

Interim findings of the Vaccinations and Immunisations Review – September 2019

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NHS England and NHS Improvement





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Introduction

CONTEXT

1. Immunisation and vaccination is one of the most impactful public health interventions in terms of reducing preventable morbidity and mortality. In England, vaccinations are offered to patients throughout their lives and are delivered through a combination of general practice led services, school health services and other providers such as community pharmacy.
2. Whilst coverage for most vaccines, especially primary courses of childhood immunisations, is high, there has been a small but steady decline in the last few years, meaning that we do not have a high enough coverage to prevent onward transmission of infections, particularly measles. One of the consequences of this is that the UK lost its “measles-free” status with the World Health Organisation (WHO). The WHO has stated that in the first six months of 2019 reported measles cases globally are almost three times as many as the same time last year.¹ There are a multitude of factors which affect this. Macro-factors include changing public attitudes to expert opinion, perception of risk of diseases which are now thankfully rare, and the impact of social media. Micro-factors include the practical logistics of accessing appointments, accurately tracking coverage and communicating with patients and parents.
3. Given this broad context, the Department of Health and Social Care (DHSC) will publish a vaccination strategy in the autumn to maintain and develop the UK’s world-leading immunisation programme.² Multiple actions are needed to address the decline in childhood immunisations. General practice has an important role to play in supporting increased uptake and the findings of this Review will feed into DHSC’s broader vaccination strategy.

¹ <https://www.gov.uk/government/news/prime-minister-orders-urgent-action-to-improve-vaccination-uptake>

² <https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document>

OVERVIEW OF THE REVIEW

4. *Investment and evolution: a five-year framework for GP contract reform* committed to undertake a review of vaccination and immunisation procurement, arrangements and outcomes in 2019.³ It is important that the contract architecture incentivises improvement in coverage, in so far as general practice can influence it, and that any barriers to this improvement (for example through complex payment arrangements) are removed.
5. The purpose of the Vaccinations and Immunisation Review is to:
 - Ensure the system incentivises achievement of appropriate uptake rates for immunisations in line with national public health uptake rates;
 - Reduce the administrative burden on general practice by simplifying the system if possible;
 - Clarify what is expected on call/recall for all S7a immunisations;
 - Address anomalies in the system that directly incentivise some vaccines but not others;
 - Look at how we deal with outbreaks and catch-up programmes;
 - Consider whether we extend the list of chargeable travel vaccines.
6. The intention of the Review is to reduce complexity, improve value and increase impact.
7. The Review forms part of a wider package of reforms to strengthen general practice and enable delivery of NHS Long Term Plan goals. It is closely aligned to the wider work we are doing to:
 - support the development of primary care networks;
 - address the serious workforce shortfall in primary care. A major new reimbursement scheme at network level will bring in over 20,000 additional staff in five defined roles;

³ <https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

- simplify and improve access and deliver digital first primary care.
8. An advisory group was established in April 2019 to oversee the Vaccinations and Immunisations Review. This comprises representatives from:
- British Medical Association (General Practitioners Committee England)
 - Department of Health and Social Care (DHSC)
 - National Institute for Health and Care Excellence (NICE)
 - NHS England and NHS Improvement
 - Pharmaceutical Services Negotiating Committee (PSNC)
 - Public Health England (PHE)
 - Royal College of General Practitioners (RCGP)
 - Royal College of Nursing (RCN)
9. The Advisory Group has met on five occasions since April 2019, with a focus to date on reviewing available data on uptake of vaccines and current GP contractual arrangements including:
- The current structure of general practice payments;
 - Incentive schemes including the childhood target incentive scheme;
 - Call and re-call requirements and opportunistic vaccination.⁴
10. Engagement events have been held with NHS England and NHS Improvement Directors of Primary Care and Public Health and Heads of Public Health, PHE Screening and Immunisation Leads, the Association of British Pharmaceutical Industries and general practice staff to hear their

⁴ Opportunistic vaccination: this is where practices opportunistically vaccinate eligible patients when they present, rather than proactively identifying and calling a patient for a vaccination.

views. The Review has also drawn on patient engagement undertaken by PHE and the Royal Society for Public Health.⁵

11. This paper summarises the interim findings of the review. Where applicable, recommendations will be taken into the 2019/20 GMS contract negotiations with the BMA (GPC England). As such, and for reasons of commercial sensitivity, we have included high level principles for reform rather than detailed proposals in this report. The final details will be published following the conclusion of negotiations.
12. The Review will continue for the remainder of the year. In the second half of the Review, the advisory group will consider:
 - Travel vaccinations;
 - Outbreaks and catch up programmes;
 - Further areas for improvement.
13. We will continue to listen to views from patients, practices and commissioners over the coming months, which will help inform the final recommendations.

