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Vaccinating outside Section 7a immunisation programmes: who, how and why?

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FOREWORD

On 23 April 2019, the authors of this roundtable discussion met to deliberate the vaccinations that fall outside of the Section 7A immunisation programme. The 3-hour meeting resulted in the production of this article. Funding for vaccinations that fall outside of the Section 7a programme is mired in confusion. Who is responsible for the payments? What are the outliers? What are the loopholes in vaccination commissioning? What are the regional differences? Where can best practice be found? When will these issues be resolved? These questions and more were discussed at length and in great detail. This article explains where these discrepancies lie, analyses specific issues that require clear guidance, and discusses the competing interests of health professionals. This discussion aims to inform the national vaccination review and hopes to shed light on areas that cause GPs and practice nurses confusion during their daily tasks. We all enjoyed the meeting, and its discussion and transformation into a working document. We hope you find this article useful and that it impacts your understanding of vaccinations that fall outside of the Section 7A programme.

INTRODUCTION

According to attendees at a roundtable discussion in London, an injection of clarity is needed in NHS vaccination policies in order to help guide the actions of health professionals who provide the treatment that protects patients from major infectious diseases.

The expert panel of senior clinical staff, NHS administrators and health economists met to discuss solutions to some of the problems that have arisen as a result of the reorganisation of primary care services introduced under the Health and Social Care Act 2012. This legislation transferred many of the public health duties from Primary Care Trusts to local authorities, Public Health England and NHS England. The contracts for most vaccines fall under, what are termed, Section 7a agreements. However, there are gaps in these specifications, which have created discrepancies. Health professionals in general practice are unsure as to whether the costs of a particular vaccine, and its administration, will be covered by NHS England, part of a Local Improvement Scheme within a Clinical Commissioning Group, or by the practice itself.

This article will focus on the vaccinations that fall outside of the Section 7a arrangements for the national immunisation schedule. Such outliers leave clinicians and practice managers uncertain as to which vaccinations should be considered a part of a practice's enhanced service obligations. If vaccinations fall outside of this service, there is further confusion as to how they should be funded.

DESCREPENCIES ARISING

Clinical Commissioning Groups have no direct responsibility for the commissioning of the vaccination programmes. As vaccines are generally classed as preventative care rather than treatment, the perception is that responsibility for the cost of the service sits within public health. If there are doubts over the reimbursement arrangements, Clinical Commissioning Groups struggle to approve non-Section 7a vaccinations. Practices also remain unsure as to how they can claim for providing the services and what funds are available. There are a range of different mechanisms through which practices can be paid, but there is a clear need to streamline this process. A more streamlined payment mechanism needs to be

considered that takes into account the work involved not just in the giving of vaccines but in the call and recall process , and overall clinic administration, to make sure everyone eligible gets invited for the appropriate vaccines. Vaccines are either procured directly from the manufacturer and reimbursed, or ordered into the practice for free via national stock (ImmForm).

At the time of writing, a national review of vaccination services, as specified in the GP contract, is being undertaken. While, this roundtable discussion was not part of the national review, the panel felt that the outcomes of their discussion should feed into the national review. The attendees hoped that the national review would examine the various issues surrounding incentives of vaccination targets, which are not aligned to the World Health Organization herd immunity target of 95%. Instead, general practices are paid incentives if they achieve a lower threshold of 70% and another if they achieve a 90% uptake. There is little motivation to achieve more than 70% or 90%.

Different incentives may be needed to compensate practices for the additional efforts required to contact missing patients and encourage them to come in for treatment. These incentives could be offered in the form of two varieties where general practices are incentivised on surveillance data. For example, achieving 95%, or staggering the incentives between 70% and 95%, to encourage progression to higher uptake rates. At present, as an example, general practices are not incentivised to move from 70% to 80%, as they receive the same payment.

The national immunisation programme was traditionally designed to prevent infectious diseases in infancy and childhood. The vaccination programme is increasingly complex and increasingly includes vaccinations for people across the life course, in pregnancy, for those with specific medical conditions, and older people. It was also discussed that for certain patients with specific long-term conditions, for example a patient with diabetes, vaccination against pneumococcal disease was as much a part of their routine treatment as the provision of insulin and metformin. It is therefore anomalous for the financial arrangements for vaccines to be organised differently to other medical services.

NHS England originally planned to issue guidance regarding the payment for non-Section 7a vaccinations in 2013; however, it now appears that this guidance will not be available until 2020. In the meantime, it should be noted that NHS England's London region has created an algorithm to help general practices claim for off label vaccines and treatment given outside the current guidelines. This may form the basis of a system that could be used in other regions (Junghans et al, 2018).

COMPLACENCY AND COMPETING PRIORITIES

Despite the undeniable success of the national vaccination programme, it was acknowledged that providing vaccinations are seen as a competing priority given the workload and demands that GPs and practice nurses face. This may be connected to time pressures, as there is insufficient time in a standard appointment to explain the purposes of the treatment to parents while also dealing with the child, particularly when administering multiple vaccinations. Support staff may also need additional training in order to manage fractious children having injections, making sure accurate recording of all vaccines are given and supporting the general management of the clinic.

During practice appointments, answers to numerous vaccination queries can be found in the Green Book Immunisation against infectious disease (more information available at: https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book), which includes all the information

on the vaccination programme and the rationale for who does and does not need vaccines. However, the attendees noted that often clinical staff are too busy to track down the information they need in such a highly detailed volume, given the time constraints of an average 10-minute general practice appointment.

