Bury GP Federation and GSK Collaborative Working

Summary and outcomes of Shingles National Immunisation Programme Improvement Project. January 2023 – May 2023

This summary has been written by GSK and the Project Manager aligned to this project with consultation from the Project Steering Committee, which includes Bury GP Federation.

Summary

The project demonstrated that delivering dedicated shingles vaccination clinics using the systems and workforce the practices already have in place effectively, for example re-establishing call/recall systems, utilising telehealth booking system and maximising underutilised clinic capacity (primarily enhanced access clinics outside of typical clinical hours), they can achieve an increased level of uptake whilst reducing the administrative resource time required. Bury GP Federation increased uptake in eligible 70 year olds by 21% and in eligible 71-79 year olds by 5% representing an additional 1,106 vaccinated patients within the project period as a result of the project interventions.

Project Overview

The aim of the Shingles National Immunisation Programme (NIP) is to lower the incidence and severity of shingles in older people. The routine programme 2021-2023, for people aged 70 years has been in place since 2013. At the same time, a catch-up programme was rolled out to those aged 71-79 years in a phased approach. Shingles NIP uptake is low, particularly in the routine cohort, 31% at 70 and 66% for those aged 71-79 in the catch-up cohort.[1]

Bury, a borough within Greater Manchester Integrated Care Board, encompasses 25 GP Practices with 210,000 patients. Of these patients, 18,000 meet the Shingles NIP eligibility criteria. Bury CCG, data published at a CCG level, has the greatest scope to increase uptake nationally (12% uptake at 70) and therefore presented an opportunity well aligned with the overall objectives.[1]

Bury GP Federation has 16 member practices. The aim of the Federation is to enhance the delivery of health and care services to the local population by taking a joint and consistent approach. The 16 practices are split into 3 Primary Care Networks (PCNs): Horizon (6 Practices), Prestwich (6 Practices) and Whitefield (4 Practices). There is also a stand-alone PCN within the Borough. Although Bury PCN (9 Practices) are not members of the GP Federation, data sharing agreements and joint initiatives allow for the benefit of a close working relationship and involvement within the scope of this project.

The collaborative working objectives were as follows and structured into 3 stages:

- Stage 1: Increase understanding of key barriers and opportunities for shingles vaccination, specific to Bury GP federation, an area of significantly lower than average shingles vaccination uptake.
- Stage 2: Test and optimise agreed identified solutions.
- Stage 3: Measure impact of solutions and document learns and further opportunities.
    - Increase Shingles vaccination within the NIP eligibility criteria across Bury GP federation in line with, as a minimum, the national average for the routine cohort.
    - Increase Bury GP Federation's shingles NIP uptake of the routine cohort (age 70) from 12% (estimated from Bury CCG data) to 31% (national average) within the project period.
    - Increase Bury GP Federation's shingles NIP uptake of the catch-up cohort exiting the programme to national average within the project period.

Summary of Identified barriers and opportunities to vaccination uptake:

Detailed review available in appendix 1

Data, Uptake and Electronic Health Record (EHR)/IT systems

- Most practices were unaware of their current shingles vaccination coverage rate across eligible patients.
- Practices felt the immunisation window is wide and the QOF indicator is for vaccination coverage of patients existing the programme, therefore shingles vaccination is not prioritised.

Workforce and clinical focus

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- Quality of patient care was high on all practices agendas, where the burden of shingles was understood across the practice, there was more urgency to vaccinate patients and vaccinate them earlier.
- Clinical resource to vaccinate patients was typically not a barrier to uptake. Administrative resource to identify and call/recall patients was.
- Having a single accountable Immunisation lead within a practice is beneficial for increasing vaccination uptake. This was often a practice manager rather than a clinical role.

Vaccination implementation approach and call/recall

- Structured and proactive call and recall is critical to successful programme implementation. Opportunistic vaccination should not be relied upon, where this was observed it correlated with low programme uptake but can be complementary to structured call/recall.
- Use of a combination of channels, including telehealth tools such as accubook, to invite and recall patients increased efficiency and the pace and scale of uptake.
- Identifying existing or underutilised clinic capacity, such as enhanced access clinics, and dedicating that to shingles vaccination enabled greater uptake at pace and scale.

Patient engagement

- The eligible population rarely declined vaccines and those that were hesitant to vaccination benefited from an opportunity to better understand the burden of shingles and the vaccination.
- Opportunistic vaccination for patients who are already attending the practice are missed due to patients having little knowledge of the vaccine and wanting time to think about it.

Solution Approach

Practices were segmented into the 3 groups based on current uptake, capability and support needs.