⁵ RSPH (2018) Moving the Needle: Promoting vaccination uptake across the life course. RSPH: London available from <https://www.rsph.org.uk/our-work/policy/vaccinations/moving-the-needle-promoting-vaccination-uptake-across-the-life-course.html>

Assessment of the current payment system and incentive structures

14. The advisory group has started by reviewing current contractual arrangements, specifically payment and incentive structures on the assumption that financial incentives and the contractual arrangements are one factor that could help drive improvements in delivery and coverage. These payment structures have not been reviewed since the implementation of the 2004 GMS contract, despite the significant increase in the number of vaccines now offered to patients through their lives.
15. This expansion in the vaccine schedule has been addressed by 'bolting' additional elements (usually item of service payments) onto the relatively simple payment structure introduced in 2004 where all routine vaccines, with the exception of seasonal influenza, were funded through a capitation payment, supplemented with incentives to support coverage of key childhood immunisations.
16. The advisory group noted the following key points in their review of current arrangements:
 - Coverage for most vaccines is high and comparable with other high-income countries⁶, although there has been a small but steady decline in the last few years.⁷ Coverage for primary courses of childhood immunisations are around 90% and we have some of the highest vaccination rates in the world for pertussis in pregnancy and flu vaccination in healthcare workers. However, there was agreement that there was scope for improvement in order to reach WHO recommended coverage targets.

⁶ http://apps.who.int/immunization_monitoring/globalsummary/timeseries/tswucoveragemcv1.html

⁷ NHS Digital (2018) Childhood Vaccination Coverage Statistics available from <https://files.digital.nhs.uk/55/D9C4C2/child-vacc-stat-eng-2017-18-report.pdf>

- Practice engagement with the vaccination programme is high, with almost all practices offering vaccination services.⁸ General practice was felt to be delivering a high quality service and the group agreed that general practice-led vaccination should continue to be the main delivery route for most vaccination programmes, even if in specific cases it was supplemented by new delivery channels and options.
- Accessibility and convenience of appointments is an important factor in contributing to uptake levels. Whilst other providers could complement existing provision in order to improve access and uptake, general practice was noted as being a convenient place for the delivery of this care, particularly for routine childhood immunisations, and is a trusted provider particularly for young children.
- There would be benefit at practice level in clarifying the different funding streams (global sum, item of service payments and incentives) and what was covered through global sum payments. This mixed payment model can make it challenging for practices to be able to monitor and model income and activity. Annex A provides a high level summary of current contractual and funding arrangements.
- There would be benefit in specifying requirements of practices in relation to call/recall requirements and how these differed from opportunistic vaccination offers.
- Expanding staffing in general practice including practice nurses and support staff, and opportunities to streamline and reduce burden will both help.
- The current childhood incentive scheme was felt to be outdated because the current coverage targets (set at 70% and 90% coverage) are misaligned to the levels of coverage required for population protection.⁹ It was felt the current “cliff edge” incentive design does not always support improvement and there are understandably areas that could be improved.

⁸ Only five practices are known to have opted out of delivering vaccinations and immunisations additional services.

⁹ http://www.euro.who.int/_data/assets/pdf_file/0008/276659/EVAP-ENG.with-front.pdf?ua=1

- There is some evidence that the QOF targets are easily understood and have supported uptake, but they only represent a fraction of the eligible groups for vaccination.¹⁰
- The challenges of ensuring up-to-date data about practice performance on key immunisation targets and maintaining an accurate medical record were also noted, together with their importance in supporting accurate data collection. Issues with data flows between secondary care, community pharmacy and general practice were noted.
- Practices would welcome more timely and accurate sharing of data to help them benchmark their performance locally and more easily see their contributions to local targets. Along with access to consistent support, information and quality education.

