NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Vaccine uptake in under 19s

Date of quality standards advisory committee post-consultation meeting:
30 November 2016.

2 Introduction

The draft quality standard for vaccine uptake in under 19s was made available on the NICE website for a 4-week public consultation period between 1 September and 29 September 2016. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 21 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Stakeholders were also invited to respond to the following statement specific questions:

5. For draft quality statement 1: Do you agree with the focus of this quality statement on recall invitations? Please give reasons for your opinion.

6. For draft quality statement 3: Do you agree with the focus of this quality statement on young offenders instead of other at-risk groups? Please give reasons for your opinion.

7. For draft quality statement 4: Do you think the statement should focus on a specific immunisation? Please give reasons for your opinion.

8. For draft developmental statement 5: Does this reflect an emergent area of cutting-edge service delivery? If so, does this indicate outstanding performance only carried out by a minority of providers that will need specific, significant changes to be put in place, such as redesign of services? Can you provide any examples of current practice in this area?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Support for the aims of the quality standard and its key areas for quality improvement.
- Need to address the barriers to design and delivery of coordinated services.
- Suggestion for every GP practice to have a vaccination lead.
- Need for investment on information systems.
- Suggestion to refer to national guidance on training requirements and ensure staff competency on administration of vaccinations.
- Suggestion to include additional groups to the equality considerations.
- Need for a nationwide adoption of Child Health Information System.
- The statements need to take into account the variable capabilities of Child Health Systems across the country.
- Suggestion to consider financial incentive for vaccination.

- A stakeholder highlighted that the advisory committee did not include practice nurses or health visitors.
- Suggestion to extend the GP appointment to a minimum of 10 minutes on areas with a high number of non-English speaking population.

Consultation comments on data collection/question 2

- The systems and structures are in place and data is already collected.
- Concern that it is not possible to collect the data for looked after children as their records are often missing.
- A stakeholder highlighted inadequate recording of vaccination history in the HIV positive population.

Consultation comments on resource impact/question 4

- Requirement for investment to improve maintenance and transferability of vaccination records.
- Impact on time and training of staff who deal with looked after children and need to access health record systems in various locations that are not compatible with one another.
- Resource implication for primary care to conduct phone calls/texts to people who have missed appointments.
- A stakeholder highlighted that most hospital departments don't have access to system one, GP records system.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Children and young people who do not attend their immunisation appointment are followed-up with a recall invitation and a phone call or text message.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Overall support for the statement as it gives guidance on how and when children/young people who have missed appointments should be followed up.
- Need to be clear on the timing of the actions and who is responsible for doing them, i.e. administration staff or healthcare professionals.
- Primary care would need additional resources but this would have to be agreed by commissioners. An annual demand and capacity exercise for GP practices would need to be negotiated via primary care contracts.
- A stakeholder questioned who will take the cost of the provision of information in different formats and languages.
- A stakeholder suggested additional equality and diversity considerations.
- Additional measure on the proportion of people sent a reminder who attended an appointment.
- Suggestion to also use the CHIS system for the school vaccination programme. It can identify missing vaccinations but not generate calls/texts.
- Expand on what the statement means for children and young people.
- A recall system could have a positive impact on the uptake of vaccination programmes with low uptake such as the MenACWY vaccine.
- Electronic records will need to be joined up across all services to allow data availability.
- A stakeholder highlighted that there are no systems in place to electronically record an attempt to contact a person.
- Possible to capture the data on the second invitation from a child health system.
- Some measures would need data collection to be developed and included in the contractual agreement.
- Personal contact can ensure receipt of information, enable discussion and allow for tailored appointments.
- Structure measure a) is done but not evidenced outside of the child health information system.
- Structure b) is sometimes done by school providers but it is not common practice.
- The outcome measure is high level.

- Suggestion to change the wording to reflect that private providers can be part of this statement.
- May be hard to identify children and young people who are disengaged with services or moving frequently around the country.
- Suggestion to include children focused social care organisations in the service providers to ensure children in care are not missed.
- Consideration is needed on whether the health professionals contact the parent/carer or the young person themselves.
- Need to differentiate primary care payment quota of 90% versus public health ambition of 95% to achieve herd immunity.
- Caution was raised about repeatedly contacting parents who have decided not to have their child immunised.

Consultation question 5

Stakeholders made the following comments in relation to consultation question 5:

For draft quality statement 1: Do you agree with the focus of this quality statement on recall invitations? Please give reasons for your opinion.

- General agreement with the focus of the statement.
- Suggestion to add home visits especially for the travelling community.
- A stakeholder highlighted the risk that providers may text instead of phone people.

5.2 Draft statement 2

Children and young people receiving a vaccination have it recorded in their GP record, their personal child health record and in the child health information system.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- General support for the focus of the statement in recording vaccinations.
- Add a process measure on proportion of children and young people with vaccination status on their records.
- Difficult to enforce and measure the statement.

- Concern about the reliability of monitoring and collecting data on the personal child health record until this system becomes digital.
- Add a requirement in the GP contract to provide accurate and timely information on vaccinations given.
- Resource implications of structure measures a) and c) as they would need an audit to be developed.
- Data sharing between CHIS and GP health records is problematic due to the lack of national standard electronic child information system. Need for investment to standardise CHIS across the country and implement a personal child health record for over 5's.
- Suggestion to also record vaccinations within the educational records to help support statements 4 and 5.
- Suggestion to include independent schools as they fall short of national reporting requirements.
- Parents often do not bring the red book to hospital and are unlikely to remember what vaccination their child has had and when.

5.3 Draft statement 3

Young offenders have their immunisation status checked on entry into the secure setting and are offered any outstanding vaccinations.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- General agreement with the focus of the statement.
- A stakeholder highlighted that this group of people can be easily missed as they are not included in routine data collection.
- Suggestion to better explain why young offenders were prioritised over other high risk groups.
- Suggestion to record the vaccination in the young offender's records and the information transferred to their GP record.
- The provider will need access to the vaccination records and data sharing arrangements should be put in place.

- Suggestion for an outcome measure on young offenders who had gaps in their vaccination history and received the vaccination whilst in the secure unit.
- Difficult to measure due to the number of different providers for health and justice.
- Suggestion to give a dose of vaccination to a newly admitted offender with no evidence of vaccination.

Consultation question 6

Stakeholders made the following comments in relation to consultation question 6:

For draft quality statement 3: Do you agree with the focus of this quality statement on young offenders instead of other at-risk groups? Please give reasons for your opinion.

- Some stakeholders said that this is a reasonable group to target due to low vaccination rates but some expressed concern the focus on young offenders is at the expense of other vulnerable groups.
- Suggestion to broaden the statement to include children in care and those in secure children's homes.
- Looked after children who should be registered with social services and their social worker can check their vaccination status.
- Focus the statement or have a separate statement on refugee children as they may have an unknown vaccination history.

5.4 Draft statement 4

Children and young people are offered vaccination as soon as it is known that they have missed a routine childhood vaccination.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Overall stakeholders supported this statement.
- Suggestion to use a specific timescale as a benchmark for local monitoring and to aid the measurability of the statement.

- Need to provide person centred services such as choice of venues and times, to maximise opportunity to have outstanding vaccinations.
- Suggestion to combine statements 4 and 5.
- Suggestion to add outcome measures on referrals for vaccination and vaccinations after referral.
- Add school health services as service providers.
- Suggestion to increase the types of healthcare professionals who can give vaccination.
- Clarify what ‘straightaway’ means.
- A stakeholder queried whether the statement suggests that ‘mop up’ services should be commissioned which would have funding implications.
- GP clinical systems should flag missing vaccinations when the healthcare professional is in a clinic with the child.
- Suggestion to focus on primary care as this is where most vaccinations happen.
- A stakeholder asked for more clarity on how this statement differs from statement 1.

Consultation question 7

Stakeholders made the following comments in relation to consultation question 7:

For draft quality statement 4: Do you think the statement should focus on a specific immunisation? Please give reasons for your opinion.

- Most stakeholders suggested not to focus on a specific vaccine as each vaccine has an important role in protecting the individual and the public.
- Focusing on a specific vaccination could give the wrong message that other vaccination programmes are not as important.
- However a stakeholder suggested that it would be appropriate to specify areas where the need for improvement is greatest.

5.5 Draft statement 5

Developmental statement: Children and young people have their immunisation status checked at key educational stages.

Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

- Stakeholders welcomed the statement as it is important to identify those who have missed routine vaccinations.
- Focus the statement on healthcare professionals checking the vaccination status of children and young people.
- A stakeholder noted the need for a sensitive approach to equality and diversity in respect to language and foreign birth.
- Suggestion to incorporate in to the national specifications for health visiting and school nursing that they are commissioned by local authorities.
- It is unclear how school nurses would access CHIS.
- Concern that school nursing teams may not be informed when a child transfers in to a new school.
- A stakeholder pointed out that the healthy child team would not have access to the child health record or red book but they have access to CHIS. They can check the vaccination status with the parents when CHIS indicates an outstanding vaccination.
- Training would be required if professionals not used to assessing vaccination status are asked to take this role and also clear guidelines to ensure consistency in data collection.
- Query on whose responsibility it will be to review vaccination status at educational transition. There are no health professionals involved in the transition to college.
- Significant resource implication for the track down of childhood vaccination data from CHIS and GPs and for the actual delivery of missed vaccinations.
- Need for electronic sharing between education, child health and GPs.
- A stakeholder suggested that this has been a contractual obligation for a long time but implementation has been variable across the country.
- Suggestion to offer vaccinations at school when children are identified as missing a vaccination than send them to their GP.

Consultation question 8

Stakeholders made the following comments in relation to consultation question 8:

For draft development statement 5: Does this reflect an emergent area of cutting-edge service delivery? If so, does this indicate outstanding performance only carried out by a minority of providers that will need specific, significant changes to be put in place, such as redesign of services? Can you provide any examples of current practice in this area?

- This statement is good practice that is not currently happening.
- Requirement for investment, change in practice targeted education to ensure that some groups are not placed at a disadvantage or stigmatised when singled out for some targeted vaccination. Query regarding how religious schools will address those issues.
- A stakeholder commented that systems are not in place to check immunisation status at school entry and it may be more appropriate for this check to take place when other vaccinations are scheduled, such as HPV.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Suggestion to include identification of those eligible for vaccination programmes.
- Suggestion to focus on uptake of flu vaccine. Suggestion for invitation of 2-4 year olds for seasonal flu vaccination.
- Suggestion to check the vaccination status of looked after children at each initial and annual health check.
- Update records when people change GP practice.
- A stakeholder suggested a statement on parental responsibility for monitoring their children’s vaccination status and acting when vaccinations are due.
- Training is a key area in need of attention.
- Suggestion to have a statement on marketing of vaccinations and celebration of vaccine success.

