Leicestershire Partnership NHS
NHS Trust

Community Pharmacy Immunisation – Fluenz/Flumist Pilot

Tejas Khatau
(Lead Pharmacist – FYPC Service)

Agreed on: 9th November 2015
Review Date: January 2016

1. PARTIES TO THE AGREEMENT

This service level agreement is between Leicestershire Partnership NHS Trust (LPT - the commissioner) and …… (please insert name of pharmacy - the provider) for the period covering 9th November 2015 to January 2016. The agreement outlines the arrangement between the two parties to ensure patients and parents have convenient access to Fluenz/Flumist vaccine.

2. Background

LPT provide a school aged immunisation service offering a variety of vaccines including Fluenz/Flumist nasal spray. Fluenz/Flumist is offered to all children in school years 1-6 across Leicester, Leicestershire and Rutland. To achieve this every school is visited once according to a schedule. Children who are home-schooled are visited in their home to offer the vaccination. LPT are committed to delivering this service via a school based approach. There are occasions where children, whose parents have consented, are not able to have the vaccine on the day of the school visit. The most common reasons are temporary exclusions (e.g. severely blocked nose, fever and wheeze) or the patient is off school on the day of the visit.

3. Aims of Service

- Pilot the administration of Fluenz/Flumist vaccine via community pharmacy for those who missed their opportunity in school;
- Prevent transmission and reduce complications of the 'flu within the community;
- Maximise uptake of Fluenz/Flumist;
- Provide patients and parents with another opportunity to receive the Fluenz/Flumist;
- Provide a service that is accessible, convenient, professional and friendly;

4. Service Outline

- Approximately 10 to 15 community pharmacies will partake in this SLA;
- Ideally these pharmacies will be spread out covering all key locations within Leicester, Leicestershire and Rutland;
- Community pharmacists will offer Fluenz/Flumist vaccine to those patients for whom they have a consent form and authorisation (see appendix 1 for full process outline).

5. Standards

<u>From Pharmacist</u>

a) Comply with the Code of Ethics for Pharmacists as stipulated in the current Medicines, Ethics and Practice;
b) Be available to offer the Fluenz/Flumist vaccine during the hours agreed below;
c) Immediately notify LPT if they foresee any difficulty in meeting their obligation under this SLA;
d) Comply with infection prevention and control measures;
e) Be accredited and delivering the national flu service (implicit within this is up-to-date with training for the management of anaphylaxis, Basic Life Support and availability of adrenaline)

f) Have completed the declaration of competence for the national flu service on the CPPE;
g) Have completed the Fluenz accredited training or completion is imminent;
h) Be competent with the administration of Fluenz/Flumist;
i) Be aware of the cautions and contra-indications for administering Fluenz/Flumist on the day (regardless of the authorisation);
j) Counsel the patient and parent on the process, complications of the flu and benefits of immunisation;
k) Seek informed consent before proceeding;
l) Ensure privacy and dignity;
m) Following vaccination, ensure that the claim form is faxed back within 2 working days;

From Pharmacy

a) Be located within Leicester, Leicestershire, Rutland or surrounding areas easily accessible by patients/parents;
b) Comply with all requirements of NHS England and General Pharmaceutical Council;
c) Have a fully functioning (ideally pharmacy/medicines grade) refrigerator;
d) Check refrigerator temperature once daily when pharmacy is open and act accordingly to any breeches;
e) Ensure stock rotation;
f) Have up-to-date SOP to cover cold chain arrangements of refrigerated medicines;
g) Clean and tidy consultation room;
h) Ensure empty syringe is disposed in a sharps bin;
i) Ensure sufficient supply of Fluenz/Flumist is available to fulfil vaccinations. Promptly email communityimms@leicspart.nhs.uk or fax 0116 295 8301 the LPT immunisation team to order more vaccines;

From Leicestershire Partnership NHS Trust

a) Actively follow up all patients for whom there was consent but were unable to receive vaccine in school;
b) Liaise with parents to offer them a choice of pharmacies or community clinic;
c) Advise parents to make contact with pharmacy prior to attending to identify suitable time/day.
d) Fax the fully completed consent form with an authorisation (Patient Specific Direction – PSD) to the selected pharmacy;
e) Ensure that vaccines are packed and transported in a validated cool box;
f) Responsibility for arranging delivery of vaccines to the pharmacy will be shared between the pharmacy and LPT. This will be negotiated on a case by case basis to ensure best use of existing resources.

6. Monitoring, Review and Audit

a) Feedback will be requested from parents and patients that accessed community pharmacy around their experience. This will be via a survey and/or a stake holder event;
b) Total number of vaccinations delivered by community pharmacies and a break down by pharmacy and area. Day of the week and time of the day vaccination took place will also be reviewed.

7. Costs and Invoicing Arrangements

a) £3.50 per patient vaccinated;
b) Invoices must be submitted promptly to Immunisation team via fax 0116 295 8301.

