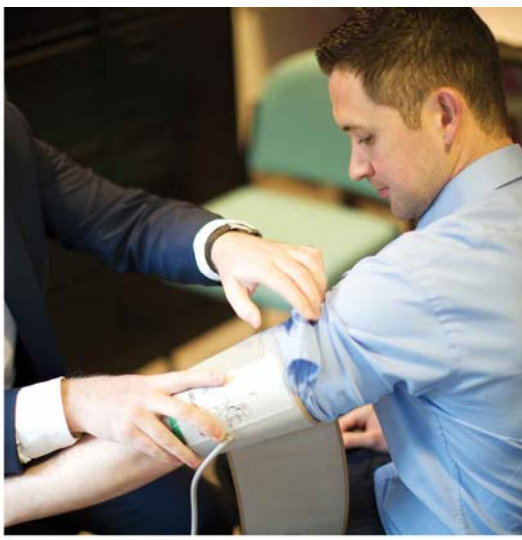
VACCINATION AND IMMUNISATION PROGRAMMES 2015/16

GUIDANCE AND AUDIT REQUIREMENTS

March 2015



www.bma.org.uk/gpc
www.nhsemployers.org
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Publication Gateway Reference Number 03264

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Section 1. Introduction

Introduction

In December 2014, NHS Employers (on behalf of NHS England[1]) and the British Medical Association (BMA) General Practitioners Committee (GPC) announced the agreed changes to the vaccination and immunisation programmes as part of the General Medical Services (GMS) contract for 2015/16.

This document provides detailed guidance for commissioners and practices[2] providing vaccination programmes commissioned by NHS England. This document will be updated as and when guidance for vaccination programmes is available.

The technical requirements for these services are outlined in the 'Technical requirements for 2015/16 GMS contract changes'[3] document. This document will also be updated.

Wherever possible, NHS England seeks to minimise the reporting requirements for the services delivered by practices where these can be supported by new systems and this guidance outlines the assurance management arrangements and audit requirements for the services detailed. This guidance is applicable in England only.

The detailed requirements for the targeted hepatitis B (newborn babies), HPV booster catch-up, MenC booster, MMR, rotavirus and shingles (routine) vaccination programmes are set out in the GMS Contract Regulations, Directions and the Statement of Financial Entitlements (SFE)[4].

The detailed requirements for the childhood seasonal influenza, MenC freshers, pertussis, shingles (catch-up) and the seasonal influenza and pneumococcal polysaccharide vaccination programmes are set out in the NHS England service specifications[5].

Working with Patient Data

Commissioners and practices will be aware of the requirements of access to patient identifiable data. Where patients have expressed a desire that their information is not shared for purposes detailed in this document, practices will need to advise the commissioner and make an appropriate note in the record.

Commissioners and practices will be aware of the need to:

- obtain the minimum necessary information for the specific purpose
- anonymise data where possible

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[1] From 1 April 2013 the NHS Commissioning Board (NHS CB) is the body legally responsible for the commissioning of primary care in England. However, the NHS CB operates under the name NHS England, therefore the name NHS England is used throughout this guidance.
[2] A practice is defined as a provider of essential primary medical services to a registered list of patients under a GMS, Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS) contract.
[3] NHS Employers. Technical requirements for 2015/16 GMS contract changes. www.nhsemployers.org/vandi
[4] DH. SFE. Available via www.nhsemployers.org/GMS201516
[5] NHS England. Service specifications. http://www.england.nhs.uk/commissioning/gp-contract/

- It is recommended that practices record access to confidential patient data in the relevant patient record, so that an audit trial is in place to fulfil the obligations of the practice towards their patients.

For further information about the requirements set by the Data Protection Act, Human Rights Act and Common Law Duty of Confidentiality as well as policy and guidance, consult your local Information Governance lead.

Verification

Commissioners must make aware to practices information they require and that the practice can reasonably be expected to obtain, in order to establish whether or not the practice has fulfilled its obligation under the programmes included in this guidance. Information required will be aggregate or anonymised information in all the majority of cases. Commissioners and practices will be mindful of the requirements for accessing patient data.

About this guidance

This document provides information on vaccination and immunisation programme contractual changes in 2015/16 as well as detailed guidance, assurance management arrangements and audit requirements to support commissioners and practices.

Commissioners and practices should ensure they have read and understood the requirements in the Regulations, Directions, NHS England service specifications, Business Rules[6], 'GMS contract 2015/16 guidance and audit requirements'[7], as well as the guidance in this document. This supersedes all previous guidance issued on these areas.

[6] HSCIC. Business Rules. www.hscic.gov.uk/qofesextractspecs
[7] NHS Employers. GMS contract 2015/16 guidance and audit requirements. www.nhsemployers.org/GMS201516

Section 2. Technical Requirements

Calculating Quality Reporting Service and the General Practice Extraction Service

The Calculating Quality Reporting Service (CQRS), together with the General Practice Extraction Service (GPES) calculates achievement and payments to practices. Both CQRS and GPES are managed by the Health and Social Care Information Centre (HSCIC).

CQRS[8] is the automated system used to calculate achievement and payments on quality services. These include the QOF, ESs and vaccination programmes.

GPES[9] collects anonymised information from general practice IT clinical systems for a wide range of purposes including payments to practices and the provision of relevant data for management information purposes. This enables commissioners to monitor and verify the delivery of various contract and service requirements.

The CQRS team works with NHS England to ensure CQRS supports the contract and any changes. Practices must be offered and agree to provide each service with their commissioner.

Payments can only be processed after commissioners have offered and practices have accepted a service on CQRS. Agreement to participate in a service on CQRS is separate to confirming acceptance of a contract for services with commissioners.

Practices authorise data collections made by GPES when they accept a Quality Service on the CQRS system.

This guidance provides information on how CQRS and GPES are used in relation to vaccination programmes. In order to support practices, CQRS also publish guidance and issue communications as services become live on CQRS or GPES, which detail how to manually declare and enter relevant data into CQRS and enable data collections. Further information on when each service will be available on CQRS and how to input data will be available on the HSCIC website[10].

Where a service is supported by CQRS, practices are required to manually enter achievement on CQRS until data can be automatically collected from practice systems by GPES. The data will be in relation to payment counts only, with zeros being entered in the interim for management information counts.

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[8] HSCIC. CQRS. http://systems.hscic.gov.uk/systemsandservices/cqrs
[9] HSCIC. GPES. http://www.hscic.gov.uk/gpes
[10] HSCIC. CQRS. http://systems.hscic.gov.uk/systemsandservices/cqrs

Technical Requirements for 2015/16

The 'Technical requirements for 2015/16'[11] document sets out additional detail on how CQRS and GPES will support services, outlines the MI count wording and provides the relevant Read2 and CTV3 codes that practices are required to use for each service. Read2 and CTV3 codes are used as the basis for the GPES data collection, which allows CQRS to calculate payment based on the aggregated numbers supplied and support the management information collections.

Changes which materially affect services supported by CQRS and GPES will be updated in the technical requirements document. This is available as a 'live' document on NHS Employers website and will be updated as services move from manual reporting to automated data collections. Relevant supporting Business Rules[12] will also be updated and available on the HSCIC website.

Although practices are required to manually enter data until GPES is available, it is still required that practices use the relevant Read2 or CTV3 codes within their clinical systems. This is because only those codes included in the technical requirements document and the supporting Business Rules will be acceptable to allow CQRS to calculate achievement and payment and enable commissioners to audit payment and service delivery. Practices will therefore need to ensure that they use the relevant codes from the commencement of the relevant service and if necessary will need to re-code patients accordingly.

[11] NHS Employers. Technical requirements for 2015/16 GMS contract changes. http://www.nhsemployers.org/vandi
[12] HSCIC. http://www.hscic.gov.uk/qofesextractspecs

Section 3. New programmes (commencing April 2015)

HPV booster

Background and purpose

Human papillomavirus (HPV) is a virus that infects the skin and mucosa of the upper respiratory and anogenital tracts. Although most infections are asymptomatic and self-limiting, genital infection is associated with genital warts and anogential cancers in both men and women. HPV viruses can be classed as either high or low risks types depending on their association with the development of cancer.

Persistent infection by high-risk HPV types is detectable in more the 99 per cent of cervical cancers. In addition to cervical cancer, HPV is often associated with less common cancers including cancer of the vulva, vagina, penis and anus and some cancers of the head and neck. The majority of HPV infections are short-lived and cause no clinical problems.

A UK sero-prevalence study showed that HPV was infrequent in girls under 14 years, but infections rose sharply from the mid-teens.

HPV vaccines are highly effective at preventing the infection of susceptible women with HPV types covered by the vaccine. Current studies suggest that protection is maintained for at least ten years, although based on immune responses protection is expected to extend further.

The national HPV immunisation programme was introduced in schools in September 2008 with all girls in year eight (aged 12 to 13 years) offered vaccinations.

To ensure that eligible girls who have missed the opportunity to be vaccinated at their school are still protected, this catch-up programme for girls aged 14 to under 18 has been introduced.

Vaccinations and immunisations are an additional service under the GMS contract. Changes to the GP contract for 2015/16 include an item of service payment of £7.64 for each dose for this programme.

Further details on background to the programme, dosage, timings and administration can be found in the Green Book[13].

Vaccination

Practices are not required to identify or call and recall eligible patients.

[13] Green Book. Chapter 18a. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

To commence a course of HPV vaccine patients must be aged from 14 years but less than 18 years, at any time during the period 1 April 2015 to 31 March 2016. For example:

- patients who are aged 13 can be vaccinated during that period provided they turn 14 by 31 March 2016
- patients who are aged 17 at any time during the service who then turn 18 after 31 March 2016 can be vaccinated
- patients who have had their 18th birthday at the start of the service (1 April 2015) cannot *start* a course of HPV vaccine under this ES

In September 2012 the recommended HPV vaccine changed from Cervarix® to Gardasil. For girls who started the schedule with Cervarix® but did not complete the course, it can be completed with Gardasil®. The course should be completed in line with the appropriate schedule depending on age at the first dose and whether one or two doses have already been given. Further details on background to the programme, dosage, timings and administration can be found in the Green Book.

Vaccines for this programme are centrally supplied through ImmForm.

Vaccination started after September 2014

If the first dose of vaccine was administered before 15 years, a two dose schedule of 0, 6-24months should be followed. If the vaccination course is interrupted then it should be resumed (using the same vaccine) but not repeated, even if more than 24 months have elapsed since the first dose or if the girl is then aged 15 years and over.

	Less than 15 years when starting HPV immunisation	
	Gardasil® (HPV types 6,11,16,18)	**Timing**
1st dose	0.5 ml	0 and 6-24 mths. For planning, a 0 and 12 months schedule is appropriate. However, a minimum interval period between doses of 6-24 months is clinically acceptable. If a course is interrupted, it should be resumed but not repeated, even if more than 24 months have elapsed since the first dose
2nd dose	0.5 ml at least six to 24 months after the first dose	
3rd dose	-	

Vaccination started before September 2014 including those starting a course aged 15 years and over

	15 years and above when starting HPV immunisation	
	Gardasil® (HPV types 6,11,16,18)	**Timing**
1st dose	0.5 ml	0, 1 and 4-6 months schedule is appropriate. All 3 doses should ideally be given within a 12-month period. If a course is interrupted, it should be resumed but not repeated, ideally allowing the appropriate interval between the remaining doses. Two doses less than six months apart are not considered adequate to provide long-term protection and a third dose should be given in line with the dosage and schedule section for the Green Book.
2nd dose	0.5 ml at least one month after the first dose	
3rd dose	0.5 ml at least three months after the second dose	

Requirements

This programme is from 1 April 2015 until 31 March 2016.

Practices participating in this programme will be required to sign up to CQRS no later than 30 June 2015.

Practices are required to:

- provide vaccination to eligible patients who self-present. Eligible patients are those:

  a. aged from 14 to less than 18 years during the period 1 April 2015 and 31 March 2016
  b. who missed the opportunity to be vaccinated through the schools programme
  c. are vaccinated in the period from 1 April 2015 to 31 March 2016.

Ensure that the patient record of those offered the vaccination are updated accordingly.

Monitoring

There is one payment count (see payment and validation) for this programme. There are no management information counts.

Practices will be required to manually input data into CQRS, on a monthly basis for the financial year 2015/16. The data input will be in relation to the payment count. For information on how to manually enter data into CQRS, please see the HSCIC website[14].

The 'Technical requirements'[15] document contains the payment count and Read codes for this programme. Although GPES will not be supporting this programme, practices are still advised to use the relevant Read codes.

[14] HSCIC. http://systems.hscic.gov.uk/cqrs/participation
[15] NHS Employers. Technical requirements for 2015/16 GMS contract changes. www.nhsemployers.org/vandi

Payment and validation

Practices who participate in this programme will be required to sign up to CQRS by no later than 30 June 2015.

Claims for payments for this programme should be made monthly, after the final completing dose has been administered. Where claims are entered manually, this should be within 14 days of the end of the month when the completing dose was administered. Where there is an automated data collection, there is a five day period following the month end to allow practices to record the previous months activity before the collection occurs. Activity recorded after the collection period is closed (five days), will not be collected and recorded on CQRS. Practices must ensure that all activity is recorded by the cut-off date, to ensure payment.

Payment will be made by the last day of the month following the month in which the practice validates and the commissioner approves the payment.

Payments are calculated by identifying the:

- Monthly count of the number of patients aged between 14 and under 18 on 31 March 2015 who have received a HPV booster vaccination by the GP practice in the reporting period; as a result of missing the provision by the Schools programme. (i.e. payment count HPV001)

Payment will be made based on the monthly count multiplied by £7.64.

It is anticipated that practices will claim for payment in the month following vaccination i.e. as soon as possible after birth, at age one month, two months and 12 months. Where vaccination is unavoidably delayed or incomplete and then delivered as soon as possible and as clinically appropriate, practices are entitled to payment (as detailed above) for the administration of doses required to complete the vaccination course. Claims must be submitted within six months of delivering the vaccine dose[16].

CQRS will calculate the monthly payment achievement data via manually entered data.

After CQRS has calculated the practice's final achievement payment, the practice should approve the payment value and declare an ‘achievement declaration’. The commissioner will then approve the payment (assuming that the criteria for the programme have been met) and initiate the payment via the payment agency's Exeter system. Once practices have submitted their data and the declaration and approval process has been followed, then payment for the programme will be sent to the payment agency for processing.

Commissioners are responsible for post payment verification. This may include auditing claims of practices to ensure that not only the vaccinations were administered but that the full protocol described in the programme was followed.

The SFE[17] sets out the administrative provisions relating to the conditions for payment under this programme (for example conditions when payment may be withheld or

[16] This is in line with SFE requirements.
[17] DH. SFE. Available via www.nhsemployers.org/GMS201516

reclaimed) and the treatment of payments in specific circumstances (for example, when contractors merge, split etc.).

Meningococcal C (MenC) booster

Background and purpose

Meningococcal disease is a life-threatening infection. It is a term used to describe two major illnesses – meningitis and septicaemia. These can occur on their own or more commonly together. Most people will make a recovery but at worst meningococcal disease causes very severe illness that can rapidly result in death.

The MenC[18] routine vaccination programme was introduced in 1999 for children and adolescents under the age of 18. In 2002, the catch-up campaign was extended to include adults under 25 years. In 2006, the course was changed from three doses to two doses (at three and four months) and a booster dose at 12 months of age. In 2013, following recommendations by JCVI, further changes were made with the primary course reducing from two doses to one (at three months) and the introduction of an adolescent booster[19] through schools programmes.

