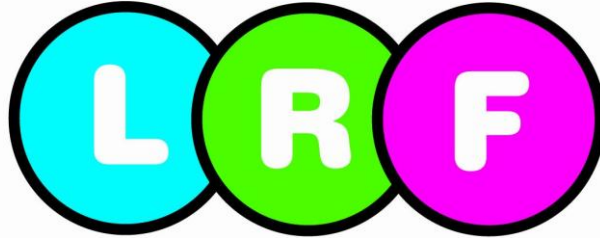


Devon • Cornwall • Isles of Scilly



Local Resilience Forum

LRF MASS VACCINATION PLAN



All items in this document are classed as open under the Freedom of Information Act unless otherwise stated. All closed items include the relevant Freedom of Information Act exemption.

Title of Document:	LRF Mass Vaccination Plan
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Author:	Debra Lapthorne
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Lead Agency:	NHS Plymouth
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Review Date:	
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Revision History

Revision Date	Version No	Summary of Change	Changes made by	Authorised by	Date
Sept 08	d1.0	Initial draft version			
Nov 08	d2.0	2 nd draft version			
July 09	d3.0	3 rd draft version			
Aug 09	d4.0	4 th draft version			
16.09.09	v1.0	Live version			

Distribution

Name	Department	Organisation

This Plan is owned by the Devon, Cornwall and Isles of Scilly LRF, maintained, and updated by the LRF Health Emergency Management Subgroup. All users are asked to advise the Secretariat of any changes in circumstances that may materially affect the plan in any way.

Details of changes should be sent to:

Devon, Cornwall and Isles of Scilly Local Resilience Forum Secretariat

Email lrf@devonandcornwall.pnn.police.uk

Devon, Cornwall and Isles of Scilly Local Resilience Forum

Mass Vaccination Plan

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DEVON, CORNWALL AND ISLES OF SCILLY LOCAL RESILIENCE FORUM

1. TITLE & OWNERSHIP

This document is entitled the 'Devon, Cornwall and Isles of Scilly LRF Mass Vaccination in The Event of a Pandemic or Other Health Emergency Plan'.

It has been produced by the Devon, Cornwall and Isles of Scilly Local Resilience Forum (LRF). The LRF has the rights of ownership of this document, with distribution being agreed by the LRF members. No amendment of this plan is permitted without the express agreement of the LRF.

BACKGROUND

The National Risk Register requires all LRFs to plan for an Influenza Pandemic. The requirement is to have the capability to have a plan in place to deal with all aspects of an out break of Influenza Pandemic across the LRF region and this plan specifically addresses the issue of mass vaccination.

Training and exercising is an essential requirement to ensure any activation of this plan is successful. Each agency is responsible for identifying key personnel who may be involved in the vaccination response to an health epidemic or pandemic. Appropriate training and exercising will be administered by the Chair of the appropriate Sub Group of the LRF.

PURPOSE OF THE DOCUMENT

The purpose of the document is to act as the overarching plan by which all mass vaccination plans are managed within this LRF area and provides the underpinning principles for the development of all tactical plans in relation to dealing with mass vaccination in response to an Influenza Pandemic or other health emergency where mass vaccination would be part of the response.

It is intended for use by all Category 1 and Category 2 responders, as defined in the Civil Contingencies Act 2004, when each respective organisation is invoking special procedures to deal with Influenza Pandemic.

The principles outlined in this document should act as guidance and therefore do not contain detailed instructions. They are intended to provide a basis of understanding upon which other multi-agency plans are developed. This is a STRATEGIC document, under which appropriate TACTICAL plans sit for each agency. These tactical plans contain the detailed information by which personnel deployed to deal with Influenza Pandemic will carry out their required functions.

The guidance emphasises the necessity to establish liaison between all the responders involved in the response from the onset of an outbreak and continually throughout at all levels of command. By its achievement each agency will be able to

carry out their roles and responsibilities to maximum efficiency as part of a unified joint strategy.

