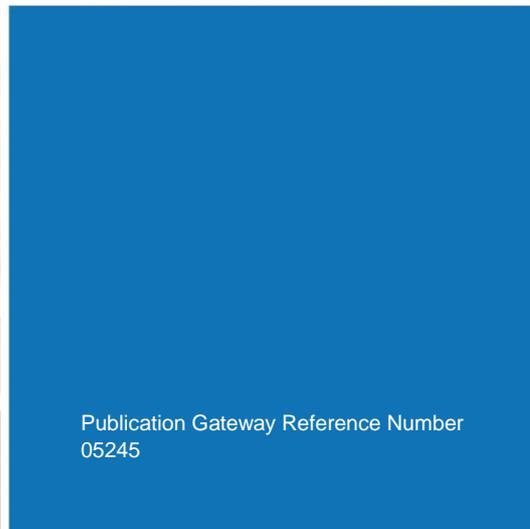
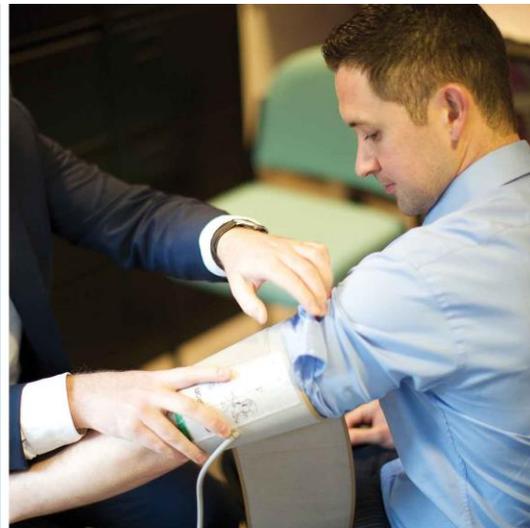


VACCINATION AND IMMUNISATION PROGRAMMES 2016/17

GUIDANCE AND AUDIT REQUIREMENTS

May 2016



Contents

Section 1	Introduction	4
	Introduction	4
	Working with patient data	4
	Verification	5
	About this guidance	5
Section 2	Technical requirements	7
	Calculating Quality Reporting Service (CQRS) and the General Practice Extraction Service (GPES)	7
	Technical requirements	8
Section 3	EXISTING PROGRAMMES (continuing April 2016)	9
	Hepatitis B (newborn babies) vaccination programme	9
	HPV booster	15
	Meningococcal ACWY aged 18 years on 31 August	19
	Meningococcal B (MenB) infants	24
	Meningococcal booster	29
	Meningococcal freshers vaccination programme	33

	Measles, mumps, rubella (MMR) (aged 16 and over) vaccination programme	37
	Pertussis (pregnant women) vaccination programme	40
	Rotavirus (routine childhood immunisation) vaccination programme	41
Section 4	EXISTING PROGRAMMES (continuing September 2016)	45
	Childhood seasonal influenza vaccination programme	45
	Seasonal influenza vaccination programme	51
	Shingles (routine aged 70) vaccination programme	68
	Shingles (catch-up) vaccination programme	72
Section 5	QUERIES PROCESS	77

Section 1. Introduction

Introduction

In February 2016, NHS Employers (on behalf of NHS England) 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 2016/17.

This document provides detailed guidance for commissioners and practices¹ 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 2016/17 GMS contract changes'² document. This document will also be updated where necessary.

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, meningococcal booster, MMR, rotavirus and shingles (routine) vaccination programmes are set out in the GMS Contract Regulations, Directions and the Statement of Financial Entitlements (SFE)³.

The detailed requirements for the childhood seasonal influenza, meningococcal ACWY aged 18 years on 31 August, meningococcal B, meningococcal freshers, pertussis, shingles (catch-up) and the seasonal influenza and pneumococcal polysaccharide vaccination programmes are set out in the NHS England service specifications⁴.

All aspects of a service specification outline the requirements for the programme. As such, commissioners and practices should ensure they have read and understood all sections of the specification as part of the implementation of the programme.

Practices are advised that to ensure they receive payment, particular attention should be paid to the payment and validation terms. Practices will need to ensure they understand and use the designated Read codes as required to ensure payment.

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

¹ A practice is defined as a provider of essential primary medical services to a registered list of patients under a GMS, PMS or APMS contract.

² NHS Employers. Technical requirements for 2016/17 GMS contract changes. www.nhsemployers.org/vandi201617

³ DH. SFE. <https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013>

⁴ NHS England. Service specifications. <http://www.england.nhs.uk/commissioning/gp-contract/>

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
- It is recommended that practices record access to confidential patient data in the relevant patient record, so that an audit trail 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

The following propositions are taken or adapted from the SFE and the Confidentiality and Disclosure of Information (GMS, PMS, APMS) Directions 2013 and its Code of Practice⁵: The Directions and Code of Practice apply equally to NHS England and CCGs operating under delegated commissioning.

The contractor must ensure that it is able to provide any information that NHS England or the commissioner may reasonably request of it to demonstrate achievement and the contractor must make that information available to the commissioner on request. In verifying that service has been achieved and information correctly recorded, the Board may choose to inspect the output from a computer search that has been used to provide information on the indicator, or a sample of patient records relevant to the indicator.

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 this purpose, 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.

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

About this guidance

This document provides information on vaccination and immunisation programme contractual changes in 2016/17 as well as detailed guidance, assurance management

⁵ NHS Primary Medical Directions. <https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013>

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 Rules⁶, 'GMS contract 2016/17 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 201617 guidance and audit requirements. www.nhsemployers.org/GMS201617

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).

CQRS⁸ is the automated system used to calculate achievement and payments on quality services. These include the quality and outcomes framework (QOF), enhanced services (ESs) and vaccination programmes.

GPES⁹ anonymises patient identifiable data which it then collects 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 website¹⁰.

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.

⁸ HSCIC. CQRS. <http://systems.hscic.gov.uk/gpcollections>

⁹ HSCIC. GPES. <http://www.hscic.gov.uk/gpes>

¹⁰ HSCIC. CQRS. <http://systems.hscic.gov.uk/gpcollections>

Technical Requirements for 2016/17

The 'Technical requirements for 2016/17'¹¹ 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 Rules¹² 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 2016/17 GMS contract changes.
www.nhsemployers.org/vandi201617

¹² HSCIC. <http://www.hscic.gov.uk/qofesextractspecs>

Section 3. Existing programmes continuing April 2016

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 (HepB) (ie 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 HepB. Prevalence is higher in adults born in high-endemicity countries, many of whom will have acquired infection at birth or in early childhood¹³. 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 areas¹⁴.

HepB 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 HepB 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 HepB will go on to develop scarring of the liver (cirrhosis) and around one in ten people with cirrhosis will develop liver cancer¹⁵.

The risk of developing chronic HepB 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 cent¹⁶.

All pregnant women should be offered screening for HepB 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 HepB should receive a complete course of HepB vaccination. The benefit of vaccination is high in this group of infants and as such vaccination should not be withheld or delayed.

The HepB 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) and at 12 months.

Vaccinations and immunisations are an additional service under the GMS contract. Under

¹³ Boxall et al. 1994; Aweis et al., 2001.

¹⁴ DH. The Green Book. Chapter 18. <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book>

¹⁵ NHS. Hepatitis B. <http://www.nhs.uk/Conditions/Hepatitis-B/Pages/Introduction.aspx>

¹⁶ DH. The Green Book. Chapter 18.

the GMS Contract for 2016/17 there is an item of service payment of £9.80 for each dose. Further details on background to the programme, dosage, timings and administration can be found in the Green Book¹⁷.

Requirements

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

Commissioners will seek to invite GP practices to participate in this ES before 30 April 2016. Payment and activity recording will be managed by CQRS¹⁸ and participating practices are required to sign-up to CQRS no later than 30 June¹⁹.

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 HepB due to their mother being HepB 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 HepB 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 HepB 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 HepB in hospital will identify most babies at risk of HepB. It is recommended that babies at risk of HepB are delivered in hospital. The hospital will routinely administer the first dose of hepB 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.

However, due to the importance of timely immunisation and risk of babies not receiving the

¹⁷ Green Book. Chapter 18.

¹⁸ Further guidance relating to CQRS will be provided by HSCIC when services are updated.

¹⁹ Practices will be required to sign-up to CQRS in order for payment to be calculated and processed.

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 2016 who are at risk of HepB by checking the mother's status.

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 guidance²⁰ 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 HepB virus incubates for up to six months and infection cannot be determined until the baby is aged 12 months. HepB 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 HepB 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 HepB 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 of HBVaxPro 10 mcg.