¹⁰ Dexter et al. 2012 Strategies to increase influenza vaccination rates: outcomes of a nationwide cross-sectional survey of UK general practice. *BMJ Open* 11;2(3). Doi: 10.1136/bmjopen-2011-000851 available from <https://bmjopen.bmj.com/content/2/3/e000851.long>

Principles for reform

17. The advisory group agreed to develop a set of future proofed recommendations which will support:
- Sustained, and where necessary, increased uptake of vaccinations and immunisations in order to protect individual health and meet public health objectives;
 - A reduction in variation in vaccination rates and in inequalities;
 - Improved personalisation of care and patient experience;
 - Where possible, a reduction in contractor burden;
 - Fair and transparent funding arrangements for general practice and community pharmacy which also secures value for money for the taxpayer;

And be deliverable within the current funding associated with immunisation.

18. The advisory group recognised the valuable contribution made by general practice to uptake levels and were keen to enhance and strengthen the delivery model rather than radically change it.

Opportunities for payment structure reform

19. The group has agreed that any reform to payment structures should aim for greater simplicity and transparency than the current system. It should seek to build on the current strong foundation for vaccine delivery, whilst addressing known weaknesses and potential areas for improvement.
20. The proposals we set out below form a component part of a wider strategy to increase uptake. They aim to support and challenge practices to maximise their impact and address the barriers to vaccination which are within their control.
21. But the advisory group acknowledges that payment structure reform can only go so far, and we need to take a holistic approach to address the multifaceted barriers to uptake.
22. The initial opportunities we have identified are to:
 - i. Simplify payment structures wherever possible and align payment mechanisms with their intended impact. We consider there should continue to be three types of payment: a capitation payment to encompass provision of the necessary infrastructure to deliver the vaccinations and immunisations services; an item of service payment should reward actual delivery of vaccinations and immunisations; and incentives could provide an additional impetus to achieve optimal coverage of specified vaccines. However, the blend of these three payment types should be adjusted. In particular for MMR there was a case for greater weight on item-of-service payments.
 - ii. Reform the current childhood immunisation target incentive scheme to help increase uptake. We have discussed:
 - (1) Alignment of the scheme with the targets set out by the WHO to ensure population protection;

- (2) Further clarification of what practices are expected to deliver;
- (3) Improved monitoring and data flows to make it easier for practices to see how they are doing and improve performance.
- iii. Consider broadening the range of vaccines included in any incentive scheme to support uptake. At present incentives to support practices to achieve optimal coverage are limited to three childhood vaccines through the Childhood Immunisation Target DES and seasonal influenza immunisation for four 'at-risk' groups in the Quality and Outcomes Framework. There may be relative benefits of a focus on other vaccines to promote improved coverage.
- iv. Consider the potential for incentives to be aimed at the primary care network in the future, particularly where achieving optimal vaccination coverage is best addressed at a community level and where there is a shared endeavour between different providers. This includes whether there are vaccines which could be safely and efficiently delivered by providers in the network other than general practice, building upon the contribution of Community Pharmacy to seasonal influenza coverage.
- v. Consider widening the range of health professionals who deliver convenient MMR vaccinations, possibly including health visitors and community health professionals, in addition to the expansion of the existing school health services.
- vi. Clarify core delivery standards including vaccine requirements, patient eligibility and call/recall requirements. Amendments to the GP contract will make it clearer what is expected of individual practices.
- vii. Clarify expectations on a programme by programme basis and ensure that these align with public health and other national targets. This is to ensure all providers are working to deliver the same ambitions.
- viii. Ensure information on vaccinations and immunisations is easily accessible and in one place for practices.
- ix. Explore the role of the primary care network and multidisciplinary team in promoting best practice among its members and maximising clinical and

administrative capacity and increasing the availability of vaccination appointments through the broader access offer.