LINKS WITH LOCAL AND REGIONAL PLANS

In the period leading up to the onset of a Pandemic the LRF will receive public announcements and restricted briefings from central government departments. The LRF will use this information to commence preparing our local response as part of the wider co-ordinated regional response. This will involve engagement with the regional tier as described in the following documents:

- The South West Regional Pandemic Influenza framework
- The South West Regional Generic Response Plan

This document has also been written to align itself to the various individual local agency plans in place, including:

- Devon & Somerset Fire & Rescue Service
- Devon & Cornwall Constabulary
- Devon County Council (Including District Councils)
- Devon PCT
- Devon Partnership Trust
- Plymouth City Council
- NHS Plymouth
- South Western Ambulance Service NHS Trust
- Cornwall County Council
- Cornwall Fire & Rescue Service
- Cornwall & Isles of Scilly PCT
- Cornwall Partnership Trust
- Council of the Isles of Scilly
- Torbay Council
- Torbay Care Trust
- Acute Trusts
- And any successor organisations that arise from structural changes during the lifetime of this document.

It should be noted, that in-depth detail regarding the health service response including the liaison between Primary Care and Acute Trusts, General Practice, other Contractor Services and the Mental Health Partnership Trusts, is included within the local health services' individual agency plans.

REVIEW & AMENDMENT

The Mass Vaccination in the Event of a Pandemic or Other Health Emergency Plan is a 'living document' therefore it is subject to review by the LRF to ensure it is current, reflects best practice, and is fit for purpose.

DEVON, CORNWALL AND ISLES OF SCILLY LOCAL RESILIENCE FORUM

MASS VACCINATION IN THE EVENT OF A PANDEMIC OR OTHER HEALTH EMERGENCY

MULTI-AGENCY CONTINGENCY PLAN

1 INTRODUCTION

Forward

1.1 The aim of this document is to outline arrangements for the mass vaccination of the population of Devon, Cornwall and the Isles of Scilly in the event of an actual or anticipated pandemic of human disease. At the time of writing, the greatest threat in this regard is that of mutation of the H5N1 influenza virus, enabling it to efficiently transmit from person to person. However it is intended that this plan may be equally applicable to mass vaccination against any disease.

1.1.1 This plan has been developed with the co-operation of the members of the Devon, Cornwall and Isles of Scilly Local Resilience Forum.

1.1.2 It is intended that this plan should be as flexible as possible so as to produce an appropriate response in a wide range of different circumstances, since it is not known when or if what form a disease requiring its activation may occur, nor how readily suitable vaccines may be available. For this reason, the plan focuses on creating a decision-making structure to direct the response, rather than attempting to cover all potential circumstances.

Review

1.2 This plan will be reviewed and updated as necessary no later than 3 years from the date of publication.

2 BACKGROUND

Statutory Requirements

2.1 The Civil Contingencies Act 2004 (CCA) requires all 'Category 1' Responders, which include the Health Agencies, Emergency Services and Local Authorities, to co-operate with each other and maintain plans to respond to civil 'emergencies'. An influenza pandemic or equivalent human disease event would undoubtedly come under the definition of 'emergency'.

Current Clinical Threat

- 2.2 The current largest threat is that of an influenza pandemic. Annual influenza epidemics are normal seasonal occurrences which, although unpleasant and debilitating, are not usually life threatening, nor do they affect sufficient numbers of people to seriously affect the social and economic fabric of the community.
- 2.2.1 Pandemic influenza occurs when a new strain emerges, which is easily transferable between humans, and against which there is little or no immunity due to its novel structure. It is not limited to any season. This type of influenza may have greater morbidity and mortality associated with it.
- 2.2.2 **In April 2009 the World Health Organisation (WHO) announced the emergence of a novel influenza A virus. This particular H1N1 strain has not circulated previously in humans and the virus is entirely new. The virus is contagious, spreading easily from one person to another, and from one country to another. On June 11th 2009 the WHO declared that the scientific conditions for declaring a Pandemic had been met.**