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

Provided HepB vaccinations are administered at the appropriate time, there are no contraindications to administering the vaccine when patients attend for routine childhood

²⁰ Green Book. Chapter 18.

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 HepB. 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. The data input will be in relation to the payment count. For information on how to manually enter data into CQRS, see the HSCIC²¹ website.

The 'Technical requirements'²² document contains the payment count and Read codes²³ 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 2016.

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.

²¹ HSCIC. Manual entry. <http://systems.hscic.gov.uk/gpcollections>

²² NHS Employers. Technical requirements for 2016/17 GMS contract changes. www.nhsemployers.org/vandi201617

²³ Please note that the code descriptions in clinical systems may not exactly match the guidance text.

Where there is an automated data collection, there is a five day period following the month end to allow practices to record the previous month's 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. (ie payment count HEP001)
- Monthly count of the number of the second hepatitis 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. (ie 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. (ie 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. (ie payment count HEP004)

Payment will be made based on the monthly count multiplied by £9.80. 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 ie 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 dose²⁴.

CQRS will calculate monthly payments, based either 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 ie checking the mother's status to identify all newborn babies at risk of HepB, administering the doses at the required time and intervals and referring at 12 months or as soon as possible thereafter for a blood test

²⁴ This is in line with SFE requirements.

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 SFE²⁵ 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.).

²⁵ DH. SFE. <https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013>

HPV booster vaccination programme

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 anogenital 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 than 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 2016/17 include an item of service payment of £9.80 for each dose for this programme.

Further details on background to the programme, dosage, timings and administration can be found in the Green Book²⁶.

Vaccination

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

To commence a course of HPV vaccine patients must be aged from 14 or 15 years but less than 18 years, at any time during the period 1 April 2016 to 31 March 2017. For example:

- patients who are aged 13 can be vaccinated during that period provided they turn 14 by 31 March 2017
- patients who are aged 17 at any time during the service who then turn 18 after 31 March 2017 can be vaccinated
- patients who have had their 18th birthday at the start of the service (1 April 2016)

²⁶ Green Book. Chapter 18a. <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book>

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, 6-24 months 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
1 st dose	0.5 ml	0 and 6-24 months. 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
2 nd dose	0.5 ml at least 6-24 months after the first dose	
3 rd 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
1 st 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. 2 doses less than 6 months apart are not considered adequate to provide long-term protection and a 3 rd dose should be given in line with the dosage and schedule section for the Green Book.
2 nd dose	0.5 ml at least 1 month after the first dose	
3 rd dose	0.5 ml at least 3 months after the second dose	

Requirements

This programme is from 1 April 2016 until 31 March 2017.

Commissioners will seek to invite GP practices to participate in this ES before 30 April 2016. Payment and activity recording will be managed by CQRS²⁷ and participating practices are required to sign-up to CQRS no later than 30 June²⁸.

Practices are required to:

- provide vaccination to eligible patients who self-present. Eligible patients are those:
 - a. aged from 14 and 15 to less than 18 years during the period 1 April 2016 and 31 March 2017
 - b. who missed the opportunity to be vaccinated through the schools programme
 - c. are vaccinated in the period from 1 April 2016 to 31 March 2017.
- 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. The data input will be in relation to the payment count. For information on how to manually enter data into CQRS, please see the HSCIC²⁹ website.

The 'Technical requirements'³⁰ 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.

Payment and validation

Practices who participate in this programme will be required to sign up to CQRS by no later than 30 June 2016.

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 working day period following the month end to allow practices to record the previous month's 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.

²⁷ Further guidance relating to CQRS will be provided by HSCIC when services are updated.

²⁸ Practices will be required to sign-up to CQRS in order for payment to be calculated and processed.

²⁹ HSCIC. Manual entry. <http://systems.hscic.gov.uk/gpcollections>

³⁰ NHS Employers. Technical requirements for 2016/17 GMS contract changes. www.nhsemployers.org/vandi201617

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 who achieved 14 years of age on or after 1 April 2015 and who have not achieved the age of 18 years who have received a HPV booster vaccination at the GP practice in the reporting period; as a result of missing the provision by the Schools programme. (ie payment count HPV001)

Payment will be made based on the monthly count multiplied by £9.80.

It is anticipated that practices will claim for payment in the month following vaccination. 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 dose³¹.

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 SFE³² 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.).

³¹ This is in line with SFE requirements.

³² NHS England. Service specification. <http://www.england.nhs.uk/resources/d-com/gp-contract/>

Meningococcal ACWY aged 18 years on 31 August 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.

There are 12 groups of meningococci (A, B, C, E, H, I, K, L, W, X, Y and Z). Groups B, C, W and Y are the most common types in the UK. Since the introduction of the routine MenC programme in November 1999 the number of cases of MenC have greatly reduced.

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 the JCVI, further changes were made with the dose at four months withdrawn and an adolescent booster was introduced along with a single dose for university freshers entering higher education for the first time³³. In 2016, following recommendations by JCVI, the dose at three months was withdrawn as the MenB vaccine offers protection against MenC for this cohort.

In February 2015, PHE presented data to the JCVI on the increase in meningococcal group W (MenW) disease in England and Wales since 2009, with the most recent cases increasing in an accelerated manner. JCVI agreed this constituted an outbreak situation and that population level control of MenW was required with urgency, to reduce the risk of further rapid increases in disease across the population. JCVI recommended a programme with a quadrivalent vaccine to vaccinate all adolescents aged 14-18 years of age against the emerging 'W' strain of the disease. The quadrivalent vaccine will also provide protection against meningococcal types A, C and Y. Vaccination of this cohort is expected to provide herd protection for the wider population.

Those aged 18 years (school year 13) on 31 August 2015 were the first cohort to be vaccinated against MenW as a priority using the MenACWY quadrivalent vaccine.

For financial year 2016/17, the MenACWY programme is targeted at 18 year olds who are leaving school in summer 2016.

The new specification also allows for catch-up with MenACWY vaccine for those who were school leaving age in summer 2015 (as above) but did not receive vaccination during 2015/16. These individuals will remain eligible up until 25 years. They should be vaccinated regardless of prior MenC status, but vaccination is not required for those who have already received a dose of MenACWY conjugate vaccine after ten years.

³³ 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

A separate programme against meningococcal for freshers (first time university/further education students) was introduced in April 2014. From August 2015 the new MenACWY vaccine was also made available for the freshers programme replacing the MenC vaccines. The freshers programme is outlined in a separate section of this guidance. There is no overlap in the age ranges for these programmes due to the cut-off dates for eligibility.

This ES is aimed at practices delivering vaccination³⁴ and immunisation programmes in England. This ES is effective from 1 April 2016 until 31 March 2017.

Vaccinations and immunisations are an additional service under the GMS contract. Changes to the GP contract for 2016/17 include an item of service payment of £9.80 for each dose for this programme.

Further details on background to the programme, dosage, timings and administration can be found in the Green Book³⁵.

Requirements

This programme is from 1 April 2016 until 31 March 2017.

Commissioners will seek to invite GP practices to participate in this ES before 30 April 2016. Practices who participate in this ES should respond to the commissioner's offer no later than 30 June. The agreement should be recorded in writing with their commissioner. Payment and activity recording will be managed by CQRS³⁶ and participating practices are required to sign-up to CQRS at the same time they accept the offer to participate in the ES – no later than 30 June³⁷.

Practices are required to:

- provide MenACWY vaccination to eligible patients. Eligible patients are those who are:
 - a. registered at the practice
 - b. aged 18 years on 31 August 2015 2016
 - c. were aged 18 years on 31 August 2015
 - d. vaccinated in the period from 1 April 2016 to 31 March 2017.
- Ensure that the patient record of those who received 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.

³⁴ Section 7a (S7a) functions are described as 'reserved functions' which are not covered by the 'enhanced services delegated to CCG' category in the delegation agreement. NHS England remains responsible and accountable for the discharge of all S7a functions. As this vaccination is defined as a S7a function, this agreement cannot be changed or varied locally.

³⁵ Green Book. Chapter 22. <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book>

³⁶ Further guidance relating to CQRS will be provided by HSCIC when services are updated.

³⁷ Practices will be required to sign-up to CQRS in order for payment to be calculated and processed.

Vaccination

For patients aged 18 years on 31 August 2016, practices are required to identify eligible patients and provide robust call and recall arrangements to ensure they are vaccinated. Any other patients eligible under this ES should be offered vaccination opportunistically.

All MenACWY vaccines for this cohort are delivered by one dose given intramuscularly into the deltoid region of the upper arm.

Vaccines for this programme are centrally supplied through ImmForm.

Monitoring

There are two payment counts (see payment and validation) for this programme. The management information counts are outlined in the technical requirements document. This programme is combined with the freshers programme on CQRS therefore the payment and management information counts apply to both programmes.

