the scope of the work.

Additional engagement is recommended with local school nurse teams and others already working in schools to inform them of the programme. Existing teams delivering other childrens’ services may also have established links in working with and supporting vulnerable children and communities, such as travelling families and looked after children.

Engaging with different faith groups

Local healthcare teams working with local NHS England teams should consider their engagement and communication with faith groups. Fluenz Tetra contains a highly processed form of gelatine derived from pigs. Some faith groups do not accept the use of porcine gelatine in medical products. Current national policy is that only those who are in clinical risk groups and have clinical contra-indications to Fluenz Tetra are able to receive an inactivated injectable vaccine as an alternative. The decision about whether to vaccinate or not rests with the parent. The child flu leaflet 'Protecting your Child against Flu' explains that the vaccine contains porcine gelatine. Further information can be found at: www.gov.uk/government/news/vaccines-and-gelatine-phe-response.

Many areas have engaged directly with local faith leaders and community workers as part of their preparatory work. In one area, a screening and immunisation lead worked together with a local faith leader to explain the programme to the local community, using a local radio phone-in programme to respond to questions and concerns. Providers will need to work closely with their commissioner to ensure communication plans are integrated.



Communication Materials

Good quality and timely communications are an essential part of the successful delivery of the programme in your area. Communication activity and materials can be separated into supporting information for:

- schools including learning support materials
- parents and carers
- children

Materials that you adapt and develop may need printing in hard copy. This will involve relying on other companies' timescales, which will need building into your project plan. PHE have updated the national communication material and supporting information for 2015/16 to include the following:

- a national **consent form**
- **template letters** to invite children in Years 1 & 2 for flu vaccination (which includes Q and A for parents)
- the “**Protecting your child against flu**” leaflet
- immunising primary school children against flu – information for head teachers and other school staff
- the poster “5 reasons to vaccinate your child against flu”

The materials for 2015/16 are now available and can be accessed via the annual flu programme website <https://www.gov.uk/government/collections/annual-flu-programme>

Providers may adapt materials to suit their local needs, for example the national consent form. Details of locally adapted materials and the narrative for these changes are presented in Appendix 3. This may help

you consider any changes that need to be made to suit your local circumstances. It is important to maintain consistency with the national suite of materials provided by PHE.

Information for schools including learning support materials

An extensive range of education and learning resources to develop children's understanding of flu, micro-organisms and the importance of immunisations and infection control is available at <http://www.e-bug.eu/>

Some of the materials are teaching aids and in many areas teachers have welcomed the school nursing team to lead a classroom session, others have preferred to use the teaching materials themselves.

The resources also include self-directed learning materials, such as Digital Flu Badges, a series of missions that children can take and earn Digital Badges (www.makewav.es/health).

Information for parents and carers

Engagement with parents about the programme is also essential to securing uptake. Information and materials have been produced for parents to support this work.

Teams might wish to consider other information that could be sent to parents at this stage or made available to parents via the school website or on your own website. These may include:

- Frequently Asked Questions for parents and carers
- schedule of dates, access to second opportunity sessions
- mailbox or contact line details to manage queries

You may want to send selected items out with your invitation letter.

Materials for children

Pre- and post-immunisation supporting materials are valuable and popular with children and young people of all ages regardless of the model of delivery chosen. Some areas for example have found the use of banners, visual aids and information about Fluenz Tetra and what to expect helpful to reinforce the approach prior to the actual administration and guided session.

Digital packs containing images for materials to engage children and young people are being made available through the NHS Employers Flu

Fighter campaign. Teams can then adapt these for use in their own campaign, and tailor it to their own audience. Please email **Flu Fighters** at NHS Employers who can provide further information.

Plans should include communication with the wider community and school as part of an inclusive approach for health promotion which may also support the roll-out of the programme in future years. Some areas appointed Flu Champions from the school year cohort, to help engage peers and support the health promotion message during school time.

Post-immunisation materials such as stickers and certificates are popular with children and help re-enforce the positive messaging around immunisation. You may also consider the use of social media to launch the programme and update on its progress.



Wired Young Carer's Group produced a song about getting a flu vaccination. It has been popular with children and is available for teams to use:

<https://vimeo.com/106076706>



Managing Consents and the Administrative Requirements

Managing the consent process and administrative requirements of the programme requires a lot of support.

The size of the team managing the admin and consent forms vary according to the size of the cohort. Teams have reported employing three staff between July and September to manage the administrative burden of the programme with a target population of less than 10,000. Whereas larger areas have reported seven full time administrative staff to manage the workload.

This is broadly supported by the analysis of workforce used in 2014/15 which shows a spread of workforce levels for a whole provider in the months prior to October from one to seven full-time equivalent (FTE) months per 10,000 target population

During roll-out, staffing to manage the consents continued with a typical team of 2 X FTE staff and 0.5 FTE for a smaller target population size of 8,000. This will vary depending on the number of schools and pupils included in the size of the cohort.

Issuing of consents to schools is a rolling programme and there are a number of options and factors to consider in terms of the timing of this activity:

- issue consent forms and letters of invitation to schools:
 - before the end of the summer term and then complete when school returns in September
 - before the end of the summer term with triaging of the consent forms completed in July and August

Teams that opt to despatch consent forms in the summer term and a number of months prior to immunisation session will need to ensure that all clinical information remains current at the point of vaccination.

- at the beginning of the new school year with administrative staff collecting returned consent paperwork from schools two weeks prior to the session date.

Given the complexity of the process and the volume of information involved, it is recommended that a clear project planning approach is taken to ensure effective timing of the consent process. Be explicit about your process for managing consent forms, including the late return of forms and measures to prevent the use of schools as a conduit for parents' queries. For example, you might consider establishing a dedicated phone line and e-mail box to manage all queries.

Key stages in the process that require staffing are:

Identification of the eligible cohort

Consider identifying the schools, if necessary, using the Department for Education database – known as EduBase. <http://www.education.gov.uk/edubase/home.xhtml>

Early identification of the cohort will inform your planning about the level of resources required. Independent schools may prefer to identify their eligible cohort and managing this will need to be discussed with the school.

Design and preparation of communication packs

Preparation of letters to parents and consent forms: The admin team need to prepare the communication packs, despatch or deliver them and collect the returned forms.

Mail-out may need to include those children being educated at home to invite them for an immunisation. This process may take considerable time and needs to be included in planning. Some teams have opted to immunise home educated children in a community clinic, but your approach will be developed locally.

The national consent form can be found [here](#). Some areas have amended the national consent form to suit their local information requirements. See Appendix 3 for an example of a consent form amended locally and a brief narrative on the changes made.

Your covering letter will need to reflect the local offer and should also signpost parents and individuals to further information, via a website and / or telephone number to address additional queries. A national invitation template letter has been produced and is available at <https://www.gov.uk/government/collections/annual-flu-programme>.

Agree the mailing approach – preferably through the satchel drop, or direct mail with pre-paid envelope for return although there are costs attached to this approach.

Development of a robust system to manage the returned information in sufficient time to plan the immunisation schedule

Have a clear plan for processing, transporting and storing large volumes of personal information.

If consents are returned via the school, the resourcing needs to be discussed with the school. Many areas have reported that for primary schools the satchel drop is the preferred method of dispatch.

Establish a named contact within the school responsible for the collection of consent forms. All returned consent forms need to be stored in a secure location.

Request schools to share class lists along with the returned consent forms.

Wherever possible a lead named person within the local healthcare team should be identified for that school. Ensure the team's contact details are available to all school staff and parents.

Return rates of consent forms vary across schools. You will need time to establish a methodology if you wish to follow up outstanding consent.

A suggested methodology is:

- make it clear to schools that they should not manage queries about consent – all these queries should be referred to the local healthcare team. Establish a dedicated phone line and an email mailbox for queries
- all forms will need to be triaged with a nurse identifying children with contra-indications, special needs or those in an at-risk group . Nurses may need to liaise directly with parents to verify clinical information and provision should be made for this
- consider allocation of staff time to manage parents' queries
- establish a process to ensure consent information is correct at the time of immunisation
- prepare lists for the immunisation session that can be taken to school and shared with the school staff on the immunisation day
- establish clear processes if consent is withdrawn or if there are changes to any personal or clinical information
- scope your approach to managing consents – some schools issued a text reminder to parents for outstanding consent forms or placed a reminder on the school website

Administration Needs of the Programme

The whole administration process needs to be resourced to support the effective implementation of the programme.

The flow chart provides an overview of the phases that need resourcing. The example produced here is based on the process adopted in Leicestershire and Rutland.



Training

Providers are responsible for ensuring that their healthcare team is appropriately trained. The training requirements for the programme will vary according to the skill mix of the team. As the programme and the workforce expands, so will the range of training needs. Workforce plans need to include sufficient time for the provision of comprehensive and appropriate training for all staff, including bank staff.

This is not intended to provide an exhaustive list of training materials. PHE have produced a detailed range of training materials for areas to use and these are available at <https://www.gov.uk/government/collections/annual-flu-programme>

Broadly, training will fall into two areas:

Training to support administration of the vaccine; and

Training to support the wider issues of working with children, such as effective communication skills

All healthcare staff will need to achieve the agreed competencies before participating in the programme. A tool for assessing competency in immunisation is available at http://www.rcn.org.uk/development/practice/public_health/topics/immunisation. 'Protected time' may need to be given to upskill bank staff to learn about working with schools and children.

Training is the responsibility of the employer; it will need to be conducted locally and be available in a variety of formats, to meet different training needs and preferred learning styles.



