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Allergy UK	Guideline	009	013	Risks and benefits of vaccines – suggest and have an awareness of allergy to common vaccine ingredients and risk – concern over the safety of vaccines or refusing to take up vaccines such as MMR in children with egg allergy and flu and Covid vaccine in people with PEG or allergy, coupled with lack of understanding among HCPs as to how to reassure people with allergies and or offer alternatives has been a common theme with Allergy UK helpline calls over the last 16 months with many people opting not to take up Covid vaccine for fear of severe allergic reactions or side effects.	Thank you for your comments. The committee thought that training is important so that health care practitioners can address any concerns that people would have about vaccination. This will include any concerns about allergies. The recommendation means that they should either be able to address the questions themselves, or signpost anyone with concerns to an appropriate source of information.
Allergy UK	Guideline	018	003	Risks and benefits of vaccination – would it be possible to include a section on concern from patients about side effects and allergies to medication ingredients	Thank you for your comments. The committee also thought it was important that people have the opportunity to address any concerns they might have about allergies or contraindications. Taking your comment into account an extra point has been added to the recommendation to highlight that the concerns that could be discussed with a healthcare practitioner include possible contraindications or allergies that could affect their ability to be vaccinated.
Allergy UK	Guideline	032	General	There is mention of vaccine safety and side effects as a reason for concern over up take of vaccines. Could this be explored further? The Allergy UK helpline receives many calls on vaccine safety – concern over risk of allergic reactions to vaccines and allergy related side effects and this forms a small portion of vaccine refusal There is a general lack of understanding among the public and often HCPs over allergy and vaccine especially with;	Thank you for your comments. The committee thought that these are important considerations but decided that there are some wider areas that should be initially prioritised for research.

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				Latex allergy and vaccines most commonly in regards to the possibility of latex in the bung, MMR and flu vaccine and egg allergy and possibility of severe allergic reactions and more recently with the Covid vaccine and safety with people with anaphylaxis as well as people with PEG and Polysorbate 80 allergy. The Covid pandemic has really bought these issue to the fore and there has been a real concern with people with allergies and a lot of confusion over the safety of vaccines. This I suspect could lead to lower vaccine uptakes in the future as people may be more aware and concerned about the risk of severe allergic reaction and side effects and is a cause for concern. This area also requires access to timely evidence based information resources about allergy and vaccines to support the general public to make decisions about their care. Allergy UK and The Anaphylaxis Campaign have experienced a deluge of desperate enquiries in response to the government's promotion of the importance and urgency of the booster vaccination. Previous information has led people living with allergies to believe that the preferred Pfizer booster will put them at risk of anaphylaxis, this has led to a lot of confusion and distrust amongst the allergic communities over what to do next.	
Association of Paediatric	Guideline	General	General	We feel that emergency departments in whom children and young people are seen, and stand-alone paediatric	Thank you for your comments. Taking this into account the committee have added emergency departments to the list

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Emergency Medicine				emergency departments, are in an excellent position to routinely promote uptake of vaccines and provide opportunistic vaccination to children should this be agreed by the child or young person / family. We therefore feel that emergency departments and their staff could feature more prominently in the sections on 'Who is it for' on page 1-2, 'Service organisation' on page 4, 'training and education' on page 8, paragraph 1.26 on page 11, and 'people who are not registered with a GP practice' on page 20; or indeed have a section addressing these issues in the emergency department.	of groups in the 'who the guideline is for 'section. The committee decided not to list emergency departments as providers in the section on 'service organisation' reflecting that any list cannot be exhaustive and include all organisations. The committee noted that if vaccinations are provided in the emergency department, then the relevant parts of this recommendation would also apply. Otherwise, in addition there is a separate recommendation for secondary and tertiary care providers who do not routinely provide vaccinations and emergency departments are listed as settings for opportunistic identification of vaccination status. In response to your comment the committee added emergency departments to the recommendation for training for healthcare practitioners who do not administer vaccinations. The committee have also added a cross reference from the section about people who are not registered with a GP to direct people back to the recommendations on opportunistic identification. As part of the committee's discussions about the evidence using different settings for vaccination, the committee explored the possibility of having drop-in immunisation clinics within or alongside hospitals. This was not considered further as it was likely to be associated with substantial resource implications, especially if these clinics were to be set up in every hospital (see evidence review D for more details and a costing exercise). However, where vaccinations are already available in a hospital setting,

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					including an emergency department, then they could be used for opportunistic vaccination This action is covered by a general recommendation in the section on identifying people eligible for vaccination and opportunistic vaccination, which also covers discussing any outstanding vaccinations. If, however, vaccinations are not available then the healthcare practitioners can encourage them to book an appointment for a vaccination elsewhere.
Association of Paediatric Emergency Medicine	Guideline	General	General	APEM would very much support having age appropriate literature for secondary school aged children, as this would be a useful tool within the emergency department should a competent young person decide to be vaccinated.	Thank you for your comments. The committee also thought that it is important to have age appropriate literature for school age children in the emergency department or any other location where vaccination may be discussed. For this reason, they included a recommendation in section 1.3 of the guideline about information and reminders which highlights that the information provided about vaccination must meet a person's communication needs. The ensures that people can understand the information provided to them and use this to make informed decisions about vaccinations.
BAME Health Collaborative	Guideline	008	013 – 020	1.1.18 In ensuring that the education of the health and social care practitioners who are in contact with people eligible for vaccination, it is important for the individuals to be aware of the barriers to vaccination in the population (such as the BAME, GIPSY communities etc) provided to them from research and the community leaders. In addition, it would be important that the presence and of local community leaders and faith leaders in vaccination centres is encouraged.	Thank you for your comments. The committee thought it was important for this group of people to be aware of barriers to vaccination and so this is included in the recommendation as one of the topics that should be covered in their education. A list of population groups who often have low vaccine uptake has also been added to the guideline, which includes people from some ethnic minority groups and people from Gypsy, Roma and Traveller communities. The committee also discussed the importance of working alongside community and faith leaders to encourage vaccination. There is also another recommendation which highlights the importance of

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					including input from people in the local community when considering the accessibility of vaccination services.
BAME Health Collaborative	Guideline	009	016 - 021	1.1.20 It would be very important the clinician who would be having the discussion with regards areas of concern to be aware of the barriers to vaccination in the population (such as the BAME GIPSY communities etc) provided to them from research and the community leaders. In addition, it is important that they have some rudimentary understanding about the efficacy and side effects of vaccines	Thank you for your comments. The committee also thought that it was important to address these concerns as they were identified as barriers to vaccination in the barriers and facilitators reviews (for more information see evidence review B). Information about this and the efficacy and side-effects of vaccines was therefore included as one of the topics that should be covered in staff training.
BAME Health Collaborative	Guideline	011	004 - 025	1.2.6 Use every opportunity to identify people eligible for vaccination, this should also include community centres, faith centres etc	Thank you for your comments. The list of places for opportunistic identification is an example of common locations or examples where this could take place. However, the list is not exhaustive and although community centres and faith centres are not specifically mentioned, they could also be used.
BAME Health Collaborative	Guideline	015	019 – 023	1.3.4 It might be important to bear in mind that in addition to being aware that expectations of who delivers vaccine services may differ by cultural background but also be aware of the barriers to vaccination in the population (such as the BAME community etc).	Thank you for your comments. Based on your feedback and other comments the committee have added a list of key barriers to uptake and population groups who often have low uptake.
BAME Health Collaborative	Guideline	016	010 – 011	1.3.6 The multidisciplinary team brought in to address the issues of non responders in the visual summaries should be aware of the barriers to vaccination in the population	Thank you for your comments. Based on your feedback and other comments the committee have added a list of key barriers to uptake and population groups who often have low uptake.

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				(such as the BAME community etc) or have individuals who can identify with the communities present.	
BAME Health Collaborative	Guideline	019	019 - 022	1.3.17 The multidisciplinary team brought in to address the issues of non responders in the visual summaries should be aware of the barriers to vaccination in the population (such as the BAME community etc) or have individuals who can identify with the communities present.	Thank you for your comments. Based on your feedback and other comments the committee have added a list of key barriers to uptake and population groups who often have low uptake. This should help the team be aware of the main issues facing people who have not responded to vaccination invites.
Bliss	Equality Impact Assessment	General	General	With reference to our general comment above on the Guideline, Bliss is surprised that the EIA also contains little reference to the increased levels of vaccine hesitancy, and distrust in services, or the factors which may drive this.	Thank you for your comments. The EIA includes equality issues that were raised during the scoping process by stakeholders or during development by the committee and explains how they have been addressed during the development of the guideline. The committee agree that vaccine hesitancy, and distrust in services are important problems that need understanding and addressing. Throughout the EIA reference is made to low vaccine uptake in specific groups and the guideline includes recommendations on making vaccinations services accessible and tailoring to local needs. This section includes key barriers to routine vaccine uptake and identifies population groups with low uptakes.
Bliss	Guideline	General	General	Throughout the guideline there is little reference to the greater levels of vaccine hesitancy, and a lack of trust in services, among some populations, including Black, Asian and Minority Ethnic communities, and people living in the most deprived areas. Bliss feels strongly that this omission is an error. It is vital to directly engage, and work more effectively, with people from communities most likely to be vaccine hesitant to improve their	Thank you for your comment. The committee looked at qualitative evidence concerning the barriers to and facilitators for routine vaccine uptake in the UK and the views of people in some of the groups you mention were represented by a number of studies included in this review. The barriers identified included misinformation, a lack of information, a lack of trust in the government and other public bodies and concerns about vaccine safety and effectiveness amongst other things.

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				maternity and neonatal outcomes, and to reduce inequality.	(These findings are presented in evidence review B.) However, these findings were not specific to Black, Asian and Minority Ethnic communities, but were also identified as barriers to vaccine uptake by other groups of people. The committee therefore made a series of recommendations aimed promoting identification of local needs and barriers to uptake and then responding in a way that is tailored to address these needs and inequalities in uptake between population groups but without naming the groups of people specifically. Another recommendation covers seeking input from local people about their needs and tailoring service hours and locations to meet them. Other relevant recommendations are aimed at identifying if people have language needs or literacy issues; providing information about the vaccination process for people who come from outside the UK; providing information in in an appropriate format and language; ensuring that vaccination staff are able to engage with people's concerns about vaccination and give them tailored responses; exploring why people decline vaccinations or do not respond to invitations and trying to address any issues raised; and ensuring that there is time during consultations to have a discussion where any concerns can be identified and addressed. In addition, people in lower socioeconomic groups may have problems travelling long distances to vaccination clinics. By increasing the number and types of settings and times available (including community centres and faith centres and even using mobile units) this should make vaccinations more accessible for everyone.