There will be one service on CQRS which will cover both this and the freshers programme

Practices will be required to manually input data into CQRS, on a monthly basis until GPES is available. For information on how to manually enter data into CQRS, see the HSCIC³⁸ website.

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, eg if month six (September) is the reporting month then the collection will take place in October. Payment counts will be cumulative and non-cumulative monthly counts from when the practice begins to deliver the programme³⁹. 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 (ie 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.

In addition to CQRS, as part of this programme, activity will also be monitored and reported via ImmForm on a monthly basis. The data will be provided to ImmForm via automated collections from practices clinical systems. Practices should also provide data to the Child Health Information Systems (CHIS) in line with standard practice.

Payment and validation

Practices participating in this programme will be required to sign up to CQRS no later than 30 June 2016.

³⁸ HSCIC. Manual entry. <http://systems.hscic.gov.uk/gpcollections>

³⁹ 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.

Claims for payments for this programme should be made monthly, after the dose has been administered. Where claims are entered manually, this should be within 12 days of the end of the month when the completing dose was administered. Where there is an automated data collection, there is a five working day period following the month end to allow practices to record the previous month's 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.

Payments are calculated by identifying the:

- Monthly count of the number of patients aged 18 years on 31 August 2016 or aged 18 years at the time of vaccination who received their earliest MenACWY vaccination administered by the GP practice within the reporting period. (ie payment count ACWY001)
- Monthly count of the number of patients who received their earliest MenACWY vaccination whilst aged at least 19 years and before attaining 26 years of age, administered by the GP practice within the reporting period. (ie payment count ACWY001)

Payment will be made based on the monthly count multiplied by £9.80.

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 specification⁴⁰ 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

⁴⁰ NHS England. Service specification. <http://www.england.nhs.uk/commissioning/gp-contract/>

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.

Meningococcal B (MenB) infants 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 together. Most people will make a recovery but at worst meningococcal disease causes very severe illness that can rapidly result in death.

There are 12 groups of meningococci (A, B, C, E, H, I, K, L, W, X, Y and Z). Groups B, C, W and Y are the most common types in the UK. Since the introduction of the routine MenC programme in November 1999 the number of cases of MenC have greatly reduced.

Meningococcal disease is more common in children under five years, with a higher number of cases in babies under 12 months and peak incidence at five months. Evidence shows that infants younger than one year old have the highest risk of MenB disease, which peaks at five months before declining gradually.

In March 2014 the JCVI recommended the vaccination of infants against MenB to protect them from this strain of meningococcal bacteria.

This routine programme is a three dose programme with the first dose given at two months (eight weeks), the second dose at four months (16 weeks) and a booster dose at 12 to 13 months. The two doses at two and four months constitute the “primary course” required to ensure optimum protection for babies ahead of peak incidence at five months of age. The third dose at 12 to 13 months provides longer term protection. A short-term catch-up element was included under this ES in 2015/16 and those children born between 1 May and 30 June 2015 remain eligible for their booster dose up to their second birthday for 2016/17.

This ES is aimed at practices delivering vaccination and immunisation programmes in England. This ES is effective from 1 April 2016 until 31 March 2017.

Vaccinations and immunisations are an additional service under the GMS contract. Changes to the GP contract for 2016/17 include an item of service payment of £9.80 for each dose for this programme.

Further details on background to the programme, dosage, timings and administration can be found in the Green Book⁴¹.

Requirements

This programme is from 1 April 2016 until 31 March 2017.

Commissioners will seek to invite GP practices to participate in this ES before 30 April 2016. Practices who participate in this ES should respond to the commissioner’s offer no later than 30 June. The agreement should be recorded in writing with their commissioner.

⁴¹ Green Book. Chapter 22. <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book>

Payment and activity recording will be managed by CQRS⁴² and participating practices are required to sign-up to CQRS at the same time they accept the offer to participate in the ES – no later than 30 June⁴³.

Practices are required to:

- provide vaccination unless contra-indicated. Eligible patients are those who:
 - a. are registered at the practice,
 - b. are born on or after 1 May 2015 and have not attained the age of two years at the time of vaccination,
 - c. MenB vaccinations should be provided alongside the existing routine childhood immunisations at two months (eight weeks), four months (16 weeks) and 12 to 13 months (inclusive).
 - d. Children eligible as part of the catch-up element under the 2015/16 ES (born between 1 May and 30 June 2015), remain eligible for their booster dose under this programme for 2016/17.
- 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.

Vaccination

As this programme will fit in with the timings for the existing routine childhood immunisations scheme there is no requirement for practices to operate additional call and recall specific to this vaccination.

Babies should have the MenB vaccine with their scheduled primary immunisations. For example they should have MenB with their first and third primary immunisations (usually scheduled at two and four months of age meaning a gap of two months between doses of MenB vaccine).

Babies in the catch-up cohort (born between 1 May and 30 June 2015) should also have MenB vaccine with their scheduled primary immunisations.

Babies should then have a booster dose of MenB vaccine at 12 to 13 months of age alongside the Hib/MenC booster, PCV13 booster and MMR.

Once the programme is established and eligible babies (ie those born on or after 1 May 2015) are a little older (but less than two years of age), some may present to the practice with missing doses of MenB vaccine. These babies should have any missing doses caught up using the 'managing babies with incomplete MenB immunisations' advice.

Managing those with incomplete MenB immunisations

If a child is aged less than one year, give two doses of MenB vaccine two months apart. The booster dose should be administered after the age of one year leaving a gap of at

⁴² Further guidance relating to CQRS will be provided by HSCIC when services are updated.

⁴³ Practices will be required to sign-up to CQRS in order for payment to be calculated and processed.

least two months between doses. The booster may be given up to the day before the child's second birthday.

If the child is over one but less than two years of age and had one dose of MenB vaccine before the first birthday, give one further dose at least two months after the first dose.

If the child is over one but less than two years of age and has had no previous MenB vaccine, give two doses two months apart.

The recommended interval between doses is two months, however where it is deemed clinically necessary, practices can provide the second dose after a four week interval.

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.

As this programme will fit in with the existing routine childhood immunisations scheme there is no requirement for practices to operate additional call and recall specific to this vaccination.

Vaccines for this programme will be centrally supplied through ImmForm.

Monitoring

There are four payment counts (see payment and validation) for this programme. The management information counts are outlined in the technical requirements document.

Practices will be required to manually input data into CQRS. For information on how to manually enter data into CQRS, see the HSCIC⁴⁴ website.

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, eg if month six (September) is the reporting month then the collection will take place in October. Payment counts will be cumulative or non-cumulative monthly counts (as appropriate) from when the practice begins to deliver the programme⁴⁵. 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 (ie 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.

In addition to CQRS, as part of this programme, activity will also be monitored and reported via ImmForm on a monthly basis. The data will be provided to ImmForm via

⁴⁴ HSCIC. Manual entry. <http://systems.hscic.gov.uk/gpcollections>

⁴⁵ 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.

automated collections from practices clinical systems. Practices should also provide data to the Child Health Information Systems (CHIS) in line with standard practice.

In addition to CQRS, as part of this programme, activity will also be monitored and reported via ImmForm on a monthly basis. The data will be provided to ImmForm via automated collections from practices clinical systems. Once established, the programme will also be monitored quarterly as part of the Cover of Vaccinations Evaluated Rapidly (COVER) programme using data collected from the CHIS. Practices should also provide data to CHIS in line with standard practice.

Payment and validation

Practices who participate in this programme will be required to sign up to CQRS by no later than 30 June 2016.

Claims for payments for this programme should be made monthly, after the dose has been administered. Where claims are entered manually, this should be within 12 days of the end of the month when the completing dose was administered. 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.

Practices should note that any first dose regardless of the age at the time of vaccination, should be recorded using the first dose code otherwise it will not be picked up as part of the data collections. The same applies for the second and booster doses. If practices do not use the correct code, their achievement and reporting may not be accurate.

Payments are calculated by identifying the:

- Monthly count of the number of patients who received a first dose of MenB vaccination from the age of 2 months and before attaining 24 months of age, administered by the GP practice within the reporting period. (ie payment count MENBI01)
- Monthly count of the number of patients who received a second dose of MenB vaccination from the age of 4 months and before attaining 24 months of age, administered by the GP practice within the reporting period. (ie payment count MENBI03)
- Monthly count of the number of patients who received a booster dose of MenB vaccination from the age of 12 months and before attaining 24 months of age, administered by the GP practice within the reporting period where the first dose of MenB vaccination was received prior to patient attaining 12 months of age. (ie payment count MENBI09)
- Monthly count of the number of patients who received a booster dose of MenB vaccination from the age of 12 months and before attaining 24 months of age, administered by the GP practice within the reporting period where the first dose of MenB vaccination was received on or after patient attaining 12 months of age. (ie payment count MENBI10)

Payment will be made based on the monthly count multiplied by £9.80.

