Southwark Immunisation Strategy and Action Plan 2019-2021

Improving uptake, reducing inequalities

Health Protection
Southwark Public Health Division
Place & Wellbeing Department

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GATEWAY INFORMATION

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GLOSSARY

CCG	Clinical Commissioning Group
CHIS	Child Health Information System
DoH	Department of Health
EVAP	European Vaccine Action Plan
GP	General Practice
HPV	Human Papilloma Virus
HRCH	Hounslow and Richmond Community Healthcare
JCVI	Joint Committee on Vaccination and Immunisation
JSNA	Joint Strategic Needs Assessment
MMR	Measles, Mumps and Rubella vaccine
NHSE	National Health Service England
NICE	National Institute of Health and Care Excellence
PACT	Parents and Communities Together Group
PHE	Public Health England
PPV	Pneumococcal Polysaccharide Vaccine
QoF	Quality and Outcomes Framework
SIT	Screening and Immunisation Team
TB	Tuberculosis
WHO	World Health Organization

CONTENTS

EXECUTIVE SUMMARY

This Immunisation Strategy and Action Plan lays down our vision for Southwark to improve coverage of vaccination programmes across the life course to protect population health and reduce inequalities.

Immunisation programmes are the safest and most cost-effective way of protecting individuals and communities from vaccine preventable diseases. Nevertheless, coverage locally in Southwark for several vaccine programmes has fallen below both locally and nationally agreed targets and there is unequivocal agreement that there are actions that could be taken to help increase immunisation coverage.

The 3 main reasons for this decline in Southwark are similar to national and international drivers related to widening inequalities, growth of underserved groups and creation of "vaccine hesitant" clusters fed by misinformation.

Through a strategic, Southwark-wide partnership approach, we have developed an action plan with 5 key priority areas that we need to focus on over the next two years (2019-2021) to achieve our vision. Our actions are evidence based where possible and cover the whole pathway of immunisation programmes across the life course, as well as addressing inequalities. There is a particular focus on programmes where uptake should be improved, for example MMR, hepatitis B in high risk children, shingles, flu and HPV.

To achieve our vision, we have set ourselves an ambition to achieve a 5% relative increase in coverage for each programme (based on the most recent coverage data) by March 2021. Where this 5% relative increase exceeds the London target, the London target has been used.

Our **5 priority areas** detailed below have embedded, evidence based actions within them:

1. **Reducing inequalities and improving uptake in the underserved –** this involves ensuring the needs of people who may be disadvantaged or suffer inequality leading to or arising from reduced immunisation uptake are addressed as a priority. This includes a wide range of population groups in Southwark potentially less likely to access immunisations, such as home-schooled and looked-after children, certain minority ethnicity groups and the travelling community. Evidence supports the need to first understand how these groups access services before tailoring specific interventions to each population. Our action plan encompasses both mapping exercises and specific interventions such as introducing a council-led programme that would ensure home schooled children are able to access school-aged immunisations.

2. **Community engagement and promotion –** we want to work closely with a range of community groups to provide information, dispel myths and effectively engage groups who may be 'vaccine hesitant' about vaccination programmes. Central to tackling this is a need for community engagement and promotion based around improved communication strategies and effective clinical and political leadership. Our actions involve targeted work and campaigning in both healthcare as well as non-healthcare settings such as nurseries, schools and Southwark community groups such as PACT (Parents and Communities) to help communities empower themselves to be well-informed about immunisations.

3. **Data sharing and quality improvement -** the timeliness and quality with which information on administration of immunisations from providers travels through onto local and national

reporting systems has been identified as an area for improvement. Our actions here include working with providers to improve timely and accurate data flow through developing best practice guidance as well a suite of actions to develop improved processes for information sharing and governance.

4. **Service delivery, call and recall –** a systematic multicomponent call/recall system is fundamental to achieving good immunisation coverage. Breaking down Southwark immunisation coverage data into practice and school level highlights significant variation across these settings, and a clear need for action. Our actions involve sharing learning from high coverage practices and schools with those doing less well but also strategic improvement of specific processes such as ensuring timely administration of hepatitis B in high risk infants.

5. **Guidance, training and development** - fundamental to delivery of immunisations within the healthcare system is the adequate training and development of healthcare staff and timely feedback on performance. Our actions involve supporting not only staff directly involved in administration but those staff who will be in positions to make every contact count and raise awareness about immunisations such as health visitors, pharmacists, doctors in addition to nursing and practice staff.

An Immunisation Implementation Group will be set up to drive forward the actions contained within the plan and continually monitor progress. This group will report into the Lambeth & Southwark Immunisation Steering Group, which in turn is accountable to the CCG Quality & Safety Committee. To achieve our vision, the process will continue to be a partnership approach with group representation from local commissioners, public health teams and providers with a collective desire to improve immunisation coverage in Southwark, protect our population and reduce inequalities.

FOREWORD

Immunisation programmes are the second most effective public health intervention after clean water. They have saved and bettered lives globally, nationally and within our borough of Southwark as well.

Effective immunisation programmes help ensure we are giving every child in Southwark the best start in life by protecting them against avoidable diseases, a commitment enshrined in our Southwark Health and Wellbeing Strategy. However, even beyond these early years, immunisation through school-years and into adulthood continue to prevent and protect against serious illnesses like cervical cancer, shingles and influenza.

Unfortunately, recent years have seen a decline in coverage of several vaccines across Southwark. This mirrors regional and global patterns and has resulted in several preventable disease outbreaks, particularly for both measles and mumps. This can have devastating consequences for families and communities. These trends are highly worrying, and this strategy sets out our shared vision in Southwark to improve vaccination coverage and population health, detailing how we intend to reverse these declines.

The causes for decline in vaccination coverage seen in Southwark are common to many other London boroughs and developed countries as well. The fall has been fuelled by the increasing spread of disinformation and “fake news” through social media and news outlets, scaremongering communities through stories of discredited, adverse impacts of vaccinations thereby creating “vaccine hesitant” clusters. However an equally important contributing factor in Southwark in particular, due to the diversity of our community, are widening societal inequalities. These have led to a generation of underserved groups, less likely to recognise they are eligible and take up vaccinations, putting them at greater risk of these serious diseases.

Our Immunisation Strategy for Southwark builds upon comprehensive learning identified from needs assessments completed across the lifecourse, using the evidence-base to inform action. It has been built and will be implemented through a partnership approach bringing together members from across Southwark Council, Southwark Clinical Commissioning Group, wider healthcare system partners and providers as well as community groups and the public. The work is particularly timely, as it gives us an opportunity to reverse problems in Southwark before they significantly worsen, synchronising well with objectives nationally such as with the NHS Long term plan, that has pledged to prioritise improvements in childhood vaccination coverage.

We greatly welcome this timely, partnership approach to tackling declining immunisation coverage, with a view to improving health and reducing inequalities in Southwark.

Professor Kevin Fenton
Strategic Director of Place and Wellbeing
Southwark Council

Dr Rob Davidson
GP and Clinical Vice Chair
NHS Southwark CCG

1. INTRODUCTION

"The two public health interventions which have had the biggest impact on health are clean water and vaccinations"
(World Health Organisation)

Background

Immunisation programmes are the safest and most cost-effective way of protecting individuals and communities from vaccine preventable diseases.[1] They aim to prevent disease at the individual level and also to achieve a level of population coverage that confers herd immunity; a form of indirect protection that occurs when a large percentage of the population has become immune to an infection.[1, 2]

Immunisation programmes have been an integral part of health services and public health for over 200 years since the ground-breaking discovery by Edward Jenner of the small pox vaccine. They have evolved rapidly and expansively in a relatively short space of time and are considered one of the greatest public health interventions in terms of measurable impact on population morbidity and mortality. According to the World Health Organization (WHO), an estimated 2-3 million deaths from diphtheria, tetanus, pertussis and measles are averted each year worldwide due to immunisations while some diseases like smallpox have been completely eradicated.[1, 2]

In England, the impact of immunisations has been equally significant. In the 1950s, England had nearly 120,000 cases of pertussis annually; by 2011 vaccination had reduced this to just 1500 cases. There were more than 60,000 cases and 3,800 deaths from diphtheria in the UK in 1940s but by 2017, this had reduced to 5 reported cases annually.[3] More recently, the HPV vaccine introduced ten years ago has been shown to reduce HPV infection by 86% and consequently a potential risk of cervical cancer by 70%.[4]

Recent challenges

Despite the success of vaccination programmes, recent years have seen a global decline in coverage leading to several national and international preventable disease outbreaks. For example, despite the UK achieving measles elimination status in 2017, we continue to see outbreaks both in the UK and in other developed countries, particularly in unvaccinated or partially vaccinated individuals.

This decline in vaccination coverage has been fuelled by a growth in the systematic spread of disinformation and "fake news" through social media and the internet which has created "vaccine hesitant" clusters who are reluctant to immunise or outright refuse immunisations.[5, 6] The greatest trigger for growth of these hesitant clusters has been the spread of disinformation in relation to the highly discredited link between MMR and autism as well as concerns about stigma and adverse effect profiles of certain vaccines such as HPV, despite well-evidenced efficacy and safety profiles.[6]

Widening societal inequalities have led to generation of underserved groups less able or willing to access immunisations due to a variety of barriers such as fear, distrust, language , poor health literacy, marginalisation or poor access to health services. Underserved populations are defined as those whose social circumstances, language, culture or lifestyle make it less likely

they will recognise they are eligible for vaccination and access health services.[7] Immunisation uptake has been shown to be lowest in poorer families, those from minority ethnic backgrounds and those who may find it more challenging to access services such as the very elderly and children with learning and physical disabilities.[8] The added concern is that if such low coverage patterns continue, they only risk exacerbating health inequalities further through a rise in incidence in preventable diseases at both the individual level and population level due to loss of benefits associated with herd immunity.

