

A photograph of three people sitting at a wooden table. On the left, a woman with short grey hair and glasses is focused on a craft project. In the middle, an older man with white hair and glasses is smiling. On the right, a woman with blonde hair is also smiling. They are surrounded by various craft materials like colorful beads and string. The background is a plain wall with a framed picture.

# Adult Vaccination Programmes

Toolkit for improving uptake 2024/25

NHS England South West Vaccination & Screening Team

Last reviewed: November 2024

# Aim of this toolkit

This toolkit has been prepared to support the effective delivery of routine adult immunisations delivered in Primary Care.

Shingles affects 1 in 4 people and predominantly those who are over 70. However, uptake rates of the shingles vaccine are falling in the South West and in England.

Invasive Pneumococcal Disease (IPD) is a major cause of morbidity and mortality and can affect anyone, however, it is more common in the very young, the elderly and those with impaired immunity or chronic conditions.

RSV is a common cause of respiratory tract infections. Symptoms usually include runny nose, cough and fever. For infants, and older adults, the virus can lead to more severe illness and hospitalisation.

The purpose of this toolkit is to help you in your practice to better protect your patients by suggesting ways to improve uptake of the shingles and pneumococcal vaccines. These suggestions are based on best practice and evidence and have been shown to work with little or no cost to your practice.



We are always looking for ways to capture best practice so if you have any suggestions you think we should include in future updates of this toolkit, please email

[england.swvast@nhs.net](mailto:england.swvast@nhs.net)

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Produced by: Hayley Ware, Screening and Immunisation Manager, NHS  
England South West

Last reviewed: November 2024 (Regina Senderowska)

Contact us at [england.swvast@nhs.net](mailto:england.swvast@nhs.net)

With thanks to: NHSE Immunisation Team, London Region who developed the  
original resource

# Shingles

# Shingles

## What is Shingles

Shingles, also known as herpes zoster, is caused by the reactivation of a latent varicella zoster virus (VZV) infection. Primary VZV infection manifests as chickenpox, a highly contagious condition that is characterised by an itchy, vesicular rash. Following this initial infection, the virus enters the dorsal root ganglia and remains there as a permanent, dormant infection.

Reactivation of this latent VZV infection, generally occurring decades later, causes shingles. There is no cure for shingles and normally painkillers are provided to relieve symptoms.

## Post-Herpetic Neuralgia

Post-herpetic neuralgia (PHN) is persistent pain at the site of the shingles infection that extends beyond the period of the rash. It usually lasts from three to six months, but can persist for longer.

PHN occurs when the reactivated virus causes damage to nerve fibres. The resultant intractable pain can severely limit the ability to carry out daily activities, and PHN is therefore a debilitating condition that can significantly impair quality of life. PHN does not respond to painkillers such as paracetamol or ibuprofen, so is extremely difficult to treat and may result in hospitalisation. There is no cure. **The most effective method of preventing PHN is the shingles vaccination.**



## Incidence

Approximately 1 in 4 people will develop shingles during their lifetime. Both the incidence and the severity of the condition increases with age. Older individuals are also more likely to develop secondary complications, such as bacterial skin infections and post-herpetic neuralgia (intractable pain).

The Green Book cites that the mortality from shingles infection in the over 70s is 1/1000.



# Shingles

More than **50,000** cases of shingles occur in the over 70s every year in England and Wales



On average, cases last **3 to 5 weeks**. Most people only get shingles once, but you can get it more than once



In this age group, around **1 in 1000** cases results in death



Almost **30%** of individuals develop a painful complication called **Post Herpetic Neuralgia (PHN)**.

Generally, this pain continues for **3 to 6 months**, but it can last even longer

Symptoms include:  
**rashes** or blisters on **one side** of the body, burning or **shooting pain**, itching, fever, **fatigue** or headache



The risk of shingles is higher in those with conditions such as **diabetes or rheumatoid arthritis**



# Shingles routine vaccination programme

## Vaccine and dosage

A non-live shingles vaccine Shingrix has replaced Zostavax in the routine immunisation programme from 1 September 2023.

Immunocompetent individuals who received Zostavax previously on the routine immunisation programme (between 70 and 79 years of age) are not eligible for additional doses of shingles vaccine and should not be revaccinated or offered Shingrix now.

### Schedule:

- Severely immunosuppressed: Shingrix vaccine offered as a two dose schedule (8 weeks to 6 months apart) to those aged 50 and over (no upper age limit)
- immunocompetent: Shingrix vaccine offered as a two dose schedule (6 to 12 months apart) to those from 60 years of age until 80 years or age in a phased implementation over a 10-year period starting with those turning 65 and 70 years of age. [A timeline for the phased implementation of the change for immunocompetent patients 2023-2033.](#)

## Individuals aged 18 to 49 years of age receiving stem cell transplant

Individuals who have received a stem cell transplant have an increased risk of developing herpes zoster which may have severe and debilitating effects. In recognition of this, it is reasonable to give adult stem cell transplant recipients who are not otherwise eligible 2 doses of Shingrix vaccine as part of their overall treatment plan.

## Vaccine contraindications

There are a number of contra-indications for the shingles vaccination so you should refer to [the Green Book](#), to check whether a patient is suitable to receive this vaccination.



