

Report on Immunisation Services in the Borough of Merton

Prepared by: NHSE (London) Immunisation Commissioning Team

Presented to: Merton Health Scrutiny Committee

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Aims

This paper provides an overview of Section 7a immunisation programmes in the London Borough of Merton. This paper focuses on childhood immunisations.

It covers the vaccine uptake for each programme and an account of what NHS England London Region is doing to improve uptake.

Members of the Merton Health Scrutiny Committee are asked to note and support the work that system partners across London, including NHSE (London), the Local Authority, and the Integrated Care Board (ICB) are doing to increase vaccination uptake in Merton.

Background

The World Health Organization (WHO) states that vaccinations are one of the public health interventions that have had the greatest impact on the world's health. Vaccination is also one of the most cost-effective public health interventions. High immunisation rates are key to preventing the spread of infectious disease, protecting from complications and deaths. Childhood immunisation in particular helps to prevent disease and promote child health from infancy, creating opportunities for children to thrive and get the best start in life.

Section 7a immunisation programmes are population-based, publicly funded immunisation programmes that cover the life course and include:

- Routine Childhood Immunisation Programme for 0-5 years
- School-age vaccinations
- Adult vaccinations
- COVID-19 vaccination programme

Routine Childhood Immunisation Programme for 0-5 years

| Age Due | Diseases protected against |
|--------------------------------|---|
| 8 weeks | Diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib) and hepatitis B |
| | Meningococcal group B (MenB) |
| | Rotavirus gastroenteritis |
| 12 weeks | Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B |
| | Pneumococcal (13 serotypes) |
| | Rotavirus |
| 16 weeks | Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B |
| | MenB |
| 1 year | Hib and Meningococcal group C (MenC) |
| | Pneumococcal |
| | Measles, mumps and rubella (German measles) |
| | Meningitis B (Men B) |
| Eligible paediatric age groups | Influenza (each year from September) |
| Three years four months | Diphtheria, tetanus, pertussis and polio (4-in-1 pre-school booster) |
| | Measles, mumps and rubella |

The full immunisation schedule can be found in the [Green Book](#). Changes to this schedule are regularly reviewed and recommendations are made at the UK Joint Committee on Vaccination and Immunisation (JCVI).

The European Region of the World Health Organization (WHO) currently recommends at least 95% of children are immunised against diseases preventable by immunisation and targeted for elimination or control, specifically, diphtheria, neonatal tetanus, pertussis, polio, Haemophilus influenzae type b (Hib), Hepatitis B, measles, mumps, and congenital rubella.

There is an expectation that UK coverage rates of all routine childhood immunisations up to 5 years of age achieve 95%.

Roles and responsibilities

The Department of Health and Social Care (DHSC) provides national strategic oversight of vaccination policy in England, with advice from the independent Joint Committee on Vaccination and Immunisation (JCVI) and the Commission on Human Medicines. They also set performance targets.

NHS England (NHSE) is responsible for commissioning national immunisation programmes in England under the terms of the Section 7a agreement, National Health Service Act 2006. NHSE is accountable for ensuring that local providers of services deliver against the national service specifications and meet agreed population uptake and coverage levels. NHSE is also responsible for monitoring providers' performance and for supporting providers in delivering improvements in quality and changes in the programmes when required.

The UK Health Security Agency (UKHSA) undertakes surveillance of vaccine-preventable diseases and leads the response to outbreaks of vaccine-preventable diseases. They provide expert advice to NHSE immunisation teams in cases of immunisation incidents.

Integrated Care Systems (ICSs) have a duty of quality improvement, and this extends to primary medical care services. ICBs provide opportunities for improved partnership working across NHSE (London), local authorities, voluntary and community sector partners to improve immunisation uptake and reach underserved areas and populations. NHSE (London), alongside ICBs, local authorities and others, will work to progress delegated commissioning for vaccination and screening. It is anticipated that the first wave of delegation of the commissioning of immunisation services will be in Spring 2024.