3 PLANNING ASSUMPTIONS

National Guidance

- 3.1 Government has announced the at risk groups that will be prioritised for vaccination once the vaccine is licensed.
- 3.1.1 Priority groups for phase 1:
- NHS and front line social care staff
 - Pregnant women subject to licensing conditions on trimesters
 - 6 months to 64 years with underlying health conditions (such as serious cardiac and respiratory conditions; kidney or liver disease or diabetes)
 - Household contacts of immunocompromised patients
 - Over 65s with underlying health conditions which puts them in the at risk groups
- 3.1.2 Priority groups for Phase 2:
- All 6 month to 5 year old children
 - All carers
 - All Poultry workers
- 3.1.3 Priority groups for Phase 3 will be announced nationally by the Department of Health when the available evidence suggests it appropriate.

Availability of Vaccine

- 3.2 It is anticipated that some vaccine stocks may be available from the beginning of October 09 and that all of the at risk groups will need to be vaccinated by the end of December 09.
- 3.2.1 Although it is thought that the first wave has peaked, it is not yet known precisely when the second wave will return, nor the severity of the illness with a second or any subsequent waves, the plan covers 3 scenarios:
- Phase 1 - Priority vaccination for at risk groups using a combination of normal arrangements such as GP practices and Occupational Health services where available and appropriate and a schools based programme if necessary.
 - Phase 2 - Medium-term rollout using district vaccination centres and GP practices.
 - Phase 3 - Mass vaccination within a very short time frame.
- 3.2.2 During Phase 1 vaccinations will be given to priority groups first.
- 3.2.3 During Phase 2 vaccinations may be administered from district vaccination centres which will vary across the PCT area, according to local circumstances.
- 3.2.4 During Phase 3, vaccinations may be administered from mass vaccination centres which will vary across the LRF area, according to local circumstances.

Population of the LRF Area

- 3.3 The population of the LRF area is approximately 1,650,000 people but this figure increases significantly during the summer months due to tourism. It is unlikely that tourists would be considered a priority group outside of their normal area of residence, due to the likely initial limited availability of vaccine during an influenza pandemic. During Phase 3 a decision would be sought from central government regarding whether or not to extend mass vaccinations, which would require securing additional supplies of vaccine, or whether to instruct temporary residents to return to their permanent area of residence to receive their vaccinations.

Capacity of Mass Vaccination Centres

- 3.4 Modelling undertaken for the Smallpox plan suggests that the entire population of the LRF area could be vaccinated within a period of 7 days using very large

numbers of centres located at or near centres of population and each staffed with 12 clinical and 10 non-clinical staff. Including the seasonal transient population would extend the period of the operation by up to 2- 4 days. Such a model is dependent on the availability of large numbers of NHS staff to support the vaccination centres and the availability of vaccine. This would be dependent on the cessation of a number of normal services in order to release NHS staff. It is not thought for the current pandemic that this will be clinically necessary in the early stages.

- 3.5 In the event of a pandemic, health care workers have a higher exposure and therefore have a potentially higher attack rate. The level of staff with family responsibilities will also tend to increase absence from work for caring duties at home, giving an assumption of between 35% and 50% of NHS staff being absent from work at some point during the outbreak. At the peak of disruption up to 40% of staff could be absent from work at the same time.

4 TRIGGER POINTS/ACTIVATION

- 4.1 Phase 1 deals with long-term, small-scale vaccination using normal General Practitioner (GP) practices premises and schools based programmes, as vaccines become available. Early modelling indicates that the combination of the numbers in the at risk groups (see 3.1) would equate to almost half of the total population.
- 4.2 Phase 2 deals with medium-term medium-scale vaccination using district centres (for example Community Hospitals or Health Clinics) as vaccines become more widely available. In order to minimise disruption to large occupational groups or organisations, PCTs should consider delivering vaccination clinics on site rather than requesting attendance at other community based clinics.
- 4.3 Phase 3 deals with mass vaccination of most or all of the population within a period of days. It is not credible that an operation of this scale would be ordered except by National Government.