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					The committee envisaged that these recommendations would enable issues like to ones you raise to be identified at the individual or community level and provide opportunities for them to be addressed. However, in response to your comment and feedback from other stakeholders the committee have now included an information box that lists population groups which are known to have or be at risk of low vaccine uptake to highlight the importance of thinking about these groups when commissioners and providers assess local needs and tailor their services to meet them. This includes people from some ethnic minority groups; people from some religious communities (for example, Orthodox Jewish communities) and people who live in an area of high deprivation amongst other groups. The committee recognised that it is important to directly engage, and work more effectively, with people from communities most likely to be vaccine hesitant to improve their maternity and neonatal outcomes, and to reduce inequality. However, there was very limited evidence identified as part of the qualitative review for pregnant women and none that specifically looked at the barriers affecting pregnant women from the communities you mention. In addition, there were very few quantitative studies that looked at interventions to increase vaccine uptake in these groups (please see evidence review F). As a result, the committee made a research recommendation to stimulate more research in this area. In response to your comment, the committee have added pregnant women

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					from ethnic minorities as a group of interest in the PICO for this research recommendation. To try to help fill other gaps in the evidence base, the committee made another research recommendation asking what the most effective and acceptable interventions are to increase uptake in populations or groups with low routine vaccine uptake in the UK. The text accompanying this research recommendation in evidence review B mentions some of the particular groups of interest including people from religious communities and immigrants. In response to stakeholder comments, the committee have added ethnic minorities to this text and have included both people from ethnic minorities and religious communities as groups of particular interest. In the draft PICO that accompanies the research recommendation.
Bliss	Guideline	General	General	For pregnant women Bliss, in line with other organisations such as NCT, believe caregivers should offer a general introduction in early pregnancy to the taking of medication of any sort. This should focus on how policy has changed in recent years, due to increased evidence, away from an approach of not taking anything, to an approach of seeking advice, and taking vaccines and medicines which have been prescribed to the woman and/or her baby. Where possible, discussion and administration of them should be offered as part of routine antenatal care. Hesitancy among pregnant women can be linked to a lack of trust in providers of health advice but receiving	Thank you for your comments. The guideline includes recommendations about pregnant women, including using antenatal visits to offer vaccination and check whether women are up to date with their vaccinations. NICE also has an antenatal care guideline which provides recommendations on discussions about other medications during pregnancy. The committee recognised the importance of trust in overcoming vaccine hesitancy and this was also raised as a facilitator in evidence review B. The committee therefore made recommendations to ensure that invitations for vaccinations come from trusted sources, such as midwives and health visitors during routine antenatal visits.

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				information or the vaccine directly from a trusted caregiver can make a difference.	
Bliss	Guideline	017 - 018	018 - 015	Consider including an additional recommendation to reference that some babies will still be receiving neonatal care when they become eligible for vaccinations. As these are administered in hospital, it is imperative that the baby's parents still receive the same information outlined in 1.3.12 and are made aware of when and how their baby's vaccinations will take place.	Thank you for your comments. The committee also thought that it is important that parents or carers who have a baby in a neonatal unit will be made aware of how and when their baby will receive vaccinations. As requested, a new recommendation has been added to the guideline which aims to ensure that parents or carers of babies who are in neonatal care units when they are eligible for their vaccinations receive relevant information and are made aware of when and how their baby's vaccinations will take place.
Bliss	Guideline	006	001 - 019	Recommendations 1.1.7-1.1.9 should be strengthened, and Commissioners encouraged to ensure that any targeted interventions to increase vaccination rates or to resolve accessibility issues, among identified populations, are developed with the involvement of those populations to ensure any resulting interventions or solutions will be effective. This needs to go beyond including ''input,'' there must be a focus on meaningful engagement and co-production where this is possible.	Thank you for your comment. Taking your comment into account the committee decided to provide additional information that these interventions should be developed as part of a system wide approach to addressing uptake. This was aimed at ensuring that any interventions are developed based on discussions with other health care providers and people and organisations within the local community (see the rationale for more details) to make sure that they are effective. This importance of involving people in the local community is also covered by another recommendation in this section in relation to the barriers they face to vaccine uptake and making services accessible. This recommendation also includes a cross reference to the section on involving people in peer and lay roles to represent local needs and priorities in NICE's guideline on community engagement, which goes into detail about this process and makes it clear that the knowledge and experience of local communities

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					and community and voluntary organisations should be used to identify and recruit people to represent local needs and priorities .
Bliss	Guideline	008	007 - 008	Consider including 'neonatal' in line 8: "...or wards such as oncology, antenatal or neonatal". Some babies will have extended neonatal stays and may still be in hospital when their vaccinations are due. As these are administered according to actual, rather than corrected, age babies born extremely premature are particularly likely to still be hospitalised when they become eligible for their first vaccines. As such, staff need to be equipped to answer questions, or signpost appropriately if parents have queries about their baby's vaccination schedule and how this will be organised. Additionally, most babies will be discharged from neonatal care within 16 weeks of admission, meaning some babies will start their vaccination course in hospital but continue to receive vaccinations in the community after discharge. It is imperative that staff can support families going home from the unit with accurate information about how their baby's vaccine schedule will be managed once they are home.	Thank you for your comments. Practitioners working on antenatal and neonatal wards have now been added to the recommendation as suggested. An additional recommendation has also been added to section 1.3 on Initial invitations. This is designed to ensure that parents or carers who have babies who are in the neonatal unit will receive all the necessary information about what vaccinations their child is eligible for and how and where these will be given.
Bliss	Visual Summary 2	General	General	If additions are made to the guideline to reference that some babies will receive some of their vaccinations while they are inpatient in neonatal care, the 'invitations' section of this flow chart should be amended to reflect for some babies, their vaccination schedule will be started in hospital and staff caring for the baby will be responsible for informing parents about vaccines,	Thank you for your comments. The committee have added a recommendation covering vaccinations for babies in neonatal units and have added this to the invitations section of the visual summary as requested.

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				gaining consent and ensuring they understand where vaccinations will take place once the baby is discharged home.	
British HIV Association (BHIVA)	Guideline	General	General	Section 1.3 When discussing links that provide information about vaccination, BHIVA would like to highlight the needs of people that may be indicated or contraindicated to receive a certain vaccine under conditions that differ from those of the general population and/or because of a specific underlying condition. Language should be sensitive to these situations and specialist input should be sought about appropriate language and links	Thank you for your comments. The committee have added information to the recommendation in section 1.3 about what the vaccination invite should contain. This now includes details on contacting a healthcare professional to discuss concerns, including possible contraindications or allergies that could affect people's ability to be vaccinated. This should give people the opportunity to address any questions over eligibility.
British HIV Association (BHIVA)	Guideline	004 - 005	General	Section 1.1 BHIVA recognises the importance of coordinated, integrated care to improve vaccine coverage and therefore welcomes the emphasis placed on the need for named vaccination leads within i) each organisation that provides or organises vaccinations and ii) within secondary and tertiary care providers who do not provide vaccinations, and fully agrees with the outlined roles. We highlight that in current practice, provision of different vaccines may occur in different locations / organisations (e.g., for the population with HIV, some vaccines may be accessed with HIV care, others within sexual health services, others within primary care) with some regional diversity. The fragmentation and variability need highlighting in the context of defining the role of	Thank you for your comments and support for these recommendations. The guideline recommends that all organisations that commission, provide or organise vaccine services have a named vaccination lead. These leads should ensure that systems are in place to identify people who are eligible for vaccination and invite them for vaccinations. As this recommendation applies to every commissioner and provider, the committee agreed that this should cover any regional variations that exist and still ensure that people are offered vaccinations. They therefore decided against adding any more detail to this recommendation.

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				vaccination leads and the scope of regional and national commissioners	
British HIV Association (BHIVA)	Guideline	008 - 009	General	Section 1.1 Addressing the educational needs of healthcare providers is important to ensure unambiguous communication and to promote vaccine uptake. Anecdotally, BHIVA's experience is that it is common for people with HIV to describe discrepant guidance about the need for / eligibility for certain vaccines. In addition to targeting education of healthcare providers, BHIVA recommends also identifying as an educational target the optimisation of communication between healthcare providers, particularly when dealing with populations that may have specific needs related to health status as well as potential socio-economic disadvantage and stigma	Thank you for your comments. The committee were aware that there can be a misunderstanding about when a vaccine is contraindicated and so they have added an additional point to the recommendation to include this. This highlights that people should be given the time, resources and support to understand when a vaccine is contraindicated, including when they have certain allergies or conditions, as well as understanding when it can still be delivered.
British HIV Association (BHIVA)	Guideline	014 - 015	General	Section 1.2 In relation to keeping vaccination records up to date, BHIVA wishes to draw attention to point 1 in Section 1.1 about the potential fragmentation of vaccine provision, which is a current barrier to maintaining fully accurate records. At present, the guidance places the onus largely on GPs, although other roles are described. It is not entirely clear from the guidance how the data will be optimally integrated. BHIVA welcomes the recommendation to give patients a printed record of the vaccination and would suggest indicating that the patient is asked specifically about submitting the record to the GP	Thank you for your comments. There was no evidence that met the inclusion criteria for our reviews on vaccine passports for vaccines on the routine schedule. However, the committee did think it was important that people were given access to their information on vaccine status. For this reason, the committee included two recommendations in section 1.2 on identifying people eligible for vaccination which indicate that people should be able to access their own vaccination records, through the use of online records or with an app,

