

1           **NATIONAL INSTITUTE FOR HEALTH AND CARE**  
2           **EXCELLENCE**

3           **Guideline**

4           **Vaccine uptake in the general population**

5           **Draft for consultation, November 2021**  
6

**This guideline covers** vaccine uptake for everyone who is eligible for vaccines that are provided on the [NHS routine UK immunisation schedule](#), apart from flu vaccination, which is covered by [NICE's guideline on flu vaccination](#). It supports the aims of the [NHS Long Term Plan](#), which includes actions to improve immunisation coverage by GPs (including the introduction of the new [GP contract](#)) and to support a narrowing of health inequalities.

This guideline will update and replace NICE guideline PH21 (published September 2009).

**This guideline does not cover:**

- Areas covered by [NICE's guideline on tuberculosis](#).
- Areas covered by [NICE's guideline on flu vaccination: increasing uptake](#).
- Travel vaccines.
- Selective immunisation programmes, as defined in the [Green Book](#).
- Seasonal vaccinations, for example flu vaccination.
- COVID-19 vaccinations.
- Catch-up campaigns alongside the introduction of a new vaccine.

**Who is it for?**

- NHS providers including general practice, pharmacy and school age immunisation providers social care providers
- prison and secure setting employers
- independent providers of NHS and social care funded services

- child health information services and other administrative services that support immunisation services
- community or voluntary sector organisations
- local authorities
- health policy makers
- NHS commissioners of clinical immunisation services
- education and training organisations
- occupational health services
- health information providers
- people using services, their families and carers
- the general public including people who are eligible for vaccination on the routine schedule, their families and carers.

#### **What does it include?**

- the recommendations
- recommendations for research
- rationale and impact sections that explain why the committee made the recommendations and how they might affect practice and services
- the guideline context.

Information about how the guideline was developed is on the [guideline's webpage](#). This includes the evidence reviews, the scope, details of the committee and any declarations of interest.

## 1 Contents

2	Recommendations .....	4
3	1.1 Service organisation.....	4
4	1.2 Identifying eligibility, giving vaccinations and recording vaccination status .	10
5	1.3 Invitations, reminders and escalation of contact.....	15
6	Terms used in this guideline .....	23
7	Recommendations for research .....	24
8	Rationale and impact.....	28
9	Named vaccination leads.....	28
10	Designing and raising awareness of payment schemes .....	29
11	Making vaccination services accessible and tailoring to local needs .....	30
12	Audit and feedback .....	33
13	Training and education for health and social care practitioners .....	34
14	Appointments and consultations .....	36
15	Keeping records up to date.....	37
16	Identifying people eligible for vaccination and opportunistic vaccination .....	39
17	Recording vaccination offers and administration .....	42
18	Invitations, reminders and escalation of contact .....	44
19	Initial invitations .....	45
20	Reminders and escalation of contact.....	50
21	People who are not registered with a GP practice .....	53
22	Vaccinations for school-aged children and young people.....	55
23	Context.....	61
24	Finding more information and committee details .....	62
25		

## 1 Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in [NICE's information on making decisions about your care](#).

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

### 2 1.1 Service organisation

#### 3 Named vaccination leads

4 1.1.1 Ensure that each organisation that provides or organises vaccination  
5 services has a named vaccination lead with responsibility (as relevant) for  
6 ensuring that:

- 7 • vaccination records are validated and updated
- 8 • people who are eligible for vaccination are identified
- 9 • invitations and reminders are sent to people eligible for vaccination
- 10 • vaccines are administered and recorded
- 11 • there is coordination between providers and other services involved in  
12 organising vaccinations.

13 1.1.2 Nominate a named person in each primary care provider to be  
14 responsible for identifying people who are [housebound](#) and need  
15 vaccination.

16 1.1.3 Social care providers and providers of other non-healthcare services (who  
17 are asked to identify people eligible for vaccination opportunistically [see  
18 [recommendation 1.2.6](#)]) should identify a named lead responsible for the  
19 organisation's approach to identifying people who are eligible for  
20 vaccination.

- 1 1.1.4 For secondary and tertiary care providers who do not provide  
2 vaccinations, ensure that there is a named vaccination lead who can  
3 identify people eligible for vaccination and signpost them to relevant  
4 services.

For a short explanation of why the committee made these recommendations, see the [rationale and impact section on named vaccination leads](#).

Full details of the evidence and the committee's discussion are in:

- [evidence review A: identification and recording of vaccination eligibility and status](#)
- [evidence review D: interventions to increase the uptake of routine vaccines by improving access](#).

## 5 **Designing and raising awareness of payment schemes**

6 These recommendations are for NHS regional and local commissioners of NHS  
7 vaccination services.

- 8 1.1.5 Raise awareness among healthcare practitioners and providers:
- 9 • about payments and funding streams to support the delivery of  
10 vaccination services, including those for populations with low  
11 vaccination rates
  - 12 • that submission of information about vaccination uptake directly affects  
13 any linked organisational incentive payments.

14 1.1.6 When designing incentive schemes for providers, take into account that  
15 using incentives to prioritise certain vaccinations could have unintended  
16 consequences on the uptake of other vaccinations.

For a short explanation of why the committee made these recommendations, see the [rationale and impact section on designing and raising awareness of payment schemes](#).

Full details of the evidence and the committee's discussion are in [evidence review G: interventions to increase the uptake of routine vaccines by improving infrastructure](#).

## 1 **Making vaccination services accessible and tailoring to local needs**

2 1.1.7 NHS commissioners and NHS providers should ensure that they identify  
3 local population needs and barriers to vaccine uptake.

4 1.1.8 In areas with low vaccine uptake, commissioners and providers should  
5 consider introducing targeted interventions to:

- 6 • overcome identified local barriers to vaccination
- 7 • address identified inequalities in vaccine uptake between different  
8 population groups.

9 1.1.9 Commissioners and providers should ensure that they:

- 10 • Include input from people in the local community about the accessibility  
11 of services (see the [section on involving people in peer and lay roles to  
12 represent local needs and priorities in NICE's guideline on community  
13 engagement](#)).
- 14 • Tailor service opening hours and locations for vaccinations to meet  
15 local needs. This should include providing multiple opportunities for  
16 people eligible for vaccination to have their vaccinations at a time and  
17 location convenient to them. Locations such as community pharmacies,  
18 clinics people attend regularly, or GP practices could be used.

19 1.1.10 Consider using sites outside healthcare settings as settings for  
20 vaccination clinics, such as mobile vaccination units or community or faith  
21 centres that provide a more family friendly environment, if this would  
22 address specific local barriers to vaccine uptake.

23 1.1.11 Consider providing vaccination services during extended hours and  
24 extended access appointments in evenings and weekends for people who  
25 may find it difficult to attend at other times. These services could be in

1 primary care or community pharmacies, or be provided by a centralised  
2 service in each local area. If possible, provide these as part of existing  
3 out-of-hours services.

4 1.1.12 Commissioners and providers should co-ordinate vaccination services  
5 between providers to minimise wastage where vaccine supply is limited.

6 1.1.13 GP practices should ensure that contractual obligations and best practice  
7 on patient registration is followed (for example, not requiring immigration  
8 status or proof of address).

For a short explanation of why the committee made these recommendations, see the [rationale and impact section on making vaccination services accessible and tailoring to local needs](#).

Full details of the evidence and the committee's discussion are in [evidence review D: interventions to increase the uptake of routine vaccines by improving access](#).

## 9 **Audit and feedback**

10 1.1.14 NHS commissioners should ensure that there is a coordinated system in  
11 place for a quarterly cycle of feedback and audits that can be compared  
12 against similar providers at a local and national level.

13 1.1.15 Providers should use available data to review current and past activity to  
14 help with continuous improvement.

15 1.1.16 To help increase vaccine uptake in the future, vaccine services should:

- 16 • evaluate initiatives for improving the uptake of routine or COVID-19  
17 vaccinations carried out during the SARS-CoV-2 pandemic
- 18 • identify any that could be used to increase the uptake of routine  
19 vaccination programmes.

For a short explanation of why the committee made these recommendations, see the [rationale and impact section on audit and feedback](#).

Full details of the evidence and the committee's discussion are in:

- [evidence review G: interventions to increase the uptake of routine vaccines by improving infrastructure](#)
- [evidence review H: multicomponent interventions to increase uptake of routine vaccines](#)
- [evidence review K: COVID call for evidence](#).

## 1 Training and education for health and social care practitioners

2 1.1.17 Ensure that health and social care practitioners who are in contact with  
3 people eligible for vaccination, but do not administer vaccines, are  
4 educated about vaccination. These could include:

- 5 • Practitioners working in primary care settings, including GP practices,  
6 optometry, NHS dental practices and community pharmacies.
- 7 • Secondary care practitioners, for example in clinics for children with  
8 chronic conditions or wards such as oncology or antenatal.
- 9 • Social care practitioners who may have contact with carers and other  
10 eligible groups, such as people with learning disabilities. This may  
11 include contact during home visits, individual needs assessments and  
12 carers' assessments.

13 1.1.18 Ensure that education for health and social care practitioners who are in  
14 contact with people eligible for vaccination, but do not administer  
15 vaccines, includes:

- 16 • an understanding of who is eligible for vaccination on the NHS routine  
17 UK immunisation schedule
- 18 • awareness of barriers to vaccination
- 19 • benefits and risks of vaccination
- 20 • where to signpost people for further information and vaccination.



1 1.1.19 Health and social care practitioners who administer vaccines should be  
2 given the time, resources and support to:

- 3 • Undertake mandatory training before administering vaccines (see  
4 [Public Health England's national minimum standards and core](#)  
5 [curriculum for immunisation training for registered healthcare](#)  
6 [practitioners](#)).
- 7 • Include training on vaccination as part of their continuing professional  
8 development plan, including how to have effective conversations about  
9 vaccination.
- 10 • Ask people for any questions and concerns they may have about  
11 vaccination and give them personalised responses (or signpost people  
12 to relevant sources).
- 13 • Provide tailored information on the risks and benefits of vaccination.
- 14 • Offer and administer vaccines.

For a short explanation of why the committee made these recommendations, see the [rationale and impact section on training and education for health and social care practitioners](#).

Full details of the evidence and the committee's discussion are in:

- [evidence review E: education interventions to increase the uptake of routine vaccines](#)
- [evidence review H: multicomponent interventions to increase uptake of routine vaccines](#).

## 15 **Appointments and consultations**

16 1.1.20 Providers should ensure that there is sufficient time in an appointment or  
17 consultation to:

- 18 • allow the clinician and individual, [family member or carer](#) (as  
19 appropriate) to have a discussion where any concerns can be identified  
20 and addressed
- 21 • gain informed consent

- 1 • administer vaccines
- 2 • complete documentation.

3

4 See also the [NICE guideline on shared decision making](#).

For a short explanation of why the committee made this recommendation, see the [rationale and impact section on appointments and consultations](#).

Full details of the evidence and the committee's discussion are in [evidence review E: education interventions to increase the uptake of routine vaccines](#).

## 5 **1.2 Identifying eligibility, giving vaccinations and recording**

### 6 **vaccination status**

7 NICE has produced a [visual summary on identifying people eligible for vaccination](#)  
8 [and opportunistic vaccination](#).

### 9 **Keeping records up to date**

10 1.2.1 GP practices should ensure that their vaccination records are updated  
11 within 2 weeks in response to new information about a person's  
12 vaccination status.

13 1.2.2 GP practices should ensure that an up-to-date template is used for  
14 recording vaccinations.

15 1.2.3 GP practices should validate their vaccination records at least monthly  
16 against data sources received. Check registered populations and vaccine  
17 eligibility and status, investigate any discrepancies and correct the record  
18 accordingly.

19 1.2.4 Child health information services (CHIS) should give GP practices a  
20 monthly update on children who are not up to date with their vaccinations.

21 1.2.5 GP practices should ensure that they have up-to-date medical records,  
22 phone numbers and addresses for people who are eligible for vaccination,  
23 or their [family members or carers](#) (if appropriate). Include the person's

1 preferred methods of contact (such as letters, texts, emails or phone calls)  
2 and whether there are additional literacy issues or language needs.