Following advice from PHE, NHS England commissioned a catch-up programme to ensure that those children who missed vaccination through the schools programme still have the opportunity to be vaccinated through general practice. This new programme is for children aged 14 – 25 years.

A separate programme against MenC for freshers (first time university/further education students) was introduced in April 2014 and is outlined in a separate section of this guidance.

Vaccinations and immunisations are an additional service under the GMS contract. Changes to the GP contract for 2015/16 include an item of service payment of £7.64 for each dose for this programme.

Further details on background to the programme, dosage, timings and administration can be found in the Green Book[20].

Requirements

Practices participating in this programme will be required to sign up to CQRS no later than 30 June 2015.

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[18] This service specification refers to MenC throughout. However, in response to an increase in the incidence of MenW cases recently and based on advice from JCVI it is possible that a quadrivalent Men ACWY vaccine may replace the monovalent MenC vaccine. In the event of a change of vaccine for this programme, this ES specification will be updated to take account of the replacement vaccine. See JCVI 1 October 2014 minutes.
https://app.box.com/s/iddfb4ppwkmtjusir2tc#/s/iddfb4ppwkmtjusir2tc/1/2199012147/22846051967/1?&_suid=141873576977305138353830119073

[19] NHS England, PHE and DH letter to the Service. May 2013.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/197618/MenC_letter_FINAL.pdf

[20] Green Book. Chapter 22. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Practices are required to:

- provide vaccination to eligible patients on an opportunistic basis or who self-present. Eligible patients are those:

    a. aged from 14 to 25 inclusive at any time during the period 1 April 2015 and 31 March 2016
    b. who have not previously had any MenC vaccination since aged ten
    c. who missed the opportunity to be vaccinated through the schools programme
    d. are vaccinated in the period from 1 April 2015 to 31 March 2016.

- Ensure that the patient record of those offered the vaccination are updated accordingly.

Vaccination

Practices are not required to identify or call and recall eligible patients.

Eligible patients must be aged between 14 and 25 years old, at any time during the period 1 April 2015 to 31 March 2016. For example:

- patients who are aged 13 can be vaccinated during that period provided they turn 14 by 31 March 2016 patients who are aged 25 at any time during the service who then turn 26 after 31 March 2016 can be vaccinated
- patients aged 26 at the start of the service (1 April 2015) cannot be vaccinated under this programme.

All meningococcal-containing vaccines are delivered by one booster dose given intramuscularly into the upper arm or anterolateral thigh.

Vaccines for this programme will be are centrally supplied through ImmForm.

Monitoring

There is one payment count (see payment and validation) for this programme. There are no management information counts.

Practices will be required to manually input data into CQRS, on a monthly basis for the financial year 2015/16. The data input will be in relation to the payment count.

For information on how to manually enter data into CQRS, please see the HSCIC website[21].

The 'Technical requirements[22] document contains the payment count and Read codes[23] relevant for this programme. Although GPES will not be supporting this programme, practices are still advised to use the relevant Read codes.

[21] HSCIC. http://systems.hscic.gov.uk/cqrs/participation
[22] NHS Employers. Technical requirements for 2015/16 GMS contract changes. www.nhsemployers.org/vandi
[23] Please note that the code descriptions in clinical systems may not exactly match the guidance text.

Payment and validation

Practices who participate in this programme will be required to sign up to CQRS by no later than 30 June 2015.

Claims for payments for this programme should be made monthly, after the final completing dose has been administered. Where claims are entered manually, this should be within 14 days of the end of the month when the completing dose was administered. Where there is an automated data collection, there is a five day period following the month end to allow practices to record the previous months activity before the collection occurs. Activity recorded after the collection period is closed (five days), will not be collected and recorded on CQRS. Practices must ensure that all activity is recorded by the cut-off date, to ensure payment.

Payment will be made by the last day of the month following the month in which the practice validates and the commissioner approves the payment

Where a practice has not recorded activity they will need to agree this activity with the commissioner who are able to adjust CQRS payments as part of the approval procedure.

Payments are calculated by identifying the:

- Monthly count of the number of patients aged between 14 years and under 26 years on 31 March who have received a MenC booster vaccination by the GP practice in the reporting period; as a result of missing the provision by the schools programme. (i.e. payment count MENCB001)

Payment will be made based on the monthly count multiplied by £7.64.

CQRS will calculate the monthly payment achievement data via manually entered data.

It is anticipated that practices will claim for payment in the month following vaccination i.e. as soon as possible after birth, at age one month, two months and 12 months. Where vaccination is unavoidably delayed or incomplete and then delivered as soon as possible and as clinically appropriate, practices are entitled to payment (as detailed above) for the administration of doses required to complete the vaccination course. Claims must be submitted within six months of delivering the vaccine dose[24].

CQRS will calculate the monthly payment achievement data via manually entered data.

After CQRS has calculated the practice's final achievement payment, the practice should approve the payment value and declare an ‘achievement declaration’. The commissioner will then approve the payment (assuming that the criteria for the programme have been met) and initiate the payment via the payment agency's Exeter system. Once practices have submitted their data and the declaration and approval process has been followed, then payment for the programme will be sent to the payment agency for processing.

Commissioners are responsible for post payment verification. This may include auditing claims of practices to ensure that not only the vaccinations were administered but that the full protocol described in the programme was followed i.e. are aged from 14 to 25, who

[24] This is in line with SFE requirements.

have not previously had any MenC vaccination since aged ten and who missed the opportunity to be vaccinated through the schools programme.

The SFE[25] sets out the administrative provisions relating to the conditions for payment under this programme (for example conditions when payment may be withheld or reclaimed) and the treatment of payments in specific circumstances (for example, when contractors merge, split etc.).

[25] DH. SFE. Available via www.nhsemployers.org/GMS201516

Section 4. Existing programmes (continuing April 2015)

Hepatitis B (newborn babies) vaccination programme

Background and purpose

PHE identified the need to introduce a consistent approach across England for the immunisation of newborn babies at risk of hepatitis B (hep B) (i.e. born to mothers identified on antenatal screening as hep B positive). As a result, targeted vaccination against hep B was commissioned via general practice for at-risk newborn babies from 1 April 2014.

The UK is a very low-prevalence country for hep B. Prevalence is higher in adults born in high-endemicity countries, many of whom will have acquired infection at birth or in early childhood[26]. Prevalence rates found in antenatal women, vary from 0.05 to 0.08 per cent in some rural areas to one per cent or more in certain inner city areas.[27]

Hep B infection can be transmitted from infected mothers to their babies at or around the time of birth (perinatal transmission). Babies acquiring infection at this time have a high risk of becoming chronically infected with the virus. It is estimated that approximately 3,000 newborn babies are at risk of perinatal transmission each year in England.

People with chronic hep B can still pass the virus on to other people, even if it is not causing any symptoms. Around 20 per cent of people with chronic hepatitis B will go on to develop scarring of the liver (cirrhosis) and around one in ten people with cirrhosis will develop liver cancer[28].

The risk of developing chronic hep B infection depends on the age at which infection is acquired. Without intervention, chronic infection occurs in 90 per cent of infants infected perinatally whereas in previously healthy adults the risk of chronic infection is closer to five per cent[29].

All pregnant women should be offered screening for hep B infection during each pregnancy and where an un-booked mother presents in labour, an urgent test is performed to ensure that vaccines can be given to babies born to positive mothers within 24-hours of birth.

All newborn babies born to mothers with hep B should receive a complete course of hep B vaccination. The benefit of vaccination is high in this group of infants and as such vaccination should not be withheld or delayed.

The hep B immunisation programme comprises four doses of the vaccine given to infants at birth (routinely in hospital), aged one month, two months (four weeks after dose one)

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[26] Boxall et al. 1994; Aweis et al., 2001.
[27] DH. The Green Book. Chapter 18. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book
[28] NHS. Hepatitis B. http://www.nhs.uk/Conditions/Hepatitis-B/Pages/Introduction.aspx
[29] DH. The Green Book. Chapter 18.

and at 12 months.

Vaccinations and immunisations are an additional service under the GMS contract. Under the GMS Contract for 2015/16 there is an item of service payment of £7.64 for each dose.

Further details on background to the programme, dosage, timings and administration can be found in the Green Book[30].

Requirements

This is a permanent programme as part of the childhood immunisation schedule.

Practices participating in this programme will be required to sign up to CQRS no later than 30 June 2015.

Practices are required to:

- identify eligible patients in the following cohort: newborn babies who are registered with the practice and who are at risk of hep B due to their mother being hep B positive when the baby is born, by checking the mother's status when new babies are registered at the practice
- provide vaccination to all newborn babies who are eligible under this programme and are identified by either the hospital, community midwife, health visitors or practice
- procure directly from the manufacturers adequate supplies of the hep B vaccine
- in the event the hospital or community midwife have been unable to administer it, provide the first vaccination dose at the earliest opportunity
- provide the second vaccination dose at age one month or as soon as possible
- provide the third vaccination dose at age two months or as soon as possible
- provide the fourth dose at age 12 months or as soon as possible
- take or refer for a blood test for hep B surface antigen (can be venepuncture or dried blood spot -heel prick) at age 12 months (this can be at the same time as the fourth dose) or as soon as possible thereafter
- ensure that the results of the blood test are communicated as soon as practicable to the patient's parents or guardian and where there is a positive result, a referral is made for early paediatric assessment
- update the patient record of those offered each vaccination and blood test to include a record of when each vaccination was administered, the date and results of the blood test.

Identifying newborn babies at risk of hepatitis B

Screening mothers during pregnancy or testing for hep B in hospital will identify most babies at risk of hep B. It is recommended that babies at risk of hep B are delivered in hospital. The hospital will routinely administer the first dose of hep B vaccination. The newborn baby's medical record (or red book) will then be updated and arrangements should be in place to ensure that information is shared with appropriate local agencies and practices to facilitate follow up.

[30] Green Book. Chapter 18.

However, due to the importance of timely immunisation and risk of babies not receiving the first dose in hospital, during a home birth or being registered out of the area, practices cannot rely on hospital notice alone. Accordingly practices are required to identify all newborn babies registered with the practice after 1 April 2015 who are at risk of hep B by checking the mother's status.

From 1 April 2015 practices will routinely identify babies up to age one when they are registered with the practice. However, "newborn", "baby" and "babies" are not defined on the basis that where immunisation is unavoidably delayed beyond the periods identified above, it is acceptable to consult clinical guidance[31] and resume vaccination as recommended on a case by case basis.

When a baby is registered at a practice, as a matter of good practice and to ensure that a vaccination course has been completed, it is recommended that practices routinely enquire as to the baby's immunisation status.

Vaccination

The hep B virus incubates for up to six months and infection cannot be determined until the baby is aged 12 months. Hep B vaccination must commence immediately from birth to prevent the virus establishing in the baby. Each dose must be delivered at the required time (the first dose within 24-hours, the second dose at one month, the third dose at two months and the fourth dose at 12 months) to improve the effectiveness of the vaccine and limit the risks of infection.

Where immunisation is delayed, it is more likely that the child may become infected. The vaccine course should resume as soon as possible and be completed. In this instance, testing above the age of 12 months is particularly important. In cases where vaccination is delayed and has not been completed at birth, at one month, two months and 12 months, practices should consult the Green Book for further detail and vaccinate and undertake further blood testing as clinically necessary and appropriate.

The recommended interval between each dose is four weeks. The interval between doses can be reduced to three weeks if there is a risk of a child missing a later dose, however the results may be sub-optimal.

Where the vaccine status of a baby (identified as at risk due to their mother being hep B positive when the baby is born) is incomplete, or there has been significant delay, practices may opportunistically complete the administration of the required doses of hep B as clinically appropriate and claim for payment.

The approved vaccine to be used for this programme in the UK, is either of the following paediatric preparations: 0.5 ml of Energix B, or 10 mcg manufactured by GlaxoSmithKline (GSK) or HBVax-Pro 5 mcg manufactured by Sanofi Pasteur MSD (SPMSD) or 0.5 ml of the equivalent adult dose.

Hep B vaccines in children aged less than 12 months are routinely given intramuscularly in the anterolateral thigh.

[31] Green Book. Chapter 18.

Provided the hep B vaccinations are administered at the appropriate time, there are no contra-indications to administering the vaccine when patients attend for routine childhood immunisations.

Blood test

Testing at age 12 months will identify any babies for whom this intervention has not been successful and who have become infected with hep B. This testing can be carried out at the same time as the fourth dose is given. It will be good practice to test as soon as possible to identify if the baby is hep B surface antigen positive.

Practices can either undertake the dried blood spot (heel prick) test or venepuncture themselves, or use an alternative local provider (including hospital provision if appropriate) commissioned locally to undertake the blood test.

There is no specific training requirement if practices choose to do the dried blood spot (heel prick) test themselves, however guidelines on how to perform this test should be followed and blood testing should only be performed where the doctor or nurse is clinically competent. This is a matter for the practice to take into account when deciding whether to do the blood test themselves or refer to a local service.

The results of the test must be communicated to the patients' parent(s) or guardian(s) and the patient record updated. Payment for the fourth dose will only be made after this has been done. It is estimated up to ten per cent of at risk babies will test positive and require a referral by the practice for paediatric assessment and further management.

Where vaccination has been delayed, blood testing is particularly important and further testing may be necessary before establishing whether to continue the vaccination course. Further details are available in the Green Book.

Monitoring

There are four payment counts (see payment and validation) for this programme. There are no management information counts.

Practices will be required to manually input data into CQRS, on a monthly basis for the financial year 2015/16. The data input will be in relation to the payment count. For information on how to manually enter data into CQRS, see the HSCIC website[32].

The 'Technical requirements'[33] document contains the payment count and Read codes[34] relevant for this programme. Although GPES will not be supporting this programme, practices are still advised to use the relevant Read codes.

Payment and validation

Practices participating in this programme will be required to sign up to CQRS no later than 30 June 2015.

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[32] HSCIC. http://systems.hscic.gov.uk/cqrs/participation

[33] NHS Employers. Technical requirements for 2015/16 GMS contract changes. www.nhsemployers.org/vandi

[34] Please note that the code descriptions in clinical systems may not exactly match the guidance text.

Claims for payments for this programme should be made monthly, after the final completing dose has been administered. Where claims are entered manually, this should be within 14 days of the end of the month when the completing dose was administered. Where there is an automated data collection, there is a five day period following the month end to allow practices to record the previous months activity before the data collection occurs. Activity recorded after the collection period is closed (five days), will not be collected and recorded on CQRS. Practices must ensure that all activity is recorded by the cut-off date, to ensure payment.

Payment will be made by the last day of the month following the month in which the practice validates and the commissioner approves the payment.

Payment under this programme will be on a monthly basis and calculated by identifying:

- Monthly count of the number of the first hepatitis B vaccination doses (given by the GP practice) administered to babies registered at the practice and identified as at risk of hepatitis B from birth, within the reporting period (i.e. payment count HEP001)35.
- Monthly count of the number of the second hepatitis B vaccination doses (given by the GP practice) administered to babies registered at the practice and identified as at risk of hepatitis B from birth, within the reporting period (i.e. payment count HEP002).
- Monthly count of the number of the third hepatitis B vaccination doses (given by the GP practice) administered to babies registered at the practice and identified as at risk of hepatitis B from birth, within the reporting period (i.e. payment count HEP003).
- Monthly count of the number of the fourth hepatitis B vaccination doses (given by the GP practice) administered to babies registered at the practice and identified as at risk of hepatitis B from birth where a hepatitis B blood test has been recorded and the results communicated to the parent or guardian (i.e. payment count HEP004).

Payment will be made based on the monthly count multiplied by £7.64. Payment for the second and third dose will be made after the practice delivers the third dose.