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				and educated about the importance of this. There is published evidence from the UK on the potential benefits of using vaccine "passports" to document the vaccination history for people with HIV (Chadwick et al. Evaluation of a vaccine passport to improve vaccine coverage in people living with HIV. Int J STD AIDS 2018;29:1190-1193. doi: 10.1177/0956462418779472). The study indicated that whereas vaccine uptake was improved using passports, full coverage was not obtained, mostly thought to be a consequence of suboptimal effectiveness of communication between specialist and primary care	
British HIV Association (BHIVA)	Guideline	006	General	Section 1.1 BHIVA recognises the existence of substantial barriers to ensuring optimal vaccine coverage among people with HIV and thus welcomes the recommendation to identify and address barriers to vaccine uptake and any underlying inequalities. In this respect, it is suggested that barriers to the offer (as well as the uptake) are also specifically mentioned in the guidance. Published evidence indicates that receiving knowledge about the benefits of vaccination and a clear, direct recommendation to undergo vaccination from healthcare providers are predictive of improved vaccine uptake among adults	Thank you for your comments. The committee decided that it would be beneficial to add a list of some of the most common barriers to vaccination into the guideline. This has now been added, based on some of the key barriers to vaccination that were identified in evidence review B, with the intention of highlighting some of the key issues that may be preventing people from accessing or consenting to vaccination.
British HIV Association (BHIVA)	Guideline	006	General	Section 1.1 BHIVA welcomes the recommendation to include community representatives when considering accessibility. We would encourage the recommendation	Thank you for your comments. The committee did not make specific recommendations on what should be recorded, as needs and barriers may vary between different areas and populations. However, they have

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				to record experiences of seeking and receiving information on vaccination from healthcare providers. BHIVA produces guidance on the use of vaccines for adults with HIV and has integrated community representation in the formulation of the guidance, including the production with community representatives of material for patients' use	recommended the use of a Joint Strategic Needs assessment and a system wide approach to addressing uptake, so issues such as how information is found and received from healthcare practitioners is likely to be included within these.
British HIV Association (BHIVA)	Guideline	007	General	Section 1.1 BHIVA welcomes the recommendation that "GP practices should ensure that contractual obligations and best practice on patient registration is followed (for example, not requiring immigration status or proof of address)". In this context, BHIVA would welcome the inclusion of specific language in relation to the need for vaccine providers (within and outside of GP services) to adopt sensitive language and attitude towards the disclosure of HIV status at the point of vaccine offer/uptake. Where for example a certain vaccine or vaccine schedule may be indicated or contraindicated because of a person's HIV status, using inappropriate language or attitude will be detrimental to vaccine uptake. The adoption of sensitive forms of communication is recommended and BHIVA is available to provide any necessary guidance around specific vaccines and language	Thank you for your comments. The committee recommended that the training for healthcare providers who deliver vaccinations includes how to have sensitive conversations. This should include discussions surrounding stigma. More information about this can be seen in the rationale of the guideline.
British HIV Association (BHIVA)	Guideline	008	General	Section 1.1	Thank you for your comments. The committee thought that there are many things that could potentially be included as part of the education for people who give vaccinations and not all could be included within the recommendations.

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				In section 1.1.18, BHIVA would welcome the inclusion of stigma (around own status or any status that may be perceived as implied by the offer of vaccination) as an important component of education of practitioners who are in contact with people eligible for vaccination	However, part of the recommendation indicates that people should be able to have effective and sensitive conversations which includes being able to discuss issues around stigma. This is explained in more detail in the rationale section for this guideline.
British HIV Association (BHIVA)	Guideline	012	General	Section 1.2 In relation to the provision of "reliable" verbal vaccine histories, BHIVA wishes to bring attention to published evidence from the UK indicating poor recalling of vaccine histories among adults with HIV. In a study from London by Molton et al. (Seroprevalence of common vaccine-preventable viral infections in HIV-positive adults. J Infect. 2010;61:73-80. doi: 10.1016/j.jinf.2010.04.004), up to 51% of adults with HIV were unsure of their vaccination history. Many confused one vaccine type with another, e.g., when describing vaccines against viral hepatitis. Thus, BHIVA would encourage being careful with verbal histories	Thank you for your comments. The committee discussed how a reliable verbal vaccine history is not always common and therefore included a recommendation that a full course of immunisations should be planned if a person does not have a documented or reliable verbal vaccine history. The committee decided that this was important, as duplication of vaccines is not generally harmful, and is more beneficial than being unvaccinated.
British HIV Association (BHIVA)	Guideline	019	General	Section 1.3 For making direct contact (e.g., via a telephone call) with people who do not respond to vaccination invites, BHIVA would recommend appropriate training is given to callers about being sensitive to confidentiality issues such as those that may be pertinent to a person's underlying condition including HIV. The same sensitivity would apply to the recommended recording of the reasons for declining vaccination	Thank you for your comments. The committee have added information to the recommendation on training and education for people who administer vaccinations. This highlights that people should be able to hold effective and sensitive conversations and should therefore mean that they are able to discuss confidential issues such as these.

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British HIV Association (BHIVA)	Guideline	024	General	Section Recommendation for research BHIVA would encourage the inclusion of i) stigma, ii) healthcare provider's communication style, and iii) direct involvement of patients into own vaccine care as the potential subjects of research into improving vaccine coverage	Thank you for your comments. The committee thought that these are important considerations but decided that there are some wider areas that should be initially prioritised for research.
British Society for Immunology (BSI)	Guideline	004	003	We support the idea of vaccination leads for providers, but believe there should also be a vaccination lead at commissioning/trust level.	Thank you for your comments. The committee discussed this and agreed that vaccination leads would also be helpful at commissioning level. The start of this recommendation has therefore been changed to include commissioners.
British Society for Immunology (BSI)	Guideline	006	019	Add in 'schools' for other vaccination sites	Thank you for your comments. This has been added to the recommendation as suggested.
British Society for Immunology (BSI)	Guideline	008	006	Add in 'health visitors'.	Thank you for your comments. The committee agreed that other healthcare staff should also receive education. This recommendation has now been updated to say that health and social care practitioners and other related staff should receive this education. This widens the group of people who should be offered education about vaccinations.
British Society for Immunology (BSI)	Guideline	016	004	Add in 'and that information or support in languages other than English may be needed'.	Thank you for your comments. There is a recommendation in section 1.3 on invitation, reminders and escalation of contact which says that any information about vaccines should be provided in a language appropriate for a person and their family.
British Society for	Guideline	018	013	Add in 'British Society for Immunology'	Thank you for your comments. As there are a number of potential sources of information depending on which vaccine is being offered, the committee decided against

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Immunology (BSI)					naming them all. Instead, the recommendation indicates that information from trusted sources should be included. This will therefore include the British Society for Immunology.
Community Practitioners' and health Visitors' Association	Guideline	007	016	Important to look at incentives to improve uptake and learn from data	Thank you for your comments. The committee agree that this is an important part of learning from interventions used for the COVID-19 vaccination programme.
Community Practitioners' and health Visitors' Association	Guideline	008	002	Agree – Make every contact count. All practitioners should be able to give information or know to refer on to others	Thank you for your comment and support for this guideline.
Community Practitioners' and health Visitors' Association	Guideline	018	016	After no action from invitations – should seek to find out if there is a problem or if it is an opted out situation then plan response	Thank you for your comments. There is more information about the action to take if people do not respond in the reminders and escalation of contact section of the guideline.
Community Practitioners' and health Visitors' Association	Guideline	049	026	Very important to have the information and understanding. Assumptions are often made about these groups while the service offer is tailored to the majority	Thank you for your comments.
Community Practitioners' and health Visitors' Association	Guideline	053	013	I agree – as the numbers are likely to be small it is important to have this as an offer	Thank you for your comments and support for this guideline.

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Company Chemists' Association	Guideline	011	021	Medicines Use Reviews are no commissioned from the national community pharmacy contractual framework. Whilst these may be commissioned locally, they are no longer common opportunities to raise vaccination. This point may benefit from referencing the new Discharge Medicines Service and the Community Pharmacist Consultation Service.	Thank you for your comments. Based on this comment and other comments, this has now been updated to a medication review.
Company Chemists' Association	Guideline	015	020	Given these patients may be unfamiliar with UK practice, there may be value in highlighting that vaccination is free of charge.	Thank you for your comments. Based on your comments, the committee have added that this could specify that vaccines are free of charge in the rationale section of the guideline.
Company Chemists' Association	Guideline	017	025	Invitations to patients should take the opportunity to highlight all avenues and routes to vaccination. For example, communications should include reference to alternate providers locally such as community pharmacies. This will maximise contact with the patient and overcome any initial barriers – such as location preference.	Thank you for your comments. The recommendation highlights that the invitation should contain information about instructions about how to book an appointment at a clinic or drop-in clinics. This should therefore include information about alternative providers if they are available.
Down's Syndrome Association	General	General	General	Over the last 2 years of the COVID-19 pandemic, there has frequently been a time lag between announcements being made by JCVI or Ministers and the announcement being actioned. This has most notably been in extending vaccine eligibility down the age range (initially for 12-17 year olds and then for Clinically Extremely Vulnerable children aged 5-11). Ministerial announcements about CEV children aged 5-11 were made on the 22 December and as at 12 January not a single piece of information on how this will be managed has been shared. The media suggests that this eligibility will be imminently actioned; however, experience tells us that there is usually at least a month's time lag. There needs	Thank you for your comments. The public communications strategies you mention are beyond the scope of this guideline and our remit and so the committee could not make recommendations on this.