For a short explanation of why the committee made these recommendations, see the [rationale and impact section on keeping records up to date](#).

Full details of the evidence and the committee's discussion are in [evidence review A: identification and recording of vaccination eligibility and status](#).

### 3 **Identifying people eligible for vaccination and opportunistic vaccination**

4 1.2.6 Use every opportunity to identify people eligible for vaccination. This could  
5 include:

- 6 • at registration in general practice
- 7 • during health and developmental reviews as part of the healthy child  
8 programme
- 9 • during the annual learning disability health check for people with  
10 learning disabilities
- 11 • when making contact with people in healthcare settings, community  
12 health clinics, sexual health services or drug and alcohol services  
13 (including hospitals, emergency departments, inpatient services,  
14 rehabilitation services and general practice)
- 15 • when making contact with women who have a newly confirmed  
16 pregnancy, and at antenatal and postnatal reviews
- 17 • on admission to day care, nurseries, schools, special needs schools,  
18 pupil referral units, and further and higher education.
- 19 • on admission to care homes
- 20 • when people visit community pharmacies for health advice, a  
21 medicines use review or a new medicine service, or to collect  
22 prescriptions
- 23 • home visits for healthcare or social care
- 24 • any health service contact with people who are homeless
- 25 • when new migrants, including asylum seekers, arrive in the country

- 1           • within 7 days of arrival in prisons and young offender institutions, during  
2           any contact with healthcare services in these places, and when people  
3           leave
- 4           • as part of a looked-after child or young person’s health plan, and during  
5           initial health assessments, and annual and statutory reviews (see also  
6           [NICE's guideline on looked-after children and young people](#))
- 7           • any contact with home-educated children
- 8           • when people start a job and during subsequent occupational health  
9           checks for all practitioners who work on site in a clinical setting even if  
10          their role is not healthcare related.
- 11   1.2.7    Offer people (or their family members and carers, if appropriate) access to  
12          online systems or apps to allow them to view and check their NHS  
13          vaccination records (or those of their child or the person they care for).
- 14   1.2.8    Providers of online systems or apps should ensure that people  
15          automatically have access to their vaccination status as part of their  
16          electronic records as the default option.
- 17   1.2.9    Use the NHS summary care record, or any other available vaccination  
18          records (including records held by the person), to opportunistically identify  
19          people who are eligible for vaccination.
- 20   1.2.10   Unless a person has a documented (or reliable verbal) vaccine history,  
21          assume that they are not immunised, and plan a full course of  
22          immunisations (see [Public Health England guidance on vaccination of  
23          individuals with uncertain or incomplete immunisation status](#)).
- 24   1.2.11   GP practices should ensure that there is a mechanism in place to check  
25          the vaccination status of people registered as temporary residents and  
26          offer any vaccinations needed.
- 27   1.2.12   Providers should routinely use prompts and reminders from electronic  
28          medical records to opportunistically identify people who are eligible for  
29          vaccination.

1 1.2.13 Midwives should offer vaccination to [pregnant women](#) during routine  
2 antenatal visits, as recommended by the [Green book and the NHS routine](#)  
3 [UK immunisation schedule](#). If the midwife cannot administer the vaccine,  
4 they should signpost women to vaccination services, drop-in clinics or  
5 their GP practice.

6 1.2.14 When people eligible for vaccination have been identified  
7 opportunistically:

- 8 • Healthcare professionals should:
  - 9 – if possible, discuss any outstanding vaccinations with them (or their
  - 10 family members or carers, if appropriate) and offer vaccination
  - 11 immediately
  - 12 – otherwise, encourage them to book an appointment to discuss the
  - 13 vaccinations or an appointment for vaccination.
- 14 • Non-healthcare professionals should signpost them to vaccination
- 15 services.

16  
17 See also recommendation 1.2.15.

For a short explanation of why the committee made these recommendations, see the [rationale and impact section on identifying people eligible for vaccination and opportunistic vaccination](#).

Full details of the evidence and the committee's discussion are in:

- [evidence review A: identification and recording of vaccination eligibility and status](#)
- [evidence review C: reminders interventions to increase the uptake of routine vaccines](#)
- [evidence review D: interventions to increase the uptake of routine vaccines by improving access](#)
- [evidence review E: education interventions to increase the uptake of routine vaccines](#)

- [evidence review H: multicomponent interventions to increase uptake of routine vaccines.](#)

## 1 **Recording vaccination offers and administration**

2 1.2.15 When offering a vaccination, record in the GP record or other medical  
3 record whether it was accepted or declined or there was no response.

4 1.2.16 When administering a vaccine, ensure that information is recorded  
5 accurately and consistently, regardless of where the vaccine is  
6 administered, and includes:

- 7 • details of consent to the vaccination (including if someone else has  
8 consented on the person's behalf, and that person's relationship to  
9 them)
- 10 • the dose, batch number, expiry date and title of the vaccine
- 11 • the date, route and site of administration
- 12 • any reported adverse reactions
- 13 • whether the vaccine was administered under Patient Specific Directions  
14 (PSDs) or Patient Group Directions (PGDs).

15 1.2.17 Providers should ensure that clinical and patient-held records (including  
16 records held on behalf of children) are updated at the time of the  
17 vaccination. If the patient-held record is not available at the appointment,  
18 give the person a printed record of the vaccination and ensure that the  
19 patient-held record is updated at a subsequent healthcare appointment.

20 1.2.18 Providers should use electronic health record templates with compulsory  
21 data fields to support accurate recording of vaccination status (see  
22 recommendations 1.2.15 and 1.2.16).

23 1.2.19 Providers should ensure that vaccinations are reported promptly (within 5  
24 working days, or in line with required standards if shorter) to GP practices  
25 and child health information service (if relevant).

1 1.2.20 Child health information services should send details of vaccinations  
2 administered outside of the GP practice to GP practices within 2 weeks or  
3 as specified in the child health information services contract if shorter.

4 1.2.21 Providers should ensure that the information they provide to GP practices  
5 and child health information services is clear and in a readily accessible  
6 format that minimises the need for manual re-entry of data.

For a short explanation of why the committee made these recommendations, see the [rationale and impact section on recording vaccination offers and administration](#).

Full details of the evidence and the committee's discussion are in [evidence review A: identification and recording of vaccination eligibility and status](#).

### 7 **1.3 Invitations, reminders and escalation of contact**

8 1.3.1 NHS England public health commissioning teams and screening and  
9 immunisation teams should ensure that there is a coordinated system in  
10 place at the local level for providers to send out invitations and reminders.

11 1.3.2 If possible, ensure that the information, invitation and any subsequent  
12 reminders are given in a format and language appropriate for the person  
13 and their [family members or carers](#) (as appropriate).

14 1.3.3 Ensure that the information, invitation and any subsequent reminders  
15 meet the person's communication needs (see [NHS England's Accessible  
16 Information Standard](#)). For more guidance on giving people information  
17 and discussing their preferences, see [NICE's guidelines on patient  
18 experience in adult NHS services](#) and [shared decision making](#).

19 1.3.4 Give people who have come from outside the UK:

- 20 • details of the NHS vaccine schedule, how it is delivered, where and by  
21 whom if they:
  - 22 – have started vaccinations before arrival and not completed them **or**
  - 23 – are eligible for vaccination.

- 1                   • help to access healthcare, if needed.

2

3                   Be aware that expectations of who delivers vaccine services may differ  
4                   by cultural background.

5 1.3.5       If people need to provide consent for vaccination but need additional  
6                   support with decision making (such as people with learning disabilities) or  
7                   if they may lack mental capacity, follow the [recommendations on](#)  
8                   [supporting decision making in NICE's guideline on decision making and](#)  
9                   [mental capacity](#).

10 1.3.6       Consider sending invitations and reminders for different vaccinations  
11                   together (for example, the pneumococcal vaccine with the flu vaccine).

For a short explanation of why the committee made these recommendations, see the [rationale and impact section on invitations, reminders and escalation of contact](#).

Full details of the evidence and the committee's discussion are in:

- [evidence review E: education interventions to increase the uptake of routine vaccines](#)
- [evidence review J: acceptability and effectiveness of interventions to increase routine vaccine uptake](#).

## 12 **Vaccinations for babies, infants and preschool-aged children, and adults**

13 NICE has produced the following visual summaries:

- 14 • [Visual summary on vaccinations for young children and older people: invitations,](#)  
15 [reminders and escalation of contact](#).
- 16 • [Visual summary on vaccinations for pregnant women: invitations, reminders and](#)  
17 [escalation of contact](#).

### 18 **Initial invitations**

19 1.3.7       Invite people who are eligible for vaccination or their family members or  
20                   carers (as appropriate) to book an appointment or attend an open access



- 1 clinic. Do this opportunistically during consultations if possible, or by letter,  
2 email, phone call or text. Use the person's preferred method of  
3 communication for invitations if possible.
- 4 1.3.8 Practitioners working in maternity services and other healthcare  
5 professionals who have contact with [pregnant women](#) should ensure that  
6 pregnant women are invited for vaccination or signposted to vaccination  
7 services or drop-in clinics.
- 8 1.3.9 Ensure that people who live in care homes or residential settings, or are  
9 [housebound](#) (or their family members or carers, as appropriate) know how  
10 to get home visits for vaccination if they are unable to attend vaccination  
11 clinics or other settings where vaccinations are available. See also  
12 recommendation 1.3.5 and [NICE's guideline on managing medicines in](#)  
13 [care homes](#).
- 14 1.3.10 Consider sending the vaccination invitation and any subsequent  
15 reminders from a healthcare professional or service that is known to the  
16 person or their family members or carers, such as a school, GP practice,  
17 doctor, nurse, midwife or health visitor.
- 18 1.3.11 Ensure that the vaccination invitation contains:
- 19 • The vaccines being offered (named in full) and the targeted diseases.
  - 20 • A statement that the NHS and the relevant provider (edit to specify the  
21 type of provider) recommends the vaccination.
  - 22 • Details on contacting a healthcare professional (for example, practice  
23 nurse, GP, school nurse or pharmacist) to discuss any concerns the  
24 person (or their family members or carers) might have.
  - 25 • Instructions for how to book an appointment at a vaccination clinic, if  
26 relevant, or where and when drop-in clinics are held. If possible, include  
27 options for online booking.
  - 28 • A reminder to bring any relevant patient-held records for updating.
- 29 1.3.12 If space allows, include the following in the vaccination invitation or  
30 provide links:

- 1           • Information on the vaccines, including:
- 2           – the potential severity of the targeted diseases
- 3           – the risks and benefits of vaccination, including individual benefits
- 4           (including to the baby for maternal pertussis vaccination) and
- 5           population benefits (protecting other people in their community)
- 6           – if relevant, the importance of having all doses of a vaccination
- 7           course
- 8           – if relevant, why some vaccines are given at specific ages (for
- 9           example, the HPV [human papillomavirus] vaccine).
- 10          • Instructions for accessing additional videos and information (including
- 11          interactive information and decision tools) from trusted sources such as
- 12          the [Oxford University's Vaccine Knowledge Project](#), [NHS England](#) and
- 13          the [World Health Organization](#). Include hyperlinks or QR codes if
- 14          possible.
- 15          • Information about what to expect at the appointment.

For a short explanation of why the committee made these recommendations, see the [rationale and impact section on initial invitations](#).

Full details of the evidence and the committee's discussion are in:

- [evidence review C: reminders interventions to increase the uptake of routine vaccines](#)
- [evidence review E: education interventions to increase the uptake of routine vaccines](#)
- [evidence review H: multicomponent interventions to increase uptake of routine vaccines](#).

## 16 **Reminders and escalation of contact**

- 17 1.3.13 Providers (such as GP practices) should identify people who do not
- 18 respond to invitations or attend clinics, vaccination appointments or other
- 19 settings where vaccinations are available and send a reminder. (See also
- 20 recommendation 1.3.10.) Confirm that the person has received the
- 21 reminder.