An outline of potential immunisation training requirements by role has been produced by the Royal College of Nursing /PHE. This can be found at http://www.rcn.org.uk/__data/assets/pdf_file/0005/553748/004479.pdf

Staff are encouraged to update their own flu immunisation status in line with the requirements of the Nursing and Midwifery Council Code: <http://www.nmc.org.uk/standards/code/>

Developing skills for staff new to working in the community

Many professionals and other workers may be new to working in the community setting and / or working with children. Dedicated modules have been developed to support those new to working with children / community setting. This can be found by following the nurses section at QNI link <http://www.qni.org.uk/>

Healthcare support workers (HSW) and nursery nurses can have a valuable role in immunisation teams so it is vital that adequate support, supervision and training are made available for them. National Minimum Standards and Core Curriculum for Immunisation Training of Health Care Support Workers has been published by PHE: <https://www.gov.uk/government/publications/immunisation-training-of-healthcare-support-workers-national-minimum-standards-and-core-curriculum>

The Royal College of Nursing statement on HCSWs administering live attenuated influenza vaccine can be found at: [HCSW and Live Attenuated Influenza Vaccination \[LAIV\] for children and young people \(March 2015\) \(PDF 360KB\)](#)

Working with Young Children and in Primary Schools

Different approaches will be required for working with primary schools and younger children compared to the delivery of immunisation programmes in secondary schools:

- there are likely to be more primary schools, each with a smaller number of children per school – you may need to plan for more travel and set-up time
- primary schools will not be familiar with the requirements of an immunisation session – local healthcare teams will need to be clear about the facilities that are needed and will want to complete a risk assessment of the space provided, in advance of the session
- younger children will need to be accompanied by a classroom assistant or agreed person to the immunisation room, who will also be able to assist with identifying and naming children, as required



Section C: Model Specific Information

School Based Delivery

This section describes some of the approaches taken by a local healthcare team delivering the programme in a school setting. It covers the following issues:

- delivery within a school setting
- engagement between an immunisation team and school nurse teams
- developing a long term sustainable programme
- making every contact count
- modelling of school based teams
 - supply and administration of Fluenz Tetra by a registered healthcare professional using a Patient Group Direction
 - supply of Fluenz Tetra® using a Patient Group Direction by a registered healthcare professional with immediate administration by a healthcare support worker (HCSW)
 - supply and administration of Fluenz Tetra using a Patient Specific Direction
- case studies
- resource and session planning
- community Pharmacy/GP mixed model

Delivery within a school setting

A healthcare team delivering the programme within a school setting has a number of clear advantages – children may be known to the school

nurse team, the service is easy to access and children do not need to be absent from school to be immunised; it involves minimal disruption to the school timetable and does not rely on parental attendance or involvement once informed consent has been provided.

Engagement between an immunisation team and school nurse teams

In areas where the healthcare team delivering the immunisation is different to the incumbent school nurse team, consideration needs to be given to the engagement with the existing school nurse team. Working effectively with school nurse teams involves early communication with partners on the schedule developed for childhood flu immunisation. To support effective working, areas may share these details with the school nurse team as early as possible and agree the established procedures to manage the reporting of safeguarding and other issues. Other teams such as school audiologists and those delivering the National Child Measurement Programme will benefit from early liaison to help prevent session clashes and ensure that schools and teams can co-ordinate the timing of sessions.

Developing a long term sustainable programme

Consideration needs to be given to developing a long term sustainable workforce strategy to resourcing the programme. In the early stages of the pilot programme, some areas used bank or temporary staff to meet the seasonal requirements of the programme. Temporary recruitment can be time consuming and sometimes difficult to attract applicants with the required skills.

As the programme extends to more primary school cohorts, short term approaches to recruitment are likely to become less sustainable. However the expansion of the programme should support areas to make longer term decisions and develop a more sustainable approach to recruitment and staffing.

Opportunities may exist for the programme in primary schools to become integrated into the wider school health programme and support the delivery of the wider Healthy Child Programme (HCP) 5-19. This may involve adjusting the timetable of HCP activities, for example sequencing of the National Child Measuring Programme after flu vaccinations have taken place from October to January. A link to the School Nursing Service Planner is here: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/303769/Service_specifications.pdf

Staff employed can then be used to support both programmes, build resilience of the wider children's public health workforce and improve access for children to school based services. Teams that have adopted this approach have not reported an impact on the wider programme performance.

Developing a longer term approach to recruitment and contracts also means that expertise is more likely to be retained for further immunisation programmes. There may be opportunities to develop the skills of healthcare support workers, introduce greater variety within roles and increase the scope for continued professional development, which in turn builds the expertise and retention of key staff.

Making Every Contact Count

Important opportunities exist with every team members' contact with a child to consider the wider health of the child, and in particular the identification of other health and wellbeing issues or safeguarding issues. This is a fundamental element of the Healthy Child Programme and maximising the school nurse contribution with children and young people is part of the valuable additional contact with children and the need to make 'every contact count': <http://www.makingeverycontactcount.co.uk/>

Teams must take into account local safeguarding policies and procedures and ensure that a safeguarding issue or other concerns can be acted upon the same day. The link to the Safeguarding Pathway is here http://media.dh.gov.uk/network/387/files/2012/11/SAFEGUARDING_ENHANCING-PROFESSIONAL-GUIDANCE.pdf

Modelling of School Based Teams Models

Supply and administration of Fluenz Tetra using a Patient Group Direction – registered healthcare professional

Patient Group Directions (PGDs) provide the legal framework under which named registered healthcare professionals can supply and administer Fluenz Tetra to a defined group of patients, who may not be individually identifiable before presentation and without them needing to be seen by a prescriber. The registered healthcare professional working with the PGD is responsible for assessing that the patient meets the criteria specified in the PGD and is therefore able to receive the medicine included in the PGD. The link to NICE guidance on PGDs is <https://nice.org.uk/guidance/mpg2>

The programme is often delivered to children within a school-based setting using a registered healthcare professional to supply and administer Fluenz Tetra under a PGD. This requires that:

1. The child is assessed by a registered healthcare professional on the day of immunisation

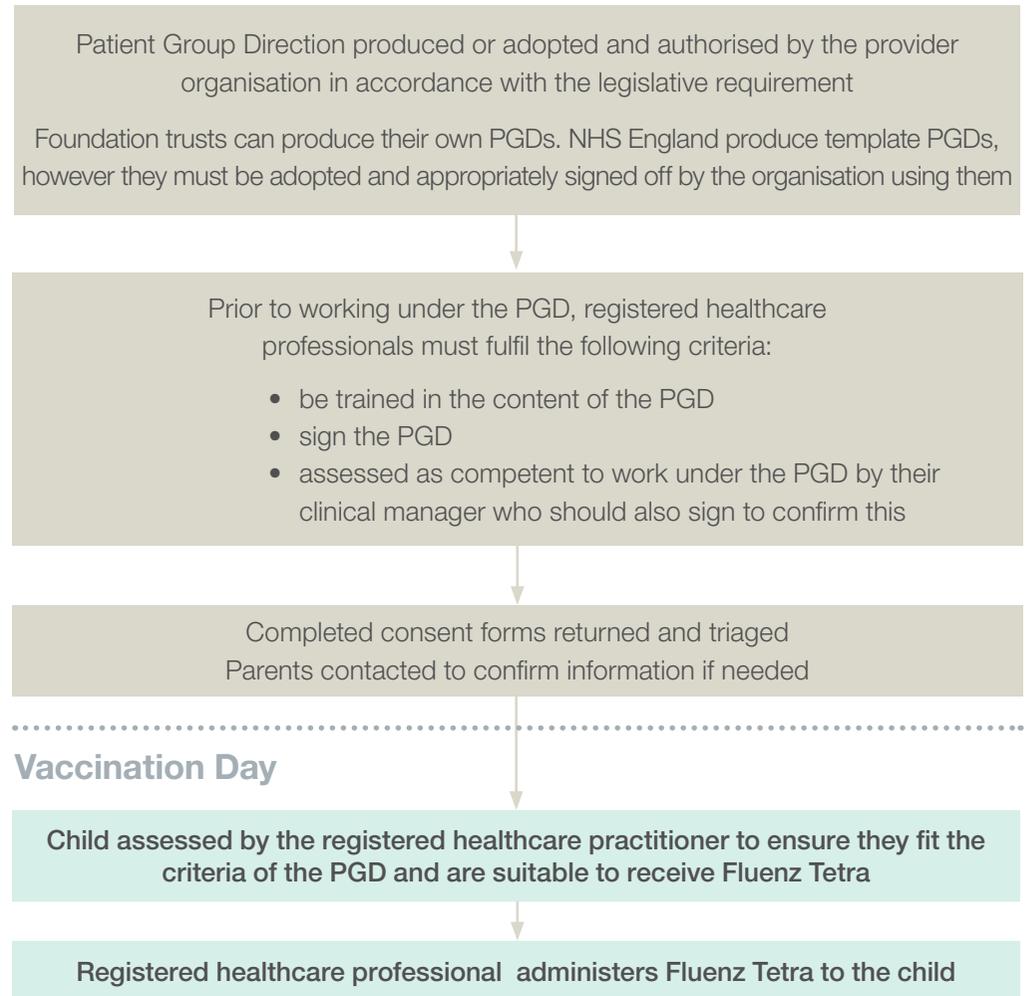
The registered healthcare professional can confirm that:

- the information provided on the Patient Consent Form remains current
- the child has not developed further symptoms / contra-indications and
- the child is fit and well to receive the Fluenz Tetra vaccine and
- the exclusion and inclusion criteria within the PGD are met

If a child does not meet the criteria of the PGD and is excluded from vaccination under the PGD, they should be referred to their GP.

Foundation trusts can produce their own PGDs. NHS England produce template PGDs, however they must be adopted and appropriately signed off by the organisation using them.