Roundtable attendees warned against complacency about the importance of a vaccination. There is a need to remind medical staff, as well as patients, of the potential impact of the re-emergence of those diseases that have been effectively controlled by the national immunisation programme. The panel thought that information regarding the importance of vaccinations and guidance on funding should be easily accessible to practice managers. There are opportunities, with the emergence of primary care networks, to facilitate greater understanding and implementation among practice staff through primary care networks' business managers to ensure more realistic time for vaccination appointments is allowed.

SPECIFIC ISSUES THAT REQUIRE CLEAR GUIDANCE

There are several issues that need to be specifically addressed in the new GP contract as well as other areas that require further guidance. These are as follows:

- **In-contracts**. There are some striking anomalies in the availability of Section 7a vaccinations for those at risk of contracting a vaccine-preventable infection from a family member. The children of hepatitis B-positive mothers, for example, are entitled to NHS-funded treatment. However, if it is the father who carries the virus, then no funding for the treatment can be provided. For the remainder of the at risk groups, as per the Green Book, this vaccination is regarded as an additional service. Patients can pay privately for this treatment, or treatment may be given in the combined hepatitis A/B vaccine for those patients who have an indication for prevention of the former condition
- **Bacillus Calmette-Guérin (BCG) vaccine.** Infants under one-year-old are covered by the Section 7a arrangements; however, older children are not.
- **Missed opportunities for vaccinations.** Practices should have a protocol to reduce missed opportunities for vaccinations such as opportunistic vaccinations. A clear process for Call and Recall also needs to be provided and be explicit within contracts
- **Patients with incomplete vaccinations.** New migrants to the UK with an uncertain vaccination history should be vaccinated in accordance to the Public Health England algorithm for people with uncertain or incomplete immunisation status, which can be found at https://www.gov.uk/government/publications/vaccination-of-individuals-with-uncertain-or-incomplete-immunisation-status. Once the patient is registered with the general practice, the practice can claim for the vaccinations through the usual route of Calculated Quality Reporting System (CQRS). However, these vaccinations are likely to be regarded as an additional service for which a practice is unlikely to receive payment. The issue here is that people coming from abroad, who have followed the schedule of their previous country, may not have been vaccinated as per UK guidance, as such practices find it difficult to know what to do. Public Health England have developed an algorithm to help with this, but some patients prefer to continue with the schedule of their country of birth and this may cause patient data to become unclear. Further confusion is also caused as some members of this population return to their country of birth to receive vaccinations
- **Post bone marrow transplantation patients.** This group of patients will generally need to be re-treated with a course of primary vaccinations. Again, there is uncertainty whether payment for this treatment can be claimed back from

NHS England, or if it is the responsibility of the practice – under its additional services commitment. Further, there needs to be a clear understanding of what vaccines people have had and to make sure these are recorded in the clinical record system and reimbursed

- **Outbreaks.** In the case of major disease outbreaks, attendees recognised the importance of cooperation between the member practices of the new primary care networks in order to provide a consistent and timely service. There is a need for clearer guidance on the arrangements for dealing with outbreaks of diseases such as hepatitis A in schools, or other institutions such as prisons. Some direction is also needed on how to recruit and deploy the staff resources that will be available in the new primary care networks to provide large scale treatment in the event of an outbreak of diseases such as influenza. These approaches will vary across different regions
- **Vaccines needed as part of a broader treatment plan.** Junghans et al (2018) identified the need for tetanus injections in a road accident victim with incomplete immunity as a typical example of treatment falling outside the remit of section 7a. Further, there are other much larger patient groups for whom the current uncertainties over treatment payments require urgent attention. For example, people who have diabetes, chronic renal failure or chronic liver disease.

TRAVEL VACCINATIONS

Presently, there are four conditions for which free vaccine treatment is available on the NHS for those travelling to countries with a significant risk of infection (polio, typhoid, cholera and hepatitis A). For all other conditions, treatment costs are normally paid in full by the traveller or their employer, if the intended trip is work-related. It is hoped that the national review will consider the provision of additional treatments such as influenza immunisation for those people travelling to countries where the virus may circulate throughout the year in the tropics and subtropics. In most cases, these treatments are likely to be administered at pharmacists or commercial vaccination centres; however, there is a strong case for supporting the dwindling number of GP practices that provide specialised travel health services as these will be able to provide guidance on other issues such as avoiding exposure to viral conditions, such as dengue and zika virus, for which there is no effective vaccine treatment currently available.

THE ROLE OF DIGITAL SERVICES

The authors highlighted the key role that digital technologies can play in ensuring that there is a cost-effective system that will enable them to monitor patients who are in need of vaccinations. The potential for using mobile telephones for call/recall of patients needing scheduled treatment is being examined by NHS Digital (2019). It may be necessary to initially develop a system that will serve the needs of the majority of patients before focussing on hard to access groups.

CONCLUSIONS

There is considerable confusion over the arrangements for the administration of those vaccines that are not routinely available under the section 7a arrangements of the national immunisation programme. During the current review of NHS General

Practitioner contracts, there is a need to provide clearer advice on the provision and payment of offering vaccinations to particular patient groups.

An expert panel of NHS clinical staff, administrators and health economists highlighted specific problems over the treatment of migrants with incomplete vaccine histories, young people who have missed out on measles, mumps, and rubella vaccinations in infancy, BCG vaccines in children over the age of one and the close relatives of people infected with the hepatitis B virus. Other important issues include the arrangements for large scale immunisations in areas with outbreaks of major infectious diseases such as hepatitis A and the system for administering vaccines as part of the personal healthcare of patients with conditions such as diabetes and chronic renal disease. Furthermore, it is hoped that the review will also provide directions for general practices and others providing full cost treatment for those undertaking foreign travel.

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