- 1 1.3.14 At a pregnant woman's first appointment after the 20-week scan,  
2 antenatal care providers should check whether they have been offered  
3 and accepted vaccination against pertussis in this pregnancy. If not,  
4 ensure they receive offers of vaccination or reminders (as relevant) at  
5 subsequent antenatal appointments or during any contact with their GP or  
6 any other healthcare provider.
- 7 1.3.15 Talk to parents or carers (as appropriate) of children aged 5 or under who  
8 have not responded to a reminder if a vaccination delay is approaching:
- 9
- 10 • 1 month for babies
  - 11 • 2 months for toddlers
  - 12 • 3 months for preschool boosters.
- 13 Explore with them the reasons for their lack of response and try to  
14 address any issues they raise.
- 15 1.3.16 For pregnant women and [older people](#) who do not respond to reminders,  
16 consider more direct contact such as a phone call. Explore with them the  
17 reasons for their lack of response and try to address any issues they  
18 raise.
- 19 1.3.17 Consider a multidisciplinary approach to address any issues raised in  
20 recommendations 1.3.15 and 1.3.16, involving other relevant healthcare  
21 professionals such as health visitors, social workers or key workers, while  
22 respecting the person's decision if they refuse vaccination.
- 23 1.3.18 Consider home visits for people who have difficulty travelling to  
24 vaccination services. Discuss immunisation and offer them or their  
25 children (as relevant) vaccinations there and then (or arrange a  
26 convenient time in the future).
- 27 1.3.19 If someone declines an offer of vaccination, record this with the reason  
28 why and make sure they know how to get a vaccination at a later date if  
29 they change their mind.

For a short explanation of why the committee made these recommendations, see the [rationale and impact section on reminders and escalation of contact](#).

Full details of the evidence and the committee's discussion are in:

- [evidence review C: reminders interventions to increase the uptake of routine vaccines](#)
- [evidence review D: interventions to increase the uptake of routine vaccines by improving access](#)
- [evidence review H: multicomponent interventions to increase uptake of routine vaccines](#).

## 1 **People who are not registered with a GP practice**

2 1.3.20 Commissioners should consider involving local authorities, health visitors  
3 or the community or voluntary sector to ensure that people who are not  
4 registered with a GP practice are identified and have opportunities to  
5 access relevant vaccinations.

6 1.3.21 Commissioners should ensure that people who are not registered with a  
7 GP practice are aware that they are eligible for NHS vaccinations, and  
8 where and how to access them.

9 1.3.22 Child health information services should send invitations to parents or  
10 carers (as appropriate) of children who are eligible for vaccination but are  
11 not registered with a GP practice or, depending on local arrangements,  
12 they could supply this information to the relevant people to send out  
13 invitations. This might include children from Traveller, Gypsy and Roma  
14 communities, newly arrived immigrants or asylum seekers.

For a short explanation of why the committee made these recommendations, see the [rationale and impact section on people who are not registered with a GP practice](#).

Full details of the evidence and the committee's discussion are in [evidence review C: reminders interventions to increase the uptake of routine vaccines](#).

## 1 **Vaccinations for school-aged children and young people**

2 1.3.23 When administering vaccinations to secondary school-aged children and  
3 young people, do this in schools if possible.

### 4 **Routine vaccinations at school**

5 NICE has produced a [visual summary on vaccinations for school-based children and](#)  
6 [young people: invitations, reminders and escalation of contact](#).

7 1.3.24 School age immunisation providers and schools should work together to  
8 organise and carry out vaccinations for secondary school-aged children  
9 and young people.

10 1.3.25 Ensure that schools are involved in sending invitations (including consent  
11 forms) for vaccinations on behalf of the providers to pupils who attend  
12 school. Make the format of the invitation accessible to parents and  
13 secondary school-aged children and young people.

14 1.3.26 Providers should ensure that young people and their parents or carers (as  
15 appropriate) have reliable information about vaccines that covers risks  
16 and benefits to help them to make informed decisions. The information  
17 should include who can consent to vaccination ([Gillick competence](#)) as  
18 well as the information listed in [recommendations 1.3.11 and 1.3.12](#) (as  
19 appropriate). (See also the [NICE guideline on babies, children and young](#)  
20 [people's experience of healthcare](#).)

21 1.3.27 Providers and schools should work together to ensure that school-based  
22 education about vaccines is available in an age-appropriate format to  
23 children and young people to increase their understanding about  
24 vaccinations.

25 1.3.28 Providers should offer incentives, such as a ticket for a prize draw, that  
26 encourage the return of consent forms.

- 1 1.3.29 If a completed consent form is not returned, send a reminder.
- 2 1.3.30 Phone the child or young person's parents or carers (as appropriate) to  
3 ask for verbal consent if they have not responded by the time preparations  
4 are being made for vaccination day. If contact cannot be made, involve  
5 other health and social care providers who may be involved with the  
6 family to help gain consent.
- 7 1.3.31 Be aware that young people under 16 can give their own consent to  
8 vaccination if they are assessed to be Gillick competent.
- 9 1.3.32 School aged immunisation providers should ensure that they have a  
10 policy in place to support school aged immunisation teams in assessing  
11 Gillick competence. Include guidance on what action to take when a  
12 young person's vaccination preference is different from that of their  
13 parents or carers.
- 14 1.3.33 Commissioners should ensure that school aged immunisation services  
15 offer catch-up vaccination sessions to children and young people who are  
16 not up to date with their routine adolescent vaccination schedule. Include  
17 an assessment for capacity to consent in the absence of parental consent  
18 or if there has been parental refusal, in line with guidance on consent in  
19 the [Green book: chapter 2](#) and from professional bodies such as the  
20 [General Medical Council's advice on making decisions](#).
- 21 1.3.34 Child health information services should provide information to school  
22 nursing teams to help them identify children and young people who are  
23 not up to date with their preschool vaccinations.
- 24 **Children and young people who do not attend mainstream schools**
- 25 1.3.35 Commissioners of vaccination services for school-aged children should  
26 ensure that children and young people who do not attend mainstream  
27 school are invited for vaccination at another setting.

For a short explanation of why the committee made these recommendations, see the [rationale and impact section on vaccinations for school-aged children and young people](#).

Full details of the evidence and the committee's discussion are in:

- [evidence review C: reminders interventions to increase the uptake of routine vaccines](#)
- [evidence review D: interventions to increase the uptake of routine vaccines by improving access](#)
- [evidence review J: acceptability and effectiveness of interventions to increase routine vaccine uptake](#).

## 1 **Terms used in this guideline**

2 This section defines terms that have been used in a particular way for this guideline.  
3 For other definitions, see the [NICE glossary](#) and the [Think Local, Act Personal Care](#)  
4 [and Support Jargon Buster](#).

## 5 **Family members or carers**

6 People with legal responsibility for decision making for an individual who is eligible  
7 for vaccination but cannot make this decision for themselves. These include parents  
8 of babies, children and young people and may also include other family members or  
9 guardians or carers if they have this responsibility (for example, if they hold a lasting  
10 power of attorney in health and welfare for another adult). See the [Green book:](#)  
11 [chapter 2 on consent](#) for more details.

## 12 **Housebound**

13 People who are unable to leave their home environment through physical or  
14 psychological illness. The decision about whether someone is classified as  
15 housebound should be made according to relevant local or national policies. This  
16 terminology is used to maintain consistency with NHS documents and websites.

## 1 **Older people**

2 Adults who are eligible for routine vaccination on the UK schedule, excluding  
3 pregnancy-related vaccinations. At the time of consultation (October 2021), the UK  
4 schedule has routine vaccinations for adults who are aged 65 years and over, but  
5 this is expected to change in line with the reduction in age of eligibility for the  
6 shingles vaccination. Consult the [Green book](#) for information about current age limits  
7 and vaccinations for older people.

## 8 **Pregnant women**

9 Women who are pregnant as well as transgender or non-binary people who are  
10 pregnant. This terminology is used to maintain consistency with NHS documents and  
11 websites.

## 12 **Recommendations for research**

13 The guideline committee has made the following recommendations for research.

### 14 **Key recommendations for research**

#### 15 **1 Increasing vaccination uptake in populations with low uptake**

16 What are the most effective and acceptable interventions to increase uptake in  
17 populations or groups with low routine vaccine uptake in the UK?

For a short explanation of why the committee made this recommendation, see the [rationale section on initial invitations](#).

Full details of the evidence and the committee's discussion are in [evidence review B: barriers to, and facilitators for, vaccine uptake](#).

#### 18 **2 Incentives aimed at individuals, family members and carers**

19 What is the effectiveness and acceptability of incentives to increase uptake of routine  
20 vaccines?

For a short explanation of why the committee made this recommendation, see the [rationale section on vaccinations for school-aged children and young people](#).



Full details of the evidence and the committee's discussion are in [evidence review G: interventions to increase the uptake of routine vaccines by improving infrastructure](#).

### 1 **3 Quasi-mandation of vaccinations**

- 2 What is the effectiveness and acceptability of quasi-mandation to increase vaccine
- 3 uptake of routine vaccines?

For a short explanation of why the committee made this recommendation, see the [rationale section on vaccinations for school-aged children and young people](#).

Full details of the evidence and the committee's discussion are in [evidence review G: interventions to increase the uptake of routine vaccines by improving infrastructure](#).

### 4 **4 Tailoring Immunisation Programmes**

- 5 Is the use of the World Health Organisation 'Tailoring Immunisation Programmes'
- 6 (TIP) approach an effective way of designing interventions to increase vaccine
- 7 uptake in a UK context?

For a short explanation of why the committee made this recommendation, see the [rationale section on vaccinations for school-aged children and young people](#).

Full details of the evidence and the committee's discussion are in [evidence review J: acceptability and effectiveness of interventions to increase routine vaccine uptake](#).

### 8 **5 Framing content in vaccination invitation letters**

- 9 What is the relative effectiveness and acceptability of different styles of phrasing
- 10 content in a vaccination invitation letter?

For a short explanation of why the committee made this recommendation, see the [rationale section on initial invitations](#).

Full details of the evidence and the committee's discussion are in [evidence review E: education interventions to increase the uptake of routine vaccines](#).

## 1 **Other recommendations for research**

### 2 **Increasing vaccination uptake in older people**

3 What are the most effective and acceptable interventions to increase routine vaccine  
4 uptake in [older people](#)?

For a short explanation of why the committee made this recommendation, see the [rationale section on initial invitations](#).

Full details of the evidence and the committee's discussion are in [evidence review B: barriers to, and facilitators for, vaccine uptake](#).

### 5 **HPV vaccination for boys**

6 What are the most effective and acceptable strategies to increase HPV (human  
7 papillomavirus) vaccine uptake in boys?

For a short explanation of why the committee made this recommendation, see the [rationale section on vaccinations for school-aged children and young people](#).

Full details of the evidence and the committee's discussion are in [evidence review B: barriers to, and facilitators for, vaccine uptake](#).

### 8 **Increasing pertussis vaccination uptake by pregnant women**

9 What are the most effective and acceptable interventions to increase pertussis  
10 vaccine uptake in pregnant women?

For a short explanation of why the committee made this recommendation, see the [rationale section on initial invitations](#).

Full details of the evidence and the committee's discussion are in [evidence review F: interventions to increase the uptake of routine vaccines for pregnant women](#).

1 **Provider incentives**

- 2 What is the effectiveness and acceptability of giving incentives to providers to  
3 increase immunisation rates in the UK?

For a short explanation of why the committee made this recommendation, see the [rationale on designing and raising awareness of payment schemes](#).

Full details of the evidence and the committee's discussion are in [evidence review G: interventions to increase the uptake of routine vaccines by improving infrastructure](#).

4 **School- versus GP-based catch-up campaigns**

- 5 What is the effectiveness and acceptability of school-based catch-up vaccination  
6 sessions compared with GP-based catch-up campaigns?

For a short explanation of why the committee made this recommendation, see the [rationale section on vaccinations for school-aged children and young people](#).

Full details of the evidence and the committee's discussion are in [evidence review J: acceptability and effectiveness of interventions to increase routine vaccine uptake](#).

7 **Incentives for school-based vaccinations**

- 8 What levels and types of incentives are effective and acceptable for increasing  
9 vaccination uptake in a school-based population?

For a short explanation of why the committee made this recommendation, see the [rationale section on vaccinations for school-aged children and young people](#).

Full details of the evidence and the committee's discussion are in [evidence review J: acceptability and effectiveness of interventions to increase routine vaccine uptake](#).