Why we need a local strategic action plan

Recent work undertaken in Southwark has identified that local vaccination coverage for several vaccines has also declined and some have now fallen below both locally and nationally agreed targets.[9-11]

The reasons driving a decline in coverage in Southwark across particular vaccines are similar to national and international causes related to widening inequalities, growth of underserved groups and creation of "vaccine hesitant" clusters fed by misinformation. The challenge for Southwark may indeed be greater, given existing inequalities in the borough, high prevalence of known underserved groups and the fact that global warnings and recent disease outbreaks highlight greater challenges may lie ahead.

Collectively, this means there is an urgent need for local strategic action and leadership to combat these declining coverage trends and protect our population against preventable diseases.

2. OUR VISION

Our vision is to improve coverage in vaccination programmes across the life course to protect population health and reduce inequalities, by addressing barriers to uptake and improving access to services

Our strategic approach integrates national, regional and local policy objectives to ensure we take a collaborative whole-systems approach to improving immunisation coverage. This involves bringing together all partners involved in commissioning, quality assurance and provision of immunisations in Southwark as depicted below in Figure 1.

To realise our vision, ambitions for improvement have been set and a detailed action plan focussed around priority areas for action has been developed to achieve this by 2021.

The action plan outlines the work that partners are doing currently plus key proposed actions that will improve access to immunisations, combat vaccine hesitancy, increase overall uptake while reducing inequalities.

It does not include travel vaccinations or flu vaccinations in health and social care workers.

Addressing our Public Sector Equality Duty

The equality duty of public sector organisations was created under the Equality Act 2010.[12] Under the Act, all public sector organisations have a duty to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

In order to achieve this, we must:

- Remove or minimise disadvantages suffered by people due to their protected characteristics.
- Take steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encourage people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Addressing inequality is a key feature throughout this Strategy and all actions undertaken will have due regard to our duties under the Act. Indeed, our first priority area for action focuses on reducing inequalities and improving immunisation coverage in the underserved.

Structure of the action plan

We have identified the five key priority areas that we need to focus on in order to achieve our vision over the next two years (2019-2021):

- Reducing inequality and improving uptake in the underserved
- Community engagement and promotion
- Data sharing and quality improvement
- Service delivery, call and recall
- Guidance, training and development

For each of these areas, the evidence about what might work has been reviewed (Section 9) and detailed actions developed. Section 10 summarises the actions, along with desired outputs, key leads and timelines.

Our ambitions

To achieve our vision, we have set ourselves an ambition to achieve a 5% relative increase in coverage based on the most recent coverage data known for each immunisation by March 2021. Where this 5% relative increase exceeds the London target, the London target has been used.

The rationale for choosing these targets is to ensure they are ambitious but potentially achievable and ultimately result in positive trajectories for all immunisations across the life course and progressively higher uptake than previous years.

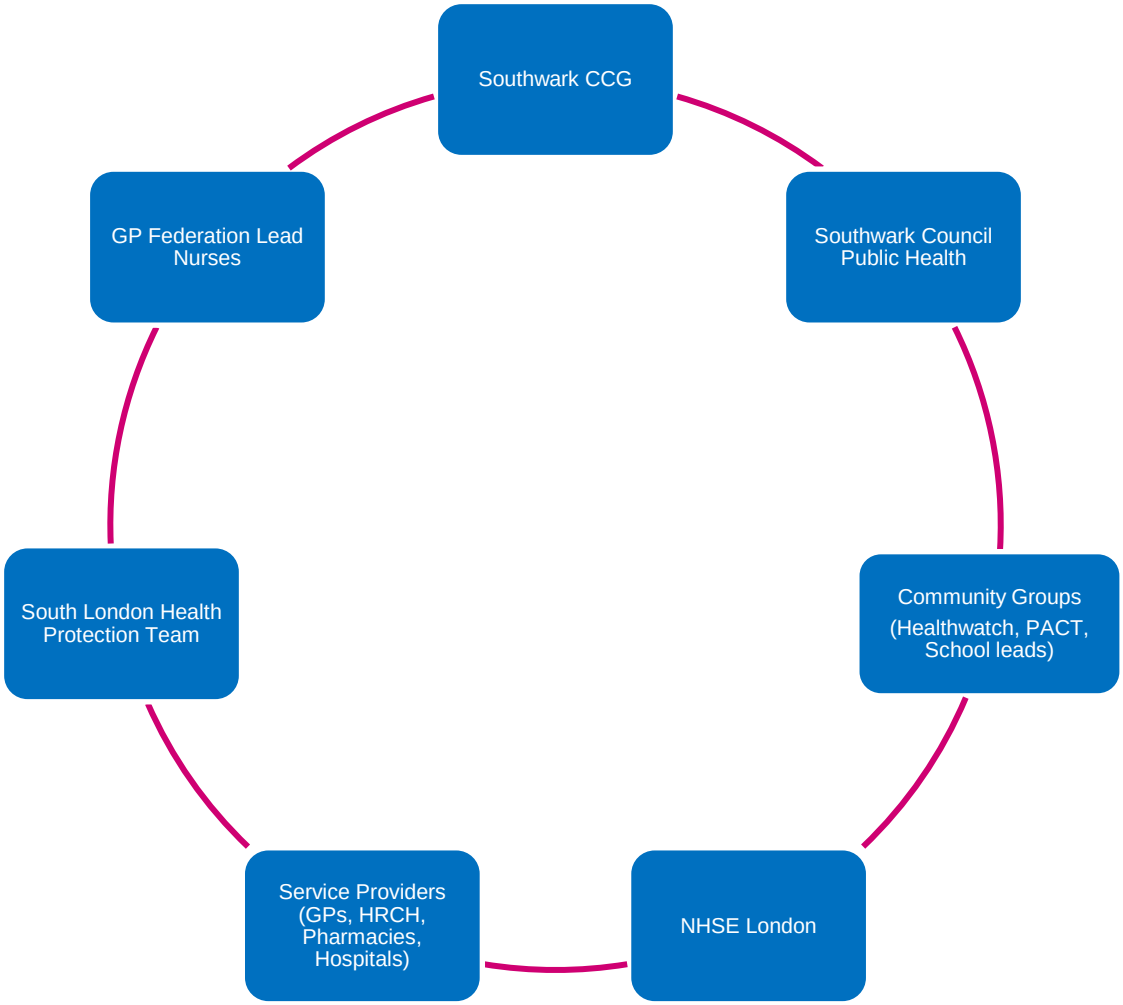


Figure 1: Stakeholders involved in Southwark Immunisation Strategic Action Plan

HRCH= Hounslow and Richmond Community Health Care (School-aged Immunisation Providers
PACT= Parents and Communities Together (led by Citizens UK, with an aim to improve health for babies in Southwark)[13]

3. IMPLEMENTATION AND GOVERNANCE

Stakeholders involved in the development of this strategy are committed to taking action to improve coverage.

An implementation group will be set up to drive forward the actions at the operational level. The membership of the team is detailed in Table 1 below and will work closely with stakeholders from Southwark Local Authority (e.g. education, communications), CCG Teams (e.g. medicines optimisation), NHSE London, GSTT Community and LAC teams, as well as Community Southwark and Healthwatch as needed for specific actions.

Table 1: Action Plan Implementation Group membership

Role	Organisation
Head of Programmes: Health Protection	Southwark Council Public Health
Primary Care Commissioning Manager	Southwark CCG
Clinical Vice-Chair and Children's Lead	GP and CCG
Consultant in Communicable Disease Control	South London Health Protection Team
Practice Nurse Leads	Southwark North & South Federations
Development and Information Manager	Southwark North Federation (Quay Health Solutions)
Southwark School Immunisation Provider Lead	Hounslow & Richmond Community Healthcare
Specialty Registrar in Public Health (Rotational)	Southwark Council Public Health

Given the volume of actions to be undertaken and staff capacity that will be needed to implement them, it is the combined knowledge, expertise and resource of members of the implementation group from across the healthcare system that will be essential in driving this work forward.

Actions will be prioritised at the first implementation group meeting ensuring workload is fairly distributed and leaders assigned to different workstreams and suites of actions as effectively as possible.

The existing Lambeth & Southwark Immunisation Steering Group will be responsible for providing senior oversight and will monitor progress against the action plan at each meeting and resolve or escalate issues communicated by the implementation team.