- A stakeholder suggested a statement on routine vaccination of premature neonates.
- Suggestion for an electronic vaccination passport for HIV positive people.
- Suggestion for all children to be given a vaccination passport.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments
1	Board of Deputies of British Jews / Jewish Medical Association UK	General comment	Attention has been drawn recently to the incidence and complications of pertussis, and to the high incidence of measles within the London Jewish community. This is occurring in particular in an area where the community is more observant, with large families, constituting a relatively uniform minority ethnic group; English is often not the first language, and previous vaccinations may have been missed. There are also areas with similar demography in Manchester and Gateshead. These demographic factors affect not only vaccination of children but also the vaccination of pregnant women against pertussis to which reference is made.
2	Board of Deputies of British Jews / Jewish Medical Association UK	General comment	The concept of a "person-centred integrated approach" to provision of services is of obvious importance in order to ensure that the vaccination coverage of this at risk Jewish community is satisfactory. This requires co-ordination not only amongst the service providers but also between them and the community. Unfortunately recent experience does not inspire confidence, in that a dedicated award winning health visitor service that targeted this community has been dismantled. Missing from this section, albeit mentioned in the individual sections below, is any reference to the key interface between commissioning of vaccination and provision, the latter of which appears to be falling increasingly heavily on general practice. NICE quality standards need to be taken into account in order to fulfil the expectations of the Health and Social Act 2012, but to "take them into account" and then implement requires clearly designated resources. It is also unclear in this section – no mention is made of a role for Public Health England in service co-ordination – have they abrogated responsibility for this area of public health?
3	Board of Deputies of British Jews / Jewish Medical Association UK	General comment	There is a clear statement that "recommendations….on specific types of training for the topic that exceed standard professional training are considered during quality statement development". Hopefully "standard" training would indeed include some recognition about minority needs, but for this particular Jewish community group additional training, to ensure familiarity with religious, social and cultural practices, is important.
4	British Infection Association	General comment	We support this document and the overall aim of increasing uptake of vaccination in those under 19.
5	Cheshire and Merseyside NHS England Local Area Team	General comment	Child Health Information Systems - The standards do not take account of the very variable capabilities of Child Health Systems across the country.

ID	Stakeholder	Statement number	Comments
6	Cheshire and Merseyside NHS England Local Area Team	General comment	Local data collection - The standards are really damaged by the fact that "local data collection" is used so often, without any discussion of how that might happen. There are no systems in place for this level of detailed data collection, and no expectations in any national contracts for it. The National Childrens digital strategy should offer an opportunity to standardise recording and collection, but cannot say what hasn't been recorded. However there are real opportunities for developing the reporting of GP level data now that GP IT systems are so well developed. Inter operability fo GP and between GP and HCild Health, systems is a challenge that has be addressed.
7	CoramBAAF Adoption and Fostering Academy	General comment	This response is being submitted on behalf of the CoramBAAF Health Group, which is also a special interest group of the Royal College of Paediatrics and Child Health (RCPCH). The Health Group was formed to support health professionals working with children in the care system, through training, the provision of practice guidance and lobbying to promote the health of these children. With over 500 members UK-wide, an elected Health Group Advisory Committee with representation from community paediatricians working as medical advisers for looked after children and adoption panels, specialist nurses for looked after children, psychologists and psychiatrists, the Health Group has considerable expertise and a wide sphere of influence. Our area of concern is the particularly vulnerable group comprised of looked after and adopted children and young people.
8	CoramBAAF Adoption and Fostering Academy	General comment	We welcome the specific inclusion of looked after children (LAC) in the list of groups at risk. Their particular circumstances often make it difficult to complete immunisations and to record data accurately and accessibly and listing them here raises awareness.
9	CoramBAAF Adoption and Fostering Academy	General comment	While it is well recognised that this is desirable, it is equally well recognised that with regard to look after children there are many barriers which make it difficult to design and deliver coordinated services. Truly and effectively addressing this is likely to require investment in capacity and systems beyond what is available within existing services.
10	Department of Health	General comment	Some of the recommendations from NICE's previous guidance on vaccine uptake have yet to be adequately implemented. It is therefore suggested that some of these should be rolled forward (edited and updated as appropriate) for inclusion in this updated QS. Particular areas that would be worthy of reconsideration for inclusion in this QS are 'information systems' (ie recording, maintaining and transferring accurate info on vaccination status of children), 'training' (which remains an area of contention) and 'targeting groups at risk of not being fully immunised' more broadly than just young offenders which the focus has moved to. The need for a local co-ordinator for

ID	Stakeholder	Statement number	Comments
			population based vaccination programmes should also be considered as there is evidence from PHE that where these roles are in place uptake is improved.
11	Department of Health	General comment	Why this QS is needed - Better to say that 'pregnant women are currently vaccinated against pertussis' rather than routinely as this was introduced as a temporary programme
12	Department of Health	General comment	Why this QS is needed - It would be useful to include a summary of the current programme for under 18s i.e. which vaccines they get as which age and where they get them eg GP/school etc. You could also include the most recent uptake figures. This would seem better that just picking a couple of examples.
13	Department of Health	General comment	Why this QS is needed – Pg 3 lists improvements in a range of outcomes expected. It is not clear why pertussis and HPV have been singled out as specific areas to see improvements over and above over vaccine areas.
14	Department of Health	General comment	Table 2 - The S7A Public Health Agreement (and PHOF) include a range of vaccine programme specific indicators which sit below the one listed from PHOF. Should they be cross referenced?
15	Department of Health	General comment	Should the S7a public health agreement be included here – it includes a number of indicators on vaccine uptake?
16	GlaxoSmithKline UK Ltd	General comment	We have no specific comments on any of the content of the QS.
17	Meningitis Research Foundation	General comment	This states that babies are protected from pertussis because older siblings, other children and pregnant women are routinely vaccinated against pertussis an example of herd immunity..However, vaccinating pregnant women against pertussis mainly protects babies directly via transfer of maternal antibody across the placenta, not by indirect or herd immunity. The maternal pertussis immunisation programme was introduced because there had been an increase in pertussis cases and deaths in infants, which demonstrated that young babies were not benefiting sufficiently from herd protection and needed to be directly protected. Perhaps a different example of herd protection should be used?
18	Neonatal and Paediatric Pharmacists Group (NPPG)	General comment	NPPG wish to support these quality statements and the potential they have to improve the uptake of immunisations in children and young people.
19	NHS England	General comment	Training States this is an implicit element therefor they do not draft any statements on this. Would be good if they could refer to it and direct to any national guidance. This would strengthen discussions with GP practices about training requirements for their staff.

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20	NHS England	General comment	"Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering services" We accept that Staff training is an implicit element of quality standards and consequently NICE do not draft statements on staff training, however as a commissioner NHS England would need assurance that staff are actually confident and competent to administer the childhood immunisation services that they are commissioned to do under Section 7A. Currently there is no assurance process in general practices or local authorities , that care is safe. This is a frequently cited issue in CQC inspection of general practice.
21	Public Health Team Sheffield City Council	General comment	We noted that the advisory committee did not include representation from practice nurses, school nurses or health visitors. This is unfortunate as these groups have a vast range of practical experience of delivering programmes and collecting data which would have aided the development of these guidelines.
22	Royal College of General Practitioners	General comment	This is a thoughtful and sensible document, immunisation against infectious diseases is the greatest triumph of public health but it is necessary to be ever vigilant, to monitor rates regularly and consider extra provision for at risk groups. The under-five record or the smartcard should have this information and it should be always available when the person makes a health service contact There are problems with the Immunisation Rate for an area. Ideally it should consider all the eligible children living in and born in an area, still resident at the turn of the year and their immunisation status. Where there is much population movement a child may be in the numerator (vaccinated) of one area while born in and in the denominator of another a few months later. Independent check on vaccination success would be to regularly sample the bloods of all children having blood taken for other reasons for antibody titre and to compare their biological immunity with their "on paper" immunity. Consideration needs to be given to parents who refuse vaccination on grounds of conscience, belief etc. Consideration should be given to rewards for vaccination-thus the full family allowance, essential for admission to nursery school, primary school, secondary school and university and even direct fiscal reward Ideally any child or young adult consulting in primary or secondary care should have an electronic record which indicates the vaccination history and any further vaccines required for the attention of the medical professional. (PS)
23	Royal College of Nursing	General comment	This is just to let you know that there are no comments to submit on behalf of the Royal College of Nursing in relation to the stakeholder engagement exercise for the vaccine uptake in under 19's quality standard.
24	Royal College of Obstetricians and Gynaecologists (RCOG)	General comment	Thank you for asking us to comment on these quality standards. Our expertise in this area is limited and our comments are few in number.

ID	Stakeholder	Statement number	Comments
25	Royal College of Paediatrics and Child Health	General comment	It might be worth adding to/including within the statements, something like “Every GP practice will have an identified healthcare professional who is responsible – and provides leadership – for the local childhood immunisation programme” [ref: https://www.nice.org.uk/guidance/ph21/chapter/1-Recommendations] I do not think there are outcome data already collected on this, but it would be easily done if local NHSE commissioners keep records of ‘Immunisation Leads’ within each practice.
26	Royal College of Paediatrics and Child Health	General comment	This could also be a key opportunity to iron out some recurrent difficulties in vaccine uptake, such as: offering flu and pertussis immunisation routinely in pregnancy [unless this is adequately covered in antenatal quality standards] recording parental and grandparental ethnicity (unless BCG is universally given) such that BCG coverage can be optimised ensuring mechanisms for follow up and immunisation of all babies born at risk of Hep B ensuring that all eligible children are invited for seasonal flu immunisation emphasising that 95% uptake is the target for most routine childhood vaccines.
27	Royal College of Paediatrics and Child Health	General comment	The Paediatric Educators Special Interest Group stress that official quality standards are regularly used by professionals and students to identify current best practice. This quality statement appears to focus mostly on school nursing and primary care which are the environments in which most childhood vaccinations occur. It may be beneficial to set a standard as to how other professionals are expected to highlight to a child’s general practitioner that they require further vaccinations.
28	Board of Deputies of British Jews / Jewish Medical Association UK	Diversity, equality and language	The particular Jewish community in London which is at “high risk” has made considerable progress over the past five years in increasing vaccination uptake. There is evidence that this is now at risk as a result of funding cuts, and shifts in provider responsibility. Ensuring that vaccination rates increase to the desirable 95% level and above in this community requires commissioning and resourcing of a “culturally appropriate” service.
29	British HIV Association, BHIVA	Question 1	BHIVA welcomes the NICE Vaccine uptake in under 19s quality standard. The draft accurately reflects key areas for quality improvement and its content is in line with the standards of care BHIVA endeavors to promote. BHIVA wishes to propose a number of additional considerations. The Society has repeatedly called upon improved vaccination coverage for people living with HIV, including children and adolescents, who in addition to suffering from a chronic illness, commonly belong to one or more of the at risk groups highlighted in the document (minority ethnic groups, non-English speaking families, other indicators of vulnerability). Adolescents transitioning into adult HIV care pose a unique set of challenges in terms of both ensuring adequate engagement and addressing specific needs (e.g., HPV vaccine for young boys). In this area, BHIVA has produced NICE-approved guidelines and conducted national audits in people living with HIV, and engaged with Primary Care to promote adequate dissemination of