Supply and Administration of Fluenz Tetra using a Patient Group Direction – registered healthcare professional



The following sections outline approaches utilising HCSWs to administer the Fluenz Tetra vaccine in accordance with a Patient Specific Direction (PSD) or where a registered healthcare professional supplies the vaccine under a PGD and then a suitably qualified HCSW administers the vaccine immediately. For both of these approaches, HCSWs must be appropriately trained and competent and supported by registered healthcare professionals available immediately on-site. HCSWs can also only work with healthy children who have no specific medical considerations. Where a PGD is for supply of a non-injectable medicine followed by immediate administration by another person, the PGD must specify that the medicine is supplied for immediate administration within a vaccination session.

HCSW administering Fluenz Tetra under a Patient Specific Direction

Some areas have adopted a model that uses HCSWs to administer the vaccine to children in accordance with a PSD. A PSD is a written instruction from a prescriber for supply and / or administration of a medicine to a named patient, after the prescriber has assessed the patient on an individual basis. A HCSW can administer any (non-injectable) medicine that is specified in the PSD using this mechanism. The prescriber is accountable and responsible for the decision to delegate the administration to someone trained. Clear protocols should be in place.

It is essential to ensure that the prescriber issuing the PSD has access to the child's consent form, health record and can speak to the child/parent to ensure that they have all the necessary clinical information to accurately assess the child and to confirm that it is appropriate for them to receive the vaccine.

In practice, this approach requires detailed advanced planning of the immunisation sessions to ensure that the PSDs are available. Planning also needs to consider whether, and if so, how, children who return forms on the day will be immunised.

This is a delivery model for supply and administration of Fluenz Tetra using both HCSW acting in accordance with PSDs supported by healthcare professionals working under a PGD.

1. All consent forms were checked in order to ensure that those children being treated with other medicines, with pre-existing conditions or allergies, were excluded from vaccination under the PSD. This reduced the potential for a child's condition to change in the period between triage and vaccination. The need for a registered healthcare professional's input on the day of vaccination was also reduced.
2. Any child identified either during initial triaging or following assessment by the independent nurse prescriber, as requiring assessment by a registered healthcare professional on the day of vaccination, had an annotation 'FAO Nurse' placed on their consent form. Late consent forms were also marked in this way as children would not be on the PSD and would therefore need to be seen by a nurse.
3. On the day of vaccination, administrative staff filter children to either:
 - a nurse if their consent form is marked 'FAO Nurse' or
 - to a HCSW if not flagged for the nurse

A registered healthcare professional named on the PGD could see any child and administer the vaccine under that PGD.

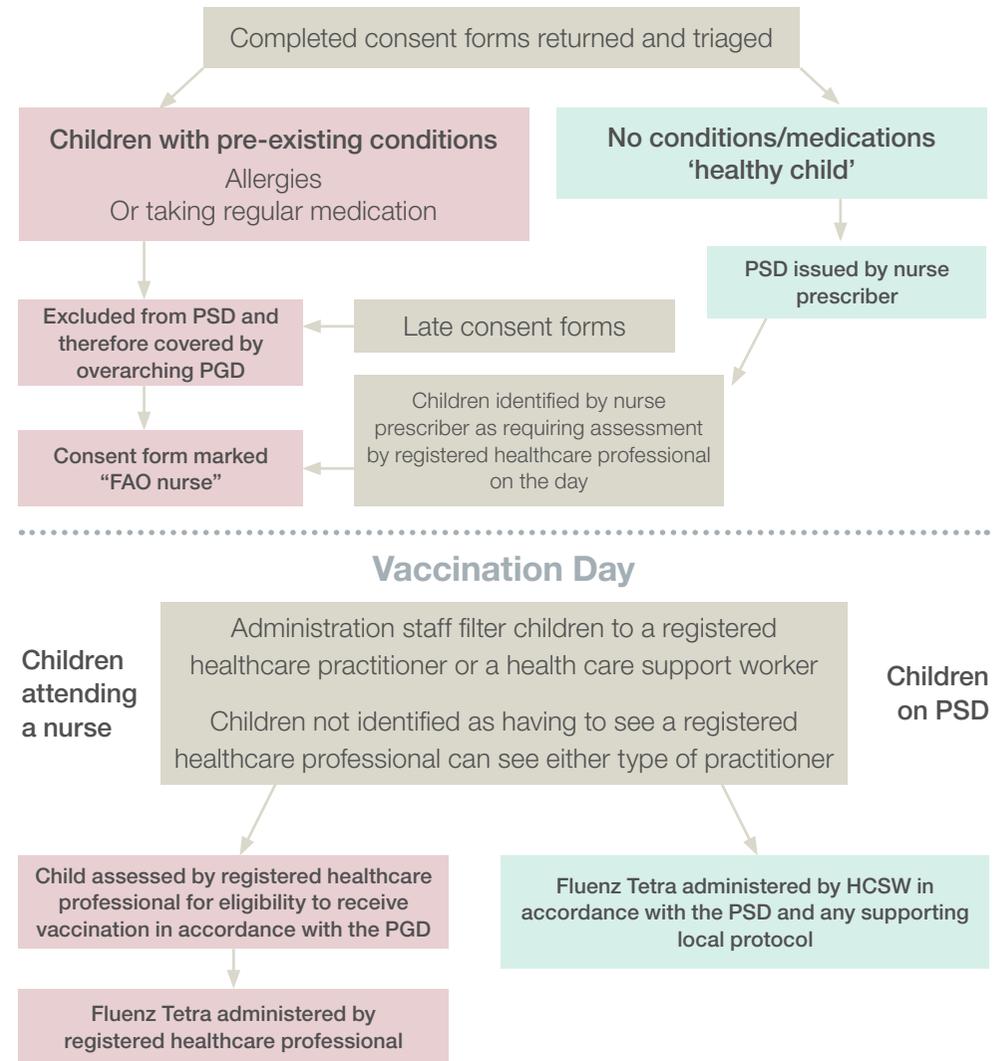
The benefits of this approach are:

- this model enabled a team to employ an effective division of labour, making the best use of team members' skills to ensure that the service is delivered in a timely and cost effective way. Further detail on the ratio of clinical and non-clinical staff can be found under resource and session planning
- most teams that use the HCSW model report that this is very well received by staff members. HCSWs consider this a development opportunity and an approach that boosts staff morale, recruitment and retention
- HCSWs have been effective in adopting this role but this is only possible with comprehensive training, assessment of competencies, and clinical support to ensure that HCSWs are not required to act outside their area of competence

Summary of key points:

- detailed advance planning is required
- nurse prescriber must assess the child utilising the completed immunisation form and issue a PSD
- utilising PSDs as part of mixed modelling can support the skill mix in teams
- issuing of PSDs needs appropriate resourcing
- maximises team members skills

HCSW administering Fluenz Tetra under a Patient Specific Direction



Supply of Fluenz Tetra® by a registered health professional using a Patient Group Direction – immediate administration by a healthcare support worker

This section outlines the approach piloted with children in Years 6 and 7. Currently, it has not been trialled with children in years 1 and 2 of primary school. However, as experience and the scope of the programme increases, this approach may become more relevant for teams to consider.

Summary of the legal position

Only specified registered healthcare professionals can work under a PGD, therefore HCSWs cannot work under a PGD. A HCSW can however legally immediately administer a non-injectable medicine after it has been supplied to a person, including if that supply was made under a PGD by a named registered healthcare professional. This enables services / organisations to use HCSWs to administer Fluenz Tetra as part of a skill mix team without the need for a PSD.

MHRA advises that if the medicine is being administered, or self-administered in the same room as the registered healthcare practitioner who has supplied the medication under a PGD, it does not have to be labelled.

If using a model whereby a registered healthcare professional supplies vaccine to a child and a HCSW administers it, it is essential that the relevant guidance is applied in full, specifically:

- the HCSW does not operate in isolation and a registered healthcare professional is in the same room as the HCSW
- the HCSW has undertaken sufficient training and been assessed as competent

Supply of Fluenz Tetra by a Registered Healthcare Professional using a Patient Group Direction - immediate administration by a Healthcare Support Worker

Patient Group Direction produced or adopted and authorised by the provider organisation
(Foundation trusts can produce their own PGDs. NHS England produce template PGDs however they must be adopted and appropriately signed off by the organisation using them)

Completed consent forms returned and triaged

.....
Vaccination Day

Child assessed by registered healthcare practitioner to ensure the child fits the criteria of the PGD and Fluenz Tetra® supplied to the child

Child directed to take the vaccine to the healthcare support worker

Healthcare support worker administers Fluenz Tetra® to the child

To use a PGD model for supply of Fluenz Tetra:

1. The patient must be assessed by a registered healthcare professional in accordance with the PGD on the day of immunisation, to ensure that there have been no changes since the completion of the consent form and that the child is able to receive the Fluenz Tetra vaccine.
2. The child can then be supplied with the Fluenz Tetra by the registered healthcare professional in accordance with the PGD.
3. The child will be required to take the medication to a waiting HCSW for it to be administered or for supervised self-administration (where appropriate). [A local protocol should be defined and followed for the administration process]

Summary of key points:

- make an assessment of the complexity of the cohort in advance of the session
- boundaries of each role need to be clearly understood and comprehensive support made available to HCSWs to ensure they do not practice beyond their area of competence
- approaches using HCSW can maximise the skills of the team and empower individuals, but systems and processes to enable HCSWs supporting immunisation should be in place to ensure that safety is not in any way compromised
- as experience with the programme increases there may be opportunities to become more flexible with the skill-mix of the team

Useful references:

PHE National Minimum Standards and Core curriculum for Immunisation Training of Health Care Support Workers <https://www.gov.uk/government/publications/immunisation-training-of-healthcare-support-workers-national-minimum-standards-and-core-curriculum>

NHS Patient Group Directions FAQs <http://www.medicinesresources.nhs.uk/en/Communities/NHS/PGDs/FAQs/What-are-the-legal-requirements-for-labelling-a-Prescription-Only-Medicine-POM-issued-via-a-PGD-before-supply-to-the-patient/>

NHS Patient Group Directions FAQs <http://www.medicinesresources.nhs.uk/en/Communities/NHS/PGDs/FAQs/Can-supply-or-administration-be-delegated-to-another-practitioner-under-a-PGD/>

Patient Group Directions: NICE Guidelines (2013) <https://nice.org.uk/guidance/mpg2>

The Royal College of Nursing statement on HCSWs administering live attenuated influenza vaccine can be found at: [HCSW and Live Attenuated Influenza Vaccination \[LAIV\] for children and young people \(March 2015\) \(PDF 360KB\)](#).