It is anticipated that practices will claim for payment in the month following vaccination i.e. as soon as possible after birth, at age one month, two months and 12 months. Where vaccination is unavoidably delayed or incomplete and then delivered as soon as possible and as clinically appropriate, practices are entitled to payment (as detailed above) for the administration of doses required to complete the vaccination course. Claims must be submitted within six months of delivering the vaccine dose[36].

CQRS will calculate monthly payments, based either via manually entered data or data collected from GPES.

After CQRS has calculated the practice's final achievement payment, the practice should approve the payment value and declare an ‘achievement declaration’. The commissioner will then approve the payment (assuming that the criteria for the programme have been met) and initiate the payment via the payment agency's Exeter system. Once practices have submitted their data and the declaration and approval process has been followed, then payment for the programme will be sent to the payment agency for processing.

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[35] This will only be applicable by exception where hospitals have not delivered the first dose.
[36] This is in line with SFE requirements.

Commissioners are responsible for post payment verification. This may include auditing claims of practices to ensure that not only the vaccinations were administered but that the full protocol described in the programme was followed i.e. checking the mother's status to identify all newborn babies at risk of hep B, administering the doses at the required time and intervals and referring at 12 months or as soon as possible thereafter for a blood test and reporting the results and recording them on the patient record and referring for paediatric assessment as necessary.

This information could be available to practices and commissioners, as an indicative check, through the management information counts. The reason for it being 'indicative' is that it is not known whether this aggregated number is directly tied to the same patients in the payment count.

The information collected for management information purposes will not be used to trigger payment but may be used for payment verification purposes. It will be available through CQRS, as and when GPES is available, to support commissioners and practices to validate requirements of the programme, as necessary, to demonstrate that the full protocol was followed.

The SFE[37] sets out the administrative provisions relating to the conditions for payment under programme (for example conditions when payment may be withheld or reclaimed) and the treatment of payments in specific circumstances (for example, when contractors merge, split etc.).

[37] DH. SFE. Available via www.nhsemployers.org/GMS201516

MMR (aged 16 and over) vaccination programme

Background and purpose

There have been significant numbers of measles cases in England in recent years. During 2012 there were 1920 confirmed cases, 1408 in 2013 falling to 99 provisional cases for the first 9 months of 2014. Many of these cases have been in teenagers and it is likely that the increase in this age group was related to the adverse publicity about the Measles, Mumps and Rubella (MMR) vaccine between 1998 and 2003 which resulted in sub-optimal vaccine coverage.

Following advice from PHE, NHS England commissioned a vaccination programme to offer MMR vaccine to patients aged 16 and over who are not fully vaccinated. This was introduced in April 2013 for one year and was extended to 31 March 2015. This updated programme commences 1 April 2015 to run until 31 March 2016.

Vaccinations and immunisations are an additional service under the GMS contract. Changes to the GP contract for 2015/16 include an item of service payment of £7.64 for each dose for this programme.

To be fully vaccinated against MMR, two injections should be administered a minimum of four weeks apart. There are two vaccines available in the UK:

1. MMRVaxPRO manufactured by SPMSD
2. Priorix manufactured by GSK.

These vaccines can be used interchangeably. Vaccines for this programme are centrally supplied through ImmForm and practices are required to record all administered doses on ImmForm.

Further details on background, dosage, timings and administration can be found in the Green Book[38].

Requirements

This programme is for one year from 1 April 2015 until 31 March 2016.

Practices participating in this programme will be required to sign up to CQRS no later than 30 June 2015.

Practices are required to:

- Provide vaccination to all unvaccinated patients aged 16 and over who present to the practice requesting vaccination. The Green Book recommends that patients born before 1970 do not require MMR vaccination
- Ensure that the patient record of those offered the vaccination are updated accordingly
- Record all administered doses on ImmForm and where suitable IT systems exist all doses administered are uploaded to ImmForm by automated data collections.

[38] Green Book. Chapters 21, 22 and 23. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Practices are also required to administer the vaccine to all unvaccinated eligible 'at-risk' children aged ten to 15, who present to the practice requesting vaccination or on an opportunistic basis. Payment for this cohort is included in existing global sum allocations, assuming the practice provides additional services. As such, no additional payment will be made for vaccinating these children.

Monitoring

There is one payment count (see payment and validation) for this programme. There are no management information counts.

Practices will be required to manually input data into CQRS, on a monthly basis for the financial year 2015/16. The data input will relate to the payment count. For information on how to manually enter data into CQRS, see the HSCIC website[39].

The 'Technical requirements'[40] document contains the payment count, Read codes[41] available for this programme. Although GPES will not be supporting this programme, practices are still advised to use the relevant Read codes.

Payment and validation

Practices participating in this programme will be required to sign up to CQRS no later than 30 June 2015.

Claims for payments for this programme should be made monthly, after the final completing dose has been administered. Where claims are entered manually, this should be within 14 days of the end of the month when the completing dose was administered. Payment will be made by the last day of the month following the month in which the practice validates and commissioner approves the payment.

Payments are calculated by identifying the:

- Monthly count of the number of MMR vaccination doses administered by the GP practice to registered patients aged 16 years and over in the reporting period who have not previously been fully vaccinated against MMR (i.e. payment count MMR001)".

Payment will be made based on the monthly count multiplied by £7.64.

CQRS will calculate the monthly payment, based on manually entered achievement data.

After CQRS has calculated the practice's final achievement payment, the practice should review the payment value and declare an 'achievement declaration'. The commissioner will then approve the payment (assuming that the criteria for the programme have been met) and initiate the payment via the payment agency's Exeter system. Once practices have submitted their data and the declaration and approval process has been followed, then payment for the programme will be sent to the payment agency for processing.

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[39] HSCIC. Manual data entry. http://systems.hscic.gov.uk/cqrs/participation
[40] NHS Employers. Technical requirements for 2015/16 GMS contract changes. www.nhsemployers.org/vandi
[41] Please note that the code descriptions in clinical systems may not exactly match the guidance text.

Commissioners are responsible for post payment verification. This may include auditing claims of practices to ensure that the full protocol described in the programme was followed i.e. patients are administered either one or two doses as necessary. If two doses are required they must be given at least four weeks apart and the patients records are updated as necessary.

The SFE[42] sets out the administrative provisions relating to the conditions for payment under programme (for example conditions when payment may be withheld or reclaimed) and the treatment of payments in specific circumstances (for example, when contractors merge, split etc.).

[42] DH. SFE. Available via www.nhsemployers.org/GMS201516

Meningococcal (MenC) freshers vaccination programme

Background and purpose

Meningococcal disease is a life-threatening infection. It is a term used to describe two major illnesses – meningitis and septicaemia. These can occur on their own or more commonly both together. Most people will make a good recovery but at worst meningococcal disease causes very severe illness that can rapidly result in death.

The MenC routine vaccination programme was introduced in 1999 for children and adolescents under the age of 18. In 2002, the catch-up campaign was extended to include adults under 25 years. In 2006, the primary course was changed to two doses (at three and four months) and a booster dose at 12 months of age. In 2013, following recommendations by JCVI, further changes were made and an adolescent booster was introduced along with a single dose for university freshers entering higher education for the first time[43].

The MenC vaccine for freshers (first time university/further education students who have received notification via UCAS to obtain MenC[44] vaccination) was introduced on 1 April 2014 and is anticipated to last until the first cohort of the school year nine vaccination programme reaches university age (2018). An estimated 400,000 students in England, aged between 17 and 25 inclusive in the financial year 2015/16 and attending university/further education for the first time will be advised to contact their practice to obtain the MenC vaccination.

This ES is aimed at practices delivering vaccination and immunisation programmes in England. This ES is effective from 1 April 2015 until 31 March 2016.

Vaccinations and immunisations are an additional service under the GMS contract. Changes to the GP contract for 2015/16 include an item of service payment of £7.64 for each dose for this programme.

Further details on background to the programme, dosage, timings and administration can be found in the Green Book[45].

Requirements

This programme is from 1 April 2015 until 31 March 2016.

Commissioners will seek to invite practices to participate in this ES before 30 June 2015. Practices will be required to confirm their participation by 31 July 2015.

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[43] NHS England, PHE and DH letter to the Service. May 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/197618/MenC_letter_FINAL.pdf

[44] This service specification refers to MenC throughout. However, in response to an increase in the incidence of MenW cases recently and based on advice from JCVI it is possible that a quadrivalent Men ACWY vaccine may replace the monovalent MenC vaccine. In the event of a change of vaccine for this programme, this ES specification will be updated to take account of the replacement vaccine. See JCVI 1 October 2014 minutes. https://app.box.com/s/iddfb4ppwkmtjusir2tc#/s/iddfb4ppwkmtjusir2tc/1/2199012147/22846051967/1?&_suid=141873576977305138353830119073

[45] Green Book. Chapter 22. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Practices participating in this programme will be required to sign up to CQRS no later than 31 July 2015.

Practices are required to:

- provide vaccination to eligible students on an opportunistic basis or who self-present (further to receiving notification via UCAS[46] that they should obtain MenC vaccination). Eligible patients are those:

    a. attending university/further education for the first time
    b. aged from 17 to 25 inclusive at any time during the period 1 April 2015 and 31 March 2016
    c. have not previously had any MenC vaccination since aged ten
    d. are vaccinated in the period from 1 April 2015 to 31 March 2016.

- Ensure that the patient record of those who received the vaccination are updated accordingly.

Vaccination

Practices are not required to identify or call and recall eligible patients.

Eligible patients will be advised by UCAS when they receive an offer of a university/further education place[47] to contact their practice. In addition, practices may opportunistically offer vaccination to eligible patients. University/further education encompasses a diverse range of courses and institutions. Practices are not required to have sight of the notification from UCAS or confirmation of a university/further education offer. When offering vaccinations opportunistically, practices should confirm with the patient that they are eligible.

Patients will have sufficient time after receiving notification via UCAS, to obtain the MenC vaccination at their usual practice. However, the programme timeframe also enables patients to register with a new practice close to their university and obtain immunisation.

Eligible patients must be aged between 17 and 25 years old, at any time during the period 1 April 2015 to 31 March 2016. For example:

- patients who are aged 16 can be vaccinated during that period provided they turn 17 by 31 March 2016
- patients who are aged 25 at any time during the programme who then turn 26 after 31 March 2016 can be vaccinated
- patients aged 26 at the start of the programme (1 April 2015) cannot be vaccinated under this ES.

All meningococcal-containing vaccines for university freshers are delivered by one booster dose given intramuscularly into the upper arm.

Vaccines for this programme are centrally supplied through ImmForm.

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[46] UCAS manages applications for 37,000 courses at 370 providers including universities, colleges or conservatoires. A leaflet notifying students applying for relevant courses will be sent to students by UCAS during the application cycle.
[47] UCAS. http://www.ucas.com/

Monitoring

There is one payment count (see payment and validation) for this programme. The management information counts will be outlined in the technical requirements document.

Practices will be required to manually input data into CQRS, on a monthly basis until GPES is available. The data input will be in relation to the payment count, with zeros being entered in the interim for the management information counts. For information on how to manually enter data into CQRS, see the HSCIC website[48].

When GPES is available, each data collection will capture data for all counts and report on activities from the start of the reporting month to the end of the reporting month. The reporting month will be the month prior to the collection month, e.g. if month five (August) is the reporting month then the collection will take place in September. Payment counts will be cumulative and non-cumulative monthly counts from when the practice begins to deliver the programme[49]. It is important to note that when GPES collects data for a given period, the collection only includes activity relating to patients registered at the reporting period end date (i.e. month end/year-end).

When data collections commence, GPES will provide to CQRS the monthly counts from the reporting month they start in, to the end of the relevant reporting month. For this programme, reporting and payment will be monthly. If a practice has declared achievement (payment and management information counts) for a month on CQRS and the commissioner has approved it, no GPES-based automated collection will be received as the payment and management information declaration in CQRS cannot be overwritten.

Payment and validation

Practices participating in this programme will be required to sign up to CQRS no later than 31 July 2015.

Claims for payments for this programme should be made monthly, after the final completing dose has been administered. Where claims are entered manually, this should be within 14 days of the end of the month when the completing dose was administered. Where there is an automated data collection, there is a five day period following the month end to allow practices to record the previous months activity before the collection occurs. Activity recorded after the collection period is closed (five days), will not be collected and recorded on CQRS. Practices must ensure that all activity is recorded by the cut-off date, to ensure payment.

Payment will be made by the last day of the month following the month in which the practice validates and the commissioner approves the payment.

Where a practice has not recorded activity they will need to agree this activity with the commissioner who are able to adjust CQRS payments as part of the approval process. Where the practice does not believe that the activity reporting and therefore the payment calculated is accurate, the practice can raise this with the commissioner who can adjust the payment if necessary.

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[48] HSCIC. Manually entry. http://systems.hscic.gov.uk/cqrs/participation

[49] Counts including the words “up to the end of the reporting period” are cumulative, whereas those counts using the word “within the reporting period” are non-cumulative.

Payments are calculated by identifying the:

- Monthly count of the number of patients aged between 17 and 25, at any point in the financial year, who have received a MenC vaccination by the GP practice in the reporting period (patients must not previously have received a MenC booster since age ten years) (i.e. payment count MENCF01).

Payment will be made based on the monthly count multiplied by £7.64.

CQRS will calculate the monthly payment, based on the achievement data manually entered or data collected by GPES.

After CQRS has calculated the practice's final achievement payment, the practice should 'approve the payment value' and submit an 'achievement declaration'. The commissioner will then approve the payment (assuming that the criteria for the ES has been met) and initiate the payment via the payment agency's Exeter system. Once practices have submitted their data and the declaration and approval process has been followed, then payment for the ES will be sent to the payment agency for processing.

Commissioners are responsible for post payment verification. This may include auditing claims of practices to ensure that not only the vaccinations were administered but that the full protocol described in the NHS England service specification[50] was followed.

The information collected for management information purposes will not be used to trigger payment but may be used for payment verification purposes. It will be available through CQRS, as and when GPES is available, to support commissioners and practices to validate requirements of the programme, as necessary, to demonstrate that the full protocol was followed.

The NHS England service specification sets out the administrative provisions relating to the conditions for payment under this ES (for example conditions when payment may be withheld or reclaimed) and the treatment of payments in specific circumstances (for example, when contractors merge, split etc.).

Payments made under this ES, or any part thereof, will be made only if practices satisfy the conditions set out in the NHS England service specification.

[50] NHS England. Service specification. http://www.england.nhs.uk/commissioning/gp-contract/

Pertussis (pregnant women) vaccination programme

For details of the requirements for the pertussis vaccination programme, see the NHS England service specification[51] on the NHS England website.

For details of the Read codes, payment and management information counts, see the 'Technical requirements'[52] document.

Details on background to the programme, dosage, timings and administration can be found in the Green Book[53].

[51] NHS England. Service specification. http://www.england.nhs.uk/commissioning/gp-contract/
[52] NHS Employers. Technical requirements for 2015/16 GMS contract changes. www.nhsemployers.org/vandi
[53] Green Book. Chapter 24. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Rotavirus (routine childhood immunisation) vaccination programme

Background and purpose

Following a recommendation by the JCVI, vaccination against rotavirus was introduced to the national immunisation programme from July 2013, to protect infants.

Rotavirus can cause gastroenteritis which may lead to severe diarrhoea, vomiting, stomach cramps, dehydration and mild fever. If unvaccinated, nearly all children would have at least one episode of rotavirus gastroenteritis before reaching the age of five years. The vaccine, given orally, is over 85 per cent effective at protecting against severe rotavirus gastroenteritis. An estimated 130,000 children with rotavirus gastroenteritis would have visited their practice and approximately 12,700 of these children would have been hospitalised in England and Wales each year if there was no vaccination programme. Deaths caused by rotavirus are rare and difficult to quantify accurately. However, in England and Wales there were approximately three to four each year prior to the vaccination programme commencing.