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				to be a much better rehearsed public communications strategy to manage public expectations about when new additions to a vaccine programme will start. These delays can be anticipated and should be set out clearly when these announcements are made.	
Down's Syndrome Association	General	General	General	Experience during the COVID-19 pandemic has highlighted that GP Learning Disability registers and in particular, registers of family-carers are very incomplete. It would have significant benefits if greater investments were made to ensure that these were as accurate as possible.	Thank you for your comments. The committee recognised that this is an important issue, but it is beyond the remit of this particular guideline. However, we will pass your comment onto the NICE surveillance team who can add it their log of things to consider for the learning disabilities guideline when it is updated.
Down's Syndrome Association	Guideline	010	019	It would be helpful if there was a clearly publicised point of contact for patients (or their appointees) to challenge or correct information relating to vaccine eligibility. Over the period of the COVID pandemic, the 119 service has become synonymous with information relating to COVID and access to vaccines, perhaps this service could in time (and when pressures of dealing with pandemic subsided) to other queries relating to vaccines?	Thank you for your comments. The committee have added information to the recommendation in section 1.3 about what the vaccination invite should contain. This now highlights that it should include details on contacting a healthcare practitioner to discuss concerns, including possible contraindications or allergies that could affect people's ability to be vaccinated. This should give people the opportunity to address any questions over eligibility.
Down's Syndrome Association	Guideline	017	008	We would add here that there is a need for a focused and differentiated approach to individuals who live in supported living settings. These are different to care homes, but share many of the same characteristics of shared living. Frequently care home residents and supported living residents are classed as one homogenous group, when their needs are very different.	Thank you for your comments. The committee agreed that it is important to ensure that people who live in supported living settings do not miss out on vaccination. They thought that one of the key issues was a lack of clear processes in place about what to do when a vaccine invitation is received, both in care homes and supported living settings. For this reason they expanded the recommendation about named leads for social care providers and other non-healthcare services. The end of this recommendation now includes how in supported living settings and care homes, there should be a policy in place covering what actions to

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					take in response to vaccination invitation letters for residents.
Down's Syndrome Association	Guideline	019	007	There may be specific schedules for certain patient groups e.g. for children who have Down's syndrome there is a recommended schedule of vaccinations as outlined by The Down's Syndrome Medical Interest Group of UK and Ireland www.dsmig.org.uk https://www.dsmig.org.uk/information-resources/by-topic/immunisation-2/	Thank you for your comments. This guideline is only for UK routine vaccinations. Additional vaccinations for people with underlying medical conditions and specific schedules for certain patient groups are not within the scope of this guideline and so the committee could not make recommendations on this.
Down's Syndrome Association	Guideline	004	004	Whilst we recognise the need for organisations to have a 'named vaccination lead', it has been our experience that patients, who would not know who the named individual is, are thus prevented from correcting any misinformation. Our understanding (during the COVID pandemic) is that only a clinician could add or remove a marker identifying a patient as being Clinically Extremely Vulnerable (and therefore eligible for priority access to a COVID vaccine). Contact with clinicians was managed by administrators (typically a practice receptionist). Some individuals experienced delays of several weeks whilst being passed between their GP practice and NHS 119 – the reception staff effectively 'gatekeeping'. This had the unintended consequence of delaying eligible and timely vaccine access.	Thank you for your comments. The vaccination lead is intended as a role to ensure all the necessary processes are in place so that people are correctly identified, invited for and given vaccinations. However, they are not meant as a direct contact for people to address concerns over eligibility or directly provide information to the individual. The committee are unable to make any recommendations to specifically address the problem you have highlighted about the identification of Clinically Extremely Vulnerable people during the COVID-19 pandemic as COVID-19 is not on the routine vaccination schedule currently. However, there is a recommendation in the training and education section that concerns education about vaccination for health and social care practitioners and other related staff who are in contact with people eligible for vaccination. This is intended to include people like GP receptionists. The training should help to ensure that these people understand

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					who is eligible for vaccination on the NHS routine UK immunisation schedule amongst other things. In addition, another recommendation the committee have added information to the recommendation about training for people who give vaccinations. This explains that these healthcare staff should be able to understand when a vaccine is contraindicated, or can be given, and that they should be able to overcome particular individual barriers to vaccination. This should help healthcare practitioners to be able to discuss vaccinations, address any concerns and determine whether individuals are eligible for vaccination.
Down's Syndrome Association	Guideline	004	013	In addition to housebound patients, it is important for primary care settings to correctly identify individuals who have a learning disability and who would require a reasonable adjustment in order for them to be able to access a vaccine. It should be remembered that this list may be more comprehensive than the GP Learning Disability Register.	Thank you for your comments. The committee recognised that there are times when adjustments need to be made to ensure that people can access vaccination services. In response to your comment, they added a point to the recommendation on the training and education in section 1.1. to ensure that people who give vaccinations are aware of how to overcome individual barriers to vaccination. By being aware of these barriers, such as when people have a learning disability, needle phobia or a sensory impairment, healthcare staff should be able to adapt and provide more accessible vaccination services.
Down's Syndrome Association	Guideline	004	016	We would cite failures within social care workforce (typically supported living providers) as being a potential hurdle here. Staff do not always understand their role in supporting an individual's access to health services and this is a weakness in the system. Frequently, letters addressed to a patient are received in a supported living setting, but internal procedures for acting on these are not clear and occasionally the correspondence is filed	Thank you for your comments. The committee discussed your comment and agreed that this is a potential barrier to vaccination uptake. They therefore added a point to the recommendation about the named leads for social care providers and other non-healthcare services to ensure that there is a policy in place covering what actions to take in response to vaccination invitation letters for residents in supported living settings and care homes.

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				away or left unattended to. Greater training and quality assurance measurers in auditing social care providers' compliance with these requirements might assist in this aim.	
Down's Syndrome Association	Guideline	005	001	It is possible that some secondary or tertiary care providers will actually have an active role in administering a vaccine e.g. a paediatrician in deciding that a Clinically Extremely Vulnerable child required a vaccine as a patient directed offer (rather than a group-directed one). It is our understanding in these cases that the clinician has oversight of ensuring the vaccine is given.	Thank you for your comments. This recommendation is for those secondary or tertiary care providers who do not provide vaccinations. For those that do provide vaccinations, the first recommendation in the section on named vaccination leads will apply. This should ensure that people who use these services are identified and offered any vaccinations for which they are eligible.
Down's Syndrome Association	Guideline	006	006	A key barrier for many patients who have a learning disability is the availability of accessible information, especially Easy Read materials.	Thank you for your comments. The recommendation about invitations for vaccinations emphasises the importance of making sure that any information, invitations and reminders meet a person's communication needs. This has now been expanded to explain that people's accessibility needs should be considered, such as the need for easy read materials.
Down's Syndrome Association	Guideline	006	009	For a significant proportion of patients who have a learning disability, it is the venous route of a vaccine that constitutes a barrier. This difficulty is most frequently seen in children, but can persist across all ages. Other formats of vaccines e.g. a nasal spray are extremely beneficial as an alternative. Whilst it is accepted that many COVID19 vaccines have used new forms of vaccine technology meaning that other formats of the vaccine have not yet been possible, the venous (only) route has been a reason why some patients have not received their vaccine, rather than any objection to having the vaccine itself.	Thank you for your comments. The committee thought it was important that individual barriers to vaccination are considered by people who administer vaccines and they discussed whether to recommend the use of alternative formats of vaccinations for some people. However, they were not aware of any vaccines on the routine schedule where alternative options such as nasal sprays are available. So instead they added a more general point to the education recommendation explaining that healthcare providers should have the knowledge to be able to help people overcome individual barriers to vaccination. This

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					would include the barriers experienced by people who have a learning disability or needle phobia.
Down's Syndrome Association	Guideline	006	018	Incorporating a vaccine offer and administration of these into the Annual Health Check for patients who have a learning disability would be a very efficient way of managing this process.	Thank you for your comments. Although NICE cannot define the terms of the Annual Health Check, the committee thought that this is a good opportunity for health care practitioners to check whether people are up to date with their vaccinations. For this reason, they included the annual learning disability health check as one of the times for opportunistic identification. This recommendation can be seen in section 1.2 on identifying people eligible for vaccination.
Down's Syndrome Association	Guideline	006	019	Pop-up vaccine centres at day service provision for adults who have a learning disability could be another useful opportunity.	Thank you for your comments. The committee could not list all possible locations for vaccination clinics within the recommendation. However, this does not exclude pop-up centres at day services because they would fall under the definition of sites outside healthcare settings that could address specific barriers to uptake.
Down's Syndrome Association	Guideline	007	003	Providing an offer of vaccines to an entire family-group or household at one time would be a helpful development, especially where a parent is an unpaid family-carer for their relative. Due to the different priority designations of a C.E.V. patient (group 4) and an unpaid carer (group 6) for COVID19 vaccines, families often had to attend different centres at different times to receive their vaccines. This was an added challenge for many parents who were juggling caring responsibilities. Seeing a carer having their vaccine at the same time as the offer was made of a vaccine to a patient who has a learning disability might have also helped with compliance (as the individual may have been able to	Thank you for your comments. The offer of vaccines to a family group or household may be beneficial in some cases, particularly as it may have been for COVID-19. However, this may be difficult to implement for vaccinations on the routine schedule, as different people within a household will be eligible for different vaccines at different times. Although this has not been recommended, there is a recommendation about training and education which includes the need for people who give vaccines to have an awareness of individual barriers to vaccination. This should help to ensure that the additional needs of some people are considered when inviting them for vaccinations.

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				model their behaviour on seeing a loved-one have the vaccine and felt reassured it was safe and not painful).	
Down's Syndrome Association	Guideline	008	013	We would especially mention the need for a focus on training and the timely sharing of information with GP practice reception staff, as they are key gatekeepers in this process. It has been our experience that this group of professionals were often misinformed or there was a significant time lag between updates about changes in policy reaching them. This often resulted in an unnecessary standoff between patient and professional, both asserting that they were right on a particular issue relating to vaccine access.	Thank you for your comments. The committee also thought that it is important for GP staff to be up to date about changes in vaccination policies. Based on your suggestion, the recommendation about training and education for people who do not administer vaccinations now highlights how education should be ongoing. By providing these people with regular training, they should be more aware of any changes in policies.
Down's Syndrome Association	Guideline	009	003	We would state here that this training should align with (or pay due regard to) the Oliver McGowan Mandatory Learning Disability Awareness training.	Thank you for your comments. The committee were aware that there are various training materials for vaccinations, but they did not think they could specify all of the potentially relevant information. However, information on considering accessibility and individual information needs has been included throughout the guideline.
Down's Syndrome Association	Guideline	010	003	It is important that issues of consent be considered *before* the actual vaccine appointment. In some cases, it only seems apparent to the practitioner that an individual has a learning disability or questions of mental capacity are raised at the actual appointment. This causes an unwelcome delay or even the cancellation of the vaccine being administered whilst additional work on checking of understanding is undertaken.	Thank you for your comments. The committee recognise that this would be useful and help to avoid delays in vaccinations. This is something that may be improved by an update of the learning disabilities register, something that has been raised by other stakeholders. However, this is beyond the remit of this particular guideline. We will therefore pass this information onto the NICE surveillance team who can add it their log of things to consider for the learning disabilities guideline when it is updated.
Down's Syndrome Association	Guideline	011	001	We would highlight the importance of Easy Read materials here for patients who have a learning disability.	Thank you for your comments. The committee discussed the importance of providing information about vaccination that is in an appropriate format for the person and that the information meets their communication needs. This is