Self-administration

Some areas have tested models using self-administration for school aged children (year 6 upwards). Self-administration was well received by pupils and may be a useful model to consider as older children are included in the programme.

Self-administration models can be adopted when a vaccine is supplied to a child or young person by a registered practitioner working under a PGD. The benefit of a self-administration model was mainly evidenced when it was adopted as the standard model of delivery where vaccines were supplied to a child by a registered practitioner and the child / young person's administration of the vaccine was observed by a HCSW. An assessment of a child's ability to self-administer needs to be made in order to ensure that children who would either prefer not to self-administer their vaccine or who struggle to do so are supported. It is anticipated that there is a practice effect in self-administering the intra-nasal Fluenz Tetra and children therefore improve if this approach is repeated in subsequent years.

For this approach to be successful students need to be prepared and well-supported and teams should give careful consideration to the advantages of incorporating peer support as part of the approach. Areas that incorporate Flu Champions into their model may need to have an existing network of peers to support this approach.

Areas using this approach have reported having a minimum of three registered nurses present and two HCSWs at every session regardless of the school size (more if needed).

Resource and Session Planning

Delivery teams typically contained:

- 3-4 immunisers
- 1-2 admin staff
- 1 member of school staff to help manage the students is also recommended. This needs to be agreed with the school in advance of the session.

Many areas report a minimum of two registered nurses and two HCSWs present at every session regardless of the size of the cohort being immunised.

From the analysis of workforce data in 2014/15 the mid-range at times of peak demand for clinical staff is 2.3 to 3.9 FTEs per 10,000 target population. This increases to 3.8 to 6.5 FTE staff at an immunisation rate of 60 per cent.

Models using HCSW in the administration of Fluenz Tetra

TABLE 1: MIXED STAFFING MODELS

HCSW	No. of FTE Clinical Band 5+ (per 10,000 immunisations)
Inclusion of HCSWs in team	0.5 – 1.5
Lower use of HCSW in team	Up to 3

Teams that used a mixed staffing model that involved HCSW used approximately 0.5-1.5 clinical Band 5+ per 10,000 immunisations. Teams that made less use of HCSW as part of their staffing model reported a higher level of clinical Band 5+, in some cases up to 3 FTE Band 5+ per 10,000 immunisations.

There was a central range of 1.2 – 1.8 FTEs (annualised) per 10,000 immunisations for the clinical workforce. This probably equates to about 3.5 – 5.5 FTEs per 10,000 immunisations on the ground during the immunisation period.

Use of a clinical workforce below Band 5 varied, but for those that did make use it was likely to equate to about 1 FTE per 10,000 immunisations on the ground.

The staffing mix will vary according to the model chosen; the complexity of the cohort, which should be assessed in advance of the session; the age of the children being immunised; and the agreed level of support from schools. As the programme extends to a wider age group, there may be opportunities to become increasingly flexible with your model, the role of HCSW in the skill mix of your team and techniques of self-administration.

The selected approach will largely determine the average throughput of the session – the time taken to immunise a given number of children. Modelling tools exist to support resource planning of the sessions, such as:

University College London - Operational Modelling Tool

As part of their Department of Health funded evaluation work, the Clinical Operational Research Unit at UCL has developed a tool to help providers plan staffing of vaccination visits to schools. The approach allows users to simulate vaccine delivery scenarios. <http://www.ucl.ac.uk/operational-research/flu>

Case studies of two school based approaches

Two case studies have been included in the toolkit to demonstrate how an area's practice changed based on their experience and learning from one year.

SUMMARY OF TWO CASE STUDIES

Area	Gateshead, Sunderland and South Tyneside	Leicestershire and Rutland
Approach / model	<p>The Gateshead, Sunderland and South Tyneside pilot used a traditional primary school based model, with immunisations delivered by existing qualified school nurses under a PGD, and by healthcare assistants under a PSD. Bank staff were used as needed, but no external staff were recruited for the pilot</p> <p>Sessions took place during the school day, with no requirement for parent (or nominated responsible adult) to be present, but parents were allowed to be present if they chose to be.</p> <p>No catch-up sessions were offered as part of this pilot approach. As part of phase 2 of the programme, a second opportunity session must be offered.</p>	<p>In Leicestershire and Rutland the vaccinations were delivered by six teams, which visited 435 primary, secondary and special schools and units over a ten week period. Additional community clinics were set up for children who were home-schooled or educated otherwise.</p>

Area	Gateshead, Sunderland and South Tyneside	Leicestershire and Rutland
Staffing and resources	<p>All staff delivering the vaccine were either qualified school nurses (or bank nurses) employed by the trust, existing Band 3 school health care assistants or Band 2 nurses seconded into Band 3 roles. Band 3 nursing assistants on the South Tyneside Foundation Trust nurse bank were also trained and supported sessions. Information and administrative staff (including Child Health Information System) were also employed by STFT. The average session comprised of:</p> <ul style="list-style-type: none"> • 1 – 2 x Band 6, • 1 x Band 5, • 3 x Band 3s and 2 x Band 2s. <p>Qualified nurses continued to manage their caseloads alongside delivery of the flu pilot, but band 3s worked exclusively on the flu pilot during the 10 week delivery.</p>	<p>The Immunisation Service Team were used and additional staff were recruited from Bank staff.</p> <p>Consent forms were assessed by a Clinical Triage Nurse as required, and where appropriate, consent forms were authorised by a Nurse Prescriber – using a personalised stamp – for administration under a PSD by a HCSW. HCSWs were trained to deliver the vaccination under the supervision of a registered nurse and were assessed as competent using the Leicester Clinical Assessment Tool framework.</p> <p>In addition to HCSWs, teams consisted of registered nurses administering the vaccine under a PGD with support from administrative staff. Each team was led by a registered nurse known as the Session Coordinator, who acted as a liaison between school staff and the team.</p>
Support	<p>Staff from PHE provided strategic leadership; the immunisation coordinator was also employed by PHE, embedded within the local NHS England team.</p>	
Communications	<p>Communications staff from the local authorities, the NHS England team, PHE and the trust were all involved in the pilot.</p>	

Area	Gateshead, Sunderland and South Tyneside	Leicestershire and Rutland
Key learning	<ol style="list-style-type: none"> 1. Establish a dedicated 'flu team' next year from within the school nursing teams in order that those staff can focus on the flu delivery and those with caseloads can ensure that the delivery of the flu vaccine is not detrimental to their normal work flows 2. Be explicit on the management of late consents 3. Produce a school pack including FAQs 4. Meet with all head teachers in advance of the session 5. Parents will not be required to attend the immunisation session 	<ol style="list-style-type: none"> 1. The approach was strongly influenced by lessons learnt in the first year following feedback from staff, schools and parents 2. New methodologies were piloted in the second year such as the role of HCSW and self-administration of the vaccine 3. An extensive communications strategy was devised in the second year along with a robust timeline for communication with all key stakeholders 4. Efforts were taken to embed the role of a Clinical Triage Nurse to assess clinical queries in advance of the session 5. The offer was extended to children who were not educated in a school setting via a community clinic setting in the second year

Community Pharmacy/GP mixed model

A community based model involves working with participating GP practices in the local area. GP practices were offered the pilot programme as a local enhanced service. The majority of practices accepted.

The community pharmacy/GP model is an approach that has been used in rural areas with a large number of geographically dispersed local primary schools. Uptake by areas using this approach has been lower than school based models and ranged from 20 – 37 per cent.

The Community Pharmacy model may require a proactive Local Pharmaceutical Committee (LPC) or other organisation, as agreed locally, to provide leadership at a local level and good partnership working across all members. It will require commissioners to identify a wholesale distribution hub who can distribute supplies to participating pharmacies.

The key tasks and functions of the lead agency (LPC or other) to ensure successful implementation of a pharmacy vaccination service are:

Initial scoping work:

- scope and agree the service model with the commissioner
- recruit pharmacies and GP practices to participate in the Programme
- seek to agree remuneration for community pharmacy provision with the commissioner

Pre-Launch:

- facilitate any training requirements – particularly practical training in basic life support, anaphylaxis management and vaccine administration. In one area this was promoted as an opportunity to ‘invest for success’ with a private training provider being self-funded by the individual pharmacies. Areas developed a Declaration of Competence that pharmacy professionals were required to complete.
- arrange / commission the IT platform for data collection
- develop and provide supporting resources – flu consultation forms, guidance notes, leaflets for parents
- planning for implementation at the start of the school year involves planning starting in the new year with monthly meetings
- consider commissioning a wholesale pharmaceutical company (or LPC) to receive supplies and manage the onward delivery of vaccines to pharmacies. Costs may be incurred with this approach. The wholesaler must have a distribution licence and must insure the vaccine from their base to each pharmacy
- general practices to be informed they should order vaccines from the stock for the Year 1 and 2 age children rather than the routine stocks of Fluenz Tetra for the 2-4 year old children
- the commissioner / LPC will need to manage ordering by pharmacies to reduce waste as boxes of 10 vaccines cannot be split
- patient Group Directions to be developed for both community pharmacies and general practice
- obtain lists of children in the offer population; this might be from schools, CHIS or GP registered population
- agree the method of despatch for invite letters
- develop a robust communication plan:

Communications

Different approaches may be taken to communication. Issues include:

- in the pilot period, the LPC in one area charged each participating pharmacy a levy (approx. £30 per pharmacy) so the communication material and public facing information (posters, flu bug stickers, local press advertising) became self-funded
- the Steering Group to agree the method of despatch for letters – either direct mail to parents and carers or via the school satchel drop. Higher levels of uptake were associated with the direct mail to parents in one of the areas

Communications Plan

The communication plan needs to detail the communication of the LPC/ LMC/lead organisation as well as communication with practices and other pharmacies. The communication strategy needs to be ongoing and sustained.

