**THE PUBLIC HEALTH RISKS EMERGING AS A RESULT OF ROUTINE PROCEDURES - SUCH AS CHILDHOOD VACCINATIONS - NOT BEING TAKEN UP DURING COVID-19**

**INTRODUCTION**

**Prevention is so much better than cure**: There are many prevention programmes designed to prevent and detect diseases at an early stage to stop them causing death and illness. These are some of the most highly cost-effective healthcare interventions; a review by NICE found that 85% of 200 case estimates of prevention programmes were cost effective. Vaccination programmes are the most cost-effective healthcare interventions

**Amazing efforts by staff:** During the COVID19 pandemic, many services have been impacted through being suspended, or by reducing services. Some may also have been affected by the public reducing their uptake. Staff in public health programmes have been going to heroic lengths to deal with the pandemic while keeping essential preventive services going

**The paltry and reducing investment in prevention and early diagnosis is now under greater threat** There is a high risk that prevention programmes will lose out for investment when finances are reduced, as will happen during the coming recession. Many of these programmes have already been deeply affected by austerity, in particular those commissioned by Local Authorities in England.

**Recovery plans**: The NHS is attempting to restart, and this must be fully funded and adhere to principles of patient and staff safety and equity. There has been a lot of great local integration and innovation in the face of a common threat, and this must be nurtured and not used as an excuse for cutting costs. Digital ways of working are not cheaper and not a replacement for face to face in many situations long term

**What is most urgent:** We believe that those programmes which are likely to present the highest risk of adverse health outcomes if not returning to full service very soon are:

1. Child and adult vaccination programmes
2. Preventing unplanned pregnancies and STIs
3. Screening programmes
4. Safeguarding for children and adults
5. Smoking cessation services, drug and alcohol services
6. Mental health and wellbeing promotion

**Here, we focus on the first three**. These are mostly delivered in primary and community care settings, so that they will be impacted by the suspension of much routine Local Government, local NHS and GMS work during the pandemic (for example, GPs have been asked to suspend all non-urgent provision)

The health visitors and school nursing services are already severely stretched and have been affected by the school closures and reduction in face to face contacts. School nursing should be restored, revitalised and established as the public health adviser to the school.

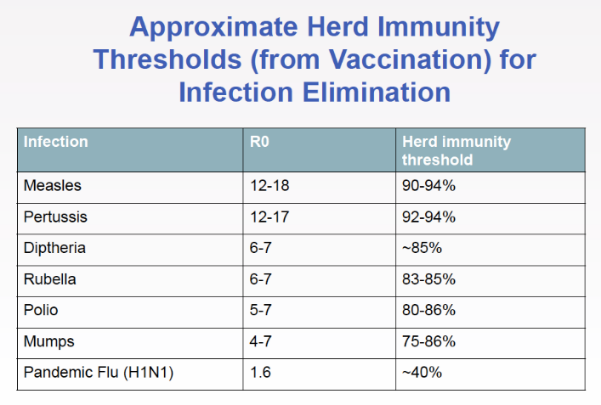
We are also concerned at the fallout impact of fake news related to COVID19 on the delivery of these programmes, which is an ongoing battle, especially for some vaccinations

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| **Key Messages**   * **Childhood vaccination programme:** the recent increase in vaccination coverage after a long fall has now been thrown into jeopardy by COVID19, with little resilience in primary care and public health departments to systematically and actively promote catch up programmes. * **Measles:** there would be a significant risk of measles outbreaks because MMR coverage in England among children was well below the threshold required for herd immunity in most areas. Measles is highly infectious with an R0 of 16 * **Influenza** vaccination programmes for children and adults will begin in September. It is vital to achieve a much higher uptake, to reduce the risks of having to manage a flu epidemic while COVID19 is still circulating. * **Screening services** should restart as soon as possible, with safety measures in place for patients and staff, and a plan for catching up all who have missed out * **Sexual health and contraception:** there is a serious risk of losing the excellent gains of the last Labour Government’s Sexual Health and Teenage Pregnancy strategies, after major cuts in the public health grant. We need a new sexual health strategy with a return to planning and collaboration rather than tendering of services * **Prevention spend**: The Government should restore public health expenditure in England to at least previous levels |

**CHILDHOOD AND ADULT VACCINATION PROGRAMMES**

**Situation:**

The routine programme is highly effective in protecting children and young people against the killer infectious diseases of childhood[[1]](#footnote-1) Most vaccine preventable diseases have high R0 numbers and require high coverage levels for effective herd immunity



Source: A. Rodger UCL and Royal Free NHS Foundation Trust

Some countries have seen falls in immunisations e.g. USA and Africa. The polio eradication and measles programmes are suffering. This will of course have a global impact and will be a potential source of infection causing UK outbreaks especially as travel increases again.