Group 1: 7 Highly engaged practices with higher existing uptake and capacity to start planning dedicated shingles clinics, identifying and inviting patients to those and reviewing prebooked appointments for additional opportunistic vaccination.
Group 2: 9 Practices with lower existing uptake who required closer support to build capability and confidence to implement and would benefit from taking best practice from Group 1.
Group 3: 9 practices who had lower engagement in the project and required further motivation and identification and implementation of more centralised solutions.

Solutions Implemented

Data, Uptake and Electronic Health Record (EHR)/IT systems

- Data review regularly centralised by the GP Federation on weeks 10, 14 and 20 of the project, practice level uptake data for 70 year olds and 71-79 year olds. Data shared across all practices to highlight variation, increase visibility and track progress.

Workforce and clinical focus

- Single accountable immunisation lead set up in each practice (within group 1 and 2) if no immunisation lead already in place.
- Project manager worked closely with the Immunisation Leads to agree and plan the implementation of proposed solutions at a practice level.
- Utilisation of an automated invite and booking system, accubook, reduced administrative resource time to fill a 55 appointment enhanced access clinic with eligible patients from 3.5 hours per clinic to 15 minutes per clinic.
- Cross-functional workforce were engaged to explore the opportunity to reach underserved populations and raise awareness in eligible populations:
    - Acute Visiting Team (AVS) a team of paramedics engaged in home visits. Unable to administer vaccines during home visits due to cool storage limitations, but did raise awareness and encourage eligible patients to book a shingles vaccination with their practice.

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- Social Prescribers. Increased awareness of shingles vaccination with eligible patients by distributing printed information and directing eligible patients to clinical staff where there were queries or to book a vaccination.

Vaccination implementation approach and call/recall

- Utilisation of existing clinic capacity within the regular planned clinics outlined in yearly business planning. These include Flu clinics, Covid-19 Booster clinics and clinically vulnerable patient review clinics. These presented coadministration opportunities, however given seasonality of these vaccine clinics they were not key enablers within the time period of these projects, with the exception of the clinical vulnerable patient reviews. All practices agree this was an opportunity to vaccinate the eligible immunocompromised patient population.
- **Enhanced access clinics** – a service offered across the federation to provide clinic time outside of normal clinic time (8am-6pm) and at weekends. Typically these clinics and associated workforce were underutilised with unfilled appointments.
    - Appointment slots were opened to all practices, with clinics added 2 weeks in advance
    - Each practice contributes towards the cost of the clinic
    - Practices with online booking platforms can send the link direct to patients or book them in directly via an alternate method.
    - Invites sent centrally by the federation to patients in 6 practices who reported challenges in doing this themselves. This was further offered to all federation PCNs due to the efficiency benefits identified.
    - Practices are responsible for transporting vaccine stock to the hub for the patients they have booked
    - The enhanced access nurse record the shingles vaccination on the patients EHR during the clinic.

Outcome

Aligned to the objectives the project delivered clear identification of the barriers and opportunities for shingles vaccination uptake and increased uptake of shingles vaccination in line with eligibility criteria of the shingles national immunisation programme. System limitation did not enable practices to provide accurate and detailed data on metrics specific to each activity such as conversion metrics from patients invited, booked and vaccinated for example. Patient health outcomes were not measured as part of this project.

PCN – Eligible Cohort (years)	February 2023	May 2023
Bury – 70	15%	32% (+17%)
Bury – 71-79	54%	58% (+4%)
Prestwich – 70	23%	43% (+20%)
Prestwich – 71-79	64%	68% (+4%)
Whitefield – 70	11%	40% (+29%)
Whitefield – 71-79	58%	63% (+5%)
Horizon – 70	15%	38% (+18%)
Horizon – 71-79	56%	62% (+6%)
All PCNs – 70	16%	37% (+21%)
All PCNs – 71-79	57%	62% (+5%)
Bury GP Federation (ex Bury PCN) **– 70**	**17%**	**40% (+23%)**
Bury GP Federation (ex Bury PCN) **– 71-79**	**60%**	**65% (+5%)**

Data will be collected bi-monthly to the end of 2023 to understand the longer term impact on shingles vaccination uptake and the legacy the project has caused across Bury GP Federation.

