July 2021

RSPH
ROYAL SOCIETY FOR PUBLIC HEALTH
VISION, VOICE AND PRACTICE

Improving Flu Vaccination Coverage Through the Public Health System Reforms and Immunisation Strategy

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The roundtables which form the basis of this paper were kindly sponsored by Sanofi Pasteur. RSPH was the sole organiser for the events and Sanofi Pasteur did not have input into the content of the roundtables or this paper.

Background

We are at a highly significant moment for flu vaccination in this country and around the world. Across both hemispheres, record low levels of influenza detections were reported last year, and fewer viruses were available for characterisation during September 2020 to January 2021. This poses a challenge for predicting what flu strains will dominate the 2021/22 flu season and thus for creating effective vaccines. On top of this, the risk of co-infection with Covid-19 remains, and vaccinators will need to deliver both Covid-19 booster jabs and flu vaccines – their third consecutive immunisation programme in a year.

Royal Society for Public Health (RSPH), with sponsorship from Sanofi Pasteur, hosted two roundtables in June 2021 to discuss how influenza vaccination coverage rates (VCR) could be improved through the changes to the public health system, and the anticipated Immunisation Strategy from the Department of Health and Social Care. These roundtables build on RSPH's report *Mind the Gap: London's low flu vaccination rates, and how to fix them* which explores why London's flu vaccination coverage rate is the lowest in the country, why the gap between the capital and the national average has increased since 2012/13, and makes a series of recommendations to improve London's performance.

This year's flu vaccination programme also takes place against the backdrop of an increase in misinformation and disinformation about vaccinations, huge pressures on primary care as GPs deal with a backlog of demand for medical care built up during the pandemic, and the transfer of health protection responsibilities from Public Health England to the UK Health Security Agency. To identify how policymakers and practitioners could rise to these challenges, we brought together a range of individuals involved in flu vaccination at a national, regional or local level:

National Stakeholders

- Angela Edwards, Seasonal Flu Lead, Public Health England
- Ellie Rose, Head of Flu Policy, Department for Health and Social Care
- Julie Hughes, Deputy Director of Public Health Commissioning and Operations and Programme Director for Flu Delivery, NHSE&I
- Michelle Falconer, Immunisation Nurse Specialist, Public Health England
- Nisha Jayatilleke, National Specialty Adviser (Immunisation) and Associate Medical Director for Herts & West Essex ICS & CCGs, NHSE&I
- Suzanna McDonald, National Programme Lead for Influenza, Public Health England

Regional and Local Stakeholders

- Emma De Zoete, Public Health Specialist, Greater London Authority
- Gemma Riley, Screening and Immunisation Coordinator (Derbyshire and Nottinghamshire), NHS England North Midlands
- Geraldine Bruce, Head of Health Protection, Hertfordshire Council
- Glen Wilson, Screening and Immunisation Lead, NHS England North (Cumbria and North East)
- Jacqueline Walker, Head of Nursing Projects, NHSE&I (London)
- Jemma Gilbert, Director of Transformation, Healthy London Partnership
- Khalida Aziz, Immunisation Commissioning Manager, NHSE&I (London)
- Marie Scouse, Assistant Director of Nursing and Quality in Primary Care, NHS Derby and Derbyshire CCG
- Nicole Klynman, Consultant in Public Health, London Borough of Hackney and City of London
- Rehana Ahmed, Screening and Immunisation Manager, NHSE&I (London)
- Paula Jackson, Screening and Immunisation Lead, NHS England South East (Thames Valley)
- Professor Sir Sam Everington, GP and Chair of Tower Hamlets CCG
- Sinead Hylton, Clinical Lead for Immunisation, Croydon Health Services

Introduction

In *Mind the Gap*, we noted how the 2012 Health and Social Care Act had centralised immunisation commissioning, disproportionately impacting London, which saw a 36-times increase in the number of patients eligible for the flu vaccine per commissioning team. But, it emerged during the roundtable discussions that the national picture was a varied one. Some participants from outside London described a similar experience to the one we described for the capital: they had experienced significant increases in the number of patients and providers for which they had oversight, and felt their ability to drive improvements had been "diluted".