The routine adult vaccination programme is against pertussis (pregnant women) , pneumococcal pneumonia, influenza and shingles (older people and those with chronic conditions). Other vaccinations are targeted at specific high-risk groups and we believe that these are the most important to maintain, including through sexual health services and drug and alcohol services. There are inequalities in coverage of some vaccination programmes, placing some groups at even greater risk of harm and widening inequities in health

Vaccine “hesitancy” is a natural response, and the anti-vaccination movement has exploited this for many years, aided by social media. There has been an increase in misinformation during the COVID19 pandemic, and this may spill over into vaccination

**Challenges**:

* **Unknown impact:** The exact impact on uptake of all vaccinations will not be fully understood until next year.
* **The out of school childhood vaccination programme has not been suspended** and messages have been clear to providers and parents to continue as usual. There are some indications that uptake of the first vaccinations at 8 weeks old has not fallen. However, disruptions to the provision of primary care during this crisis could further undermine population levels of herd immunity, particularly in large cities eg London. Many GP Practices have started to phone parents before the vaccination is due to address concerns and increase attendance: this can shorten the face to face consultation time
* **Measles is a major concern:** MMR coverage in England among children aged 24 months had already fallen well below the threshold required for herd immunity in most areas. UK had attained WHO elimination status, but it was withdrawn because measles is spreading in the community. One analysis of health records showed that uptake of the first dose of MMR dropped by about 20% in early April, with some later recovery. The uptake of the second dose of MMR during COVID-19 is not known, but as the emphasis has been on the vaccinations given up to and including 12 months, it is possible this has fallen.

Over 60% of 754 health visitors responding to a survey in May 2020 by Institute of Health visiting reported contact with families who had cancelled or postponed their children’s vaccinations. (personal communication iHV)

* **Flu vaccination programme**: this will start in September and will be extended to at least one further school age group this year. Children can be at risk from flu and younger ones are an important source of onward infection. Children are vaccinated largely in school settings, and adults in GP Practices: this will pose additional challenges this year because of measures to reduce COVID transmission. At the same time, it is even more important that coverage is very high this year. It would be exceedingly difficult to manage a flu epidemic while COVID19 is still circulating
* **the Meningitis ACWY vaccination** at age 14 is important to catch up, as this has been suspended while schools are closed, to prevent meningitis cases rising over this winter. For other teenage vaccinations such as DTP boosters and HPV, timing is less vital and a few months delay is unlikely to have a major impact.
* **Pregnancy pertussis vaccination** coverage was 68.8% in 2018/19 in England and any further drop will risk the return of whooping cough in young infants. In 2012, there was a major rise in pertussis infections resulting in deaths in young infants. Pertussis vaccination in pregnancy was introduced and this has resulted in a major reduction in infant deaths. However there have been deaths (one in each of 2018 and 2019) in infants of unimmunised mothers. The provision of the vaccine to pregnant women is either via midwifery service or GP and it is often not clear who should do it.
* **HPV vaccination** for girls aged 12 to 13 is reaching its 80% target in all 4 UK countries, and needs to maintain this to help eradicate HPV-associated cervical and other cancers. HPV vaccination was introduced to boys of the same age last year, without a catchup programme
* **Targeted immunisations**, such as those given in sexual health and drug and alcohol misuse settings may not have been given and there will be a backlog there. BASHH reports that 1st Hep A, B and HPV vaccine for high risk patients are being maintained but put repeat doses on hold, unless very high risk.
* **Coronavirus vaccine**: If an effective coronavirus vaccine is produced, the majority of the public will probably accept it, however we are concerned that uptake may be affected because of genuine doubts about a vaccine that will have been produced very quickly, or disinformation about it.