## 1 **Rationale and impact**

2 These sections briefly explain why the committee made the recommendations and  
3 how they might affect practice.

## 4 **Named vaccination leads**

5 [Recommendations 1.1.1 to 1.1.4](#)

## 6 **Why the committee made the recommendations**

7 The committee recognised several key stages in the vaccination process: updating  
8 records; identifying people eligible for vaccination and inviting them for vaccination;  
9 and administering the vaccines. Based on their experience, the committee agreed  
10 that in the absence of a named lead, vaccine-related tasks for each organisation that  
11 provides or organises vaccinations may not be prioritised and completed, given the  
12 many other conflicting demands on people's time. The named lead would not  
13 necessarily carry out these functions themselves but would be responsible for  
14 making sure they happened.

15 People who are housebound are less likely to be vaccinated because they cannot  
16 attend appointments or vaccination clinics. Having a named person in each GP  
17 practice to identify these people will help to ensure that they are vaccinated.

18 The committee were keen to promote opportunistic vaccinations as part of their  
19 overall strategy to increase uptake, and for this to take place in a range of settings  
20 (see recommendations in the [section on identifying people eligible for vaccination  
21 and opportunistic vaccination](#)). They recognised that it was not possible to vaccinate  
22 people in some non-healthcare settings, such as during home visits for social care.  
23 But these settings do provide opportunities to signpost people to vaccination  
24 services and having a named lead should help ensure that there is a strategy in  
25 place to do this. Other healthcare settings where vaccines are not routinely  
26 administered, such as hospitals or other secondary or tertiary care providers, could

1 also be used for opportunistic identification. In these settings, the named lead could  
2 be any suitably trained healthcare professional, such as a nurse, doctor or  
3 pharmacist.

#### 4 **How the recommendations might affect practice**

5 These recommendations are not expected to need significant additional resources. It  
6 is likely that the named vaccination leads in healthcare settings would be existing  
7 members of staff. There are likely to be some small costs for the reallocation and  
8 reorganisation of tasks to the named lead in each scenario, but all of the activities  
9 should already be part of usual practice, and the benefits of having a named lead to  
10 ensure these tasks are carried out is expected to outweigh these costs. Although  
11 checking for eligibility for vaccination is not always usual practice in non-healthcare  
12 settings, it is unlikely to be a resource-intensive task.

13 Many GP practices already have a register of people who are housebound that the  
14 nominated lead could use. In practices that do not have a register, the lead could  
15 identify them by reviewing people who decline vaccination because they cannot  
16 attend the surgery and coding them appropriately. This is not expected to have a  
17 significant resource impact.

18 [Return to recommendations](#)

#### 19 **Designing and raising awareness of payment schemes**

20 [Recommendations 1.1.5 to 1.1.6](#)

#### 21 **Why the committee made the recommendations**

22 Although funding is already available for vaccination programmes, the committee  
23 agreed that in their experience, healthcare practitioners and providers are not always  
24 aware of all of the funding streams available to them, particularly if they change  
25 frequently or are only available for short periods of time. Therefore, it is important for  
26 commissioners to raise awareness of these funding options because access to more  
27 funding will help providers to develop their vaccination schemes, potentially  
28 increasing access to vaccinations. In addition, the committee wanted to raise  
29 awareness among healthcare providers about the need to submit data on

1 vaccination uptake rates to enable them to take advantage of organisational  
2 incentives such as those provided by the [Quality and Outcomes Framework](#) for GPs.

3 There was some evidence that provider incentives could increase the uptake of  
4 routine vaccinations. However, this evidence comprised a small number of non-UK  
5 based studies. Although organisational incentives for vaccination are currently in use  
6 in the UK, they are subject to change, and it is unclear what types and levels of  
7 incentives are most effective in the UK. The committee therefore included a [research](#)  
8 [recommendation on provider incentives](#).

9 The committee expressed concern that targets for some vaccinations may  
10 inadvertently result in those vaccinations being prioritised over other, non-targeted,  
11 vaccines. It is therefore important that commissioners consider the potential for  
12 unintended consequences when designing incentive schemes for providers. By  
13 highlighting these considerations, the committee thought that commissioners and  
14 providers should be able to develop ways to mitigate any reductions in uptake of  
15 non-incentivised vaccinations that are detected using local uptake data. These could  
16 involve reminding practitioners about the importance of other non-incentivised  
17 vaccinations.

### 18 **How the recommendations might affect services**

19 Raising awareness about funding streams and payments for providers is unlikely to  
20 need any additional resources because it could be done as part of existing  
21 communications between commissioners and providers. Because the funding  
22 streams already exist, no additional resources to provide funding would be needed.

23 Making commissioners aware of potential unintended consequences of prioritising  
24 certain vaccinations when using incentives is unlikely to need additional resources.  
25 This could be communicated to commissioners during the process of designing  
26 incentive schemes.

27 [Return to recommendations](#)

### 28 **Making vaccination services accessible and tailoring to local needs**

29 [Recommendations 1.1.7 to 1.1.13](#)

## 1 **Why the committee made the recommendations**

2 Based on their experience and the qualitative evidence, the committee agreed that it  
3 is important that commissioners and providers identify the needs of their local  
4 communities because this will enable them to tailor their vaccination services to  
5 address these needs. In areas of low uptake, targeted interventions may be needed,  
6 such as allowing extra time for healthcare professionals to identify and contact  
7 people eligible for vaccination. The committee did not state a specific threshold for  
8 identifying areas of low vaccine uptake because this can vary between different  
9 vaccines. Also, there may be some areas that have high vaccine uptake overall but  
10 subpopulations with low uptake. Targeted interventions could also involve  
11 developing ways for people to access vaccinations more easily, although the specific  
12 interventions used will vary depending on the local area, the community and its  
13 culture. The use of targeted interventions in areas of low uptake could potentially  
14 reduce some of the barriers to vaccination and increase vaccine uptake. This could  
15 also help to reduce inequalities between population groups and between areas of  
16 higher and lower vaccine uptake.

17 Evidence showed that inconvenient times and locations for vaccinations were  
18 barriers to uptake, and that providing alternative locations improved uptake.

19 The committee agreed that offering vaccination outside normal hours and having a  
20 range of settings would increase the number of people who are able to attend and  
21 access the services. However, they recognised that the specific needs will vary  
22 between different populations and that services need to be tailored to meet these  
23 needs. So they decided against recommending specific ways to increase access  
24 because public health teams and providers would know best how to meet local  
25 needs and understand local barriers to access. However, as part of this process,  
26 care would need to be taken to ensure that expanding the range of settings did not  
27 increase wastage of vaccines associated with unused stocks or lead to shortages of  
28 vaccines in some settings due to under-ordering to avoid wastage. GP practices, for  
29 example, would need to be able to plan their orders based on the numbers of eligible  
30 people.

31 The committee also highlighted the importance of using input from the local  
32 community when making decisions over the accessibility of services because

1 increased community engagement could help ensure that services meet local needs  
2 and make it easier for people to be vaccinated.

3 The evidence identified a range of barriers to vaccine uptake for specific populations,  
4 such as immigrants and the Traveller, Roma and Gypsy communities. This included  
5 problems with registering with a GP practice, which makes it harder for people to be  
6 identified as eligible and invited for vaccination, or for them to book vaccination  
7 appointments. The committee were aware that some providers may ask for specific  
8 information, such as immigration status and proof of address, at registration.  
9 Therefore, they decided it was important to highlight that this type of information is  
10 not required, and that primary care providers should ensure that their patient  
11 registration systems follow the standards of best practice. This will remove  
12 unnecessary barriers to accessing vaccination services.

### 13 **How the recommendations might affect services**

14 The ability to design services based on local needs will mean that providers can  
15 address any barriers to vaccination specific to their communities, thereby providing  
16 the opportunity to increase vaccine uptake and address inequalities in these areas.  
17 The impact on practice will therefore vary between areas. If the targeted  
18 interventions result in increased vaccine uptake, they are likely to also have time-  
19 saving and cost-saving benefits in the longer term, such as reducing the workload  
20 needed to identify, contact and vaccinate people who do not initially get vaccinated.

21 Identifying local population needs and tailoring hours and locations of vaccination  
22 services to meet those needs is not expected to need significant additional  
23 resources. This is already expected in current practice and these recommendations  
24 are aimed at making this identification and tailoring of services more consistent  
25 across the country.

26 Providing multiple opportunities and locations for more convenient vaccination is  
27 likely to be associated with some additional resource use. However, some of the  
28 costs are likely to be offset by the significant savings and other benefits from  
29 avoiding outbreaks and their associated care costs, and saving practitioner time for  
30 chasing up people who have missed vaccination. Increasing the opportunities for  
31 vaccination may be particularly beneficial in some areas, such as rural areas, where



1 there may be fewer GP practices and pharmacies and a greater distance to travel to  
2 access services. Although there may still be a cost associated with this  
3 recommendation, it is expected to be small and the benefits of providing more  
4 accessible vaccination locations are expected to outweigh the costs.

5 Out-of-hours or weekend services for vaccination would be associated with a  
6 significant resource burden if provided on top of existing services solely for the  
7 purpose of delivering vaccinations. Combining them with existing out-of-hours  
8 provision will help to contain costs.

9 [Return to recommendations](#)

## 10 **Audit and feedback**

11 [Recommendations 1.1.14 to 1.1.16](#)

### 12 **Why the committee made the recommendations**

13 The evidence from studies on the effects of audit and feedback was inconclusive and  
14 varied in quality due to limitations with the design of some studies. These studies  
15 frequently included additional interventions such as provider education or bonuses,  
16 which made the effects of audit and feedback harder to isolate. Some showed  
17 increased vaccine uptake whereas in others, the studies could not detect a  
18 difference in uptake between the interventions and control (usual care or another  
19 non-vaccine related intervention). In particular, 1 study was identified that used a  
20 multicomponent provider intervention that included audits and feedback with provider  
21 reminders and education, and this showed greater vaccine uptake than usual care.  
22 This study provided support for the use of multiple interventions including audit and  
23 feedback to increase uptake. It also reflected the committee's experience of the  
24 benefits to providers and healthcare practitioners of being aware of their current  
25 vaccination activity and how it compares with other similar providers.

26 The committee recommended provider education and the use of alerts to facilitate  
27 opportunistic vaccination by providers (see the rationales for [training and education  
28 for health and social care practitioners](#) and [identifying people eligible for vaccination  
29 and opportunistic vaccination](#)). They also agreed that feedback needs to be available  
30 regularly to help providers keep track of their progress. In addition, if providers make

1 use of this data, it can help to develop practices for continuous improvement as well  
2 as providing opportunities to share examples of good practice or effective  
3 interventions with similar providers.

4 While the guideline was in development, many vaccination initiatives were  
5 introduced that aimed to increase the uptake of COVID-19 vaccines or ensure the  
6 continued and increased uptake of routine vaccinations during the pandemic. It was  
7 too soon for these initiatives to be evaluated as part of the current guideline  
8 development process because there is currently little evidence available relating to  
9 the effectiveness of these new initiatives. The committee agreed that it was  
10 important that these interventions (and others that may be introduced later in the  
11 pandemic) be formally evaluated in future so that any effective interventions,  
12 particularly those that raise vaccination rates in areas of low uptake, can be applied  
13 to routine vaccination programmes.

#### 14 **How the recommendations might affect services**

15 These recommendations are not expected to need significant additional resources.  
16 Feedback and review is already current practice in some areas and the data on  
17 vaccine uptake is already reported. There may be an administrative cost associated  
18 with compiling these feedback reports, but this will be small.

19 Evaluating initiatives used to increase vaccine uptake during the coronavirus  
20 pandemic is not expected to need significant additional resources because it is likely  
21 that the data on vaccine uptake will already be collected, and any costs associated  
22 with compiling this evidence are likely to be small. There is likely to be an  
23 administrative cost associated with evaluating this evidence. But it is not expected to  
24 be significant, and this evaluation is likely to be a one-off activity.