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					highlighted in the recommendations in section 1.3 on invitations, reminders and escalation of contact. There is also information about the importance of using suitable literature to facilitate a discussion in section 1.1 on appointments and consultations. Easy read materials are mentioned specifically in the rationale section for this recommendation.
Down's Syndrome Association	Guideline	011	009	The Annual Health Check appointments for patients who have a learning disability should be key in this process, however, these have been paused during COVID times (for an extended period in many cases) and the GP Learning Disability Registers are frequently incomplete, so it is well known that many eligible patients are not included in this.	Thank you for your comments. This guideline is for routine vaccinations and so the recommendations will extend beyond the duration of the pandemic, when the annual health check appointments are more routine. The list of methods to identify people eligible for vaccination are not limited to those included in the examples and so other methods can also be used to identify this group of people.
Down's Syndrome Association	Guideline	012	010	Pre-employment checks will be key, especially as mandatory COVID19 vaccines are now a requirement for deployment in health and social care roles.	Thank you for your comments.
Down's Syndrome Association	Guideline	014	002	Many patients who have a learning disability may have declined a vaccine not because of an objection to the vaccine, but for a practical issue relating to accessibility of a setting or an unmet reasonable adjustment request. Most frequently this is based upon the need for a different format of the vaccine e.g. a nasal spray, which may not be possible. At the point of declining a vaccine, a timely referral should be made to specialist learning disability services e.g. a Community Learning Disability Nurse who may have additional strategies to employ which could ensure the patient is able to access their vaccine.	Thank you for your comments. The committee thought it was important that individual barriers to vaccination are considered by people who administer vaccines. They were not aware of many vaccines where options such as nasal sprays are available but they did think it was important to highlight that the additional needs of some people need to be considered. They therefore added an additional point to the education recommendation indicating that people should have the ability to overcome individual barriers to vaccination which includes those experienced by people who have a learning disability or needle phobia.

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Down's Syndrome Association	Guideline	015	014	This has frequently failed across the period of the COVID19 pandemic. Easy Read materials were frequently not sent to relevant patients (or people were told to in an inaccessible letter to request it in a different format). There were different approaches across the devolved nations of the UK, with some nations failing to provide Easy Read materials at all.	Thank you for your comments. The committee were aware of the importance of people receiving information that meets their communication needs. The inclusion of a recommendation about the importance of ensuring that this information is sent should increase the number of people who receive the relevant information.
Institute of Health Visiting	Evidence review D	043	013 - 017	Cost effectiveness and resource use: Consideration should be given to current workforce capacity and workforce shortages. For example, health visiting services are experiencing a national workforce crisis with a shortage of 5000 health visitors. Conti G & Dow A (2021) Rebuilding the health visiting workforce: costing policy. https://bit.ly/3DSD8KE https://ihv.org.uk/wp-content/uploads/2021/11/State-of-Health-Visiting-Survey-2021-FINAL-VERSION-25.11.21.pdf	While NICE is able to make recommendations on ways to improve uptake of routine vaccinations, it is beyond our remit to recommend changes to workforce planning. The committee considered the current workforce when making recommendations and emphasised that these recommendations should already be current practice and are aiming to reduce variation rather than requiring additional capacity. Additionally, the committee were aware that acute staff shortages are possible (e.g., due to the covid pandemic) and these short-term issues may lead to differences in implementation of the recommendations in the short-term. However, the committee hope that by presenting recommendations for the actions they think should be taken, and by whom, this will facilitate the development of workplace plans by the relevant authorities to achieve the improvements in routine vaccine uptake that are needed.
Institute of Health Visiting	Guideline	General	General	Current workforce shortages would need to be taken into consideration across all the recommendations and a workforce plan is needed to deliver these recommendations in full	Thank you for your comments. While NICE is able to make recommendations on ways to improve uptake of routine vaccinations, it is beyond our remit to recommend changes to workforce planning. The committee considered the current workforce when making recommendations and emphasised that these recommendations should already be current practice and

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					are aiming to reduce variation rather than requiring additional capacity. Additionally, the committee were aware that acute staff shortages are possible (e.g., due to the covid pandemic) and these short-term issues may lead to differences in implementation of the recommendations in the short-term. However, the committee hope that by presenting recommendations for the actions they think should be taken, and by whom, this will facilitate the development of workplace plans by the relevant authorities to achieve the improvements in routine vaccine uptake that are needed.
Institute of Health Visiting	Guideline	004	004	To state what the minimal professional requirements are needed to be a vaccination lead and details of whether this is an administrative and/or clinical role, for example: trained nurse, doctor, or pharmacist within the recommendations. This will help organisations with workforce planning.	Thank you for your comments. The committee discussed whether there should be minimum requirements for the vaccination lead. However, they thought that this would vary depending on the functions of the organisation the lead worked for and so decided against making this more explicit. In some places the named lead will need to be a healthcare professional while in other someone without medical qualifications may be better suited to carrying out this role. Each organisation will have to make this decision themselves based on the vaccination related functions they carry out. The committee thought it was more important that the vaccination lead is someone who has access to the relevant information and facilities that they need, and so this was added as a new recommendation in the section about vaccination leads.
Institute of Health Visiting	Guideline	004	009	To also include: • that reminders' can be sent to people through a variety of methods such as: text, phone, letter, email and using online platforms which can reduce missed appointments:	Thank you for your comments. Recommendations on sending reminders are in section 1.3 of the guideline. The recommendations on initial invitations for babies, infants and preschool-aged children, and adults includes methods of sending invitations such as letter, email, phone call or

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				https://www.england.nhs.uk/2018/10/nhs-to-trial-tech-to-cut-missed-appointments-and-save-up-to-20-million/ • preferred method of contact is recorded on the patient record system	text and using people's preferred methods of contact if possible. In addition, there is a recommendation in section 1.2 about keeping contact information up to date and recording preferred methods of contact.
Institute of Health Visiting	Guideline	004	013	To include: Babies and children are dependent on their parents and carers to take them to vaccination appointments. If the parent is housebound, the baby/child most likely is too. It is important to identify babies and children of parents/carers who are housebound and for health care professionals to be aware of local 'Was Not Brought' protocols. For example: Nottingham City Council, NHS Nottingham City CCG and the NCSCB (2017) Rethinking Did Not Attend: https://www.youtube.com/watch?v=dAdNL6d4lpk	Thank you for your comments. The committee agreed with your comment that children whose parents or carers are housebound need to be identified and offered alternative methods to access vaccination. For this reason, parents and carers who are housebound have been added to the list of people who should know how to get home visits for vaccination. Information about the 'Was not brought' protocol has also been added to the rationale if there are missed appointments and lack of response to invitations.
Institute of Health Visiting	Guideline	005	001	This section should include a named vaccination lead for Specialist Community Public Health Nursing services (health visitors support uptake of vaccinations in pregnancy, the postnatal period, and for children 0-5 years; and school nurses for school aged children – some school nursing services also manage the delivery of the childhood immunisation service in schools). Health visitors are ideally placed to contribute to a "whole system" approach to improving immunisation uptake, through the universal reach of the Healthy Child Programme https://ihv.org.uk/wp-content/uploads/2019/11/7.11.19-Health-Visiting-in-England-Vision-FINAL-VERSION.pdf	Thank you for your comments. The named vaccination leads are identified by the processes their organisation performs rather than which service they work and therefore the committee have not added the requested services. It is expected that the services you name would be covered by this recommendation already if they perform any of the processes detailed in the recommendations, as are GP services, midwives and school age immunisation teams which are also not named. Health visitors have been added to examples within the guideline of people who can identify people eligible for vaccinations and support vaccination services. The Healthy

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				Health visitors promote uptake of the full child health immunisation schedule at their universal health visiting contacts: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/899423/PHE_Complete_Immunisation_Schedule_Jun2020_05.pdf Population vaccination coverage which includes MMR vaccine and that children should receive for two doses by the time they reach five years of age is recommended in the revised health child programme commissioning guide (PHE 2021) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/967176/SP_Commissioning_Guide_3.pdf To enable vaccination leads within health visiting services, this would require workforce investment due to significant workforce crisis whereby there is a shortage of 5000 health visitors in England: Conti G & Dow A (2021) Rebuilding the health visiting workforce: costing policy. https://bit.ly/3DSD8KE	Child Programme has also been mentioned as one of the opportunities that should be used for opportunistic identification. While NICE can make recommendations on ways to improve uptake of routine vaccinations, they cannot recommend changes to workforce planning. However, the committee hope that by presenting recommendations for the actions they think should be taken, and by whom, this will facilitate the development of workplace plans by the relevant authorities to achieve the improvements in routine vaccine uptake that are needed.
Institute of Health Visiting	Guideline	006	004 - 008	This section addresses NHS commissioners and NHS providers – consideration should also be given to integrated working with other parts of the healthcare system. This will be increasingly important within the Government's plans for Integrated Care Systems proposed in the Health and Care Bill. For babies, children and families this should include integrated approaches with the Specialist Community Public Health Nursing services (health visiting and school nursing).	Thank you for your comment. The committee agreed that this should include working with other parts of the healthcare system as well as the local community. They therefore decided to include additional information about the need for these interventions to be developed as part of a system wide approach to addressing uptake. This will ensure that any interventions are developed based on discussions with other health care providers and people and organisations within the local community. Further