23. The detail of these recommendations and how they could be operationalised will be discussed in the contract discussions with GPC England.
24. The advisory group has also identified several broader recommendations, which whilst not contractual, will be necessary to the success of any contractual changes. These include:
 - i) continue to provide information about vaccine safety and effectiveness to tackle concerns about misinformation and 'vaccine hesitancy'
 - ii) Improvements to the flow and timeliness of data to general practice from other providers.
 - iii) Greater data transparency to help practices to monitor their performance.
 - iv) Availability and use of IT tools to support the identification of people both eligible for particular vaccinations and those with an incomplete vaccine history, to support opportunistic offers.
 - v) Improvements to the availability and quality of training for staff through work currently being progressed by the NHS England and NHS Improvement Section 7a team in line with the national minimum training standards.

Next steps

25. We look forward to discussing the outputs of this interim report with patients, commissioners and industry, and to working with the advisory group and other key stakeholders to develop further recommendations.
26. Comments on this report can be shared at england.pcstrategyandnhscontracts@nhs.net by 15 November 2019.
27. Recommendations will be taken into the 19/20 GMS contract negotiations with the BMA (GPC). Agreed changes to the GP contract would be implemented from April 2020 onwards.
28. Recommendations from this Review will also feed into the development of DHSC's emerging vaccination strategy which is expected to be published shortly.
29. NHS England and NHS Improvement would like to thank all those who have given their time and expertise to support the work of the review thus far. In particular we are grateful for the support of the Advisory Group and all those who participated in our engagement events.

Annex A: Summary of contractual arrangements

30. In 2004, the new General Medical Services contract defined vaccination and immunisation services as two 'Additional Services': one for childhood vaccinations and the other for adult vaccinations. Included in this service were all the routine childhood immunisations, travel vaccines, a small number of adult vaccines and expectations of general practice in the event of outbreaks of specified conditions.
31. Practices could choose to opt out of the delivery of these services (as they could for all additional services). Those who did so experienced a reduction in their global Sum payments of 1-3% depending upon whether they opted out of providing childhood immunisations, adult immunisations or both.
32. These Additional Services were supplemented by two Directed Enhanced Services (DES): the Childhood Immunisation Scheme and Seasonal Influenza vaccination. These remain in place today.
33. The childhood immunisation scheme DES describes the additional incentives available to practices who achieve either a lower (70%) or upper target (90%) of completed doses of specified childhood immunisations in children turning two years and five years.
34. The seasonal flu DES describes an item of service payment for the delivery of a flu vaccination and the groups of patients who are eligible for this vaccination.
35. However, since the 2004 contract was agreed there has been a significant increase in both the number of vaccines in the childhood and adult schedule and the complexity of eligibility criteria.
36. The contractual response to new vaccines being added to the schedule to date has been to 'bolt' these on to the existing contractual mechanisms. This has usually included agreement of an item of service payment for the delivery of the vaccination and the description of the who should be offered the service

and when being defined in either the Statement of Financial Entitlements (the legal document which describes practice payments) or an Enhanced Service specification.

37. Whilst these responses have provided a contractual mechanism to ensure continued support and funding for general practice to deliver vaccination services it has also created more complex payment arrangements than those envisaged in 2004. The table below summarises the vaccines provided through general practice and their respective funding mechanisms.

38.

Vaccine(s)	Payment
Anthrax, diphtheria, tetanus and polio, hepatitis A, MMR, MenC, rabies, typhoid and paratyphoid	Global sum
Cholera, hepatitis (polio and typhoid may be offered to persons traveling abroad)	Global sum
Routine childhood immunisations	Directed enhanced service – targeted payment scheme Global sum
Childhood seasonal influenza	Item of service
Hepatitis B (at risk children)	Item of service
HPV	Item of service
Meningococcal B	Item of service
Meningococcal completing dose	Item of service
Meningococcal ACWY freshers	Item of service
Rotavirus	Item of service
Pneumococcal Conjugate (PCV)	Item of service
Seasonal influenza	Item of service
Pertussis	Item of service
Measles, Mumps and Rubella (16 and over)	Item of service
Seasonal influenza	Item of service
Pneumococcal Polysaccharide (PPV)	Item of service
Shingles (2 separate programmes)	Item of service
Seasonal influenza vaccinations - coronary heart disease, stroke, diabetes and chronic obstructive pulmonary disease	QOF - thresholds