However, others felt that they had developed good working relationships across the public health system in their area to maintain a place-based approach to immunisation, and that the recommendations we made in *Mind the Gap* around data collection and data sharing were also in place in their area. Our aim in this paper, therefore, is to explore how the commissioning and delivery system of flu vaccinations can be 'levelled up' by applying nationwide the best practice seen in the annual flu programme and from the Covid-19 vaccination roll-out.

Several characteristics of a successful flu vaccination programme in particular stood out from our roundtable discussions: well-resourced local delivery and outreach; making the most of trusted relationships; co-ordination and collaboration across multiple partners and between the local and national levels of the system; in-depth data collection and interrogation; and professional public health leadership. The forthcoming changes to the public health system and an anticipated new immunisation strategy from the Department for Health and Social Care should support these ways of working, making them the norm across the country. This paper presents several recommendations to achieving this goal.

Key Recommendations

- The UK Health Security Agency (UKHSA) must have robust, well-resourced regional teams to serve as a channel of communication and intelligence between local providers and the central policy and advisory teams. While NHS England and Improvement (NHSE&I) will retain responsibility for commissioning screening and immunisations, UKHSA will have a significant part to play in providing advice and evidence on vaccines and vaccine-preventable diseases. Therefore, it should have oversight of regional and demographic disparities in coverage, and develop guidance on addressing these inequalities for NHS England Local Teams to implement.
- As the public health system goes through a period of transition, the Department for Health and Social Care (DHSC) must ensure that Screening and Immunisation Teams (SITs) gain, or as a minimum do not lose, capacity. DHSC should develop contingency plans for the potential loss of workforce through the transition, and provide training and support for any change in roles, remit or responsibilities for those involved in immunisation. Professional public health leadership should also be maintained for SITs.
- UKHSA should pick up the attitudinal research which Public Health England has conducted, including attitudes to flu vaccination. These findings should be mapped against uptake data to monitor whether concerns about the co-administration of Covid-19 booster jabs and flu vaccinations are having an effect. This should then be used to evaluate whether specific engagement efforts are required to address these concerns and thereby ensure high coverage of both vaccinations.
- Under the new GP contract, practices are paid a standardised item of service fee of £10.06 for each dose of the routine vaccinations that they administer, and there are incentive payments awarded to Primary Care Networks (PCNs) which achieve a specified level of coverage (e.g. over 90% for MMR and diphtheria, tetanus and pertussis). NHSE&I should also introduce incentives for practices which increase uptake in historically underserved groups, and the Global Sum Payment (£164.5m in 2020/21) should be increased by at least 5% specifically to provide funding for flexible delivery models.
- DHSC should review the possibility of centralising procurement of flu vaccines to support diverse delivery models and ensure reliable supply across providers.

- Integrated Care Systems (ICSs) should facilitate collaboration between community pharmacies, general practice, voluntary organisations, housing providers, and other health and care services to drive immunisation uptake, and establish dedicated teams for flu vaccination with representatives from across the local system. One expression of such partnerships should be pop-up clinics or outreach teams which aim to reach groups who experience greater barriers to accessing vaccinations or are more hesitant about the vaccine.
- PCNs and ICSs should develop data dashboards, showing in real-time the coverage rate of each provider, and encourage the sharing of best practice across the area. These can be used by General Practice partners to evaluate performance and request support from Screening and Immunisation Teams in-season.
- Learnings from the denominator development for the Covid-19 vaccination programme should be applied to future flu seasons – in particular, there should be greater clarity on the denominators for flu vaccination and they should be developed in partnership with local teams.
- NHSE&I should work with General Practice IT system providers to improve their ability to flow data effectively to the central database and their direct interoperability so that data on coverage levels is accurate and patients' GP records can be updated irrespective of where they receive the flu vaccine.
- NHSE&I's national call/ recall service should introduce text messaging or email as a mode of communication; allow for flexibility in the timing of the communication with eligible patients to ensure it is responsive to patterns of uptake by cohort and aligned with levels of vaccine supplies; and explore setting up an inbound call centre and/or web chat for patients to ask questions about the flu vaccination.
- Members of the wider public health workforce should support vaccinators by having conversations about the importance of the flu vaccination for those at-risk with whom they come into contact. Employers should support those who want to improve their skills and confidence in this respect to take RSPH's *Level 2 Award in Encouraging Vaccination Uptake* and to draw on guidance produced by the NHS for health and social care staff.