ID	Stakeholder	Statement number	Comments
			information and integration of activities. This work has highlighted several aspects that are relevant to the NICE consultation: Incomplete or missing vaccination records are common in this population and recall of vaccination histories is poor. Education is needed for young people and their families. Susceptibility to vaccine-preventable infections is prevalent in HIV positive children and adolescents, and higher than in the general population. Specialist services that care for children have a role to play in offering or promoting ascertainment of vaccination needs, and where required offer immediate vaccination or referral. Specialist services that care for adults affected by vaccine-preventable infections require clear guidance about the need to determine pro-actively whether children in the same household have been offered appropriate vaccination and follow-up (e.g., hepatitis B). Education is needed for healthcare professionals in order to overcome persisting misperceptions around safety and efficacy of vaccination in HIV-positive people. Such misperceptions are a substantial obstacle to achieving high vaccine coverage in this population (e.g., MMR). Improved, streamlined and effective two-ways communication is required between specialist and primary care/childhood services about offering and recording vaccination.
30	CoramBAAF Adoption and Fostering Academy	Question 1	A key area has been missed. As stated below, a centralised national data recording system is needed to truly address this issue and would have far more impact with fewer resource implications than the local data collection recommended, given the difficulty of accessing data from various sources with incompatible recording systems! See our response to Question 2.
31	NHS England	Question 1	Yes, the quality statements would improve reporting and follow up and facilitate the identification of those with missing immunisations. Data would be available and collectable for some statements but less so for others – offender data should be incorporated into the standard ImmForm/COVER collections/surveys so that it forms part of the routine monitoring – this data is not readily available to Screening and Imms Teams, also data collection/audits would need to be incorporated in to service specifications and as mandatory requirements of contracts (particularly where these are required by primary care) as without these we can encourage but cannot enforce.
32	Meningitis Research Foundation	Question 1	Does the draft quality standard accurately reflect the key areas for quality improvement?|It largely reflects key areas for improvement however it: does not deal very thoroughly with children or young people who are not registered with a GP. We feel that there should be a recommendation which tries to capture these children. could include a statement about checking the vaccination status/GP registration status of children who are looked after (not just young offenders) as social services may have an opportunity to do this.

ID	Stakeholder	Statement number	Comments
33	Public Health England	Question 1	Does this draft quality standard accurately reflect the key areas for quality improvement? One major missing priority area of work that has not been captured is training – we have suggested that this should be included as one of the 5 quality statements potentially by merging statements 4 and 5 and adding on the new statement on training. Training is a key area in need of urgent attention since the 2013 re-organisation. It would be a straightforward area to develop some measurables for and would help empower nurses to request that they are released and get funding for training as specified in the PHE national minimum standards. We have seen a small but steady decline in coverage for 12 month old and 24 month old children since 2013 and an increasingly complex schedule to implement with the introduction of several new programmes (rotavirus, MenB, flu vaccine for children, shingles). This combined with added pressure on capacity in primary care means that training is essential to support frontline staff to continue to deliver a high quality programme and maintain public trust through a willingness to engage with parents and answer questions fully and confidently.
34	Royal College of Paediatrics and Child Health	Question 1	Does this draft quality standard accurately reflect the key areas for quality improvement? Overall we feel that these statements accurately reflect the key areas for quality improvement.
35	British HIV Association, BHIVA	Question 2	BHIVA wishes to highlight that recording of vaccination histories are often inadequate in the HIV-positive population. Systems are not sufficiently standardised to ensure maintenance of transferable records of vaccinations that may be delivered in different care settings. Looking forward, an electronic “vaccination passport” accessible at multiple points of care (i.e., linked to the patient rather than the location of care) would provide a solution. Currently some HIV centres are proposing to pilot paper vaccination passports that integrate information with primary care/children services.
36	CoramBAAF Adoption and Fostering Academy	Question 2	Our members have advised that it is not remotely possible to collect the data regarding the proportion of LAC who have their vaccination recorded in their personal child health record. These records are often missing for LAC and there are no current systems for recording this information. At the present time it is necessary to access records from GPs (often for LAC this involves multiple GPs) and child health information systems to obtain accurate data as to whether a given child’s immunisations are up to date. This requires considerable time and effort and is particularly difficult when the data systems in different areas are not compatible, and usually reveals that the GP and child health information system records provide different information. To really provide improvement in immunisation uptake we strongly recommend development of a centralised national data recording system. This would be of particular benefit for LAC, children in need and refugee children but would ultimately benefit all

ID	Stakeholder	Statement number	Comments
			children. Our members have also reported significant difficulties regarding children with protected addresses on databases. These children are missing immunisations as they do not receive the letters / invitations advising that they are due an immunisation. This should be addressed nationally.
37	Public Health England	Question 2	Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place? A number of the measurables you are proposing need review and amendment as currently described they are not feasible to collect and are actually not useful measures. We have tried to provide more specific feedback under each of the statements but it would be useful to have a more in-depth technical discussion once there is agreement on the five quality indicators.
38	Royal College of Paediatrics and Child Health	Question 2	Are local systems and structures in place to collect data for the proposed quality measures? Data should be readily accessible for these outcome measures and is already routinely collected.
39	British HIV Association, BHIVA	Question 3	BHIVA runs educational sessions for both HIV specialists and primary care clinicians that include information on its NICE-approved guidelines. This is followed by regular audits (e.g., vaccination coverage against recommended targets).
40	British HIV Association, BHIVA	Question 4	Clarification is needed about commissioning in order to address existing geographical variability around which vaccines are deliverable within which context. Investment is required to improve maintenance and transferability of vaccination records.
41	CoramBAAF Adoption and Fostering Academy	Question 4	Definitely not! In our members' view it will be difficult if not impossible to adequately implement the QS for looked after children within existing services, given the recognised factors which affect such delivery, including moves in and out of care and within the care system, children placed out of the area of their responsible local authority, and difficulty accessing information when health record systems in various regions are not compatible with one another. Skilled and persistent efforts at engagement are often required for LAC, children in need, young offenders and refugee children and this would require additional capacity, training and more time in job plans. See our other responses for details of what is needed.
42	NHS England	Question 4	Most statements would be achievable with minimal resource for most providers. Much of the activity is already carried out but is not currently supported by evidence/data collection – this would need to be incorporated into service specifications and contracts. There would potentially be a resource implication for primary care to conduct phone calls/texts to DNAs – this would need to be mandated as part of their service requirement.

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43	Royal College of Paediatrics and Child Health	Question 4	Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? In the hospital setting there is no uniform way of checking a child's vaccination status. Most hospital departments do not have access to system one. Parents often do not bring a "red book" to hospital and are unlikely to know what vaccinations their child has had and exactly when. This is a potential missed opportunity for increasing uptake which is not addressed in the current standards.
44	Board of Deputies of British Jews / Jewish Medical Association UK	1	Given the nature of this Jewish community, a recall system using a tracking and invitation system is much less likely to succeed than a system which is supplemented by members of the community itself, with the endorsement of the religious authorities. This has to be an essential part of the equality and diversity considerations. Commissioners of services need to make provision for this type of service. As noted above, in this field the interface and linkage between clinical commissioning groups and service providers needs to be defined and resourced, taking into account "hard to reach" groups to try to achieve herd immunity.
45	Cheshire and Merseyside NHS England Local Area Team	1	These quality statements are very good but the "data source: local data collection" is a simplistic and unhelpful summary of the difficulties that will prevent such a measure being monitored: the evidence refered to for structure and process is just not available. Nor is it in the contracts that support delivery. So a whole national negotiation of new data requirements and expectations in the GP contract would be needed. The Statements are nevertheless a very useful list for use as Quality Standards, for audit and peer review purposes.
46	Department of Health	1	QS1 - refers to 'a re-call invitation AND a phone call or text message' - do NICE mean that these actions will be taken at the same time or as an escalation process or something else? It is a bit ambiguous as currently drafted.
47	Department of Health	1	Outcome - the outcome given is very high level, it is not clear how we would know if the QS achieved or contributed to that outcome. Could we also have an indicator such as: 'Proportion of those sent a reminder who attended an appointment' which would be the more direct outcome of the QS?
48	Department of Health	1	Healthcare professionals – is this really an action for healthcare professionals. It seems more for admin staff. Or, is it just that a health care professional is the signatory?
49	Department of Health	1	Commissioners (reference to CHIS system for tracking non-attendances etc) - Can that be used for the school vaccination programme too? If not how do we ensure suitable data collection for the school programmes via QS?
50	Department of Health	1	What the QS means for Children & Young people (CYP) – this states that CYP 'who have missed an appointment for an immunisation are contacted by their health visitor, nurse or doctor to arrange another appointment' but should it go on to talk about more than just the action, for example,the outcome ie 'This is expected to increase uptake of vaccinations ensuring that more CYP are protected against vaccine preventable diseases.'