The rotavirus immunisation programme comprises two doses of rotavirus vaccine given to infants at the age of two months and three months (two doses four weeks apart) when they attend for their first and second routine childhood immunisations.

Vaccinations and immunisations are an additional service under the GMS contract. Changes to the GMS contract for 2015/16 include an item of service payment of £7.64 for a completed course of rotavirus vaccination.

Further details on background to the programme, dosage and timings can be found in the Green Book[54].

Requirements

This programme is for one year from 1 April 2015 until 31 March 2016.

Commissioners will seek to invite practices to participate in this ES before 30 June 2015. Practices will be required to confirm their participation by 31 July 2015.

Practices participating in this programme will be required to sign up to CQRS no later than 31 July 2015.

Practices are required to:

- Administer a completed course of vaccine as specified in the SFE. For the purpose of this programme, a completed course is defined as 'two doses of rotavirus vaccination'. The first dose of the vaccine is to be administered from age six weeks (the earliest the vaccine can be given). Patients should only receive the first dose of Rotarix if they are aged under 15 weeks. A minimum of four weeks is required between doses. The second dose is due before the patient reaches the age of 24 weeks.

[54] Green Book. Chapter 27b. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

- Ensure that the patient records of those offered the vaccination are updated accordingly.
- Record all administered doses on ImmForm and where suitable IT systems exist all doses administered are uploaded to ImmForm by automated data collections.

Patients who inadvertently receive the first dose of rotavirus vaccine at age 15 weeks or older should still receive their second dose at least four weeks later provided they are still under 24 weeks of age at the time. The reason for the 15 week age limit is to minimise a potential risk of intussusception[55].

The vaccine can be administered with other childhood vaccines, meaning it can be given at the routine first and second childhood immunisations appointments.

The vaccine to be used for this programme is Rotarix, which will be centrally supplied through ImmForm and is manufactured by GSK and is administered orally.

Monitoring

There is one payment count (see payment and validation) for this service. The management information counts will be outlined in the technical requirements document.

Practices will be required to manually input data into CQRS, on a monthly basis, until GPES[56] is available. The data input will be in relation to the payment count, with zeros being entered in the interim for the management information counts. For information on how to manually enter data into CQRS, see the HSCIC website[57].

When GPES is available, each data collection will capture data for all counts and report on activities from the start of the reporting month to the end of the reporting month. The reporting month will be the month prior to the collection month, e.g. if month five (August) is the reporting month then the collection will take place in September. Payment counts will be cumulative and non-cumulative monthly counts from when the practice begins to deliver the programme[58]. It is important to note that when GPES collects data for a given period, the collection only includes activity relating to patients registered at the reporting period end date (i.e. month end/year-end).

When data collections commence, GPES will provide to CQRS the monthly counts from the reporting month they start in, to the end of the relevant reporting month. For this programme, reporting and payment will be monthly. If a practice has declared achievement (payment and management information counts) for a month on CQRS and the commissioner has approved it, no GPES-based automated collections will be received as the payment and management information declaration in CQRS cannot be overwritten.

The 'Technical Requirements'[59] document contains the payment counts, management

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[55] Green Book.
[56] Details as to when and if GPES becomes available to support this service will be communicated via the HSCIC.
[57] HSCIC. Manually entry. http://systems.hscic.gov.uk/cqrs/participation
[58] Counts including the words "up to the end of the reporting period" are cumulative, whereas those counts using the word "within the reporting period" are non-cumulative.
[59] NHS Employers. Technical requirements for 2015/16 GMS contract changes. www.nhsemployers.org/vandi

information counts, Read codes[60] relevant for this ES. The Read codes will be used as the basis for the GPES data collection, which will allow CQRS to calculate payment and support the management information collections, when available. Although practices will be required to manually enter data until GPES is available, it is still required that practices use the relevant Read codes from the start of the ES. This is because only those included in this document and the supporting Business Rules[61] will be acceptable to allow CQRS to calculate achievement and payment and for commissioners to audit payment and service delivery. Practices will need to ensure that they use the relevant codes and if necessary re-code patients as required.

Supporting Business Rules will be published on the HSCIC website. Commissioners and practices should refer to these for the most up to date information on management information counts.

Payment and validation

Practices participating in this programme will be required to sign up to CQRS no later than 31 July 2015.

Claims for payments for this programme should be made monthly, after the final completing dose has been administered. Where claims are entered manually, this should be within 14 days of the end of the month when the completing dose was administered. Where there is an automated data collection, there is a five day period following the month end to allow practices to record the previous months activity before the collection occurs. Activity recorded after the collection period is closed (five days), will not be collected and recorded on CQRS. Practices must ensure that all activity is recorded by the cut-off date, to ensure payment.

Payment will be made by the last day of the month following the month in which the practice validates and commissioner approves the payment.

Where a practice has not recorded activity they will need to agree this activity with the commissioner who are able to adjust CQRS payments as part of the approval process. Where the practice does not believe that the activity reporting and therefore the payment calculated is accurate, the practice can raise this with the commissioner who can adjust the payment if necessary.

Payments are calculated by identifying the:

- Monthly count of the contractor's registered patients who have a completed rotavirus immunisation (2 doses) given before 24 weeks of age in the reporting period (i.e. payment count ROTA001).

Payment will be made based on the monthly count multiplied by £7.64. Only one payment will be made per patient vaccinated.

CQRS will calculate the monthly payments, based on the achievement data either via manually entered data or data collected from GPES.

After CQRS has calculated the practice's final achievement payment, the practice should

[60] Please note that the code descriptions in clinical systems may not exactly match the guidance text.
[61] HSCIC. Business Rules. www.hscic.gov.uk/qofesextractspecs

approve the payment value and declare an ‘achievement declaration’. The commissioner will then approve the payment (assuming that the criteria for the programme has been met) and initiate the payment via the payment agency's Exeter system. Once practices have submitted their data and the declaration and approval process has been followed, then payment for the programme will be sent to the payment agency for processing.

Commissioners are responsible for post payment verification. This may include auditing claims of practices to ensure not only that the practice has administered a completed course, but that the full protocol described in the programme was followed i.e. the vaccination was given from age six weeks (the earliest the vaccine can be given) and with a minimum of four weeks between doses and that the second dose is given before the patient reaches the age of 24 weeks. This information will be available to commissioners and practices, through CQRS in aggregated numbers, as an indicative check, through the management information counts as and when GPES is available. The reason for it being 'indicative' is that it is not known whether this aggregated number is directly tied to the same patients in the payment count.

The information collected for management information purposes will not be used to trigger payment but may be used for payment verification purposes. It will be available through CQRS, as and when GPES is available, to support commissioners and practices to validate requirements of the programme, as necessary, to demonstrate that the full protocol was followed.

The SFE[62] sets out the administrative provisions relating to the conditions for payment under programme (for example conditions when payment may be withheld or reclaimed) and the treatment of payments in specific circumstances (for example, when contractors merge, split etc.).

[62] DH. SFE. Available via www.nhsemployers.org/GMS201516

Section 5. Existing programmes (continuing September 2015)

Childhood seasonal influenza vaccination programme

Background and purpose

In 2012 the JCVI recommended that the seasonal influenza programme be extended to all children aged two to under 17. The roll-out of this extended programme will be phased in over a period of time ensuring a manageable and successful implementations process. The first cohort of patients to be vaccinated from 1 September 2013 was children aged two and three years. From 1 September 2014, the ES was extended to include all children aged two, three and four years old (but not aged less than two or aged five or over) on 1 September 2014.

From 1 September 2015 this ES includes children aged two, three and four years old (but not aged less than two or aged five or over) on 31 August 2015. The date of eligibility has change to be in line with the schools programmes.

Further phasing and consideration of how the programme will be extended to school age children will be informed by pilots and through collaboration between Public Health England (PHE), NHS England and the Department of Health (DH).

The childhood seasonal influenza ES supplements the seasonal influenza ES which vaccinates children aged six months and over who have clinical conditions which put them at risk of the effects of influenza. Children aged two, three and four but not aged less than two or aged five or over (including those defined as at-risk) are excluded from the seasonal influenza ES to avoid duplication.

The objective of influenza immunisation is to protect those who are most at risk of serious illness or death should they develop influenza and to reduce transmission of the infection, thereby contributing to the protection of vulnerable patients who may have a suboptimal response to their own immunisations.

The childhood seasonal influenza vaccination programme is an ES aimed at delivering vaccination and immunisation programmes in England. This ES is effective from 1 September 2015 to 31 March 2016 for patients aged two, three and four (but not aged less than two or aged five or over) on 31 August 2015. Healthy children that turn two after 31 August 2015 should not be offered the vaccine.

Payment of £7.64 for each dose of influenza vaccination will be made to practices delivering this ES in accordance with the NHS England service specification.

Details on this programme and the wider seasonal influenza programme can be found in the NHS England, PHE and DH annual flu letter and flu plan, the Green Book[63] and the ES

[63] Green Book. Chapter19. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

specification[64].

Requirements

This programme is from 1 September 2015 to 31 March 2016.

Commissioners will seek to invite practices to participate in this ES before 30 June 2015. Practices will be required to confirm their participation by 31 July 2015.

Practices participating in this programme will be required to sign up to CQRS no later than 31 August 2015.

Practices are required to:

- Provide influenza vaccination to all eligible patients registered at the practice unless contra-indicated.
- Eligible patients are those who:

    a. are registered patients; and are
    b. aged two, three or four on 31 August 2015 (but not aged less than two or aged five or over),

- Patients should be vaccinated on a:

    a. proactive call basis, if not considered at-risk, or
    b. proactive call and recall[65] basis, if considered at-risk as defined in the annual flu letter (extract included at the childhood annex).

- Immunisation is contra-indicated where the patient has previously had a confirmed anaphylactic reaction to a previous dose of the vaccine, or to any component of the vaccine.
- Vaccination must be delivered during the period of this ES, namely between 1 September 2015 and 31 March 2016, with vaccinations concentrated between 1 September 2015 and 31 December 2015.
- Vaccination must be with the appropriate vaccine and dosage[66, 67]:

    a. One dose of Fluenz Tetra® (which will be centrally supplied), is required for eligible patients who are not contra-indicated.
    b. Eligible patients included in an at-risk group will also require a second dose of Fluenz Tetra®, where they have not received influenza vaccination previously (and are aged between two to less than nine years) at least four weeks after the first dose.

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[64] NHS England. Childhood seasonal influenza vaccination programme service specification. http://www.england.nhs.uk/commissioning/gp-contract/

[65] NHS. PMS Directions. Influenza and pneumococcal scheme requires that practices develop a proactive and preventative approach to offering immunisations by adopting robust call and reminder systems for at-risk patients, with the aims of maximising uptake and meeting PH targets.

[66] The at-risk groups, vaccines and dosages are defined in the NHS England, PHE and DH tripartite letter and the Green Book.

[67] The at-risk groups are also defined in the childhood annex of this guidance.

c. Where Fluenz Tetra® is contra-indicated, children defined as at-risk will require one dose of a suitable inactivated influenza vaccine (which will be centrally supplied), except where an eligible patient has not received influenza vaccination previously (and are aged between six months to less than nine years), in which case a second dose of a suitable inactivated influenza vaccine is required at least four weeks after the first dose. PHE does not recommend that inactivated influenza vaccines are used for healthy children.

- Ensure that the patient record of those vaccinated are updated as set out in the ES specification.
- Record all administered doses on ImmForm and where suitable IT systems exist all doses administered are uploaded to ImmForm by automated collections.

Vaccine

This programme is for all registered patients aged two, three and four (but not aged less than two or aged five or over) on 31 August 2015. For example, patients will not be eligible for childhood seasonal influenza vaccination under this ES if they are aged one or under, or five or over on 31 August 2015. However patients turning five during the timeframe 1 September 2015 to 31 March 2016 will remain eligible as they were within the eligible age range on 31 August 2015. Healthy children that turn two on or after 31 August 2015 should not be vaccinated.

Eligible patients should be vaccinated as soon as the vaccine is available. Widespread immunisation may continue until December 2015 but where possible should be completed before influenza starts to circulate in the community. However, influenza can circulate later that this and clinicians should apply clinical judgement to assess the needs of individual patients for immunisation beyond this point. This should take in to account the level of flu-like illness in the community and the fact that the immune response following immunisation takes about two weeks to fully develop. Under this ES, practices may continue to vaccinate eligible patients until 31 March 2016 for whom they will receive payment.

Where two doses are clinically indicated, they must be delivered at least four weeks apart.

See the Green Book for information about administration and dosage.

All vaccines for this ES will be centrally supplied through ImmForm and practices are required to record all administered doses on ImmForm. The vaccine centrally supplied for this programme is Fluenz Tetra® for all cases except where children defined as at-risk are contra-indicated where inactivated influenza vaccine will be supplied. PHE does not recommend that inactivated influenza vaccines are used for healthy children. Fluenz Tetra® and the inactivated influenza vaccines for use in those whom Fluenz Tetra is contra-indicated can be ordered online from ImmForm as per other centrally supplied vaccines.

Fluenz Tetra® is a live attenuated influenza vaccine and is supplied in an applicator that allows a divided dose to be administered in each nostril (total dose of 0.2 ml - 0.1 ml in each nostril). The device allows intranasal administration to be performed without the need for additional training. Administration of either dose does not need to be repeated if the patient sneezes or blows their nose following administration. There are no data on the effectiveness of Fluenz Tetra® when given to children with a heavily blocked or runny

nose (rhinitis) attributable to infection or allergy. As heavy nasal congestion might impede delivery of the vaccine to the nasopharyngeal mucosa, deferral of administration until resolution of the nasal congestion or an appropriate alternative intramuscularly administered influenza vaccine should be considered. Fluenz Tetra® has a short shelf-life and doses will have a use-by date and the latest expiry date is expected to be around January /February[68]. Clinical advice on seasonal influenza immunisation is that vaccinations should be given as early as possible before influenza starts circulating in the community. PHE does not recommend that inactivated influenza vaccines are used for healthy children, however in the event that a child defined as at-risk presents for vaccination after stocks of Fluenz Tetra® have expired, the inactivated vaccine is an option at the clinical discretion of the GP.

Inactivated influenza vaccines for intramuscular administration are supplied as suspensions in pre-filled syringes. They should be shaken well before they are administered.

Some of the summaries of product characteristics (SPCs) for intramuscular inactivated influenza vaccines indicate that young children can be given either a 0.25 ml or a 0.5 ml dose. JCVI has advised that where these alternative doses are indicated in the SPC, the 0.5 ml dose of intramuscular inactivated influenza vaccine should be given to infants aged six months or older and young children because there is evidence that this dose is effective in young children[69].

Advice in this guidance document should be read in conjunction with chapter 19 of the Green Book.

Monitoring

The payment and management information counts will be outlined in the technical requirements document when available.

Practices will be required to manually input data into CQRS, on a monthly basis, until GPES[70] is available. The data input will be in relation to the payment count, with zeros being entered in the interim for the management information counts. For information on how to manually enter data into CQRS, see the HSCIC website[71].

