NHSEI engagement on the future shape of vaccination services and opportunities to integrate the COVID-19 vaccination programme with other NHS-delivered immunisations

Royal College of General Practitioner comments, 7 October 2022

1. **Do you agree with the proposed vision for a future vaccination offer to the public (annex A)? If not, why not?**

Overall, the aims set out to underpin the NHSEI vision for a future vaccination in annex A describe positive goals which we would agree with, including to improve uptake and coverage, address health inequalities relating to vaccine uptake, make every contact with individuals count and to build on the raised awareness of the importance of vaccinations from the COVID-19 pandemic.

However, the detail of how this is all achieved operationally will be important, and it is not yet possible to make a fully informed opinion on how this is best achieved. There may be some trade-offs between achieving each aim, and it is essential that striving for increased efficiencies of scale or other changes does not inadvertently weaken some of the key strengths and benefits of existing vaccination programmes in England. We see vaccinations as a broadly important part of general practice, working with other services in the community. Moving towards these goals for vaccinations should be part of the wider direction of travel towards neighbourhood teams, as set out in the Fuller Stocktake, which will require a wide range of actions and resources.

At least in the near-future, general practice should retain a key role in vaccinations. This doesn't necessarily mean that all, or even a majority, of vaccinations should be delivered by general practice staff, and non-clinical staff can play an important role in the delivery of vaccinations, with appropriate clinical oversight.

The proposals set out would require additional funding, including for infrastructure and workforce training and expansion (both clinical and non-clinical).

There were some varied views from our wider clinical network on the vision around integration of COVID-19 vaccinations with flu vaccinations, particularly around workload implications. Some felt that they needed to see further data and evidence before being able to determine the appropriate covid vaccination schedule and how it is best integrated.

2. **What national, regional, or local barriers currently exist to achieving this vision?**

The lack of workforce across NHS services is a limiting factor to achieving this vision, particularly of nursing staff. Estates would need to reviewed in light of this vision, and vaccination provision should be included in wider reviews of the needs of primary and community care estate. There are also various issues with technology and data which we have outlined in other answers to this engagement exercise. Vaccine misinformation also remains an issue that needs to be tackled in a comprehensive way.

3. **What national, regional, or local enablers would support this vision?**

Tapping into the expertise of clinicians and other staff who have direct experience of managing and delivering vaccinations locally will be critical across national, regional and local levels of planning.

We agree that actions to improve technology and data infrastructure should be used to enhance the experience of booking and recording vaccinations for patients and staff. NHSEI should consider how to help improve practice IT systems to enable patients to book directly into vaccination services, including within general practice, by-passing the usual reception routes where that's possible. Systems should enable patients to see when their appointment is and change it where needed. Care should be taken to ensure that previous appointments are cancelled if an alternative appointment is booked, especially if different systems are being used for different vaccination sites. Lessons should be learnt from the use of the COVID-19 national booking system for PCN vaccination sites.

There is significant work required to ensure that IT systems across a locality can share patient vaccination information - both appointment booking and vaccination history - easily and effectively, so that there is an accurate shared record of vaccination data. This is important to avoid duplication of efforts and to make sure patients receive the right information. Once again, lessons can be learnt from the daily sharing of COVID-19 vaccination data across systems.

IT systems for the recording of vaccinations should be procured with co-administration needs in mind, as was done last year for COVID-19 and flu vaccinations. This single point of data entry can significantly increase vaccination clinic efficiency. As far as we understand, the Pinnacle co-administration template which was available last year has not been re-procured.

Data quality and recording is also key to supporting the goals set out in this vision. IT systems must be designed with structured data entry in mind making the process as simple and quick as possible for vaccinators while ensuring accurate recording of the required information. Steps should include restricting what can be entered into certain fields, such as the batch number, in order to avoid errors and minimise variation. This is critical to allowing for accurate recording and analysis and, in particular, for certification purposes.

One suggestion from our network is to consider creating a centralised system within local areas which trains, employs and maintains a stand-by group of individuals who can be deployed to take on additional work at peak vaccine demand times within primary care. Part of this could be about provision of a pot of flexible funding to allow practices to enlist the support of other staff during peak times in ways that are most suitable to their community.

Another practical suggestion was to barcode all vaccines to enable fast and accurate recording with the right code of vaccines on the GP IT System.