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51	Department of Health	1	Equality and Diversity considerations – 'a telephone call may be preferable to a letter or text message' – this links to comment 8 where is it unclear if letters, phone calls and texts are all needed or not.
52	Meningitis Now	1	General comment about "catch-up" programmes using the recent MenACWY vaccine as an example. In 2015 and 2016, young people aged 17-18 years have been offered this vaccine, mainly via an invitation from their GP. The uptake has been low as seen in this report for 2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/553736/hpr3216_menACWY_VCa.pdf Although we appreciate that this particular "catch-up" programme only has one more year to run, with another cohort of 17-18 year olds again being offered the vaccine by their GP in April 2017, a recall system could have a positive impact on the uptake of this vaccine. Such a system could also have positive impact on any future "catch up" programmes with this age group.
53	NHS England	1	Immunisation Appointments recommendations: Request for an annual demand and capacity exercise for GP practices would need to be negotiated via primary care contracts Checks at all appointments in all services on child's immunisation requires data availability – either via parent (not just their recall of imms) or electronic records being joined up across all services. Information to be provided in different formats and languages – this is a significant cost impact – who's paying
54	NHS England	1	It will be very hard to measure telephone calls or texts made by all 8000~ General Practices and the numerous school based immunisation providers. It won't be easy for them to log these calls and electronic systems to measure them automatically are not embedded in health services. Data collection for this will be highly resource dependent - in the current climate of low resources, particularly in primary care this will be an issue. A second invitation from a child health system or provider system will be easier to evidence and capture data on. I agree with this focus on recall invitations but worry that text and phone call data won't be available. I think there should be something about data cleansing and providers ensuring the data they hold on children is up to date - with links to national care records system - to better ensure that parents actually receive the invitation at a their correct address.
55	NHS England	1	Yes agree – personal contact confirms receipt of information, allows for discussion/Q&A and allows appointments to be tailored as opposed to having to be rearranged as not convenient. More difficult to ignore personal contact than just a letter.
56	NHS England	1	Structure (a) This is done but not evidenced outside of the child health information system.
57	NHS England	1	Structure (b) This rarely happens. Sometimes done by school providers, text messaging re: HPV programme

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58	NHS England	1	Process (a) Would need an audit/data collection to be developed. Child health information services (CHIS) could provide this data relatively easily but would be an additional data collection requirement and would potentially have resource implications. Would need to be a mandatory audit/data collection for primary care (included in the service spec/contractual agreement)
59	NHS England	1	Process (b) Would need audit development for primary care, would need to be incorporated into contractual agreement – would potentially have significant resource implications for primary care.
60	NHS England	1	CHIS can send reminders/new appointments but cannot phone/text. Whilst the Child health information system can be used to identify missing imms/non attenders (missing imms lists already generated and sent to practices by some CHISs) – not all CHISs are involved in call/recall.
61	NHS England	1	It is felt that the statement assumes the provider of immunisation services are GP's, School Nurses and Health Visitors – with services going through procurements this could include Private Providers who create an Immunisation Team rather than use the traditional school nurse delivery model –recommend changing the wording to reflect this.
62	NHS England	1	This statement may be hard to measure if there are difficulties in identifying those children and young people who have missed vaccinations as they are often those totally disengaged with services or moving around the country frequently?
63	NHS England	1	This statement will be hard to measure as systems are not in place to electronically record an attempt to contact the child/young person/parent/carer but does record 'failed to attend appointment'.
64	NHS England	1	Consideration may be required as to whether the health professionals contact the parent/carer or the young person themselves (those able to consent for themselves/may not be living with parents/carers)
65	NHS England	1	There is overall support for this statement as it gives specific guidance on how and when it is expected that Providers follow up children/young people who have missed vaccinations. Work will be needed to set up local data capture methods to meet the quality standard recommendations.
66	NHS England	1	Differentiating primary care payment quota of 90% versus public health ambition of 95% to achieve herd immunity.
67	Phizer UK Ltd	1	Children who are cared for by social care organisations are highlighted as an at risk group for not being fully immunised. We would suggest that the section related to what the statement means for service providers is redrafted to include children focussed social care organisations (who are part of the source recommendation). In order to ensure that this group is not missed.

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68	Phizer UK Ltd	1	We would suggest that the section and statement pertaining to "What the quality statements means for children" is redrafted as it currently reads that the child would be contacted irrespective of age. Ideally this should be the responsible person or organisation(s), and for those children of secondary school age we would suggest that both the child and responsible person are contacted to maximise the response to a recall invitation.
69	Public Health England	1	The core National Service specification for the National Immunisation Programme includes a requirement for arrangements that enable providers to identify and recall under or unimmunised individuals and to ensure that such individuals are offered immunisation in a timely manner. In most areas this is done through the Child Health Information System (CHIS). The CHIS Service specification and contracts should include this requirement. Some areas are now using GP systems to generate immunisation invitation letters but this is not universally the case – it is important to note that this requirement is not included in the General Medical Services contract. There is also no specific requirement to use phone or text messaging for call-recall so not sure how feasible it is to implement this or where at the cost implications associated with implementing this quality statement. If it is envisaged that GPs will be expected to do call recall and specifically to phone or text reminders to parents, they will want additional funding to deliver this. This would need to be agreed by commissioners (NHS England) in the first instance. Recall is important but if a child does not attend on the second or third invitation then it is possible they may no longer be at that address. Efforts should be made to confirm if the child has moved house. Some parents forget to inform their GP practice when they move house so their details don't get updated until they register the child with a new GP. Correct addresses can often be confirmed with schools. It is worth acknowledging that some communities / population groups miss appointments because of access issues e.g. there are long waiting times for immunisation appointments or clinics are only available during work hours. Enhanced call/recall arrangements should therefore be supported by adequate staffing levels in primary care to support the delivery of sufficient immunisation clinics to meet local demand and flexible clinic times.
70	Royal College of General Practitioners	1	The prescriptive nature of this statement requiring two mechanisms of follow up as standard may not always be appropriate. A better statement would therefore be: "Children and young people who do not attend vaccinations are proactively followed-up. This should include a follow up invitation and, to improve uptake, where appropriate to the level of risk, should also include a phone call, text message or visit." (JH)
71	Vaccine Preventable Disease Programme – Public Health Wales	1	Public Health Wales fully supports the statement that children and young people who do not attend their immunisation are followed-up with a recall invitation and a phone call or text message but feel that this statement could be more explicit to ensure targeted action on follow up at ages by designated health care professionals e.g.

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			after two fail to attends following invitation, if it is a child < 5 years the health visiting service should Check for inaccurate child health (CH) records (reporting the child is unvaccinated when GP records show they have received the vaccination) and update CH departments as appropriate. Check that the child's details are correct, i.e. name and address, check these details with the GP practice as the child may have moved. Update CH department as appropriate. Document in the appropriate section of the health visiting record. Contact should be made with the family to investigate the reason for non attendance. Document in the child's health visiting record any action taken around the missed appointments i.e. home visits or reappoint. Support the family to make alternative arrangements to ensure the child is vaccinated.
72	British HIV Association, BHIVA	Question 5	BHIVA agrees that a system for recalling is required that is sensitive to specific needs e.g., literacy, language, confidentiality. We wish to highlight the role that specialist services can play in promoting ascertainment of needs and engagement.
73	CoramBAAF Adoption and Fostering Academy	Question 5	Recall invitations are particularly important for LAC but the manner and skill in engaging this group is also extremely important. Repeated invitations may be needed as well as additional resources for skilled and persistent engagement.
74	Department of Health	Question 5	Consultation Question – Yes, agree with the focus but with some points of clarification and suggestions as set out above.
75	Meningitis Research Foundation	Question 5	Yes, but perhaps it should also mention the possibility of carrying out home visits to increase uptake rates in hard to reach groups. Especially if many of these people are living in the same area, for example the travelling community.
76	NHS England	Question 5	Question 5 For draft quality statement 1: Do you agree with the focus of this quality statement on recall invitations? Please give reasons for your opinion. I agree with the focus on recall invitation coupled with phone/email follow-up This quality standard seems to assume that each immunisation has a single provider who reappoints those who do not attend. For teenage immunisations (Men ACWY) the initial appointment may be a from a school immunisation service but if missed then the child may go to their GP practice especially if the school term or school year has ended. Suggest amendment: 'Children and young people who do not attend their immunisation are followed-up with a letter to explain how to arrange another appointment and a phone call or text message' Also the statement suggests that the child should continue to be reappointed if they repeatedly Do Not Attend. Suggest the full standard is there for the first DNA only: 'Children and young people who do not attend their first appointment for an immunisation are followed-up with a letter to explain how to arrange another appointment and a phone call or

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			text message' A phone call and a text message are quite different in terms of resource required and patient impact. This standard will encourage Providers to text parents rather than phone them.
77	Royal College of Obstetricians and Gynaecologists (RCOG)	Question 5	We agree with focus of quality statement on recall investigations. Seems appropriate to ensure vaccine uptake and emphasises proactive role of healthcare providers.
78	Royal College of Obstetricians and Gynaecologists (RCOG)	Question 5	For draft quality statement 1: Do you agree with the focus of this quality statement on recall invitations? We agree that recall invitations should be routine for children not brought to vaccination appointments for any reason. Clinicians will use these quality statements as a learning tool and we feel that the statement needs to be explicitly clear whose role/ responsibility it is to follow this up.
79	Board of Deputies of British Jews / Jewish Medical Association UK	2	If the service is commissioned in a form that takes into account community needs, then record keeping by providers via either CHIS and / or PCHR should be satisfactory. If the general practices are the service providers then they need to be resourced by the clinical commission groups to fulfil this task, and this needs to be clear in their guidelines.
80	Cheshire and Merseyside NHS England Local Area Team	2	The statement is good. Again, "local data collections" is used as a catch all, in a most unrealistic way. For example…"proportion of …who have a vaccination who have it recorded in their GP record." How is the denominator to be calculated/ found; and how are GP systems to be interrogated to get the numerator?
81	Department of Health	2	QS2 - it might be useful to build in about transferring/keeping imms records up to date when patients move between GPs practices, have certain vaccinations in schools etc. For example, at the end could it perhaps say something like 'and these records are updated when patients change GP practices'. The alternative would be to have a separate QS aimed specifically at information systems as suggested in comment 1.
82	Department of Health	2	Quality measures – process - could we consider including a process indicator to ensure that records are updated, for example, when patients leave and join GP practices?
83	Department of Health	2	Outcome – these focus on process. Could we also include an outcome measure to demonstrate if QS2 made a difference. For example: 'proportion of CYP with vaccination status on their records'?
84	Department of Health	2	Data source – how can we ensure better collection from school vaccination programmes?
85	Department of Health	2	Service providers – should we add in about transferring and updating records when children move GP practices, for example, ensuring children are removed from the GP practice so the denominator is not artificially large
86	Department of Health	2	Commissioners – should we add at the end 'whatever the location i.e. GP or school'?

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87	NHS England	2	Agree with the principle. Not sure how you would enforce this with GP practices given the current vagueness of their contract in respect of immunisations particularly the additional services. Not clear how you would measure whether this had been done or not – what monitoring systems would be put in place to collect this information from GP practices
88	NHS England	2	Agree with the principle. Not sure how you would enforce this with GP practices given the current vagueness of their contract in respect of immunisations particularly the additional services. Not clear how you would measure whether this had been done or not – what monitoring systems would be put in place to collect this information from GP practices
89	NHS England	2	Statement on page 14 ref CHIS: It identifies registered eligible children, sends out lists to GP practices and sends appointments directly to patients. No CHIS in Wessex sends appointments directly to parents – they write to parents notifying them that their child is due for a vaccination and asking them to make an appointment
90	NHS England	2	Information Systems:They have recommended that GPs use the same vaccination information sent to CHIS for sending for payment! These collections are not aligned. Any change needs to be negotiated via GPC. There are good reasons for the way that the GP contract payments are structured: it ensures that GPs don't simply forget about children when they have passed the age when the vaccination should normally be given. In Wessex we used to get CHIS to validate target payments – that had to stop when NHS England introduced the national PCSE service States there may be additional costs incurred (? For whom – probably us) for eliminating backlogs of patients in individual practices. It would be more effective to put a requirement into the GP contract that they should provide accurate and timely data to CHIS on registered children; and provide accurate and timely information about immunisations given and immunisation status so that CHIS records are up to date
91	NHS England	2	Recording on the PCHR will be difficult to monitor and collect data on. Most of these records are still Red book hard copy and therefore don't have IT solutions to capture codes etc. The move to having a digital PCHR will help with this but until them data on recording in PCHR will be problematic. Recording on GP and CHIS systems can be easily audited and data collected by coding. Obtaining numerators and denominators for GP delivered Imms will be relatively easy. But for Imms given by none GP providers it will be problematic to measure how many are immunised for example at school and this data reaches the GP. This would require comparison between providers and provider systems which might be an issue and run into restrictions from Data protection/sharing concerns.