5 ROLES AND RESPONSIBILITIES

- 5.1 All Category One Responders within this plan have a general responsibility, in accordance with the CCA, to maintain business continuity plans which identify their most critical services. Staff delivering those services may be eligible for priority for vaccination under Phase 1 & 2 (see Part 3 – **Planning Assumptions**)

5.1.1 NHS organisations:

- Receipt, appropriate storage, security, distribution, notification of those requiring a vaccine and administering of vaccines

- Maintain records of vaccinated individuals
- Training of non-clinical staff to deliver vaccinations, where required, including other Category One responders who may be required to provide support at vaccination centres. This will include clerical support as well as non-clinical vaccinators and other duties that may be identified
- Implementation of appropriate clinical governance arrangements to support the delivery of the mass vaccination programme

5.1.2 South Western Ambulance Services Trust:

- Support to vaccination centres, particularly for anaphylaxis response

5.1.3 Devon and Cornwall Constabulary:

- General duty of preservation of life & property, and investigation of crime
- Convene & Chair Strategic Co-ordination Group (Gold)
- Establish Multi-Agency Silver Control(s)
- Maintain public order
- Respond to requests from NHS to assist with security in the event of an incident regarding vaccine stocks or for other issues related to the vaccination programme.
- Establish traffic plans around mass vaccination sites to minimise congestion and allow essential staff and supplies to gain access

5.1.4 Local Authorities:

- Identify vulnerable & non-mobile people unable to attend vaccination centres in conjunction with primary care staff
- Provision of pre-identified premises, including use of or change of use of schools, set-up for operation, janitorial services
- Assist with non-clinical staff at Vaccination Centres This will include clerical support as well as other duties that may be identified.

6 NOTIFICATION PROCEDURE

6.1 In the event of a pandemic or other public health emergency the notification of a decision to activate this plan will be given by the Devon, Cornwall and Isles of Scilly Local Resilience Forum.

6.2 The responsibility for notifying the priority groups or public to present for a vaccination lies with the Primary Care Trusts under the guidance of the SCG.

7. COMMAND, CONTROL AND CO-ORDINATION

Single-Agency Response

- 7.1 It is anticipated that the activation of this plan using Phase 1 will be co-ordinated by the PCTs Flu Directors using existing management and clinical structures, for example GP services.
- 7.2 The activation of Phase 2 of this plan could require a single or multi agency response depending on the number of people in the priority groups and the timescale and the availability of vaccine.

Multi-Agency Response

- 7.3 Phase 3 of this plan will require the formation (if not already in existence) of the nationally accepted structure for command & control of major incidents, of which there are 3 levels:

- 1. Strategic (Gold)**
- 2. Tactical (Silver)**
- 3. Operational (Bronze)**

- 7.3.1 The three management levels are recognised in this plan. This enables the integration of management processes across the responding agency boundaries. Each responding agency will initiate their internal procedures for complying with the requirements of the multi-agency response.

8 OPERATION

Venues

- 8.1 During Phase 1 normal primary care services will be used.
- 8.2 In Phase 2 it is anticipated that GP practices and local community Hospitals will be used as local vaccination centres.
- 8.3 Because of the changing nature and the number of General Practitioners; Community Hospitals and the services that they deliver a full list is not listed here.
- 8.4 A full and up to date list will be provided on implementation of this plan by each respective Primary Care Organisation.
- 8.5 Since Phase 3 involves most, if not all, of the population of the LRF area , there is no question of maintaining 'business as usual'. Therefore Local Authority controlled premises *will* be taken out of normal use and prepared as mass vaccination centres.

Welfare

8.6 Centres should be set up and equipped to provide basic facilities: sheltered queuing, toilets, seating, drinking water etc. It is not clinically necessary to remain behind for a limited time period post vaccination, so in order to keep the centres running efficiently, people will not be encouraged to stay longer than necessary to receive the vaccination.

