LONDON ASSEMBLY

Health Committee

Infant immunisation

January 2003

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Chair's foreword

London's Health Service does a remarkable job in providing care and support to all Londoners. It is a testimony to the dedication of all health professionals, care workers and NHS management that Londoners receive, in general, very high levels of care.

The London Assembly is empowered by law to scrutinise any issue considered to be important to Greater London, including health issues. This scrutiny is carried out by the Assembly's Health Committee. Our scrutinies are designed to bring political and public focus to issues of immediate concern to Londoners.

One of the issues that is currently provoking public debate in London is that of child immunisation. It is for this reason that the London Assembly's Health Committee chose this subject for the first in its series of short scrutinies.

The infant immunisation scrutiny has been carried out on a cross-party basis and I am grateful to my fellow committee members for their commitment to this. I would also like to pay tribute to Dr Sue Atkinson, Director of Public Health for London, who so generously gave of her time and knowledge.

As lay people we cannot, of course, give recommendations on the efficacy or otherwise of immunisation. The purpose of the report is to summarise the evidence presented to us and to highlight for further consideration areas where we believe information is lacking or where the Department of Health's position is not sufficiently clear. Consequently, this report contains our recommendations to the Department of Health.

Elizabeth Howlett
Chair of the London Assembly Health committee

The Health Committee

The London Assembly's Health Committee was established in May 2002. It has a unique role, in that unlike local authorities and other organisations, it can identify and investigate health issues that are of concern to London as a whole. The Committee is flexible in its remit, and is not bound to issues emanating from individual localities or health authorities.

The Committee can also work across agency boundaries and encourage participation from the voluntary sector, the private sector and local people, ensuring that these diverse views are reflected in its work.

In May 2002, the Assembly agreed the following membership of the Health Committee for the year 2002/03:

Elizabeth Howlett (Chair)	Conservative
Meg Hillier (Deputy Chair)	Labour
Richard Barnes	Conservative
Lynne Featherstone	Liberal Democrat
Jenny Jones	Green
Trevor Phillips	Labour

The terms of reference of the Health Committee are as follows:

- To examine and report from time to time on:
  - the strategies, policies and actions of the Mayor and the Functional Bodies.
  - matters of importance to Greater London as they relate to the promotion of health in London.
- To liaise, as appropriate, with the London Health Commission when considering the Health Committee's scrutiny programme;
- To consider health matters on request from other standing committees and report its opinion to that standing committee;
- To take into account in its deliberations the cross cutting themes of; the achievement of sustainable development in the United Kingdom; and the promotion of opportunity;
- To respond on behalf of the Assembly to consultations and similar processes when within its terms of reference.

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Executive Summary

London's falling levels of infant immunisation cover present a real threat to the health of young (and not so young) Londoners, and are of grave concern to health professionals and families alike. This is particularly true for MMR (measles, mumps and rubella), but is also true of other serious childhood diseases such as whooping cough and tetanus. Our scrutiny, drawing on the excellent work of Dr Sue Atkinson, Regional Director of Health for London, sets out the evidence in a clear and systematic fashion to show how London underperforms other UK and world cities.

The scrutiny reveals that there is a significant gap in our understanding of why the level of infant immunisation cover has fallen through the late 1990s. Falling public confidence has played a part. A lack of trust in the MMR vaccine may have affected the take-up of other childhood vaccinations. But we highlight a wide variation in health district performance in delivering cover for London's children. The Department of Health has moved to implement action plans in the poorest performing boroughs and we welcome this move. We will return to this issue next year to see whether the action plans have stopped the downward trend in cover.

As London's elected representatives we have concerns that are specific to London that the Department of Health needs to address:

- With an increasingly mobile population, how can the NHS best keep track of infants as their families move in and out of the capital?
- How does the Department of Health intend to ensure that new residents in London have appropriate immunisation cover? Is enough being done at the national level to ensure that new entrants into the UK have sufficient understanding of UK immunisation policy?