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92	NHS England	2	Structure (a) Would need audit to be developed and would have resource implications to undertake it. Indications of recording come via COVER/ImmForm surveys (high uptake indicates high levels of recording, as if not recorded vaccinations would not be reflected in the uptake)
93	NHS England	2	Structure (b) The use of the hand held record (red book) is not reliable and would result in data quality issues. Parents often fail to bring the red book and this increases with child's age.
94	NHS England	2	Structure (c) Recording indicated by uptake in COVER/ImmForm surveys. Would need to audit and cross reference, GP records, Schools Imms Records (if not using same system as CHIS) and CHIS record – this would have resource implications.
95	NHS England	2	Denominators would need to be those eligible not those who received a vaccination – as you would only know those who received vaccination if it was recorded. Hand held record is not reliable data.
96	NHS England	2	What statement means for …. Commissioners page 13 Requirements need to be mandated in service spec and contracts – enhanced agreements include recording on the GP system, we encourage and remind re: notifications (especially opportunistic) vacs to CHIS but cannot mandate/hold to account.
97	NHS England	2	There are some systems and processes in place but these are different in each local authority area. There is no national standard electronic child information system and this causes problems when data sharing is needed between CHIS and GP Health Records.
98	NHS England	2	This quality measure may be hard to implement as many children and young people being vaccinated in schools do not bring their personal child health record (red book) with them. This means the health professional cannot be responsible for this being accurately documented and makes it a major problem to collect the data. There is no national personal health record for the over 5's.
99	NHS England	2	Whilst it is acknowledged that NICE cannot assess affordability in Quality Standards, it is felt that investment would be needed in order to standardise CHIS across the country to make them more compatible with each other and other systems.
100	NHS England	2	In order to implement a personal health record for the over 5's, investment would be required. Without a personal health record this Quality Standard will be difficult to achieve and monitor as a local dataset.
101	NHS England	2	I am generally supportive of this statement. It may not be necessary to record flu immunisations on CHIS as this is a lot of extra work/cost and CHIS is not needed for scheduling (as only a single dose in nearly all children) and the risk of double immunisation is low as the only provider currently is the child's GP practice for 2/3/4 and school immunisation teams for 5/6/7 year olds.

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102	NHS England	2	I am generally supportive of this statement. It may not be necessary to record flu immunisations on CHIS as this is a lot of extra work/cost and CHIS is not needed for scheduling (as only a single dose in nearly all children) and the risk of double immunisation is low as the only provider currently is the child's GP practice for 2/3/4 and school immunisation teams for 5/6/7 year olds.
103	NHS England	2	Ensuring accurate and timely data recording and transfer – READ codes, electronic mechanisms via CHIS. (p14)
104	Pfizer UK Limited	2	We would suggest that where possible vaccination is also recorded within the educational records as this would help support statement 4 and importantly the developmental statement (number 5)
105	Public Health England	2	The standard states that the proportion of children and young people receiving a vaccination who have it recorded in their personal child health record should be measured. How is this data going to be gathered? It would require retrospective analysis of PCHR books. If a low percentage had up to date immunisation in the book it doesn't mean they are not immunised, it probably means the parents forgot to bring it to the appointment. Gathering this data is of limited benefit because a failure to record in the PCHR book will be blamed on the GP by parents and on the parents by GPs. An unintended consequence of this standard may be GPs being disinclined to immunise babies if the parents forget the Red Book. The current denominators and numerators selected for the related outcome measures are not appropriate i.e. Numerator – the number in the denominator who have their vaccination recorded in their GP record. Denominator – the number of children and young people receiving a vaccination – how are you going to measure this? The only way of checking whether a vaccination record is complete for a patient on the GP record or the CHIS is to compare the vaccination status in both systems. If there is a mismatch then one is incorrect. One of the common reasons for a mismatch in the vaccination record between the CHIS and the GP record is a child moving from one area to another. You could add checking of immunisation status of children moving into a new GP practice as a trigger point to make sure the immunisation record has moved with them. This quality statement should make explicit mention of recording of vaccines given in schools. In some areas, school health teams enter this information directly onto the child health information system. They should also be sending it to GP practices where it should then be entered into the child's clinical record. In some areas, this does not happen and often the information is sent to the practice but not entered into individual clinical records. It is seen as a bit of a time consuming task for the practice. This can contribute to the mismatch we sometimes see with GP and child health records. CHIS are also able to send lists of recently vaccinated children to GP practices so they can ensure individual records are correct and up to date. This search usually includes all children registered at that practice vaccinated during a defined time

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			period and can include those recently vaccinated at the practice and at school / home. So again, there can be reluctance at the practice to go through them all individually.
106	Public Health Team Sheffield City Council	2	This is standard practice in Sheffield.
107	Royal College of General Practitioners	2	This is reasonable goal other than it is clearly advocating a duplication of effort. A major problem with current immunisation is that there are essentially two versions of 'the truth': the GP and child health records. Having 2 discrete records for the same information causes a mismatch of information; from GPs' practice and discussion the RCGP feels that GPs are not reliably informed of vaccines given at school, e.g. HPV, school leaving booster, influenza. Therefore, outside of the preschool vaccination programme, GPs are effectively cut out of participating in improving uptake. It must be remembered that the GP record is the enduring health record throughout life and the GP acts as the health care co-ordinator throughout life. Therefore it must be accurate. This statement is statement is not consistent with a paperless and joined up NHS information process. This statement therefore would be better as expressed as: "Children and Young people receiving a vaccination should have it recorded in the personal health record and in an electronic medical record accessible to the child health information system and General Practice Health Record." This would require investment (but should be included somewhere within each STP footprint Digital Roadmap) to enable the electronic joining up, but there would be no need for NICE to be prescriptive about the method. (JH)
108	Sanofi Pasteur MSD	2	Local arrangements should include independent schools. A survey undertaken by the School and Public Health Nurse Association (SAPHNA) in 2014 found that only 19.2% of independent school nurses reported that they shared their immunisation data in line with the national reporting requirements.
109	UCL Great Ormond Street Institute of Child Health	2	It is good practice for a record of immunisation to be made in several places including the PCHR. In my capacity as chair of the national PCHR committee, I am aware that some practice nurses do not record immunisations in the PCHR or only record limited information. This is partly because in the context of an immunisation appointment, PNs now have to not only administer a number of vaccines (at 8 weeks, this is 4 including one given orally, and the new MenB which may require more explanation as well as instruction about administration of paracetamol) and they simply have too much to do in the time allocated. We will be reviewing the content of the immunisation recording page in the PCHR to establish which items are absolutely necessary.

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110	Vaccine Preventable Disease Programme – Public Health Wales	2	Public Health Wales fully supports this statement. We suggest more detail adding up to their 19th birthday and expand to add all children should be given a user friendly vaccine passport that lists completed immunisations and lists those outstanding at age 16 when they can leave school. This would require resources but should be a gold standard for public health and user engagement and could be generated by child health it would help to empower young people to take ownership.
111	Cheshire and Merseyside NHS England Local Area Team	3	This is a great standard and needs to be incorporated into Secure setting health care contracts. SO its something for the Secure Commissioning arm of NHS England to look at. There is a missing bullet under structure: Any secure setting health care provider should be commissioned to check vaccination status of individuals under 20 who are admitted to their setting.
112	Department of Health	3	Rationale- No objection to a QS on young offenders but not clear from the rationale why they have been prioritised over other high risk groups listed on Pg2 where young offenders have not been included. Could we not include other key groups in this QS too or have another QS for other high priority groups (perhaps rollover the Recommendation from 2009 (see comment 1) which has not yet been fully implemented.
113	Department of Health	3	Structure – do NICE need to include something about having the offer (and hopefully) vaccination recorded in their records and this information transferred to their GP record too?
114	Department of Health	3	Outcome – could we also include something like 'the proportion of those who had gaps in their vaccination history who had the appropriate vaccination whilst in secure setting'?
115	Department of Health	3	Service providers – could the end include ' and details are passed on to the GP after vaccination has taken place?'
116	Department of Health	3	Commissioners – could the end include 'and passed details on to the GP after vaccination has taken place?'
117	Department of Health	3	What quality statement means – could this be expanded beyond process issues, for example, to say that it will 'increase the proportion of young people protected and / or reduce incidence of vaccine preventable disease / outbreaks in secure settlings' (assuming that is the case)
118	NHS England	3	Would require the provider to have access to previous immunisation records - this must be facilitated by the commissioner and data sharing arrangements put in place. Once that is in place this should be easy to do. I agree with this quality statement
119	NHS England	3	Yes agree – other high risk groups are generally picked up via routine performance monitoring and local work with Partners. Data for this group is not included in routine data collection and so requires a specific, targeted approach – this group can be easily missed due to the often transient nature and rapid transfer between prisons and the fact that often these individuals are not registered with a GP.