Staffing

8.7 In phase 1 it is anticipated that GP practices with additional support from PCTs will deliver vaccinations to the at risk groups, outside of the school aged children cohort who will be offered a schools based vaccination programme delivered by a combination of Specialist Community Public Health Nurses such as School Nurses and Health Visitors, supported by other PCT staff. It is anticipated that staff delivering vaccination will be operating under a National Patient Group Direction.

8.8 It is anticipated that during phases 2 and 3 that the disease would have resulted in some loss of clinical workforce either as a result of illness or caring responsibilities. Therefore alternative mechanisms of staffing vaccination centres have been considered.

Staff numbers

8.9 As stated above, this document does not suggest numbers of staff required for each vaccination centre, as this will depend upon the structure of the vaccination programme. This will be detailed in the PCTs operational plans for mass vaccination but will include.

- Staff – Senior clinical staff for treatment for adverse effects.
- Staff for preliminary pre assessment- see 8.7.1 below
- Senior clinical staff for re-assessment of those failing the preliminary re-assessment pathway.
- Staff to administer vaccine see 8.7.1 below
- Staff to record vaccine details (clerical)

8.9.1 Ideally these tasks would be undertaken by clinical staff. In the event of a mass vaccination with some shortages of such staff, these roles could be undertaken by non clinical staff who have been given appropriate training and satisfy the governance arrangements of the commissioning organisation.

Modelling Assumption

8.10 This modelling is based on the work done previously as part of the smallpox planning for mass vaccination within a short time period. It should be a helpful guide to enable appropriate operational planning to be put in place for all three scenarios.

8.10.1 The following is aimed to help guide PCTs, Local Authorities and GP practices in identifying the number and type of premises which will be fit for purpose for mass vaccination centres. The assumption is based on 80% of the population being vaccinated over a 3 day period with 48 hours allocated to the setting up of vaccination centres and the training of vaccinators. It is anticipated that the vaccine will be available in multi-dose vials therefore requiring additional work in drawing up individual doses.

1 Vaccination Station staffed by 2 vaccinators can vaccinate one person every 2 minutes which equates to 30 people per hour. This task cannot physically be done for the whole shift therefore it is anticipated that vaccinators will switch between roles and extra personnel will be required.

Based on a 9 hour shifts = max 270 vaccinations per station. However for planning assumptions we work on 250 per shift which will allow for some breaks.

1 vaccination station per vaccination centre = 500 vaccinations per day

** Based on a 18 hour working day (2 shifts of 9 hours)*

Number Vaccinations Centres	Number Vaccination Stations	Number Vaccinated per day	Total Number vaccinated after 3 days
1	1	500	1,500
1	2	1,000	3,000
1	3	1,500	4,500
1	4	2,000	6,000
1	6	3,000	9,000
1	8	4,000	12,000
1	12	6,000	18,000
1	20	10,000	30,000
1	166	83,000	250,000

A single vaccination centre would require the following staff:

Number of Staff minimum requirements	1 vaccination station		2 vaccination stations *	
	per 9 hour shift	Total for Day	per 9 hour shift	Total for Day
Vaccinators	2	4	4	8
Clinical Staff	1	2	1	2
Admin / Management	3	6	3	6

*If additional stations are used this requires multiples of the staff resources. Security issues are not included in the modelling although may become necessary if large scale centres are used.

Modelling the number of vaccination stations required (80% of total list size)

Scenario 1 (small GP Practice -1875 list size)

Vaccinate 1,500 patients in 3 days = 1 vaccination station

Staff per shift = 4 trained vaccinators, 2 clinical staff, 6 admin/management.

Scenario 2 (medium size GP practice - 7,500 list size)

Vaccinate 6,000 patients in 3 days = 4 vaccination stations

Staff per shift =16 trained vaccinators, 4 clinical staff, 12 admin /management staff.

Scenario 3 (Large GP Practice – 15,000 list size)

Vaccinate 12,000 patients in 3 days = 6 vaccination stations

Staff per shift = 24 trained vaccinators, 6 clinical staff, 18 admin /management.