Furthermore, we seek to stimulate a national debate on a number of areas where radical action may be needed to deliver a service more suited to the 21st Century. In particular:

- We believe that the Department of Health should initiate a childhood call & recall system to enable children to be recalled throughout their childhood and into adulthood to ensure that no cohort is lost forever to appropriate immunisation cover.
- To close information gaps on levels of vaccination, the Department of Health should require all practitioners who vaccinate using single dose vaccines to provide data to the NHS. The practice should also be required to record and report adverse side-effects to the NHS.

We also have serious concerns over the current incentive structure that pays GPs to deliver the vaccinations:

Will the current financial incentive structure for GPs help deliver higher immunisation levels or is a different incentive structure needed, perhaps rewarding health visitors?

1 Introduction

1.1 Department of Health officials originally briefed members of the Environment Committee in Spring 2002 on the low level of MMR cover in London, and the Committee referred the issue for further scrutiny to the newly established Health Committee. Members of the Health Committee felt that there were a number of significant issues to do with infant immunisation more broadly and moved to hold a single scrutiny session on this topic.

1.2 Members have from the start of the scrutiny been clear that though the MMR vaccination remains controversial it should not be the central focus for this scrutiny.

1.3 **Rather, the focus for this report is the issue of infant immunisation cover across London.** And the Committee's role is to gather and assess the available evidence.

1.4 In late September 2002, the Health Committee launched its scrutiny. The terms of reference for the scrutiny were to:

- consider the current levels of vaccine coverage in London and the related public health issues;
- compare the level of immunisation coverage with other major cities in the UK and abroad; and
- consider what efforts are being made in London to increase vaccination rates and educate the public about the risks of contagious diseases such as TB, measles, mumps and rubella.

1.5 The Committee received a number of written submissions from the medical profession as well as contributions from JABS (Justice, Awareness and Basic Support) and from SENSE (The National Deaf Blind and Rubella Association). In October, we held a one-off session with Dr Sue Atkinson, Regional Director for Public Health in London, to discuss issues surrounding childhood immunisation in London. We are grateful for the time she and her team dedicated to increasing our awareness and understanding of this complex issue.

1.6 This report presents our considerations and concerns. In the spirit of encouraging a positive dialogue between the Department of Health and the London Assembly we make a number of recommendations to which we wish the Department of Health to respond.

1.7 Infant immunisation policy is a controversial area to tackle in a short scrutiny. It is an issue where the tensions between public interest and personal choice are brought into sharp relief. Society as a whole must judge the appropriate balance between individual rights and public responsibilities. The UK has a liberal approach to childhood immunisation; we choose persuasion over coercion. However, as serious childhood disease immunisation rates fall there comes a point (as there has, already, with measles) when public health risks escalate, perhaps to unacceptably high levels.

1.8 As a panel of lay people it is not for us to comment on the complex scientific arguments around immunisation, which are best addressed by experts. The purpose of this report is simply to summarise the evidence presented to us and to highlight for further consideration areas where we believe information is lacking or where the Department of Health's position is not sufficiently clear for the general public to appreciate what policy it is trying to achieve and how.

1.9 Our aim is to support the delivery of quality health services and to help Londoners access all available and relevant information they need to take important health decisions.

2 Why vaccinate?

2.1 The case for childhood vaccination programmes as set out by the Department of Health is that "vaccination has been demonstrated repeatedly to be cost-effective, indeed even cost saving, a standard rarely expected of other healthcare interventions"[1]. In her presentation to the Committee, Dr Atkinson emphasised that "public vaccination programmes have saved millions of lives over the end part of the last century. [And] …gives children the best chance of not catching these serious diseases…[I]t contributes not only to the [safety of the] individual child but also to the safety of other children in the family and to communities".

2.2 Central to public safety is the concept of "herd immunity" or group protection. Herd immunity exists where a sufficiently high proportion of the population is vaccinated against a particular disease so that it is harder for that disease to spread across the community if there is an initial outbreak. So the decision to vaccinate does not only affect your child. It affects other children as well. The health profession's desired level of herd immunity varies from disease to disease depending on the infectivity of the disease. For example, measles is very infectious so a very high level of vaccination cover is required to secure herd immunity, whereas mumps is less infectious so herd immunity can be secured with a lower level of vaccination cover.