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 administration. Claims must be submitted within six months of delivering the vaccine dose⁴⁶.

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 service specification⁴⁷ 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.).

⁴⁶ This is in line with SFE requirements.

⁴⁷ DH. SFE. <https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013>

Meningococcal booster 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 together. Most people will make a 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 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 booster⁴⁸ through schools programmes. In 2016, following recommendations by JCVI, the dose at three months was withdrawn as the MenB vaccine offers protection against MenC for this cohort

This programme ensures those children who missed vaccination through the schools programme still have the opportunity to be vaccinated through general practice. This programme is for children and adults aged 14 to 25 years. For 2016/17, this programme relates to those children aged 14 and 15 years on or after 1 April 2015 only.

In February 2015, PHE presented data to the JCVI on the increase in meningococcal group W (MenW) disease in England and Wales since 2009, with the most recent cases increasing in an accelerated manner. JCVI recommended a programme with a new quadrivalent vaccine to vaccinate all adolescents aged 14-18 years of age against an emerging 'menW' strain of the disease. The quadrivalent will also provide protection against meningococcal types A, C and Y. Vaccination of this cohort is expected to provide herd immunity for the wider population. .

Those aged 18 years (school year 13) on 31 August 2015 were the first cohort to be vaccinated against MenW as a priority using the MenACWY quadrivalent vaccine. Separate programmes against meningococcal disease for those aged 18 years on 31 August 2016 and freshers (first time university/further education students) are outlined in separate sections of this guidance.

Vaccinations and immunisations are an additional service under the GMS contract. Changes to the GP contract for 2016/17 include an item of service payment of £9.80 for each dose for this programme.

Further details on background to the programme, dosage, timings and administration can be found in the Green Book⁴⁹.

⁴⁸ 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

⁴⁹ Green Book. Chapter 22. <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book>

Requirements

Commissioners will seek to invite GP practices to participate in this ES before 30 April 2016. Payment and activity recording will be managed by CQRS⁵⁰ and participating practices are required to sign-up to CQRS no later than 30 June⁵¹.

Practices are required to:

- provide vaccination to eligible patients on an opportunistic basis or who self-present. Eligible patients are those:
 - a. aged 14 or 15 years on or after 1 April 2015
 - b. who missed the opportunity to be vaccinated through the schools programme
 - c. are vaccinated in the period from 1 April 2016 to 31 March 2017.
- Ensure that the patient record of those offered the vaccination are updated accordingly.

To support practices to identify eligible patients, the following table provides details of the planned implementation of the meningococcal catch-up programme.

Cohorts by financial year⁵²

Financial year	Academic year	Delivery route	When
2015/16	Year 13s	Primary care	August to September 2015
	Years 9 or 10	School-based	January to March 2016
	Year 11	School-based	January to March 2016
2016/17	Year 9 or 10	School-based	January to March 2017
	Year 11	School-based	January to March 2017
2017/18	Years 9 or 10	School-based	January to March 2018
	Year 11	School-based	January to March 2018

Vaccination

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

Eligible patients must be aged 14 or years on or after 1 April 2015. For example:

- patients who are aged 13 on 1 April 2016 cannot be vaccinated under this programme
- patients who are aged 14 years on 1 April 2016 and turn 15 years on 2 April 2016 can be vaccinated

⁵⁰ Further guidance relating to CQRS will be provided by HSCIC when services are updated.

⁵¹ Practices will be required to sign-up to CQRS in order for payment to be calculated and processed.

⁵² Based on detail in MenACWY bipartite letter. <https://www.gov.uk/government/publications/menacwy-vaccine-introduction>

- patients who are aged 16 years or older on 1 April 2016 cannot be vaccinated under this programme.

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

Vaccines for this programme will be 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. The data input will be in relation to the payment count. For information on how to manually enter data into CQRS, see the HSCIC⁵³ website.

The 'Technical requirements'⁵⁴ document contains the payment count and Read codes⁵⁵ 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 who participate in this programme will be required to sign up to CQRS by no later than 30 June 2016.

Claims for payments for this programme should be made monthly, after the dose has been administered. Where claims are entered manually, this should be within 12 days of the end of the month when the completing dose was administered. Where there is an automated data collection, there is a five working day period following the month end to allow practices to record the previous month's 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 14 years on or after 1st April 2015 who have not yet attained the age of 26 years who have received a Meningococcal booster vaccination by the GP practice in the reporting period; as a result of missing the provision by the Schools programme. (ie payment count MVB001)

⁵³ HSCIC. Manual entry. <http://systems.hscic.gov.uk/gpcollections>

⁵⁴ NHS Employers. Technical requirements for 2016/17 GMS contract changes. www.nhsemployers.org/vandi201617

⁵⁵ Please note that the code descriptions in clinical systems may not exactly match the guidance text.

Payment will be made based on the monthly count multiplied by £9.80.

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 ie 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 dose⁵⁶.

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 SFE⁵⁷ 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.).

⁵⁶ This is in line with SFE requirements.

⁵⁷ DH. SFE. <https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013>

Meningococcal 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, an adolescent booster was introduced along with a single dose for university freshers entering higher education for the first time⁵⁸. In 2016, following recommendations by JCVI, the dose at three months was withdrawn as the MenB vaccine offers protections against MenC for this cohort.

The MenC vaccine for freshers (first time university/further education students) 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).

In February 2015, JCVI recommended a programme with a new quadrivalent vaccine to vaccinate all adolescents aged 14-18 years of age against an emerging 'menW' strain of the disease. The quadrivalent will also provide protection against meningococcal groups A, C and Y. Vaccination of this cohort is expected to provide herd immunity for the wider population.

Those aged 18 years (school year 13) on 31 August 2015 were the first cohort to be vaccinated against MenW as a priority using the MenACWY quadrivalent vaccine. A separate programme against meningococcal disease for freshers (first time university/further education students) is outlined in a separate section of this guidance.

This ES is aimed at practices delivering vaccination and immunisation programmes in England. This ES is effective from 1 April 2016 until 31 March 2017.

Vaccinations and immunisations are an additional service under the GMS contract. Changes to the GP contract for 2016/17 include an item of service payment of £9.80 for each dose for this programme.

Further details on background to the programme, dosage, timings and administration can be found in the Green Book⁵⁹.

Requirements

This programme is from 1 April 2016 until 31 March 2017.

Commissioners will seek to invite GP practices to participate in this ES before 30 April

⁵⁸ 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

⁵⁹ Green Book. Chapter 22. <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book>

2016. Practices who participate in this ES should respond to the commissioner's offer no later than 30 June. The agreement should be recorded in writing with their commissioner. Payment and activity recording will be managed by CQRS⁶⁰ and participating practices are required to sign-up to CQRS at the same time they accept the offer to participate in the ES – no later than 30 June⁶¹.

Practices are required to:

- provide vaccination to eligible students on an opportunistic basis or who self-present. Eligible patients are those:
 - a. attending university/further education for the first time
 - b. aged from 19 years on 31 August 2016 to 25 years by 31 March 2017.
- 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.

Practices should 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 can be vaccinated 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 19 years on 31 August 2016 and up to 25 years on 31 March 2017. For example:

- patients who are aged 18 can be vaccinated during that period provided they turn 19 by 31 August 2016
- patients who are aged 25 at any time during the programme who then turn 26 after 31 March 2017 can be vaccinated
- patients aged 26 at the start of the programme (1 April 2016) 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.

⁶⁰ Further guidance relating to CQRS will be provided by HSCIC when services are updated.

⁶¹ Practices will be required to sign-up to CQRS in order for payment to be calculated and processed.

Monitoring

There are two payment counts (see payment and validation) for this programme. The management information counts are outlined in the technical requirements document. This programme is combined with the 18 years programme on CQRS therefore the payment and management information counts apply to both programmes.

Practices will be required to manually input data into CQRS, on a monthly basis until GPES is available. For information on how to manually enter data into CQRS, see the HSCIC website⁶².

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, eg if month five (August) is the reporting month then the collection will take place in September. Payment counts will be cumulative or non-cumulative monthly counts (as appropriate) from when the practice begins to deliver the programme⁶³. 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 (ie 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 30 June 2016.

There will be one service on CQRS which will cover the freshers' programme and also the MenACWY programme.

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 month's 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.

⁶² HSCIC. Manual entry. <http://systems.hscic.gov.uk/gpcollections>

⁶³ 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.