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120	NHS England	3	This statement may be hard to measure due the number of different Providers for health and justice. Who will be responsible for checking the immunisation status – will they have access to CHIS across the UK as young people are not necessarily in an institution in their local area. It may not be a health professional who makes the initial assessment.
121	NHS England	3	Unable to comment on the details of this – would suggest Health and Justice Commissioners will have input.
122	Pfizer UK Limited	3	The focus of the statement should be broadened beyond the young offenders group. While this may catch many young people in respect of their teenage vaccinations it does miss out on those children who are in care from a young age and who are likely to miss out on being vaccinated. The briefing document used to help prioritise the areas for quality improvement did not specifically highlight any statistics to select young offenders over other at risk groups. Therefore we would encourage the committee to consider broadening this quality statement to include those children in care also.
123	Public Health England	3	Do you agree with the focus of this quality statement on young offenders instead of other at-risk groups? Please give reasons for your opinion. Public Health England fully supports and advocates for full age appropriate immunisation programmes to be in place within the secure estate. The Health and Justice team have prepared some specific input in relation to immunisation of young offenders which is included below. In response to your consultation question about the focus on this QS we would welcome a more inclusive approach that covers all 'high risk groups'. This would more accurately reflect need and have a bigger impact at the population level. As a minimum you should also include looked after children' here. The main challenge with broadening the scope is developing measurables as routine immunisation data for the childhood programme is collated at the aggregate level nationally. Data collections for the newer programmes e.g. rotavirus and meningococcal B programmes do include ethnicity so there is some experimental national coverage data available by ethnicity however these data are not of very good quality or useful at the local level where numbers of certain ethnic groups can be quite small. Very happy to discuss in more detail should you wish to explore opening this up to other high risk groups. Specific feedback from the Health and Justice team on QS3 in its current form: In order for an immunisation programme to achieve its full potential all young offenders must have their immunisation status checked on entry into the secure setting and offered and administered any outstanding vaccinations. Identifying and delivering missed immunisations not only protects the young person but also increases the coverage within the setting therefore reducing the risk of cases or outbreaks of serious disease. If there is no documented evidence of vaccination at the time of the health check into secure accommodation, the vaccine should be offered / given at that time as this group of young people

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			can be quite mobile and may move on before the health team receive any immunisation information that has been requested from other areas. The military have a good system, if there is no evidence of vaccination at the new recruits entry health check they get a dose. Additional doses will do no harm. Children in contact with the youth justice and those placed on welfare orders are a particularly vulnerable group who face many health inequalities. There is compelling evidence and concern to suggest that young people in contact with custodial settings often come from populations or groups at high risk of certain infectious diseases and have significantly more severe physical health problems than the general population. They have often missed out on opportunities for screening and immunisation programmes due to decreased school attendance and a lack of engagement with primary healthcare. Many children and young people have missed out on having their immunisations or have gaps in their immunisation history. Evidence shows that for many children and young people their experience of a secure setting brings them into contact with sustained and meaningful health services for the first time providing opportunities for identifying and treating previously unrecognised and undiagnosed health problems in a meaningful and sustained manner. It enables the provision of support for on-going healthcare and treatment, and this can be maintained on a return to their community. However there is also concern that children and young people in custodial settings miss out on opportunities for healthcare prevention programmes such as screening and immunisation due to fractured care pathways and social constraints. The factors above serve to exacerbate the additional vulnerabilities experienced by children and young people within the secure estate and potentially place them at risk of significant longer term health problems as they grow into adulthood, with the very real risk of a reduction in their life expectancy. In order to improve the life chances of children and young people in the secure estate, to reduce reoffending and to address health inequalities it is vital that they receive the best available health care appropriate to their age and needs Secure settings differ in terms of their age, design, construction and delivery of health care facilities. In addition, the turnover of children and young people can be high and living in close proximity to each other and these are all factors which increase the potential for cases and outbreaks of infectious diseases such as measles, mumps and meningitis. Immunisation is a simple and effective way of protecting children and young people against certain diseases whilst also protecting others by helping to control serious diseases in the community.
124	Vaccine Preventable Disease Programme – Public Health Wales	3	This advice seems sensible and is welcomed, there should be a focus on vaccinating young people within the justice system who are extremely vulnerable and are known to have multiple health needs. Public Health Wales would want to ensure that this recommendation includes those within the youth justice estate – secure children's homes –

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			as well as young offender facilitates. This should include secure children's homes and Young Offender units. This objective should be feasible and should incorporate those eligible for HPV/MSM
125	British HIV Association, BHIVA	Question 6	We recognise the opportunity and relevance of targeting young offenders. However we are concerned that this statement may be interpreted as a sole focus at the expense of other vulnerable groups.
126	CoramBAAF Adoption and Fostering Academy	Question 6	We agree that young offenders are an important group but it is unclear who would have responsibility to implement this statement. We are aware of considerable difficulties with health service delivery and standards for health provision for this work and immunisation should also be addressed. We also suggest a specific focus is needed on refugee children and young people, particularly those who are unaccompanied by a responsible adult and where health and immunisation history may be completely unknown. Given the increasing number entering the UK and the lack of health history combined with the disruption to health provision in many of their countries of origin this group should merit special attention and provision. The immunisation status of these children should be checked at entry to a refuge. Additional resources may be needed for engagement, interpreter services and catch up on missed immunisations, etc.
127	Department of Health	Question 6	Consultation Question – No objection to a QS on young offenders but not clear on the rationale why this group over others. Would like consideration as to whether there are other at-risk groups such as (perhaps) refugees who might also need a QS or be included in QS3?
128	Meningitis Research Foundation	Question 6	No, we think that this quality statement should also try to encompass other at risk groups such as looked after children. Looked after children should be registered with social services so there is an opportunity for their social worker to check their immunisation status and whether they are registered with a GP.
129	NHS England	Question 6	There is support for this quality statement but we don't think this should be the only "at risk" group prioritised as this is inequitable for other vulnerable groups.
130	NHS England	Question 6	Question 6 For draft quality statement 3: Do you agree with the focus of this quality statement on young offenders instead of other at-risk groups? Please give reasons for your opinion. This seems a reasonable group to target as have low immunisation rates and are a captive audience
131	NHS England	Question 6	Question 6 For draft quality statement 3: Do you agree with the focus of this quality statement on young offenders instead of other at-risk groups? Please give reasons for your opinion. This seems a reasonable group to target as have low immunisation rates and are a captive audience

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132	Public Health Team Sheffield City Council	Question 6	Yes, we agree that this would be a good idea. Sheffield School Nursing Service currently check vaccination status and provide vaccination if necessary at one of our children's secure units. This is an ad-hoc arrangement. We are not clear what the commissioning arrangements would need to be for this to be a more formal service offer.
133	Royal College of Paediatrics and Child Health	Question 6	For draft quality statement 3: Do you agree with the focus of this quality statement on young offenders instead of other at-risk groups? This statement seems appropriate. Looked after children are another potential focus.
134	Board of Deputies of British Jews / Jewish Medical Association UK	4	The offer of vaccinations for those that have missed routine vaccinations is obviously appropriate. Commissioners need to ensure that the resources and facilities for this are available. The approach to this statement needs to be sensitive to equality and diversity with respect to language and foreign birth.
135	Cheshire and Merseyside NHS England Local Area Team	4	Once again, the use of "local data collection" is unrealistic and impracticable. It is difficult to see how the denominator "children known to have missed a vaccination " can be ascertained.
136	Department of Health	4	QS4 You might want to reconsider using the phrase 'as soon as it is known' as it is not clear what that would mean in practice (hours, days, weeks) and how it would be measured? If a specific timescale is deems to be good practice then it should be made clear so it could be used as a benchmark for local monitoring/ to work towards?
137	Department of Health	4	Structure – could something be included to demonstrate that person centred services are being provided ie choice of venues/times etc to maximise opportunities to have outstanding vaccinations
138	Department of Health	4	Process (a) and (b) – if it is agreed that 'as soon as it is known' is not measurable then these measures will need to be revised accordingly'
139	Department of Health	4	Outcome - could we include some outcomes that are more specific to QS4 such as 'proportion identified as having missed vaccinations who are referred on for vaccination 'and' proportion of those referred on who are vaccinated'?
140	Department of Health	4	Service providers - could school health services be added?
141	Department of Health	4	What the quality statement means for CYP – it would be helpful to clarify what 'straightaway' means in practice – how would it be quantified / measured?
142	NHS England	4	I do not know how this would be measured It seems to suggest that we should commission 'mop up' services – where would the funding come from where these are not already covered e.g. via enhanced services?
143	NHS England	4	Ascertaining the denominator is problematic since often the CHIS and the GP systems are not up to date and therefore knowing exactly which children are missing vaccines can be difficult. It may be better to concentrate on certain vaccines or certain ages. I don't see how the COVER programme provides this data - it is not timely enough. I

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			think this statement should concentrate on children at pre-school or school entry to ensure they have have MMR and other preschool vaccines.
144	NHS England	4	No – focusing on a specific immunisation gives the wrong message, may lead to interpretation that other programmes are less important and the infections against which they protect are less serious/life changing/life threatening.
145	NHS England	4	Structure – Should include signposted as well as offered (may not be practicable for providers to offer – logistics of vaccine management and transportation by school imms providers for very small numbers e.g. MMR or may not be contracted under 7a programme to delivery opportunistic primary/childhood imms)
146	NHS England	4	Process (a) Would be identifiable relatively easily by school imms but may need a specific search for primary care (adolescents and infant imms where CHIS do not call/recall) – this would have resource implications – could be onerous on primary care. Where CHIS involved in call/recall – identify infants with missing imms and flag/provide details to GPs but would then need data collection tool to identify those offered. Would need to be part of spec/contract. Data collection/reliability may be problematic where programmes/delivery crosses providers e.g. school and GP.
147	NHS England	4	Process (b) Information available but this would be an additional data collection – would need to be included in spec/contract.
148	NHS England	4	Equality and Diversity Page 20 Needs to take account of parental choice – some parents coming from aboard actively chose to follow the schedule in their country of origin and not the UK – this needs to be reflected in the child's record (CHIS and GP).
149	NHS England	4	This standard may be difficult to measure as it is likely that there will be a crossing of services – if the child/young person is identified by one agency as having missed a vaccination they may have to refer to a different agency – who would be responsible for capturing the data – and following up to find out the outcome. Referral doesn't always convert into the child turning and being vaccinated.
150	NHS England	4	There is a need to identify who has the responsibility and access to the information in order to check imms status for children and young people. In terms of highly mobile children , e.g. travelling communities, looked after children, youth justice who will responsible and what systems will be available to review their status, bearing in mind it is more likely to be assessed by a non-health professional e.g. probation officer.
151	NHS England	4	For children missing vaccinations, GP clinical systems should flag this up to parents/families/guardians when healthcare professional is in a clinic with child's OR parents' records appear on screen.

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152	Pfizer UK Limited	4	The focus of the statement could be improved to focus on the rate limiting step which is regularly checking the immunisation status of a child. The source recommendation details this as an important step and the offering of the vaccination is a sub point. If this element is either not incorporated into this statement, with an associated measure, or as a separate statement it is possible that while the statement may be implemented it will not significantly affect the number of unvaccinated children. For example if only 10 of every 100 children are asked their status and 1 is found to need a vaccination, it is possible to achieve a 100% success rate by just immunising one child. However the status of 90 other children has not been ascertained and therefore 9 other children may have missed the opportunity to receive their vaccinations. Therefore we would recommend that the process of checking immunisation status at every opportunity is incorporated into this statement. While statements usually contain only one concept, these are so closely related and dependent on each other that they are both needed. We acknowledge that statements 1 and 2 are attempting to address this point through systems and recording. However, they are not geared towards actively checking the immunisation status of a child. These statements may be beneficial in the future but there will be current cohort who will not be captured within these systems at this point who need to be checked and immunised.
153	Pfizer UK Limited	4	This statement should continue to focus on all immunisations and not any singular vaccine as all are important in controlling disease and its associated outcomes
154	Public Health England	4	Best to focus on primary care as this is where most immunisation happens. Build on every contact counts. Suggest opportunities for possible prompting/checking of immunisation status e.g. any attendance at primary care, attendance for annual flu jab (for limited age groups done in primary care), every new registration (after moving for example – particularly important for new entrants / migrants). Very difficult to have a specific measure on this. Routine COVER statistics will not tell you if this has specifically made a difference as COVER may not improve even though children are being caught up later on (COVER measures vaccines given at the appropriate times with only a limited period available for catch-up) You could focus on a couple of immunisations only as indicators e.g. pre-school booster or coverage with one and two doses of MMR – important for our commitment to eliminate measles and rubella. You could assess this at different ages to that recorded through COVER (at 1, 2 and 5 years of age) – any improvement in coverage after 5 years will be due to opportunistic catch up. We suggest you merge Quality Statement 4 and 5 – they are two sides of the same coin. This would create the opportunity to include a quality statement on training of health professionals delivering the immunisation programme.

