Extract from 2024-25 QoF

VI001. The percentage of babies who reached 8 months old in the preceding 12 months, who have received at least 3 doses of a diphtheria, tetanus and pertussis containing vaccine before the age of 8 months	18	89-96%
VI002. The percentage of children who reached 18 months old in the preceding 12 months, who have received at least 1 dose of MMR between the ages of 12 and 18 months	18	86-96%
VI003. The percentage of children who reached 5 years old in the preceding 12 months, who have received a reinforcing dose of DTaP/IPV and at least 2 doses of MMR between the ages of 1 and 5 years	18	81-96%
VI004. The percentage of patients who reached 80 years old in the preceding 12 months, who have received a shingles vaccine between the ages of 70 and 79 years	10	50-60%

VI – rationale for inclusion of indicator set

i. Vaccination currently prevents 2-3 million deaths worldwide every year [139]. Recently, the World Health Organization (WHO) listed vaccine hesitancy as one of their top 10 biggest threats to global health. Health workers, especially those in communities, remain the most trusted advisors and influencers of vaccination decisions and play a key role in providing patients with trusted, credible information on vaccines[140].

Note on vaccinations delivered overseas

i. Where a patient has been vaccinated overseas in accordance with the UK National Vaccination Schedule (i.e. the schedule of the overseas country conforms to the UK schedule) practices can record delivery of the vaccination in their clinical system to ensure that the vaccination counts towards QOF achievement. For avoidance of doubt, if a patient has been vaccinated overseas in accordance with the UK national schedule and appropriate evidence has been provided of this vaccination event, the patient should count as a success in respect of any relevant QOF indicator – it should not simply trigger a Personalised Care Adjustment.

[139] https://www.who.int/en/news-room/fact-sheets/detail/immunization-coverage
[140] https://www.who.int/news-room/spotlight/ten-threats-to-global-health-in-2019

ii. When a patient or their representative reports that a vaccination has been delivered overseas or in another setting, individual clinicians should exercise their judgement to determine that a vaccination has been delivered and to record it in the patient record. The Green Book states, "If children and adults coming to the UK do not have a documented or reliable verbal history of immunisation, they should be assumed to be unimmunised and a full course of required immunisations should be planned." Patients arriving from overseas with a "documented or reliable verbal history of immunisation" can be assumed to be immunised and recorded as such in the GP patient record – though in the case of reliable verbal histories, it may not be possible to record the batch number or exact vaccination date.

iii. Where a patient has been vaccinated overseas in accordance with the UK national schedule, the practice can ensure that the vaccination counts towards QOF achievement but does not attract an item of service payment by coding the vaccination event in the following way:

1. Backdate the event date of the vaccination SNOMED code to accurately reflect when the vaccination was delivered.
2. Set the GMS flag to 'No' (for EMIS and Cegedim practices) or the 'Event done' flag to 'No' (for TPP practices).[141]
3. If the vaccination is for MMR or Shingles, use the "MMR vaccination given by other healthcare provider" or "Shingles vaccination given by other healthcare provider" SNOMED code.[142]
4. Add free text associated with the vaccination SNOMED code to note the date the vaccine was given and where.

Note on automated Personalised Care Adjustment (PCA) introduced in 2023/24

i. As part of the changes to the GP Contract 2023/24 published on 6 March 2023, a new PCA was introduced for VI001, VI002 and VI003 to take into account patients who registered at the practice too late (either too late in age, or too late in the financial year) to be vaccinated in accordance with the UK

[141] The purpose of the GMS flag is to denote when an activity was delivered in fulfilment of the practice's GMS (inclusive of PMS and APMS) contract (GMS=True), or either delivered by the practice outside the GMS contract or delivered by another healthcare provider (GMS=False). TPP has not implemented a GMS flag, but offers analogous functionality in the form of an 'Event done' flag which, if set to false, denotes that the practice did not deliver the activity.
[142] 'Vaccination given by other healthcare provider' SNOMED codes exist for a limited number of vaccines. MMR and Shingles are the only vaccinations in QOF with a 'vaccination given by other healthcare provider' code available.