Local authority public health teams deliver population health initiatives including improving access to health and engagement and promotion of immunisations overall.

Pre-school and adult vaccinations are usually delivered by GP surgeries. They are commissioned through the NHS GP contract. Five core GP contractual standards have been introduced to underpin the delivery of immunisation services: a named lead for vaccination service, provision of sufficient convenient appointments, standards for call/recall programmes and opportunistic vaccination offers, participation in nationally agreed catch-up campaigns, and standards for record-keeping and reporting. One of the five Quality and Outcomes Framework (QOF) domains is childhood vaccinations and shingles vaccination, rewarding GP practices for good practice.

School-age immunisations are commissioned by the seven regional NHSE teams and delivered through School Age Immunisation Services (SAIS).

Vaccinations are also provided by maternity services, some outreach services, and community pharmacies.

Inclusion and Equity

The problem is not just overall coverage but the variation in coverage across groups, which can increase the likelihood of preventable outbreaks locally. Groups with lower coverage include migrants, urban communities, more deprived communities, and certain ethnic groups.

People migrating to the UK can have different vaccination schedules or lower vaccination rates overall. This may be due to different national vaccination schedules, missed vaccinations in the country of origin, or missed opportunities for vaccination after arrival to the UK.

Geographic vaccine coverage varies, with lower coverage in urban areas and London, compared to England as a whole.

At a national level, there are some small inequalities by socioeconomic status, with coverage being slightly lower in lower socio-economic groups.

For the routine childhood vaccinations, there is no simple relationship between ethnicity and coverage. The relationship varies by immunisation programme and by area. However, coverage does appear to be more consistently lower than White-British children in certain ethnic groups, for example, Black Caribbean, Somali, White Irish, and White Polish populations. Some ethnic groups, notably South Asian ethnicities, have broadly similar and sometimes higher vaccination coverage than White children. For MMR these relationships were less consistent, in that coverage in children of White ethnicity could be lower or the same as other non-White groups, thought to perhaps reflect differences with respect to awareness of the MMR controversy. For HPV, lower indicators of coverage were consistently seen for non-White ethnic groups.²

Data Nationally

Overall, coverage for most vaccines in England is high and comparable with other high-income countries although there has been a small but steady decline in the last few years. Nationally, in 2021-2022, vaccine coverage decreased by 0.2% to 1.1% depending on the vaccine. No vaccines met the 95% target. Coverage for the 6-in-1 at 5 years decreased from 95.2% in 2020-21 to 94.4% in 2021-22.

Data Regionally

Historically and currently, London performs lower than the national (England) average across all the immunisation programmes. Uptake in London has also fallen over the past 6 years and has fallen further than elsewhere in the country.

Every borough in London is below the 95% WHO target. For some vaccines such as MMR, all London boroughs have an uptake below 90%. Two-thirds of all measles cases in 2023 in England were in London.

London has a highly mobile population, a large migrant population, and areas of high deprivation. In London, vaccine uptake is lower in areas of higher deprivation compared with areas of low deprivation across all ethnicities.