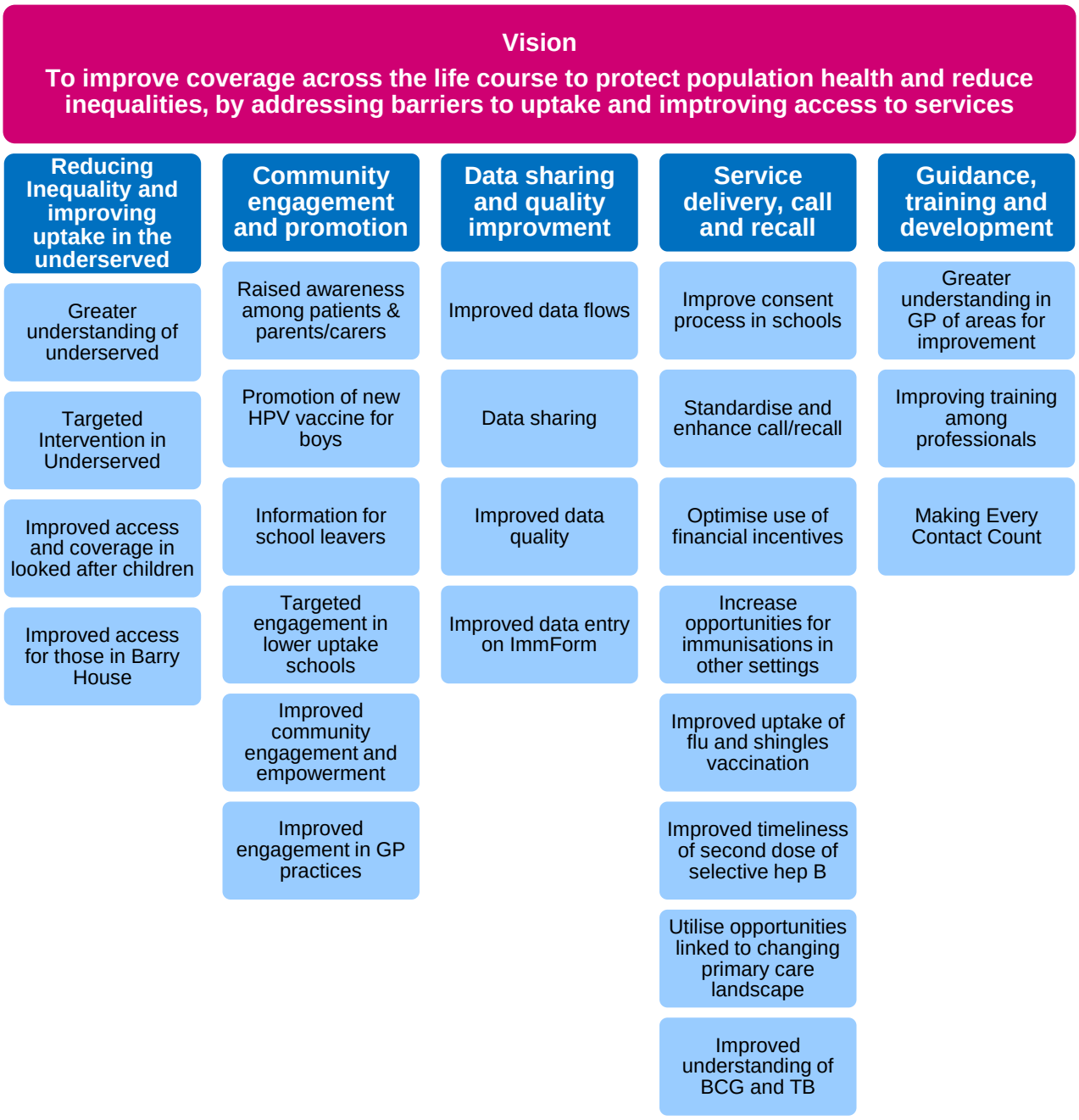
The Steering Group are accountable to the CCG Quality & Safety Committee who will be kept informed of progress via the quarterly report submitted

4. COMMUNICATION AND DISSEMINATION

This strategy and action plan will be signed off by the CCG Integrated Governance and Performance Committee following the meeting in April 2019. It will then be circulated to stakeholders and implementation will commence from May 2019, when the first implementation group meeting will be scheduled.

5. PLAN ON A PAGE

The plan on a page for our Immunisation Strategy and Action plan is depicted below and outlines our vision, 5 priority areas and the outputs we hope to achieve within each. Further detail on priority areas, outputs and actions is provided in Sections 9 and 10.



6. POLICY CONTEXT

National policy

The World Health Organisation (WHO) immunisation work in Europe is guided by the European Vaccine Action Plan 2015-2020 (EVAP), which was adopted in 2014 and includes commitments to eliminate measles and rubella and control hepatitis B infection.[2] In addition, WHO provides

some coverage targets for member states, for example that >95% of children should be immunised against diphtheria, tetanus, pertussis, and other vaccine-preventable childhood conditions.

In the UK, responsibility for driving strategy and policy falls on the Joint Committee on Vaccination and Immunisation (JCVI). They liaise with a multiplicity of organisations across the health service to help oversee delivery and expansion of the vaccination programmes as shown in Table 2.

The NHS immunisation schedule is devised on recommendations of the JCVI and encompasses vaccination across the life course (Table 3). The importance of immunisations is highlighted in the NHS Long term plan where improvement in childhood immunisation coverage is cited as a major priority.[14]

The national delivery framework and local operating model has been agreed jointly by Department of Health, NHS England, local government and Public Health England to set out how immunisation programmes in England are coordinated under the NHS Public Health Section 7a agreement. [15] Under Section 7A, immunisations are directly commissioned by NHS England in order to develop a unified national approach though some flexibility is allowed to facilitate innovation and address specific challenges faced within communities.

Table 2: Organisations involved in immunisation policy development, quality assurance and service delivery in the UK

JCVI, PHE, NICE	Programme-level clinical policy-making, including the vaccination schedule
Department of Health	National strategic oversight, policy and finance of national programmes
PHE	Working with NHS England to improve and sustain the successful delivery of existing programmes. Communicating clinical policy updates
NHS England	Routine commissioning of national screening and immunisation programmes
SIT	Ensuring that immunisation services commissioned by NHS London area team meet national service specifications
Local Authority public health	Independent scrutiny and challenge of immunisation arrangements of NHSE, PHE and providers. Responsibility for the health of the local population and for reducing health inequalities
CCGs	A duty of quality improvements regarding immunisation programmes delivered by primary care providers
Primary care providers	Contractual obligation for service delivery

JCVI: Joint Committee on Vaccines and Immunisation
PHE: Public Health England
NICE: National Institute for Health and Care Excellence
SIT: Screening and Immunisation Team
CCG: Clinical Commissioning Group

Public Health England is responsible for producing the service specifications for the individual immunisations included as part of Section 7a, providing scientific, rigorous impartial advice, evidence and analysis to NHS England's commissioning teams as well as publishing the Public Health Outcomes Framework.[16]

Table 3: NHS immunisation schedule (Autumn 2018) by JSNA age group

JSNA Age Group	Schedule	Vaccine	Doses	Administered at	Diseases protected against
Pre-school (0-3yrs)	Routine	DTaP/IPV/Hib/Hep B (6-in-1)	3	8,12 and 16 weeks	Diphtheria, tetanus, pertussis, polio, Haemophilus influenza type b (Hib), Hepatitis B
		PCV	3	8, 16 weeks and 1 year	Pneumococcal disease
		Rotavirus	2	8 and 12 weeks	Rotavirus gastroenteritis
		Men B	3	8, 16 weeks and 1 year	Meningococcal group B
		Hib/MenC	1	1 year	Meningococcal group C plus Hib
		MMR*	2	1 year and 3 years and 4 months*	Measles, mumps and rubella
		DTaP/IPV booster (4-in-1)	1	3 years	Diphtheria, tetanus, pertussis, polio
		Flu	1	All children aged 2 & 3 yo	Influenza
	Selective	Hep B¥	3	3 additional doses at birth, 4 weeks and 1 year ¥	Hepatitis B
		BCG§	1	Up to 1 year to high risk babies §	Tuberculosis
		Flu	1	Children at-risk (6mths-17 yo)	Influenza
School-aged (4-16yrs)	Routine	Td/IPV (Booster)	1	14 years (Year 9)	Tetanus, polio
		HPV**	2	Girls aged 12-13 years (1st dose in School year 8, second 6-12 months later)	cervical cancer, genital warts
		Men ACWY***	1	14 years (Year 9)***	Meningococcal groups A, C, W and Y disease
	Selective	Flu	1	Reception to Y5	Influenza
Adults (17+ yrs)	Routine	Pneumococcal (PPV)	1	65 years and over	Pneumococcal disease
		Shingles (Herpes Zoster)	1	70/78 yrs or who missed until age of 80	Shingles
		Maternal pertussis	1	Pregnancy after 16-weeks (ideally before 32 weeks)	Pertussis (in infants)
	Selective	Flu	1	Adults 'at-risk'* (17– 64 yo), Older Adults (65+) and Pregnancy	Influenza

* **MMR -** Since 2008, Southwark has recommended an accelerated schedule of dose 2 of MMR from 18 months (but at least 3 months after first immunisation) rather than at 3 years 4 months in the NHS immunisation schedule**.**
¥ **Hep B** in at-risk groups - 1 dose of monovalent (Engerix B) in hospital at birth and 2 doses in GP at 4 weeks and 52 weeks alongside a blood test for Hep B surface antigen. These doses are in addition to normal Hep B included in routine schedule in 6 in 1
§ **BCG** - This is also recommended for older children as an opportunistic vaccination (no call/recall) aged 1-16 years who have an increased risk of developing tuberculosis (TB), such as children with parent/grandparent born in countries with high levels of TB (≥40/100,00), children who have lived in countries with high levels of TB for >3 months and those who have come into close contact with somebody infected with smear-positive pulmonary or laryngeal TB. Children aged 5-16 years must also be confirmed to be tuberculin negative through testing. BCG vaccination is rarely given to anyone over the age of 16 – and never over the age of 35, as it doesn't work well in adults.
**** HPV** - Girls who miss either of their HPV vaccine doses are still entitled to the vaccine on the NHS up to their 18th birthday. HPV will start being offered to school aged boys in the near future.
*** **Men ACWY** - vaccination is also offered by GPs to first-time college and university students who haven't already had the vaccination in school

For those delivering vaccinations, Immunisation against infectious disease (The Green Book) provides a comprehensive, online resources with up to date information about these vaccinations in the UK.[17]

Regional policy

NHS England (London) immunisation team facilitate the commissioning of the Section 7a agreement across London.[16] Organisations within the local health economies (CCGs, PHE, Local Authorities, Defence Medical Services, and NHS England) then work together across the whole pathway to follow evidence based approaches to implementation of immunisations put forward by the JCVI. These pathways can be used in contracting with providers, aligning incentives and accountability for outcomes.