## Vaccination Programme and co-administration with pneumococcal, influenza and covid vaccines

All eligible patients should be offered the shingles vaccination by their GP all year round.

Shingles vaccines can be given concomitantly with PPV, RSV, Covid-19 vaccination and all influenza vaccines.

# Identifying eligible patients for shingles vaccine

## Who is eligible?

From 1 September 2023, the immunocompetent individuals from 60 years of age became eligible for the Shingrix vaccine in a phased implementation over a 10-year period starting with those turning 65 and 70 years of age.

The severely immunosuppressed cohort has been expanded to offer Shingrix to individuals aged 50 years and over, with no upper age limit.

Since patients effectively move in and out of eligibility (i.e. by turning 65 or 70 and then by turning 80 or identified as severely immunosuppressed), practices need to review their eligible patients regularly, and ensure newly eligible patients are contacted to make them aware of their eligibility.

The links below are useful to enable you to identify eligible patients:

- [E-learning for healthcare](#)
- [Shingles, Green Book, chapter 28a](#)
- [Practice checklist](#)
- [Shingles: guidance and vaccination programme](#)
- [Shingles vaccination: guidance for healthcare practitioners](#)
- [NHSE South West – Patient Group Direction](#)
- [Shingles vaccine eligibility calculator - from Sept 2023](#)
- [Shingles vaccine eligibility posters](#)
- [Health Publications](#)

UK Health Security Agency

## Eligibility for shingles vaccine

If you have a severely weakened immune system (as described in the Green book chapter) you will be offered the shingles vaccine from 50 years of age

If you are over 70 years of age and have not had shingles vaccine before you remain eligible up to your 80th birthday

ELIGIBLE FROM (YOUR BIRTHDAY)	DATES OF BIRTH	PROGRAMME START DATE	PROGRAMME YEAR
CATCH UP STAGE 1 70 <sup>th</sup>	1 September 1953 – 31 August 1954	1 September 2023	Year 1
	1 September 1954 – 31 August 1955	1 September 2024	Year 2
	1 September 1955 – 31 August 1956	1 September 2025	Year 3
	1 September 1956 – 31 August 1957	1 September 2026	Year 4
	1 September 1957 – 31 August 1958	1 September 2027	Year 5
65 <sup>th</sup>	1 September 1958 – 31 August 1959	1 September 2023	Year 1
	1 September 1959 – 31 August 1960	1 September 2024	Year 2
	1 September 1960 – 31 August 1961	1 September 2025	Year 3
	1 September 1961 – 31 August 1962	1 September 2026	Year 4
	1 September 1962 – 31 August 1963	1 September 2027	Year 5
CATCH UP STAGE 2 65 <sup>th</sup>	1 September 1963 – 31 August 1964	1 September 2028	Year 6
	1 September 1964 – 31 August 1965	1 September 2029	Year 7
	1 September 1965 – 31 August 1966	1 September 2030	Year 8
	1 September 1966 – 31 August 1967	1 September 2031	Year 9
	1 September 1967 – 31 August 1968	1 September 2032	Year 10
60 <sup>th</sup>	1 September 1968 – 31 August 1969	1 September 2028	Year 6
	1 September 1969 – 31 August 1970	1 September 2029	Year 7
	1 September 1970 – 31 August 1971	1 September 2030	Year 8
	1 September 1971 – 31 August 1972	1 September 2031	Year 9
	1 September 1972 – 31 August 1973	1 September 2032	Year 10
ROUTINE 60 <sup>th</sup>	on or after 1 September 1973	1 September 2033	Year 11 onwards

immunisation  
The safest way - protect yourself

Patients often are not aware they are eligible, and therefore it is important the practice identifies and invites eligible patients.



# Severely immunosuppressed

## Box: Definition of severe immunosuppression for the Shingrix vaccine programme

### Individuals with primary or acquired immunodeficiency states due to conditions including:

- acute and chronic leukaemias, and clinically aggressive lymphomas (including Hodgkin's lymphoma) who are less than 12 months since achieving cure
- individuals under follow up for chronic lymphoproliferative disorders including haematological malignancies such as indolent lymphoma, chronic lymphoid leukaemia, myeloma, Waldenstrom's macroglobulinemia and other plasma cell dyscrasias (N.B: this list not exhaustive)
- immunosuppression due to HIV/AIDS with a current CD4 count of below 200 cells/ $\mu$ l.
- primary or acquired cellular and combined immune deficiencies – those with lymphopaenia (<1,000 lymphocytes/ $\mu$ l) or with a functional lymphocyte disorder
- those who have received an allogeneic (cells from a donor) or an autologous (using their own cells) stem cell transplant in the previous 24 months
- those who have received a stem cell transplant more than 24 months ago but have ongoing immunosuppression or graft versus host disease (GVHD)