The Importance of Local Interventions and Relationships

"We've seen in the Covid-19 [vaccination] programme that local collaboration and outreach and inreach into local communities has really made the difference. Yes, you can get high numbers of the people who are always going to hunt out a vaccine. But for the people that we really want to access it, who are maybe not necessarily anti-vaxx but maybe just hesitant and need a bit more support to access it, or a bit more information, that really small, local community- or neighbourhood-level intervention is what's needed."

The evidence from our roundtable discussions suggests that **what happens at the local level makes a huge difference to flu vaccination coverage**. Knowledge of the local population and local providers, having a sense of responsibility for a particular area, strong local professional leadership and neighbourhood-level data which can be used for targeting areas of low uptake were all mentioned as key ingredients to making a vaccination programme successful.

For example, it was noted that at the local level:

- There is knowledge about which populations are not being vaccinated, not just those who are, and where there is missing data.
- Insights into concerns about, and barriers to, vaccination can most easily be gathered and addressed.
- There is knowledge about what Make Every Contact Count opportunities can be harnessed in local health and care services, and which at-risk groups these services reach so any opportunities for signposting or opportunistic vaccinations can be utilised.
- Community leaders and trusted sources can be readily identified and engaged with.

By the same token, if not applied on the ground, policies and mechanisms designed at the central level do not have their desired impact. We heard, for example, of Covid-19 vaccination centres which were asking patients for proof of address or ID despite the fact that the protocols developed by DHSC required neither of these.

Therefore, the new public health system should invest **significantly in local delivery models, and the regional tier should work to ensure that national policies are consistently applied, and as a channel of intelligence and communication** between the centre and local providers. Some of the feedback we received about the roundtable events themselves concerned the value of bringing individual providers together with those at the centre. The regional teams of the UK Health Security Agency should facilitate this sort of cross-system engagement as a matter of course.

Increasing Access

We heard through the roundtable discussions that increasing access to flu vaccinations requires collaboration and system partnerships. Several participants were able to describe how this had proved effective in their area, particularly with joint working between Screening and Immunisation Teams and Sustainability and Transformation Partnerships (STPs), or across PCNs.

However, we also heard of areas where there could be greater, or more systematic, cooperation. For example, one representative from a Screening and Immunisation Team told us that she often heard from CCGs and GPs that pharmacies were *"taking their patients"*. She wanted to see greater collaboration between the two on the grounds that *"there are more than enough patients to vaccinate for both to earn a decent income".*

“I think the Covid pandemic has driven that [partnership working] forward massively: in the past, we would have heard ‘Oh, that’s NHS England’s role, that’s not a CCG role’ or ‘that’s not a local authority role’. Now it’s much more about what we need to do together.”

Another participant went beyond this and suggested voluntary sector organisations be increasingly embedded into the system, as these organisations were often most effective at engaging with inclusion health groups:

“Where we’ve got highest uptake in the homeless population, it’s where housing providers and voluntary sector providers are absolutely working hand in glove with local health care providers. And so, I think local ownership is absolutely key, and there’s also an opportunity here to think about wider ownership around vaccination and other organisations seeing getting that uptake level up as part of their general role, and not being just a health system issue.”