When GPES is available, each collection will capture data for all counts and report on activities from the start of the reporting month to the end of the reporting month. The reporting month will be the month prior to the collection month, e.g. if month five (August) is the reporting month then the collection will take place in September. Payment counts will be cumulative and non-cumulative monthly counts from when the practice begins to deliver the programme[72]. It is important to note that when GPES collects data for a given period,

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[68] As Fluenz Tetra® is a live vaccine, actual expiry dates are not yet known. Practices should check the expiry dates and use their stock accordingly.
[69] Heinonen et al., 2010.
[70] Details as to when and if GPES becomes available to support this service will be communicated via the HSCIC.
[71] HSCIC. Manually entry. http://systems.hscic.gov.uk/cqrs/participation
[72] Counts including the words “up to the end of the reporting period” are cumulative, whereas those counts using the word “within the reporting period” are non-cumulative.

the collection only includes activity relating to patients registered at the reporting period end date (i.e. month end/year-end).

When data collections commence, GPES will provide to CQRS the monthly counts from the reporting month they start in, to the end of the relevant reporting month. For this programme, reporting and payment will be monthly. If a practice has declared achievement (payment and management information counts) for a month on CQRS and the commissioner has approved it, no GPES-based automated collection will be received as the payment and management information declaration in CQRS cannot be overwritten.

The 'Technical requirements'[73] document contains the payment counts, management information counts, Read codes[74] relevant for this ES. The Read codes will be used as the basis for the GPES data collection, which will allow CQRS to calculate payment and support the management information collections, when available. Although practices will be required to manually enter data until GPES is available, it is still required that practices use the relevant Read codes from the start of the ES. This is because only those included in this document and the supporting Business Rules[75] will be acceptable to allow CQRS to calculate achievement and payment and for commissioners to audit payment and service delivery. Practices will need to ensure that they use the relevant codes and if necessary re-code patients as required.

Supporting Business Rules will be published on the HSCIC website. Commissioners and practices should refer to these for the most up to date information on management information counts.

Payment and validation

Practices participating in this programme will be required to sign up to CQRS no later than 31 August 2015.

Claims for payments for this programme should be made monthly, after the final completing dose has been administered. Where claims are entered manually, this should be within 14 days of the end of the month when the completing dose was administered. Where there is an automated data collection, there is a five day period following the month end to allow practices to record the previous months activity before the collection occurs. Activity recorded after the collection period is closed (five days), will not be collected and recorded on CQRS. Practices must ensure that all activity is recorded by the cut-off date, to ensure payment.

Payment will be made by the last day of the month following the month in which the practice validates and the commissioner approves the payment.

Where a practice has not recorded activity they will need to agree this activity with the commissioner who are able to adjust CQRS payments as part of the approval process. Where the practice does not believe that the activity reporting and therefore the payment

[73] NHS Employers. Technical requirements for 2015/16 GMS contract changes. www.nhsemployers.org/vandi

[74] Please note that the code descriptions in clinical systems may not exactly match the guidance text.

[75] HSCIC. Business Rules. www.hscic.gov.uk/qofesextractspecs

calculated is accurate, the practice can raise this with the commissioner who can adjust the payment if necessary.

Payment under this ES will be on a monthly basis and calculated by identifying the:

- Monthly count of seasonal influenza vaccination given to patients aged two, three and four (but not aged less than two or aged five or over) on 31 August 2015. (i.e. payment count).
- Count of second doses given to patients within the same month but at least four weeks after the first dose.

Payment will be made based on the monthly count multiplied by £7.64. Only one payment will be made per dose delivered. Where two doses have been delivered, practices may be required to provide evidence as to why the second dose was indicated. Where evidence does not support delivery of a second dose, the practice will not be paid for the second dose.

CQRS will calculate the monthly payment, based on the achievement data either via manually entered data or data collected from GPES.

After CQRS has calculated the practice's final achievement payment, the practice should review the payment value and declare an ‘achievement declaration’. The commissioner will then approve the payment (assuming that the criteria for the ES has been met) and initiate the payment via the payment agency's Exeter system. Once practices have submitted their data and the declaration and approval process has been followed, then payment for the programme will be sent to the payment agency for processing.

Commissioners are responsible for post payment verification. This may include auditing claims of practices to ensure that not only that the practice administered a completed course, but that the full protocol described in the ES specification[76] was followed. This information could be available to commissioners and practices as an indicative check, through the management information counts. The reason for it being 'indicative' is that it is not known whether this aggregated number is directly tied to the same patients in the payment count.

The information collected for management information purposes will not be used to trigger payment but may be used for payment verification purposes. It will be available through CQRS, as and when GPES is available to support commissioners and practices to validate requirements of the ES, as necessary, to demonstrate that the full protocol was followed.

The NHS England ES specification sets out the administrative provisions relating to the conditions for payment under this ES (for example conditions when payment may be withheld or reclaimed) and the treatment of payments in specific circumstances (for example, when contractors merge, split etc.).

Payments made under this ES, or any part thereof, will be made only if practices satisfy the conditions set out in the ES specification.

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[76] NHS England. Service specification http://www.england.nhs.uk/commissioning/gp-contract/

Childhood annex

Groups included in the national flu immunisation programme as defined in the annual flu letter and Green Book.

Eligible groups	Further details
Chronic respiratory disease aged six months and over	Asthma that requires continuous or repeated use of inhaled or systemic steroids or with previous exacerbations requiring hospital admission. Chronic obstructive pulmonary disease (COPD) including chronic bronchitis and emphysema; bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Children who have previously been admitted to hospital for lower respiratory tract disease.
Chronic heart disease aged six months and over	Congenital heart disease, hypertension with cardiac complications, chronic heart failure, individuals requiring regular medication and/or follow-up for ischaemic heart disease.
Chronic kidney disease aged six months and over	Chronic kidney disease at stage 3, 4 or 5, chronic kidney failure, nephrotic syndrome, kidney transplantation.
Chronic liver disease aged six months and over	Cirrhosis, biliary atresia, chronic hepatitis
Chronic neurological disease aged six months and over	Stroke, transient ischaemic attack (TIA). Conditions in which respiratory function may be compromised due to neurological disease (e.g. polio syndrome sufferers). Clinicians should consider on an individual basis the clinical needs of patients including individuals with cerebral palsy, multiple sclerosis and related or similar conditions; or hereditary and degenerative disease of the nervous system or muscles; or severe neurological or severe learning disability.
Diabetes aged six months and over	Type 1 diabetes, type 2 diabetes requiring insulin or oral hypoglycaemic drugs, diet controlled diabetes.
Immunosuppression aged six months or older	Immunosuppression due to disease or treatment, including patients undergoing chemotherapy leading to immunosuppression, bone marrow transplant, HIV infection at all stages, multiple myeloma or genetic disorders affecting the immune system (e.g. IRAK-4, NEMO, compliment deficiency). Individuals treated with or likely to be treated with systemic steroids for more than a month at a dose equivalent to

	prednisolone at 20 mg or more per day (any age), or for children under 20 kg, a dose of 1 mg or more per kg per day. It is difficult to define at what level of immunosuppression a patient could be considered to be at a greater risk of the serious consequences of influenza and should be offered influenza vaccination. This decision is best made on an individual basis and left to the patient's clinician. Some immune-compromised patients may have a suboptimal immunological response to the vaccine.
Asplenia or dysfunction of the spleen aged six months or older	This also includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction.
People in long-stay residential or homes	Vaccination is recommended for people living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality.

PHE state that this list is not exhaustive and the clinicians should apply clinical judgement to take into account the risk of influenza exacerbating any underlying disease that a patient may have, as well as the risk of serious illness from influenza itself. Influenza vaccination should be offered in such cases even if the individual is not in the clinical risk groups specified above.

Seasonal influenza and pneumococcal polysaccharide vaccination programme

Background and purpose

Immunisation is one of the most successful and cost-effective health protection interventions and is a cornerstone of public health. High immunisation rates are key to preventing the spread of infectious disease, complications and possible early death among individuals and protecting the population's health through both individual and herd immunity.

For most healthy people, influenza is an unpleasant but usually self-limiting disease. However, children, older people, pregnant women and those with underlying disease are at particular risk of severe illness if they catch it.

Pneumococcal infection is caused by Streptococcus pneumoniae – a common cause of pneumonia and can also lead to invasive disease including meningitis and septicaemia. Invasive disease is common in young children, who are offered protection against 13 serotypes of S. pneumoniae through the pneumococcal conjugate vaccination (PCV13) programme. Children aged under two years are covered under the SFE. In older children and adults, severe pneumococcal infection predominantly affects those with underlying conditions and the elderly.

The aim of the seasonal influenza and pneumococcal polysaccharide vaccination programmes is to protect those who are most at risk of serious illness or death should they develop influenza or pneumococcal disease, by offering protection against the most prevalent strains of influenza virus and against 23 serotypes of S. pneumoniae. This will be achieved by delivering evidence-based, population wide immunisation programmes that:

- identify the eligible population and ensure effective and timely delivery with optimal coverage based on the target populations
- is safe, effective, of a high quality and is independently monitored; and
- is delivered and supported by suitably trained, competent and qualified healthcare practitioners.

NHS England has been directed to establish a seasonal influenza and pneumococcal ES. This ES will support NHS England, on behalf of PHE in delivering vaccination and immunisation programmes in England.

This ES is effective from 1 April 2015 for the pneumococcal element and 1 September 2015 for seasonal influenza. Both end on 31 March 2016. Patients eligible for vaccination under this ES are defined in the part one and part two of this section.

Where a practice agrees to participate in this ES, they will be expected to deliver vaccinations to eligible patients for both the seasonal influenza and pneumococcal vaccination programmes. The arrangements to deliver this ES supersede any previous local agreements.

The vaccines recommended for **seasonal influenza** vaccinations are:

- Fluenz Tetra® for patients aged two to 17 years unless contra-indicated in which case a suitable inactivated influenza vaccine should be used.
- A suitable inactivated influenza vaccine for all other eligible patients.

The vaccine recommended for **pneumococcal polysaccharide** vaccination is the pneumococcal polysaccharide vaccine 23 (PPV23) vaccine Pnuemovax® II.

Payment of £7.64 for each dose of seasonal influenza or PPV23 vaccine will be made to practices delivering this ES in accordance with the NHS England service specification[77].

Details on the national seasonal influenza vaccination programme including dosage, timings and administration can be found in the NHS England, PHE and DH annual flu letter and annual flu plan and chapter 19 of the Green Book.

Details on the pneumococcal vaccination programme including dosage, timings and administration can be found in chapter 25 of the Green Book.

Part one: pneumococcal polysaccharide vaccination programme

Requirements

The pneumococcal element of the ES commences on 1 April 2015 until 31 March 2016.

Commissioners will seek to invite practices to participate in this ES before 30 June 2015. Practices will be required to confirm their participation by 31 July 2015.

Practices participating in this programme will be required to sign up to CQRS no later than 31 July 2015.

Practices are required to:

- Provide PPV23 vaccination to all eligible patients registered at the practice unless contra-indicated. Eligible patients are those who are previously unvaccinated since aged two, who are:

    a. patients aged 65 and over; and
    b. patients aged two[78] to 64 years defined as at-risk in the Green Book[79].

- Patients should be vaccinated on either:

    a. a proactive call basis, if not considered at-risk, or
    b. a proactive call and recall basis, if considered at-risk with the aim of maximising uptake in at-risk patients[80].

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[77] NHS England. Service specification. http://www.england.nhs.uk/commissioning/gp-contract/
[78] Practices should ensure that patients aged two to four years (inclusive) have received the recommended course of PCV13 prior to further pneumococcal vaccination with PPV23.
[79] Green Book. Chapter 25. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book (The at-risk groups for pneumococcal polysaccharide are available in pneumococcal annex)
[80] Section 8 of the Directions state that practice must have robust call and reminder systems to contact at-risk patients with the aim of maximising uptake in the interest of at-risk patients and meeting any PH targets.

- Immunisation is contra-indicated where the patient has previously had a confirmed anaphylactic reaction to a previous dose of the vaccine, or to any component of the vaccine.
- Vaccination must be delivered during the period of this ES, namely between 1 April 2015 and 31 March 2015.
- Vaccinations delivered under this ES must be with the appropriate vaccine and dosage[81]:

    a. One dose is required for all eligible patients.
    b. Where a patients has indicted they wish to be vaccinated for either vaccination, but are physically unable to attend the practice (for example is housebound), the practice must make all reasonable effort to ensure the patient is vaccinated.

- Ensure that the patient record of those vaccinated are updated as set out in the ES specification.
- Record all the administered doses on ImmForm and where suitable IT systems exist all doses administered are uploaded to ImmForm by automated collections.

Vaccine

Vaccination will be offered to all registered patients that meet the criteria defined under the 'requirements' section.

Only one dose of PPV23 is required to provide life-time protection for patients aged two and over. The seasonal influenza vaccination programme offers an opportunity (using the same call and recall system) to provide PPV23 alongside influenza to unvaccinated people in risk groups and those who have just turned 65. As pneumococcal infection is a recognised complication of influenza, providing the two vaccines together early in the season will increase the level of protection to vulnerable individuals over the winter period.

There are some patients with specific diseases such as splenic dysfunction, asplenia and chronic renal failure which may require vaccination every five years. Practices should contact their commissioner to reach local agreement on the re-vaccination of these patients.

For detailed information about doses and administration for this programme and the wider pneumococcal disease area see the Green Book.

Practices are required to order vaccines for this ES direct from the manufacturers.

The PPV23 vaccine (Pneumovax® II) is manufactured by SPMSD. PPV23 vaccines are supplied as single doses of 0.5 ml. PPV can be given at the same time as other vaccines such as DTaP/IPV/Hib, MMR, MenC, Hib/MenC and influenza. The vaccines should be given in separate sites, preferably in separate limbs. If given in the same limb, they should be at least 2.5 cm apart.

[81] Green Book. Chapter 25. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Monitoring

Although seasonal influenza and PPV23 are a joint programme under one ES, they are set up as separate services on CQRS and GPES. As practices who agree to participate in this ES will be expected to deliver vaccinations to eligible patients for both the seasonal influenza and pneumococcal vaccination programmes, practices would be expected to sign up to both services on CQRS.

Practices will be required to manually input data into CQRS, on a monthly basis, until GPES[82] is available. The data input will be in relation to the payment count only, with zeros being entered in the interim for the management information counts.

For information on how to manually enter data into CQRS, see the HSCIC[83] website.

For PPV23 there are three payment counts (see payment and validation). The management information counts will be detailed in the technical requirements document.

When GPES is available, each data collection will capture data for all counts and report on activities from the start of the reporting month to the end of the reporting month. The reporting month will be the month prior to the collection month, e.g. if April is the reporting month then the collection will take place in May. Payment counts will be cumulative and non-cumulative monthly counts from when the practice begins to deliver the programme[84]. It is important to note that when GPES collects data for a given period, the collection only includes activity relating to patients registered at the reporting period end date (i.e. a monthly collection would only include patients registered with the practice at the month end).

When data collections commence, GPES will provide to CQRS the monthly counts from the relevant month they start in to the end of the relevant reporting month. For this ES, reporting and payment will be monthly. If a practice has declared achievement (payment and management information) for a month on CQRS and the commissioner has approved it, no GPES-based automated collection will be received as the payment declaration in CQRS cannot be overwritten.