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 patients aged 18 years on 31 August 2016 or aged 18 years at the time of vaccination who received their earliest MenACWY vaccination administered by the GP practice within the reporting period. (ie payment count ACWY001)
- Monthly count of the number of patients who received their earliest MenACWY vaccination whilst aged at least 19 years and before attaining 26 years of age, administered by the GP practice within the reporting period. (ie payment count ACWY001)

Payment will be made based on the monthly count multiplied by £9.80.

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 specification⁶⁴ 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.

⁶⁴ NHS England. Service specification. <http://www.england.nhs.uk/commissioning/gp-contract/>

MMR (aged 16 and over) vaccination programme

Background and purpose

Measles activity in England has been at historically low levels since the MMR catch-up campaign in 2013, with 103 and 91 cases confirmed during 2014 and 2015 respectively. However, an increase in measles was observed at the end of 2015 with two identified clusters in South East England. Since early 2016, cases of measles have been confirmed across London and the East of England, predominantly in unimmunised adolescents and young adults (aged 14 to 40 years) without a history of recent travel.

This programme was introduced in April 2013 to immunise patients over the age of 16 years who are not fully vaccinated. This programme commences 1 April 2016 to run until 31 March 2017.

Vaccinations and immunisations are an additional service under the GMS contract. Changes to the GP contract for 2016/17 include an item of service payment of £9.80 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 Book⁶⁵.

Requirements

This programme is for one year from 1 April 2016 until 31 March 2017.

Commissioners will seek to invite GP practices to participate in this ES before 30 April 2016. Payment and activity recording will be managed by CQRS⁶⁶ and participating practices are required to sign-up to CQRS no later than 30 June⁶⁷.

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.

⁶⁵ Green Book. Chapters 21, 22 and 23. <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book>

⁶⁶ Further guidance relating to CQRS will be provided by HSCIC when services are updated.

⁶⁷ Practices will be required to sign-up to CQRS in order for payment to be calculated and processed.

- Record all administered doses on ImmForm and where suitable IT systems exist all doses administered are uploaded to ImmForm by automated data collections.

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. The data input will relate to the payment count. For information on how to manually enter data into CQRS, see the HSCIC⁶⁸ website.

The 'Technical requirements'⁶⁹ document contains the payment count, Read codes⁷⁰ 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 2016.

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. (ie payment count MMR001)

Payment will be made based on the monthly count multiplied by £9.80.

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

⁶⁸ HSCIC. Manual entry. <http://systems.hscic.gov.uk/gpcollections>

⁶⁹ NHS Employers. Technical requirements for 2016/17 GMS contract changes. www.nhsemployers.org/vandi201617

⁷⁰ Please note that the code descriptions in clinical systems may not exactly match the guidance text.

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 the full protocol described in the programme was followed ie 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 SFE⁷¹ 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.).

⁷¹ DH. SFE. <https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013>

Pertussis (pregnant women) vaccination programme

For details of the requirements for the pertussis vaccination programme, see the NHS England service specification⁷² on the NHS England website.

For details of the Read codes, payment and management information counts, see the 'Technical requirements'⁷³ document.

Details on background to the programme, dosage, timings and administration can be found in the Green Book⁷⁴.

⁷² NHS England. Service specification. <http://www.england.nhs.uk/commissioning/gp-contract/>

⁷³ NHS Employers. Technical requirements for 2016/17 GMS contract changes. www.nhsemployers.org/vandi201617

⁷⁴ 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 2016/17 include an item of service payment of £9.80 for a completed course of rotavirus vaccination.

Further details on background to the programme, dosage and timings can be found in the Green Book⁷⁵.

Requirements

This programme is for one year from 1 April 2016 until 31 March 2017.

Commissioners will seek to invite GP practices to participate in this ES before 30 April 2016. Practices who participate in this ES should respond to the commissioner's offer no later than 30 June. The agreement should be recorded in writing with their commissioner. Payment and activity recording will be managed by CQRS⁷⁶ and participating practices are required to sign-up to CQRS at the same time they accept the offer to participate in the ES – no later than 30 June⁷⁷.

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

⁷⁵ Green Book. Chapter 27b. <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book>

⁷⁶ Further guidance relating to CQRS will be provided by HSCIC when services are updated.

⁷⁷ Practices will be required to sign-up to CQRS in order for payment to be calculated and processed.

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.

- 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 intussusception⁷⁸.

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 programme. The management information counts are outlined in the technical requirements document.

Practices will be required to manually input data into CQRS, on a monthly basis, until GPES⁷⁹ is available. For information on how to manually enter data into CQRS, see the HSCIC⁸⁰ website.

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, eg if month five (August) is the reporting month then the collection will take place in September. Payment counts will be cumulative or non-cumulative monthly counts (as appropriate) from when the practice begins to deliver the programme⁸¹. 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 (ie 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'⁸² document contains the payment counts, management

⁷⁸ Green Book.

⁷⁹ Details as to when GPES is available will be communicated via the HSCIC.

⁸⁰ HSCIC. Manual entry. <http://systems.hscic.gov.uk/gpcollections>

⁸¹ 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.

⁸² NHS Employers. Technical requirements for 2016/17 GMS contract changes. www.nhsemployers.org/vandi201617

information counts, Read codes⁸³ 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 Rules⁸⁴ 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 June 2016.

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 month's 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. (ie payment count ROTA001)

Payment will be made based on the monthly count multiplied by £9.80. 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.

⁸³ Please note that the code descriptions in clinical systems may not exactly match the guidance text.

⁸⁴ HSCIC. Business Rules. www.hscic.gov.uk/qofesextractspecs

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 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 ie 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 SFE⁸⁵ 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.).

⁸⁵ DH. SFE. <https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013>

Section 4. Existing programmes (continuing September 2016)

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 in order to ensure 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 2016. The date of eligibility changed to be in line with the schools programmes.

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 2016 to 31 March 2017 for patients aged two, three and four (but not aged less than two or aged five or over) on 31 August 2016. Healthy children that turn two after 31 August 2015 should not be offered the vaccine.

Payment of £9.80 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 plan⁸⁶, the Green Book⁸⁷ and the ES specification⁸⁸.

⁸⁶ PHE. Seasonal influenza. <https://www.gov.uk/government/collections/annual-flu-programme>

⁸⁷ Green Book. Chapter 19. <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book>

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

Requirements

This programme is from 1 September 2016 to 31 March 2017.

Commissioners will seek to invite GP practices to participate in this ES before 30 June 2016. Practices who participate in this ES should respond to the commissioners' offer no later than 31 July 2016. The agreement should be recorded in writing with their commissioner.

Payment and activity recording will be managed by the Calculating Quality Reporting Service (CQRS)⁸⁹ and participating practices are required to sign-up to CQRS at the same time they accept the offer to participate in the ES – no later than 31 July⁹⁰.

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 2016 (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 recall⁹¹ basis, if considered at-risk as defined in the annual flu plan⁹² (extract included at the seasonal influenza 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 2016 and 31 March 2017, with vaccinations concentrated between 1 September and 31 December 2016.
- Vaccination must be with the appropriate vaccine and dosage^{93, 94}:
 - a. One dose of live attenuated inactivated vaccine (LAIV) (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 LAIV, 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.

⁸⁹ Further guidance relating to CQRS and GPES will be provided by HSCIC when services are updated.

⁹⁰ Practices will be required to sign-up to CQRS in order for payment to be calculated and processed.

⁹¹ 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.

⁹² PHE. Seasonal influenza. <https://www.gov.uk/government/collections/annual-flu-programme>

⁹³ The at-risk groups, vaccines and dosages are defined in the annual flu letter and the Green Book. PHE. Seasonal influenza. <https://www.gov.uk/government/collections/annual-flu-programme>

⁹⁴ The at-risk groups are also defined in the seasonal influenza annex of this guidance.

- c. Where LAIV 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 2016. 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 2017. However patients turning five during the timeframe 1 September 2016 to 31 March 2017 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 2016 should not be vaccinated.

Eligible patients should be vaccinated as soon as the vaccine is available. Widespread immunisation may continue until December 2016 but where possible should be completed before influenza starts to circulate in the community. However, influenza can circulate later than 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 2017 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 LAIV 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. LAIV and the inactivated influenza vaccines for use in those whom LAIV is contra-indicated can be ordered online from ImmForm as per other centrally supplied vaccines.

LAIV 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 LAIV 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. LAIV has a short shelf-life and doses will have a use-by date and the latest expiry date is expected to be around January /February⁹⁵. 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 LAIV 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 children⁹⁶.

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

Monitoring

There are two payment counts (see payment and validation) for this programme. The management information counts are outlined in the technical requirements document.

Practices will be required to manually input data into CQRS, on a monthly basis, until GPES⁹⁷ is available. For information on how to manually enter data into CQRS, see the HSCIC⁹⁸ website.