4. **Across all immunisation programmes, what is currently working well at national, regional or local level (e.g. commissioning frameworks, workforce models, supply routes etc) that you would not want to be lost? And what is working less well?**

The UK has relatively high vaccination rates and this may be in part due to the strong role of general practice. There are significant strengths to existing vaccination programmes. Previous changes to vaccination programmes agreed in 2021 haven't been given significant time to bed-in. While it is important to continue to build on improvements and positive learnings, there is no evidence to suggest we should be making drastic changes to vaccinations programmes overall. Any major changes will also take time, due to procurement and planning cycles. The current planning cycle for flu vaccinations also means that providers have to plan a year in advance, which can be quite rigid and doesn't able much flex in the system to adapt.

It is crucial that any changes to vaccination programmes do not have a major impact on the holistic care that general practice provides. While some of the delivery of vaccinations could potentially move to other providers, and indeed some vaccinations are already delivered in other settings, vaccinations programmes should remain a key part of general practice. For example, 'opportunistic' vaccinations play a key role in high uptake of vaccines, and we need to make sure this is not lost. This means that practice settings and other traditional settings need to retain the ability to deliver key vaccinations.

It will be important to ensure any vaccination programme considers sufficient availability to people who are house-bound, which is currently delivered by GP teams and district nurses.

It is widely felt that patients are more likely to attend premises they are familiar with such as their GP practice or community pharmacy and asking people to travel further or somewhere less familiar may reduce uptake. Any increase in physical distance for patients to travel could act as a barrier to vaccination update. Vaccinations need to be convenient to access. Repeated surveys also show that patients have trust their GPs and their teams, and there is a real risk that removing some vaccinations services away from practice settings could potentially reduce uptake.

General practice and community pharmacies were able to play such a crucial role in pandemic vaccination efforts because they have been set up to do this for their local populations for some time, particularly reaching the most vulnerable through general practices. This includes training in immunisations and vaccinations which is crucial, as well as being integrated as part of their communities. It is important we don't lose this strength.

As outlined above, there needs to be better recording and reporting systems for vaccinations, including rapid data flows between different systems, so as not to rely on the patient knowing their history of vaccinations.

Communication and commissioning have vastly improved, but we have received feedback that there is still a need to give practices more advanced warning and information regarding planned vaccination campaigns. This includes practices that aren't directly involved in delivering vaccinations within primary care, as patients often contact practices as a first port of call for queries.

Some GPs have fed back to us that delivery of vaccines has been varied, which can risk wasted appointments and increased workload, and therefore there was a call for improved reliability.

Childhood vaccinations rates have improved, however, those that don't attend are at higher risk of needing more care. Further efforts should be focussed here.

5. **Based on your experience and knowledge, what delivery approaches drive the best uptake and coverage in all immunisation programmes, particularly amongst under-served communities? How could these approaches be scaled up, adapted or applied to a wider set of immunisations?**

Personal approaches from people within a community drives good uptake from patients. Primary care staff should be supported with dedicated resources to reach harder-to-reach groups, but approaches should also consider how to involve community leaders and the third sector to enhance impact.

Effective communications at a local and national level are helpful. This should include clear communication about individual benefits. Social media has been effectively used to give repeated nudges, providing easy to understand information on why vaccines matter, and rebuttal of antivax commentary. There could be better information made available directly to the patient about vaccinations e.g. through patient apps and other communication campaigns to help to avoid repeated contacts to primary care to ask questions. Dispersing where vaccinations are delivered across providers could also potentially lead to patient confusion about where to go for what, and this would need to be factored into any decisions and planning.

Making vaccinations as accessible as possible is important to driving up uptake. Ways to do this includes utilising schools, community centres, drop-in clinics at various times, places of employment and community pharmacists to make vaccinations as accessible as possible

The South-Central-West (SCW) Oxford initiative is a useful example of a programme aimed at increasing uptake. Specialised nurses were appointed to practices. One of their roles was sorting out coding of vaccines to ensure this was properly recorded. They also looked at timings available and then reached out to people within the community to talk about what would work for them. This enabled practices to adapt their programme to meet the needs of patients. They also worked to help education people about the importance of vaccinations at a local level which proved effective.

6. **What innovations are you aware of in the delivery of covid or other vaccinations, either through piloting or full implementation, that you would want to keep or see applied more widely? Have any of these innovations been delivered in spite of barriers and, if so, could those barriers be removed to help the innovation to continue?**

For the general population, vaccinations need to be easily accessible and reliable. Only those in harder-to-reach or some high-risk groups require more tailored innovations.