25 [Return to recommendations](#)

#### 26 **Training and education for health and social care practitioners**

27 [Recommendations 1.1.17 to 1.1.19](#)

## 1 **Why the committee made the recommendations**

2 There was very limited evidence for the effect of provider education or information  
3 alone on vaccine uptake. However, this intervention was a component of several  
4 multicomponent studies that showed increased vaccine uptake. In particular, 1 study  
5 of multicomponent provider interventions that included education for practitioners  
6 showed an increase in vaccine uptake compared with usual care. Qualitative  
7 evidence also highlighted how education can help healthcare practitioners feel  
8 confident when discussing vaccination with people, and that some practitioners need  
9 training in how to administer vaccines.

10 The committee acknowledged that Public Health England's core curriculum for  
11 immunisation training for registered healthcare practitioners sets out content to be  
12 covered by practitioners who are administering vaccinations. However, they agreed  
13 that providers should be given the time to undertake this training and to revisit it as  
14 part of their continuing professional development because a lack of support and  
15 dedicated time could act as a barrier to completing it. In addition, the committee  
16 highlighted the importance of providers being able to ask for and respond to people's  
17 concerns, have effective vaccination conversations and provide tailored information  
18 on benefits and harms to help overcome information-related barriers to uptake.

19 The committee also agreed that vaccine-related education is important for people,  
20 such as staff in GP practices and those who work in social care, who do not give  
21 vaccinations but are in contact with those eligible for it. Using their experience, the  
22 committee agreed that these people need a basic knowledge of immunisation  
23 practices and issues so that they can hold simple conversations about the benefits of  
24 vaccination and are able to signpost people to relevant sources of more detailed  
25 information. These recommendations are aimed at increasing staff confidence in  
26 relation to vaccination, and at making every contact count to increase the  
27 opportunities for people to discuss and receive vaccinations.

## 28 **How the recommendations might affect services**

29 These recommendations are not expected to need significant additional resources.  
30 The lower intensity education for health and social care staff not directly involved in  
31 administering vaccines would be likely to need some additional resources to compile

1 the information. However, the content is generally freely available, and the costs  
2 associated with delivering it could be contained by providing materials (such as a  
3 booklet or accessible webpage) rather than delivering education in person.  
4 Delivering education materials in this way is not expected to have a significant  
5 resource impact, even in heterogeneous groups such as social care practitioners  
6 whose education packages may not necessarily include information on vaccination.

7 Healthcare practitioners and social care providers who administer vaccinations  
8 already have to complete mandatory training. Ensuring that there is time and  
9 resources for this training and for including training as part of continuing professional  
10 development, is not expected to have a substantial impact because this is generally  
11 already current practice.

12 [Return to recommendations](#)

## 13 **Appointments and consultations**

14 [Recommendation 1.1.20](#)

### 15 **Why the committee made the recommendation**

16 There are several stages in each vaccination appointment, including discussing any  
17 concerns that a person has about vaccination, gaining consent, administering  
18 vaccines and completing the necessary documentation. Despite this, vaccination  
19 appointments can be relatively short. The evidence highlighted that a lack of time  
20 during consultations can lead to rushed or incomplete discussions about  
21 vaccinations and thus be a barrier to uptake. The committee therefore decided that it  
22 was important to highlight each of the stages of a vaccination appointment and the  
23 need to allocate sufficient time for each one, although they were unable to say how  
24 long the appointment should be.

25 Providing sufficient time for appointments may help to improve vaccination rates for  
26 people who have concerns by allowing them time to discuss safety and other issues  
27 with a trained healthcare provider, and is likely to help providers accurately record  
28 vaccinations.

## 1 **How the recommendation might affect services**

2 This recommendation is not expected to have a substantial resource impact because  
3 although additional staff time can be costly, it is expected that only a relatively small  
4 proportion of people eligible for vaccination will need a longer appointment for the  
5 purposes of addressing specific concerns. Additionally, the activities that should be  
6 carried out during a vaccination appointment are already current practice, so it is not  
7 likely that the recommendations will result in longer appointments.

8 [Return to recommendations](#)

## 9 **Keeping records up to date**

10 [Recommendations 1.2.1 to 1.2.5](#)

## 11 **Why the committee made the recommendations**

12 Based on their expertise and experience, the committee agreed that it was important  
13 to ensure that records at GP practices are accurate and up to date to help identify  
14 people eligible for vaccination. Vaccines administered by other providers need  
15 adding to GP records. The committee agreed that a 2-week time limit was a realistic  
16 timeframe for this work given competing demands for time in GP practices. GP  
17 practices can use the bulk transfers of information about children who are not up to  
18 date with their vaccinations provided by child health information services to help  
19 keep their records up to date. The GP practices can also use this information to  
20 facilitate their targeting of unvaccinated children for vaccination invitations and  
21 reminders.

22 The committee noted that discrepancies can occur between GP records and other  
23 sources of information, such as records from child health information service,  
24 pharmacies that provide vaccinations for older people and providers in any other  
25 settings. These can result in people not being identified as eligible for vaccination or  
26 being wrongly identified as eligible when they have already been vaccinated or have  
27 moved out of the area. Investigating and resolving any such discrepancies regularly  
28 should improve the identification and recording of eligibility and status. Using up-to-  
29 date clinical system templates should also help with accurate record keeping.

1 When a person has been identified as eligible for vaccination, it is important that their  
2 GP practice is able to contact them easily to invite them to be vaccinated. Some of  
3 the studies using invitations and reminders interventions reported issues with out-of-  
4 date contact details or use of unsuitable types of reminders, such as text messages  
5 for people who do not own a mobile phone. The qualitative evidence showed that an  
6 inability to speak English relatively fluently or understand the spoken or written  
7 language is a barrier to vaccine uptake for some people because it can make it  
8 harder to register at a GP practice and book appointments, and to ask for or  
9 understand information about vaccinations. In addition, low literacy levels can  
10 prevent people from accessing written information and may occur with or without the  
11 language barriers mentioned above. By making it clear whether a person has  
12 specific language or literacy requirements, it is more likely that any communications  
13 they receive will be in a language and format that they can understand.

#### 14 **How the recommendations might affect practice**

15 The resource use associated with ensuring that patient contact details are up to date  
16 is likely to be variable. For most of the population, it will be straightforward and there  
17 will be no cost impact. But more intensive methods will be needed for some people,  
18 such as those who have frequent changes of address or those who have no fixed  
19 address. However, collecting contact information is not only necessary for vaccine  
20 reminders but for various healthcare needs, so any resource impact would be shared  
21 across these areas and have a broader benefit.

22 Regular validation of vaccination records against other sources by GP practices will  
23 lead to an increase in workload initially. However, once the current records have  
24 been checked, this workload would be expected to drop to a lower level because  
25 fewer discrepancies would be found.

26 The other recommendations in this section are not expected to need significant  
27 additional resources. Some small administrative costs may be incurred from  
28 allocating time for these tasks, but the tasks themselves should already be being  
29 done so should not need additional resources.

30 [Return to recommendations](#)

## 1 **Identifying people eligible for vaccination and opportunistic** 2 **vaccination**

### 3 [Recommendations 1.2.6 to 1.2.14](#)

#### 4 **Why the committee made the recommendations**

5 Based on their expertise and experience, the committee agreed that as well as  
6 inviting people for vaccination routinely (see the [recommendations on invitations,](#)  
7 [reminders and escalation of contact](#)), opportunistic identification and vaccination are  
8 important parts of an integrated strategy to increase vaccine uptake in the general  
9 population. This was supported by evidence showing that opportunistic vaccination  
10 in some settings increased vaccine uptake.

11 In the absence of specific evidence about how and where to opportunistically identify  
12 people eligible for routine vaccinations, the committee based their recommendation  
13 on [recommendation 1.3.1 in the NICE guideline on flu vaccination: increasing](#)  
14 [uptake](#). The committee added several settings, including those outside the  
15 healthcare system, and points of contact with the healthcare system where they  
16 agreed that people eligible for vaccination could be identified. They also included  
17 some specific groups that may need more specific approaches (such as people who  
18 misuse alcohol, are homeless, use drugs, are asylum seekers or in prisons).  
19 Because these people may not be in routine contact with the healthcare system,  
20 special consideration is needed to assess their eligibility for vaccination. The  
21 committee also noted that looked-after children and young people and those who are  
22 educated at home or outside mainstream schooling are particularly at risk of missing  
23 vaccinations. The list is not intended to be exhaustive.

24 The committee were aware of several barriers to opportunistic vaccination. For  
25 example, the lack of an integrated record-keeping system makes it hard for people  
26 eligible for vaccination to be identified. The committee agreed that if people can  
27 easily check their immunisation status, or that of their child or the person they care  
28 for using online systems such as digital apps, this would help them to stay up to date  
29 with their vaccinations. However, the committee were aware that routine vaccination  
30 records are not automatically available even when a person has signed up to the  
31 NHS app or has requested access to their GP records. People may need to contact

## DRAFT FOR CONSULTATION

1 their GP practice to activate access to the vaccination records section of their GP  
2 record, whereas ideally these would be available by default. The NHS app currently  
3 shows COVID vaccinations and this functionality could be expanded to include  
4 routine vaccination status.

5 NHS summary care records could also be used to identify people eligible for  
6 vaccination. However, these records are not accessible to all healthcare practitioners  
7 and cannot be checked by non-healthcare staff. In these cases, the committee  
8 agreed that any other available vaccination record, such as patient-held records,  
9 could be used for opportunistic identification.

10 There are additional issues with identification if people have uncertain vaccination  
11 histories. For example, this could be because they have come from outside the UK  
12 or they have moved around a lot within the UK. The committee were aware of the  
13 Public Health England guidance on vaccinating people with uncertain or incomplete  
14 immunisation status. It states that, unless there is a documented or reliable verbal  
15 vaccine history, people should be assumed to be unimmunised and a full course of  
16 immunisations planned. The committee agreed with this approach because  
17 duplicating vaccinations is generally not harmful but remaining unvaccinated could  
18 leave people open to infection.

19 The committee also noted that, in their experience, it can be more difficult to ensure  
20 that people who are registered as temporary residents have their vaccination status  
21 checked. It is important that GP practices have a mechanism in place to identify  
22 these people and assess their eligibility for vaccination to ensure that they are not  
23 overlooked.

24 The evidence showed that reminders to the provider in electronic medical records  
25 were effective at increasing vaccine uptake. The committee therefore wanted to  
26 highlight their use as prompts for opportunistic conversations about due and overdue  
27 vaccinations. The provider could then offer immediate vaccination if possible.

28 There was no evidence on invitations or reminders specifically for pregnant women,  
29 but the committee were confident that the evidence of the effectiveness of reminders  
30 for the other age groups and life stages would also apply to this group (see the  
31 [rationale section on initial invitations](#) for more details). The Green book recommends



1 pertussis vaccination for pregnant women between 16 and 32 weeks, so the  
2 committee decided that it would be appropriate for midwives to opportunistically offer  
3 and remind women of this vaccination during routine antenatal visits.

4 The evidence showed that opportunistic vaccination increased uptake and was  
5 consistent with a [making every contact count](#) approach. Ideally, people eligible for  
6 vaccination would be able to discuss their outstanding vaccinations and be offered  
7 vaccination immediately. But the committee were aware that this may not be  
8 possible in all healthcare settings and would not be possible in non-healthcare  
9 settings, so alternative options are needed.

## 10 **How the recommendations might affect practice**

11 Using more opportunities to identify people eligible for vaccination may lead to an  
12 increase in the numbers of people who are vaccinated on the spot or signposted to  
13 vaccination services. Healthcare settings that are not normally involved in  
14 vaccination may start to identify people eligible for vaccination and administer  
15 vaccines. Vaccinations provided as part of the routine UK immunisation schedule  
16 have already been assessed to be cost effective, and therefore increasing the  
17 number of people vaccinated is also expected to be cost effective.

18 Using existing records to facilitate opportunistic vaccination is not expected to need  
19 significant additional resources because the mechanisms for sharing and accessing  
20 these records are already in place.

21 Opportunistic identification, offers and vaccinations are not expected to need  
22 significant additional resources. Existing records can be used to check eligibility for  
23 opportunistic vaccination, and mechanisms for sharing and accessing these records  
24 are already in place. Opportunistic vaccination is not likely to incur additional  
25 resources, because it would only be offered at venues where there is already  
26 vaccine storage available and where practitioners are qualified to give vaccinations.