In *Mind the Gap*, we recommended that NHSE&I explore using pop-up clinics for flu vaccination, particularly aimed at the younger individuals of the at-risk patient cohort, as our research showed that this group found accessing appointments to be more of a barrier. These pop-up clinics have been a common feature of the Covid-19 vaccination programme, often aimed at groups with greater hesitancy about the vaccine, in particular those from ethnic minority backgrounds. When we asked attendees one thing they'd like to see in the upcoming Immunisation Strategy from DHSC, **increased funding for flexible delivery models** like pop-up clinics, specialist clinics and outreach services in order to increase access to groups with lower uptake rates was among the responses.

Based on attendees' reflections in the roundtables, it seems that different models of delivering the flu vaccination can be an effective means of increasing uptake if they are **sustained**, rather than one-off events, and **make use of trusted relationships** and **familiar environments**. Additionally, one participant explained that as staff uptake can influence overall uptake, especially in residential settings, being able to **vaccinate staff at the same time as residents** was a helpful approach for outreach or pop-ups.

By contrast, we heard that mass vaccination sites in areas of high hesitancy were not seeing high levels of attendance. It was theorised that this may be because there is not as much a sense of individualised care or a pre-existing relationship, and the venue may be unfamiliar. Mass-vaccination sites thus may be useful in increasing choice for those who are already positive about receiving the vaccine, but not necessarily increase overall uptake. Serving the first purpose, however, is not without its merits, as it can reduce pressure on General Practice. What must be coupled, however, is flexibility with sustainability – reaching people en masse is evidently crucial, but so is keeping the vaccinator workforce from burn-out.

Support and Supply from the Centre

> **“If you want to make an impact at scale, I think you need to consider how you manage the vaccine supply more efficiently going forward.”**

It was widely agreed by participants at our England-wide roundtable that supply of the flu vaccine was an issue every year, with last season posing particular challenges. It was recognised that it would take time to centralise procurement of the flu vaccine, and that this move may face resistance from general practice, but that the benefits of a centralised supply would be numerous. This approach, we were told, had been considered before 2012, and that now would be an opportune moment to revisit it. It was noted that a risk of moving to central procurement could be that providers might not take up the Direct Enhanced Service if it were not financially viable.

But, as the only immunisation programme for which GP practices order their own supply, flu vaccination is an anomaly, and given the increasing complexity of the programme – with an increasing choice of vaccines, more cohorts to be vaccinated, and more providers – many participants thought the benefits were clear:

- It would save the time of Screening and Immunisation Teams (SITs) who currently have to conduct manual counts of vaccine stock in each provider to give assurance to the system about the levels which are available.

- It would mean all practices had the approved vaccine, as currently many practices order their stock before NHSE&I's flu letter is sent out in order to access discounts. This means they may not have ordered the priority vaccine.
- Having centrally held stock would make pop-up vaccination clinics easier, as vaccines would not need to be moved from multiple GP practices to the pop-up site and then returned.

Another way the centre can support local delivery is through a national call/ recall service. This had been tried for the first time in the 2020/21 flu season, and we heard in a presentation from NHSE&I that it had been effective in either increasing uptake or reducing the downward trajectory in uptake. It was noted in the evaluation that there were concerns in general practice that the national service conflicted with their local call/recall initiatives. This concern was reiterated from a participant in the discussion who explained that his practice's call/recall service allowed him to send a personalised text message to a patient and for them to respond with any questions. He argued that this method was effective in building on relationships of trust and addressing people's concerns about being vaccinated.

Nevertheless, it did seem in our discussions that there was still a place for a national call/ recall service, particular in directing patients to opportunities to be vaccinated outside of general practice. Given the current pressures on primary care, making the most of community pharmacy providers, for example, seems highly apposite. Thus, we would support the recommendation in NHSE&I's evaluation of the national call/recall service to **allow for flexibility on the timing of the contact** with eligible patients to ensure it is responsive to patterns of uptake by cohort and aligned with levels of vaccine supplies.