There is value in a member of the LPC attending school assemblies to promote and engage both schools and their pupils. If there is a capacity issue consider commissioning the school nurse or immunisation lead to fulfil this role.

The communications plan should also scope all means to engage parents, such as letters, text updates, school website, newsletters and local press.

The local authority may co-ordinate the production of letters. This needs to be agreed locally but plans need to be made for the printing of letters that do not involve schools.

During vaccination season:

- lead from the LPC/lead organisation to provide ongoing assistance and advice to pharmacies
- co-ordinate stock ordering by pharmacies to minimise wastage. Pharmacies place orders into central point held by LPC who then placed a central order via Immform
- maintain contact with all stakeholders and continued steering group meetings

Data management

In one model vaccinations were recorded on the standalone web-based IT platform which can provide real time data for the sub-regional team. The recorded vaccination provides an automatic e-mail to GP practices; the email transfer must be by secure means. Areas adopting this model need to scope how they can work closely with GPs to ensure this information is collected. In other areas uptake data were provided via GPs to the screening and immunisation leads.

There is no direct notification sent to CHIS and pharmacies will want to scope how best to get vaccination recorded on CHIS.

Summary of key issues

Strengths associated with the Community Pharmacy approach are:

- an available, suitably trained workforce who require a minimal uplift in training
- children are accompanied by an adult or carer and complete consent at the time of presentation and therefore establishing informed consent is relatively straightforward
- existing IT systems may enable pharmacies to complete and provide data to other stakeholders (such as the local NHS teams) in real time

However there are also a number of challenges that need to be managed as part of the Community Pharmacy model:

- pharmacies do not have ready access to the school cohort lists and plans need to be agreed between the local authority and the LPC to agree the approach to identifying cohorts and the mailout. Experience from one area was that a mailout to parents at home generated a greater response than letters sent via the satchel drop
- commission a wholesale pharmaceutical company / organisation to deliver supplies to multiple pharmacies – costs will be incurred
- arranging vaccine delivery to multiple sites
- risk of higher wastage than other models. Wastage needs to be monitored by pharmacy providers

Acknowledgements

We are grateful to members of the Workforce Development Working Group, colleagues and partners involved in the extension of the national flu immunisation programme to children, for their contributions to the toolkit.

In particular we would like to acknowledge the valuable contributions of partners who gave their time and materials generously and these include:

Nisha Thanki and Suzanne Leatherland, Leicestershire Partnership NHS Trust:

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Julie Thornton, South Essex Partnership Trust;

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Jeff Forster, Chief Officer, Cumbria Local Pharmaceutical Committee,
and colleagues in Gateshead, Tyne and Wear NHS England North.

Appendices

The below Appendices can be viewed over the following pages

Appendix 1: Example of a local agreement between immunisation team and local school

Appendix 2: Process maps – gateshead public health team

Appendix 3: Consent Form with local amendments

The link to the national template form can be found at <https://www.gov.uk/government/collections/annual-flu-programme> . This has been updated to support implementation of the extension of the annual flu programme to children in 2015/16.



Immunisation Team
Address and contact details

NAME AND ADDRESS OF SCHOOL
Dear XXXXXX

date

LOCAL AGREEMENT FOR PRIMARY SCHOOL BASED FLU IMMUNISATION SESSION

Please can you review the date below as a potential date for the delivery of a flu immunisation session:

Tuesday 25th November 2014

In readiness for the sessions consent forms and information booklets should be distributed to parents of all children on roll, including those children who have been excluded. Completed consent forms should be returned to school prior to immunisations taking place.

Please can they be collated into class order and a class list attached.

The Immunisation Nurses will arrive at approximately 9am to prepare for the session and will aim to start by 9.30am. May I ask that you have the following ready for the Nurses' use.

- 1. A member of school staff to maintain the order and discipline of the pupils. This is crucial to the smooth running of the session and is not the Nurses' responsibility.**
2. A room of sufficient size with good lighting and ventilation to accommodate five tables for the Immunisation Nurses' use and to allow a degree of privacy for each pupil. Chairs for the nurses and pupils.
3. Screens, if necessary, to provide privacy to the pupils being immunised.
4. A waiting area for the pupils where they can be prepared for the vaccination. A table and chair for the administration clerk.
5. An area with a crash mat where pupils may be attended to should they feel unwell and a jug of water with disposable cups.
6. Access to hand washing facilities.
7. A secure storage area for the vaccines and equipment during lunchtime if the session is likely to be all day.
8. Car parking facilities for the day if possible, or at least provision to drop off equipment.



South Essex Partnership University 
NHS Foundation Trust

   www.SEPT.nhs.uk

Practice has shown that setting a standard rate for pupil attendance does not work due to the nature of the session and the number of Immunisation Nurses attending. Therefore, it is requested that you liaise with your Immunisation Team prior to the session to determine the appropriate frequency of pupil attendance.

Following vaccination, pupils will be required to remain on the school site for a minimum of 30 minutes. Therefore, this should be taken into account when arranging the schedule.

The Immunisation Nurses will aim to complete the programme within the time allowed and with the minimum of disruption to the normal running of the school. However, please be aware that should unplanned events occur completion of the programme is not guaranteed. Should sessions need to be cancelled or rearranged we will endeavour to give you a minimum of one week's notice.

If, due to sickness, safe practice cannot be maintained sessions may be cancelled without notice.

Please do not hesitate to contact the Immunisation Team should you have any queries regarding the arrangements for the vaccination programme.

Thank you in anticipation of your acknowledgement and support.

Yours faithfully

Name
Immunisation Nurse

Please complete and return to:-

The Immunisation Team, xxxxxxxxxxxxxx

I acknowledge I have received and read the Local Agreement and confirm that a flu immunisation session(s) will be accommodated on the date (s) specified below:

School: ABC Primary School

Date (s): Tuesday 25th November 2014

Could you please let us know the maximum amount of children in each year group?