27 Where vaccinations cannot be given, practitioners would simply need to know what  
28 local services to signpost people to or where people should book appointments to  
29 discuss vaccination or be vaccinated.

1 Ensuring automatic access to electronic records is not expected to need additional  
2 resources because the mechanisms for making these records available to patients  
3 through the NHS app are already in place, for example, COVID-19 vaccination  
4 status.

5 [Return to recommendations](#)

## 6 **Recording vaccination offers and administration**

7 [Recommendations 1.2.15 to 1.2.21](#)

### 8 **Why the committee made the recommendations**

9 The committee based these recommendations on information from the [NHS England](#)  
10 [enhanced service specifications for GP contracts](#) covering pneumococcal, pertussis  
11 and shingles vaccinations and committee expertise. All of these specifications  
12 include a requirement to record vaccination offers, consent and details about the  
13 vaccine, including batch and site of administration, and adverse reactions. The  
14 committee included the dose of the vaccine, route and site of administration and  
15 details of consent on the basis of information for public health professionals on  
16 [immunisation in the Green book](#).

17 Recording when vaccinations have been declined should ensure that people are not  
18 repeatedly offered unwanted vaccinations. Also recording the reason for the refusal  
19 could provide information for future discussions to try to address why the person  
20 declined vaccination and overcome any barriers. If this information is available at a  
21 population level, this could help public health teams locally or nationally when  
22 designing strategies to increase vaccine uptake by targeting key barriers for the  
23 general population or specific subgroups. Recording a lack of response will enable  
24 non-responders to be followed up.

25 The committee also agreed that updating patient-held records with information about  
26 new vaccinations will ensure that people are aware of their vaccination status (or the  
27 status of the people they care for) and are able to request or chase up vaccinations if  
28 they wish to. Because some people may not have their vaccination record with them  
29 at the time of vaccination, the committee thought it was important for a printout to be  
30 provided as a temporary measure until the main record can be updated. However,

1 they agreed it was best to update the records when the vaccinations are  
2 administered where possible because it could not be guaranteed that the record  
3 would be updated accurately later.

4 The committee agreed that accurate and timely updating of clinical records after  
5 vaccination is essential. One method to ensure accuracy and consistency of patient  
6 records is the use of compulsory vaccination fields in electronic health records.  
7 Providers also need to promptly report vaccinations to primary care, if the  
8 vaccination is carried out elsewhere, and to child health information services (if  
9 relevant). Child health information services can play an additional role in helping  
10 ensure that GP-held vaccination records are up to date by regularly sending  
11 information about new vaccinations to GP practices, if this service is included in their  
12 local contract. The 2-week time limit was based on committee consensus regarding  
13 a reasonable time period for this information to be relayed to the GP practice.  
14 However, the child health information services specification or local contracts may  
15 specify a different time period.

16 The committee noted that in some cases, the data supplied by other providers and  
17 child health information services needs to be reformatted before it can be added to  
18 patient records. This can be time consuming, therefore ensuring that the information  
19 is supplied in a format that is clear and readily accessible will help the GP practice.

## 20 **How the recommendations might affect practice**

21 Recording offers and administration of vaccines is expected to be associated with  
22 some administrative costs to set up and record this information, but these costs are  
23 expected to be small. It should save staff time – and therefore future costs – when  
24 following up people and processing information.

25 GP practices already update their records when vaccination notifications are  
26 reported from other providers and having to do this within a certain timeframe is not  
27 expected to lead to additional work. Providers already report information on  
28 vaccinations to primary care and child health information services. If the information  
29 is reported in a clear and readily accessible format, this may save GP practices time  
30 in not having to chase up inaccessible or unclear reports.

1 The recommendations on what to record when vaccinations are carried out broadly  
2 reflect current practice and the additional detail about vaccination offers is not  
3 expected to take much additional time to record.

4 Using compulsory data fields in electronic health record templates is not expected to  
5 need additional resources because this is already possible and is simple to  
6 implement with current systems.

7 [Return to recommendations](#)

## 8 **Invitations, reminders and escalation of contact**

9 [Recommendations 1.3.1 to 1.3.6](#)

### 10 **Why the committee made the recommendations**

11 The committee agreed that several processes needed to be in place to ensure that  
12 invitations and reminders were effective. They agreed that encouraging cooperation  
13 between providers and the local healthcare system would avoid duplication of effort.  
14 For example, the child health information services department could be contracted at  
15 the local level to send out invitations for young children (primary and preschool) on  
16 behalf of GP practices.

17 The qualitative evidence highlighted that some people (including some immigrants  
18 and Travellers, Roma and Gypsies) experience language barriers, and some cannot  
19 read or write in their own language. This can prevent them from accessing  
20 information about vaccines and make it harder for them to navigate the UK  
21 healthcare system to obtain vaccinations. Providing invitations and reminders in a  
22 language and format that the person, their family member or carer (as appropriate)  
23 can understand should help to increase vaccine uptake.

24 The qualitative evidence highlighted that some people from abroad had difficulties  
25 registering with GP practices to access NHS services. Differences in vaccination  
26 schedules between countries can also cause confusion. The committee therefore  
27 agreed that giving people information about the UK vaccination schedule could help  
28 them determine their eligibility for vaccination on the UK schedule. The committee  
29 also recognised that information alone might be insufficient and that some people  
30 might need help to understand the information and access healthcare.

1 The committee were also aware that the people who administer vaccinations can  
2 vary between the UK and other countries, and this can make some people hesitant  
3 about vaccination. Giving people from other countries information about who  
4 administers vaccinations in the UK, and where this takes place, can reassure people  
5 about what is standard practice and potentially remove 1 of the barriers to  
6 vaccination.

7 The committee discussed how consent can be a barrier to vaccination for some  
8 adults who need support with decision making or who may lack the mental capacity  
9 to consent. Although there was no evidence for these populations, the committee  
10 thought it was important to promote equality by ensuring that all people are given the  
11 support necessary to make informed decisions on vaccination. They noted that the  
12 [NICE guideline on decision making and mental capacity](#) provides clinicians with  
13 guidance on what to consider when discussing consent for adult vaccinations.

14 The evidence showed that bundling flu and pneumococcal vaccination invitations  
15 and reminders together was more cost effective than targeting pneumococcal  
16 vaccination separately. The committee agreed that sending invitations and reminders  
17 for different vaccinations together could be an effective way to increase vaccination  
18 uptake and reduce the number of reminders and vaccination appointments needed  
19 in some cases. However, they noted that this might not be clinically appropriate or  
20 effective for all combinations of vaccinations.

## 21 **How the recommendations might affect practice**

22 These recommendations are not expected to need significant additional resources.  
23 They are either easily incorporated into current practice, are required by law, or are  
24 anticipated to have lower administration costs by combining services for multiple  
25 vaccinations.

26 [Return to recommendations](#)

## 27 **Initial invitations**

28 [Recommendations 1.3.7 to 1.3.12](#)

## 1 **Why the committee made the recommendations**

2 The evidence showed that invitations or reminders were more effective than controls  
3 (mainly usual care, the format of which varied between different studies) at  
4 increasing vaccine uptake in all age groups (apart from pregnant women, see below)  
5 that have routine vaccinations. Reminders of different types were better than usual  
6 care at increasing vaccine uptake. However, in most cases the evidence did not  
7 show whether particular types of invitations or reminders were more effective than  
8 others. Evidence that did show a difference came from single trials with small  
9 numbers of participants. Therefore, the committee agreed that a variety of methods  
10 could be used to contact people eligible for vaccination, based on the evidence and  
11 the 2019 GP contract. The committee agreed that 1 of the recipients' preferred  
12 methods of contact should be used when sending out invitations and noted that  
13 invitations given face-to-face in other appointments (opportunistic invitations) were  
14 also likely to be effective.

15 There was no evidence on whether invitations were effective in increasing vaccine  
16 uptake among pregnant women, but the committee agreed that the advice that  
17 applies to invitations for the general population should apply for pregnant women.  
18 Pregnant women have regular contact with their midwives, as well as other  
19 healthcare professionals such as health visitors and GPs. Therefore, they could  
20 receive in-person invitations, be signposted to vaccination services or offered  
21 vaccination during these appointments.

22 The committee agreed that some people, such as people living in care homes or  
23 other residential settings and those who are housebound, may be unable to attend  
24 vaccination clinics or other settings where vaccinations are available and are  
25 therefore at risk of remaining unvaccinated. The committee agreed that it is  
26 important that these people or their family members or carers (as appropriate) can  
27 arrange home visits for vaccination.

28 The qualitative evidence showed that healthcare providers who have built  
29 relationships with people (or their parents or carers) are likely to be trusted and able  
30 to positively influence the decision to vaccinate. However, not everyone has regular  
31 contact with a particular provider, and medical records that would be used to  
32 generate invitations may not show who a person has most contact with. The

1 committee were also aware that in some areas, standardised invitations from a more  
2 centralised service are used, which may be difficult to personalise. Therefore, the  
3 committee agreed that using the name of a provider or service that is known to the  
4 person in the invitation and any subsequent reminders might be useful.

5 There was some evidence that education or information slightly increased vaccine  
6 uptake compared with usual care or another control intervention when all the studies  
7 were analysed together. However, most of the individual studies did not show that  
8 these interventions were better. The qualitative evidence highlighted barriers to  
9 vaccination that could be addressed by providing information or education, but there  
10 was little detailed evidence to suggest how these barriers could be overcome  
11 successfully. Because of the limitations above and taking into account that  
12 educational interventions are more expensive and labour intensive than giving  
13 information, the committee recommended providing information instead. The  
14 committee agreed that it was helpful to provide this information with the invitations.

15 The committee were aware that the invitations may differ in size depending on their  
16 format and they therefore came up with a list of points the invitation should contain to  
17 be useful. They also recommended a second list of items to include if space allowed.

18 For items that should be included:

- 19 • The qualitative evidence showed that people did not necessarily link vaccinations  
20 to the prevention of specific diseases. For example, people did not always  
21 connect HPV (human papillomavirus) vaccination to the prevention of cervical  
22 cancer.
- 23 • The qualitative evidence showed that many people trusted the NHS and that  
24 people were more likely to accept recommendations to be vaccinated from  
25 healthcare practitioners that they trusted.
- 26 • Some people may not attend vaccination appointments if they have not had their  
27 questions answered in advance. Providing contact details should make arranging  
28 this discussion easier.
- 29 • The committee agreed that letting people know about drop-in clinics can help  
30 those who find it difficult to get to appointments. They also discussed how giving  
31 people hyperlinks to book directly could make it easier to book appointments.

## DRAFT FOR CONSULTATION

- 1 • A reminder to bring any patient-held records enables providers to keep  
2 vaccination records up to date and means that people are aware of their current  
3 vaccination status.

4 For items that should be included if space allows:

- 5 • The qualitative evidence showed that some people underestimate the severity of  
6 certain diseases (for example, measles and shingles), and improved  
7 understanding of these issues may motivate people to have the vaccines.
- 8 • The committee agreed with the qualitative evidence that many people are worried  
9 about vaccine side effects and think they are being understated or hidden. Clearly  
10 explaining the benefits of vaccinations compared with the risk and severity of their  
11 side effects could help persuade people to have vaccines. Explaining individual  
12 and population benefits may help persuade people in under-vaccinated areas  
13 understand the additional benefits of vaccination to their communities. Studies  
14 show that many people did not understand the need for maternal pertussis  
15 vaccination to protect the baby during pregnancy and were worried about adverse  
16 effects during the baby's development.
- 17 • Many people do not finish vaccination courses and do not understand why they  
18 should have boosters, so the committee agreed that an explanation of these  
19 factors is important to help people be properly protected.
- 20 • Studies showed that people did not necessarily understand why HPV vaccination  
21 was offered to young people before they were likely to be sexually active.  
22 Therefore, giving information about why a vaccination is given at a particular age  
23 may help to increase uptake.
- 24 • The qualitative evidence showed that people wanted information about vaccines  
25 from reliable sources but were unsure where to look. Providing links to trusted  
26 sites could help answer any outstanding questions about vaccines or the  
27 vaccination process, and interactive tools could help with the decision-making  
28 process. In addition, evidence from 1 quantitative study showed an increase in  
29 pertussis vaccine uptake in pregnant women using an interactive tool compared  
30 with non-specific advice about vaccinations in general. The committee agreed that  
31 a variety of options would be best because, in their experience, different people



1 prefer different formats of information and not everyone has access to a smart  
2 phone to be able to use QR codes.