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				Through their universal reach, these public health services, commissioned to deliver the Healthy Child Programme by local authorities, have a pivotal role in identifying unvaccinated individuals and supporting uptake of immunisations through evidence-based information and personalised advice to support individuals with vaccine hesitancy. They also have a 'placed based' role to identify system problems which create access issues for certain groups and can advocate on behalf of communities to influence local policies. Services should ensure they are accessible to all groups, particularly those individuals and groups who do not currently experience easy access to services (for example the Gypsy/ Traveller community, asylum seekers and individuals who are not registered with a GP), and consequently do not experience the same health outcomes as the rest of the population. Including health visitors in local initiatives to improve the uptake of vaccinations for babies and children will require investment into the health visiting workforce due to national shortage of health visitors. Conti G & Dow A (2021) Rebuilding the health visiting workforce: costing policy. https://bit.ly/3DSD8KE	information about the use of a systems wide approach is available in the rationale of the guideline. While NICE is able to make recommendations on ways to improve uptake of routine vaccinations, it is beyond our remit to directly control workforce planning. The committee are aware that investments into the workforce will affect the implementation of the recommendations. However, the committee hope that by presenting recommendations for the actions they think should be taken, and by whom, this will facilitate the development of workplace plans by the relevant authorities to achieve the improvements in routine vaccine uptake that are needed.
Institute of Health Visiting	Guideline	006	019 - 22	To include family hubs as locations for the 0-5 population to help increase uptake. Family hubs are one of the 6 key action areas in the 'Best start in life, a vision for the 1001 critical days (DHSC 2021) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973112/The_b	Thank you for your comments. The committee also thought that family centres are good examples of alternative settings for vaccination clinics. These have been added to the recommendation as suggested

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				est_start_for_life_a_vision_for_the_1_001_critical_days.pdf For housebound individuals, or communities that do not currently experience easy access to services (listed in comment 6) commissioners and providers should consider an 'outreach' service when no suitable alternative solution is available.	The committee were aware of the importance of making services accessible for people who are housebound. For this reason, they included a recommendation about home visits for this group of people which can be seen in section 1.3 of the guideline under initial invitations.
Institute of Health Visiting	Guideline	008	005 - 006	to include health visitors within this statement.	Thank you for your comments. The committee agreed that other healthcare staff should also receive education. This recommendation has now been updated to say that health and social care practitioners and other related staff should receive this education. This widens the group of people who should be offered education about vaccinations.
Institute of Health Visiting	Guideline	008	016 – 020	To include: • Vaccine hesitancy because the World Health Organisation (WHO) lists vaccine hesitancy as one of the top ten global threats to health https://www.who.int/news-room/spotlight/ten-threats-to-global-health-in-2019 Haroune & King (2020) https://pubmed.ncbi.nlm.nih.gov/32478497/ also highlight the risks of vaccine hesitancy • Awareness for health and social care professionals that for pregnant women, babies, and children under the age of 5, families can be signposted to the health visitor for support. • Health visitors can utilise making every contact count (MECC) https://www.makingeverycontactcount.co.uk/ at the five mandated healthy child programme reviews and offer	Thank you for your comments. This recommendation is aimed at people who are in contact with people who are eligible for vaccination but who do not administer vaccines, such as GP receptionists or people who work in social care. The committee did not think it was necessary for these people to have an in-depth knowledge of how to address issues such as vaccination hesitancy. Instead, by knowing where to signpost people for further information, they will be able to direct people to healthcare practitioners who will have a more detailed knowledge of issues relating to vaccinations. The recommendation about education for people who administer vaccines includes the ability to have effective conversations, part of which involves talking to people with vaccine hesitancy. Following your comments, a statement has been added to the recommendation in section 1.2 about what to do when

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				enhanced support to families with vaccine hesitancy to improve vaccine uptake.	people have been opportunistically identified for vaccination. This highlights that the person who opportunistically identifies someone should think about referring parents of children to the health visitor or school nurse, as age appropriate. Health visitors have also been added to the list of people who can identify people for opportunistic vaccination, as suggested.
Institute of Health Visiting	Guideline	009	010	To include vaccine hesitancy Haroune & King (2020) https://pubmed.ncbi.nlm.nih.gov/32478497/ WHO 2019: https://www.who.int/news-room/spotlight/ten-threats-to-global-health-in-2019	Thank you for your comments. The recommendation about education for people who administer vaccines includes the ability to have effective conversations, part of which involves talking to people with vaccine hesitancy. Information about this was included in the qualitative barriers and facilitators evidence review (evidence review B) and is summarised in the rationale section of the guideline.
Institute of Health Visiting	Guideline	009	018	Recent national policy places an even greater emphasis on the importance of personalised and individualised care. https://www.england.nhs.uk/personalisedcare/ https://www.longtermplan.nhs.uk/areas-of-work/personalised-care/ Consideration should be given for a more personalised response if the patient is housebound due to ill health/disability (and is a parent of a baby/child who requires vaccination)	Thank you for your comments. The committee thought that people who are housebound due to disability are covered by the existing recommendation for home visits. However, they thought that it was important to highlight home visits for children whose parents or carers are housebound. This group has been added to the recommendation.
Institute of Health Visiting	Guideline	009	021	To include shared decision making when gaining consent https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making	Thank you for your comments. The committee thought that vaccination should take place based on a discussion involving shared decision-making. For this reason, the end of this recommendation includes a reference to NICE's shared decision-making guideline so that people are aware

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					of the importance of including this when discussing and gaining consent for vaccinations.
Institute of Health Visiting	Guideline	010	019	The iHV would advocate for interoperability and information sharing between GPs, CHIS and HV services to flag children who have not been immunised to support a conversation at the next contact as part of the Healthy Child Programme	Thank you for your comments and support for this guideline.
Institute of Health Visiting	Guideline	011	002	To include keeping email addresses up to date. Particularly relevant for mobile/traveling families, telephone numbers and addresses change frequently but email addresses are more likely to stay the same. To add: 'A method to flag on the patient system if information is required in an accessible format or if an interpreter is required'. https://www.england.nhs.uk/ourwork/accessibleinfo/	Thank you for your comments. Following your suggestion, email addresses have been added to the list of contact information that should be kept up to date. Although we have not specified that a flag should be added for if someone needs accessible information, the committee discussed the importance of providing information about vaccination that is in an appropriate format for the person and that the information meets their communication needs. This is highlighted in the recommendations in section 1.3 on invitations, reminders and escalation of contact. There is also information about the importance of using suitable literature to facilitate a discussion in section 1.1 on appointments and consultations.
Institute of Health Visiting	Guideline	011	007	To add at the end of the sentence: 'and health visitor and school nursing targeted contacts via the family home, via digital platforms and via the telephone.	Thank you for your comments. Health visitor and school nursing targeted contacts have been added to the recommendation as suggested.
Institute of Health Visiting	Guideline	011	024	To include specialist health visitors supporting homeless families.	Thank you for your comments. The committee were aware that there are many different ways that people can be identified as eligible for vaccination. They therefore decided to make a list of some of the possible ways in which people

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					can be identified, but this does not exclude other methods not included in the examples.
Institute of Health Visiting	Guideline	012	020	To add that children under the age of five who have transferred into the UK from overseas may not have a complete immunisation record or have a GP registration. In these instances, refer the family to the health visitor for support with registering with the GP and immunisations.	Thank you for your comments. There is a recommendation in section 1.3 that people who have come from outside the UK should be given information about the NHS vaccine schedule and help to access healthcare if needed. This would include referral to the health visitor if necessary.
Institute of Health Visiting	Guideline	013	001 - 005	To include health visitors who see pregnant women from 28 weeks gestation at the antenatal contact. Health visitors can provide a safety net to make sure screening and immunisation pathways are followed correctly and completed PHE 2019: https://phescreening.blog.gov.uk/2019/01/24/helping-health-visitors-to-make-every-contact-count-for-screening-and-immunisation/ Health for all children, fifth edition: https://oxfordmedicine.com/view/10.1093/med/9780198788850.001.0001/med-9780198788850	Thank you for your comments. The committee thought that health visitors are very unlikely to administer vaccinations and so they were not included in this recommendation. However, there is another recommendation about providing reminders for vaccination and this includes the role of health visitors.
Institute of Health Visiting	Guideline	013	008 - 013	To include for children under the age of five, refer to the health visitor	Thank you for your comments. The committee agreed that referring to the health visitor or school nurse can be important and added this to the recommendation based on your suggestion.
Institute of Health Visiting	Guideline	014	015	To be specific that the patient held records for children are called the Personal Child Health Record Book (PCHR) which will become digital from 2023 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973112/The_b	Thank you for your comments. The committee decided not to specify the title so that the recommendation remains relevant if the title were to change in future or if there were any other records used.

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				est_start_for_life_a_vision_for_the_1_001_critical_days.pdf	
Institute of Health Visiting	Guideline	016	001	To include for transfer into the UK from overseas for pregnant women and children under the age of five 5, refer to health visitor who will be able to deliver a transfer in visit to help the family with GP registration and support with identifying any missed vaccinations and enabling access to ensure completion of vaccine schedule.	Thank you for your comments. The committee discussed this and agreed that referrals to the health visitor can be helpful for pregnant women and children under 5. However, they thought that this is covered by the section of the recommendation about people from outside of the UK being given help to access healthcare, if this is needed.
Institute of Health Visiting	Guideline	016	010	Invitations and reminders for different vaccinations should be sent as one when possible and appropriate to do so, to improve uptake of vaccination.	Thank you for your comments. The committee agree that this is a useful way to try and increase uptake and to avoid sending someone multiple invites and reminders.
Institute of Health Visiting	Guideline	017	004	To include health visiting services	Thank you for your comments. The committee recognised that health visitors play an important role in ensuring that pregnant women and young children are vaccinated. They are mentioned directly in other recommendations in the guideline, but the committee agreed that they would be covered by the umbrella term of healthcare practitioners in the recommendation for initial invitations for pregnant women rather than list all the healthcare staff separately. However, the committee have added health visitors to the recommendation about checking whether pregnant women have been vaccinated.
Institute of Health Visiting	Guideline	017	022	To include details on contacting health visiting services	Thank you for your comments. The information on what the invitation should contain includes details on contacting a healthcare practitioner and instructions on how to book an

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					appointment. This will include health visiting services if relevant to the person being sent the invitation.
Institute of Health Visiting	Guideline	017	028	To include PCHR for children under the age of 5	Thank you for your comments. If this is an invitation for a childhood vaccination, then it is expected that the invitation should include information about bringing the PCHR.
Institute of Health Visiting	Guideline	018	003	To include: All vaccinations given during pregnancy will provide babies with immunity in the first few weeks of life https://www.nhs.uk/common-health-questions/childrens-health/how-long-do-babies-carry-their-mothers-immunity/	Thank you for your comments. The committee thought it was important to highlight the benefits and risks to the baby as well as the mother, and therefore included this as part of the information that should be included with an invite for vaccination.
Institute of Health Visiting	Guideline	019	004 – 006	To amend sentence to include health visitors: 'If not, ensure they receive offers of vaccination or reminders (as relevant) at 5 subsequent antenatal appointments or during any contact with their GP, **health visitor** or any other healthcare provider'.	Thank you for your comments. The committee agreed that health visitors should also be included in the recommendation for pregnant women and so they have added this group to the recommendation as suggested.
Institute of Health Visiting	Guideline	019	007 – 014	Amend sentence: Talk to parents or carers (as appropriate) of children aged 5 or under… To: Contact, and provide an opportunity for a discussion on vaccinations, for parents or carers of children 5 or under …. To include in this page: • vaccine hesitancy, • to implement local 'was not brought' protocol with frequent missed appointments and no response to invitations • to implement local child safeguarding protocols if appropriate	Thank you for your comments. Throughout the guideline there is information on the importance of discussing vaccination, which would include vaccine hesitancy, and so the committee did not think it needs to be specifically stated in this recommendation. More information has been added to the rationale for this section to highlight that a response to frequent missed appointments may be to implement local 'was not brought' protocols. The committee decided not to state this directly in the recommendations because the response may vary depending on circumstances.