2.3 Despite such benefits from immunisation cited by health professionals, public concern with the safety and efficacy of the existing childhood vaccination programme is growing. The Department of Health recognises that "the greatest threat to vaccination is resistance to continuing vaccination in the face of declining prevalence of many infectious diseases and heightened fears over vaccine safety." In particular, there is concern that despite medical research finding no link between MMR and autism or Crohn's disease, there is falling public confidence and continuing media speculation about the safety of the MMR jab and the infant immunisation programme as a whole.

2.4 The significant levels of public concern over infant immunisation indicate to us that the Department for Health needs to undertake a project bringing together the body of research and evidence, and ensuring that this information is communicated beyond medical professionals to the wider public.

Recommendation 1

Given widespread public concerns, there should be a review by the Department of Health of the reporting systems of possible side effects following vaccination in order to bolster public confidence. With regard to MMR, we recommend that this review cover children who have the multiple dose jab, the single jab and those who have no cover at all.

[1] "Vaccine programmes and policies" – Salisbury, Beverly and Miller – British Medical Bulletin 2002:62, 201-11

3 Recent trends in childhood immunisation coverage

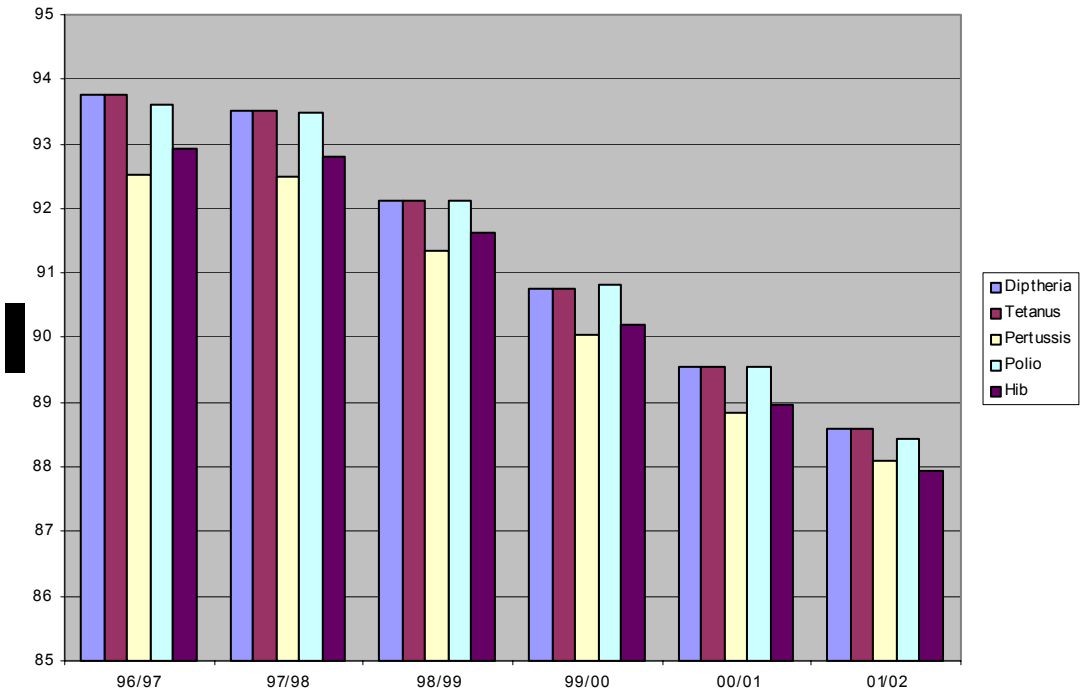
London versus the national average

3.1 The Department of Health publishes annual data [2] on the percentage of children who have received immunisation cover by their second birthday for the following diseases: polio, diphtheria, tetanus, pertussis (whooping cough) and haemophilus influenza (a cause of meningitis) as well as measles, mumps and rubella. Data were not grouped into a single London index until 1998/9, but data for the different district health authorities were aggregated to produce a London index that goes back to the early 1990s.