Providers commissioned for immunisation services include GPs, school vaccination teams, pharmacies and maternity services and they deliver these programmes according to the national service specifications.

Clinical Commissioning Groups (CCGs) have a duty of quality improvement and this extends to primary medical care services delivered by GP practices for immunisation. The flow of funding and contracts regarding immunisations is also via CCGs, however the NHS England area team remain the commissioning body.[15]

Local Government is the leader of the local public health system and is responsible for improving and protecting the health of local people and communities. This often involves collaborative work with CCGs in quality assurance of immunisation programmes.

NHSE (London) have set up a London Immunisation Partnership Board which helps oversee delivery of vaccination programmes, undertake “deep dive” exercise to quality assure programmes and strategically develop coordinated actions to be implemented at the regional level to improve problem areas. They published a 2-year Immunisation plan for London in

2017/18 to improve immunisation uptake and coverage and set out targets within London for individual vaccinations. The overall aims of this plan are to:

- Improve information management systems and data management across London
- Improve provider performance with specified immunisation targets
- Increase patient choice and access
- Capture patient views and experience
- Implement best-practice in call/recall

Local policy

The Southwark Health and Wellbeing Strategy 2015-2010 lists ensuring the best possible start to life for children, young people and their families as a major priority. Falling immunisation coverage in specific areas like MMR are acknowledged as important areas for action.[18]

Locally, Southwark also hosts a joint Lambeth & Southwark Immunisation Steering Group which is responsible for overseeing, scrutinising, and challenging arrangements between NHSE (London) and local providers. Functions include:

- Monitoring local coverage data and making recommendations for action.
- Scrutinising and challenging the arrangements of NHSE, PHE and providers.
- Addressing inequalities and improving access to underserved groups.
- Reviewing and updating a Lambeth and Southwark Immunisation risk log identifying areas for action and concern
- Providing assurance to the Director of Public Health of local immunisation programme quality.

The group consists of local representatives from Public Health teams, South London Health Protection Team, CCGs, NHSE (London) as well as providers, clinical and service management colleagues. It is accountable to the Southwark CCG Quality and Safety sub-Committee which in turn is accountable to the CCG Governing Body.

Within the Southwark GP contracts, key performance indicators (KPIs) have been added to the premium specification to incentivise practices to meet national targets. The KPIs relate to:

- Percentage of eligible adults aged 65 or over who have received a flu vaccination
- Percentage of eligible children who have received 3 does of the DTap / IPV/ Hib/HepB vaccine at any time by 24 months

In addition to this, the general practice quality outcome framework (QOF) also measures the percentage of patients with long term conditions that have received an annual flu vaccination.

7. IMMUNISATION DATA

Time trends for all immunisations delivered as part of the NHS immunisation schedule (where data is available in the public domain) are displayed in Tables 4-6 for the three financial years between 2015-2018.

Our ambition for improvement is included along with the London target.

Pre-school immunisations (0-3 years)

Immunisations in pre-school children are mostly delivered in primary care. Exceptions are BCG in babies which is delivered on behalf of the maternity unit by GSTT Community team, and the first dose of hepatitis B for babies born to hepatitis B positive mothers which is given in the maternity unit.

Uptake of pre-school immunisations in Southwark generally falls below targets although it is fairly consistent with the rest of London (Table 4).

Table 4: Coverage trends and ambitions for pre-school immunisations

Immunisation	Area	2015/16	2016/17	2017/18	Trend	London Target	Strategy Ambition
DTaP/IPV/Hib/HepB @12 mths	SWK	86.3	89.6	90.6		95%	95%
	LON	89.2	88.8	89.2			
	ENG	93.6	93.4	93.1			
PCV @ 12 mths	SWK	86.5	89.6	91.4		95%	95%
	LON	90.0	89.2	89.7			
	ENG	93.5	93.5	93.3			
Rotavirus @ 12 mths	SWK		85.6	87.9		95%	92%
	LON		89.2	86.5			
	ENG		89.6	90.1			
MenB@ 12 months	SWK			89.4		95%	94%
	LON			87.9			
	ENG			92.5			
DTaP/IPV/Hib/HepB @ 24 mths	SWK	91.6	93.7	92.5		95%	95%
	LON	92.2	91.6	91.7			
	ENG	95.2	95.1	95.1			
PCV @ 24 mths	SWK	85.4	88.5	86.1		90%	90%
	LON	85.6	84.5	84.3			
	ENG	91.5	91.5	91.0			
Hib/MenC @24 mths	SWK	85.6	88.8	87.5		90%	90%
	LON	85.9	84.2	85.1			
	ENG	91.6	91.5	91.2			
MMR (Dose 1) @2yrs	SWK	86.1	88.5	87.8		90%	90%
	LON	86.4	85.1	85.1			
	ENG	91.9	91.6	91.2			
MMR (Dose 2) @5yrs	SWK	85.3	86.9	81.8		85%	85%
	LON	81.7	79.5	77.8			
	ENG	88.2	87.6	87.2			
DTaP/IPV (Booster) @ 5 years	SWK	74.0	78.6	83.5		90%	88%
	LON	78.3	76.9	75.9			
	ENG	86.3	86.2	85.6			
Flu (aged 2 years)	SWK	29.1	28.9	35.8		50%	40%
	LON	26.6	30.3	33.2			
	ENG	35.4	38.9	42.8			
Flu (aged 3 years)	SWK	30.7	33.1	35.1		50%	40%
	LON	28.8	32.6	33.3			
	ENG	37.7	41.5	44.2			

Target reached
Within 5% points of target
At least 5% points below target

SWK=Southwark, LON=London, ENG=England
Flu data is reported as of January of that financial year. All other data is as of March respectively.

For pre-school immunisations the main areas to focus on are:

- MMR
  Uptake of MMR1 and MMR2 are both below the London target of 90% and 85% respectively. Over the past few years there have been several outbreaks of measles in London (and nationally) and to drive an increase in coverage and to protect babies earlier, Southwark has recommended an accelerated schedule of MMR2 from 18 months old rather than at 3 years 4 months.
- Hepatitis B in high risk babies
  A second challenge identified is hepatitis B vaccine to babies born to hepatitis B positive mothers. These babies should have their first dose within 24 hours of birth (in the hospital) and second dose at 4 weeks of age as well as a final dose and test for infection at 52 weeks in general practice. This is addition to the routine immunisation schedule. Concerns have been raised about timely administration of the 4 week dose in particular (published data is not available).
- Flu in 2 and 3 year olds
  Flu vaccine uptake in children aged 2 and 3 years, as well as at-risk groups between age of 6months and 5 years is considerably below London targets and is an area that needs further action.

School-aged Immunisations

Immunisations given in schools to school-aged children include HPV, Men ACWY, Td/IPV booster as well as flu. In Southwark, immunisations to school-aged children are delivered by HRCH (Hounslow and Richmond Community Health Care). Uptake is generally comparable or better than for London, although recently HPV uptake has decreased (Table 5).

Table 5: Coverage trends and ambitions for school-aged immunisations

Immunisation	Area	2015/16	2016/17	2017/18	Trend	London Target	Strategy Ambition
HPV (Dose 1)*	SWK	89.7	86.4	72.9		90%	90%¥
	LON	83.9	83.8	81.0			
	ENG	87.0	87.2	86.9			
HPV (Dose 2)**	SWK	84.5	84.2	80.7		90%	88%¥
	LON	80.7	77.7	78.4			
	ENG	85.1	83.1	83.8			
Td/IPV	SWK	93.7	79.2	81.7		80%	80%
	LON	69.2	77.1				
	ENG	79.1	82.3				
Men ACWY	SWK	65.6	60.8	83.2		80%	80%
	LON	61.5	67.1				
	ENG	76.4	79.0				
Flu (School-years)§	SWK		46.9	48.9		50%	50%
	LON	40.2	43.8	47.8			
	ENG	55.1	55.4	59.6			

Target reached
Within 5% points of target
At least 5% points below target

SWK=Southwark, LON=London, ENG=England
Flu data is reported as of January of that financial year. All other data is as of March respectively.

For school-aged immunisations the main areas to focus on are:

- HPV
  HPV is offered routinely to girls aged 12-13 at school. In Southwark 2 doses are given: one in Year 8 and a second in Year 9 with coverage for both still below ideal target of 90%. Dose 1 uptake in 2017/18 was particularly low.
- Flu
  Coverage in school-aged children remains slightly below target

Adult Immunisations

The routine immunisations offered to adults are Pneumococcal (PPV), shingles and pertussis for pregnant woman while flu is offered to those aged 65+ years of age and to those in clinically at-risk groups. All are administered in the GP setting however; PPV and Flu are also commissioned for delivery through pharmacies while a pilot has taken place in 2018 to commission pertussis through maternity clinics in Southwark.

Immunisation coverage for PPV and Shingles in Southwark was lower than the London average and below target (Table 6).