Data for Merton

| Immunisation | England | London | SWL | Croydon | Kingston upon Thames | Merton | Richmond upon Thames | Surrey | Sutton | Wandsworth |
|-------------------------|---------|---------|---------|---------|----------------------|---------|----------------------|---------|---------|------------|
| 12m_DTaPIPVHib3 | ↓ 91.9% | ↓ 87.9% | ↑ 89.7% | ↑ 85.2% | ↓ 89.6% | ↑ 91.0% | ↑ 85.3% | ↑ 91.6% | ↑ 91.5% | ↑ 89.4% |
| 12m_MenB | ↓ 91.6% | ↓ 87.4% | ↑ 89.6% | ↑ 84.6% | ↓ 91.0% | ↑ 90.3% | ↑ 85.9% | ↑ 91.5% | ↑ 91.5% | ↑ 89.3% |
| 12m_PCV | ↓ 94.0% | ↑ 90.5% | ↑ 92.0% | ↑ 88.6% | ↓ 92.4% | ↑ 93.0% | ↑ 88.2% | ↑ 93.9% | ↑ 93.9% | ↑ 90.4% |
| 12m_Rota | ↑ 89.3% | ↑ 85.9% | ↑ 88.3% | ↑ 85.7% | ↓ 89.2% | ↑ 89.1% | ↑ 83.3% | ↑ 89.7% | ↑ 91.1% | ↑ 87.4% |
| 24m_DTaPIPVHib3_Primary | ↑ 93.0% | ↑ 88.8% | ↑ 90.9% | ↑ 88.3% | ↓ 90.3% | ↑ 90.9% | ↑ 91.0% | ↓ 91.9% | ↓ 91.2% | ↑ 90.8% |
| 24m_HibMenC_Booster | ↓ 88.9% | ↓ 81.6% | ↓ 80.7% | ↓ 77.2% | ↓ 85.7% | ↓ 80.7% | ↑ 81.8% | ↓ 79.8% | ↓ 83.0% | ↑ 83.4% |
| 24m_MenB_Booster | ↓ 87.8% | ↓ 80.0% | ↓ 80.7% | ↓ 78.1% | ↓ 83.9% | ↓ 81.0% | ↑ 80.8% | ↓ 79.6% | ↓ 84.5% | ↑ 83.7% |
| 24m_MMR1 | ↓ 89.0% | ↓ 82.2% | ↓ 81.8% | ↓ 79.5% | ↓ 86.5% | ↑ 82.7% | ↑ 83.6% | ↓ 79.7% | ↓ 86.2% | ↑ 85.2% |
| 24m_PCV_Booster | ↓ 88.5% | ↓ 80.6% | ↓ 81.5% | ↓ 79.0% | ↑ 86.3% | ↑ 83.4% | ↑ 82.4% | ↓ 80.0% | ↓ 84.9% | ↑ 83.7% |
| 5y_DTaPIPV_Booster | ↑ 84.0% | ↑ 74.7% | ↑ 77.4% | ↑ 74.0% | ↑ 80.1% | ↑ 72.3% | ↑ 74.5% | ↓ 81.7% | ↑ 79.5% | ↑ 68.4% |
| 5y_DTaPIPVHib3_Primary | ↑ 93.5% | ↑ 89.0% | ↓ 90.3% | ↓ 87.3% | ↑ 90.9% | ↑ 90.3% | ↑ 92.9% | ↓ 90.9% | ↓ 91.5% | ↑ 89.0% |
| 5y_HibMenC_Booster | ↓ 91.0% | ↑ 85.5% | ↑ 87.4% | ↑ 84.4% | ↑ 87.1% | ↑ 84.4% | ↑ 86.7% | ↓ 90.0% | ↑ 88.3% | ↑ 83.9% |
| 5y_MMR1 | ↑ 92.9% | ↑ 87.5% | ↑ 90.0% | ↑ 86.3% | ↑ 90.8% | ↑ 85.9% | ↑ 90.0% | ↑ 92.6% | ↑ 91.3% | ↑ 86.2% |
| 5y_MMR2_Booster | ↑ 85.2% | ↑ 75.2% | ↑ 79.1% | ↑ 73.7% | ↑ 80.0% | ↑ 73.4% | ↑ 74.3% | ↑ 83.1% | ↑ 80.7% | ↑ 76.5% |

Cover of vaccination evaluated rapidly (COVER) Programme 22-23. Date July-Sept 2022.