### Individuals on immunosuppressive or immunomodulating therapy including:

- those who are receiving or have received in the past 6 months immunosuppressive chemotherapy or radiotherapy for any indication
- those who are receiving or have received in the previous 6 months immunosuppressive therapy for a solid organ transplant
- those who are receiving or have received in the previous 3 months targeted therapy for autoimmune disease, such as JAK inhibitors or biologic immune modulators including
- B-cell targeted therapies (including rituximab but for which a 6 month period should be considered immunosuppressive), monoclonal tumor necrosis factor inhibitors (TNFi), T-cell co-stimulation modulators, soluble TNF receptors, interleukin (IL)-6 receptor inhibitors.,
- IL-17 inhibitors, IL 12/23 inhibitors, IL 23 inhibitors (N.B: this list is not exhaustive)

### Individuals with chronic immune mediated inflammatory disease who are receiving or have received immunosuppressive therapy

- moderate to high dose corticosteroids (equivalent  $\geq 20$ mg prednisolone per day) for more than 10 days in the previous month
- long term moderate dose corticosteroids (equivalent to  $\geq 10$ mg prednisolone per day for more than 4 weeks) in the previous 3 months
- any non-biological oral immune modulating drugs e.g. methotrexate  $> 20$ mg per week (oral and subcutaneous), azathioprine  $> 3.0$ mg/kg/day; 6-mercaptopurine  $> 1.5$ mg/kg/day, mycophenolate  $> 1$ g/day) in the previous 3 months
- certain combination therapies at individual doses lower than stated above, including those on  $\geq 7.5$ mg prednisolone per day in combination with other immunosuppressants (other than hydroxychloroquine or sulfasalazine) and those receiving methotrexate (any dose) with leflunomide in the previous 3 months

Individuals who have received a short course of high dose steroids (equivalent  $> 40$ mg prednisolone per day for more than a week) for any reason in the previous month.

## Criteria for severely immunosuppressed

Severely immunosuppressed individuals represent the highest priority for vaccination given their risk of severe disease.

Please note that criteria for severely immunosuppressed are **not** the same criteria as for other vaccines such as influenza.

Visit [Shingles \(herpes zoster\): the green book, chapter 28a](#) for full definition of severe immunosuppression eligible for the Shingrix vaccine.

There's a vaccine to help protect you from the pain of

# Shingles



# Pneumococcal

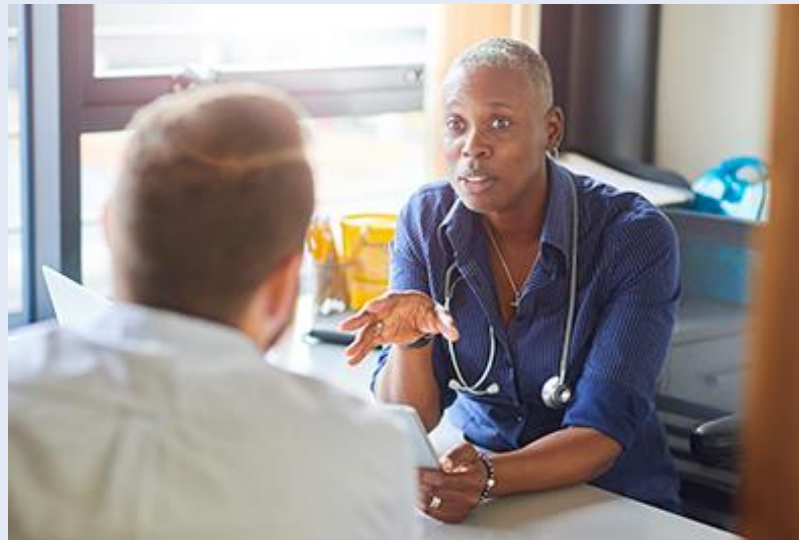
# Pneumococcal disease

## What is Pneumococcal disease?

Pneumococcal disease is the term used to describe infections caused by the bacterium *Streptococcus pneumoniae* - also known as *Pneumococcus*. Infections are either non-invasive or invasive. Non-invasive diseases include middle ear infections (otitis media), sinusitis and bronchitis. Invasive pneumococcal disease (IPD) includes septicemia, pneumonia and meningitis.

IPD is a major cause of disease and death globally and in the UK. In 2005/6, there were 6,346 confirmed cases of invasive pneumococcal disease in England and Wales. It particularly affects the very young, the elderly, people with no spleen or a non-functioning spleen, people with other causes of impaired immunity and certain chronic medical conditions. Recurrent infections may occur in association with skull defects, cerebrospinal fluid (CSF) leaks, cochlear implants or fractures of the skull.

There are more than 90 different pneumococcal types (serotypes) that can cause disease in humans.



# Pneumococcal disease

More than **5,000** cases of IPD are diagnosed each year in England.



Seasonal peaks are noted during **winter months** in addition to **outbreaks in enclosed areas**, such as prisons or homeless Shelters.



IPD is a significant cause of **morbidity & Mortality** globally and in the UK.



Complications can follow after mild illness and lead to **more serious infections**.

**Pneumonia symptoms include:**  
a high temperature, a cough,  
shortness of breath, chest pain,  
an aching body, feeling very tired,  
loss of appetite or feeling confused  
(common in older people).



The risk of Pneumococcal disease is greater for adults aged **65 years or older** and for those with conditions such as Chronic obstructive pulmonary disease (COPD).