3.2 The latest statistical release shows that:

- immunisation cover for the cohort of children reaching their second birthday in 2001-02 for England as a whole has fallen from the peak coverage levels achieved in the mid-1990s;
- London's cover has been consistently below the national average;
- London's cover has dropped from the peak achieved in 1996-97; and
- the gap between levels achieved in the capital and the national average is widening.

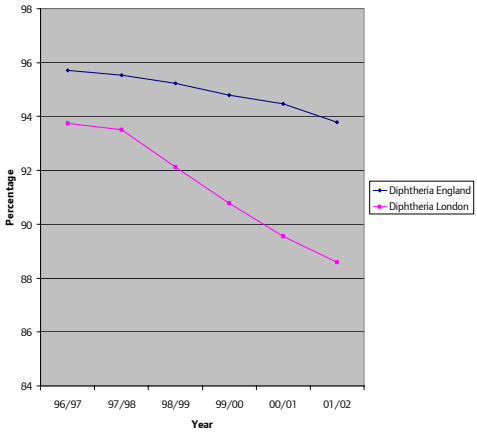
Rates of immunisation cover in London



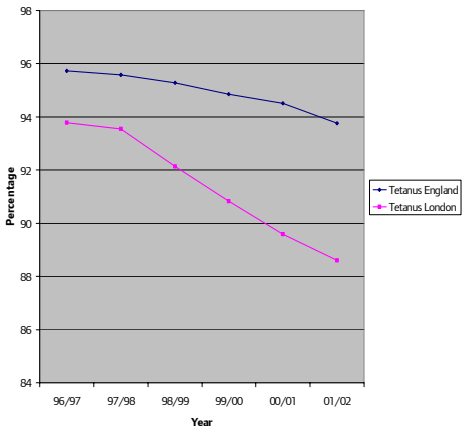
Source: Department of Health

[2] NHS Immunisation Statistics, England 2001-02

Diphtheria - Percentage of children immunised by their second birthday

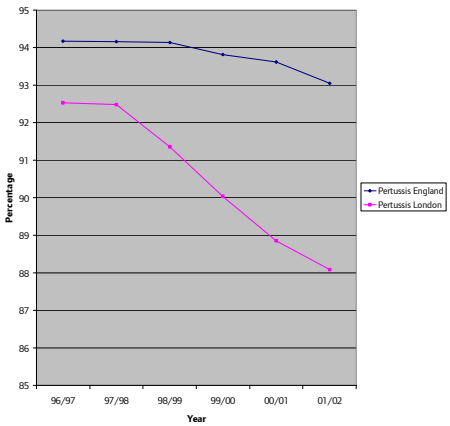


Tetanus - Percentage of children immunised by their second birthday

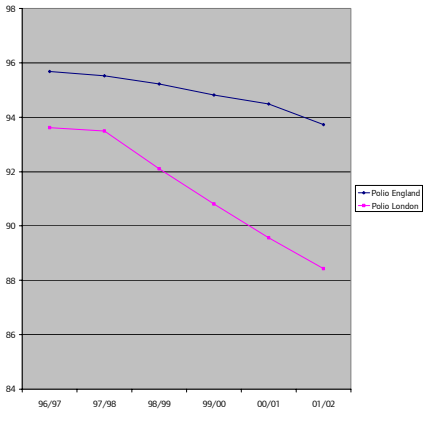


Source: Department of Health

Pertussis - Percentage of children immunised by their second birthday



Polio - Percentage of children immunised by their second birthday



Source: Department of Health

3.3 Data provided by the Department of Health show that immunisation coverage in London is significantly lower than other major cities in the UK [see tables below]. As children start primary school coverage rates normally pickup. But London rates remain below the national average and below those achieved in other UK cities (bar Manchester). The decline in coverage for MMR for 2 year olds in London has been particularly marked. Only 73% of children in London have had MMR vaccine by age 2 years, compared with a national average of around 85%[3].