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, eg if month five (August) is the reporting month then the collection will take place in September. Payment counts will be cumulative or non-cumulative monthly counts (as appropriate) from when the practice begins to deliver the programme⁹⁹. 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 (ie 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

⁹⁵ 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.

⁹⁶ Heinonen et al., 2010.

⁹⁷ Details relating to the availability of GPES support will be communicated via the HSCIC.

⁹⁸ HSCIC. Manual entry. <http://systems.hscic.gov.uk/gpcollections>

⁹⁹ 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.

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'¹⁰⁰ document contains the payment counts, management information counts, Read codes¹⁰¹ 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 Rules¹⁰² 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 2016.

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 month's 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.

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

- Monthly count of the number of patients aged two, three and four years (but not aged less than two years or aged five years or over) on 31 August 2016 who have received a

¹⁰⁰ NHS Employers. Technical requirements for 2016/17 GMS contract changes. www.nhsemployers.org/vandi201617

¹⁰¹ Please note that the code descriptions in clinical systems may not exactly match the guidance text.

¹⁰² HSCIC. Business Rules. www.hscic.gov.uk/qofesextractspecs

first dose of seasonal influenza vaccination given by the GP practice within the reporting period. (ie payment count CFLU002)

- Monthly count of the number of patients aged two, three and four years (but not aged less than two years or aged five years or over) on 31 August 2016 who have received a second dose of seasonal influenza vaccination given by the GP practice within the reporting period. (ie payment count CFLU003)

Payment will be made based on the monthly count multiplied by £9.80. 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 specification¹⁰³ 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.

¹⁰³ NHS England. Service specification. <http://www.england.nhs.uk/commissioning/gp-contract/>

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.

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 2016 for the pneumococcal element and 1 September 2016 for seasonal influenza. Both end on 31 March 2017. 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 polysaccharide vaccination (PPV23) programmes.

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

- LAIV 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 manufactured by Sanofi Pasteur MSD.

Payment of £9.80 for each dose of seasonal influenza or PPV23 vaccine will be made to practices delivering this ES in accordance with the NHS England service specification¹⁰⁴.

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: PPV23 programme

Requirements – PPV23

The pneumococcal element of the ES commences on 1 April 2016 until 31 March 2017.

Commissioners will seek to invite GP practices to participate in this ES before 30 April 2016. Practices who participate in this ES should respond to the commissioner's offer no later than 30 June. The agreement should be recorded in writing with their commissioner.

Payment and activity recording will be managed by CQRS¹⁰⁵ and participating practices are required to sign-up to CQRS at the same time they accept the offer to participate in the ES – no later than 30 June¹⁰⁶.

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 two¹⁰⁷ to 64 years defined as at-risk in the Green Book¹⁰⁸.
- Patients should be vaccinated on either:
 - a. a proactive call basis, if not considered at-risk, or

¹⁰⁴ NHS England. Service specification. <http://www.england.nhs.uk/commissioning/gp-contract/>

¹⁰⁵ Further guidance relating to CQRS will be provided by HSCIC when services are updated.

¹⁰⁶ Practices will be required to sign-up to CQRS in order for payment to be calculated and processed.

¹⁰⁷ 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.

¹⁰⁸ Green Book. Chapter 25. <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book> (The at-risk groups for PPV are available in pneumococcal annex)

- b. a proactive call and recall basis, if considered at-risk with the aim of maximising uptake in at-risk patients¹⁰⁹.
- 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 2016 and 31 March 2016.
- Vaccinations delivered under this ES must be with the appropriate vaccine and dosage¹¹⁰:
 - a. One dose is required for all eligible patients.
 - b. Where a patient has indicated they wish to be vaccinated for either vaccination, but are physically unable to attend the practice (eg 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 – PPV23

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.

¹⁰⁹ 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. The targets are set out in the annual flu plan. <https://www.gov.uk/government/collections/annual-flu-programme>

¹¹⁰ Green Book. Chapter 25. <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book>

The 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.

Monitoring – PPV23

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 PPV 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 GPES¹¹¹ is available. For information on how to manually enter data into CQRS, see the HSCIC¹¹² website.

For PPV23 there are three payment counts (see payment and validation). The management information counts are 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, eg if April is the reporting month then the collection will take place in May. Payment counts will be cumulative or non-cumulative monthly counts (as appropriate) from when the practice begins to deliver the programme¹¹³. 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 (ie 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'¹¹⁴ document contains the payment counts, management information counts and Read codes¹¹⁵ 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 Rules¹¹⁶ will be acceptable to allow

¹¹¹ Details relating to the availability of GPES support will be communicated via the HSCIC.

¹¹² HSCIC. Manual entry. <http://systems.hscic.gov.uk/gpcollections>

¹¹³ 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.

¹¹⁴ NHS Employers. Technical requirements for 2016/17 GMS contract changes. www.nhsemployers.org/vandi201617

¹¹⁵ Please note that the code descriptions in clinical systems may not exactly match the guidance text.

¹¹⁶ HSCIC. Business Rules. www.hscic.gov.uk/qofesextractspects

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.

Payment and validation

Practices who participate in this programme will be required to sign up to CQRS by no later than 30 June 2016.

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 12 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 month's 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 years or over as at 31 March 2017, who have received a pneumococcal vaccination by the GP practice, within the reporting period. (ie payment counts PNEU001)
- Monthly count of patients aged 2 years to 64 years on 31 March 2017 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. (ie payment count PNEU002)
- Monthly count of patients aged 2 years to 64 years on 31 March 2017 and identified as at risk by the Read code 65WB. or XaM2n "requires a pneumococcal vaccination" who have received a pneumococcal vaccination by the GP practice in the reporting period (excluding patients identified in count PNEU002). (ie payment count PNEU003)

Payment will be made based on the monthly count multiplied by £9.80. 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 specification¹¹⁷ 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 - influenza

This programme is from 1 September 2016 to 31 March 2017.

Commissioners will seek to invite GP practices to participate in this ES before 30 June 2016. Practices who participate in this ES should respond to the commissioners' offer no later than 31 July 2016. The agreement should be recorded in writing with their commissioner.

Payment and activity recording will be managed by the Calculating Quality Reporting Service (CQRS)¹¹⁸ and participating practices are required to sign-up to CQRS at the same time they accept the offer to participate in the ES – no later than 31 July¹¹⁹.

¹¹⁷ NHS England. Service specification. <http://www.england.nhs.uk/commissioning/gp-contract/>

¹¹⁸ Further guidance relating to CQRS and GPES will be provided by HSCIC when services are updated.

¹¹⁹ Practices will be required to sign-up to CQRS in order for payment to be calculated and processed.

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
 - c. patients aged six months and under two years and patients aged five to 64 years defined as at-risk in the Green Book¹²⁰; 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 patients¹²¹.
- 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 2016 and 31 March 2017, with vaccinations concentrated between 1 September and 31 December 2016.
- 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. LAIV (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 LAIV 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 LAIV.
 - e. Where a patient has indicated they wish to be vaccinated for either vaccination, but are physically unable to attend the practice (for example is housebound),

¹²⁰ 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)

¹²¹ 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.

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 - influenza

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 to 31 December 2016 in order to achieve the maximum protection to the populations. Practice may continue to vaccinate eligible patients until 31 March 2017 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 £9.80 per dose (either one or two doses as clinically appropriate) per eligible patient vaccinated.

See the Green Book for detailed information about administration and dosage¹²².

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 LAIV for all cases except where contra-indicated where an appropriate¹²³ 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.

LAIV 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 LAIV 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.

¹²² Green Book. Chapter 19. <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book>

¹²³ Practices should check that the vaccine they use is age appropriate for the patients they are vaccinating ie Fluarix Tetra is licensed for patients aged three and over only.

LAIV has a short shelf-life and doses will have a use-by date and the latest expiry date is expected to be around January/February¹²⁴. 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 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 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 children¹²⁵.

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 - influenza

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 GPES¹²⁶ is available. For information on how to manually enter data into CQRS, see the HSCIC¹²⁷ website.

There are five payment counts (see payment and validation) for this programme. The management information counts are 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, eg if October is the reporting month then the collection will take place in November. Payment counts will be cumulative or non-cumulative monthly counts (as appropriate) from when the practice begins to deliver the programme¹²⁸. 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 (ie a monthly collection would only include patients registered with the practice at the month end).

¹²⁴ As the nasal spray is a live vaccine, actual expiry dates are not yet known. Practices should check the expiry dates and use their stock accordingly.

¹²⁵ Heinonen et al., 2010.

¹²⁶ Details relating to the availability of GPES support will be communicated via the HSCIC.