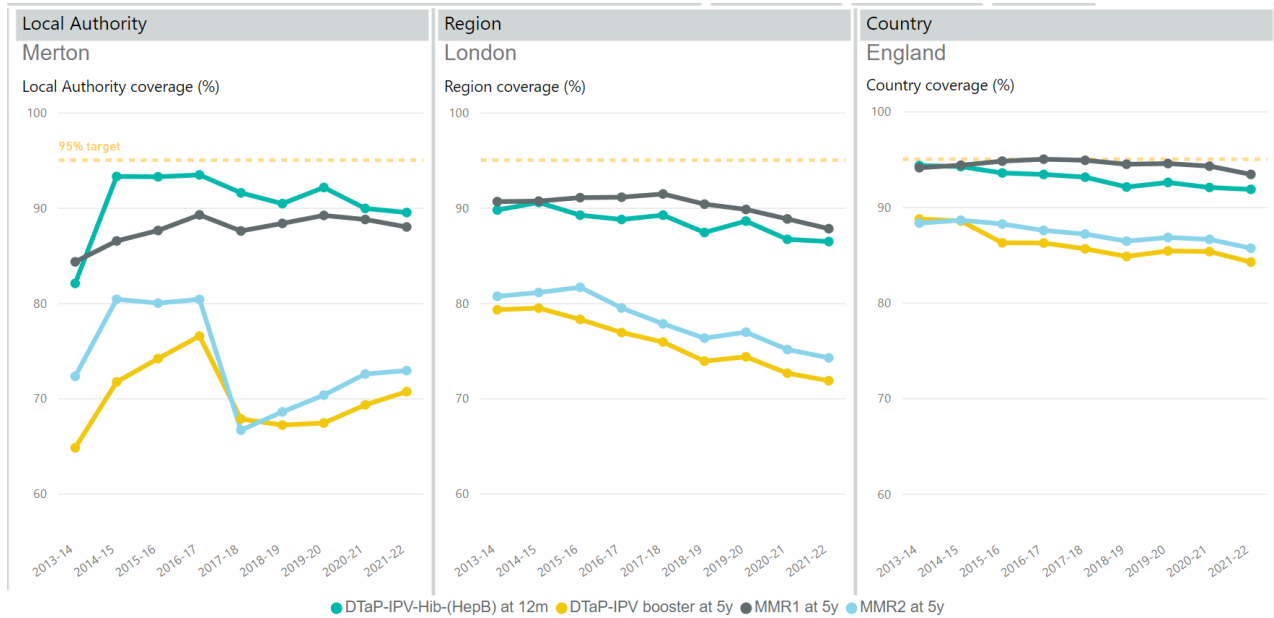
In Quarter 3 (July-September 2022) there was a slight overall increasing trend across almost all of the childhood vaccinations (green arrow), except for the two booster doses of Hib/MenC booster and the Meningitis B booster.

For the primary childhood dose Merton has a higher uptake of the 6 in 1 primary dose at 2 years (91%) than the London average (89%).

Uptake for the 4 in 1 pre-school booster dose of DTaP/IPV is lower in Merton (72%) than the London average of 75%.

Uptake for MMR1 at 2 years is slightly higher in Merton (83%) than the London average (82%).

Uptake of MMR2 at 5 years in Merton (73%) is lower than the London Average (75%).



Following a similar pattern to nationally and in London, uptake of the primary 6 in 1 dose and MMR1 in Merton has decreased slightly over the last 3 years.

The uptake for the booster dose of DTaP/IPV at 5 years in Merton has increased over the last 3 years and is now approaching the London average.

The uptake of MMR2 in Merton has increased over the last 5 years but remains below the London average.

Challenges

System

- COVID-19: pausing some programmes, redeployment of workforce and introduction of the COVID-19 vaccination programme.
- Complexities in data collection: some data is not recorded, not uploaded, not correctly cleansed, or the denominator population may not be up to date.
- Access to appointments: wider pressures on GP services and limited workforce.
- Inconsistent reminder systems- call/ recall.

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Community

- London's high population mobility affects data collection and accuracy. There is a 20-40% annual turnover on GP patient lists which affects the accuracy of the denominator for COVER submissions. A 2017 audit showed that by the age of 12 months, 33% of infants moved address at least once.
- Large numbers of underserved populations who are associated with lower uptake of vaccinations than the wider population.
- Large migrant population who may not be registered or have their past immunisation history accurately recorded.