Table 6: Coverage trends and London targets for school- immunisations

Immunisation	Area	2015/16	2016/17	2017/18	Trend	London Target	Strategy Ambition
PPV	SWK	56.9	56.7	57.7		75%	63%
	LON	65.3	64.3	64.4			
	ENG	70.1	69.8	69.5			
Shingles	SWK	42.3	30.4	29.2		60%	45%
	LON	47.1	41.3	37.5			
	ENG	54.9	48.3	41.0			
Maternal Pertussis	SWK	56.5	72.9	71.4		70%	70%
	LON	49.8	72.6	60.2			
	ENG	60.7	72.6	70.8			
Flu (6mths-64 years at risk)*	SWK	44.4	47.3	44.2		50%	49%
	LON	43.7	47.1	45.4			
	ENG	45.1	48.6	48.9			
Flu (aged >64)	SWK	66.6	65.3	66.2		75%	71%
	LON	66.4	65.1	66.9			
	ENG	71.0	70.5	72.6			
Flu (pregnant)	SWK	40.8	40.9	44.9		50%	50%
	LON	38.6	39.5	41.1			
	ENG	42.3	44.9	47.2			

Target reached
Within 5% points of target
At least 5% points below target

SWK=Southwark, LON=London, ENG=England
Flu data is reported as of January of that financial year. All other data is as of March respectively.
Shingles ambition was chosen to reflect coverage in 2015/16 to ensure it is ambitious but potentially achievable.

For adult immunisations the main areas to focus on are:

- Shingles
  The particularly low coverage for Shingles is partly linked to a change in the eligibility criteria in April 2017 which meant more individuals became eligible (from age of 70 or 78 until they turned 80).

- Flu
  Coverage in at risk groups when those aged 6months-64 years in Southwark were grouped was just below target in 2017/18. However, this masks the fact that coverage in those aged 6mth-5 years at-risk was 37.9%, for 5-16 years was 32.9% in 2017/18 while in those aged 16-64 years at-risk in Southwark, coverage was actually meeting the London target of 52.9% in 2017/18. There is also scope for improvement with adults aged 65+ years.

Variation between practices

Southwark immunisation coverage masks that there is considerable variation in uptake across GPs as illustrated through Box and Whisker plots for immunisation coverage data at the practice level in 2017/2018 (Figure 2). These practices are grouped into two GP federations: Quay Health Solutions in the North and Improving Health Limited in the South though not all 35 practices in Southwark had data available on national reporting systems.

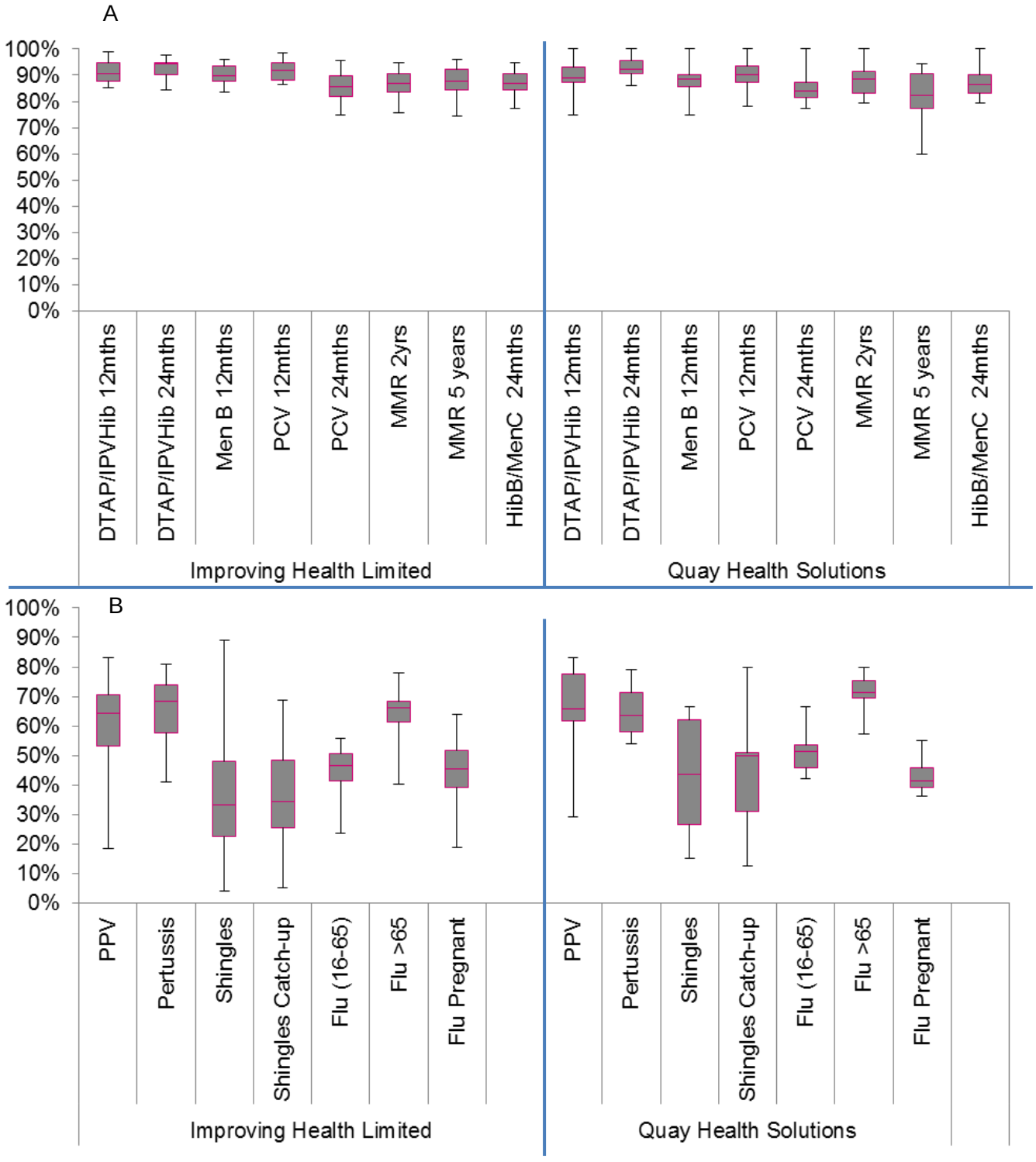
- In Figure 2 below, the middle pink line represents the median coverage in practice for each immunisation, the box itself is the interquartile range, while the minimum and maximum value highlight the full range of coverage values.

- For the pre-school (Figure 2A), widest range in coverage was observed for the MMR reported at 5 years in particular for Quay Health Solutions as a result of some outlying practices.

- For the adult immunisations (Figure 2B), much greater variation was seen in practice level across all immunisations. The coverage for shingles was the most variable, with coverage as low as 5% reported in some practices and as high as 90% in others.

- Collectively this data, highlights clear cause for further investigations and scope for shared learning from practices reporting higher coverage

Figure 2: Box and Whisker Plots demonstrating variation in immunisation coverage for pre-school immunisations (A) and adult immunisations (B) in practices based across both GP Federations in Southwark in 2017/18



8. BARRIERS TO HIGHER UPTAKE IN SOUTHWARK

Stakeholders involved both in service commissioning and delivery from across Southwark were consulted through interviews and questionnaires as part of the development of the needs assessments, to identify factors affecting immunisation uptake in Southwark.[9-11]

Several of these barriers related to the challenge of managing a highly mobile population in Southwark, inconsistent call/recall systems, trust among recipients of information received by patients/parents and financial prioritisation by providers.

Table 6 Barriers to Immunisation uptake in Southwark

Barrier	Detail
Population movement	In and out of London; between boroughs; from abroad; within Southwark. High number of temporarily housed families & individuals not registered with a GP.
Movement of staff	Higher turnover of staff in GP practices and community roles.
Staff understanding and promotion	Health Visitors and School Nurses have capacity to influence immunisations to a greater extent through modifications to their agreed roles
Parents' knowledge and understanding	Lack of awareness of changing immunisation pathways and availability. Lack of appreciation of severity of diseases.
Accessibility of GPs	Large families and underserved groups can face a logistical challenge of attending GP. There is a shortage of trained immunisation workforce.
Trust in the information they receive	Inconsistent messages and information patients suspect may not be accurate, being denied detail may create vaccine hesitancy. Needs to be more clear, concise and consistent.
Financial Incentivisation	Current contracts may not adequately incentivise practices to prioritise immunisation uptake other than for flu.
Inconsistent call/recall systems	Inconsistency in and unsystematic call/recall systems across practices were highlighted as a major barrier.
Consent process for school immunisations	Logistical barriers.
Data recording, data accuracy and data flow onto reporting systems	Complexity of the coding, recording and reporting of immunisations leaves considerable room for error in the system, meaning inaccuracies then transfer through to nationally reported data. This is a challenge at both GP level and in settings other than GPs where immunisations are given.

Data flows

The complexity of immunisation data flows across the system was highlighted during stakeholder consultation. Data is reported for immunisation across several platforms as detailed below.

Pre-school Immunisations

- Routine - GPs send data via CHIS (Child Health Information System) to COVER (Cover of vaccination evaluated rapidly) from which national and local reports can be generated for coverage statistics. GPs are also asked to send data to Immform (which also acts as the governments vaccine ordering facility) for childhood vaccinations but our work highlighted that this is not completed by all GPs meaning real-time updates are not readily available.
- Hepatitis B in high risk infants **-** the acute trust sends data directly to NHS England and the GP following administration of the first dose at birth, while the GP sends this data as well as details of their own dose administrations via CHIS to COVER**.**
- BCG - given by Acute and Community trusts only and data following administration is sent by them to the GP and directly to NHS England.

School-aged Immunisations

- Routine – HRCH submit data periodically to the GP who then sends it onto NHS England via CHIS. HRCH also send this data directly to NHS England, to Immform and to Public Health England annually.

