

Clinical and scientific letters

Letters not directly related to articles published in *Clinical Medicine* and presenting unpublished original data should be submitted for publication in this section. Clinical and scientific letters should not exceed 500 words and may include one table and up to five references.

A cross-sectional audit of the uptake of the seasonal influenza vaccination by medical staff at a London hospital

As clinicians, we have a responsibility to protect our patients from infection. This includes vaccination against transmittable illnesses. The *Seasonal flu plan* from the Department of Health states that the flu vaccine ‘protects healthcare workers’ and ‘reduces the risk of transmitting the flu to their vulnerable patients’.¹ It recommends that all healthcare professionals and social care workers with direct patient contact undergo flu vaccination.¹

In February 2013 we conducted an audit of 52 medical staff to get a cross-sectional view of flu vaccine uptake at Charing Cross Hospital, London, UK. The audit was conducted anonymously in questionnaire format. Our audit showed that only 35% of staff had been vaccinated against influenza for that winter. Of the 35% that did have the vaccine, most were physicians rather than surgeons. There was no significant difference between level of seniority and vaccination uptake. Eight of the 18 people who had the vaccine still contracted influenza during the winter.

The most common reason for not having the vaccine was a lack of awareness of its availability. Other common reasons included previous experience of side effects, concerns regarding vaccine efficacy and a fear of needles or injections (Fig 1).

Of all 52 respondents, 29 (58%) knew about the Department of Health guidelines advising all clinical staff to have the

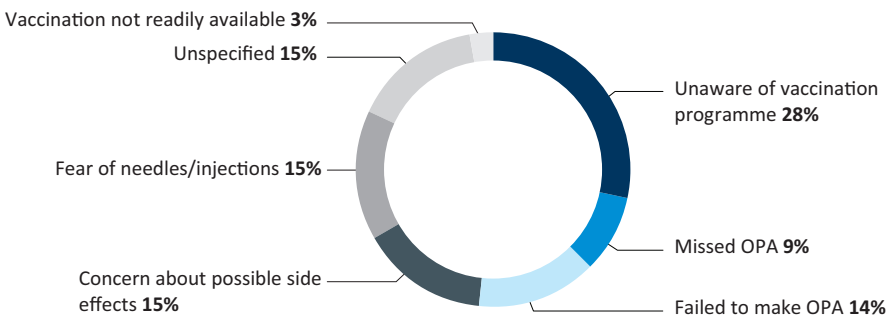


Fig 1. Reasons given by medical staff at Charing Cross Hospital for not having influenza vaccination in winter 2012–13. OPA = outpatient appointment.

flu vaccination. A large proportion (38%), equally divided between physicians and surgeons, knew of the guidelines and yet still did not have the vaccine. Over half of foundation year (FY) 1 doctors were unaware of the guidelines, whereas this was the case for only 2 out of 7 consultants.

A significant proportion of medical staff in this hospital failed to be vaccinated, which raised some important issues. We recognise the limitations of our small sample size, yet our findings are in line with national figures revealed in the Public Health England report *Seasonal influenza vaccine uptake amongst frontline healthcare workers (HCWs) in England: Winter season 2012/13*.² This revealed a 42.4% uptake among all doctors, excluding general practitioners. This suggests a significant failing of health protection policy. While some barriers to vaccination are not modifiable, there needs to be more emphasis on education of medical staff. This is particularly evident among FY doctors, who are an important group to target in order to influence future vaccination uptake rates as they progress through their medical careers. Concerns about vaccination efficacy are understandable as there is a dearth of good evidence. A systematic review did suggest significant reduction in mortality due to pneumonia and all causes if both patients and healthcare workers were vaccinated.³

In order to improve vaccination rates, we suggest that the vaccine should be offered routinely as part of the occupational health screening. Additionally, vaccination information should be delivered as part of hospital trust induction programmes.

Consultants in particular should emphasise the importance of vaccination to their junior staff as part of their commitment to public health protection.

There is evidently significant margin for improvement and strategic measures should be implemented to improve vaccination uptake as part of our duty of care to our patients.

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