Scenario 4 (Locality/community level – 37,500 people)

Vaccinate 30,000 patients in 3 days = 20 vaccination stations in a large centre

Staff per shift= 80 trained vaccinators, 20 clinical staff, 60 Admin/management & stewards and or security staff determined after appropriate risk assessment.

Equipment and consumables

8.11 Each vaccination centre will require the following equipment:

Item	Sourced from
Admin and clerical supplies for recording data	PCT
Personal Protective Equipment such as gloves (PPE)	National stockpile
Equipment for administering the vaccine	National stockpile
Scales for children (if weight related dose needed)	PCT
Sharps bins	NHS supplies
Drugs (plus paediatric dosing schedules) <ul style="list-style-type: none"> • Adrenaline for anaphylaxis 	PCT

Infection Control

8.12 This section refers to infection control procedures, local procedures will be followed and detailed in PCTs operational plans for mass vaccination.

8.13 The PCTs have access to the national stockpile of PPE and also have made contingency plans locally.

Patient Records

8.14 It will be necessary to record certain details about patients and the vaccine they receive. It is assumed that in Phase 1 normal Primary Care reporting systems will be used to record the vaccination. However, in Phases 2 and 3 the proforma in Appendix 1 can be used to fulfil this function. It is designed to be completed by the patient.

8.14.1 The proforma will perform several functions:

- Provide patient information pre-vaccination.
- Provide a structured questionnaire to facilitate screening pre-vaccination.
- Act as a record of screening.
- Act as declaration of understanding/consent by patient or carer.
- Act as a paper record of vaccination including batch details.
- Act as a record of consultation for those requiring more detailed assessment by clinical staff prior to vaccination.
- Provide a separate sheet which can be detached as a patient advice leaflet.

8.14.2 The proforma can either be retained or the information inputted onto clinical or other systems. The speed at which this is done will depend on work force capacity and the requirements of the government reporting system.

Language Issues

8.15 The proforma will need to be piloted to assess suitability. The proforma can be produced in different languages depending on the predominant language requirements of the local population. For ease of assessment, the sections requiring patient answers can be written in the target language, with the English version directly beneath. There should also be a line asking "do you have any other concerns". In this way, if the person has answered the screening questions indicating they have no contraindications, and have signed to say they have read and understood the guidance, they can be directed to receive the vaccine.

8.16 If further assessment is required, translation books and access to language line should be available. Rather than having multiple versions available at all sites, it may be preferable to have one version stored on a lap top and printed as required.

IT Support

8.17 It is not possible to determine the level of IT support that may be needed at this stage. Therefore this issue will need to be addressed when the exact details of the mass vaccination campaign are known.

9 SECURITY, STORAGE AND DISTRIBUTION

Security

9.1 The issue of security needs to be considered in terms of the receipt of the delivery, storage and distribution of the vaccine. It has been assumed that the Police and Armed Forces will not in the event of a pandemic have sufficient capacity to provide security for the vaccine at local levels. The use of normal primary care systems should reduce the need for this.

Storage

9.2 Storage planning assumptions for the vaccines (based on requirements for current seasonal flu vaccine) include:

- To be kept at 2-8°C, protected from sunlight and should not be frozen
- Sufficient space to retain the second dose of the course for every member of local population
- Special arrangements dependent on vaccine (i.e. single dose or multi-dose preparation)
- 'First in first out' stock management principles should be adhered to, to ensure effective stock rotation
- Approved refrigerators are available for the storage of pharmaceutical products, and must be used for vaccines and diluents.

9.3 The specific plans for storage will need to be confirmed when the availability of the vaccine is announced. The facilities required will depend on the amount of vaccine likely to be available. Early indications are that the NHS will be able to draw down stocks in line with their delivery plans therefore it is not anticipated that PCTs will need to store whole population stocks at the same time.

Distribution

9.4 The distribution mechanism may vary depending on the phase of implementation and therefore the number of centres that require a supply of the vaccine. A stock control system will also be needed to ensure there is a clear audit trail of where the vaccine has been delivered to.