¹²⁷ HSCIC. Manual entry. <http://systems.hscic.gov.uk/gpcollections>

¹²⁸ 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'¹²⁹ document contains the payment counts, management information counts and Read codes¹³⁰ 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 Rules¹³¹ 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 – influenza

Practices who participate in this programme will be required to sign up to CQRS by no later than 31 July 2016.

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 month's 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.

¹²⁹ NHS Employers. Technical requirements for 2016/17 GMS contract changes. www.nhsemployers.org/vandi201617

¹³⁰ Please note that the code descriptions in clinical systems may not exactly match the guidance text.

¹³¹ HSCIC. Business Rules. www.hscic.gov.uk/qofesextractspects

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

- Monthly count of patients aged 65 years and over on 31 March 2017, who have received a seasonal influenza vaccination by the GP practice, within the reporting period. (ie payment count SFLU001)
- Monthly count of the number of eligible patients, identified as at risk, where the risk is clearly demonstrated by at least one clinical Read code in the patients record, who have received a first dose of seasonal influenza vaccination given by the GP practice in the reporting period. (Eligible patients are aged 6 months to 64 years on 31 March 2017, excluding patients aged 2, 3 and 4 years as at 31 August 2016). (ie payment count SFLU002)
- Monthly count of the number of eligible patients, identified as at risk, where the risk is clearly demonstrated by at least one clinical Read code in the patients record, who have received a second dose of seasonal influenza vaccination given by the GP practice in the reporting period. (Eligible patients are aged 6 months to 9 years on 31 March 2017, excluding patients aged 2, 3 and 4 years as at 31 August 2016). (ie payment count SFLU004)
- Monthly count of the number of 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., who have received a first dose of seasonal influenza vaccination given by the GP practice in the reporting period. (Eligible patients are aged 6 months to 64 years on 31 March 2017, excluding patients aged 2, 3 and 4 years as at 31 August 2016). (ie payment count SFLU003)
- Monthly count of the number of 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., who have received a second dose of seasonal influenza vaccination given by the GP practice in the reporting period. (Eligible patients are aged 6 months to 9 years on 31 March 2017, excluding patients aged 2, 3 and 4 years as at 31 August 2016). (ie payment count SFLU005)

Payment for seasonal influenza and PPV23 will be made based on the monthly count multiplied by £9.80. 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 specification¹³² 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.

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 2017 (i.e. born on or before 31 March 1952).
Chronic respiratory disease aged 2 to 64 years	Asthma (only if so severe it requires continuous or frequently repeated use of systemic steroids see immunosuppression group). Chronic respiratory disease including chronic obstructive pulmonary disease (COPD), chronic bronchitis, 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 aged 2 to 64 years	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

¹³² NHS England. Service specification. <http://www.england.nhs.uk/commissioning/gp-contract/>

Eligible groups	Further details
aged 2 to 64 years	transplantation. (Re-immunisation is recommended every 5 years) ¹³³ .
Chronic liver disease aged 2 to 64 years	Chronic liver disease, cirrhosis, biliary atresia, chronic hepatitis.
Diabetes aged 2 to 64 years	Diabetes mellitus requiring insulin or oral hypoglycaemic drugs NOT diabetes that is diet controlled.
Immunosuppression & asplenia or dysfunction of the spleen aged 2 to 64 years	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 at all stages, multiple myeloma or genetic disorders affecting the immune system (e.g. IRAK-4, NEMO, complement deficiency) and individuals likely to be on 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. (Re-immunisation is recommended every five years for individuals with asplenia or splenic dysfunction).
Individuals with cochlear implants aged 2 to 64 years	It is important that immunisation does not delay the cochlear implantation.
Individuals with cerebrospinal fluid leaks e.g. following trauma or major skull surgery aged 2 to 64 years	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.

¹³³ For those patients requiring a PPV vaccination every five years, practice should make arrangements with their local commissioner with regards to payment. This ES only provides automatic payment for the first dose delivered.

Seasonal influenza annex

Groups included in the national seasonal influenza immunisation programme as defined in the annual flu plan¹³⁴ and Green Book

Eligible groups	Further details
All patients aged 65 years and over	"Sixty-five and over" is defined as those aged 65 years and over on 31 March 2017 (ie born on or before 31 March 1952).
Chronic respiratory disease aged 6 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 6 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 (eg polio syndrome sufferers). Clinicians should offer immunisation to all patients with a learning disability ¹³⁵ . 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 6 months and over	Type 1 diabetes, Type 2 diabetes requiring insulin or oral hypoglycaemic drugs, diet controlled diabetes.

¹³⁴ PHE. Seasonal influenza. <https://www.gov.uk/government/collections/annual-flu-programme>

¹³⁵ 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 LAIV is not licensed for adults so practice should attempt to vaccinate using an injectable vaccine. Previously, it has been found that LAIV 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 LAIV vaccine off license.

Eligible groups	Further details
Immunosuppression aged 6 months and over	<p>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 (eg IRAK-4, NEMO, complement deficiency).</p> <p>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.</p> <p>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.</p> <p>Some immune-compromised patients may have a suboptimal immunological response to the vaccine.</p>
Asplenia or dysfunction of the spleen aged six months and over	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).
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	Where locum GPs wish to be vaccinated, they should be vaccinated by their own GP (<i>all other GP's and primary care staff are the responsibility of their employer as part of occupational health arrangements</i>).

* 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^{136, 137}.

Influenza and pneumococcal annex: Vaccines and dosage

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 - (individuals with CKD, asplenia or splenic dysfunction re-immunise every 5 years)
65 and over	PPV23	1 single dose - (individuals with CKD, asplenia or splenic dysfunction re-immunise every 5 years)

Seasonal influenza vaccination programme (as defined in the annual flu plan¹³⁸)

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	LAIV 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	LAIV 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

¹³⁶ Only those patients eligible for vaccination as defined in this ES specification will be paid for under this ES.

¹³⁷ 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.

¹³⁸ PHE. Seasonal influenza. <https://www.gov.uk/government/collections/annual-flu-programme>

Eligible groups	Vaccine	Dosage
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.

Shingles (routine aged 70) vaccination programme

Background and purpose

The incidence of shingles in England and Wales is estimated to be around 790 to 80 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^{139, 140}.

In March 2010, the JCVI recommended that patients aged 70 to 79 (inclusive) should be routinely offered vaccination against shingles.

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 shingles routine 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. However, patients aged 70 on or after 1 September 2013 remain eligible until their 80th birthday. Therefore the date of birth range for patients eligible to receive the shingles vaccination under this ES is 2 September 1942 to 1 September 1946.

Vaccinations and immunisations are an additional service under the GMS contract. The GMS Contract for 2016/17 includes an item of service at £9.80 payment for each dose.

Further details on background to the programme, dosage, timings and administration can be found in the Green Book¹⁴¹.

Requirements

This programme is for one year from 1 September 2016 until 31 August 2017. For guidance for the 2016/1 programme (1 September 2015 until 31 August 2016) please see the 2015/16 guidance¹⁴².

Commissioners will seek to invite GP practices to participate in this ES before 30 June 2016. Payment and activity recording will be managed by CQRS¹⁴³ and participating practices are required to sign-up to CQRS no later than 31 July¹⁴⁴.

Practices are required to:

- Provide vaccination to all eligible patients aged 70 but not yet 71 on 1 September 2016, who have not previously had a shingles vaccination, who present to the practice requesting vaccination and on an opportunistic basis.

¹³⁹ Green Book. Chapter 28a. <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book>

¹⁴⁰ van Hoek et al., 2009

¹⁴¹ Green Book. Chapter 28a. <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book>

¹⁴² NHS Employers. Vaccination and immunisations guidance 2015/16 guidance and audit requirements. www.nhsemployers.org/vandi201516

¹⁴³ Further guidance relating to CQRS will be provided by HSCIC when services are updated.

¹⁴⁴ Practices will be required to sign-up to CQRS in order for payment to be calculated and processed.

- 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.

Under the GMS contract for 2016/17, providers of this programme will be paid an item of service payment of £9.80 for each previously unvaccinated patient who receives the routine shingles vaccination within the period 1 September 2016 until 31 August 2017.

This vaccination programme comprises a single injection. 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

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

Practices will be required to manually input data into CQRS, on a monthly basis, until GPES¹⁴⁵ is available. For information on how to manually enter data into CQRS, see the

¹⁴⁵ Details relating to the availability of GPES support will be communicated via the HSCIC.

HSCIC¹⁴⁶ website.

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, eg if October is the reporting month then the collection will take place in November. Payment counts will be cumulative or non-cumulative monthly counts (as appropriate) from when the practice begins to deliver the programme¹⁴⁷. 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 (ie 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'¹⁴⁸ document contains the payment counts, management information counts and Read codes¹⁴⁹ 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 Rules¹⁵⁰ 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 July 2016.