**Actions**:

* **Closely monitor the childhood vaccination programmes and put in catch up campaigns** if any sign of a drop, especially for MMR. Anti-vaccination sentiment is probably not the main factor in the UK. Access, infrastructure and information provision are probably more important. Measures to ensure equity of coverage for all must be strengthened
* **Plan a major flu vaccination campaign** with additional resources, removing previous barriers and using a greater variety of delivery mechanisms to ensure even higher uptake this year, including in health and social care workers
* **Plan a Meningitis ACWY catch up** campaign for teenagers
* **Clarify delivery of pertussis vaccination** in pregnant women to increase uptake
* **Primary Care should actively work with local partners to increase vaccination uptake** using innovation such as the now usual practice of contacting parents with a phone call before the vaccination appointment, to address concerns and increase attendance
* **Prepare a public messaging campaign for a new coronavirus vaccination** well in advance
* **Excellent call recall systems**: to maintain a proper service and to catchup on any missed immunisations requires a good IT system and a call-recall system. It should be proactive and not rely on parents/patients to remember and get in touch with services.
* **Staff should be professionally trained** to answer the mostly predictable questions from parents.

**SCREENING PROGRAMMES**

**Situation:**

Newborn bloodspot, and the newborn examinations, have been barely affected. Initial problems with newborn hearing screening were rectified.

Routine screening programmes - breast, bowel and cervical cancer screening, aortic aneurysm and diabetic eye screening have been paused in Scotland, Wales and NI. In England, while there has been no official announcement, screening has also, in effect, been suspended. Although some screening programmes are restarting now, we are concerned that this will take time and have adverse impacts

NHS England monthly performance data in June showed 60% fewer people with suspected cancer were urgently referred to a specialist in April compared to the same month in 2019 and the number of first treatments for cancer fell by 21%. This includes all referrals from GPs and screening services with no breakdown of the data, but will certainly include some people whose cancers would have been diagnosed through the screening programmes, who will now have a delay in diagnosis and treatment.

**Challenges**

* **There will be a large backlog of screening and follow up of abnormal results**, and there will be people presenting with more advanced disease.
* **Restarting services will be difficult** because of measures to protect patients and staff will impair efficiency

**Actions**

* **Screening services should restart as soon as possible**, with safety measures in place for patients and staff
* **Alternative ways of screening should be more rapidly explored**, for example the potential to move to more self-taken HPV tests to reduce clinical examination
* **There should be a review of the impacts of suspending screening services**, and a strategy in place in each of the Devolved Nations to prioritise people for catchups

**CONTRACEPTION AND SEXUAL HEALTH**

**Situation:**

Contraception and sexual health services are provided through a mix of primary care, community, private/ not for profit and secondary care sectors. Sexual health services in England have been commissioned through Local Government using the Public Health grant since 2012, which has been cut significantly. COVID19 has caused many of these services to be suspended, reduced, or moved onto fewer sites, thus reducing access. Much has been moved to a digital service, but much still requires face to face consultations, for examination, treatments, contraception provision or vaccination.

**Challenges**

* **Significant drop in access to most non-emergency services**: The British Association of Sexual Health And HIV (BASHH) carries out regular surveys of clinicians and in May 2020, clinicians reported an immediate pattern of difficulty in maintaining services for a range of populations, despite service mitigations such as telephone and digital solutions. Only 28% of sites are currently operational with many closed due to lockdown restriction, with many bringing services onto one site. Over half of respondents (65%) reported overall capacity was >60% (vs 51% in April). The impact was most pronounced in populations with vulnerabilities or with the most complex needs.
* **Contraception:** Many services may have virtually stopped providing Long Acting Reversible Contraception (LARC), such as Implants and IUCDs. These have been key to reducing unplanned pregnancies particularly in young women. We are concerned that there may be longer term delays to getting back to full service provision, so a reduced use of LARCs may lead to an increase in unwanted pregnancies
* **Abortion care:** policy on access has changed several times, although services have remained open throughout. Medical abortion by taking tablets at home was approved in March and continues
* **Sexually transmitted infections**: Routine STI testing may have been affected, as services are restricted and as NHS laboratories have been diverted into COVID testing. As unidentified cases are not treated and therefore there is no contact tracing, there is a risk of increasing incidence of STIs and outbreaks

**Actions**

* **Campaign for a new sexual health strategy** with a return to planning and collaboration rather than tendering of services.
* **Services should be fully funded and make locally informed decisions** to prioritise returning face to face capacity. This should not be an opportunity to save money through more digital services which are sometimes an appropriate way to provide care, but not cheaper if provided to a high quality.
* **The top priorities** are
  + Vulnerable Populations where there is evidence that lack of access is causing harm
  + Complex clinical & non-clinical need
  + Access to Long Acting Reversible Contraception (LARCs)
* **Medical abortion should continue to be available through telemedicine** even as face to face services return, and be considered to become available long term

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