As mentioned above, engagement with charitable or faith communities and public leaders of communities helped to improve up-take of COVID-19 with harder to reach communities.

One suggestion was providers having access to 'pop-up' options for vaccinations in places where there is already high footfall, such as religious centres or other community centres, may be useful. This may be more effective in some areas than others.

7. **Are you aware of any improvements that are being considered or planned for existing immunisation programmes that you are involved in or otherwise? What benefit are these expected to have? What national actions would support these improvements?**

Recruitment of volunteers and training new vaccinators from non-healthcare backgrounds is underway in some areas.

West Yorkshire & Harrogate are reviewing their Estates Strategy to look at utilising empty/vacant shops in town centres which would work as vaccination hubs for high volume/high footfall programmes.

See the example of the South-Central-West (SCW) Oxford initiative above.

8. **What would be the critical elements of a future delivery model in your region/system/organisation, and what commissioning and contracting approach is best suited to the delivery of this model?**

A mixed approach would be preferable and one size does not fit all, and different vaccinations may need different approaches. For most general vaccinations, a national approach may work for the majority of the population, but harder to reach and high-risk groups should be targeted with local enhanced services.

The RCGP is not able to go into detail about contracting details at this stage as this is predominantly BMA GPC business.

9. **What are the additional activities/interventions that are currently, or could be, offered as part of or alongside a vaccination episode?**

This will very much depend on the workforce involved in vaccinations and time/capacity which is already very stretched. However, this does or could include:

- Smoking cessation and signposting
- Blood pressure check ups
- COPD checks
- Weight check-ups and sign posting re weight management
- Diabetes prevention counselling
- Reminders on national screening programmes i.e. smears and bowel
- Any other overdue health activity or check
- Pregnancy advice for those at childbearing age
- Research study invitations
- Mental health checks

10. **What high level outcomes should we seek to achieve across immunisation programmes? For example: levels of uptake and coverage within the population; avoidable morbidity and mortality; improvements in coverage for relevant under-served populations within that geography; reductions in avoidable outbreaks; etc.**

Overall, we agree with the high-level aims set out in the vision. We saw high uptake for COVID-19 vaccines, and although it is important to try and build on the learnings from COVID-19, some of the high uptake may be due to the emergency situation and significant publicity it received. It may not be possible to entirely sustain the same levels of uptake.

On top of the aims already identified, high-level outcomes should also include:

- Good levels of up-take overall, but particularly amongst more deprived communities, underserved populations, and high-risk groups
- Reduction in avoidable sickness and mortality, including severity of infection
- Avoidance of harm
- Increased levels of informed consent in patient populations
- A very high (almost complete) childhood vaccines coverage
- For those with learning difficulties, there should be an aim for full coverage of seasonal flu and covid vaccines
- For those aged 60+ there should be an aim of high coverage of the flu vaccine

11. **Please highlight any other important issues which you believe we should be aware of when designing the delivery arrangements for future vaccination services, setting out: (a) why you think these need to be taken into consideration; and (b) any views you have of how these should be managed through appropriate commercial mechanisms.**

Evidence around how far people will travel for vaccinations and how this affects uptake needs to be taken into consideration in planning vaccination programmes.

Workforce should be a key consideration for any proposed vaccination programme. Funding for vaccinations sometimes contributes to funding for part of a full-time member of staff within a practice. When combined with other practice activity, this often makes up a full-time member of staff who can provide holistic care for patients. It is important that any movement of vaccinations programmes does not inadvertently reduce the number of staff in general practice able to deliver whole-person care. Consideration should also be given to whether roles being created to wholly deliver vaccines would be varied enough to create sustainable careers.

As GPs generally do not deliver vaccinations directly themselves - rather it is usually the nursing team - any changes to where or how vaccinations are delivered should not overstate the workload savings for GPs specifically.

We received some feedback about the "mandatory training" for staff to be involved in vaccinations, and that this needs reviewing.

Learnings from other countries - including Scotland - should be incorporated into the vision as further intelligence is gathered. Scotland's model has seen some vaccinations predominantly moved out of general practice. It is too soon to make a full judgement on these changes, but there are a number of concerns with progress so far emerging. This includes of reports of vaccination centres competing for trained staff including nurses, and excess vaccines being passed back to GP practices.

It is essential that any programme created is not completely 'top down' and involves those on the ground delivering local services. It is also important that there isn’t too much unnecessary bureaucracy in rolling out any vaccine programme.