# Pneumococcal vaccine and contraindications

## The Pneumococcal Vaccine

There are two types of pneumococcal vaccine recommended in the UK National Immunisation Programme PCV13 (not available for adults) and PPV23, which provide protection against different serotypes. The vaccines are inactivated (do not contain live organisms) so cannot cause the diseases against which they protect.

### **Pneumococcal Polysaccharide Vaccine 23 (PPV23):**

Adults aged 65 years and over, and clinical risk groups aged 2 years or over:

- a single dose of 0.5ml of PPV23

Patients often are not aware they are eligible, and therefore it is important the practice focuses on identifying eligible patients.

The links below are useful to enable you to identify eligible patients:

- [E-learning for healthcare](#)
- [Pneumococcal, Green Book, chapter 25](#)
- [NHSE South West – Patient Group Direction](#)
- [Pneumococcal disease: guidance, data and analysis](#)
- [Pneumonia NHS](#)

## The Pneumococcal Vaccination Schedule

All eligible patients that are over 2 years old should be offered their single Pneumococcal PPV23 vaccination by their GP all year round.

However: antibody levels are likely to decline rapidly in individuals with asplenia, splenic dysfunction or chronic renal disease and, therefore, re-immunisation with PPV23 is recommended every five years in these groups. Revaccination with PPV23 is currently not recommended for any other clinical risk groups or age groups.

Pneumococcal vaccines can be given at the same time as other vaccines such as influenza

## Contraindications

There are very few individuals who cannot receive pneumococcal vaccines.

However, you should refer to the Green Book to check whether a patient is suitable to receive this vaccination. Pages 9-10 should be referred to from this link:

[The Green book of immunisation: chapter 25 - pneumococcal \(publishing.service.gov.uk\)](#)

Further training resources:

[Pneumococcal Disease Overview](#) | [PNEUMOVAX® 23](#) | [MSD Connect UK](#)

# Identifying eligible patients for pneumococcal vaccines

[Annexe A: priority groups for pneumococcal polysaccharide 23-valent vaccine \(PPV23, Pneumovax®23\) - GOV.UK \(www.gov.uk\)](#)

[The Green book of immunisation: chapter 25 - pneumococcal \(publishing.service.gov.uk\) \(page 7\)](#)

Clinical risk group	Examples (decision based on clinical judgement)
Asplenia or dysfunction of the spleen	This also includes conditions that may lead to splenic dysfunction such as homozygous sickle cell disease and coeliac syndrome.
Chronic respiratory disease (chronic respiratory disease refers to chronic lower respiratory tract disease)	This includes chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema; and such conditions as bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Children with respiratory conditions caused by aspiration, or a neurological disease (such as cerebral palsy) with a risk of aspiration. Asthma is not an indication, unless so severe as to require continuous or frequently repeated use of systemic steroids (as defined in Immunosuppression below).
Chronic heart disease	This includes those requiring regular medication and/or follow-up for ischaemic heart disease, congenital heart disease, hypertension with cardiac complications, and chronic heart failure.
Chronic kidney disease	Nephrotic syndrome, chronic kidney disease at stages 4 and 5 and those on kidney dialysis or with kidney transplantation.
Chronic liver disease	This includes cirrhosis, biliary atresia and chronic hepatitis.
Diabetes	Diabetes mellitus requiring insulin or anti-diabetic medication. This does not include diabetes that is diet controlled.
Immunosuppression	Due to disease or treatment, including patients undergoing chemotherapy leading to immunosuppression, bone marrow transplant, asplenia or splenic dysfunction, complement disorder, HIV infection at all stages, multiple myeloma or genetic disorders affecting the immune system (such as IRAK-4, NEMO). Individuals on or likely to be on systemic steroids for more than a month at a dose equivalent to prednisolone at 20mg or more per day (any age), or for children under 20kg, a dose of 1mg or more per kg per day.
Individuals with cochlear implants	Individuals receiving cochlear implants are at high risk of invasive pneumococcal disease, with highest risk around the time of the implant. Vaccination should ideally be given before the intervention, but should not delay the implant. The vaccine should be given as soon as possible after that.
Individuals with cerebrospinal fluid leaks	This includes leakage of cerebrospinal fluid such as following trauma or major skull surgery (does not include CSF shunts).
Occupational risk	Please see page 10

# Respiratory Syncytial Virus RSV

## What is RSV?

Respiratory syncytial virus is a common cause of acute respiratory tract infections which are usually mild and self-limiting. The virus is transmitted via respiratory droplets (coughing, sneezing), through close contact with an infected person or contact with contaminated surfaces. Symptoms usually include runny nose, cough and fever. For infants, and older adults, the virus can lead to more severe illness and hospitalisation.

## Who is at risk of RSV?

RSV infections are very common. Almost all children get them at least once before they're 2 years old.

They're not usually serious, but some babies and adults have a higher risk of getting seriously ill, particularly:

- babies under 6 months old
- young children who were born prematurely
- **adults over 75 years**
- babies, children and adults with a weakened immune system, or long-term lung or heart conditions
- people who smoke tobacco and babies exposed to tobacco smoke



## Incidence

Although the exact burden of disease in elderly adults is comparatively poorly understood due to a relative lack of testing, it is considered to have a substantial morbidity and mortality.