Rec	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6

Signature Name Date



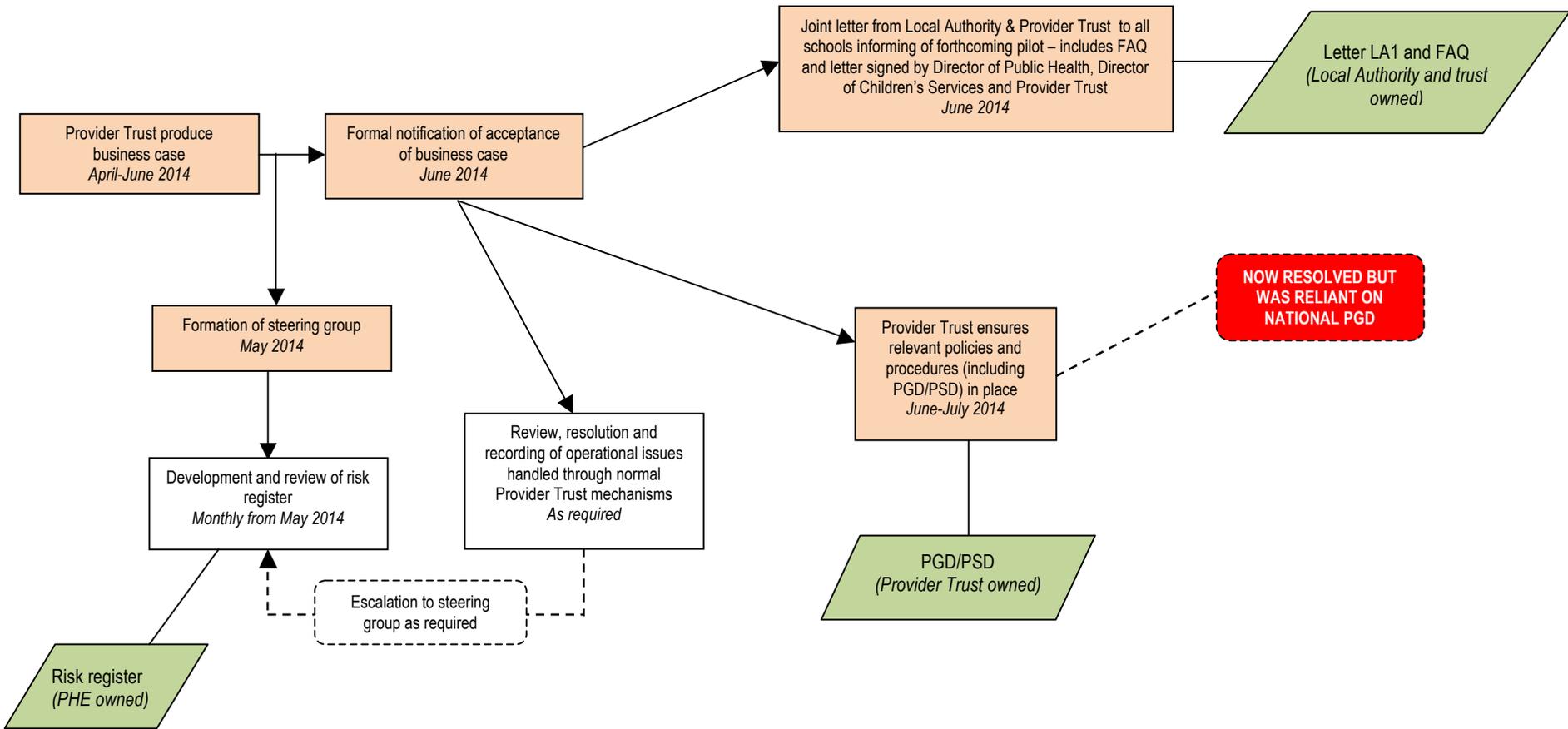
Public Health
England

Gateshead, South Tyneside and Sunderland childhood flu pilot 2014

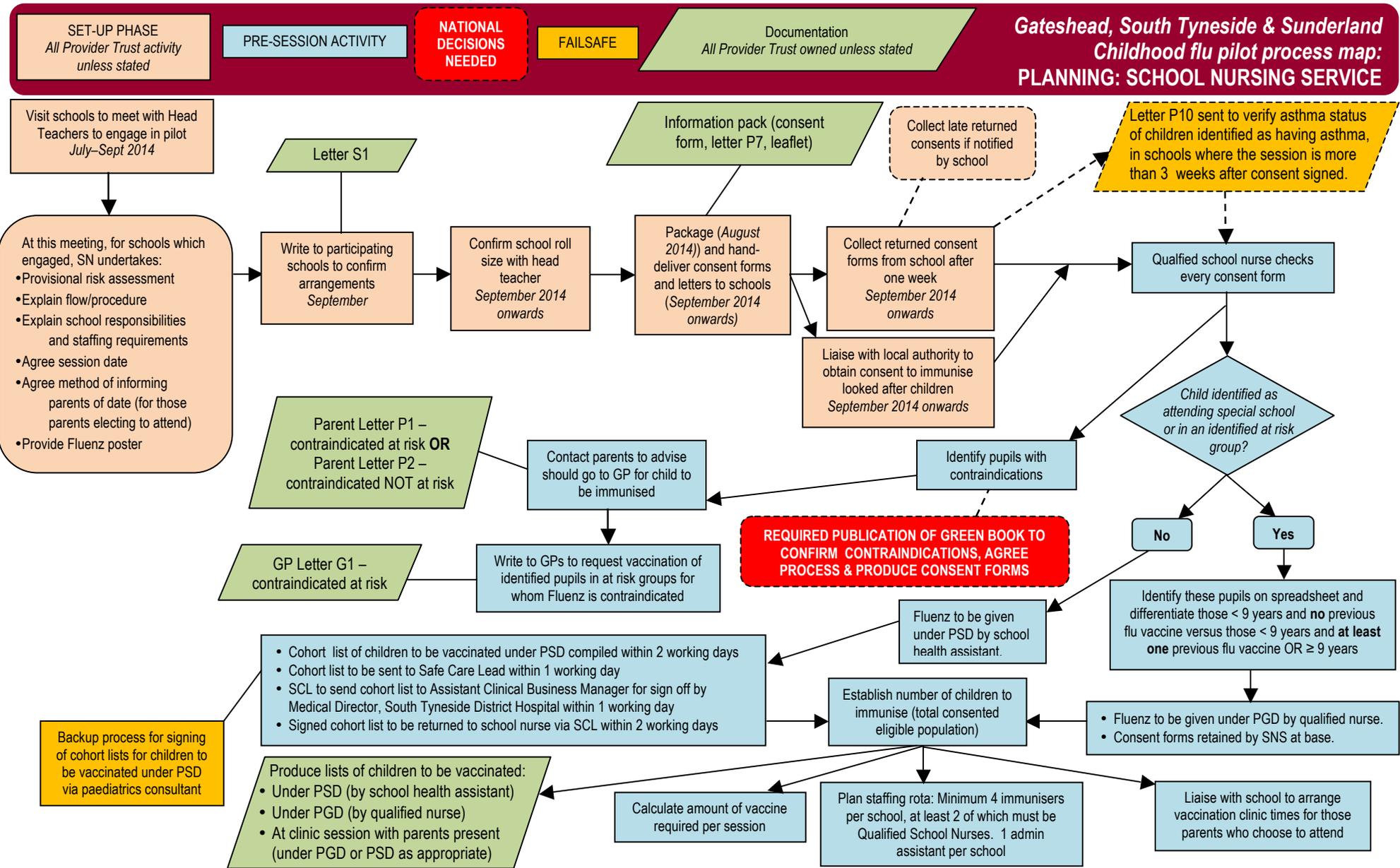
Process maps

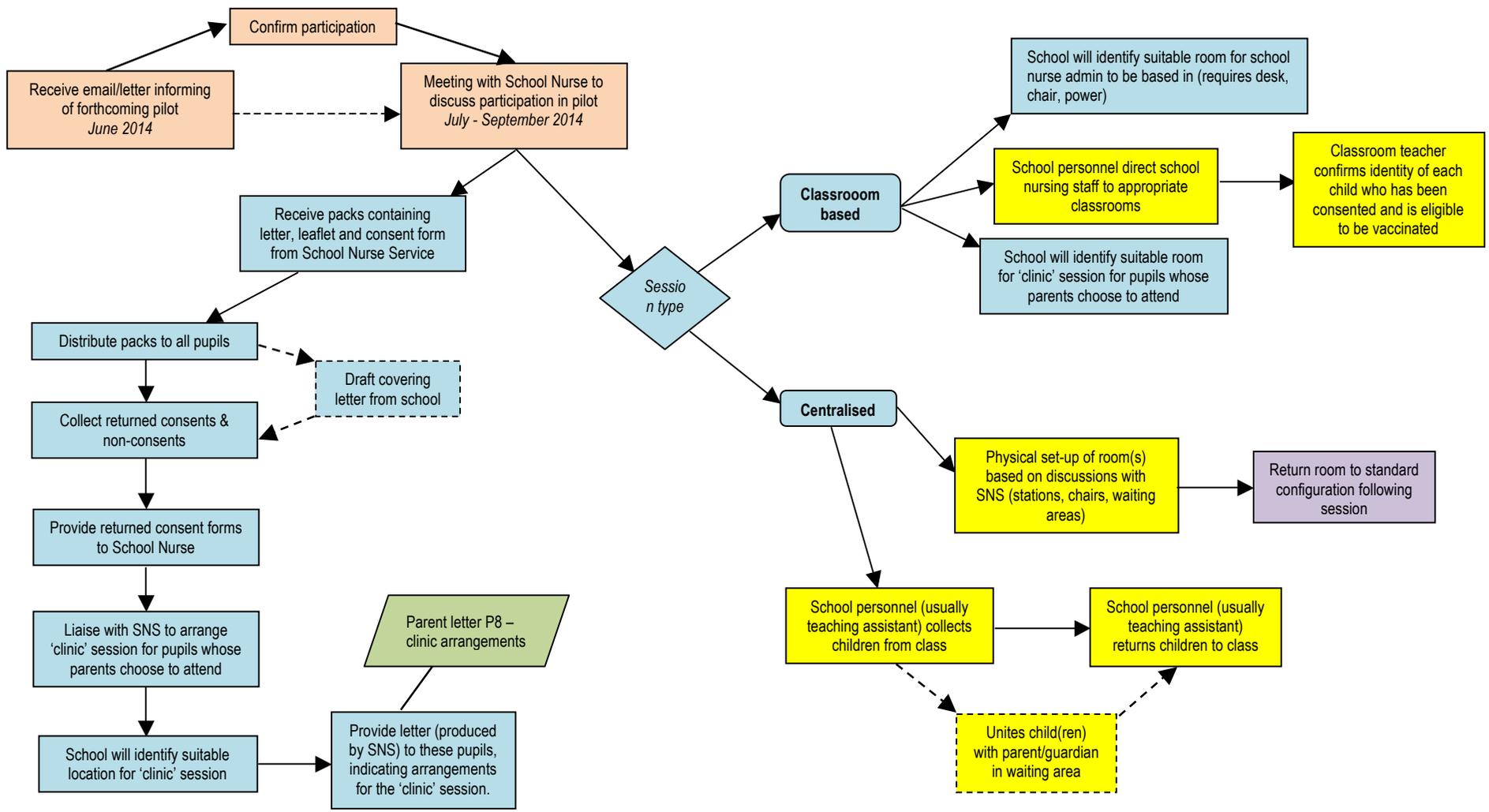
August 2014

DRAFT



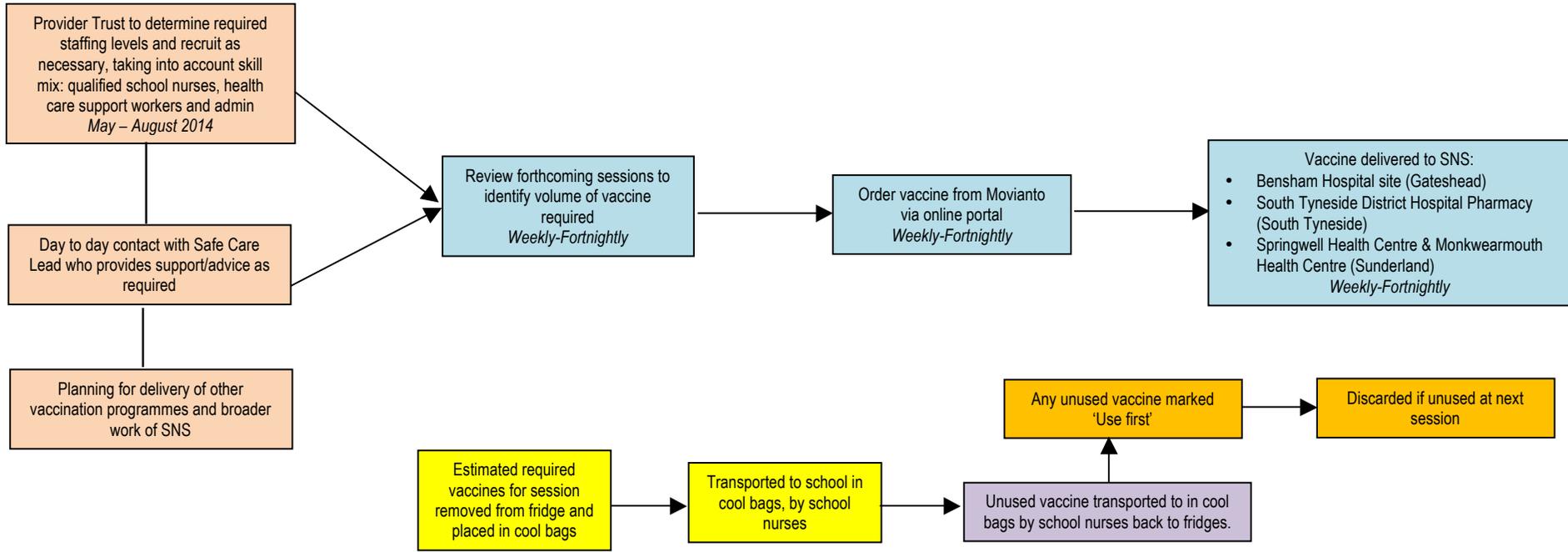
**Gateshead, South Tyneside & Sunderland
Childhood flu pilot process map:
PLANNING: SCHOOL NURSING SERVICE**



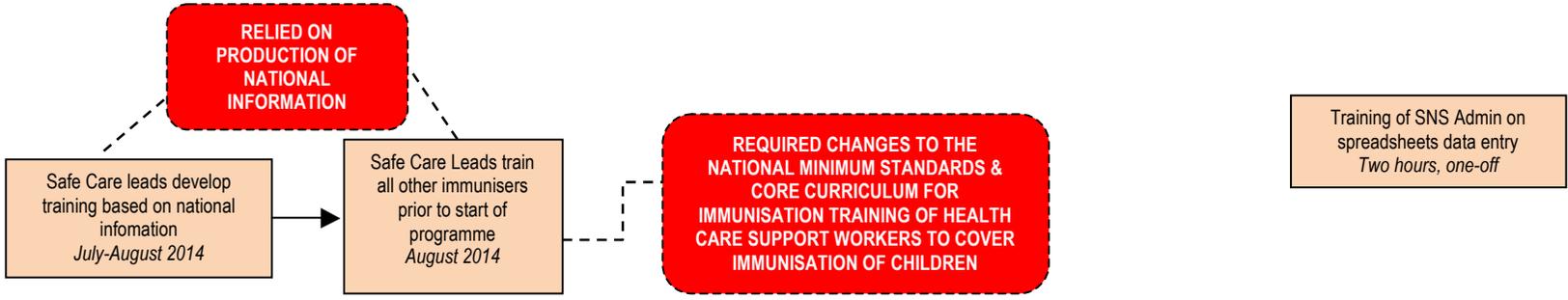


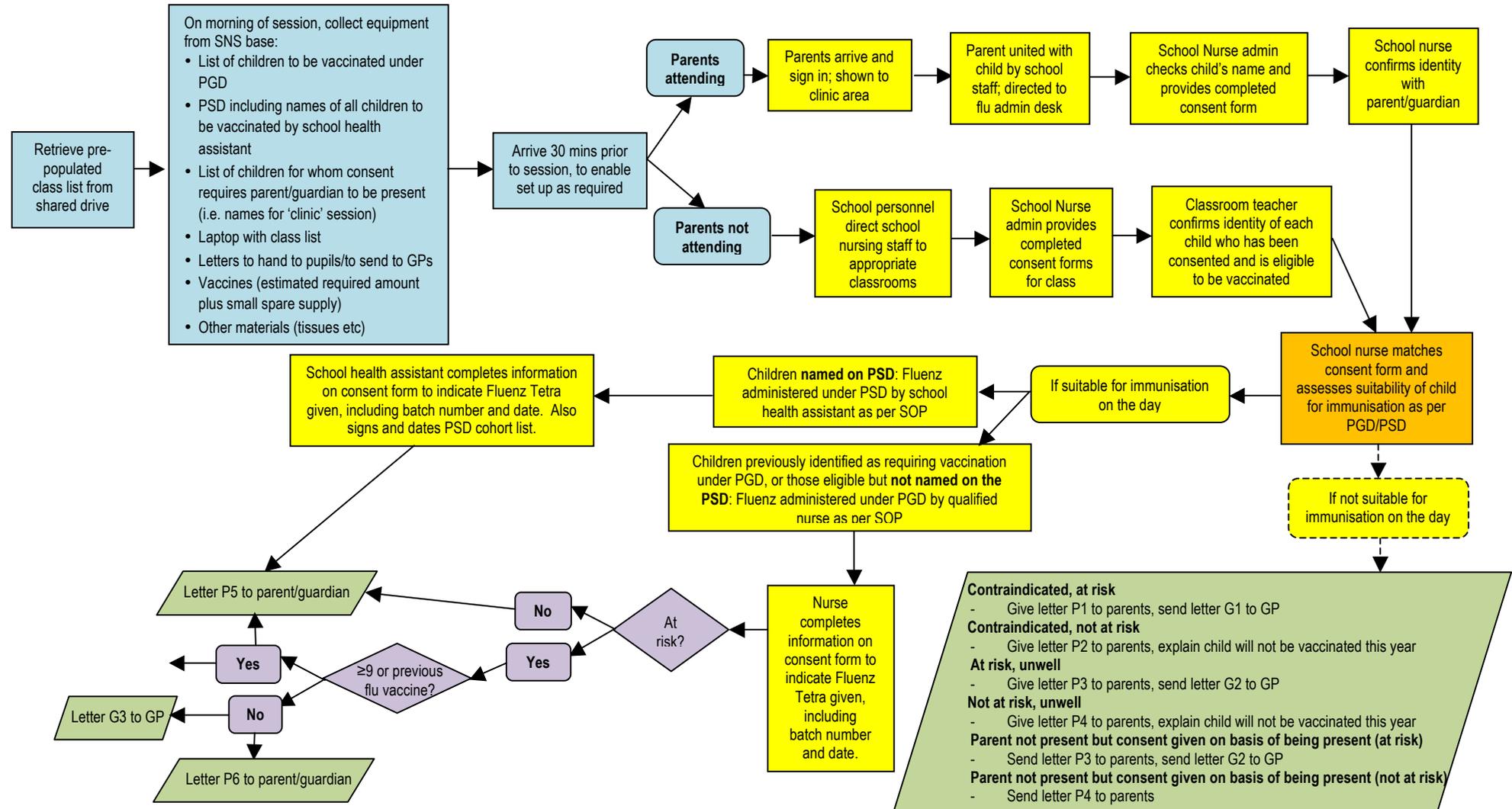
SET-UP PHASE **PRE-SESSION ACTIVITY** **SESSION ACTIVITY** **POST-SESSION ACTIVITY** **FAILSAFE** **NATIONAL DECISIONS NEEDED**

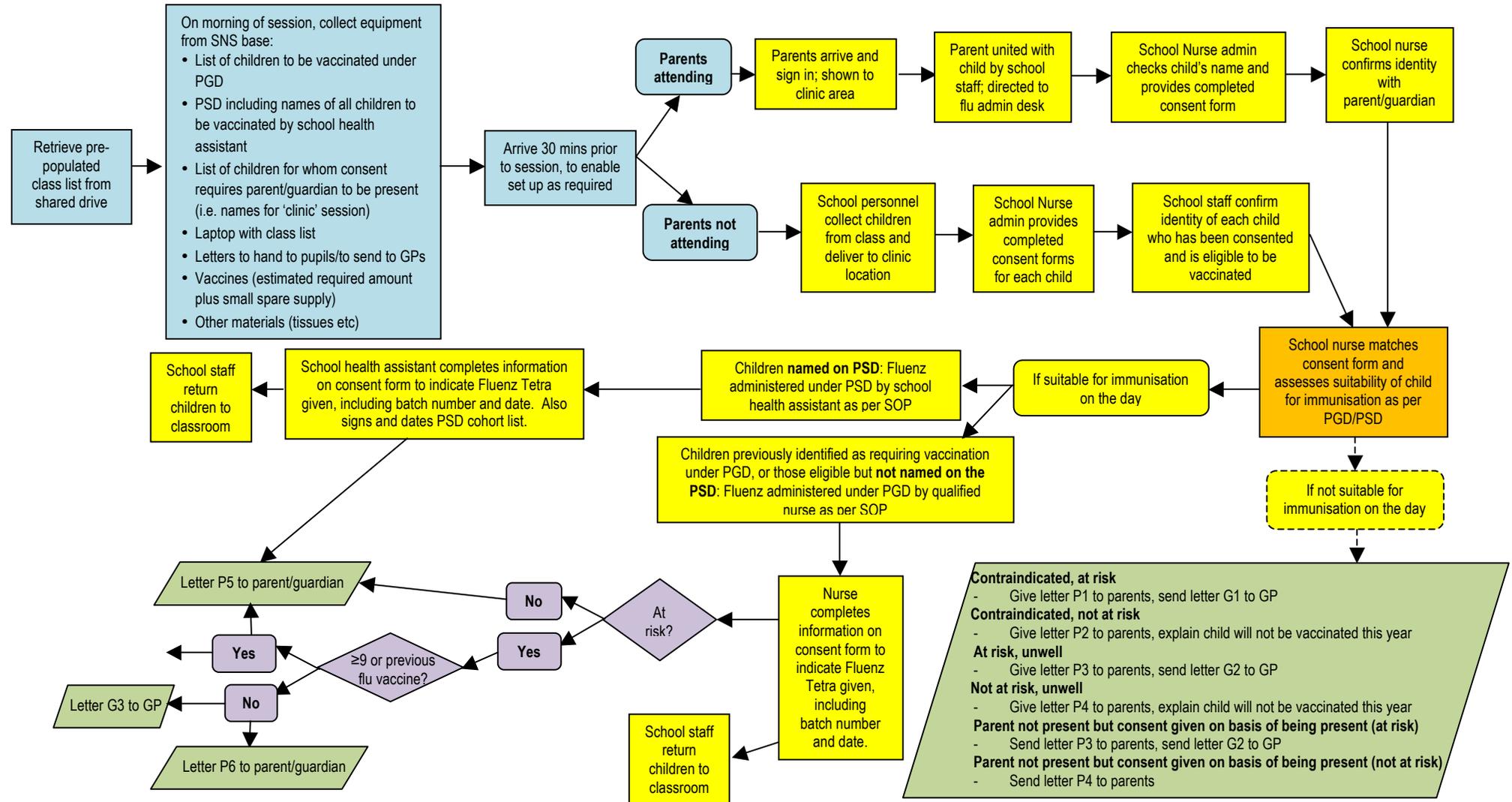
Gateshead, South Tyneside & Sunderland Childhood flu pilot process map: LOGISTICS & TRAINING