- 3 • The qualitative evidence showed that people found attending a vaccination  
4 appointment for the first time or during the COVID-19 pandemic could be a  
5 stressful experience and that uncertainty about the process and safety was likely  
6 to be a barrier to attendance. Explaining the process and any COVID-19 related  
7 safety measures could remove this barrier.

## 8 **Research recommendations**

9 The committee were interested in whether certain methods of framing of information  
10 within invitations would be more effective at encouraging vaccine uptake than others  
11 (for example, gaining immunity to disease versus avoiding catching a disease). None  
12 of the identified studies looked at this directly and so the committee wrote a [research  
13 recommendation on framing content in vaccination invitation letters](#).

14 The committee noted that there was a shortage of evidence for interventions to  
15 increase the uptake of routine vaccinations in pregnant women (pertussis  
16 vaccination) and older people (shingles and pneumococcal vaccinations), with this  
17 being particularly pronounced for the former group. The committee therefore made a  
18 [research recommendation to try to stimulate more research about effective  
19 interventions to increase pertussis vaccination uptake for pregnant women](#) and  
20 another [research recommendation for older people](#).

21 Finally, the committee agreed that it is especially important to try to increase routine  
22 vaccine uptake in groups, communities or populations with low uptake. They noted  
23 that there was limited evidence for groups of particular interest: Travellers, Gypsy  
24 and Roma; looked-after children and children not in mainstream education; migrants,  
25 asylum seekers and religious groups; and that the evidence was mainly qualitative in  
26 nature. Therefore, the committee included a [research recommendation to stimulate  
27 research on effective interventions to increase uptake in these and other groups of  
28 people with low routine vaccine uptake](#).

## 1 **How the recommendations might affect practice**

2 These recommendations are not expected to need significant additional resources.  
3 The format and content of invitations, and who these invitations are addressed from,  
4 are expected to be easily incorporated into the current approach to invitations.

5 Ensuring that people who live in care homes or residential settings, or who do not  
6 leave the house (or their family members or carers) are aware of how to access  
7 home visits for vaccination is unlikely to need substantial additional resources,  
8 because access to home visits is already in the GP contract and is common practice  
9 for people who are unable to attend clinics.

10 [Return to recommendations](#)

## 11 **Reminders and escalation of contact**

12 [Recommendations 1.3.13 to 1.3.19](#)

## 13 **Why the committee made the recommendations**

14 The committee agreed that it is important to identify people who do not respond to  
15 invitations or do not attend scheduled clinics or vaccination appointments, because  
16 these people may respond to a reminder. In addition, some people may not have up-  
17 to-date contact details, for example, if they have moved house recently, so it is  
18 important to check that they have received the invitation and reminder. This may  
19 mean using another method of contact in some cases.

20 For pregnant women, the Green book recommends vaccination between 16 and  
21 32 weeks of pregnancy. Therefore, reminders can be provided at antenatal  
22 appointments after the 20-week scan or when they have contact with a GP or other  
23 healthcare provider, such as health visitor.

24 For babies and young children whose parents or carers (as appropriate) have not  
25 responded to the reminder, the committee agreed that the follow-up needs to occur  
26 rapidly and needs a conversation. Delays may cause some parents to think it was  
27 acceptable to defer vaccination. This could lead to them delaying subsequent  
28 vaccinations, which would expose the child to a higher risk of getting the diseases  
29 targeted by the vaccines. The time limits recommended were based on committee

1 consensus aimed at preventing delays. The limits were shortest for babies because  
2 they have vaccinations due at 2, 3 and 4 months old and it is important that these  
3 are carried out in a timely manner as discussed above. Reminders for older people  
4 are less time sensitive because they can be vaccinated for shingles and pneumonia  
5 over a period of several years.

6 There was qualitative evidence to show that if a person does not respond after being  
7 sent a reminder, an escalating system of contact can be effective in increasing  
8 uptake. The committee agreed that this approach matched their experience, and it  
9 was also supported by quantitative evidence from a study looking at an escalating  
10 reminders intervention that showed an increase in the number of people being  
11 vaccinated with the intervention compared with usual care.

12 The committee agreed that initial vaccine invitations and reminders should use  
13 methods – such as a text or email – that are not labour intensive or costly. For  
14 people who continue not to respond, escalating reminders may initially involve a  
15 phone call from a GP receptionist, then from the practice nurse and finally from the  
16 GP, until the person is vaccinated or declines vaccination. However, this approach  
17 could be resource intensive and the evidence did not show that using escalating  
18 reminders was more effective than other forms of reminders. Despite this, the  
19 committee agreed that these more intensive methods of contact represented an  
20 appropriate use of NHS resources because the group of people needing to be  
21 contacted in this manner is likely to be relatively small and to consist of people in  
22 groups or communities with lower vaccination rates.

23 An economic analysis of the cost effectiveness of direct conversations with parents  
24 and carers of babies and toddlers who are behind on their vaccinations showed that  
25 the average cost per additional person vaccinated when using a direct contact  
26 intervention was estimated to be lower than the fee for the service that GPs receive  
27 for delivering administering vaccines. On this basis, the committee agreed that the  
28 direct contact intervention would be a cost-effective use of resources. The committee  
29 also noted the very serious negative consequences of the diseases vaccinated  
30 against in babies and toddlers (and the high costs of treating those conditions), and  
31 were therefore confident that this would be an acceptable use of resources.

## DRAFT FOR CONSULTATION

1 The committee agreed that when contact is made with a person who has not  
2 responded to an invitation or reminder to be vaccinated, it is important to try to  
3 understand the reasons behind the lack of response or delay in vaccination because  
4 this could enable any barriers to vaccination to be addressed. For example, if the  
5 person is concerned about vaccine safety and side effects, a conversation about this  
6 at the time of contact or a consultation with a nurse or GP may be able to persuade  
7 them to be vaccinated. In other cases, if access is a barrier to vaccination, then  
8 telling the person about out-of-hours clinics and other settings for vaccination may  
9 enable them or their children to be vaccinated.

10 The committee agreed that in some cases, a multidisciplinary approach could be  
11 helpful in overcoming barriers to vaccination. People such as social workers and  
12 health visitors may already be in direct contact with a person who has not responded  
13 to vaccination invitations and reminders and may therefore have more opportunities  
14 to discuss immunisation with them. Health visitors have multiple contacts with the  
15 families of babies and young children under 2 years as part of the Healthy Child  
16 Programme (2021). They could use these as opportunities to discuss, educate,  
17 signpost and support families to access immunisations if they were made aware of  
18 unvaccinated children. This information could be supplied by child health information  
19 services directly to the health visitors, but there might need to be a local agreement  
20 for health visitors to take on this work.

21 Evidence showed that providing vaccinations at home increased uptake compared  
22 with usual care. However, the committee were aware that home visits would be  
23 costly so they should be reserved for people who are unable to travel to vaccination  
24 clinics, appointments or other settings where vaccinations are available. Using these  
25 restrictions should ensure that the proportion of the population who would need  
26 home visits would be small because they would be offered only when all other routes  
27 to vaccination have been exhausted. This recommendation should help ensure that  
28 people who are housebound, for example, are vaccinated and improve access for  
29 other underserved populations, thus reducing inequalities.

30 The committee agreed that it was important to record when people declined to be  
31 vaccinated so they were not offered vaccinations repeatedly, because this can be  
32 annoying and a waste of resources. However, they recognised that people can

1 change their minds so they wanted to make them aware that the offer of vaccination  
2 remains open if they wanted to take it up in the future.

### 3 **How the recommendations might affect practice**

4 Direct conversations with parents and carers of babies and toddlers who are behind  
5 on their vaccinations are likely to have additional costs for staff time.

6 Identifying and providing additional reminders or offers of pertussis vaccination to  
7 pregnant women not already immunised is not expected to need additional  
8 resources, because these reminders can be given at existing antenatal  
9 appointments, and midwives already have a patient record in which vaccination  
10 status can be checked.

11 Escalation of contact is likely to need additional resources because it is generally  
12 associated with more intensive tasks that need more staff time.

13 Home vaccination visits would be associated with considerable additional resource  
14 use but the proportion of the population who would need them would be small  
15 because home visits would be offered only when all other routes to vaccination have  
16 been exhausted.

17 [Return to recommendations](#)

### 18 **People who are not registered with a GP practice**

19 [Recommendations 1.3.20 to 1.3.22](#)

### 20 **Why the committee made the recommendations**

21 The committee were aware that some people such as some Travellers, immigrants  
22 and asylum seekers are not registered with a GP practice and so will not receive  
23 vaccination invitations or reminders unless a different approach is taken to identify  
24 them. This is also reflected in the qualitative evidence, which showed that some  
25 Travellers and immigrants have difficulty registering with a GP practice and  
26 accessing healthcare from the NHS. The committee agreed that unless these people  
27 are made aware that they are eligible for NHS vaccinations and given help to access  
28 them, they are unlikely to be vaccinated. The committee agreed that local authorities,

1 health visitors or community involvement could help to ensure that these people are  
2 not overlooked for vaccinations.

3 Children who are not registered with a GP practice may still be registered with child  
4 health information services (CHIS). In these cases, where they are commissioned to,  
5 CHIS can send invitations to parents or supply this information to providers directly.  
6 CHIS can also include a message to encourage the parent or carer (as appropriate)  
7 to register the child with a GP practice. However, it is likely that some children will  
8 not be registered with either service and will need to be identified using alternative  
9 approaches as detailed in recommendation 1.3.20.

## 10 **How the recommendations might affect practice**

11 Involving local authorities, health visitors or the community or voluntary sector in  
12 identifying people not registered with a GP practice and ensuring they have  
13 opportunities to access vaccination may have an impact on resource use, but the  
14 committee considered this to be an appropriate use of NHS resources. Outbreaks of  
15 vaccine-preventable diseases are very costly and have significant health  
16 consequences for the population, so it is worth the additional effort of identifying and  
17 vaccinating people not registered with a GP practice. Identifying people not  
18 registered with a GP practice is not only necessary for vaccination but for various  
19 healthcare needs, so any resource impact would be shared across these areas and  
20 have a broader benefit.

21 Raising awareness about eligibility and how to access vaccination for people not  
22 registered with a GP practice is not expected to need additional resources. It is  
23 current practice to provide leaflets to new migrants about what vaccines are on the  
24 UK vaccination schedule, and where and how to access these. This information  
25 already exists and would be simple to pass on to people not registered with a GP  
26 practice once they have been identified.

27 Ensuring that invitations are sent to parents or carers of children not registered with  
28 a GP practice is not expected to need significant additional resources because child  
29 health information services already have a register of children, whether they are  
30 registered with a GP practice or not, and this information can be passed on to those  
31 sending out invitations for vaccination.

1 [Return to recommendations](#)

## 2 **Vaccinations for school-aged children and young people**

3 [Recommendations 1.3.23 to 1.3.35](#)

### 4 **Why the committee made the recommendations**

5 The committee agreed, based on their experience, that vaccinating school-aged  
6 children and young people at school was the most efficient and convenient way to  
7 vaccinate this population. But they recognised that this may not be possible in all  
8 cases because not all school-aged children and young people attend school.

### 9 **Routine vaccinations at school**

10 The committee agreed, based on their experience, that although vaccination  
11 programmes for school-aged children and young people are unique enough to need  
12 a separate set of recommendations, the main steps of the process are the same as  
13 for the other age groups and life stages. They all involve an initial invitation for  
14 vaccination, a reminder and then an escalation of contact for people who do not  
15 respond. However, the invitations are sent by schools on behalf of the vaccination  
16 providers. The qualitative evidence highlighted logistical barriers that providers face  
17 with running vaccination sessions in schools and that these could be overcome with  
18 support from the schools involved. However, they noted that schools do not always  
19 prioritise vaccinations and that it is very important that providers have a good  
20 relationship with the school to facilitate sending invitations to eligible pupils and  
21 running the school-based vaccination sessions.