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Institute of Health Visiting	Guideline	019	015 – 018	To include Vaccine hesitancy	Thank you for your comments. Exploring any issues should include a discussion of any reasons for vaccine hesitancy.
Institute of Health Visiting	Guideline	019	019 - 022	To include: Implementation of local 'was not brought' protocols and child safeguarding protocols for unborn baby https://hipsprocedures.org.uk/assets/clients/7/HIPS%20Unborn%20Baby%20Protocol%20One%20Minute%20Guide.pdf	Thank you for your comments. The committee have added information about 'was not brought' protocols into the rationale section of the guideline.
Institute of Health Visiting	Guideline	020	009 - 014	CHIS to link with health visiting service as they may be visiting the family	Thank you for your comments. This recommendation is specifically about the sending of invitations and reminders so would not necessarily involve the health visiting service. Other recommendations relating to reminders and escalation of contact include involving these services if needed.
Institute of Health Visiting	Visual Summary 1	General	General	Identifying people eligible for vaccination and opportunistic vaccination Visual resource To amend the first text box – Use every opportunity to identify eligible people. For example, during contacts in health and social care settings and in other settings such as **patient's homes**, schools, nurseries, and prisons To add to the box 'Signpost to vaccination services': for 0-5 population – connect to health visiting service To include wording in the text box 'update records': patient held records and Personal Child Health Record (PCHR) for children under the age of 5	Thank you for your comment. The visual summary is intended to represent the recommendations in summary form. The longer list of settings and situations where a person could be identified opportunistically can be found in the recommendation, but the list is not intended to be exhaustive. In the visual summary we have included a few examples but due to space constraints we are unable to reproduce the entire recommendation. We have there for not made this addition. Based on your earlier comment, the committee have added a point about referring a child's parents or carers to the health visitor or school nurse, as age appropriate, to the recommendation about what action to take if a child or

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					young person is identified opportunistically. We have added this to the visual summary as well. We have not added the text about the PCHR as this does not reflect the wording of the recommendation and we already have text about patient held records in the visual summary.
Institute of Health Visiting	Visual Summary 2	General	General	Vaccinations for young children and older people **In the Escalation section:** For children – the invite will need to be sent to the person with parental responsibility: this sentence would benefit from making this clearer: "Invite people who are eligible for vaccination or their family members or carers (as appropriate) For consent to immunisation to the valid, it must be given freely, voluntarily and without coercion by an appropriately informed person who has the mental capacity to consent to the administration of the vaccines in question. This will be the person themselves, someone with parental responsibility for an individual under the age of 18 years (16 years in Scotland), someone authorised to do so under a Lasting Power of Attorney (LPA) for health and welfare, or someone who has the authority to make treatment decisions as a court appointed deputy. For children under the age of five - to include that health visitors will have a discussion with parents or carers if they have not responded to an appointment rather than use the term 'talk to'	Thank you for your comments. The visual summary is intended to summarise the recommendations and there are limitations in what can be included without making the diagram incomprehensible. The text about invitations reflects the recommendation and is intended to cover children and adults who are eligible for vaccination, which is why this choice of wording has been used and we have not made your suggested edits. At the bottom of this visual summary we have a box on accessible information and supported decision making which covers many of the points you raise about consent and there are more recommendations in the guideline that aim to ensure that people are able to make informed decision about being vaccinated. The definition of family members or carers provides information about people having legal responsibility for decision making on behalf of another individual. The use of the wording' talk to' has been retained as this reflects the recommendation. The recommendation also covers exploring the reasons for the lack of response and

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				To include the term vaccination hesitancy within the flow chart. Haroune & King (2020) https://pubmed.ncbi.nlm.nih.gov/32478497/ WHO 2019: https://www.who.int/news-room/spotlight/ten-threats-to-global-health-in-2019 For the sentence: Consider a multidisciplinary approach to address any issues raised, involving other relevant healthcare professionals such as health visitors, social workers or key workers, while respecting the person's decision if they refuse vaccination – Add: Specifically for children – practitioners should consider local 'Was Not Brought (WNB) policy if children are not brought to their vaccination appointment by their parent/carer https://hipsprocedures.org.uk/assets/clients/7/Child%20not%20brought%20to%20appointment%20leaflet%20v4.pdf	addressing issues raised which clarifies that this is intended to be a conversation rather than a lecture. Since we do not mention vaccine hesitancy in the recommendations we cannot include reference to it in this summary. We have also been unable to add information about the 'was not brought' policy to the summary as this is not contained in the recommendation. The committee have however, added this information to the rationale in the guideline to address your comment. The committee did not refer to safeguarding issues directly in their recommendations, however this could be instigated as part of the multidisciplinary approach to addressing why people have not responded to vaccination invitations and reminders should it be deemed necessary.

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				Specifically for children where there have been frequent missed appointments or no response to invitations, there should be consideration of child safeguarding and wider health needs/neglect https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf	
Institute of Health Visiting	Visual Summary 3	General	General	Vaccinations for pregnant women **In the Invitation Section:** To include Health visitors in the group of professionals who may see pregnant women. **In the Escalation section:** To include health visitor to support families with vaccine hesitancy at antenatal contact from 28 weeks With frequent missed appointments or no response to invitations – to follow local WNB policy (unborn baby) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf and for consideration of wider health needs/neglect/child safeguarding (for unborn baby) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf	Thank you for your comments. The invitations section includes both people working in maternity services and other healthcare practitioners who have contact with pregnant women. This should therefore include any health visitors who see pregnant women. As the visual summary is a summary of sections of the guideline, we cannot add any additional information to it that is not included in the recommendations. For this reason, we cannot specify health visitors supporting the family from 28 weeks or child safeguarding for the unborn baby. However, the visual summary includes the need to consider a multidisciplinary approach to any issues raised. This includes relevant healthcare practitioners, such as health visitors, and so their role is acknowledged within this summary. In addition, there is a recommendation in the guideline about reminders for pregnant women that now includes health visitors among the list of healthcare practitioners who come into contact with pregnant women and be involved in ensuring they are offered vaccinations. We have reflected this addition in the visual summary which now mentions health visitors directly.

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Janssen	General	General	General	Guideline, Evidence Reviews We thank NICE for the opportunity to comment on NICE guideline on vaccine uptake in the general population. Overall, we are supportive of the guideline being published and believe that the recommendations are supportive in improving the increased uptake of free vaccination programmes among people who are eligible. It describes ways to increase awareness and how to use all opportunities in primary and secondary care to identify people who should be encouraged to have the vaccination within the NHS in England and Wales. Below we provided specific comments on the section of the guideline.	Thank you for your comments and support for this guideline.
Janssen	Guideline	General	General	A number of new respiratory syncytial virus (RSV) prophylactics are reaching the late stages of their clinical development programmes, including long-acting monoclonal antibodies and new vaccines. It is likely that one or more of these will replace the current monoclonal palivizumab programme (Hogdson 2020). If seasonal vaccinations such as flu vaccination are not covered in this draft guideline, what plans are in place to support new RSV vaccination programme(s) should they become available and ensure these are managed cohesively and in a timely way alongside seasonal flu vaccinations to increase uptake of both programmes? With vaccines not in scope of horizon scanning activities via the UK PharmaScan database, we would welcome a clarification on how NICE, NHS England and NHS Improvement would plan and prepare the NHS for the	Thank you for your comments. NICE's guideline on flu vaccination: increasing uptake covers flu vaccination separately. We are unable to comment about the introduction of new vaccines. If RSV vaccination is added to the routine schedule it will be covered by the vaccine uptake guideline, but otherwise it is out of scope of this current work. We are also unable to comment on how NHS England and NHS Improvement would plan and prepare the NHS for the introduction of new vaccines and support faster/higher vaccine uptake through the NHS.