Individual

- Lack of trust or confidence in vaccines or other health service or complacency.
- Saturation of vaccine offer post the COVID-19 pandemic and COVID-19 vaccination programme.
- Increasing disinformation
- Lack of awareness of the immunisation schedule

Actions

Increasing vaccination uptake is complex and requires a suite of interventions. Work is ongoing at a national, regional, system, and place level to increase uptake in Merton.

A strong focus for Merton, SWL and London is to increase childhood immunisation coverage overall to pre-pandemic levels and to identify the communities which are persistently missed from vaccination and other health services. A particular high risk in 2023 is the sub-optimal childhood MMR1 and 2 coverage (below 95%) which increases the risk of preventable measles outbreaks. To reduce the risk of poliovirus transmission, a strong focus remains on identifying and supporting underserved communities of Merton and London.

National and Regional

- A London Immunisation Strategy is currently being developed to both improve vaccination uptake and reduce inequalities. The first draft of the London Immunisation Strategy will be reviewed by the London Immunisations Board in late June 2023.
- NHSE London funds local Immunisation Coordinators across the region. These coordinators provide a critical interface between GP practices, ICBs and NHSE-L to ensure that immunisation strategic plans get delivered through services on the ground.
- A national NHSE MMR vaccination call and recall service was implemented between September and December 2022. This promoted the take-up of the MMR vaccine amongst individuals between the ages of 1 to 25 years through letters and texts.
- NHSE-L has commissioned UKHSA to deliver immunisation training to all vaccinators in London. Confident and competent staff are crucial to building and maintaining trust and delivering a high-quality service. This includes listening to parental concerns or reservations and preventing any vaccine incidents.
- Vaccinations have been added to the Making Every Contact Count London [resource hub](#) to facilitate using every available opportunity to engage with the public to increase vaccination.
- A regional communications campaign took place across London in March 2023 to encourage the uptake of missed MMR doses. This included media, social media, health ambassadors, translated materials, and attendance at local events and community groups.
- In a concentrated effort to reach all missed children and ensure London remains polio-free, a funded regional catch-up programme through the School Age Immunisation Service and GP practices is underway to provide DTaP catch-up, MMR catch-up, and full-schedule catch-up. We anticipate

that the first quarter findings and uptake rates for London will be available by January 2024.

- The London Immunisation Board, The Mayors Health Board, and SW London Integrated Care Board have all agreed on the 10 principles for London vaccination. Action will now focus on developing this into a comprehensive delivery approach tailored to community needs and building on Borough-led health initiatives.

10 Principles for London Vaccination Programmes



These principles were developed for the London Health Board building on existing work and evidence and with a focus on reducing inequalities. They have been collectively written and agreed by UKHSA, London Councils, ADHP London, GLA, OHID and NHS to identify areas for collaborative working and system leadership and to underpin the next phase of partnership and delivery of all London Vaccination.

Diversity and Inclusion



1. Focus on equity at all stages of the programme (design, delivery, monitoring and evaluation) focusing on hyper-local models with equality as central to the mission as volume



2. Building strength through diversity bringing diversity and community voices around the table, including the workforce as they cannot and should not be separated from the communities they are a part of.

Community centered: Population Health approach



3. Committing to Community First and Community Driven approaches: putting communities into the core of programmes, particularly marginalised groups, hearing their voices, engaging with them, co-producing activities and building culturally competent campaigns.



4. Placing people at the centre of delivery: improving access for those targeted for vaccinations as well as thinking more holistically around vaccination messaging and engaging with communities around their health and health services more generally.

Spotlight on the early years



5. A focus on improving childhood immunisation uptake: acting early in the life course and with a partnership commitment to emphasise promotion of childhood vaccinations making every contact count across all settings and opportunities and identifying children with missed immunisations or those who are unregistered.

Ways of working: Embedding sustainability and leveraging opportunities



6. Ensure immunisations as part of every conversation on health, being integral to health and well-being and not a standalone agenda for our residents and their families.



7. Working to one goal with one voice: a multi-system pan London approach working with partners across organisational boundaries and in collaboration with the clear beat that we all need to work together to increase vaccination rates for London.