national schedule (or, where they differ, the requirements of the relevant QOF indicator).

ii. From April 2023, this new automated PCA has been built into the business rule logic underpinning the QOF V&I GPES extracts and applies in circumstances where a child is registered with a practice and:

1. there is insufficient time to provide any incomplete vaccinations either within the required timeframes to meet the indicator requirements, or
2. where a child has an incomplete vaccination status and is now older than the cut-off age required by the indicator.

iii. The PCA cannot be applied manually and will be automatically applied by the indicator logic. The PCA will be superseded in the extract logic by success (i.e. the relevant vaccinations being given before the relevant cut-off age required by the indicators). The PCA applies once the individuals are registered with the practice and the relevant logic parameters are met. Where the PCA is applied, it will remove the child from both the denominator and numerator thus not impacting on achievement of the relevant indicator.

iv. In the event a child is registered with a practice and has already reached the relevant indicator's cut off age - where the cut off age is 8 months for VI001, 18 months for VI002 and 5 years for VI003 - and had incomplete vaccinations, then the automatic PCA will be applied. This is because it is by no fault of the practice that this child was not vaccinated.

v. However, for a child that is registered with a practice at an age younger than the cut off age for the relevant indicator, then the PCA is flexibly applied depending on both the time remaining prior to the child reaching the cut off age and the number of outstanding doses. A timeframe of 31 days per outstanding dose from registration date to meeting the cut off age for the indicator is applied. Further information can be found in the business rules.

vi. Practices may want to check whether this PCA is active on the system by using the various system reporting tools such as 'How am I driving?' before the end of the financial year.

vii. Some examples of how the new PCA applies to the three V&I indicators are provided below:

For VI001.

i. If a child is registered with a practice on or after 7 months of age and has two or fewer doses of diphtheria, tetanus and pertussis containing vaccine prior to

registering then the PCA would automatically be applied as there would be insufficient time to offer and administer the required doses.

ii. If a child is registered with a practice on or after 6 months of age and has one or no doses of diphtheria, tetanus and pertussis containing vaccine prior to registering then the PCA would automatically be applied as there would be insufficient time. However, if a child registered with the practice at 6 months of age and had already had two doses of diphtheria, tetanus and pertussis containing vaccine prior to registering and the third dose was not given by the practice before the child turns 8 months, then the practice would not achieve the indicator for this specific child – this is because the practice would have had sufficient time to give the remaining dose.

iii. If a child registered with a practice on or after 5 months of age and had no doses of diphtheria, tetanus and pertussis containing vaccine prior to registering then the PCA would automatically be applied as there would be insufficient time. However, if a child registered with the practice at 5 months of age and had already had one or two doses of diphtheria, tetanus and pertussis containing vaccine prior to registering and the third dose was, or second and third doses were, not given by the practice before the child turns 8 months, then the practice would not achieve the indicator for this specific child – this is because the practice would have had sufficient time to give the remaining one or two dose(s).

iv. If a child registered with a practice between 1-4 months of age and had no doses of diphtheria, tetanus and pertussis containing vaccine prior to registering and the practice does not give all three doses before the child turns 8 months old, then the practice would not achieve the indicator for this specific child. The automated PCA would not apply.

For VI002.

i. If a child has reached 17 or 18 months of age when registering with the practice and had not had an MMR vaccination, then the automatic PCA will be applied. However, if the child is 16 months or younger and does not receive one dose of MMR vaccination before they turn 18 months, then the practice would not achieve this indicator for the specific child.