Table 1: Percentage immunised by their 2nd birthday : 2001/02						
	No. children	Diptheria Tetanus, Pertussis	Polio	Hib	MMR	Men C
England	572, 888	94	94	93	84	85
London	94,204	89	88	88	75	70
Birmingham	14,003	94	93	93	82	79
Leeds	7,848	93	93	92	83	84
Manchester	5,467	89	89	87	80	70
Glasgow		96	96	96	87	96
Liverpool	5,054	93	93	93	84	92

Source: Department of Health

Table 2: Percentage immunised by their 5th birthday : 2001/02							
		Diptheria, Tetanus, Polio		Pertussis	Hib	MMR	
	No. children	Primary	Primary and booster	Primary	Primary	1st dose	2nd dose
England	608,436	94	81	93	93	91	74
London	90,274	89	70	88	88	83	58
Birmingham	14,539	96	79	95	95	95	75
Leeds	8,187	83	76	92	91	90	73
Manchester	6,950	77	60	75	74	75	54
Glasgow*		95					91
Liverpool	5,639	96	71	94	95	93	63

Source: Department of Health

Across London

3.4 There are significant differences between districts. In 2001-02 Enfield & Haringey, Lambeth, Southwark & Lewisham, and East London & the City had coverage rates for diphtheria, tetanus, pertussis and polio of around of 85%, while Redbridge & Waltham Forest, Barking & Havering and Kingston & Richmond achieved levels of coverage of over 93%. For measles coverage there are large variations across London; from 61% in Kensington, Chelsea, Westminster to 86% in Redbridge and Waltham Forest.[4] The pattern that emerges is that the inner city areas have lower coverage. For most of the childhood illnesses there is a clear relationship between high levels of

[3] Evidence to the Health Committee from Dr Sue Atkinson, 24 October 2002
[4] Evidence to the Health Committee from Dr Sue Atkinson, 24 October 2002

deprivation and less take up of immunisation. Though for measles, there has been a high incidence of cases in more affluent areas.

International comparisons

3.5 The Department of Health has explained to us that it is difficult to compare coverage in London with other major world cities as the methods used to estimate coverage vary considerably by country. Within these methodological limitations London's immunisation coverage is significantly lower than these comparison cities.

Table 3: Estimated International City vaccination coverage by 24 months

	Diptheria, Tetanus, Pertussis - 3 doses	Polio 3 doses	Hib 3 doses	MMR
London	89	88	88	75
Paris*	99	99	-	91
Amsterdam**	95	-	93	91
New York City***	93	83	92	90
Los Angeles City***	95	91	89	92

**Data based on 24 month health certificates 2001: % of children immunised per 100 certificates. Data (unpublished) provided by PHLS.*

4 Why is coverage in London so low?

4.1 Dr Atkinson explained to us that childhood coverage is lower in London than England as a whole, and generally somewhat lower than other major cities for a number of reasons:

- London's high population mobility
- London's high level of ethnic diversity
- London's high levels of deprivation
- Methods of recording may underestimate coverage

4.2 These characteristics also apply, however, to other UK cities. We would be interested to receive more detailed evidence from the Department of Health that the levels of population mobility, ethnic diversity and deprivation in London exceeds that of other cities to an extent that explains London's underperformance when compared with those cities. Even were that proved, there would still need to be an explanation for the fact that the differential between London and the national average is widening.

4.3 Dr Atkinson contends that because of a very mobile population London's figures may be underestimated by up to 5%, and that some localised Department of Health studies have shown higher coverage than routine data. If this were the case then London's coverage levels would come close to the national average. But health professionals and the public can't be sure this is the case.

4.4 Coverage data in the UK is collected through the GP surgeries. After each immunisation, the GP submits a completed form to the local computer unit. There is a financial incentive for the GP to return high levels of immunisation coverage, so the accuracy of the data is considered to be very high. Vaccination coverage levels in London could only be underestimated if the population of vaccinated children in a district was higher than GP data indicated. This could only happen if the children of families migrating into London had been vaccinated but not been picked up by local GPs. But presumably it is also possible that the data may overestimate coverage levels; children of families that migrate into London may not have been vaccinated and may not make initial contact with GPs. A better, computerised tracking system is needed to make such data more accurate.