The 'Technical requirements'[85] document contains the payment counts, management information counts and Read codes[86] relevant for this ES. The Read codes will be used as the basis for the GPES data collection, which will allow CQRS to calculate payment and support the management information collections, when available. Although practices will be required to manually enter data until GPES is available, it is still required that practices use the relevant Read codes from the start of the programme. This is because only those included in this document and the supporting Business Rules[87] will be acceptable to allow CQRS to calculate achievement and payment and for commissioners to audit payment

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[82] Details relating to the availability of GPES support will be communicated via the HSCIC.
[83] HSCIC. http://systems.hscic.gov.uk/cqrs/participation
[84] Counts including the words "up to the end of the reporting period" are cumulative, whereas those counts using the word "within the reporting period" are non-cumulative.
[85] NHS Employers. Technical requirements for 2015/16 GMS contract changes. www.nhsemployers.org/vandi
[86] Please note that the code descriptions in clinical systems may not exactly match the guidance text.
[87] HSCIC. Business Rules. www.hscic.gov.uk/qofesextractspecs

and service delivery. Practices will therefore need to ensure that they use the relevant codes and if necessary re-code patients as required.

Supporting Business Rules will be published on the HSCIC website. Commissioners and practices should refer to these for the most up to date information on management information counts.

Payment and validation

Practices who participate in this programme will be required to sign up to CQRS by no later than 31 July 2015.

Claims for payments for this programme should be made monthly, after the final completing dose has been administered. Where claims are entered manually, this should be within 14 days of the end of the month when the completing dose was administered. Where there is an automated data collection, there is a five day period following the month end to allow practices to record the previous months activity before the collection occurs. Activity recorded after the collection period is closed (five days), will not be collected and recorded on CQRS. Practices must ensure that all activity is recorded by the cut-off date, to ensure payment.

Payment will be made by the last day of the month following the month in which the practice validates and commissioner approves the payment.

Where a practice has not recorded activity they will need to agree this activity with the commissioner who are able to adjust CQRS payments as part of the approval process. Where the practice does not believe that the activity reporting and therefore the payment calculated is accurate, the practice can raise this with the commissioner who can adjust the payment if necessary.

Payments are calculated by identifying the:

- Monthly count of patients aged 65 and over as at 31 March 2015, who have received a pneumococcal vaccination by the GP practice, within the reporting period. (i.e. payment count PNEU01)
- Monthly count of patients aged 2 to 64 on 31 March 2015 and identified as at risk, with at least one clinical Read code in the patient's record, who have received a pneumococcal vaccination by the GP practice within the reporting period. (i.e. payment count PNEU02)
- Monthly count of patients aged 2 to 64 on 31 March 2015 and identified as at risk by the Read code 65WB. or XaM2n "requires a pneumococcal vaccination" who received a pneumococcal vaccination by the GP practice in the reporting period (excluding patients identified in count PNEU002). (i.e. payment count PNEU03)

Payment will be made based on the monthly count multiplied by £7.64. Only one payment will be made per dose delivered for each programme.

CQRS will calculate the monthly payment, based on the achievement data either via manually entered data or data collected from GPES.

After CQRS has calculated the practice's final achievement payment, the practice should review the payment value and declare an 'achievement declaration'. The commissioner

will then approve the payment (assuming that the criteria for the ES has been met) and initiate the payment via the payment agency's Exeter system. Once practices have submitted their data and the declaration and approval process has been followed, then payment for the programme will be sent to the payment agency for processing.

Commissioners are responsible for post payment verification. This may include auditing claims of practices to ensure that not only that the practice administered a completed course, but that the full protocol described in the ES specification[88] was followed. This information could be available to commissioners and practices, as an indicative check, through the management information counts as and when GPES is available. The reason for it being 'indicative' is that it is not known whether this aggregated number is directly tied to the same patients in the payment count.

The information collected for management information purposes will not be used to trigger payment but may be used for payment verification purposes. It will be available through CQRS, as and when GPES is available, to support commissioners and practices to validate requirements of the ES, as necessary, to demonstrate that the full protocol was followed.

The NHS England service specification sets out the administrative provisions relating to the conditions for payment under this ES (for example conditions when payment may be withheld or reclaimed) and the treatment of payments in specific circumstances (for example, when contractors merge, split etc.).

Payments made under this ES, or any part thereof, will be made only if practices satisfy the conditions set out in the ES specification.

Part two: seasonal influenza vaccination programme

Requirements

This programme is from 1 September 2015 to 31 March 2016.

Commissioners will seek to invite practices to participate in this ES before 30 June 2015. Practices will be required to confirm their participation by 31 July 2015.

Practices participating in this programme will be required to sign up to CQRS no later than 31 August 2015.

Practices are required to:

- Provide seasonal influenza vaccination to all eligible patients registered at the practice unless contra-indicated. Eligible patients are those who are:

    a. patients aged 65 and over
    b. pregnant women

[88] NHS England. Service specification. /http://www.england.nhs.uk/commissioning/gp-contract/

c. patients aged six months and under two years and patients aged five to 64 years defined as at-risk in the Green Book[89]; and
d. locum GPs.

- Patients should be vaccinated on either:

  a. a proactive call basis, if not considered at-risk, or
  b. a proactive call and recall basis, if considered at-risk with the aim of maximising uptake in at-risk patients[90].

- Immunisation is contra-indicated where the patient has previously had a confirmed anaphylactic reaction to a previous dose of the vaccine, or to any component of the vaccine.
- Vaccination must be delivered during the period of this ES, namely between 1 September 2015 and 31 March 2015, with vaccinations concentrated between 1 September 2014 and 31 December 2015.
- Vaccinations delivered under this ES must be with the appropriate vaccine and dosage as defined in the Green Book:

  a. One dose of inactivated influenza vaccine (which will be centrally supplied), is required for patients aged six months and over but not two years or over at the time of vaccination.
  b. Fluenz Tetra® (which will be centrally supplied), is required for patients aged two years and over but not 18 years or over at the time of vaccination who are not contra-indicated. Where Fluenz Tetra® is contra-indicated, for children defined as at-risk one dose of a suitable inactivated influenza vaccine (which will also be centrally supplied) is required.
  c. One dose of inactivated influenza vaccine is recommended for all other patients eligible under this ES including those patients aged six months and over but not yet two years old at the time of vaccination. Vaccines for patients aged 18 and over should be ordered direct from the manufacturers.
  d. Patients aged six months and over but not nine years or over at the time of vaccination, defined as at-risk who have not received influenza vaccination previously, will require a second dose of either Fluenz Tetra®.
  e. Where a patient has indicted they wish to be vaccinated for either vaccination, but are physically unable to attend the practice (for example is housebound), the practice must make all reasonable effort to ensure the patient is vaccinated.

- Ensure that the patient record of those vaccinated are updated as set out in the ES specification.
- Record all the administered doses on ImmForm and where suitable IT systems exist all doses administered are uploaded to ImmForm by automated collections.

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[89] Green Book. Chapter 19. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book (At-risk groups for seasonal influenza are available in seasonal influenza annex)
[90] Section 7 of the Directions state that practice must have robust call and reminder systems to contact at-risk patients with the aim of maximising uptake in the interest of at-risk patients and meeting any PH targets.

Vaccine

Vaccination will be offered to all registered patients that meet the criteria defined under the 'requirements' section.

The target timeframe for seasonal influenza vaccinations is four months from 1 September 2014 to 31 December 2015 in order to achieve the maximum protection to the populations. Practice may continue to vaccinate eligible patients until 31 March 2016 for whom they will receive payment.

Where two doses of vaccine are to be administered, this must be done at least four weeks apart. Payment under this ES will be on a monthly basis, based on an item of service payment of £7.64 per dose (either one or two doses as clinically appropriate) per eligible patient vaccinated.

See the Green Book for detailed information about administration and dosage[91].

Vaccines for children aged six months to 17 years (inclusive) will be centrally supplied and practices are required to record all administered doses on ImmForm. The vaccine licensed for children is Fluenz Tetra® for all cases except where contra-indicated where an appropriate[92] inactivated vaccine is recommended for children defined as at-risk. As these vaccines will be centrally supplied, practices will not be able to claim administration fees.

Practice are required to order vaccines for all other patients eligible for vaccination as part of the ES direct from the manufacturers. This includes patients aged 18 and over defined as at-risk, pregnant women, patients aged 65 and over and locum GPs. The list of available influenza vaccines and the manufacturer are detailed in the annual flu letter.

Fluenz Tetra® is a live attenuated influenza vaccine and is supplied in an applicator that allows a divided dose to be administered in each nostril (total dose of 0.2 ml - 0.1 ml in each nostril). The device allows intranasal administration to be performed without the need for additional training. Administration of either dose does not need to be repeated if the patient sneezes or blows their nose following administration. There are no data on the effectiveness of Fluenz Tetra® when given to children with a heavily blocked or runny nose (rhinitis) attributable to infection or allergy. As heavy nasal congestion might impede delivery of the vaccine to the nasopharyngeal mucosa, deferral of administration until resolution of the nasal congestion or an appropriate alternative intramuscularly administered seasonal influenza vaccine should be considered.

Fluenz Tetra® has a short shelf-life and doses will have a use-by date and the latest expiry date is expected to be around January/February[93]. Clinical advice on seasonal influenza immunisation is that vaccinations should be given as early as possible in order for immunity to increase before the virus begins to circulate. Where a child presents for vaccination after the intranasal vaccine has expired, practices can deliver the vaccinations

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[91] Green Book. Chapter 19. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

[92] Practices should check that the vaccine they use is age appropriate for the patients they are vaccinating i.e. Fluarix Tetra is licensed for patients aged three and over only.

[93] As Fluenz Tetra® is a live vaccine, actual expiry dates are not yet known. Practices should check the expiry dates and use their stock accordingly.

to children defined as at-risk using one of the centrally supplied inactivated influenza vaccine.

Inactivated influenza vaccines for intramuscular administration are supplied as suspensions in pre-filled syringes. They should be shaken well before they are administered. Some of the summaries of product characteristics (SPCs) for intramuscular inactivated influenza vaccines indicate that young children can be given either a 0.25 ml or a 0.5 ml dose. JCVI has advised that where these alternative doses are indicated in the SPC, the 0.5 ml dose of intramuscular inactivated influenza vaccine should be given to infants aged six months or older and young children because there is evidence that this dose is effective in young children[94].

Care must be taken not to confuse the two 'Tetra' brands. Fluenz Tetra® (a quadrivalent live attenuated intranasal influenza vaccine) will be supplied for use in eligible children aged three to 17 years FluarixTM Tetra (a quadrivalent inactivated intramuscular influenza vaccine) will also be supplied.

Advice in this guidance document should be read in conjunction with chapter 19 of the Green Book. Practices are required to order vaccines for patients aged 18 and over for this ES direct from the manufacturers.

Monitoring

Although seasonal influenza and PPV23 are a joint programme under one ES, they are set up as separate services on CQRS and GPES. As practices who agree to participate in this ES will be expected to deliver vaccinations to eligible patients for both the seasonal influenza and pneumococcal vaccination programmes, practices would be expected to sign up to both services on CQRS.

Practices will be required to manually input data into CQRS, on a monthly basis, until GPES[95] is available. The data input will be in relation to the payment count only, with zeros being entered in the interim for the management information counts. For information on how to manually enter data into CQRS, see the HSCIC[96] website.

The payment and management information counts will be outlined in the technical requirements document.

When GPES is available, each data collection will capture data for all counts and report on activities from the start of the reporting month to the end of the reporting month. The reporting month will be the month prior to the collection month, e.g. if October is the reporting month then the collection will take place in November. Payment counts will be cumulative and non-cumulative monthly counts from when the practice begins to deliver the programme[97]. It is important to note that when GPES collects data for a given period, the collection only includes activity relating to patients registered at the reporting period end date (i.e. a monthly collection would only include patients registered with the practice at the month end).

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[94] Heinonen et al., 2010.
[95] Details relating to the availability of GPES support will be communicated via the HSCIC.
[96] HSCIC. http://systems.hscic.gov.uk/cqrs/participation
[97] Counts including the words "up to the end of the reporting period" are cumulative, whereas those counts using the word "within the reporting period" are non-cumulative.

When data collections commence, GPES will provide to CQRS the monthly counts from the relevant month they start in to the end of the relevant reporting month. For this ES, reporting and payment will be monthly. If a practice has declared achievement (payment and management information) for a month on CQRS and the commissioner has approved it, no GPES-based automated collection will be received as the payment declaration in CQRS cannot be overwritten.

The 'Technical requirements'[98] document contains the payment counts, management information counts and Read codes[99] relevant for this ES. The Read codes will be used as the basis for the GPES data collection, which will allow CQRS to calculate payment and support the management information collections, when available. Although practices will be required to manually enter data until GPES is available, it is still required that practices use the relevant Read codes from the start of the programme. This is because only those included in this document and the supporting Business Rules[100] will be acceptable to allow CQRS to calculate achievement and payment and for commissioners to audit payment and service delivery. Practices will therefore need to ensure that they use the relevant codes and if necessary re-code patients as required.

Supporting Business Rules will be published on the HSCIC website. Commissioners and practices should refer to these for the most up to date information on management information counts and Read codes.

Payment and validation

Practices who participate in this programme will be required to sign up to CQRS by no later than 31 August 2015.

Claims for payments for this programme should be made monthly, after the final completing dose has been administered. Where claims are entered manually, this should be within 14 days of the end of the month when the completing dose was administered. Where there is an automated data collection, there is a five day period following the month end to allow practices to record the previous months activity before the collection occurs. Activity recorded after the collection period is closed (five days), will not be collected and recorded on CQRS. Practices must ensure that all activity is recorded by the cut-off date, to ensure payment.

Payment will be made by the last day of the month following the month in which the practice validates and commissioner approves the payment

Where a practice has not recorded activity they will need to agree this activity with the commissioner who are able to adjust CQRS payments as part of the approval process. Where the practice does not believe that the activity reporting and therefore the payment calculated is accurate, the practice can raise this with the commissioner who can adjust the payment if necessary.

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[98] NHS Employers. Technical requirements for 2015/16 GMS contract changes. www.nhsemployers.org/vandi

[99] Please note that the code descriptions in clinical systems may not exactly match the guidance text.

[100] HSCIC. Business Rules. www.hscic.gov.uk/qofesextractspecs

Payments are calculated by identifying the:

- Monthly count of patients aged 65 and over on 31 March 2015, who have received a seasonal influenza vaccination by the GP practice, within the reporting period.
- Monthly count of seasonal influenza vaccination doses given by the GP practice to eligible* patients, identified as at risk, where the risk is clearly demonstrated by at least one clinical Read code in the patients record in the reporting period.
- Monthly count of seasonal influenza vaccination doses given by the GP practice to eligible patients*, identified as at risk, where the risk is not clearly demonstrated by at least one clinical Read code in the patients record but is identified by the Read code 9OX4. in the reporting period.

  * Eligible patients are aged six months to 64 years on 31 March 2015, excluding patients aged 2, 3 and 4 as at 31 August 2015

Payment for seasonal influenza and PPV23 will be made based on the monthly count multiplied by £7.64. Only one payment will be made per dose delivered for each programme.

Where a patient has been administered a second dose of an appropriate seasonal influenza vaccine, the commissioner may request evidence as to why a second dose has been given, in the event that the second dose was not clinically indicated commissioners may choose to claw back payment for that dose.

CQRS will calculate the monthly payment, based on the achievement data either via manually entered data or data collected from GPES.

After CQRS has calculated the practice's final achievement payment, the practice should review the payment value and declare an ‘achievement declaration’. The commissioner will then approve the payment (assuming that the criteria for the ES has been met) and initiate the payment via the payment agency's Exeter system. Once practices have submitted their data and the declaration and approval process has been followed, then payment for the programme will be sent to the payment agency for processing.

Commissioners are responsible for post payment verification. This may include auditing claims of practices to ensure that not only that the practice administered a completed course, but that the full protocol described in the ES specification[101] was followed. This information could be available to commissioners and practices, as an indicative check, through the management information counts as and when GPES is available. The reason for it being 'indicative' is that it is not known whether this aggregated number is directly tied to the same patients in the payment count.