8. Permission for and encouragement of innovation and creativity: to continue working in new ways and thinking more holistically about vaccination for whole communities.



9. Freedom and funding to explore different hyper-local approaches: This might include, for example, vaccines in new spaces, models of delivery for the school-aged population or the housebound.



10. Amplifying impact through an evidence approach: a commitment to continue to collect, evaluate and share outputs, to ensure, and be able to evidence equitable access of uptake, value for money and best use of our skilled workforce.

System and Place

- A three-year immunisations strategy for South West London (SWL) is being developed with partners, which will include six borough-specific immunisation delivery plans. It is anticipated this will be available in the late summer or early autumn. The aim of the strategy will be to support boroughs by providing a framework within which to operate, setting key priorities for SWL as well as at borough level based on local need.
- The focus of the immunisation strategy for Merton is improving the uptake of preschool boosters and MMR.
- Working with local GP practices to ensure correct coding of vaccination data, unregistering children who have moved, sending text reminders, and opening additional vaccination clinic slots in the school holidays.
- Insight-led behaviour change campaigns: multiple channels to reach Merton's local community: digital advertising including social media, google, and advertising on other relevant websites, radio adverts, ad-vans, billboards, street ambassadors, and community champions.

- Developing partnerships: fortnightly meetings are held with the ICB and Local Authority communications colleagues and regular meetings with providers. The Merton Immunisation Steering Group meet quarterly and reports into a SWL Operational Delivery Group chaired by the ICB. Partnership working has been used to: develop and share content, provide up-to-date information for community champions, host webinars, and engagement opportunities, and identify relevant pop-up locations for the local community.
- Working with the voluntary sector: a new grants programme for community organisations. Funding was prioritised for events likely to reach communities experiencing health inequalities. During the events, residents received tailored messages which focused on vaccinations and included other information including cost of living support and mental health services.
- Information to support an informed decision: responding to misinformation circulating on vaccinations using local insight. Recently, an audit of the feedback from over 6000 South West London residents was used to create a new leaflet responding to misinformation. This was shared in a range of different languages.

Case study example

Local Vaccine Coordinator working with Merton's GP practices

GP practices are supported to review their immunisation records. For example, at one Merton GP surgery preschool booster uptake rose from 50% to 75% when already delivered vaccine doses were correctly recorded. These reviews also identify all the children with incomplete vaccine schedules for targeted action. Reasons identified include refusals amongst some families for all vaccinations, patients who have left the country but have not been deregistered from the GP practice, doses given a few days early so they are not recognised in the data collection process, and some children who have recently moved to Merton from abroad but have not given their vaccination history to the GP practice. There is a recognition that opportunistic vaccination when the child attends the GP practice for other reasons is key to accessing these groups: Making Every Contact Count.

Appendix 1: Immunisation schedule

| Routine childhood immunisations | | | | |
|---------------------------------|---|-------------------|--------------------------|-----------------|
| Age Due | Diseases protected against | Vaccine given | Trade name | Usual Site |
| 8 weeks | Diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib) and hepatitis B | DTaP/IPV/Hib/HepB | Infanrix hexa or Vaxelis | Thigh |
| | Meningococcal group B (MenB) | MenB | Bexsero | Left thigh |
| | Rotavirus gastroenteritis | Rotavirus | Rotarix | By mouth |
| 12 weeks | Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B | DTaP/IPV/Hib/HepB | Infanrix hexa or Vaxelis | Thigh |
| | Pneumococcal (13 serotypes) | PCV | Prevenar 13 | Thigh |
| | Rotavirus | Rotavirus | Rotarix | By mouth |
| 16 weeks | Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B | DTaP/IPV/Hib/HepB | Infanrix hexa or Vaxelis | Thigh |
| | MenB | MenB | Bexsero | Left thigh |
| 1 year | Hib and Meningococcal group C (MenC) | Hib/MenC | Menitorix | Upper arm/thigh |