We would also concur with the recommendations in that evaluation to **set up an inbound call centre to create an opportunity for dialogue** and address an individual's concerns or questions about the vaccination, and to **introduce text messaging or email as a mode of communication.** As we observed in *Mind the Gap*, young and mobile populations, as well as those who do not have a fixed address are harder to reach by letter, and are also less likely to receive the flu vaccination if they are at-risk than the over-65 cohort. Therefore, developing a national call/ recall service which is designed to drive uptake in this group would be particularly valuable, and may be able to reach more people who are not registered with GPs and would otherwise be missed by a local call/ recall.

Data and IT Systems

A recurrent theme in our roundtable discussions was the importance of robust data and data systems and accurate denominators to delivering successful vaccination programmes. For example, the ability to access uptake data for all providers and cohorts on a weekly basis can enable in-season monitoring and support practices where uptake rates are lower. Participants thought that leaders in GP practices, PCNs, ICSs, and in regional and national flu teams should be **able to interrogate data for flu vaccination coverage** at the appropriate level in order to **evaluate their own performance and seek or provide support as necessary.**

Several roundtable participants described data flow between providers and the centre, and different IT systems, as a significant problem for flu vaccination programmes. It was thus recommended that NHSE&I apply significant pressure on GP IT Systems like EMIS and TPP to be directly interoperable, and flow data effectively to the central database. This would enable data to flow to the centre and then be pushed back out to regional Screening and Immunisation Teams so they can address any issues while the coverage rate for that season can still be improved.

It was also recommended that the significant efforts into denominator development and tracking for Covid-19 be taken forward into planning for the flu programme. One recommendation was for **greater clarity on the denominators for flu vaccination, and for them to be built together with local areas,** so they know when they have reached their targets.

In order to reduce inequalities in uptake, two suggestions were made regarding data: one was to have inclusion groups incorporated into data dashboards. The other was to have access to anonymised record level data so that SITs could work together with local authorities and CCGs or ICSs to target neighbourhoods where uptake rates among underserved groups are lower than average. Both of these recommendations could help evaluate whether increasing the number of providers, or having dispersed delivery models, increases uptake across the whole population, rather than simply creating choice.

A data dashboard which brought together the figures for each practice in a PCN was also described as a way of driving best practice, because it generated a sense of healthy professional competition and encouraged practices to ask those with higher rates for guidance.

Building Confidence and Reducing Complacency

“We have an example in Waltham Forest where a trusted and long-established practice personally contacted several persistent refusers to motivate them to take the flu jab and around a third of these refusers changed their minds - all because the GP took the time to have conversations.”

Misinformation and disinformation about vaccinations have been present throughout the Covid-19 pandemic. Participants at our roundtable unanimously agreed that trying to “myth-bust” rarely increased people’s intention to vaccinate as it tended to make the misinformation more memorable and lent credibility to anti-vaccination campaigners. Instead, trusted sources – namely healthcare professionals – taking the time to speak to patients proved the most effective approach. Indeed, PHE’s attitudinal surveys have consistently showed that people’s most trusted source of information about vaccination is their healthcare professional.

PHE’s research, however, has shown that the public do not tend to think of flu as a serious illness, and that this complacency can result in a lower intention to vaccinate. This may have been exacerbated, it was noted, by attempts to minimise the severity of Covid-19 by describing it as “just like flu”.

Therefore, an **effective communications** strategy for the 2021/22 flu season is vital, and it should take advantage of several opportunities which have emerged through the pandemic. For example, it was observed that the public's health literacy around virus transmission, vaccinations and risk factors had substantially increased. So, communications about flu vaccination should transfer that increased understanding developed with regards to Covid-19 and apply it, in the public's mind, to flu. In addition, awareness of the winter pressure on the NHS was also described as being high, so flu vaccination could be presented as a way of supporting frontline health care staff.