RSV has been estimated to account for 175,000 annual GP episodes in those age 65 years and older in the UK and an estimated 5000-7500 deaths in older adults in England and Wales every winter, the vast majority of which occur in adults over 75 years.



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RSV infections occur year-round but primarily within the period **October to March**, for about six weeks.



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RSV LRTI may manifest as exacerbations of **underlying chronic obstructive pulmonary disease** or cardiovascular disease.

Those infected by RSV experience a range of **acute respiratory infection (ARI)** symptoms such as: rhinitis, cough, shortness of breath, wheeze, lethargy and fever.



In **immunocompromised patients**, RSV can cause severe infections with mortality rates as high as 80%.\*



*\*Falsey AR, Walsh EE. Respiratory syncytial virus infection in adults. Clin Microbiol Rev. 2000 July*

# RSV routine vaccination programme

## Vaccination Programme from September 2024

From 1 September 2024, the RSV vaccine should be offered to the following cohorts:

- Routine cohort

All adults turning 75 years of age on or after 1 September 2024 (born on or after 1 September 1949) should be offered RSV vaccination on or shortly after their 75th birthday. **This is a year-round, ongoing programme.**

- Catch-up cohort

Individuals aged 75 years old to 79 years old on the 1 September are eligible as part of the catch-up campaign. These individuals remain eligible until they turn 80 years of age with the exception of those who turn 80 within the first year of the programme, who are eligible until 31 August 2025.

## Optimal timing of vaccination

Although vaccination can be given all year round, vaccinating as many eligible individuals as possible before the onset of the main RSV season in the winter will have the greatest impact. This will provide individuals with protection and could reduce transmission of the virus.

For those eligible for the catch-up campaign, as many as possible should be vaccinated during September and October 2024 prior to the expected RSV season.

For those turning 75 years of age between March and October each year, the vaccine should ideally be given by the end of October before RSV activity increases, otherwise soon after turning 75 if this occurs during the RSV season (November to February).

## Reporting adverse reactions

Abrysvo is a newly licensed vaccine and is subject to additional monitoring under the black triangle (▼) labelling scheme by the Medicines and Healthcare products Regulatory Agency (MHRA).

All suspected adverse reactions should be reported to the MHRA via the Yellow Card scheme:

- online at Yellow Card Scheme
- downloading and using the Yellow Card app for Apple devices or Android devices
- by calling the Yellow Card scheme on 0800 731 6789 (9am to 5pm)

# RSV routine vaccination programme

## Co-administration with other vaccines

RSV vaccines can be safely co-administered with Shingrix shingles vaccine and pneumococcal vaccines.

It is recommended that RSV vaccine is not routinely scheduled to be given to an older adult at the same appointment or on the same day as an influenza or COVID-19. No specific interval is required between administering the vaccines. If it is thought that the individual is unlikely to return for a second appointment or immediate protection is necessary, Abrysvo can be administered at the same time as influenza and/or COVID-19 vaccination. Clinicians can use their discretion, on an individual basis, to administer Abrysvo at the same time as influenza and/or COVID-19 vaccine where not doing so may mean the patient is not vaccinated in a timely manner.

## RSV programme promotional materials

Older adult leaflets and posters:

- [RSV vaccination for older adults - .GOV.UK](https://www.gov.uk/government/publications/older-adults-rsv-vaccine-leaflet)
- [Older Adults Leaflet](#) (HealthPublications – available in many languages)
- [Older Adults Poster](#) (HealthPublications)
- [RSV Vaccinations | Help Us Help You - Vaccinations | Campaign Resource Centre \(dhsc.gov.uk\)](https://www.dhsc.gov.uk/campaign-resource-centre)

## Further resources for RSV programme

The links below are useful to learn more about the RSV vaccination programme and to enable you to identify eligible patients:

- [Immunisation - e-learning for healthcare](#)
- [Respiratory syncytial virus: the green book, chapter 27a](#)
- [Respiratory syncytial virus \(RSV\) programme: information for healthcare professionals](#)
- [Recording link for older person RSV vaccine programme webinar](#) and slides: [Slides for older person RSV vaccine programme webinar](#)
- [NHSE South West – Patient Group Direction](#)
- [RSV NHS](#)



# Practical delivery



# Ordering stock and creating alerts

## Vaccine Ordering

Shingrix, PPV23 and RSV are available to order through ImmForm. Healthcare professionals should refer to the ImmForm website on a regular basis for up-to-date information on vaccine availability.

Please note each dose of Shingrix costs the NHS £160, PPV23 costs £16.80 per vaccine and RSV is £158 per dose.

Please ensure that stocks of vaccines are rotated and that you do not overstock as this can lead to excessive wastage. **It is recommended that practices hold no more than 2 weeks' worth of stock**, unless you are planning a dedicated and focused campaign in which case it may be appropriate to order more stock.

The pack of Abrysvo® vaccine is physically larger than most other vaccines supplied via ImmForm. Each single dose pack measures **73mm x 35mm x 116mm** (H x W x D). Please ensure you have enough fridge capacity before placing large orders.