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Appendix 1:

Barrier/Opportunity identified	Lower uptake practice behaviour observed	Higher uptake practice behaviour observed
• Most practices were unaware of their uptake rate, how they were currently performing as a practice or across any of the eligible cohorts and what good looked like for shingles vaccination uptake.	• No existing shingles programme eligibility searches or cadence of running searches established within their Electronic Health Record (EHR) System (EMIS used across all practices).	• Call/recall systems were in place and regularly reviewed, ideally monthly to identify newly eligible patients within the previous month or month to come. • IT and EHR system knowledge gaps were addressed, with regular staff training sessions and issues reported to the EMIS help services.
• Single accountable immunisation lead	• No accountable immunisation lead or a view that all staff do a bit of vaccination.	• The majority of practices had one Practice Nurse lead. Training other staff members to deliver vaccines to support the Practice Nurse mean they can offer more appointments. •
• Shingles QOF indicator not a key driver for vaccination uptake.	• 28% practices failed to achieve the lower QOF threshold (50%) • Some awareness of that shingles vaccination is a QOF indicator, but limited understanding of the level of achievement required was or how they were tracking against this. • Where there was awareness of the indicator, there is a perception that the 10 points available for a upper threshold of 60% uptake, resulted in it being deprioritised vs other QOF indicators. • Given the nature of the QOF indicator being for the % of patients who have turned 80 who are vaccinated, it resulted in QOF being completely deprioritised in the period immediately ahead of the QOF deadline as practices who were not close to achieving their points were unable to catch up. • Practices felt the window of opportunity to vaccinate patients is wide, 10 years before a patients turns 80, which allows them to concentrate on other areas of healthcare and catch-up	• 64% of practices had achieved the full QOF potential. • Shingles was prioritised year round to enable achievement of the QOF indicator. • Practices prioritise shingles patients as they become eligible and therefore build up less of a backlog of unvaccinated eligible patients.

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	at a later date, however this opportunity never arises.	
• Quality patient care was high on all practice agendas and they understood that this age group make up some of their most vulnerable patients.	• Without a practice wide understanding of the burden of shingles, there was less motivation to combat underperformance.	• Practices which understood the burden shingles could have on their patients were motivated to increase their uptake.
• A perception from the GP Federation that low uptake could be due to lack of resources.	• A minority of practices identified clinical staff as a barrier to uptake. • Administrative resource across most practices was identified as a significant bottleneck for identifying eligible patients from the EHR system and inviting patients in for their vaccination either via a admin phone call or coordination of a letter. • This resulted in some dedicated vaccination clinic appointments not being filed and idle clinical time during these clinics. • HCAs are unable to offer the vaccine to housebound patients whilst conducting visits. • Care home administration is rarely considered.	• The majority of practices disputed clinical resource being a barrier to uptake, believing that they had enough existing clinical resource available to vaccinate patients. This was, in part, due to returning staff increasing capacity following redeployed during the COVID-19 pandemic.
• Opportunistic vaccination	• Relied upon opportunistic vaccination or believed that opportunistic vaccinate was sufficient. • Typically within appointments there was not time to raise shingles vaccination and/or vaccinate the patient.	• Opportunistic vaccination complemented a structured call/recall process. • Administrative staff are trained and confident to spot opportunistic appointments and knowledgeable on the vaccine. For example, when patients contact the practice to book an appointment, instead of simply adding them to the calendar, the reception staff will bring up the patient record, which will flag eligibility for the shingles vaccination.
• Call and Recall	• Limited or no structured and proactive call and recall in place. • Reliance on administrative staff completing a call list, with limited review on effectiveness. • Patients rarely followed up if they initially decline.	• Structured and regular call and recall in place. • Utilisation of telehealth and other digital solutions, such as accubook, to efficiently contact and book in larger number of patients.

GSK

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	• Low awareness of NHS centrally procured telehealth and digital solutions available to be utilised.	• Combination of channels used, ie letter, SMS and phone call if patients did not respond. • Well adapted to and a strong understanding of the requirements and communication preferences of their community
• Patient vaccine fatigue and hesitancy due to COVID-19 booster programmes	• Patients were hesitant of receiving the shingles vaccine as they had less knowledge of it and needed time to consider it, a barrier which was difficult to overcome if offered opportunistically due to appointment time pressures or due to knowledge limitations for admin staff offering vaccinations on a phone call.	• Experience showed that age group rarely declined vaccinations. • If a patient did decline the vaccine, they are asked why, and advice is directed to an appropriate HCP. A shingles information leaflet is sent to the patient at the point of contact, helping the patient to make an informed choice on whether to receive the vaccine and reducing time spent answering queries in the practice.
• Logistical considerations	• Some confusion within the basic operational elements of ordering the vaccines, delivery times and perceived cost to the practice, resulting in hesitancy to focus on shingles vaccination.	• Practice staff understood vaccine stock delivery processes and timescales. • Single accountable individual who ordered vaccine stock from ImmForm.

References

1. UKHSA annual data 2021-22 Vaccine uptake guidance and the latest coverage data - GOV.UK (www.gov.uk)