8. Duration, Re-negotiation and Contract Changes

The duration of this agreement is from 9th November 2015 to January 2016.

9. Complaints and Serious Adverse Events

Complaints and serious incidents will be dealt with through existing processes and in accordance with current Trust policy.

10. Termination of the Agreement

In view of the short duration of this agreement, an early termination is not permitted; unless a party is in breach of the terms of agreement,

11. Authorisation to the Agreement

I/We agree to abide by the requirements of this agreement and the monitoring arrangements contained therein.

Community Pharmacy Signatory

Name: **Position:**

Signature: **Date:**

Pharmacists Providing the Service and Their Typical Working Pattern

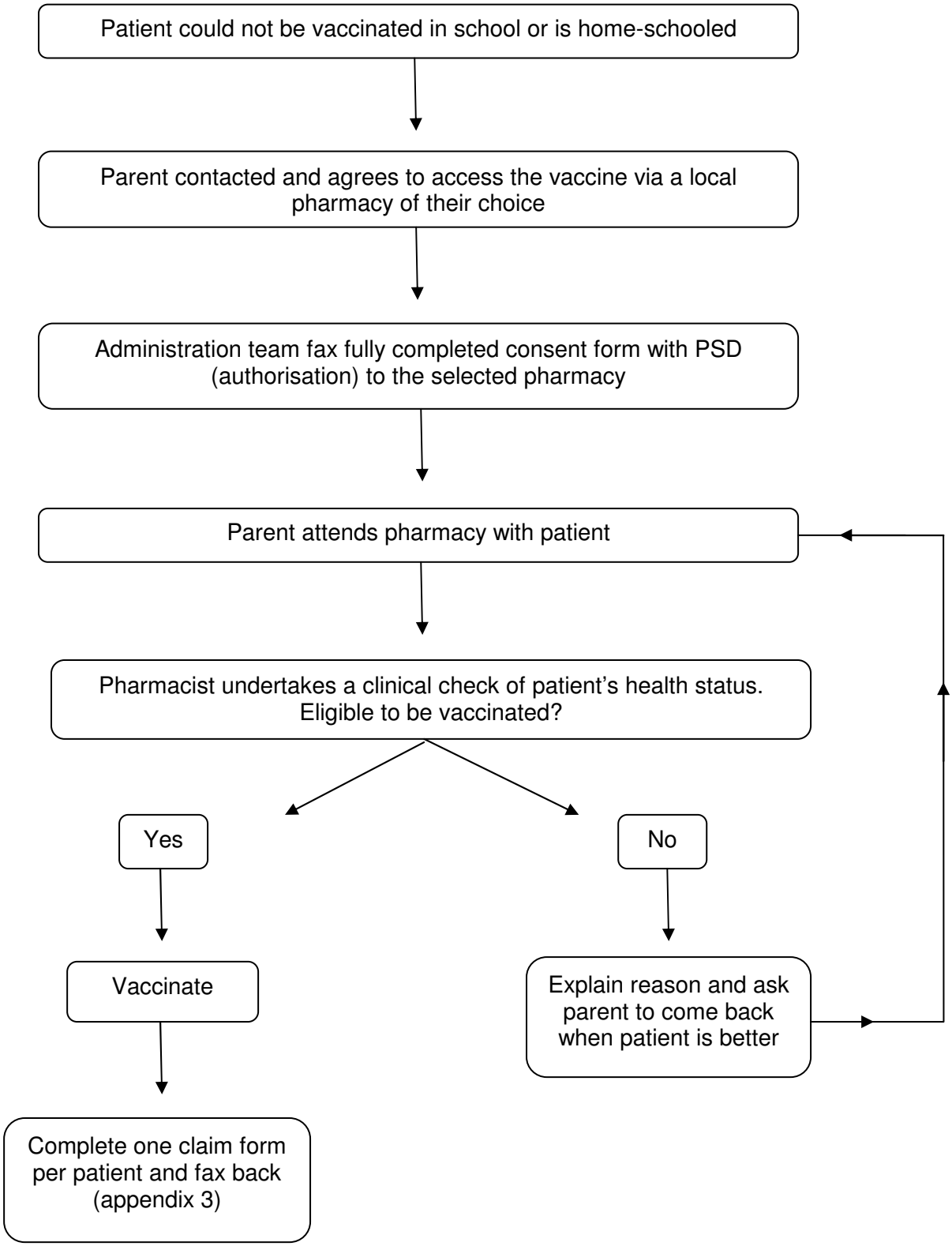
Name of Pharmacist	Typical Working Days	Typical Working Hours

Signed on behalf of LPT

Tejas Khatau (Lead Pharmacist – FYPC Service)
……
Name

09/11/2015
……
Signature & Date

Appendix 1 - Outline of Process



Appendix 2 – Example of Consent Form

Important information: Please read the accompanying patient information leaflet and the notes section on the letter before completing this form.