When ordering stock from Immform, stock should be ordered separately for the older adults and infant RSV protection programme (given to pregnant patients). Although the same Abrysvo® vaccine will be used for both the older adult and the vaccination of pregnant women, they will be listed as separate items on ImmForm and the vaccine allocated for each programme should be managed independently where possible. **However, this should not present a barrier to vaccination.**

## Using searches and pop up alerts for opportunistic appointments

Set up your clinical system to identify all eligible patients and generate pop-up alerts on their patient record, so that staff are reminded to offer the vaccination opportunistically each time the patient's record is opened. Ensure that clinicians are trained to monitor these alerts so that no patients are missed. If your system is not able to do this, notifications can be set up manually.

Accurate and complete patient data is needed, including identifying 'ghosts' – patients who have transferred out of the area or died, but are still sent invitations for vaccinations

Identify if there are any persons now eligible for vaccination (ie Shingrix as per the severely immunosuppressed cohort expansion who were previously contraindicated/not eligible)

[Shingles Eligibility Searches](#) and [Shingles vaccination programme technical guidance](#) provide you with instructions on conducting searches and sending out communication to eligible patients.

The Ardens RSV Searches are available for practices to download via [RSV Vaccination Resources : Ardens EMIS Web](#)

# Coding and recording

The correct code should be used to record that a vaccination has been given. GPES auto-extracts Shingles and Pneumococcal data.  
All reasonable steps should be taken to ensure that the medical records of patients receiving the vaccination are kept up to date and in particular include any refusal.

SHINGLES CLINICAL CODES	
Code description	SNOMED concept ID
Administration of vaccine product containing only Human alphaherpesvirus 3 antigen for shingles (procedure)	722215002
Administration of first dose of vaccine product containing only Human alphaherpesvirus 3 antigen for shingles (procedure)	1326101000000105
Administration of second dose of vaccine product containing only Human alphaherpesvirus 3 antigen for shingles (procedure)	1326111000000107
Requires vaccination against herpes zoster (finding)	1730561000000103
Herpes zoster vaccination (procedure)	859641000000109
Herpes zoster vaccination given by other health care provider (finding)	868511000000106

PNEUMOCOCCAL CLINICAL CODES	
Code description	SNOMED concept ID
Subcutaneous injection of pneumococcal vaccine (procedure)	871833000
Pneumococcal vaccination given (situation)	170337005
Pneumococcal vaccination given (finding)	310578008
Administration of pneumococcal polysaccharide 23 valent vaccine (procedure)	571631000119106
Subcutaneous injection of pneumococcal vaccine (procedure)	871833000
Pneumococcal vaccination given by other healthcare provider (finding)	382551000000109
Pneumococcal vaccination given by other healthcare provider (situation)	1324631000000100
Requires a pneumococcal vaccination (finding)	247951000000102

RESPIRATORY SYNCYTIAL VIRUS (RSV) CLINICAL CODES	
Code description	SNOMED Concept ID
Administration of vaccine product containing only Human orthopneumovirus antigen (procedure) <b>***Used for payment***</b>	1303503001
Human orthopneumovirus vaccination contraindicated (situation)	999036351000230105
Human orthopneumovirus vaccination declined (situation)	999036361000230108

# Payments

## Requirements for payment

The Pneumococcal Polysaccharide Vaccine (PPV), Shingles and RSV programmes are Essential Services and NHSE no longer publish Service Specifications for these programmes. The requirements are set out within the GP contract SFEs and documentation: [NHS England » GP Contract](#). Practices must sign up to Service Offers on CQRS to ensure payment flows correctly.

## Payment Claims

All vaccinations administered to eligible patients attract an IoS fee of £10.06.

Each financial year NHS Digital publish a full list of the business rules, service indicators, description and indicator IDs for payment purposes: [Business rules 2023-2024 - NHS Digital](#) and [Business rules 2024-2025 - NHS Digital](#).

Payment for these vaccinations is calculated by an automated GPES extraction via CQRS (Calculating Quality Reporting Service).

Once approved by the commissioner, payment is made to practices monthly by PCSE, following the month the activity was delivered.

Practices should check their data monthly and only declare it if it is correct. Any queries should be raised with the South West Vaccination and Screening CQRS Team using the agreed process.

Their email address is [england.swcqrs@nhs.net](mailto:england.swcqrs@nhs.net)



## Vaccine costs

As the vaccine is centrally supplied, no claim for reimbursement of vaccine costs or personal administration fee apply.

# Payments (2)

## Conditions of payment

- The practice must have signed up to deliver the programmes via CQRS.
- All patients in respect of whom payments are being claimed were on the practice list at the time the vaccine was delivered and when the GPES extraction occurred.
- All patients in respect of whom payments are being claimed were in an eligible cohort
- The practice did not receive payment from any other source in respect of the vaccine
- The practice submitted the claim within six months of administering the vaccine (3 months for Seasonal Flu)



## How is QOF payment calculated?

- If the lower threshold is reached, the lowest points are awarded, if the higher threshold is reached, the highest points are awarded.
- Anything between the two thresholds achieves the relative number of points.
- Practices can see their QOF achievement data in CQRS from April.
- The calculation figure is based on the agreed data (extract and manual adjustment where applicable and evidence based)



# Payments (Shingles programme)

## GPES payment extracts following the shingles vaccination expansion from 1 September 2023

All eligible individuals should be offered two doses of Shingrix.