For VI003.

i. If a child registered with a practice on or after 4 years and 11 months of age and had either (1) two MMR vaccinations but no booster DTap/IPV or (2) only

one MMR and the booster DTap/IPV, then the automatic PCA will be applied as there is insufficient time.

ii. If a child registered with a practice on or after 4 years and 10 months of age and had either (1) only had one MMR and no booster DTap/IPV or (2) no MMR but had the booster DTap/IPV, then the automatic PCA will be applied as there is insufficient time.

iii. If a child registered with a practice on or after 4 years and 9 months of age and had no MMR vaccinations and no booster DTap/IPV, then the automatic PCA will be applied as there is insufficient time.

iv. If a child registered with a practice younger than 4 years and 9 months of age and does not receive both MMR vaccinations and the booster DTap/IPV then the practice would not achieve the indicator for this specific child.

VI001 (NICE 2020 menu ID: NM197)

VI001 Rationale

i. Diphtheria, tetanus and pertussis (whooping cough) are acute infectious diseases that can have severe complications. The routine immunisation schedule states that the hexavalent (6-in-1) vaccine is due at 8, 12 and 16 weeks old for immunisation to diphtheria, tetanus and pertussis (DTaP) as well as poliomyelitis (IPV), haemophilus influenzae type B (Hib) and hepatitis B (Public Health England 2020).

ii. The indicator supports early vaccination according to the routine immunisation schedule. Measurement by 8 months old allows for vaccination deferral due to febrile illness but aims to achieve immunisation against the named acute infectious diseases as early as possible.

iii. The lower threshold for this indicator has been lowered to 89% and the upper threshold has been raised to 96% to extend the payment thresholds for this indicator.

VI001 Reporting and verification

i. See indicator wording for requirement criteria.

ii. The only personalised care adjustment applicable is where the intervention described in the indicator is contraindicated for the patient.

VI002 (NICE 2020 menu ID: NM198)

VI002 Rationale

i. MMR is the combined vaccine that protects against measles, mumps and rubella. These are highly infectious conditions that can have serious complications such as meningitis and encephalitis. The first MMR vaccine (MMR1) is due as part of the routine vaccination schedule for England within a month of the child's first birthday (Public Health England 2020).

ii. The indicator supports early vaccination with the first dose of the MMR vaccine according to the routine immunisation schedule. Measurement by 18 months old allows for vaccination deferral due to febrile illness but aims to achieve vaccination as early as possible.

iii. The lower threshold for this indicator has been lowered to 86% and the upper threshold has been raised to 96% to extend the payment thresholds for this indicator.

VI002 Reporting and verification

i. See indicator wording for requirement criteria.

ii. The only personalised care adjustment applicable is where the intervention described in the indicator is contraindicated for the patient.

VI003 (NICE 2020 menu ID: NM199)

VI003 Rationale

i. The indicator supports immunisation according to the routine immunisation schedule. Measurement by 5 years old aims to achieve full immunisation against these infectious diseases before children start school.

ii. The lower threshold for this indicator has been lowered to 81% and the upper threshold has been raised to 96% to extend the payment thresholds for this indicator.

VI003 Reporting and verification

i. See indicator wording for requirement criteria.

ii. The only personalised care adjustment applicable is where the intervention described in the indicator is contraindicated for the patient.

VI004 (based on NM201)

VI004 Rationale

i. Shingles is caused by the reactivation of a latent varicella zoster virus infection. Incidence and severity of disease are associated with increasing age. The routine immunisation schedule states that the shingles vaccine is due at 70 years old (Public Health England 2020). Patients remain eligible for the vaccination until their 80th birthday.

ii. The indicator supports vaccination against shingles for patients 70 years old and over. The effectiveness of the shingles vaccine decreases with increasing age so earlier vaccination is encouraged to ensure optimal protection against shingles.

VI004 Reporting and verification

i. See indicator wording for requirement criteria. Patients should have received a complete course to be included in the numerator for this indicator. Practices may use a personalised care adjustment if the vaccine is contraindicated or if the patient has declined vaccination.