The information collected for management information purposes will not be used to trigger payment but may be used for payment verification purposes. It will be available through CQRS, as and when GPES is available, to support commissioners and practices to validate requirements of the ES, as necessary, to demonstrate that the full protocol was

[101] NHS England. Service specification. http://www.england.nhs.uk/commissioning/gp-contract/

followed.

The NHS England service specification sets out the administrative provisions relating to the conditions for payment under this ES (for example conditions when payment may be withheld or reclaimed) and the treatment of payments in specific circumstances (for example, when contractors merge, split etc.).

Payments made under this ES, or any part thereof, will be made only if practices satisfy the conditions set out in the ES specification.

Seasonal influenza annex A

Groups included in the national seasonal influenza immunisation programme as defined in the annual flu letter and Green Book

Eligible groups	Further details
All children aged 2 to less than 5 years old	All those aged 2, 3 and 4 years old (but not 5 years or older) on 31 August 2015 (i.e. date of birth on or after 1 September 2010 and on or before 1 September 2013).
All patients aged 65 years and over	"Sixty-five and over" is defined as those aged 65 years and over on 31 March 2016 (i.e. born on or before 31 March 1951).
Chronic respiratory disease aged six months or older	Asthma that requires continuous or repeated use of inhaled or systemic steroids or with previous exacerbations requiring hospital admission. Chronic obstructive pulmonary disease (COPD) including chronic bronchitis and emphysema; bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Children who have previously been admitted to hospital for lower respiratory tract disease.
Chronic heart disease aged six months or older	Congenital heart disease, hypertension with cardiac complications, chronic heart failure, individuals requiring regular medication and/or follow-up for ischaemic heart disease.
Chronic kidney disease aged six months or older	Chronic kidney disease at stage 3, 4 or 5, chronic kidney failure, nephrotic syndrome, kidney transplantation.
Chronic liver disease aged six months or older	Cirrhosis, biliary atresia, chronic hepatitis.

Eligible groups	Further details
Chronic neurological disease aged six months or older	Stroke, transient ischaemic attack (TIA). Conditions in which respiratory function may be compromised due to neurological disease (e.g. polio syndrome sufferers). Clinicians should offer immunisation to all patients with a learning disability[102] Clinicians should offer immunisation, based on individual assessment, to vulnerable individuals including those with cerebral palsy, multiple sclerosis and related or similar conditions; or hereditary and degenerative disease of the nervous system or muscles; or severe neurological disability.
Diabetes aged six months or older	Type 1 diabetes, type 2 diabetes requiring insulin or oral hypoglycaemic drugs, diet controlled diabetes.
Immunosuppression aged six months or older	Immunosuppression due to disease or treatment, including chemotherapy leading to immunosuppression, bone marrow transplant, HIV infection (all stages,) multiple myeloma or genetic disorders affecting the immune system (e.g. IRAK-4, NEMO, compliment deficiency). Individuals treated with or likely to be treated with systemic steroids for more than a month (dose equivalent to prednisolone at 20 mg or more per day (any age), or for children under 20 kg, a dose of 1 mg or more per kg per day). It is difficult to define at what level of immunosuppression a patient could be considered to be at a greater risk of the serious consequences of influenza and should be offered seasonal influenza vaccination. This decision is best made on an individual basis and left to the patient's clinician. Some immunocompromised patients may have a suboptimal immunological response to the vaccine.
Asplenia or dysfunction of the spleen aged six months or older	This also includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction.
Pregnant women	Pregnant women at any stage of pregnancy (first, second or third trimesters).

[102] Practices are advised of the importance to ensure patients with learning disabilities are vaccinated. Patients with a learning disability are included in the eligibility for payment under this ES. PHE understand the difficulty with vaccinating this group with injectable vaccines. PHE advises that Fluenz Tetra is not licensed for adults so practice should attempt to vaccinate using an injectable vaccine. Previously, it has been found that Intanza is easier to use in similar patients and is less distressing. However, in the event that an injectable vaccine is not appropriate, GP's can use their clinical discretion to use the intranasal vaccine.

Eligible groups	Further details
People in long-stay residential or homes	Vaccination is recommended for people living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality. This does not include, for instance, prisons, young offender institutions, or university halls of residence.
Carers	Those who are in receipt of a carer's allowance, or those who are the main carer of an elderly or disabled person whose welfare may be at risk if the carer falls ill.
Locum GPs	Locum GPs should be vaccinated by their own GP. All other GP's and primary care staff are the responsibility of their employer as part of occupational health arrangements.
Health and social care staff	Health and social care workers who are in direct contact with patients/service users should be vaccinated by their employer as part of an occupational health programme.

* not included in this but are covered by other national and local agreements and pilot arrangements.

PHE state that this list is not exhaustive and the clinicians should apply clinical judgement to take into account the risk of influenza exacerbating any underlying disease that a patient may have, as well as the risk of serious illness from influenza itself. Influenza vaccination should be offered in such cases even if the individual is not in the clinical risk groups specified above[103, 104].

[103] Only those patients eligible for vaccination as defined in this ES specification will be paid for under this ES.

[104] JCVI have advised that morbidly obese people (defined as BMI>40) could also benefit from a seasonal influenza vaccination. Many of this patient group will be eligible for vaccination under another risk category due to other health complications that obesity places on them. However, funding has not been agreed to cover this cohort as part of this ES. Practices are able to use clinical judgement to vaccinate patients in this group, but vaccinations for morbidly obese patients with no other risk factor are not eligible for payment under this ES. The inclusion of this cohort in subsequent years is under consideration.

Pneumococcal polysaccharide annex

Groups covered by this ES and included in the pneumococcal polysaccharide immunisation programme as defined in the Green Book

Eligible groups	Further details
Patients aged 65 years and over	"Sixty-five and over" is defined as those aged 65 years and over on 31 March 2016 (i.e. born on or after 31 March 1951).
Chronic respiratory disease	Asthma (only if so severe it requires continuous or frequently repeated or use of systemic steroids, see immunosuppression). Chronic respiratory disease including chronic obstructive pulmonary disease (COPD), chronic bronchitis and emphysema, bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Children with respiratory problems caused by aspiration or a neurological condition (e.g. cerebral palsy).
Chronic heart disease	Congenital heart disease, hypertension with cardiac complications, chronic heart disease, chronic heart failure, individuals requiring regular medications and/or follow-up for ischaemic heart disease.
Chronic kidney disease	Chronic kidney disease at stages 4 and 5, nephrotic syndrome, kidney dialysis and those with kidney transplantation
Chronic liver disease	Chronic liver disease, cirrhosis, biliary atresia, chronic hepatitis
Diabetes	Diabetes mellitus require insulin or oral hypoglycaemic drugs NOT diabetes that is diet controlled
Immunosuppression & asplenia or dysfunction of the spleen	Immunosuppression due to disease or treatment, chemotherapy bone marrow transplant, asplenia or splenic dysfunction, this also includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction. HIV infection (all stages), multiple myeloma or genetic disorders affecting the immune system (e.g. IRAK-4, NEMO complemented deficiency) and individuals likely to be on systemic steroids for more than a month (dose equivalent to prednisolone at 20 mg or more per day (any age), or for children under 20 kg, a dose of 1 mg or more per kg per day).
Individuals with cochlear implants	It is important that immunisation does not delay the cochlear implantation.
Individuals with cerebrospinal fluid leaks e.g. following trauma or major skull surgery	Individuals with cerebrospinal fluid leaks e.g. following trauma or major skull surgery

Only those patients eligible for vaccination as defined in the NHS England service specification will be paid for under this ES.

Influenza and pneumococcal annex: Vaccines and dosage

Seasonal influenza vaccination programme (as defined in the annual flu letter)

Eligible groups	Vaccine	Dosage
6 months to less than 2 years in clinical risk groups	Inactivated influenza vaccine	1 dose unless first influenza vaccination in which case a second dose is recommended at least 4 weeks after the first
2 years to less than 9 years in clinical risk groups	Fluenz Tetra® unless contra-indicated then a suitable inactivated influenza vaccine is recommended	1 dose unless first influenza vaccination in which case a second dose is recommended at least 4 weeks after the first
9 years to less than 18 years in clinical risk groups	Fluenz Tetra® unless contra-indicated then a suitable inactivated influenza vaccine is recommended	1 dose
18 years and over in clinical risk groups	Inactivated influenza vaccine	1 dose
65 years and over	Inactivated influenza vaccine	1 dose

For a list of the available inactivated vaccines, suppliers and the appropriate age indications see the annual flu letter.

Pneumococcal polysaccharide vaccination programme (as defined in the Green Book)

Eligible groups	Vaccine	Dosage
2 to 4 years in clinical risk groups	PPV23	1 single dose, after an age appropriate course of PCV13
5 to 64 years in clinical risk groups	PPV23	1 single dose
65 and over	PPV23	1 single dose

Shingles (routine aged 70) vaccination programme

Background and purpose

The incidence of shingles in England and Wales is estimated to be around 790 to 880 cases per 100,000 people per year for those aged 70 to 79 years. The risk and severity of shingles increases with age and can lead to post herpetic neuralgia (PHN) and hospitalisation. It is estimated that, in people aged 70 years and over, around one in 1000 cases of shingles results in death[105, 106].

In March 2012, the JCVI recommended that patients aged 70 to 79 (inclusive) should be routinely offered vaccination against shingles. The roll out of this extended programme will be considered by NHS England, PHE and the DH and will be phased in over a period of time due to both vaccine supply and ensuring a manageable implementation process.

The shingles (routine aged 70) vaccination programme was introduced from 1 September 2013, comprising a single injection, offered routinely to patients who are aged 70 as at 1 September that year.

The catch-up ES is outlined in a separate section in this guidance.

The date of birth range for patients eligible to receive the shingles (routine aged 70) vaccination is 2 September 1944 to 1 September 1946. However, patients that were aged 70 on or after 1 September 2013 remain eligible for vaccination until their 80th birthday.

Vaccinations and immunisations are an additional service under the GMS contract. The GMS Contract for 2014/15 includes an item of service at £7.64 payment for each dose.

Further details on background to the programme, dosage, timings and administration can be found in the Green Book[107].

Requirements

This programme is for one year from 1 September 2015 until 31 August 2016.

Commissioners will seek to invite practices to participate in this ES before 30 June 2015. Practices will be required to confirm their participation by 31 July 2015.

Practices participating in this programme will be required to sign up to CQRS no later than 31 August 2015.

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[105] Green Book. Chapter 28a. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book
[106] van Hoek et al., 2009
[107] Green Book. Chapter 28a. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Practices are required to:

- Provide vaccination to all eligible patients aged 70 but not yet 71 on 1 September 2015, who have not previously had a shingles vaccination, who present to the practice requesting vaccination and on an opportunistic basis.
- Provide vaccination to all eligible patients who achieved the age of 70 on or after 1 September 2013.
- Ensure that the patient record of those offered the vaccination are updated accordingly.
- Record all administered doses on ImmForm and where suitable IT systems exist all doses administered are uploaded by automated data collections.

Vaccination

Practices are not required to call and recall eligible patients but instead offer vaccination opportunistically to eligible patients when they access general practice services.

This vaccination programme comprises a single injection.

Under the GMS contract for 2015/16, providers of this programme will be paid an item of service payment of £7.64 for each previously unvaccinated patient who receives the routine shingles vaccination within the period 1 September 2015 until 31 August.

Vaccines for this programme are centrally supplied through ImmForm and practices are required to record all administered doses on ImmForm.

The shingles vaccination may be given at the same time as inactivated influenza vaccination. It can also be given at the same time as pneumococcal for those patients who are eligible for both vaccinations. If the shingles vaccine is given at the same time as other vaccinations, care should be taken to ensure that the appropriate route of injection is used for all the vaccinations and to check there are no contraindications to administering the shingles vaccine to individuals in at-risk groups presenting for seasonal influenza vaccination. If additional immunisations are required, refer to the Green Book for advice on administering the shingles vaccine with other vaccines.

Patients who request vaccination who are not included in either the routine shingles programme or shingles catch-up programme patient cohorts may be vaccinated, at the practice's discretion. However, practices are advised that this should only occur where eligible patients have already been vaccinated or offered the vaccination and the practice is using up their left over stocks. If a practice chooses to vaccinate patients not included in the eligible patient cohort, then these patients would not be eligible for payment under this programme.

The shingles vaccination can be delivered by any suitably trained and competent member of the practice's clinical staff, including Healthcare Assistants (HCAs), who can provide vaccinations under Patient Specific Directions (PSDs). However, ultimately the responsibility lies with the prescriber. Individuals should be named and assessed for provision of this programme, with the governance emphasis on training and competency.

Monitoring

The payment count and management information counts will be outlined in the technical requirements document.

Practices will be required to manually input data into CQRS, on a monthly basis, until GPES[108] is available. The data input will be in relation to the payment count only, with zeros being entered in the interim for the management information counts. For information on how to manually enter data into CQRS, see the HSCIC website[109].

When GPES is available, each data collection will capture data for all counts and report on activities from the start of the reporting month to the end of the reporting month. The reporting month will be the month prior to the collection month, e.g. if October is the reporting month then the collection will take place in November. Payment counts will be cumulative and non-cumulative monthly counts from when the practice begins to deliver the programme[110]. It is important to note that when GPES collects data for a given period, the collection only includes activity relating to patients registered at the reporting period end date (i.e. a monthly collection would only include patients registered with the practice at the month end.)

When data collections commence, GPES will provide to CQRS the monthly counts from the relevant month they start in to the end of the relevant reporting month. For this vaccination programme, reporting and payment will be monthly. If a practice has declared achievement (payment and management information) for a month on CQRS and the commissioner has approved it, no GPES based automated collection will be received as the payment declaration in CQRS cannot be overwritten.

The 'Technical requirements'[111] document contains the payment counts, management information counts and Read codes[112] relevant for this programme. The Read codes will be used as the basis for the GPES data collection, which will allow CQRS to calculate payment and support the management information collections, when available. Although practices will be required to manually enter data until GPES is available, it is still required that practices use the relevant Read codes from the start of the programme. This is because only those included in this document and the supporting Business Rules[113] will be acceptable to allow CQRS to calculate achievement and payment and for commissioners to audit payment and service delivery. Practices will therefore need to ensure that they use the relevant codes and if necessary re-code patients as required.

Supporting Business Rules will be published on the HSCIC website. Commissioners and practices should refer to these for the most up to date information on management information counts and Read codes.

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[108] Details as to when and if GPES becomes available to support this service will be communicated via the HSCIC.
[109] HSCIC. http://systems.hscic.gov.uk/cqrs/participation
[110] Counts including the words "up to the end of the reporting period" are cumulative, whereas those counts using the word "within the reporting period" are non-cumulative.
[111] NHS Employers. Technical requirements for 2015/16 GMS contract changes. www.nhsemployers.org/vandi
[112] Please note that the code descriptions in clinical systems may not exactly match the guidance text.
[113] HSCIC. Business Rules. www.hscic.gov.uk/qofesextractspecs

Payment and validation

Practices who participate in this programme will be required to sign up to CQRS by no later than 31 August 2015.

Claims for payments for this programme should be made monthly, after the final completing dose has been administered. Where claims are entered manually, this should be within 14 days of the end of the month when the completing dose was administered. Where there is an automated data collection, there is a five day period following the month end to allow practices to record the previous months activity before the collection occurs. Activity recorded after the collection period is closed (five days), will not be collected and recorded on CQRS. Practices must ensure that all activity is recorded by the cut-off date, to ensure payment.

Payment will be made by the last day of the month following the month in which the practice validates and commissioner approves the payment.