Recommendation 2

With an increasingly mobile population, we would welcome comment from the Department of Health as to how they believe the NHS can best keep track of infants moving between PCTs in the capital. We would also welcome information as to the prevalence of TB and rickets in children in London.

4.5 We would also welcome some more information on why many other capital cities have better coverage rates than London. Differences are not down just to different ways of collecting the data. Dr Atkinson admitted to us despite the methodological differences (other cities use surveys rather than actuals) the data may accurately reflect real differences in coverage level; "it may well be that they do have better immunisation rates than us and that is quite likely to be the case."

Recommendation 3

We would welcome the Department providing us with research on vaccination programmes in mobile urban populations. If such research isn't available we recommend that such work be commissioned urgently.

Falling public confidence

4.6 Dr Atkinson acknowledged that falling public confidence has also played a role in falling coverage rates. She argued that the fall in MMR coverage had a lot to do with "individuals making choices and particular communities therefore being more susceptible because individuals have made choices about not having the measles jab". Though difficult to prove there does seem to be a correlation between the sharp drop in public confidence in the MMR vaccine and a loss of confidence in the childhood immunisation programme as a whole.

4.7 The consequences of this kind of safety-fear "contagion" are grave. It is possible that only when public confidence in the MMR vaccine has been re-established will the decline in coverage for all childhood vaccines be halted. Unless this decline is reversed, London is likely to face many years of low levels of coverage for serious childhood illnesses, and a high risk of serious outbreaks and increased risks of epidemics.

Recommendation 4

We recommend that the Department of Health reviews its strategy for promoting childhood immunisation. As part of that review they should focus on resourcing information given to parents and training for health professionals in discussing vaccination issues with parents.

Variable health service delivery

4.8 During questioning by the Committee, Dr Atkinson suggested that there might be something in the way the delivery of health services is organised that helps explain why some London health districts are better at delivering higher levels of coverage than others. Dr Atkinson argued that part of the reason was geographical in that small pockets of deprivation could drag down average district levels of cover. But also local professional priorities played a role, as Dr Atkinson made clear "some of which may be to do with how it (immunisation policy) is developed; the health professionals; the different primary care groups; what focus they have on it; and some health visitors, as individuals, may be more focused on it than others."

5 Case study: measles

5.1 Measles can be a child killer. It is caused by a very infectious virus. The Department of Health advises that "it is often a mild disease but if there are complications it can be very dangerous. It causes a high fever and a rash and can go on to cause chest infections, fits and brain damage. About one in every 15 children who develop measles is at risk of complications, and in serious cases it can kill." Babies in their mothers' wombs are also at risk.

5.2 As measles is very contagious, coverage levels need to be around 90% to offer group protection (or "herd" immunity). **None** of London's health authorities achieve this level of coverage for children at 2 or 5 years of age. And coverage levels have been on a downward trend since 1997-98. For the cohort of children with low levels of cover the risks of catching measles remain with them throughout their life. As they get older these cohorts may decide to get cover themselves. However, at present there is not a call and recall system to give those unprotected during childhood a second chance.

Recommendation 5

We believe that the Department of Health should initiate a childhood call and recall system to enable children to be recalled through their childhood and into adulthood to ensure that no cohort is lost forever to appropriate immunisation cover.

5.3 Furthermore, it is clear that some parents have chosen to pursue a single jab option rather than MMR; choosing to go private in order to access the vaccine in this form. But, the NHS does not collect data on the single jab. In their written submission, JABS argued that some 4,000 parents had sought the single measles jab in the Northwest of England alone. We note from her evidence that Dr Atkinson's primary objective for the fight against the measles virus is to ensure that as many children as possible have at least one dose, which at least offers some degree of protection.

Recommendation 6

To close information gaps on levels of vaccination, the Department of Health should require all practitioners who vaccinate using single dose vaccines to provide data to the NHS. The practice should also be required to record and report adverse side-effects to the NHS.

Recommendation 7

That the Department of Health carry out a survey of parents who have not had their children immunised with the MMR vaccine.