If the Joint Committee on Vaccination and Immunisation gives approval for co-administering the vaccines for flu and Covid-19, this will reduce the pressure on primary care, as one participant explained:

> **"The extra work to do those two [vaccinations for flu and Covid-19] separately will be mammoth with winter coming on. I can't overstate the recovery programme in the NHS. The waiting lists are completely out of control and the risk in terms of cancers is just enormous. So, people need to look at the wider context."**

However, there may be concerns among patients about their immune system being "overloaded". Recent attitudinal polling in Scotland, one participant told us, had found evidence of this. But, at the same time, there had been similar concerns around the Men-B vaccine which had not ultimately affected behaviour once it was introduced.

UKHSA should therefore pick up the attitudinal research which PHE has undertaken. Data about willingness to have the flu vaccination should be mapped against uptake data to monitor whether concerns about the co-administration of Covid-19 booster jabs and flu vaccinations are having an effect. This should then be used to evaluate whether specific engagement efforts are required to address these concerns and thereby ensure high coverage of both vaccinations.

As the pressure on the vaccinator workforce will continue to be high, we think there is a role for the wider public health workforce to answer people's questions about, and build confidence in, vaccinations. Accordingly, we have recently launched our Level 2 Award in Encouraging Vaccination Uptake; we would encourage employers across the public health and social care sectors to support their staff to take the qualification.

The difference in impact of engagement over one-way communication cannot be overstated, and participants wanted to see the **peer advocacy** which had emerged during the Covid-19 vaccine programme taken forward for the long term. This advocacy existed at both national and local levels – for example, one participant told us of how charities supporting people with a particular health condition had been able to assuage concerns around their suitability for the vaccine. The knowledge and relationships built up through this experience should certainly be built upon and **harnessed for future immunisation programmes.**

Risks of the Transition

> **"Quite often when we bring in a new system or make changes, that's when we see a drop in uptake. We lose staff, we lose knowledge, we lose confidence, and we lose the high uptake as well."**

Several participants raised concerns about the impact on staff of the transition from Public Health England to the UK Health Security Agency. With a loss of staff would come the loss of their expertise, local knowledge and the relationships they had built up with local partners, it was noted.

It was also observed that *"the flu programme, as well as the inequalities work for other immunisation programmes, relies on us working very closely with our local authority director of public health and their teams, as well as our colleagues in the NHS".* Therefore, if Screening and Immunisation Teams move substantively into the NHS, there is a risk of them losing professional public health leadership and their place in the "wider public health family". It was emphasised during the discussion that staff should be **provided training as their roles change** alongside **continued support and professional leadership.**

Mind the Gap made the case that the 2012 Health and Social Care Act which replaced Primary Care Trusts with NHS England Local Teams had led to a decline in coverage rates in London as there was an increase in the number of patients per commissioning team, and the role of immunisation coordinator was largely lost. Any change to the system of commissioning immunisations to come through the new DHSC strategy should be used as an opportunity to restore the ratio, with the impact on the teams responsible for eligible parents in every region assessed, and any potential risks to capacity addressed.

Conclusion

The UK is at an incredibly important moment for public health, and immunisation more specifically. On one hand, appreciation of how vaccinations can underpin social and economic life is widespread and to the fore of most people's minds. But on the other, misinformation about Covid-19 and its vaccine programme could easily spread over to people's perceptions of, and confidence in, other immunisations. At the same time, the demands on our health and care workforce have been unrelenting for 18 months, and primary care is likely to be overwhelmed for the foreseeable future.

Our roundtables focused on how those opportunities could be acted upon, and the risks mitigated. Based on those discussions, we recommend the Government and all leaders in the public health system embed the following principles into their policies and action:

- Empower providers at the local level to act on their insights
- Work collaboratively to increase access to, and confidence in, vaccinations
- Maintain a focus on reducing demographic and regional disparities in coverage
- Use data to drive improvements in coverage
- Support staff through the transition and retain professional public health leadership