Adult Immunisations

- Routine - The providers for vaccinations administered to adults vary depending on the vaccine. All non-GP providers are required to notify the registered GP of a particular immunisation administered within 24 hours. Following this, the GP then periodically submits a report of this data to NHS England and Immform (which like for pre-school is often inconsistent/incomplete).

9. AREAS FOR ACTION

Collectively, stakeholder feedback and evidence reviews completed as part of the 3 needs assessments identified 5 priority areas within which specific strategic actions could be taken to improve immunisation in Southwark.

- Reducing inequality and Improving uptake in underserved populations
- Community engagement and promotion
- Data sharing and quality improvement
- Service delivery, call and recall
- Guidance, training and development

Reducing inequality and improving uptake in the Underserved

Central to our action plan is ensuring the needs of people who are disadvantaged or suffer inequality leading to or arising from reduced immunisation uptake are addressed as a priority**.** Inequality in society gives rise to underserved groups less likely to access immunisation, which in turn exacerbates these inequalities further through increasing risk of vaccine-preventable diseases among these communities. A number of population groups identified to be at higher risk of being underserved for immunisations in the literature are known to reside in Southwark at higher than average regional prevalence (Figure 3).[8] Evidence suggests that these groups require more targeted intervention to meet their differing needs.[19]

For certain ethnic groups such as Latin American and Jewish populations, evidence supports developing an enhanced understanding of their needs and how they may or may not engage with health services.[7] In other underserved groups, such as home-schooled children or looked

after children, identification of these groups is needed before engagement and service delivery can be improved.[20]

Figure 3: Underserved groups in Southwark

The risk of not addressing these underserved populations is widening health inequality. For example, if unprotected individuals gather within geographical areas or social groups, outbreaks can still occur even if adequate overall borough-wide coverage is achieved.[8]

What works

- Understanding the prevalence, location of underserved groups in the community and how they access services. (NICE, DoH)[7, 8]
- Removing logistical barriers to access for those with disability or language barriers e.g. mobile or home-based immunisation, incentives for parents to bring their children for immunisation; special clinics solely for immunisation. (NICE)[20]
- Health professionals checking the immunisation history of new migrants, including asylum seekers, when they arrive in the country. (NICE)[20]
- Checking the immunisation status of looked-after-children (LAC) during their initial health assessment, the annual review health assessment and statutory reviews. Ensuring outstanding immunisations are addressed as part of the child's health plan. (NICE)[20]
- Peer-led approaches where people with lived experience (for example, people who have been homeless, or who are from particular cultural backgrounds) are working alongside health and social care professionals to provide information that is accessible and appropriate to the “target group”. (NICE)[7]
- Partnership working with local organisations (for example, drug and alcohol services) and voluntary sector groups working with underserved populations (such as carers or people who are homeless). (NICE)[7]

Community engagement and promotion

Vaccine hesitancy, defined as delay in acceptance or refusal of vaccines despite availability of vaccination services, is now recognised as a complex and growing problem that requires

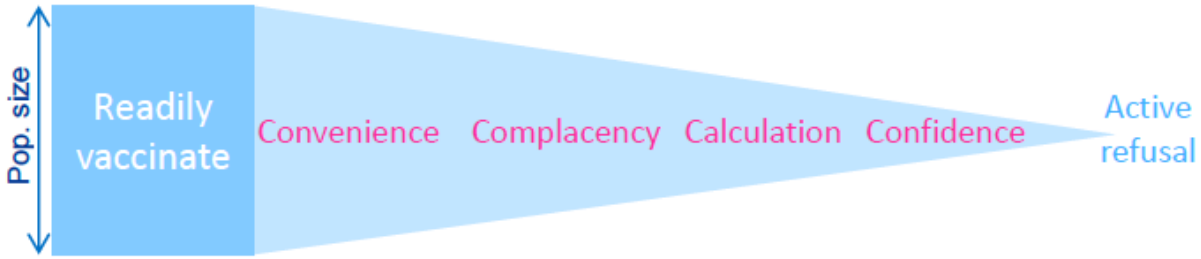
monitoring and action.6, 21 The growth of vaccine hesitant clusters in society has been perpetuated through social media and the internet spreading “fake news” about harms of vaccination and triggering declines in vaccination coverage.6 Addressing the concerns of the vaccine-hesitant is a major public health challenge given immunisation programs rely on high coverage and herd immunity.22 It is too complex a phenomenon for there to be a single best strategy and understanding the root causes of vaccine hesitancy and refusal in population subgroups is fundamental in allowing development of targeted actions to fit each context. 21

Fundamentally, the vaccine hesitant are a group already known to access services and can be divided into 4 main categories:

- Those driven by **convenience -** frustrated by difficulties in accessing immunisations
- Those who underestimate the risk of non-immunisation - **complacency**
- Those who actively weigh-up the pros and cons – **calculation**
- Those who lack **confidence** in the immunisation (Figure 4).

These groups make up most of the populations before we reach “**active refusal**”.[23]

Figure 4: Vaccine hesitancy spectrum



Central to tackling this systematic spread of disinformation and addressing all levels of hesitancy is a need for community engagement and promotion based around improved communication strategies, effective clinical and political leadership and public health messaging campaigns.[22]

In particular, tackling the “complacency” to “confidence” spectrum requires community leadership, participation and empowerment to drive an improvement in quality of communication to constructively challenge the vaccine hesitant and improve discourse around immunisation.[6] This cannot be solely reliant on health professionals. “Bottom up” communication is as important as “top down” communication from health professionals.

Effective use of non-clinical contact points and organisations is also effective (public sector leaders, voluntary organisations, community groups, nurseries, schools, councils, public spaces) alongside clinical contact points between health systems and communities (GPs, hospitals, pharmacies).[7, 20]

What works

- Transparent, concise and easy to understand communication. (Lancet)[21]
- Using pharmacies, retail outlets, libraries and local community venues for disseminating accurate, up-to-date information on immunisation with links to further information on trusted websites (NHS Choices) and avenues to ask for further information. (NICE)[20]
- Ensuring all staff involved in immunisation services are appropriately trained with the communications skills and the ability to answer questions. (NICE, PHE)[20, 24]
- Checking immunisation records when a child joins a nursery, school, playgroup. This should be carried out in conjunction with childcare or education staff and parents. (NICE)[20]
- School nursing teams, working with GP practices and schools, providing information in an appropriate format (for example, as part of a immunisation question and answer session) and offering catch up or referrals for immunisation services.(NICE)[20]
- Head teachers, school governors, children's services and immunisation coordinators working with parents to encourage schools to become venues for vaccinating local children.
- Providing information in a variety of formats on the benefits of immunisation against infections, tailored when needed for different communities and groups. For example, offering translation services and providing information in multiple languages.(NICE)[20]
- Working with statutory and voluntary organisations, such as parents groups and those representing people with relevant medical conditions, to increase awareness of vaccination among eligible groups (and their parents or carers, if relevant).(NICE)[7]
- Using workplaces to deliver prompts and reminders in various printed and digital formats which include information about vaccination locations and times.(NICE)[7]

Data sharing and quality improvement

An understanding of the flow of information through the system that captures immunisation coverage is key to knowing how to intervene, whether interventions are successful and how the system for data capture as a whole can be improved. This ranges from ensuring quality data recording and capture through to transmission of this information onto local and national reporting systems.

Administration of immunisations in settings other than GP (schools, pharmacies, hospitals), requires notification of the GP where immunisation records should be integrated and held.[25] Though these responsibilities are usually outlined in service specifications made as part of commissioning of the immunisation programmes, concerns have been raised by stakeholders about the timeliness and quality of some of the information that travels through from providers onto the reporting systems.[9, 11] This is what ultimately informs local and national policy for action, hence the need for this to be both timely and accurate.

Some quality concerns among these were immunisation specific in particular in relation to recording of immunisation delivered antenatally e.g. influenza and pertussis where ncorrect Read coding in general practice of delivery dates can skew coverage statistics.[20]

Delivery of hepatitis B vaccination to high-risk babies born to infected mothers has also been highlighted as a concern among stakeholders.[10] It is accepted that there is a need for a more robust local process to ensure 100% of babies are vaccinated in the appropriate 4 week window which might require improved data sharing to allow support to be provided to underperforming practices.