9.5 It is vital during the distribution phase that the cold chain is maintained in order to ensure the vaccine remains viable. Domestic cool boxes should not be used to store, distribute or transport vaccines. Validated cool boxes (with maximum – minimum thermometers) and ice packs from a recognised medical supply company should be used. Individual manufacturers' instructions should be strictly adhered to.

9.6 Vaccines must be kept in the original packaging, wrapped in bubble wrap (or similar insulation material) and placed into a cool box with cool packs as recommended by the manufacturer's instructions. This will prevent direct contact between the vaccine and the cool packs and will protect the vaccine from any damage, such as being frozen.

10 COMMUNICATIONS

10.1 In order to manage public expectations and reactions, effective communication through the media will be crucial at all three phases of this plan.

10.2 In Phase 1 and 2 the key communication messages will be the explanation of priorities, public reassurance, prevention of public disorder. The communications will be managed by the PCT in conjunction with the Local Medical Committee (LMC). It is anticipated that high priority recipients to be notified through their own work channels or via their GP.

10.3 In Phase 3 (assuming a multi agency response is required) in order to ensure consistency of message, all public communications will be co-ordinated through the multi-agency SCG Media Briefing Centre, which will in turn liaise with Regional and Central Government. The communication messages will focus on the process of calling people to the vaccination centres, emphasis on attending on foot if possible and the identification of non-mobile vulnerable people.

11 VULNERABLE AND HARD TO REACH GROUPS

11.1 Vulnerable and hard to reach groups are defined below:

- Those not receiving communications inviting them to present for a vaccination
- Those unable to process that communication
- Those unable to get to the vaccination centre
- Those unable to notify the PCT they cannot attend/have not received a vaccination

11.2 Each organisation should hold a list of vulnerable people with whom they regularly come into contact. In the event of a need to instigate this plan the lists can be merged and specific actions taken to identify and offer a vaccination where appropriate.

12 AVAILABILITY AND PRIORITISATION

12.1 This will be dealt with at a national level.

13 REVIEW

13.1 This document will be reviewed in three years. The next review date is 1 December 2011.

14 MONITORING, COMPLIANCE AND EVALUATION

14.1 PCTs will be required to implement appropriate monitoring systems and ensure compliance as part of the national reporting requirements.

15 ASSOCIATED DOCUMENTS

15.1 This document should be read in conjunction with the **Devon, Cornwall and Isles of Scilly Local Resilience Forum** Pandemic Influenza Plan.

Adult Patient Vaccination Proforma**Vaccination Proforma for state product/condition****Introduction**

Outline reason for vaccination programme.

Describe what vaccine will do.

Give an estimate of its effectiveness.

Explain what it will not do.

Explain that it may not be suitable for everybody.

Describe the assessment process required prior to receipt of the vaccine.

Patient details

Name

Address

DOB

GP name and address

Pre-assessment questionnaire

Structure in yes/no format with instruction to circle the appropriate answer e.g.:

Contraindications- Are you allergic to eggs? Yes/No

Do you have any other allergies? Yes/No

Medical conditions- Do you have asthma? Yes/No

Current Health- Have you had fever in past 24hrs? Yes/No

The questions in this section will vary according to the product profile. The questions should be phrased in such a way that the answer would normally be No- thus making it easier to spot the "wrong" answer and refer for further assessment.

Complications/side effects

Potential side effects and risk should be explained.

Pre-assessment

Answers checked by.....Name:

Outcome – suitable for vaccine Proceed to vaccination area

Needs further assessment Refer to secondary assessment

Signed.....

Adult Patient statement of understanding and consent

I have read and understood the above guidance and consent to receiving the stated vaccine.

Signed..... date.....

Child Vaccination: Statement by parent or Guardian Proforma

I have read and understood the above guidance, and give consent for vaccination for the following child

Name of child

Signed..... Print name.....

State relationship..... Date.....

Vaccination details

Date (pre-stamped)

Batch number

Staff identification

This page to be retained as a record of vaccination