MMR vaccine coverage (first dose – not single dose) London health authorities, at ages 2 and 5, January – March 2002.		
Health Authority	% coverage at 24 months	% coverage at 5 years
Barking and Havering	85.9	87.5
Barnet	70.0	86.0
Bexley and Greenwich	64.8	81.1
Brent and Harrow	72.3	80.8
Bromley	67.5	88.1
Camden and Islington	73.1	85.5
Croydon	68.5	81.4
Ealing, Hammersmith and Hounslow	78.0	84.2
East London and the City	68.9	81.5
Enfield and Haringey	77.4	83.9
Hillingdon	79.8	90.4
Kensington, Chelsea and Westminster	60.9	82.9
Kingston and Richmond	71.3	83.7
Lambeth, Southwark and Lewisham	69.6	78.1
Merton, Sutton and Wandsworth	73.3	79.9
Redbridge and Waltham Forest	86.0	89.1
LONDON	73.1	83.3

Source: Department of Health

The 2001/02 South London outbreak

5.4 Dr Atkinson explained to us that an outbreak of measles cases last winter (2001/02) centred on inner south London boroughs. There were 133 confirmed cases, with 37% in Lambeth, Southwark and Lewisham and 16% in Merton, Sutton and Wandsworth.

5.5 Most cases occurred in children resident in more affluent neighbourhoods. Most of the confirmed cases had not had the MMR vaccine. This pattern of the location of the measles outbreaks is in marked contrast to data on the outbreaks of the other childhood disease; which are concentrated in the poorer boroughs.

5.6 In evidence to the committee, Dr Atkinson stressed that because of low London-wide vaccination levels, "there are potentials for further outbreaks… the pattern of measles outbreaks may well continue across London and we know there are the risks that that may happen". Dr Atkinson outlined the action plans, complemented with more resources, put into place in the 12 London health districts with the lowest rates. These action plans include efforts to improve accuracy of data as well as more outreach work to communicate with vulnerable families. A detailed picture of exactly where immunisation cover is particularly low will, however, only slowly emerge as the Primary Care Trusts bed down. For now, the Department of Health appears unable to identify accurately if there are faith or ethnic groups who have particular objections to immunisation. Nevertheless, Dr Atkinson assured us that significant efforts were being made to try and reach out to normally marginalised ethnic and cultural groups.

5.7 We welcome the introduction of these plans, but we remain concerned that the Department was slow to mobilise resources to prioritise actions to halt the slide in MMR coverage. When asked why measles coverage levels were allowed to

slide, Dr Atkinson argued that "people who have been concerned about immunisation have been raising it for some time. It has become much more in the public domain in the last year. In London, the fact that we did have an [measles] outbreak [in South London last winter] drew it to more people's attention; that's the public as well as professionals…it's sometimes difficult to know what action needs to be taken when." Dr Atkinson commented further "for those [areas] that are showing the poor uptake levels, then we do need to get them to focus on these. The action plans will be helpful as a kick-start for that but that needs to be maintained and it needs to be followed through."

5.8 **We intend to take evidence on the efficacy of these "action plans" and will report to the Assembly late next year as to whether they have affected coverage levels.**

6 Looking to the future

Changing the incentives structure for health professionals

6.1 In the UK GPs get paid when they reach certain coverage targets. Nevertheless it is often the health visitor who gives the jabs and good health workers do a lot of proactive work visiting parents and encouraging them to have their children vaccinated. We are concerned that the financial incentives may not be properly set so as to help break the declining trend in vaccination cover. There is as Dr Atkinson noted a lot of debate about the financial incentives and we would like the Department to share that debate with us.

Recommendation 8

We would welcome the Department's comments on whether they believe the current financial incentive structure for GPs can help deliver higher immunisation levels or whether a different incentive structure, perhaps rewarding health visitors, should be considered.

6.2 Other countries incentivise in different ways. In Australia a "maternity immunisation allowance" is paid for children aged 18-24 months who are fully immunised or have an approved exemption from immunisation. [5] This is an additional payment over and above standard maternity benefits.