What works

- Ensuring local healthcare commissioning organisations and GP have a structured, systematic method for recording, maintaining and transferring accurate information on vaccination status. Vaccination information should be recorded in patient records, child health record and the child health information system (CHIS) and should be reconciled and consistent.(NICE)[7]
- Clinical systems should be used for identifying eligible groups and working out vaccine supply. (NICE)[7]
- Private providers having clear processes to allow them to inform the relevant GP practice about an immunisation administered under private care. (NICE)[20]
- Ensuring up-to-date information on vaccination coverage is available and disseminated to all those responsible for immunisation. (NICE)[20]
- Ensuring staff are appropriately trained to document vaccinations accurately in the correct records using the right Read codes. (NICE)[20]
- Having systems in place to ensure regular update and maintenance of the databases for recording immunisation status. This should involve ensuring records are transferred when someone moves out of the area, while also following up on information to ensure it is not duplicated or missing. (NICE)[20]
- Integrating local care pathways for hepatitis B vaccination for high risk babies born to infected mothers which will allow health professionals to provide advice and support to prevent hepatitis b transmission, to highlight the importance of the vaccination timing, how to access it and a robust and mapped means of patient follow up through information systems such as CHIS. (NICE)[20]

Service delivery, call and recall

Increasing access, optimising service delivery and systematic call/recall have all been demonstrated to be key components in achieving good immunisation coverage. [26]

Questionnaires completed with Southwark practice nurses and managers revealed that access to appointments for immunisation as well as significant variability in call/recall systems across GP surgeries may be contributing to sub-optimal coverage.[10]

Variation in coverage is not limited to GPs and it is known that coverage targets always remains lower and more challenging to achieve in certain local schools than others. Targeted strategic work with practices and schools with lower coverage can have a significant impact on both overall coverage and reducing inequalities.[8]

With regards to school-aged immunisation, one of the greatest logistical challenges remains communication with parents about the purpose of vaccination and how best to obtain consent.[27] School-aged children can self-consent to all school-delivered vaccines, however the engagement and support of parents through this process remains key. Use of electronic-consent forms is currently being trialled in Southwark with a view to determining if this can overcome some of these traditional logistical barriers while also helping to prevent development of vaccine-hesitant clusters.[11]

Increasing access to immunisation services through pharmacy's, hospital and hub clinics can also play an important role in improving service delivery across the lifecourse.[7, 20]

What works

- Systematic multicomponent call/recall (including call, text messages, letters and email). (Cochrane, NICE)[20, 26]
- Tailoring invitations for immunisation and reminders when someone does not attend appointments. (NICE)[20]
- Improving access to immunisation services by extending clinic times and evening and weekend services in primary care and pharmacy. (NICE)[20]
- Targeted strategic work with practices and schools identified to have lower than average coverage. (DoH)[8]
- Ensuring enough immunisation appointments are available so that all patients, local children in particular, can receive the recommended vaccinations on time. (NICE)[7]
- Ensuring parents and patients know how to access immunisation services. (NICE).[20]
- Providing multiple opportunities and routes for eligible people to have their vaccinations through community pharmacies, GP surgeries or clinics they may attend regularly for a chronic condition.(NICE)[7]
- Commissioners raising awareness among providers about financial remuneration linked to vaccination.(NICE)[7]
- Organisations responsible for agreeing quality indicators (such as QOF) should be aware that revising target conditions may encourage providers to meet targets for flu vaccination. (NICE)[7]
- Ensuring young people fully understand what is involved in immunisation so that those who are aged under 16 can consent to vaccinations while simultaneously ensuring parents have opportunities to address concerns. (NICE)[20]

Guidance, training and development

Fundamental to delivery of immunisations within the healthcare system is the adequate training and development of healthcare staff. Increasing challenges around vaccine hesitancy and a greater number of vaccinations now on the schedule then ever before (with additional vaccines to be introduced such as HPV in boys in the near future).

Public Health England and the Royal College of Nursing have put together a curriculum and guidance for immunisation for registered healthcare practitioners recognising this. However, it remains the responsibility of local commissioners and providers to facilitate training delivery, ensuring it meets this standard and enforce attendance.[24]

Immunisation advice and administration now takes place in a multitude of settings e.g. general practice, schools, hospitals, prisons, occupational health, maternity, neonatal and paediatric services, pharmacies, sexual health clinics, long term care settings. Equally, there are many different professionals involved in administering vaccines now, from doctors, nurses, pharmacists, midwifes, health visitors, healthcare assistants to social care staff. This also means training needs to meet the requirements of these varying settings and professionals to make every contact count.

Stakeholder feedback emphasised the need for timely two-way communication between providers and commissioners around areas where there are greatest challenges. For example, GP surgeries with low coverage for certain vaccines being made aware of this and equally commissioners being made aware of low uptake/ barriers in certain schools around administration of a vaccine so that training and interventions can be orientated accordingly.

What works

- Ensuring all staff involved in immunisation services are appropriately trained with annual updates particularly around the knowledge and communications skills needed to handle challenging questions. (NICE, PHE)[20, 24]
- Ensuring health professionals who deliver vaccinations have received training that complies national minimum standards for immunisation training. (PHE, NICE)[20, 24]
- Assigning dedicated staff (for example, a flu or MMR vaccination champion) to increase immunisation awareness and uptake.(NICE)[7]
- Training peers to vaccinate their co-workers e.g. for flu and encouraging uptake and challenging barriers e.g. that the flu vaccine can give you flu. (NICE)[7]
- Making every contact count (MECC) – making the most of opportunities for raising awareness and offering vaccination. (NICE)[7]

10. ACTION PLAN – A PARTNERSHIP APPROACH

This strategic action plan has been built iteratively, in partnership with stakeholders detailed earlier and through discussion around current problems in Southwark, the evidence base and an assessment of potential solutions. We have detailed this 2 year action plan below segmented into our 5 priorities:

Priority 1 Reducing inequality and improving uptake in the underserved
Priority 2 Community Engagement and Promotion
Priority 3 Data Sharing and Quality Improvement
Priority 4 Service Delivery, Call and Recall
Priority 5 Guidance, Training and Development

The section of the action plan copied below provides a summary of the actions that will be taken. The full working action plan is more detailed and includes details about each action, indicators against which we will measure our success, cost implications and is designed to be flexible to allow actions to evolve and be adapted as needed.

PRIORITY 1 REDUCING INEQUALITY AND IMPROVING UPTAKE IN THE UNDERSERVED							
Ref no	**Output**	**Action summary**	**Pre-school**	**School aged**	**Adult**	**Lead**	**Working with**
1.1	**Greater understanding of our underserved populations**	**1.1a Mapping exercise of our underserved groups** **- Looked after children (LAC)** **- Home schooled children** **- Traveller/Gypsy Community** **- Minority ethnic groups** **- Barry House** **- Hostels/rough-sleepers** **- New migrants** **- Pupil Referral Units**	yes	yes	yes	Public Health	CCG HPT LAC Community Southwark
1.2	**Targeted intervention in underserved populations**	**1.2a Develop ways of increasing engagement and targeted interventions using findings from mapping work for each underserved group**	yes	yes	yes	Public Health	Community Southwark CCG GP Leads
		1.2b Deliver information via organisations already in contact with certain hard to reach groups including but not limited to social care, drugs and alcohol services	yes	yes	yes	Public Health	Other LA teams Community Southwark PACT
		1.2c Intervention to target parents of home schooled children e.g. invitations to parents of home-schooled children for immunisation in council settings	no	yes	no	Public Health	HRCH LA Education team
1.3	**Improved access to vaccinations and coverage in LAC**	**1.3a Ensure immunisations are addressed as part of LAC health reviews and care plans**	yes	yes	no	GSTT Community LAC Team	Public Health
		1.3b Raise Awareness of immunisation catch-up clinics for Southwark LAC	yes	yes	no	GSTT Community LAC Team	Public Health

		1.3c Arrange for LAC teams to speak at PLT and PN forums	yes	yes	no	GSTT Community LAC Team	Public Health
		1.3d Improve data sharing between HRCH and Southwark LAC teams	no	yes	no	GSTT Community LAC Team	Public Health HRCH
		1.3e Offer training to GSTT community paediatricians and practice staff around LAC	yes	yes	no	GSTT Community LAC Team	
1.4	**Improved access to vaccinations in Barry House**	**1.4a Review and improve immunisation services delivered in Barry House**	yes	yes	yes	CCG	Public Health
PRIORITY 2 COMMUNITY ENGAGEMENT AND PROMOTION							
Ref no	**Output**	**Action summary**	**Pre-school**	**School aged**	**Adult**	**Lead**	**Working with**
2.1	**Raised awareness among patients and parents/carers of immunisations**	**2.1a Disseminate information to parents prior to child starting school about pre-school immunisations in reception packs**	yes	yes	no	Public Health	HRCH LA Education Team GP Federation Nurse Leads
		2.1b Provide information to children centres, nurseries and pre schools reinforcing importance of checking immunisation status	yes	no	no	Public Health	
		2.1c Effective use of posters and promotional materials in council and NHS sites	yes	yes	yes	Public Health CCG	
		2.1d Develop an immunisation communication strategy to include a suite of messages suitable for delivery through political leaders, clinical leaders, social media and newsletter	yes	yes	yes	Public Health	Public Health LA Communications teams GP Federation Nurse Leads HPT

		2.1e Literature review to develop best practice about communicating information around immunisations to vaccine-hesitant groups	yes	yes	yes	Public Health	HPT GP Federation Nurse Leads
2.2	**Raised awareness of the new HPV vaccine for boys**	**2.2a Raise awareness among parents/carers through campaigning for HPV in school aged boys prior to rollout**	no	yes	no	HRCH	Public Health
2.3	**Raised awareness of school leaver vaccines, specifically Men ACWY and MMR**	**2.3a Promotional campaigns about Men ACWY and MMR in years 5, sixth forms and universities**	no	yes	no	Public Health	LA Education Team Universities Schools
2.4	**Improved vaccination coverage among schools where engagement is lowest**	**2.4a Attend Head Teachers and governors meetings to raise awareness about immunisations**	no	yes	no	HRCH	Public Health
		2.4b Focused engagement work with schools refusing flu vaccine	no	yes	no	HRCH	Public Health
		2.4c Focused engagement work with schools with lower HPV uptake	no	yes	no	HRCH	Public Health
		2.4d Encourage schools to nominate immunisation leads	no	yes	no	HRCH	Public Health
		2.4e Advocate and provide improved MMR offer in schools	no	yes	No	HRCH	Public Health
		2.4f Work with HRCH to identify and target those schools with lower uptake	no	yes	no	HRCH	Public Health
2.5	**Improved Community engagement and empowerment**	**2.5a Work with PACT to devise ways of incorporating immunisations into their programmes including their 10 week course run for new parents in Southwark**	yes	yes	no	Public Health	PACT HRCH CCG