TRAINING







LETTERS (all Provider Trust owned unless stated)

- G1** GP letter for children who have a contraindication to Fluenz Tetra but are in an at risk group for flu – request IM vaccine in practice.
- G2** GP letter for children who are in an at risk group for flu but were not able to receive Fluenz Tetra on the day (e.g. due to illness, or parent not present) – request Fluenz Tetra or IM in practice.
- G3** At risk child vaccinated; second dose needed.
- LA1** Local authority/Provider Trust invitation to take part in pilot (*Local Authority/trust owned*).
- P1** Parent letter for children who have a contraindication to Fluenz Tetra but are in an at risk group for flu – direct to GP.
- P2** Parent letter for children who have a contraindication to Fluenz Tetra but are **NOT** in an at risk group for flu (egg allergy).
- P3** Parent letter for children who are in an at risk group for flu but were not able to receive Fluenz Tetra on the day (e.g. due to illness, or parent not present) – direct to GP.
- P4** Parent letter for children who are **NOT** in an at risk group for flu and were not able to receive Fluenz Tetra on the day (e.g. due to illness, or parent not present) – no vaccination.
- P5** Child received Fluenz; no further action needed.
- P6** Child received Fluenz; second dose needed – direct to GP.
- P7** School Nursing service letter to parents inviting vaccination.
- P8** Clinic arrangements for parents electing to attend the session.
- P9** Parent letter for children educated out of school.
- P10** Parent letter to confirm asthma status of children for whom the consent was completed more than 3 weeks before the vaccination session.
- S1** School Nursing service confirmation of arrangements with schools.

Important information: The nasal influenza vaccine is being offered to your child and is to be given at their school. Please ensure that you have read the accompanying information before completing this form. For further information please visit: www.leicspart.nhs.uk. Should you have any questions you can contact the Childhood Flu Immunisation Team, by telephone: 0300 300 0007, or by e-mail: childhoodfluimms@leicspart.nhs.uk

Please complete this form for your child as fully as possible using BLOCK CAPITALS using black or blue ink. Please read the notes section for further clarification.

PART 1: Patient Information and Contact Details

Child's Surname:		Child's NHS Number: <small>See notes</small>	
Child's First Name:		Doctor's name:	
Child's Date of Birth:	Age:	Doctor's address:	
Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <small>Please tick</small>		Postcode:	
Home address:		Doctor's telephone number:	
Postcode:		School name:	
		School year:	Class:

We may wish to contact you to discuss any queries. Please provide your contact details.

Daytime contact number:	Evening contact number:
Email address:	
Would you be happy to be contacted to find out what you thought about this service? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please tell us how we can contact you: <input type="checkbox"/> post <input type="checkbox"/> email	

PART 2: Consent Declaration

I confirm I have parental responsibility for the above named child (See notes).

I am the parent / guardian / carer (Please delete as appropriate).

I have read and understood the information given to me about the nasal 'flu vaccine.

I understand that information provided will be shared with my GP to update my child's health records.

YES, I CONSENT for my son / daughter to receive the nasal 'flu vaccine.

Please tick

Name:

Signature:

Date:

**Continue to PART 3:
Medical Information.**

NO, I DO NOT CONSENT for my son / daughter to receive the nasal 'flu vaccine.

Please tick

Name:

Signature:

Date:

Please let us know why you do not want your child to have the 'flu vaccine:

- My child has (in the past four months) or will be having the vaccine at our GP surgery.
- Do not feel that the vaccine is necessary.
- Due to a previous allergic reaction to the vaccine.
- Due to the contents of the vaccine.
- Other (please state)

Thank you for completing this form.

Please return this form to your child's school within one week of receiving it using the envelope provided.

PART 3: Medical Information

Please complete this section fully as any gaps may lead to the vaccine not being given. Please tick.

	No	Yes	If yes, please give details:
1. Has your child had their 'flu vaccine in the last four months at your GP surgery?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has your child had the nasal 'flu vaccine before?	<input type="checkbox"/>	<input type="checkbox"/>	

	No	Yes	If yes, please give details
3. Has your child had a bad reaction to any previous 'flu vaccine or to a medicine called gentamicin?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does your child have an egg allergy, which has been confirmed by a specialist doctor or at an allergy clinic?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Does your child have asthma?	<input type="checkbox"/>	<input type="checkbox"/>	
If yes to the above question, please list the medication they take:			
Drug name and strength	Dosage	How often	
EXAMPLE: <i>Clenil Modulite inhaler 100 microgram</i>	<i>2 puffs</i>	<i>Twice a day</i>	
.....	
.....	
.....	
.....	
	No	Yes	If yes, please give details
6. Has your child got a health condition or are they receiving treatment that severely weakens their immune system?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Please include the name of the condition, drugs prescribed and consultant</i>
7. Is anyone in your family currently having treatment that severely weakens their immune system (e.g. bone marrow transplant recipient requiring isolation)?	<input type="checkbox"/>	<input type="checkbox"/>	
8. If yes to the above question, can your child avoid close contact with them for two weeks after receiving the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Is your child receiving oral salicylate therapy (i.e. aspirin)?	<input type="checkbox"/>	<input type="checkbox"/>	

Thank you for completing this form.

Please return this form to the school within one week of receiving it using the envelope provided.

FOR CLINICAL USE ONLY	
Child within programme age range – 01/09/2003 – 31/08/2009	<input type="checkbox"/> VACCINE DETAILS
Signed consent for vaccination	<input type="checkbox"/> Vaccine name: Fluenz Tetra
Pre-vaccination assessment for 'flu completed	<input type="checkbox"/> PGD <input type="checkbox"/> PSD
Child not immunised today due to:	Date given: Batch number: Expiry date:
Absent <input type="checkbox"/> Not well on the day <input type="checkbox"/>	
Asthma: severe, refer to GP <input type="checkbox"/> Previous severe reaction <input type="checkbox"/>	
Asthma: wheeze on the day <input type="checkbox"/> Rhinitis on the day <input type="checkbox"/>	
Child refused (none given) <input type="checkbox"/> Salicylate (oral) therapy <input type="checkbox"/>	Assessed by / Vaccine administered by (PRINT):
Child refused (partially given) <input type="checkbox"/> Unanswered medical query <input type="checkbox"/>	PRINT NAME:
Confirmed egg allergy <input type="checkbox"/> Unsigned form <input type="checkbox"/>	SIGNATURE:
DOB out of programme range <input type="checkbox"/> Vaccination at GP <input type="checkbox"/>	Second dose recommended <input type="checkbox"/>
Immunosuppression (child) <input type="checkbox"/>	Refer to SNIFFLE2 study <input type="checkbox"/>
Immunosuppression (family) <input type="checkbox"/>	Verbal consent for referral gained. <input type="checkbox"/>
NOTES:	
FOR OFFICE USE ONLY (DATE AND PRINT NAME)	
Referral date for second dose	

Overview of consent form design and lessons learnt

The consent pack was locally designed and agreed in year one and revised based on feedback received.

The consent pack included a letter to the parent or carer, a locally designed Patient Information Leaflet, consent form and a return envelope. A section on how to complete the consent form was included in the accompanying letter. This section included details on where to find the NHS number and parental responsibility guidance. The pack also included instructions on how interpretation services could be accessed in key languages.

Consent forms were designed and colour coded according to the type of school (blue for primary school age children, lilac for special schools and nurseries).

The key learning points and suggested considerations are:

- Consider the consent form design and other relating processes simultaneously and design them in tandem.
- Consider utilising a universal design for the consent form, where possible. See the national template.
- Ensure there is sufficient clarity regarding parental responsibility on the form.
- Consider the use of coloured boxes to indicate “Yes consent” and “No consent” to provide clarity on the consent decision.
- Ensure there is sufficient space provided on the consent form for authorisation under PSD.
- Consider how best to simplify the asthma question so that children who may be contraindicated can be easily identified. The vast proportion of clinical questions that arose related to asthma.
- If local amendments have been made, test out the consent form in advance with parents and carers.
- Keep the language clear to alleviate any concerns arising due to limited literacy.
- Consider additional signposting for language assistance.
- Consider providing a larger space for comments from the administrator or clinician.
- Ensure consent for any additional doses or use of an injectable vaccine is gained at the initial consent stage. Ensure the letter and consent form provide additional clarity regarding the provider, the offer and the timescales involved.
- Consider the process arrangements to confirm a change of consent i.e. yes to no and the reverse.