| | | | | |
|--------------------------------|---|--|----------------------|-----------------|
| | Pneumococcal | PCV booster | Prevenar 13 | Upper arm/thigh |
| | Measles, mumps and rubella (German measles) | MMR | MMRvaxPro or Priorix | Upper arm/thigh |
| | MenB | MenB booster | Bexsero | Left thigh |
| Eligible paediatric age groups | Influenza (each year from September) | Live attenuated influenza vaccine LAIV | Fluenz Tetra | Both nostrils |
| Three years four months | Diphtheria, tetanus, pertussis and polio | dTaP/IPV | Boostrix-IPV | Upper arm |
| | Measles, mumps and rubella | MMR (check first dose given) | MMRvaxPro or Priorix | Upper arm |
| 12-13 years | Cancers and genital warts caused by specific human papillomavirus (HPV) types | HPV (2 doses 6 to 24 months apart) | Gardasil | Upper arm |
| 14 years Year 9 | Tetanus, diphtheria and polio | Td/IPV (check MMR status) | Revaxis | Upper arm |
| | Meningococcal groups A, C, W and Y | MenACWY | Nimenrix | Upper arm |
| | | | | |

Selective childhood immunisation programmes

| Target group | Age and schedule | Disease | Vaccines required |
|--|-------------------------------------|--------------|--|
| Babies born to hepatitis B infected mothers | At birth, 4 weeks and 12 months old | Hepatitis B | Hepatitis B (Engerix B/HBvaxPRO) |
| Infants in areas of the country with tuberculosis (TB) incidence \geq 40/100,000 | Around 28 days old | Tuberculosis | BCG |
| Infants with a parent or grandparent born in a high incidence country | Around 28 days old | Tuberculosis | BCG |
| Children in a clinical risk group | From 6 months to 17 years of age | Influenza | LAIV or inactivated flu vaccine if contraindicated to LAIV or under 2 years of age |

Adult Immunisation Programme

| | | | |
|---------------------------|---|---|---|
| 65 years old | Pneumococcal (23 serotypes) | Pneumococcal Polysaccharide Vaccine (PPV) | Pneumovax 23 |
| 65 years of age and older | Influenza (each year from September) | Inactivated influenza vaccine | Multiple |
| 70 to 79 years of age | Shingles | Shingles | Zostavax3 (or Shingrix if Zostavax contraindicated) |
| Pregnant women | At any stage of pregnancy during flu season | Influenza | Inactivated flu vaccine |
| | From 16 weeks gestation | Pertussis | dTaP/IPV (Boostrix-IPV) |

The complete routine immunisation schedule from February 2022 (publishing.service.gov.uk)

Appendix 2: Data Collection

Data is uploaded into Child Health Information Service (CHIS) from GP practice records via a data linkage system. The CHIS provides quarterly and annual submissions to the UKHSA for their publication of statistics on 0-5s childhood immunisation programmes. This is known as Cohort of Vaccination Evaluated Rapidly (COVER) and these are the official statistics. Annual data is more complete and should be used to look at longer-term trends.

COVER monitors immunisation coverage data for children in the UK who reach their first, second, or fifth birthday during each quarter. Children having their first birthday in the quarter should have been vaccinated at 2, 3, and 4 months, those turning 2 should have been vaccinated at 12/13 months and those who are having their 5th birthday should have been vaccinated before 5 years, ideally 3 years 3 months to 4 years.

There are known complexities in collecting data on childhood immunisations. Indeed, since 2013, London's COVER data is usually published with caveats, and drops in reported rates may be due to data collection or collation issues for that quarter.

Production of COVER statistics in London involves a range of individuals and organisations with different roles and responsibilities. London has four CHIS Hubs – North East London (provider is North East London Foundation Trust, NELFT), South East London (provider is Health Intelligence), South West London (provider is Your Healthcare CIC), and North-West London (provider is Health Intelligence). These Hubs are commissioned by NHSE to compile and report London's quarterly and annual submissions to UKSA for COVER.

A 'script' or algorithm is utilised to electronically extract anonymous data from the relevant data fields to compile the reports for COVER within the caveats specified. For example, for the first dose of MMR, any child who had their MMR vaccination before their first birthday is not included and so appears unvaccinated.