22 The evidence for young people aged 11 to 18 years eligible for HPV vaccination  
23 consistently highlighted that young people want to be involved in discussions about  
24 vaccination. The committee therefore agreed that information provided about the  
25 vaccinations needs to be aimed at both the parents or carers (as appropriate) and  
26 the young people themselves. The general contents of the information would be the  
27 same as for vaccinations for young children and adults, but tailored to the relevant  
28 vaccinations for this age group. Although not discussed in the evidence, the  
29 committee decided that it was important for the information to also cover Gillick  
30 competence so that both parents and young people are fully aware of all the options  
31 for vaccine consent. They also agreed that sending the invitation for vaccination to

## DRAFT FOR CONSULTATION

1 the young people and secondary school-aged children as well as to the parents or  
2 carers would help them be involved in the process.

3 The committee agreed that school-based education is a key method of ensuring that  
4 children and young people understand the importance of vaccinations and can ask  
5 questions about their concerns. This was mentioned in the qualitative evidence as  
6 1 of the acceptable methods of giving young people information about vaccinations  
7 and is already standard practice in some schools. They agreed that this education  
8 should be age appropriate.

9 The committee agreed that 1 of the main barriers to school vaccinations is the low  
10 rate of return of consent forms. This means that school immunisation teams are  
11 unaware of whether parents or carers consent to their child being vaccinated and  
12 they have to spend time chasing up people who do not respond. One study indicated  
13 that a programme that incentivises the return of consent forms could increase the  
14 number of forms returned, and that most of these consent forms were about  
15 vaccination acceptance. The committee agreed that in their experience, for school-  
16 based vaccinations, a positive consent form would lead to vaccination and therefore  
17 that this intervention was likely to increase the number of children and young people  
18 who are vaccinated. In addition, although some incentives, such as prize draws, will  
19 have an associated cost, this is expected to be offset by a reduction in the time and  
20 costs of nurses having to contact parents and carers of children and young people  
21 who have not returned their consent form.

22 The committee discussed the acceptability of incentivising other parts of the  
23 vaccination process. However, they decided that incentivising consent form return  
24 rather than vaccination is likely to be more acceptable, because it is encouraging  
25 decision making rather than the vaccination itself. There was some concern over the  
26 ethics and effectiveness of the financial incentive used in the study because in some  
27 communities, such as faith schools, a money-based incentive could be perceived as  
28 gambling and be inappropriate and ineffective. As a result, the committee did not  
29 specify the exact type of incentive in the recommendation so that local providers can  
30 make their own decisions on what is most appropriate for their local community.



## DRAFT FOR CONSULTATION

1 The committee agreed that a reminder should be sent out in cases where the  
2 consent form has not been returned. However, even with invitations and standard  
3 reminders, there will still be some young people who do not return a consent form  
4 and a more direct method of contact (a phone call) can be made before vaccination  
5 day or even on vaccination day if there is time. The committee discussed other ways  
6 to encourage families to return consent forms and thought that contact from other  
7 health and social care providers who already know the family, such as school  
8 nurses, could be helpful.

9 In addition, the committee noted that catch-up sessions would ensure that children  
10 and young people who are not up to date with their vaccinations have other  
11 opportunities to be vaccinated. These sessions are currently limited to children and  
12 young people who have missed school-based vaccinations, but they could be  
13 expanded to provide opportunities to catch up on earlier preschool vaccinations.  
14 There was a shortage of evidence for catch-up campaigns, with only a single study  
15 identified that provided results in favour of school-based catch-up sessions over  
16 referring pupils to GP practices in the UK. The committee took this evidence into  
17 account and used their clinical experience of the importance of catch-up sessions to  
18 make a recommendation on this topic. However, they also included a [research](#)  
19 [recommendation on school- versus GP-based catch-up campaigns](#) to increase the  
20 evidence base and to examine the acceptability of catch-up sessions in these  
21 settings. To help with identifying these children and young people, child health  
22 information services can provide vaccination histories to providers.

23 The committee agreed that it was important to highlight that young people under 16  
24 may be able to consent to their own vaccinations if they are assessed to have the  
25 competence and understanding to appreciate what it involves. These young people  
26 are said to be Gillick competent.

27 The assessment of Gillick competence, and when it was appropriate for young  
28 people to be assessed for competence and allowed to consent to vaccination for  
29 themselves, was a key discussion point. The committee decided that if the consent  
30 form had not been returned, and it was not possible to contact parents or carers,  
31 young people should be assessed for Gillick competence. They also agreed that  
32 young people whose parents or carers had refused consent should be given the

1 opportunity to be assessed for competence. They recognised that this assessment  
2 might be difficult to carry out on vaccination day itself because of the potentially large  
3 numbers of young people involved. However, there may be more capacity to carry  
4 out these assessments before catch-up vaccination sessions. Committee  
5 discussions also highlighted the need for school immunisation teams to feel  
6 supported if they are assessing for Gillick competence; in particular when young  
7 peoples' wishes differ from that of their parents or carers. Therefore, they thought it  
8 important for providers to have policies to support local teams with these decisions.

### 9 **Additional research recommendations**

10 The committee made several research recommendations that were linked to school-  
11 based vaccinations or that came out of discussions relating to school-based  
12 vaccinations. Although the committee made a recommendation for incentivising  
13 consent form return for school-based vaccinations, this was based on evidence for a  
14 financial incentive for consent form return. It was unclear whether non-financial  
15 incentives would also be effective in this setting and what levels of financial or non-  
16 financial incentives would be effective. The committee wrote a [research  
17 recommendation on incentives for school-based vaccinations](#). They were also  
18 interested in whether incentives would be effective and acceptable for other age  
19 groups or life stages and so they wrote a similar [research recommendation on  
20 incentives aimed at individuals, family members and carers](#).

21 Another potential method of increasing vaccine uptake in school-based children and  
22 young people and the wider populations is using mandates. The evidence looked at  
23 mandating vaccinations or education to allow access to schools in the US. However,  
24 very few studies were identified that looked at the effectiveness of mandation, and  
25 the qualitative evidence about acceptability was mixed. The committee therefore  
26 made a [research recommendation on quasi-mandation of vaccinations](#).

27 There was limited quantitative and qualitative evidence for HPV vaccination in boys  
28 because routine HPV vaccination for boys has only recently been introduced in many  
29 countries, including the UK and US. The committee agreed that it is important to  
30 understand whether similar barriers and facilitators apply to HPV vaccination for  
31 boys as for girls and whether the same interventions are effective for them. They  
32 made a [research recommendation on HPV vaccination for boys](#) to reflect this.

1 Finally, the committee discussed whether using the World Health Organization  
2 'Tailoring Immunisation Programmes' approach would be an effective way of  
3 designing interventions to increase vaccine uptake in a UK context. Some qualitative  
4 evidence was identified that used this approach, but it was unclear if it had been  
5 used to help design any of the interventions included in this guideline. The  
6 committee made a [research recommendation on Tailoring Immunisation](#)  
7 [Programmes](#).

### 8 **Children and young people who do not attend mainstream schools**

9 The committee were aware that not all children and young people attend mainstream  
10 schools, such as those who are home educated, chronically unwell, have local  
11 authority tutoring, are in faith or independent schools that do not routinely hold  
12 vaccination sessions, or those in young offender institutions. These children and  
13 young people could be at risk of not being vaccinated but it was unclear to the  
14 committee how they could be identified effectively using the current system. They  
15 therefore agreed that it would be best for commissioners of the vaccination services  
16 for school-aged children to ensure that systems are put in place to identify and  
17 vaccinate these people.

### 18 **How the recommendations might affect practice**

19 These strategies are already current practice in most schools, and are unlikely to  
20 have a resource impact. Offering one-off vaccination days to vaccinate children at  
21 school is likely to be less resource intensive than contacting and booking  
22 appointments for children individually in other settings.

### 23 **Routine vaccinations at school**

24 Invitations and reminders for routinely offered school-based vaccination programmes  
25 are not expected to have a substantial resource impact, because the recommended  
26 activities are current practice in most schools that provide mass vaccination days.  
27 Providing a specification for the approach to these reminders is unlikely to have  
28 resource implications.

29 Ensuring school-based vaccination education is accessible to children and young  
30 people is not expected to have a substantial resource impact, because this

1 information is readily available and could simply be distributed to children and young  
2 people during school hours.

3 If more providers offer an incentive for returning consent forms, this is likely to  
4 increase the number of forms returned, which may lead to an increase in vaccine  
5 uptake. Although some incentives, such as prize draws, will have an associated cost,  
6 this is expected to be offset by a reduction in the time and costs of nurses having to  
7 contact parents and carers of children and young people who have not returned their  
8 consent form. The NHS already uses incentives (such as prize draws) to obtain  
9 feedback for certain initiatives, so this is not a completely new approach.

10 Involving other health and social care providers that are in contact with the family to  
11 help gain consent where contact cannot be made through the school is not expected  
12 to need significant additional resources, because this is likely to be for a smaller  
13 group, and those people should already be in contact with the family.

14 Putting policies in place for assessing Gillick competence may increase the  
15 vaccination team's confidence in performing the assessment, thereby increasing the  
16 number of young people who are assessed for competence and allowed to consent  
17 to their own vaccination. This will help to reduce 1 of the barriers to vaccination and  
18 potentially increase vaccine uptake in this group.

19 Child health information services already hold vaccination records of children and  
20 young people, so identifying those who are not up to date with pre-school  
21 vaccinations and informing the school nursing teams is not expected to need  
22 significant additional resources.

### 23 **Children and young people who do not attend mainstream schools**

24 This is not expected to need significant additional resources because local  
25 authorities already have a duty to know which children and young people do not  
26 attend mainstream schools and they have contact details for their parents or carers.  
27 Local authorities could therefore contact these people on behalf of vaccination  
28 providers to arrange vaccination in a suitable setting.

29 [Return to recommendations](#)

## 1 **Context**

2 Vaccinations provide personal and population-level protection against many  
3 diseases. High vaccine uptake rates create population-level protection, leading to  
4 herd immunity. This protects both immunised and non-immunised people. Examples  
5 of non-immunised people include those who are highly susceptible to disease such  
6 as newborn babies and older people, and people who cannot be vaccinated for  
7 medical reasons or for whom vaccines are contraindicated. In contrast, vaccines for  
8 some diseases such as shingles only protect those who receive them and provide  
9 minimal indirect protection to other people.

10 The UK routine vaccination schedule covers key vaccinations for different stages in  
11 life including childhood, adolescence, pregnancy and old age (currently 65 years and  
12 older). Although vaccination levels in general in the UK are relatively high, levels of  
13 uptake vary between vaccines and the age groups they are targeted at. For  
14 example, 5-in-1 coverage of children measured at 5 years was 95.2% in 2019/2020,  
15 whereas 83.9% of Year 9 girls completed the 2-dose HPV (human papillomavirus)  
16 vaccination course in 2018/19. By contrast, from April 2018 to March 2019, shingles  
17 vaccine uptake for the 70-year-old routine cohort was only 31.9%, pneumococcal  
18 vaccine uptake for all people aged 65 and over was 69.2% and pertussis vaccine  
19 coverage in pregnant women was 68.8%.

20 Vaccination rates need to be actively maintained, and ideally increased, in the face  
21 of increasing vaccine scepticism and misinformation. In addition, certain population  
22 groups (such as Gypsy, Roma and Travellers, refugees and asylum seekers) have  
23 lower levels of vaccination than the general public. Additional or different actions  
24 may be needed to increase their vaccination rates.

25 Reasons for low uptake may include poor access to healthcare services; inaccurate  
26 claims about safety and effectiveness, which can lead to increased concerns and a  
27 reduction in the perceived need for vaccines; and insufficient capacity in the  
28 healthcare system to provide vaccinations. In addition, problems with the recording  
29 of vaccination status and poor identification of people who are eligible to be  
30 vaccinated may have contributed to low uptake.

1 **Finding more information and committee details**

2 To find NICE guidance on related topics, including guidance in development, see the

3 [NICE webpage on immunisation](#).

4 For details of the guideline committee, see the [committee member list](#).

5 © NICE 2021. All rights reserved. Subject to [Notice of rights](#).