Claims for payments for this programme should be made monthly, after the dose has been administered. Where claims are entered manually, this should be within 12 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 month's activity before the collection occurs. Activity recorded after the

¹⁴⁶ HSCIC. Manual entry. <http://systems.hscic.gov.uk/gpcollections>

¹⁴⁷ 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.

¹⁴⁸ NHS Employers. Technical requirements for 2016/17 GMS contract changes. www.nhsemployers.org/vandi201617

¹⁴⁹ Please note that the code descriptions in clinical systems may not exactly match the guidance text.

¹⁵⁰ HSCIC. Business Rules. www.hscic.gov.uk/qofesextractspecs

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.

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

- Monthly count of the number of registered patients aged 70 years at any point between 1 September 2013 and 1 September 2016 (inclusive), who have a record of receiving a shingles vaccination by the GP practice within the reporting period. (ie payment count SHROU01)

Payment will be made based on the monthly count multiplied by £9.80.

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 ie 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 SFE¹⁵¹ 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.).

¹⁵¹ DH. SFE. <https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013>

Shingles (catch-up) vaccination programme

Background and purpose

In March 2010, the JCVI recommended that patients aged 70 to 79 (inclusive) should be routinely offered vaccination against shingles.

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 2016 to 31 August 2017¹⁵² for patients aged 78 on 1 September 2016. Patients eligible for vaccination under this programme since it was introduced, remain eligible for vaccination until their 80th birthday.

Payment of £9.80 for each dose of shingles 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 Book¹⁵³.

Requirements

This programme is for one year from 1 September 2016 until 31 August 2017. For guidance for the 2015/16 programme (1 September 2015 until 31 August 2016) please see the 2015/16 guidance¹⁵⁴.

Commissioners will seek to invite GP practices to participate in this ES before 30 June 2016. Practices who participate in this ES should respond to the commissioners' offer no later than 31 July 2016. The agreement should be recorded in writing with their commissioner.

Payment and activity recording will be managed by the CQRS¹⁵⁵ and participating practices are required to sign-up to CQRS at the same time they accept the offer to participate in the ES – no later than 31 July¹⁵⁶.

Practices are required to:

- Provide vaccination to eligible patients who are aged 78 years on 1 September 2016, 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.

¹⁵² NHS England. Service specification. <https://www.england.nhs.uk/commissioning/gp-contract/>

¹⁵³ Green Book. Chapter 28a. <https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book>

¹⁵⁴ NHS Employers. Vaccination and immunisations guidance 2015/16 guidance and audit requirements. www.nhsemployers.org/vandi201516

¹⁵⁵ Further guidance relating to CQRS and GPES will be provided by HSCIC when services are updated.

¹⁵⁶ Practices will be required to sign-up to CQRS in order for payment to be calculated and processed.

- Record all administered doses on ImmForm and where suitable IT systems exist all doses administered are uploaded by automated collections.

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 2016 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 2016 will not be eligible for shingles vaccination under this ES.

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

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

Practices will be required to manually input data into CQRS, on a monthly basis, until GPES¹⁵⁷ is available. For information on how to manually enter data into CQRS, see the HSCIC¹⁵⁸ website.

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

¹⁵⁷ Details relating to the availability of GPES support will be communicated via the HSCIC.

¹⁵⁸ HSCIC. Manual entry. <http://systems.hscic.gov.uk/gpcollections>

reporting month will be the month prior to the collections month, eg if October is the reporting month then the collection will take place in November. Payment counts will be cumulative or non-cumulative monthly counts (as appropriate) from when the practice begins to deliver the programme¹⁵⁹. 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 (ie 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'¹⁶⁰ document contains the payment counts, management information counts and Read codes¹⁶¹ 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 Rules¹⁶² 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 July 2016.

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 month's 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.

¹⁵⁹ 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.

¹⁶⁰ NHS Employers. Technical requirements for 2016/17 GMS contract changes. www.nhsemployers.org/vandi201617

¹⁶¹ Please note that the code descriptions in clinical systems may not exactly match the guidance text.

¹⁶² HSCIC. Business Rules. www.hscic.gov.uk/qofesextractspecs

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.

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

- Monthly count of the number of registered patients who are aged 78 or 79 years (but who have not attained the age of 80 years) on 1 September 2016, who have a record of receiving a shingles vaccination by the GP practice within the reporting period and who were not aged 80 years at the point of vaccination. (ie payment count SHCUP01)

Payment will be made based on the monthly count multiplied by £9.80.

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 (ie 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 specification¹⁶³ 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

¹⁶³ NHS England. Service specification. <http://www.england.nhs.uk/resources/d-com/gp-contract/>

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

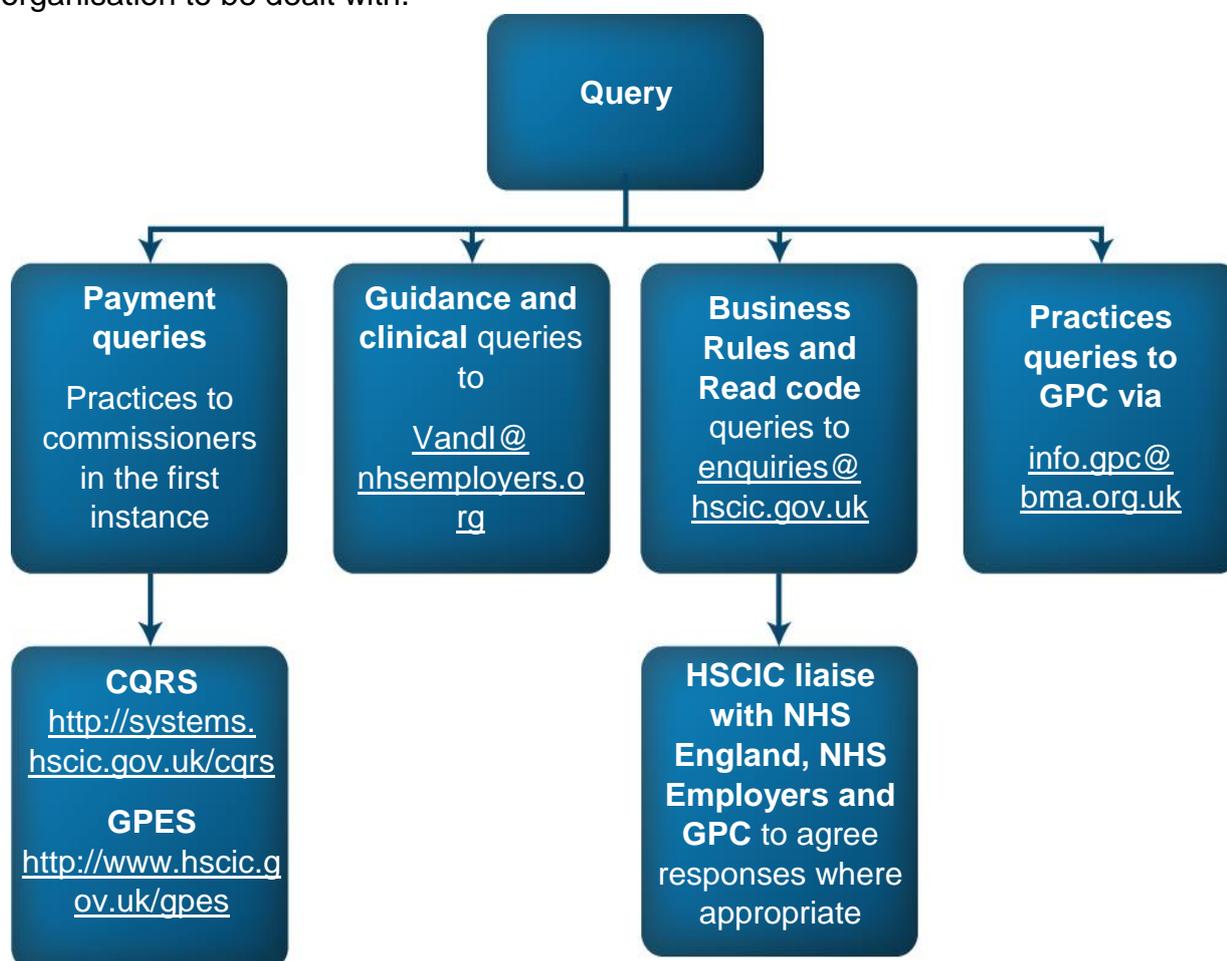
Payments made under this ES, or any part thereof, will be made only if practices satisfy the conditions set out in the NHS England service specification.

Section 5. Queries

Queries can be divided into three main categories:

1. those which can be resolved by referring to the specification, guidance or FAQs¹⁶⁴,
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.



¹⁶⁴ 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

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