CHIS Hubs are commissioned to check the reports run and are expected to refresh the reports before final submission to UKHSA. CHIS Hubs are also commissioned to 'clean' the denominator by routinely undertaking 'movers in and movers out' reports. This is to ensure the denominator is up to date with the children currently resident in London. They are also expected to account for the vaccinations of unregistered children in London. There are ongoing issues with CHIS Hubs keeping up to date with movers in and removals which is picked up in contract performance meetings with the NHSE (London) commissioners.

Immunisation data is extracted from London's general practices' IT systems and uploaded onto the CHIS systems. This isn't done directly by the CHIS Hubs. Instead, data linkage systems provided by three different providers provide the interface between general practices and CHIS. Two of these providers – QMS and

Health Intelligence – are commissioned by NHSE whilst 4 boroughs in outer North-East London commission a separate system.

NHS (London) Immunisation Commissioning Team receives data linkage reports from QMS and Health Intelligence. This provides a breakdown by general practice of the uptake of vaccinations in accordance with the COVER cohorts and cohorts for Exeter (for payments). This information is utilized by the team as part of the 'COVER SOP', to check against the COVER submissions by CHIS to question variations or discrepancies.

While data linkage systems provide an automated solution to manual contact between CHIS and General Practices, data linkage does not extract raw data. General practices have to prepare the data for extraction every month. This will vary between practices how automated the process is, but it can be dependent upon one person to compile the data in time for the extraction by the data linkage system providers and should this person be on annual or sick leave, there will be missing data.

General practices have to prepare data for four immunisation data systems – COVER, ImmForm (although this is largely done by their IT provider of Vision, EMIS or TPP SystemOne, all of whom are commissioned by their ICS), CQRS (the payments system run by NHS England for the payment of administration of the vaccine) and Exeter (payments system, whereby practices receive targeted payments for achieving 70% or 90% uptake of their cohorts – these cohorts are different to the COVER cohorts of children). Preparation of data for the systems again will vary between practices but this can be time and resource intensive. There is also an array of codes that can be used to code the vaccination (if a code different to what the data linkage system recognises is utilised, it results in the child looking unvaccinated) and there are difficulties with coding children who received their vaccinations abroad or delays in information on vaccinations given elsewhere in UK being uploaded onto the system in time for the data extraction.

Whilst NHSE (London) immunisation commissioning team verify and pay administration of vaccines that are part of the Section 7a immunisation programmes, they do not commission General Practices directly. Vaccination services, including call/recall (patient invite and reminder systems) are contracted under the General Medical Services (GMS) contract. This contract is held by primary care commissioning directorates of NHSE.

For most newer vaccine programmes and for those targeting people older than 5 years vaccination and population data is extracted directly from general practice systems using ImmForm, an online platform.

Appendix 3: Contacts

| Name, Role | Contact |
|---|---|
| <p>Dawn Hollis, Head of ANNB Screening, Immunisations, CHIS, CARS & Digital Transformation</p> <p>NHS England - London Region</p> | <p>dawn.hollis@nhs.net</p> |
| <p>Rehana Ahmed, Senior Immunisation Commissioning Manager</p> <p>NHS England – London Region</p> | <p>rehanaahmed@nhs.net</p> |
| <p>Susan Elden, Public Health Consultant – Immunisations</p> <p>NHS England – London Region</p> | <p>susan.elden1@nhs.net</p> |
| <p>Eleanor Walker-Todd, Commissioning Manager</p> <p>NHS England – London Region</p> | <p>Eleanor.walkertodd@nhs.net</p> |
| <p>Katie Craig, Immunisation Commissioning Officer</p> <p>NHS England – London Region</p> | <p>Katie.Craig2@nhs.net</p> |
| <p>Ryan Grocock, Specialty Registrar in dental public health, report author</p> <p>NHS England – London Region</p> | <p>Ryan.grocock@nhs.net</p> |

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