

Expert testimony to inform NICE guideline development

Section A: Developer to complete

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Guideline title:	Flu Vaccination – increasing uptake
Guideline Committee:	Public Health Advisory Committee
Subject of expert testimony:	Outreach Vaccination Service for Underserved Populations
Evidence gaps or uncertainties:	[Research questions or evidence uncertainties that the testimony should address are summarised below]
	<ol style="list-style-type: none"> 1. What in your opinion are the particular barriers to increasing uptake in this clinical risk group? 2. What factors do you think would facilitate improvements in uptake in this clinical risk groups? 3. Are there particular factors that should be taken into account when making recommendations to this group?

Section B: Expert to complete

Summary testimony: [Please use the space below to summarise your testimony in 250–1000 words. Continue over page if necessary]

Outreach Vaccination Service for Underserved Populations

The term medically underserved in England is applied to populations who experience difficulties accessing routine health care services including essential vaccinations. Homeless people internationally are at increased risk of influenza due to of high rates of smoking, chronic lung disease, other co-morbidities, poor nutrition, and crowded living conditions. Our work has demonstrated that homeless people have high levels of chronic health problems predisposing them to severe complications of influenza, but vaccine uptake levels that are less than half those seen among eligible GP patient groups in England. Current estimates of the proportion of homeless people accessing influenza vaccination who are considered eligible due to a known clinical risk criteria are likely to underestimate the total proportion who are eligible due to high risk of undiagnosed health conditions in this population.

Many health programmes in developed economies routinely offer influenza vaccination to people who are homeless in recognition of their increased risk of severe complications and also due to the public health consequences of congregate living in confined airspaces. Following publication of our research findings demonstrating high rates of vaccine eligibility, high levels of willingness to be vaccinated and low levels of access we advocated for a policy to vaccinate all homeless people living in hostels, accessing daycentres and drug services for influenza, regardless of clinical risk group. We successfully made the case to commissioners for a pan-London universal influenza vaccination campaign delivered alongside the routine screening provided by Find&Treat. Commissioners agreed that a universal service was likely to result in greater uptake in those with diagnosed and undiagnosed chronic disease and would also have the potential benefit of reducing the risk of influenza outbreaks in congregate settings such as hostels and day centres. Commissioners also agreed to extend vaccination to frontline staff working with homeless people, who, while eligible under existing recommendations to vaccinate health and social care staff, were not accessing vaccination services.

1. What in your opinion are the particular barriers to increasing uptake in this clinical risk group?

Service barriers: The principle barrier and cause of exclusion for homeless people, irrespective of existing diagnosed clinical risk conditions, is the low levels of access to and uptake of routine primary care appointment based services. We have been successful in increasing access to influenza vaccination for homeless people in London by adopting the following service model and approach

- a) Outreach – Find&Treat provide a pan-London case finding and case management service for homeless and vulnerable populations which screens around 8,000 people per year for active tuberculosis and blood borne viral infections. We outreach point-of-care diagnostics using a mobile health unit and provide accompanied referral and support for onward care. Influenza vaccination is now routinely offered to all clients accessing the service. This outreach model could be readily incorporated into the routine work of health providers working with homeless and vulnerable populations. Our vaccination

service can function independent to the mobile health unit using a portable cold chain to outreach the service to hostels and day-centres, winter shelters and street populations.

- b) On-the-spot / No appointment: Offering vaccination opportunistically. Appointment based systems are a significant barrier to homeless people. Wherever possible providers should aim to outreach onsite vaccination services to facilities where homeless populations are either resident or attending for other services and support.
- c) Staff attitudes: Many homeless people have got poor experiences of trying to use health services and this is commonly cited as the major reason for avoiding contact with health professionals unless in emergency.

Patient barriers:

- a) **Stigma / misinformation:** As in the general population, homeless people demonstrate low levels of awareness of the importance of vaccination and a range of misinformation that can deter people from accepting the offer of vaccination. Our work has found the key reasons for reluctance / refusal are that the vaccine will cause flu; that the vaccine does not work; that the vaccine provides protection beyond one year; that the person is immune and not at risk; and more extreme examples such as vaccination causes sterility. It is important, as in all vaccination efforts, to ensure that staff can provide clear and reassuring information. This information is often best provided through fellow homeless clients / peers who can act as local flu champions and promote awareness and uptake.
- b) **Trust and engagement:** Providers should involve homeless people wherever possible in the design and delivery of targeted vaccination programmes. Find&Treat have achieved high rates of vaccine uptake by using people with a lived experience of homelessness to work alongside health staff and provide information and support in a manner and language accessible and appropriate to people who are experiencing homelessness.

2. What factors do you think would facilitate improvements in uptake in this clinical risk groups?

- a) Outreach (See above)
- b) Integration - opportunistically offering vaccination alongside other planned and unplanned health care appointments / integrating influenza vaccination with other health interventions including comprehensive health checks and targeted screening initiatives.
- c) Whole team approach – NHS providers should pro-actively engage health and social care professionals who work with homeless people and provide information and awareness resources. It is essential to have clear and consistent messages and multiple offers of vaccination where possible to promote high uptake
- d) Right attitude – (see Staff Attitudes)
- e) Peer led – Flu Champions (See Trust and Engagement)
- f) Word of mouth – this is often the most effective means of disseminating health messages and addressing stigma, misinformation and concerns among homeless people. People who have accepted vaccination should be asked to encourage others to come forward.
- g) Documentation and information sharing - Providing simple vaccination

handheld records can be effective. We provide printed cards documenting the vaccine given, date, by whom and who to contact for further information. We also consent patients to share details with GPs, if the patient is registered, and provide lists of persons opportunistically vaccinated to local specialist GP providers.

3. Are there particular factors that should be taken into account when making recommendations to this group?

High rates of existing clinical risk conditions and low vaccine uptake among homeless people is a clear example of the inverse care law. Local commissioners have a duty to address health inequalities and integrate services and should be encouraged to support local NHS staff in the design and delivery of appropriate targeted influenza initiatives to ensure that underserved populations are able to benefit from vaccination.

References to other work or publications to support your testimony' (if applicable):

Story A, Aldridge RW, Gray T, BurrIDGE S, Hayward AC. Influenza vaccination, inverse care and homelessness: cross-sectional survey of eligibility and uptake during the 2011/12 season in London. BMC Public Health. 2014 Jan 16;14:44.

Bucher S, Brickner P, Vincent R (2006) Influenza like illness among homeless persons. Emerg Infect Dis 12: 1162-1163

O'Connell JJ. Nontuberculous respiratory infections among the homeless. Semin Respir Infect. 1991;6(4):247–53.

Expert testimony papers are posted on the NICE website with other sources of evidence when the draft guideline is published. Any content that is academic in confidence should be highlighted and will be removed before publication if the status remains at this point in time.