Please complete this form fully using BLOCK CAPITALS and black/blue ink.

ONLY ONE CHILD PER FORM.

PART 1: Patient Information and Contact Details			
Child's Surname:			Child's NHS Number:
Child's First Name:			
Child's Date of Birth:		Age:	Child's Gender: ☐ Male ☐ Female
Name of School:			Home address:
School year:	Class:		Postcode:
GP surgery:			
We may wish to contact you to discuss any queries and for feedback. Please provide your contact details.			
Daytime contact number:			Evening contact number:
Email address:			

PART 2: Consent Declaration (complete only ONE part below)

I confirm that I have parental responsibility for the above named child.
I have read and understood the information given to me about the flu vaccine.
I understand that information provided will be shared with my GP to update my child's health record.

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

☐ **YES, I CONSENT** to the injectable flu vaccination only if Fluenz Tetra® nasal vaccine is not suitable due to medical reasons.

Parent's name: .....

Parent's signature: ..... ✍

Date: .....

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

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)* .....

.....

Parent's name: .....

Parent's signature: ..... ✍

Date: .....

Your relationship to the child *(circle as appropriate)*:

- Mother / Father
- Step Mother / Step Father
- Formal care arrangement with a court order - Kinship (Family/Friend) Carer / Foster Carer / Residential Care worker / Adoptive Parent / Special Guardianship
- Informal care arrangement by Family or Friend

Continue to PART 3: Medical Information

Your relationship to the child *(circle as appropriate)*:

- Mother / Father
- Step Mother / Step Father
- Formal care arrangement with a court order - Kinship (Family/Friend) Carer / Foster Carer / Residential Care worker / Adoptive Parent / Special Guardianship
- Informal care arrangement by Family or Friend

Thank you for completing this form.

Please turn over for additional questions

PART 3: Medical Information

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

	Yes	No	If yes, please give details:
1. Has your child had their flu vaccine since September 2015 at the GP surgery?	☐	☐	*Date:*
2. Does your child use inhalers on a **daily** basis for asthma?	☐	☐	*If yes, please refer to the patient information leaflet for additional key information before completing the box below.*

Please refer to the prescription or the label on the inhaler.

Drug name and strength	**Dosage**	**How often**
EXAMPLE: Clenil Modulite inhaler 100 microgram	*2 puffs*	*Twice a day*
.....	.....	.....
.....	.....	.....
.....	.....	.....

	Yes	No	If yes, please give details
3. Has your child had a bad reaction to **any** previous flu vaccine or to an antibiotic called gentamicin?	☐	☐	
4. Does your child have an anaphylactic reaction (severe allergy) to eggs, which has been confirmed by a specialist doctor or at an allergy clinic? *See patient information leaflet for the definition of "anaphylactic".*	☐	☐	
5. Is your child receiving oral salicylate therapy (e.g. aspirin)?	☐	☐	
6. Has your child got a health condition that severely weakens their immune system (e.g. receiving treatment for leukaemia)?	☐	☐	*If yes, please include the name of the condition, drugs prescribed and consultant.*

7. Is anyone in your family currently having treatment that severely weakens their immune system (e.g. bone marrow transplant recipient requiring isolation)?	☐	☐	*If yes, can your child avoid close contact with them for two weeks after receiving the nasal flu vaccine?* ☐ **Yes** ☐ **No**
8. Has your child been diagnosed with a bleeding disorder (e.g. Von Willebrand disease or haemophilia) or are they taking anticoagulant therapy (e.g. warfarin)?	☐	☐	

Thank you for completing this form.

OFFICE USE ONLY	**Inputted**		**Scanned**	

Child not immunised today due to:	*Circle one*	
Absent	DOB out of range	
Unanswered medical query	Unsigned form	
Not well on the day	Rhinitis on the day	
Vaccination at GP	Previous severe reaction	
Confirmed anaphylaxis to egg	Salicylate (oral) therapy	
Immunosuppression (child)	Immunosuppression (family)	
Child refused (partially given)	Child refused (none given)	

Given under:	☐ PGD	☐ PSD
Vaccine type:	☐ Fluenz Tetra	☐ Injectable
If injectable given, site of injection (arm)	☐ Left	☐ Right
Batch no. and exp. date		

Second dose referral letter completed ☐

NOTES:

Name, signature and date

PSD

***
Authorisation (PSD) stamp will be here
***

Appendix 3 – Record of Vaccination and Claim Form

Patient Details

Patient Name	

Patient DoB	
Patient NHS Number	

Vaccination Details

I confirm that I have administered Fluenz/Flumist *(delete one)* at a dose of 1 spray in each nostril.

Batch Number:

Expiry Date:

Date of administration:

Time of administration:

Additional Comments/Notes (optional)

Pharmacist Name:

Pharmacist Signature:

Pharmacy stamp/details:

Please fax completed form to 0116 295 8301 within 2 working days.

NOTE: One form per patient please