Protecting Londoners

6.3 We believe that more must be done to ensure that all children of people migrating into London have received adequate vaccination coverage. London is a magnet for people from across the globe. People come for pleasure, to work, to settle and some to seek asylum. The number of people coming into the UK increases every year and the majority pass through, and often remain, in London. The number of countries and areas within those countries from where people come also increases as the cost of foreign travel falls and as communication technologies encourage the strengthening of networks and communities. Health authorities need to work with local authorities to ensure that new residents are registered so that health authorities have accurate coverage data. But there may also be a role for policy at the national level to ensure that authorisation for long-term visas or visa extensions or extended leave to remain includes a detailed explanation of current government policy on immunisation cover.

Recommendation 9

We would welcome comment from the Department of Health as to how they intend to ensure that new residents in London have appropriate immunisation cover. We would also welcome comment from the Department as to whether enough is being done at the national level to ensure that new entrants into the UK have sufficient understanding of UK immunisation policy.

[5] http://www.health.qld.gov.au/

Annex A: Recommendations

1. Given widespread public concerns, there should be a review of the reporting systems of possible side effects following vaccination in order to bolster public confidence. With regard to MMR, we recommend that this investigation cover children who have the multiple dose jab, the single jab and those who have no cover at all.

2. With an increasingly mobile population, we would welcome comment from the Department of Health as to how they believe the NHS can best keep track of infants moving between PCTs in the capital. We would also welcome information as to the prevalence of TB and rickets in children in London.

3. We would welcome the Department providing us with research on vaccination programmes in urban mobile populations. If such research isn't available we recommend that such work be commissioned urgently.

4. We recommend that the Department of Health reviews its strategy for promoting childhood immunisation. As part of that review they should focus on resourcing information given to parents and training for health professionals in discussing vaccination issues with parents.

5. We believe that the Department of Health should initiate a childhood call and recall system to enable children to be recalled through their childhood and into adulthood to ensure the no cohort is lost forever to appropriate immunisation cover.

6. To close information gaps on levels of vaccination, the Department of Health should require all practitioners who vaccinate using single dose vaccines to provide data to the NHS. The practice should also be required to record and report adverse side-effects to the NHS.

7. That the Department of Health carries out a survey of parents who have not had their children immunised with the MMR vaccine.

8. We would welcome the Department's comments on whether they believe the current financial incentive structure for GPs can help deliver higher immunisation levels or whether a different incentive structure, perhaps rewarding health visitors, should be considered.

9. We would welcome comment from the Department of Health as to how they intend to ensure that new residents in London have appropriate immunisation cover. We would also welcome comment from the Department as to whether enough is being done at the national level to ensure that new entrants into the UK have sufficient understanding of UK immunisation policy.

We look forward to continuing our constructive dialogue with the Department of Health and welcome their input on these important issues.

Annex B: Orders and translations

For further information on this report or to order a bound copy, please contact:

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Haddii adiga, ama qof aad taqaanid, uu doonaayo inuu ku helo koobi ah warbixinta oo kooban iyo talooyinka far waaweyn ama farta qofka indhaha la' loogu talagalay, ama luuqadooda, oo bilaash u ah, fadlan nagala soo xiriir telefoonkan 020 7983 4100 ama email-ka cinwaanku yahay assembly.translations@london.gov.uk

Annex C: Principles of Assembly scrutiny

The powers of the London Assembly include power to investigate and report on decisions and actions of the Mayor, or on matters relating to the principal purposes of the Greater London Authority, and on any other matters which the Assembly considers to be of importance to Londoners. In the conduct of scrutiny and investigation the Assembly abides by a number of principles.

Scrutinies:

- aim to recommend action to achieve improvements;
- are conducted with objectivity and independence;
- examine all aspects of the Mayor's strategies;
- consult widely, having regard to issues of timeliness and cost;
- are conducted in a constructive and positive manner; and
- are conducted with an awareness of the need to spend taxpayers money wisely and well.

More information about the scrutiny work of the London Assembly, including published reports, details of committee meetings and contact information, can be found on the GLA website at http://www.london.gov.uk/approot/assembly/index.jsp

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