		2.5b Strategic work with Community Southwark and Healthwatch to disseminate information to engage communities around immunisation such as through Healthwatch bulletin	yes	yes	yes	Public Health	Community Southwark Healthwatch CCG
2.6	**Improved engagement in GP practices**	**2.6a Deliver timely communication around immunisation performance across practices to GPs as part of routine CCG medicines optimisation team visits**	yes	no	yes	CCG Medicines Optimisation Team	Public Health
		2.6b Identify practice staff forums to promote immunisation work and provide guidance	yes	no	yes	CCG	Public Health
PRIORITY 3 - DATA SHARING AND QUALITY IMPROVEMENT							
Ref no	**Output**	**Action summary**	**Pre-school**	**School aged**	**Adult**	**Lead**	**Working with**
3.1	**Improved data flow**	**3.1a Map out data flow pathways for school immunisation programmes to help remove potential impediments to data flow**	no	yes	no	HRCH	Public Health
		3.1b Improve timely data flow between pharmacies and GP practices	no	no	yes	Public Health	LPC NHSE London
		3.1c Clarify pathways for data flows from private providers	yes	no	yes	Public Health	CCG GP Leads
		3.1d Improve systems within GP practices receiving, storing and uploading immunisation data	yes	yes	yes	CCG	Public Health
3.2	**Improved data sharing**	**3.2a Develop best practice for information sharing to practices**	yes	yes	yes	Public Health	NHSE London CCG GP Federation Nurse Leads HPT

		3.2b Develop information sharing protocol for selective hepatitis B programme	yes	no	no	Public Health CCG	NHSE London GP Federation Nurse Leads HPT
3.3	**Improved data quality**	**3.3a Ensure practices are using correct Read codes for MMR**	yes	no	no	CCG	GP Federation Nurse Leads
		3.3b Improved coding and capture of maternity immunisation data	no	no	yes	CCG	GP Federation Nurse Leads
		3.3c Removal of "ghost" patients from practices that can skew immunisation coverage statistics	yes	no	yes	CCG	
		3.3d Support implementation of the e-redbook	yes	no	no	NHSE London	Public Health
3.4	**Improved data entry on ImmForm**	**3.4a Improving timely uploads to ImmForm to allow its use as real-time management tool for monitoring and improving uptake**	yes	no	yes	CCG	GP Federation Nurse Leads
3.5	**Review of "near misses" and incidents**	**3.5a Identify and share learning from reported "near misses" and incidents**	yes	yes	yes	HPT	Public health
PRIORITY 4 – SERVICE DELIVERY, CALL AND RECALL							
Ref no	**Output**	**Action summary**	**Pre-school**	**School aged**	**Adult**	**Lead**	**Working with**
4.1	**Improve the consent process in school programmes**	**4.1a Support implementation of e-consent in schools**	no	yes	no	HRCH	
		4.1b Support process of self consent in schools	no	yes	no	HRCH	
4.2	**Standardised and enhance call/recall systems across the borough**	**4.2a Develop a standardised multi component call/recall system for practices in Southwark**	yes	no	yes	Public Health	CCG GP Federation Nurse Leads
		4.2b Explore using GP Federations for call/recall	yes	no	yes	Public Health	CCG GP Federation Nurse Leads

		4.2c Targeted work with schools with low coverage	no	yes	no	Public Health	HRCH
		4.2d Pilot work using CHIS for call/recall	yes	yes	no	NHSE London	
		4.2e Exploring introduction of e-consent forms for GP surgeries for immunisation to facilitate carers/relatives in bringing children to immunisation appointments	yes	no	no	GP Federation Lead Nurse	Public Health HRCH
4.3	**Optimising the use of financial incentives available locally**	**4.3a Optimise use of national and local financial incentives for practices as a motivational tool e.g. proposed introductions of QOF immunisation indicators, local KPIs and using these alongside standard remuneration to practices to highlight financial benefits to practices of immunising patients**	yes	no	yes	CCG	Public Health NHSE London
4.4	**Increased opportunities for vaccination in other settings**	**4.4a Advocate for MMR and shingles to be given in pharmacies**	yes	no	yes	Public Health CCG	NHSE London HPT
		4.4b Use GP hubs to improve access to vaccinations	yes	no	yes	CCG	Public Health GP Federation Nurse Leads
4.5	**Improved understanding of TB and BCG**	**4.5a Mapping of TB and BCG across South London to examine vaccine coverage and effectiveness**	yes	no	no	HPT	
4.6	**Improved uptake of flu vaccination**	**4.6a Targeted visits for practices and schools with low flu vaccine uptake**	yes	yes	yes	CCG	
		4.6b Producing regular reports throughout flu season regarding practice performance	yes	no	yes	CCG	NHSE London
		4.6c Provision and wide promotion of flu catch-up clinics for school children	no	yes	no	HRCH	NHSE London GP Federation Nurse Leads

		4.6d Targeted actions to improve flu uptake in 2 and 3 years olds	yes	no	no	CCG Public Health	GP Federation Nurse Leads PCNs
		4.6e Targeted actions to improve flu uptake in the under 65s at risk	yes	yes	yes	CCG Public Health	GP Federation Nurse Leads
4.7	**Improved uptake of shingles vaccine**	**4.7a Develop a structured project management approach with MSD (shingles vaccine manufacturer) to improving shingles uptake with coordinated actions, milestones and KPIs**	no	no	yes	Public Health	Medicines Optimisation Team CCG GP Federation Nurse Leads
		4.7b Review practice level data and establish best practice for shingles	no	no	yes	Public Health CCG	Medicines Optimisation Team GP Federation Nurse Leads
		4.7c Promotional materials sent to all practices by MSD	no	no	yes	Public Health	Medicines Optimisation Team CCG
		4.7d Training and awareness raising among Federations and practices through MSD	no	no	yes	Public Health CCG	Medicines Optimisation Team GP Federation Nurse Leads
4.8	**Selective hep B programme - improved timeliness of second dose and test for infection**	**4.8a Develop process to enable early contact with practices when they have a baby at high risk of contracting hep B**	yes	no	no	CCG Public Health	CHIS NHSE London GP Federation Nurse Leads
		4.8b Improve processes around testing for infection at 1 year	yes	no	no	CCG Public Health	CHIS NHSE London
		4.8c Find opportunities to raise awareness of selective hep B among practice staff e.g. newsletters	yes	no	no	CCG Public Health	GP Federation Nurse Leads
		4.8d To explore use of CHIS as a failsafe for babies at high risk of hep B	yes	no	no	NHSE London	CHIS

4.9	**Realise opportunities linked to changes in primary care landscape**	**4.9a Consider opportunities for improving immunisation delivery through primary care networks**	yes	no	yes	CCG	Public Health GP Federation Nurse Leads
4.10	**Improved uptake of PCV in children with sickle cell disease**	**4.10a Review of pneumococcal uptake in children with sickle cell disease**	yes	no	no	Public Health	HPT
PRIORITY 5 - GUIDANCE, TRAINING AND DEVELOPMENT							
Ref no	**Output**	**Action summary**	**Pre-school**	**School aged**	**Adult**	**Lead**	**Working with**
5.1	**Greater understanding among practice staff of uptake and areas for improvement**	**5.1a Develop a bulletin for GPs and Federations that includes practice level data and shares best practice**	yes	no	yes	CCG	Public Health
		5.1b Targeted communications with practices with lowest uptake rates	yes	no	yes	CCG	Public Health
		5.1c Ensure GP practices are aware of methods and importance of reporting vaccine incidents for shared learning	yes	no	yes	CCG	GP Federation Nurse Leads
		5.1d Raise awareness among practices that NHSE (London) offer a 'deep dive' exercise on immunisation if support is needed	yes	no	yes	NHSE London	CCG
		5.1e Develop practice level immunisation uptake dashboard through collaborative work with federations	yes	no	yes	CCG	GP Federation Nurse Leads Public Health
5.2	**Greater awareness of other health professionals of immunisation programmes**	**5.2a Ensure immunisations training is part of Health Visitor specification**	yes	no	no	Public Health	GSTT Community
		5.2b Ensure immunisations training is part of School Nursing specification	no	yes	no	Public Health	GSTT Community

		5.2c Encouraging GP surgeries to have designated immunisation nurse and administrative champions who are highly familiar with good call/recall processes	yes	no	yes	CCG	Public Health
		5.2d Ensure mandatory and update training is attended by all immunisers in practice	yes	no	yes	CCG	Public Health
5.3	**MECC (Making Every Contact count) - getting immunisations into every conversation**	**5.3a Linking in with Pharmacy services such as Pharmacy First as well as hospital services to ensure immunisation is incorporated into every contact**	yes	no	yes	Public Health	LPC
		5.3b Utilise practice system alerts to facilitate MECC in GP	yes	no	yes	Public Health	
		5.3c Maximise use of opportunities for health visitors and other health professionals to discuss or deliver missed immunisations e.g. practices giving lists of children with missed immunisations to School Nurses	yes	yes	no	Public Health	CCG HRCH

Ref no= reference number, CCG= Clinical Commissioning Group, CHIS= Child Health Information System, GP= General Practice, GSTT= Guys and St Thomas, HPT=South London Health Protection Team, HRCH=Hounslow and Richmond Community Health Care (School-aged Immunisation Providers), LA= Local Authority, LAC= Looked-after children, LPC=Local Pharmaceutical Committee, NHSE (London)= NHS England (London), PACT= Parents and Communities Together (led by Citizens UK, aims to improve health for babies in Southwark)

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