Please note that from a purely clinical perspective there is no specific upper timing for the second dose and instead it is clinically more important that an individual does get a second dose. To operationally encourage the provision of the second dose within a reasonable timeframe in England, we have required the second dose is given within the timeframes set out above. However, in light of the clinical position, we will include within the GPES payment extracts counts which do not require an upper timing between the doses, so there will be three counts for each cohort:

- one payment count for the first dose;
- one payment count for the second dose given within the timeframe between doses; and
- one payment count for the second dose with only a lower timing and no upper timing (note: for the immunocompetent cohort there is an upper age limit of 82 years regardless).

## The severely immunosuppressed cohort

The severely immunosuppressed cohort will be automatically identified via the GPES extract. However, due to the restrictions in the way data can be extracted from GP clinical systems, we are unable to exactly extract data in accordance with the Green Book definitions for the Shingles severely immunosuppressed cohort. To address this and support general practice, we have requested and had approval for a new clinical code for 'needs shingles vaccination'. This code will enable clinicians to use clinical discretion when identifying an individual who should be offered Shingrix due to their severely immunosuppressed status but who will not be picked up by the automated definitions in the GPES business rules. As such, there will be additional payment counts for those clinically identified as severely immunosuppressed from aged 50 years through usage of the new 'needs shingles vaccination' code.

## QOF

The Shingles programme attracts a **QOF incentive of 10 points** with thresholds of 50% (lower) to 60% (higher). There is no point allocation for meeting the lower threshold. This is aimed at incentivising optimal performance of immunisation and to ensure everyone is up to date with their recommended planned vaccinations as part of the routine national vaccination programmes and to prevent vaccine-preventable diseases

Name	Description	Highest Points (HP)	Lower Threshold (LT)	Higher Threshold (HT)
VI004	The percentage of patients who reached 80 years old in the preceding 12 months, who have received a shingles vaccine between the ages of 70 and 79 years.	10.00	50.00	60.00

# Payments (Shingles programme)

## Shingles vaccination programme payments counts from 1 September 2023

- Severely Immunosuppressed 50 years and over (six extracts)
  - 50+ 1st dose
  - 50+ 2nd dose given between 8 weeks to 186 days after first dose
  - 50+ 2nd dose given at least 8 weeks after first dose until any time thereafter
  - 50+ and 'needs shingles vaccination' 1st dose
  - 50+ and 'needs shingles vaccination' 2nd dose given between 8 weeks to 186 days after first dose
  - 50+ and 'needs shingles vaccination' 2nd dose given at least 8 weeks after first dose until any time thereafter
- Immunocompetent 70-79 years (three extracts)
  - 70-79 1st dose
  - 70-79 2nd dose given between 186 days to 372 days after first dose
  - 70-79 2nd dose given at least 186 days after first dose until 81 years
- Immunocompetent 65 years (three extracts)
  - 65 years on or after 1 September 2023 and at point of vaccination 1st dose
  - 65 years on or after 1 September 2023 and at point of vaccination 2nd dose given between 186 days to 372 days after first dose
  - 65 years on or after 1 September 2023 and at point of vaccination 2nd dose given at least 186 days after first dose (this cohort will remain eligible until 69 years of age over the five year catch-up at which point they will move into the 70-79 cohort until 81 years of age)



# Payments (RSV programme)



South West Collaborative  
Commissioning Hub

## GPES payment extracts from 1 September 2024

All eligible individuals should be offered one dose of RSV (Respiratory Syncytial Virus) vaccine .

## Payment for individuals turning 80 in the first year who remain eligible until 31 August 2025

Payment claims post the individuals 80th birthday will need to be requested manually by submitting a manual amendment request form to the SW VaST CQRS team [england.swcqr@nhs.net](mailto:england.swcqr@nhs.net)

The NHSE national Policy and Contracting Team are working on adding an additional ID indicator for individuals turning 80 in the first year who remain eligible until 31 August 2025, and if successful will run a retrospective extraction.

Until confirmation is received either way, all requests will be held on file and an update will be issued as soon as possible. This will avoid the risk of generating a double payment thus necessitating a retrospective reclaim.

## Payment for the Infant Protection programme – vaccination of pregnant women and people

Payments will be supported by CQRS for the infant protection programme (vaccination of pregnant women), but activity will need to be entered manually by the practice. Please bear in mind the infant protection programme will be primarily offered as part of the maternity care pathway and practices are required to offer on an opportunistic basis.