Where a practice has not recorded activity they will need to agree this activity with the commissioner who are able to adjust CQRS payments as part of the approval process. Where the practice does not believe that the activity reporting and therefore the payment calculated is accurate, the practice can raise this with the commissioner who can adjust the payment if necessary.

Payments are calculated by identifying the:

- Monthly count of the number of registered patients aged 70 on 1 September 2015 who have a record of receiving a shingles vaccination at the GP practice in the reporting period" (i.e. payment count).
- Monthly count of the number of registered patients who achieved the age of 70 on or after 1 September 2013 who have a record of receiving a shingles vaccination at the GP practice in the reporting period" (i.e. payment count).

Payment will be made based on the monthly count multiplied by £7.64.

CQRS will calculate the monthly payment, based on the achievement data either via manually entered data or data collected from GPES.

After CQRS has calculated the practice's final achievement payment, the practice should review the payment value and declare an 'achievement declaration'. The commissioner will then approve the payment (assuming that the criteria for the programme has been met) and initiate the payment via the payment agency's Exeter system. Once practices have submitted their data and the declaration and approval process has been followed, then payment for the programme will be sent to the payment agency for processing.

Commissioners are responsible for post payment verification. This may include auditing claims of practices to ensure that not only the vaccinations were delivered but that the full protocol described in the programme was followed i.e. the patient's records were updated appropriately. This information could be available to commissioners and practices, as an indicative check, through the management information counts as and when GPES is available. The reason for it being 'indicative' is that it is not known whether this aggregated number is directly tied to the same patients in the payment count.

The information collected for management information purposes will not be used to trigger payment but may be used for payment verification purposes. It will be available through CQRS, as and when GPES is available, to support commissioners and practices to validate requirements of the programme, as necessary, to demonstrate that the full protocol was followed.

The SFE[114] sets out the administrative provisions relating to the conditions for payment under this programme (for example conditions when payment may be withheld or reclaimed) and the treatment of payments in specific circumstances (for example, when contractors merge, split etc.).

[114] DH. SFE. Available via www.nhsemployers.org/GMS201516

Shingles (catch-up) vaccination programme

Background and purpose

In March 2012, the JCVI recommended that patients aged 70 to 79 (inclusive) should be routinely offered vaccination against shingles. The roll out of this extended programme will be considered by NHS England, PHE and the DH and will be phased in over a period of time due to both vaccine supply and ensuring a manageable implementation process.

The shingles (routine aged 70) vaccination programme was introduced from 1 September 2013, the details of which are outlined in a separate section of this guidance.

The shingles catch-up vaccination programme is aimed at delivering vaccination and immunisation programmes in England. This ES is effective from 1 September 2015 to 31 August 2016[115] for patients aged 78 on 1 September 2015. Patients eligible for vaccination under this programme since it was introduced, remain eligible for vaccination until their 80th birthday.

Payment of £7.64 for each dose of shingles (Herpes Zoster) vaccination will be made to practices delivering this ES.

Further details on background to the programme, dosage, timings and administration can be found in the Green Book[116].

Requirements

This programme is for one year from 1 September 2015 to 31 August 2016.

Commissioners will seek to invite practices to participate in this ES before 30 June 2015. Practices will be required to confirm their participation by 31 July 2015.

Practices participating in this programme will be required to sign up to CQRS no later than 31 August 2015.

Practices are required to:

- Provide vaccination to eligible patients who are aged 78 years on 1 September 2015, who have not previously had a shingles vaccination who present to the practice requesting vaccination and on an opportunistic basis.
- Provide vaccination to patients eligible for vaccination under this programme since it was introduced until they turn 80.
- Ensure that the patient record of those offered the vaccine are updated in line with the ES specification.
- Record all administered doses on ImmForm and where suitable IT systems exist all doses administered are uploaded by automated collections.

[115] NHS England. Service specification. http://www.england.nhs.uk/ourwork/commissioning/gp-contract/
[116] Green Book. Chapter 28a. https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Vaccine

Practices are not required to operate call or recall, but instead offer vaccination opportunistically to eligible patients when they access practice services.

This vaccination programme, comprising a single injection, will now be offered to all registered patients aged 78 on 1 September 2015 and patients eligible for vaccination under this programme since it was introduced, remain eligible for vaccination until their 80th birthday. For example, patients aged 77 or 80 on 1 September 2015 will not be eligible for shingles vaccination under this ES. However patients turning age 80 during the timeframe 2 September 2014 to 31 August 2014 will remain eligible as they were within the eligible age range on 1 September 2014.

Vaccines for this ES will be centrally supplied through ImmForm and practices are required to record all administered doses on ImmForm.

The shingles vaccination may be given at the same time as inactivated influenza vaccination. It can also be given at the same time as pneumococcal for those patients who are eligible for both vaccinations. If the shingles vaccine is given at the same time as other vaccinations, care should be taken to ensure that the appropriate route of injection is used for all the vaccinations and to check there are no contraindications to administering the shingles vaccine to individuals in at-risk groups presenting for seasonal influenza vaccination. If additional immunisations are required, refer to the Green Book for advice on administering the shingles vaccine with other vaccines.

Patients who are not included in either patient cohort for the routine shingles or shingles catch-up programmes who request vaccination may be vaccinated, at the practice's discretion. However, practices are advised that this should only occur where eligible patients have already been vaccinated or offered the vaccination and the practice is using up their left over stocks. If a practice chooses to vaccinate patients not included in the eligible patient cohort, then these patients would not be eligible for payment under the ES specification.

The shingles vaccination can be delivered by any appropriately trained and competent member of the practice's clinical staff, including HCAs under PSDs. However, ultimately the responsibility lies with the prescriber. Individuals should be named and assessed for provision of this programme, with the governance emphasis on training and competency.

Monitoring

The payment count and management information counts will be outlined in the technical requirements document.

Practices will be required to manually input data into CQRS, on a monthly basis, until GPES[117] is available. The data input will be in relation to the payment count only, with zeros being entered in the interim for the management information counts. For information on how to manually enter data into CQRS, see the HSCIC[118] website.

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[117] Details as to when and if GPES becomes available to support this service will be communicated via the HSCIC.

[118] HSCIC. http://systems.hscic.gov.uk/cqrs/participation

When GPES is available, each data collection will capture data for all counts and report on activities from the start of the reporting month to the end of the reporting month. The reporting month will be the month prior to the collections month, e.g. if October is the reporting month then the collection will take place in November. Payment counts will be cumulative and non-cumulative monthly counts from when the practice begins to deliver the programme[119]. It is important to note that when GPES collects data for a given period, the collection only includes activity relating to patients registered at the reporting period end date (i.e. a monthly collection would only include patients registered with the practice at the month end.)

When data collections commence, GPES will provide to CQRS the monthly counts from the relevant month they start in to the end of the relevant reporting month. For this ES, reporting and payment will be monthly. If a practice has declared achievement (payment and management information) for a month on CQRS and the commissioner has approved it, no GPES-based automated collection will be received as the payment declaration in CQRS cannot be overwritten.

The 'Technical Requirements'[120] document contains the payment counts, management information counts and Read codes[121] relevant for this ES. The Read codes will be used as the basis for the GPES data collection, which will allow CQRS to calculate payment and support the management information collections, when available. Although practices will be required to manually enter data until GPES is available, it is still required that practices use the relevant Read codes from the start of the programme. This is because only those included in this document and the supporting Business Rules[122] will be acceptable to allow CQRS to calculate achievement and payment and for commissioners to audit payment and service delivery. Practices will therefore need to ensure that they use the relevant codes and if necessary re-code patients as required.

Supporting Business Rules will be published on the HSCIC website. Commissioners and practices should refer to these for the most up to date information on management information counts and Read codes.

Payment and validation

Practices participating in this programme will be required to sign up to CQRS no later than 31 August 2015.

Claims for payments for this programme should be made monthly, after the final completing dose has been administered. Where claims are entered manually, this should be within 14 days of the end of the month when the completing dose was administered. Where there is an automated data collection, there is a five day period following the month end to allow practices to record the previous months activity before the collection occurs. Activity recorded after the collection period is closed (five days), will not be collected and

[119] Counts including the words "up to the end of the reporting period" are cumulative, whereas those counts using the word "within the reporting period" are non-cumulative.
[120] NHS Employers. Technical requirements for 2015/16 GMS contract changes. www.nhsemployers.org/vandi
[121] Please note that the code descriptions in clinical systems may not exactly match the guidance text.
[122] HSCIC. Business Rules. www.hscic.gov.uk/qofesextractspecs

recorded on CQRS. Practices must ensure that all activity is recorded by the cut-off date, to ensure payment.

Payment will be made by the last day of the month following the month in which the practice validates and commissioner approves the payment.

Where a practice has not recorded activity they will need to agree this activity with the commissioner who are able to adjust CQRS payments as part of the approval process. Where the practice does not believe that the activity reporting and therefore the payment calculated is accurate, the practice can raise this with the commissioner who can adjust the payment if necessary.

Payments are calculated by identifying the:

- Monthly count of the number of registered patients aged 78 on 1 September 2015 who have a record of receiving a shingles vaccination at the GP practice in the reporting period" (i.e. payment count).
- Monthly count of the number of registered patients eligible for vaccination under this programme since it was introduced until they turn 80 who have a record of receiving a shingles vaccination at the GP practice in the reporting period" (i.e. payment count).

Payment will be made based on the monthly count multiplied by £7.64.

CQRS will calculate the monthly payment, based on the achievement data either via manually entered data or data collected from GPES.

Payment should be made by the last day of the month following the month in which the practice and commissioner approve the payment. Where CQRS has not been provided with data (i.e. the practice has not enabled the collection or the collection is not supported by their system supplier) the data will need to be entered onto CQRS manually.

After CQRS has calculated the practice's final achievement payment, the practice should review the payment value and declare an 'achievement declaration'. The commissioner will then approve the payment (assuming that the criteria for the ES has been met) and initiate the payment via the payment agency's Exeter system. Once practices have submitted their data and the declaration and approval process has been followed, then payment for the programme will be sent to the payment agency for processing.

Commissioners are responsible for post payment verification. This may include auditing claims of practices to ensure that not only the vaccinations were delivered but that the full protocol described in the ES specification[123] was followed. This information could be available to commissioners and practices, as an indicative check, through the management information counts as and when GPES is available. The reason for it being 'indicative' is that it is not known whether this aggregated number is directly tied to the same patients in the payment count.

The information collected for management information purposes will not be used to trigger payment but may be used for payment verification purposes. It will be available through CQRS, as and when GPES is available, to support commissioners and practices to

[123] NHS England. Service specification. http://www.england.nhs.uk/resources/d-com/gp-contract/

validate requirements of the ES, as necessary, to demonstrate that the full protocol was followed.

The NHS England service specification sets out the administrative provisions relating to the conditions for payment under this ES (for example conditions when payment may be withheld or reclaimed) and the treatment of payments in specific circumstances (for example, when contractors merge, split etc.).

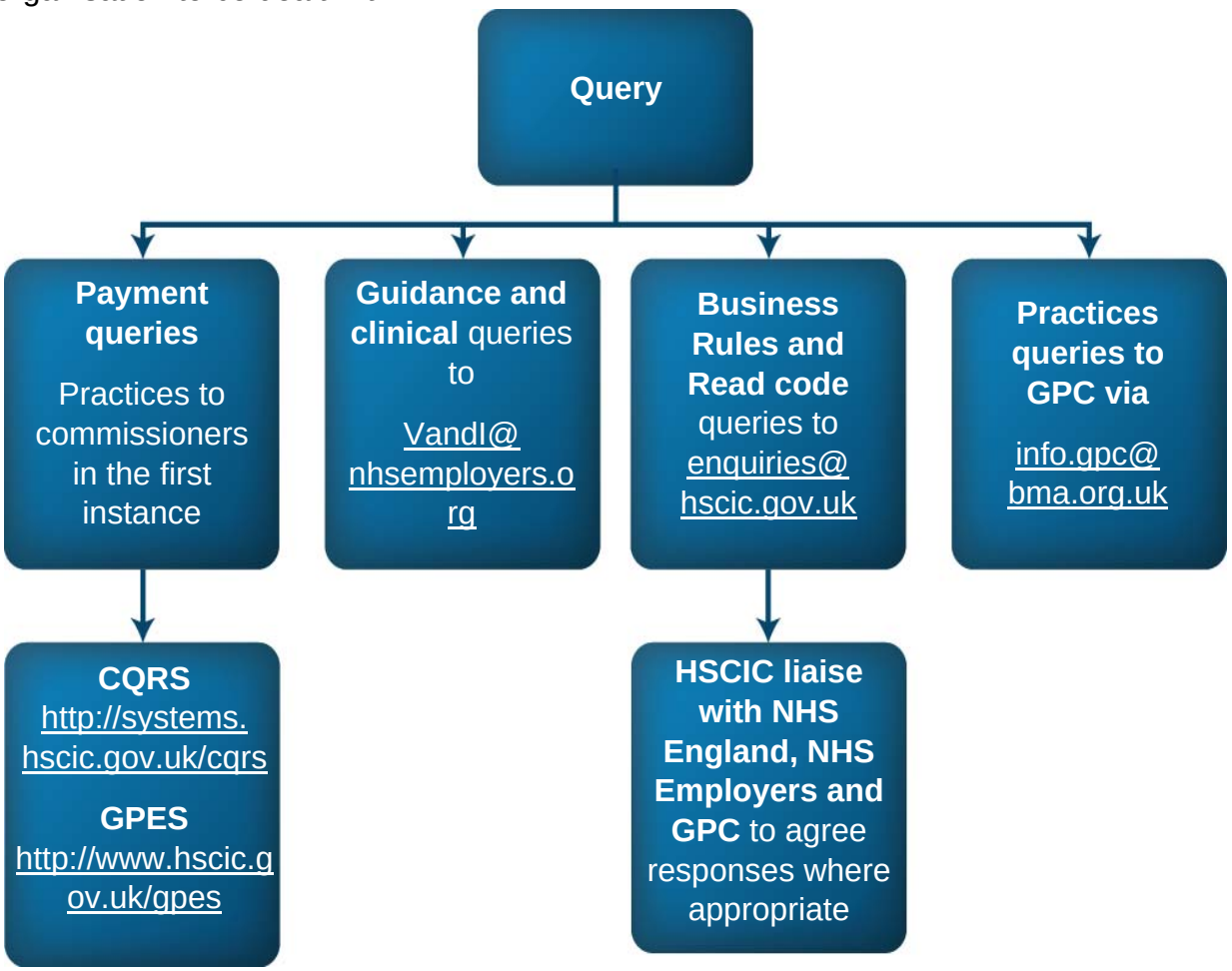
Payments made under this ES, or any part thereof, will be made only if practices satisfy the conditions set out in the NHS England service specification.

Section 6. Queries

Queries can be divided into three main categories:

1. those which can be resolved by referring to the specification, guidance or FAQs[124],
2. those which require interpretation of the guidance or Business Rules,
3. those where scenarios have arisen which were not anticipated in developing guidance.

Within these categories, there will be issues relating to coding, Business Rules, payment, clinical issues and policy issues and in some cases the query can incorporate elements from each of these areas. If there are queries which cross the above areas, the recipient will liaise with the other relevant parties in order to resolve/respond. In addition, where a query has been directed incorrectly, the query will be redirected to the appropriate organisation to be dealt with.



[124] NHS Employers. FAQs. www.nhsemployers.org/GMS/FAQs

General Practitioners Committee
www.bma.org.uk/gpc

NHS Employers
www.nhsemployers.org

NHS England
www.england.nhs.uk