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155	Public Health Team Sheffield City Council	4	This would be aided by having a wider range of potential vaccinators. For example in Sheffield Health Visitors do not provide vaccination. A key way to increase uptake would be to increase the pool of community based vaccinators. We note that this guideline does not make reference to the workforce implications of increasing vaccination uptake. We appreciate this may be out of the scope of the guideline but think it is a key issue to ensure increased uptake via increased opportunity for vaccination. A related example in Sheffield is that midwifery services agreed for the 15/16 flu season to offer flu vaccination to pregnant women at their 20 week hospital appointment. This increased our uptake of this vaccination locally by a substantial amount.
156	UCL Great Ormond Street Institute of Child Health	4	This is very important but maybe difficult to gather data for children seen in different settings e.g. gathering information that a child been offered vaccination from hospital settings, particularly from tertiary and quaternary services. How will this be done? The issue of who funds the vaccines also needs to be addressed if hospitals and other settings are going to carry out immunisation. It also requires that staff are well trained in assessing children's vaccine status which will need regular updating.
157	Vaccine Preventable Disease Programme – Public Health Wales	4	Making every contact count (MECC) is endorsed by Public Health Wales we fully support this statement. In primary care consideration will need to be given to contracts /national enhanced service agreements to ensure there is remuneration for outstanding vaccines given in primary care that are part of the routine schools service. This will support primary care to give opportunistic outstanding immunisations at for example at an asthma clinic or a travel assessments to children and young people who have missed routine school immunisation sessions. Public Health Wales agrees that it should be all relevant outstanding vaccines – multiple vaccines can be given safely at one contact. School Nurses routinely give 2 vaccines. Practice staff are giving 4 and 5 it is existing practice. Governance issues with vaccine storage in schools requires robust protocols. Wales has examples of school nursing teams that offer outstanding MMR vaccine at the same time at as Td/IPV and Men ACWY. The schools programme has faced an increase in volume of work with catch up MenACWY and expanding children's flu so consolidating good practice to encompass checking of vaccination status and administration of outstanding vaccines has come down the list of priorities. The increase in resources for the school nursing services and child health to support Men ACWY and children's flu provides an opportunity for these experienced and successful workforces to implement this statement as it moves forward with resources. It could further be supported if child health issued populated consent forms in advance of the school immunisation session so school nurses, parents and students are aware of outstanding immunisations in advance .

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158	British HIV Association, BHIVA	Question 7	BHIVA believes that it would be appropriate for the guidelines to specify areas where need for improvement is greatest both in terms of infection threat/disease impact on the individual and relevance to public health. There are also areas where performance against benchmark indicators is poor and in need of focused attention (e.g., hepatitis B vaccination for children and adolescents at risk).
159	CoramBAAF Adoption and Fostering Academy	Question 7	No, all immunisations are important and missing immunisations is an issue for children and LAC of all ages. Immunisation schedules in the countries of origin of refugees may not be the same as the UK and these vulnerable children should have their status checked on entry to a refuge and receive all the appropriate immunisations once they are living in the UK.
160	Department of Health	Question 7	Consultation Question – If it was necessary to focus on a specific vaccination then MMR would probably be the best vaccine as it acts as a useful proxy for all vaccinations but in an ideal world it would be better not to focus on a specific vaccine.
161	Meningitis Research Foundation	Question 7	We agree with this statement, but suggest there should be an emphasis on opportunistic vaccination. For example: "Healthcare professionals (such as GPs, practice nurses, health visitors and paediatricians) ensure that when they identify children and young people who have missed a routine childhood vaccination, they offer to adminster the vaccination as soon as they next see the child/YP or refer the child or young person to a service that can give the vaccination." As currently written this QS could mean that health professionals should simply offer an appointment to be vaccinated, but with hard-to-reach groups who do not often see a health professional it is better to use the encounter to vaccinate the child if the parent is willing (or the YP if they are willing). For example, university students offered MenACWY vaccine on the spot at Fresher's Fairs are more likely to be vaccinated than if they are offered an appointment.
162	Meningitis Research Foundation	Question 7	No. All immunisations are important and by addressing all immunisations it allows children to who are at risk of not being immunised several opportunities to be recognised throughout childhood. In our comment 2 above we argue that the emphasis should be on opportunistic vaccination, and that way any vaccines that have been missed can be offered opportunistically as soon as the child is seen by a health professional.
163	NHS England	Question 7	We do not think should focus on a specific vaccination as they are all important for the child and wider community.
164	NHS England	Question 7	Question 7 For draft quality statement 4: Do you think the statement should focus on a specific immunisation? Please give reasons for your opinion. A single vaccination approach is simpler to implement as stakeholders only need knowledge about one vaccine eg: MMR. However greatest protection would be from including all

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			immunisations. Greater clarity would be useful on how this differs from Draft Quality Standard 1. Presumably this is more about say Health Visitors checking immunisation status and referring children to their GP Practice.
165	NHS England	Question 7	Question 7 For draft quality statement 4: Do you think the statement should focus on a specific immunisation? Please give reasons for your opinion. A single vaccination approach is simpler to implement as stakeholders only need knowledge about one vaccine eg: MMR. However greatest protection would be from including all immunisations. Greater clarity would be useful on how this differs from Draft Quality Standard 1. Presumably this is more about say Health Visitors checking immunisation status and referring children to their GP Practice.
166	Public Health Team Sheffield City Council	Question 7	No we don't think the NICE guideline should specify a particular vaccination. Locally we have a 2 year improvement plan for Vaccination and Immunisation uptake improvement which is signed off by Public Health England , the Clinical Commissioning Group and Local Authority Public Health. This sets local areas for action which can include specific vaccinations where it has been identified that uptake needs to improve. The advantage of a local plan is that providers have assessed the uptake evidence and are committed to improvement. Guidance could be provided along these lines in the NICE guidance.
167	Royal College of Obstetricians and Gynaecologists (RCOG)	Question 7	No I don't think that the focus should be on a specific vaccine as each of the childhood vaccines have an important role to play in the health of the individual, in providing herd immunity and in the protection of unborn children who may be affected by exposure to some common childhood illnesses.
168	Royal College of Obstetricians and Gynaecologists (RCOG)	Question 7	For draft quality statement 4: Do you think the statement should focus on a specific immunisation? It is appropriate that concerns about any and all vaccinations are addressed. The onus on discussion with the child or young person is excellent.
169	Board of Deputies of British Jews / Jewish Medical Association UK	5	Monitoring vaccinations at developmental stages - to identify those that have missed routine vaccinations - is obviously appropriate. Commissioners need to ensure that the resources and facilities for this are available. The approach to this statement needs to be sensitive to equality and diversity with respect to language and foreign birth.
170	Cheshire and Merseyside NHS England Local Area Team	5	Checking at key educational stages….This is entirely practicable as an augmentation of the school years vaccination programmes. There is no reason why it should not be introduced into national service specifications. However, it would have significant resource implications: both for the efforts needed to track down childhood vaccinations data from CHIS and form GPs; and for the actual delivery of missed vaccinations.

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171	Department of Health	5	Rationale - it would be useful to set out what the education stages are in the rationale (as set out on Pg 23) rather than say 'such as' and just include a couple. It would also be good to know if they are the minimum in terms of this QS
172	Department of Health	5	Outcome – it would be useful to have an outcome measure that could identify the increase in uptake as a result of the QS, for example, 'proportion who were identified as not having had vaccinations who went on to be vaccinated' etc
173	Department of Health	5	Commissioners – rather than make sure CYP have their vaccination status checked should it be to make sure healthcare professionals check the vaccine status of CYP ie have the action aimed at the healthcare professional not the CYP?
174	Department of Health	5	What the QS means for CYP – could it finish along the lines 'so that action can be taken to offer vaccination to those who have missed it to reduce the risk of developing vaccine preventable disease'?
175	NHS England	5	Contribution of educational settings: This statement seems not to grasp the complexity of the commissioning process. Whatever good practice used to happen in the past is subject to change now that commissioning is in Local Authorities. Health visiting and school nursing are increasingly moving from universal to targeted as LAs look to ways of saving money. There are no transition checks between primary and secondary schools. Our ability to influence those services is limited and is NICE guidance even binding on LA PH commissioners? Extended school role for acting as venues for vaccinating children – who would lead this discussion with schools? There is no routine contact by GPs with children going to school for the first time and any requirement for GPs to check children's immunisation status when they change educational settings would need a change of contract
176	NHS England	5	The health child team - I assume this means the school health advisor team? They will not have access to the personal child health record or Red Book since it is parent held and many parents can't find it by the time children start schools. But these teams should have access to CHIS and they could then check the accuracy with the parents if that systems indicates missing vaccines. Commissioners can easily add this requirement into the school health advisor specification - this is now the responsibility of the Local Authorities. There will need to be arrangements and data sharing agreements between providers and CHIS. Checking older children 16+ when they transfer school will be almost impossible - 6th form colleagues tend not the have School health teams going in in many areas - they may have their own health service but it is unlikely to be commissioning do by the LA or NHS England.
177	NHS England	5	Examples - in my previous area of work our CHIS used to send lists of children who failed to attend a second immunisation appointment to the child's nominated health visitor so they could discuss the miss appointment with