# Vaccination offer

Practices should ensure that their call/recall and opportunistic offers of vaccination are made in line with the agreed national standards detailed below. Please note there might be different criteria for clinical risk groups, please visit the [Green Book](#) for full details

Vaccination and Immunisation Programme	Age Eligibility	Type of offer
<b>Pneumococcal Polysaccharide Vaccine (PPV)</b> GP practices are required to offer pneumococcal polysaccharide vaccination to all eligible patients registered at the GP practice; unless contra-indicated and is usually a single dose of vaccine.  Booster doses may be required at five yearly intervals for individuals with no spleen, splenic dysfunction or chronic renal disease (as per Green Book guidance).	65 years old  2-64 years in defined clinical risk groups	Proactive call and recall if in a defined clinical risk group including newly diagnosed as in clinical risk group.  Proactive call at 65 years old if not in a defined clinical risk group, opportunistic offer or if requested thereafter.
<b>Shingles routine</b> GP practices are required to provide shingles vaccinations to all eligible registered patients. From 1 September 2023: <ul style="list-style-type: none"> <li>The severely immunosuppressed cohort: individuals aged 50 years and over, with no upper age limit</li> <li>The immunocompetent cohort: individuals from 60 years of age in a phased implementation over a 10-year period starting with those turning 65 and 70 years of age until aged 80 years.</li> </ul>	50 years old with no upper age limit for the severely immunosuppressed cohort  Turning 60, 65 or 70 years old (depending on the implementation stage) until aged 80 years	Severely immunosuppressed cohort: call at 50 years old (opportunistic or if requested after with no upper age limit) including newly diagnosed as severely immunosuppressed.  Immunocompetent cohort: Call at when become eligible ie turning 60, 65 or 70 (depending on the implementation stage), opportunistic or if requested until aged 80 years.
<b>RSV</b> All adults turning 75 years old on or after 1 September 2024 will be eligible for the routine programme and should be offered a single dose of the RSV vaccine on or after their 75th birthday.	All adults aged 75-79	Proactive call and recall older adults (age 75-79) for their vaccine when they become eligible.  This vaccination can be opportunistically and on request offered in GP practices to eligible pregnant women and patients (usually offered in maternal services).

# More tips and information

## Who can administer the vaccine?

In addition to GPs and Nurses, Healthcare Assistants can administer the shingles and pneumococcal vaccines, if they are appropriately trained, meet the required competencies and have adequate supervision and support. Healthcare Assistants can administer the vaccines if they are appropriately trained and meet the required competencies and have adequate supervision and support. Healthcare assistants cannot use a PGD as legal authorisation for administration, and therefore a Patient Specific Direction is required, which ensures each patient has been clinically assessed by a prescriber to confirm that it is safe and appropriate for them to receive the vaccine.

Further information on legal authorisations such as PGDs and PSDs is available [here](#). The list of professions that can use a PGD as legal authorisation is [here](#). Professions not listed here are not yet included in the regulations and so they must not use PGDs as legal authorisation.

## Care Homes & Housebound patients

Consider running immunisation clinics at any nursing homes that your practice serves following cold chain guidance as appropriate. Not only will this ensure that these patients are offered their shingles and pneumococcal vaccination, but it also provides an easy opportunity to administer the vaccine to a large number of eligible patients and can occur when administering other vaccines, such as flu or Covid-19.

Make sure your housebound patients are offered the vaccine too, with or without their annual influenza vaccination. District nurses are also able to administer the shingles and pneumococcal vaccine.

## Checking your practice uptake rates

You should check your practice performance and uptake rates regularly. To do this, you should log onto [ImmForm](#) where you can view past performance and uptake rates for the quarter. You will also see your denominator data (the size of your eligible population).

📞 0207 183 8580

✉️ [helpdesk@immform.org.uk](mailto:helpdesk@immform.org.uk)





# Inviting and informing patients

## Phone your patients

General awareness of the vaccination and the seriousness of infection are poor. A personal telephone call is often all it takes to encourage a patient to book an immunisation appointment. The call should therefore be undertaken by someone who is well briefed on what the shingles vaccination can offer patients.

A 2005 Cochrane review found that patient recall systems can improve vaccination rates by up to 20%: telephone calls were the most effective method.

## Text or write to patients

Sending text or email reminders is a cheap and easy method of improving appointment attendance. For patients who do not have mobile phones or email, letters and telephone calls should be used.

Sending a birthday card or letter may help encourage patients to attend their vaccination appointment (ie shingles vaccination invite postcards are available [here](#)).

Letters should be personal and from the named GP.

Send immunisation information alongside the invitation letter to ensure that patients are given sufficient information to reach an informed decision about vaccination ie [Vaccination NHS](#), [Vaccine Knowledge](#) or any printed leaflets [HealthPublications](#)

## Publicise vaccination information in your surgery and online

Some examples of easy publicity approaches include:

- a) Display bunting, leaflets, and posters around the surgery and in clinic rooms
- b) Add messages to the waiting room TV screen
- c) Advertise on the practice website
- d) Add a message to the prescription counterfoils
- e) Publicise in patient newsletters

Resources available here: [HealthPublications](#) / [NHS vaccinations and when to have them](#) / [Help Us Help You - Vaccinations](#)

## Make Every Contact Count

Talk to your patients about vaccination (and consider administering it) **during other appointments**, to save multiple attendances at the surgery.

Vaccine confidence resources which are aimed at **supporting healthcare professionals in having vaccine conversations with their patients** are available on the FutureNHS platform and can be accessed [here](#)

They provide guidance for effectively addressing low vaccine confidence and empowering informed decisions among patients.