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			parents. Our school health providers has access to the CHIS so they could check a child's Imms status at any time and it was in their specification that they should check Imms status at the school entry point, Year 6 (when they did the national child measurement programme) and when the child started senior school. When the school nurses did the adolescent immunisations it was another chance to check Imms status. What didn't happen though was them giving the missing vaccines - the parents were simply directed to their GPs. Ideally the provider discovering the missing immunisations should be able to give the vaccines - this would require a redesign or increase on contracts. Additional payment streams for some vaccines to not lend themselves to other providers giving missing vaccines - e.g all preschool vaccines are in the GP contract and paid for as part of the global sum. Commissioners would struggle to identify or extract funds from GPs to pay school nurses or school immunisers to give the missing vaccine.
178	NHS England	5	No not really cutting edge service delivery – many providers do this to some extent but informally, this is encouraged but is often restricted by limited resource within school nursing/immunisation teams and changes to contracts as a result of the transfer of commissioning for 5-19 services to LA's who may not have immunisations as a priority. Often on entry to school (the first health check) immunisations will be checked and the child signposted to the GP (immunisations not administered by the school nursing team at this stage). School Nursing Teams/Immunisation Teams are often not notified when a child moves/transfer schools – the child would be identified when they next go in to deliver a specific programme. Would need a change in commissioning intentions to require school nursing/immunisation teams to deliver any missing immunisation, this would potentially impact on their service and vaccine management, as don't routinely order/store/carry the childhood imms – could include in service specification/contract that they should check and signpost at every opportunity.
179	NHS England	5	Rationale- Needs incorporating in to the national specifications for Health visiting and School nursing as these services are now commissioned by LA's.
180	NHS England	5	Process (c) School nursing teams may not be informed when a child transfers in to a school, they may not be picked up until they go in to deliver another programme.
181	NHS England	5	Process (d) Does this mean college or University? This relies on the individual registering with the university practice. Many university practices will already carry out missing imms checks.
182	NHS England	5	There is support for this developmental standard but it needs to be recognised that there are many changes happening within the traditional school nursing service who provided most of the school based immunisation programmes. School Nursing is commissioned by local authorities as part of the 0-19 agenda and this does not include immunisations. Immunisations are commissioned by NHS England. As local authorities look to redesign 0-19

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			services there are budgetary cuts happening and recommissioning of services is not joined up – 0-19/imms procurements do not happen at the same time which is causing a destabilisation of the workforce. Our area is currently out to procurement across 13 local authority areas – this has translated into 3 lot sizes, each with multiple local authority areas within it. Some of the traditional school nursing services have not provided any staff for TUPE. We are unable to share at present how we think the imms programmes will be delivered but it could include private providers, dedicated imms teams, or continued school nurse delivery.
183	NHS England	5	Training would be required if non health professionals or health professionals not used to assessing vaccination status are asked to assess vaccination status at the key stages of education transition/transfers to new schools – aware that training is not the remit of Quality Standards but thought it should be raised as an area of challenge. . Health visitors in many areas do not see children at school entry although they do a records review so whose responsibility will it be to review status at educational transition? For older children transition is year six and nine, who will review at this point – education or health?
184	NHS England	5	This developmental standard will be a challenge to achieve especially linked to checking immunisation status of young people moving to colleges as there are no health professionals involved in this transition.
185	NHS England	5	This developmental standard will be a challenge to achieve as educational providers are not commissioned by Health. Given the pressures within education we are unsure who would be responsible for checking immunisation statuses of children as this could be large cohorts if you consider the transition between Primary and Secondary Schools. It is unclear how they would access CHIS to check imms status of individual children.
186	NHS England	5	We suggest that a useful point of checking the imms status of looked after children would be at each initial and annual health check.
187	NHS England	4-5	These could easily be combined as they are very similar. Could be: Checks at key educational stages, or at any point that it is discovered that a child has missed a vaccine…
188	Public Health England	5	See above – QS 4 and 5 feel quite similar and you may want to merge them. Checking is important but what is more important is being able to catch children up as a direct result of that check. Not sure that this is a developmental quality statement. It has been in place and a contractual obligation for a long time. The issue is whether it is actually implemented in practice – we know this to be very variable across the country. In addition some areas may check status but then send children to their GP for catch-up – we know this is not effective and best for the school nursing team to catch children up directly in schools when they have them as a captured audience. Maybe a developmental quality statement could be something around using CHIS to develop an 'immunisation passport' – a printout of

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			vaccines recorded on the system for each school leaver. In order for this to work we would need to be confident that the CHIS continues to be updated with the child's immunisation history until their19th birthday. Although this is the requirement in service specifications we are aware that in practice the records are often not accurate beyond age 5 years. Here is a summary of contractual levers currently in place for catching up children with MMR. Included here as could help with your thinking as you develop these quality standards: Unvaccinated and partially vaccinated children aged under 16 years and women of child bearing age, are currently eligible for MMR as part of the General Medical Services global sum. Adults aged 16 and over, including women of childbearing age, who are not fully vaccinated with MMR, are eligible in 2015/16 for MMR as part of an enhanced service. GP new patient registration consultation provides a vital opportunity to assess immunisation status and offer missing doses of vaccines accordingly. Ideally new migrants should have a reliable written record of their immunisations, however if no record is available then vaccination should be offered as per the Vaccination of individuals with uncertain or incomplete immunisation status. Following birth, the 6-8 week post-natal maternal check offers another opportunity for the GP to check the mother's MMR status. In addition, antenatal care provides multiple opportunities to discuss the family's MMR status and raise awareness of reporting rash and contact with rash illness in pregnancy. School nurse health checks at the ages of 4 to 5 years (Reception / school year one), 10 to 11 years of age (school years 6-7) and the mid-teen review should be another opportunity to check children's MMR status and offer or refer them for MMR vaccination. Checking MMR status should also form part of the contracts for the teenage booster (Td-IPV and ACWY) vaccinations and any missing doses offered where needed to ensure that everyone has received both doses.
189	Public Health Team Sheffield City Council	5	We think that this would be a good idea and agree that school and college entry points could be useful time points to undertake this. There would be significant resource implications for this work locally the workload would most likely impact the school nursing service.
190	UCL Great Ormond Street Institute of Child Health	5	This is very important but maybe difficult to gather these data and do to measure in practice particularly currently with such pressure on NHS services. It will require training to be provided to those collecting these data and clear guidelines will need to be developed to ensure consistency in data collection.
191	Vaccine Preventable Disease Programme – Public Health Wales	5	Public Health Wales fully supports this statement it has been existing policy in Wales to routinely check MMR status at primary and secondary school entry since 2005. To support this statement there needs to be robust data quality from the child health records – this requires electronic sharing between education and child health and GP's and we are along from this and it will require resourcing. However it should be feasible to check immunisation status at every scheduled school immunisation session by the provision of populated consent forms and any outstanding

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			immunisations should be provided at the contact for flu, HPV , Td/IPV ,MenACWY in school programmes or signposted to next appointment /service. Wales is developing a set of school immunisation standards and child health immunisation process standards in an attempt to ensure consistency reduce inequalities and improve uptakes. The child health system is fundamental to the successful operation and delivery of immunisation programmes so it is essential that adequate resources are directed towards supporting the system to facilitate access to accurate data on immunisation status.
192	British HIV Association, BHIVA	Question 8	This is a welcome proposal that can address current gaps in ascertainment and provision and facilitate maintenance of good records – it will require investment and change in practice. It will also require targeted education to ensure that some groups are not placed at a disadvantage (i.e., not offered vaccination on account of HIV status, based on misperceptions) or stigmatised when singled out for some targeted vaccinations without adequate sensitivity (e.g., HPV vaccine in young HIV positive or MSM boys; Hepatitis B vaccination for contacts). How will religious schools address these matters?
193	CoramBAAF Adoption and Fostering Academy	Question 8	We are not convinced of the value in checking immunisation status at key educational stages. Normally there is no immunisation activity scheduled at entry to secondary school. The preferred time to check would be after the age when HPV immunisation is scheduled so that missed immunisations could be given then. Systems are generally not in place to check at entry to secondary school and developing this may not be the best use of the resources required.
194	Department of Health	Question 8	Consultation Question - No objections to this but not sure it is cutting edge. It seems more like good practice (making every contact count) that does not appear to be happening and a QS is needed to try and ensure it happens
195	Royal College of Paediatrics and Child Health	Question 8	For draft developmental statement 5: Does this reflect an emergent area of cutting-edge service delivery? If so, does this indicate outstanding performance only carried out by a minority of providers that will need specific, significant changes to be put in place, such as redesign of services? This is not within our area of expertise to answer, however if it is the case that this is achievable by school nurses on entry to school it would be a helpful learning point for clinicians to highlight that here.
196	Cheshire and Merseyside NHS England Local Area Team	Suggestion for additional statements	These are really good aspirational and audit standards. Many of the suggested measures are totally impractical. The standards are a really good start. Peer Review visits such as are undertaken for Screening Programmes would be a great way to use the Standards. Considerable work is needed to find ways to measure the most important standards The emphasis on missed vaccinations, follow up and checking at milestones is good. The challenge of data collection and handling should not be underestimated. The standards would benefit from an additional statement:

ID	Stakeholder	Statement number	Comments
			that large scale and local marketing of vaccinations, and celebration of vaccine success, is essential. The statements need to be incorporated into future contracts with, for example, GPs, to ensure delivery. Some more of the standards could usefully be called "developmental", especially in their measures.
197	Department of Health	Suggestion for additional statements	This new QS misses the start of the process ie. having systems in place to identify those who are eligible for the different vaccination programmes and inviting them for vaccination in the first place. Could this have a QS or perhaps could this aspect be merged with QS1 so it is about the identification, invitation and recall?
198	NHS England	Suggestion for additional statements	Summary of suggested quality improvement: Areas seem very broad – could detract from focus on uptake Flu needs to be for all eligible children not just diabetes (due to impact on population and individual health)
199	NHS England	Suggestion for additional statements	Active invitation for seasonal flu vaccination, particularly for the 2-4 year olds, given gradual decline in uptake. Positive comms re: efficacy and dispelling myths is integral.
200	Royal College of Paediatrics and Child Health	Suggestion for additional statements	It would be beneficial to have a quality statement regarding routine vaccination of premature neonates. This is an area of consideration both in neonatal units and general practice.
201	Royal College of Nursing	No comment	This is just to let you know that there are no comments to submit on behalf of the Royal College of Nursing in relation to the stakeholder engagement exercise for the vaccine uptake in under 19's quality standard. Thank you for the opportunity to participate.

Registered stakeholders who submitted comments at consultation

- Board of Deputies of British Jews/Jewish Medical Association UK
- British HIV Association
- British Infection Association
- Cheshire and Merseyside NHS England Local Area Team

- CoramBAAF Adoption and Fostering Academy
- Department of Health
- GlaxoSmithKline UK Ltd
- Meningitis Now
- Meningitis Research Foundation
- Neonatal and Paediatric Pharmacists Group (NPPG)
- NHS England
- Pfizer UK Limited
- Public Health England
- Public Health Team Sheffield City Council
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Obstetricians and Gynaecologists
- Royal College of Paediatrics and Child Health
- Sanofi Pasteur MSD
- UCL Great Ormond Street Institute of Child Health
- Vaccine Preventable Disease Programme – Public Health Wales