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				introduction of new vaccines and support faster/higher vaccine uptake through the NHS. Reference(s): Hodgson et al. Evaluating the next generation of RSV intervention strategies: a mathematical modelling study and cost-effectiveness analysis. BMC Medicine (2020) 18:348	
Janssen	Guideline	General	General	There is a possibility to clarify and give further guidance on special populations (similar to pregnant women already covered in the document). The special populations that could benefit from this would be at-risk individuals who do not meet the eligibility criteria for immunisation recommended by JCVI. For example: the routine programme for shingles is for people aged 70 years, however some individuals are at increased risk of disease earlier in their life due to both diseases (for example: autoimmune diseases) and treatment initiation (for example 43mmune-modulators). Issues can arise regarding eligibility and funding, when recommendations advise vaccinating outside the Green Book age cut off. These scenarios can cause confusion with regards to eligibility and who should administer the vaccine. These patients are often detected in tertiary centres and when referred to the immunisation providing service, there can be some resistance by the service providers. The document could provide guidance that some individuals at increased risk or anticipating immunosuppressive therapy should be assessed for	Thank you for your comments. The scope of this guideline covers high risk people for vaccinations that are on the routine schedule, but we did not find any evidence for interventions to improve uptake in these groups. The committee did not make any separate recommendations for these people for this reason and because they agreed that the issues to do with eligibility and funding of this group were too specific to be covered superficially in a general guideline on vaccine uptake, but rather merited more detailed guidance than they were able to provide. However, the committee did add a recommendation in response to stakeholder comments about consulting the green book and expert advice when uncertainties exist around contraindications and allergies. They also clarified in the vaccination invitation recommendation that concerns around vaccination could be due to possible contraindications or allergies that could affect the person's ability to be vaccinated. The committee also made a new recommendation, in response to stakeholder comments, about the need for compatible computer systems or processes to improve

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				vaccine eligibility before starting treatment that may contra-indicate future vaccination. Reference(s): Holroyd, C.R., Seth, R., Bukhari, M., Malaviya, A., Holmes, C., Curtis, E., Chan, C., Yusuf, M.A., Litwic, A., Smolen, S. and Topliffe, J., 2019. The British Society for Rheumatology biologic DMARD safety guidelines in inflammatory arthritis. *Rheumatology*, *58*(2), pp.e3-e42.	communication between different parts of the health system. There is currently limited integration between these different systems, and this makes it harder for information, including why an individual needs to be vaccinated at a different time to that stated in the routine schedule, to be shared between different healthcare settings to the detriment of the patient. If this recommendation is implemented, then tertiary care providers can flag the reasons that they are referring people to the service that is providing the immunisations to facilitate their vaccination. However, the committee also recognised that suitable policies would need to be in place to make it clear to providers that these people are eligible for vaccination and how these vaccinations are funded, but this was more information than the committee could provide in this guideline.
Janssen	Guideline	010 - 015	General	We are supportive of this section 1.2 on *Identifying eligibility, giving vaccinations and recording vaccination status*. We strongly believe that encouraging the recording of a person's vaccination eligibility and status regardless of the setting (e.g. health system level, service provider level, NHS or private) is essential to support uptake of vaccination in the general population. This will ensure that every contact with health care providers counts towards increasing vaccination status of those eligible. This requires a coordinated approach to enable <u>all</u> providers of vaccination (NHS and private) to have online/readily access to a person's vaccination status to record whether they have been offered/received/declined a vaccine.	Thank you for your comments and support for this guideline.

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Janssen	Guideline	014	020 - 022	We suggest that an additional point is added to strengthen the recording of **eligibility criteria** with compulsory data fields in electronic health record templates (if this is not already the case). Eligibility criteria is a critical consideration for the identification of eligible groups but also for public health research and outcomes e.g. evaluation of vaccine effectiveness between vaccinated and unvaccinated eligible groups, monitoring of vaccination coverage and ultimately the impact of vaccination levels on population health. Adequate data system controls should be considered to maintain up to date eligibility criteria and these should be updated as and when required.	Thank you for your comments. This recommendation is referring to the recording of data after someone has been offered a vaccinated and so eligibility would already have been determined by this point. We have updated the end of this recommendation to say that this is referring to the recording of vaccination offers and administration to make it clearer which stage of the vaccination process we are referring to.
Janssen	Guideline	032	027	Providing multiple opportunities and locations for vaccination whilst likely to increase vaccine uptake and be associated with additional resource use; this could offset some of the costs, but it is important to note that the expenditure from the vaccination service is likely to be from a separate operational budget than that of the savings.	Thank you for your comment. The committee recognised that this is an important point, however recommending changes to funding streams is out of our remit. The committee have now noted the issue of different operational budgets in the rationale.
Janssen	Guideline	036	024	Without guidance or a suggested time, it may be difficult for local services to justify and implement longer appointments when needed.	Thank you for your comments. The committee considered appointment length but decided that they could not recommend what this should be. The research questions in this review did not look at appointment times and so the committee did not have any evidence on which to make a recommendation on appointment length.
Janssen	Guideline	040	018	Suggestion to amend wording from: "The committee agreed with this approach because duplicating vaccinations is generally not harmful but remaining	Thank you for your comments. This has been updated as suggested.

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				unvaccinated could leave people open to **infection**." to "The committee agreed with this approach because duplicating vaccinations is generally not harmful but remaining unvaccinated could leave people at risk of **developing disease**" Reason for suggestion: some immunisation strategies aim at prevention disease manifestation not necessarily infection.	
Janssen	Guideline	045	003	In relation to tailoring information for people from other countries as well as educating people on who provides vaccinations in the UK, it may be relevant to contextualise certain immunisations in the UK landscape to account for geographical or cultural differences. For example: contextualising and explaining the UK's strategy for pertussis immunisation, where the pregnant women are vaccinated to confer protection to their newborn babies, whereas some countries recommend cocooning or vaccinating the babies. Reference(s): Esposito S, Stefanelli P, Fry NK, Fedele G, He Q, Paterson P, Tan T, Knuf M, Rodrigo C, Weil Olivier C, Flanagan KL, Hung I, Lutsar I, Edwards K, O'Ryan M and Principi N (2019) Pertussis Prevention: Reasons for Resurgence, and Differences in the Current Acellular Pertussis Vaccines. Front. Immunol. 10:1344. Public Health England (PHE). UK and international immunisation schedules comparison tool. https://www.gov.uk/government/publications/uk-and-	Thank you for your comments. The committee thought it was important to provide sufficient information to help people understand the basic information about how vaccinations are provided in the UK. Once the person has accessed vaccination services they can then be given more specific information about the vaccinations that they are eligible for.

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				international-immunisation-schedules-comparison-tool [Last accessed 12/01/2022]	
Liverpool School of Tropical Medicine	Guideline	005	008 - 011	1.1.5 Raise awareness and payments: set up a system/ allow us to register so private travel clinics are able to offer free NHS vaccines? Hep A, typhoid, MMR, DTaP, Influenza, Hep B, Covid. this would take the pressure of the GP surgeries.	Thank you for your comments. Recommendations for the use of non-NHS services such as private travel clinics are beyond our remit. However, there is a recommendation in the guideline that providers should assess local population needs and barriers to vaccination and use this information to develop interventions aimed at increasing vaccination uptake. If this includes access to services, then provision of vaccinations at other locations is something that could be considered by local commissioners.
Liverpool School of Tropical Medicine	Guideline	006	001 – 003, 023 - 025	1.1.11 mentions community pharmacies but not travel clinics. Most travel clinics open evenings and weekends.	Thank you for your comments. Recommendations for the use of non-NHS services such as private travel clinics are beyond our remit. However, there is a recommendation in the guideline that providers should assess local population needs and barriers to vaccination and use this information to develop interventions aimed at increasing vaccination uptake. If this includes access to services, then provision of vaccinations at other locations is something that could be considered by local commissioners.
Liverpool School of Tropical Medicine	Guideline	006	014 - 017	1.1.9 tailor services using community pharmacies? – why can't travel clinics be included in this section? If community pharmacies are. There are 1000's of travel clinics in England, travel vaccination nurses are specialist vaccination nurses and are here to administer to adults and children. We identify people often who need to complete MMR and other NHS vaccines. It is an inequality that privately funded community pharmacies should be allowed but travel clinics are not.	Thank you for your comments. Recommendations for the provision of non-NHS services such as private travel clinics are beyond our remit. However, there is a recommendation in the guideline that providers should assess local population needs and barriers to vaccination and use this information to develop interventions aimed at increasing vaccination uptake. If this includes access to services, then provision of vaccinations at other locations is something that could be considered by local providers.

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Liverpool School of Tropical Medicine	Guideline	006	019 - 022	1.1.10 other healthcare settings – this should include private travel clinics – if a system can be set up to allow private travel clinics to offer NHS vaccines just like the community pharmacies are permitted to do so we would be happy to do this	Thank you for your comments. Recommendations for the provision of non-NHS services such as private travel clinics are beyond our remit. However, there is a recommendation in the guideline that providers should assess local population needs and barriers to vaccination and use this information to develop interventions aimed at increasing vaccination uptake. If this includes access to services, then provision of vaccinations at other locations is something that could be considered by local providers.
Liverpool School of Tropical Medicine	Guideline	028	018 – 020	Overall strategy should include travel clinics, as we are in the perfect position to identify opportunistic vaccines and it would be better service for the individual and take the pressure of GP surgeries and increase the uptake in the general population.	Thank you for your comments. Recommendations for the provision of non-NHS services such as private travel clinics are beyond our remit. However, there is a recommendation in the guideline that providers should assess local population needs and barriers to vaccination and use this information to develop interventions aimed at increasing vaccination uptake. If this includes access to services, then provision of vaccinations at other locations is something that could be considered by local providers.
London School of Hygiene and Tropical Medicine (LSHTM)	Evidence review C	065	Figure 1	More detail could have been provided on the role of face to face interactions to discuss questions or provide more information about immunisation (mentioned as a facilitator in Figure 1). The place of vaccination information as part of call recall could also have been discussed in more detail.	Thank you for your comments. Although face to face communication was found to be a facilitator in the qualitative barriers and facilitators evidence review (see evidence review B), there was no corresponding quantitative evidence found for this in this reminders quantitative review. The evidence in review C identified there involved the use of methods including emails, texts, telephone calls, letters in most studies with very few using face to face invitations, and these were often as part of escalating contact to involve home visits if no response was seen to less intensive methods of communication. It was not possible to determine the effectiveness of the face to face component of invitation and reminders

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					interventions. Although evidence for the specific effectiveness of face-to-face conversations was not identified as part of this review, the committee were aware of its importance. This is why providing opportunities for discussions with healthcare providers, including face to face ones, are included at various stages throughout the guideline. These include during vaccination appointments or consultations and during opportunistic identification of eligible people. In addition, the vaccination invitation letter should include information about contacting a healthcare practitioner to discuss concerns and this could involve a face-to-face conversation.
London School of Hygiene and Tropical Medicine (LSHTM)	Evidence review E	General	General	Whilst the evidence does seem conclusive about the limited role educational interventions play in increasing vaccination uptake I think we do need to be cautious about this. Firstly, it is inherently difficult to attribute intention and action to interventions that seek to improve understanding, secondly there has been a lot of progress made in how intervention beneficiaries are involved in the development of interventions, which may increase the effectiveness of future education interventions. Finally, we have responsibility for ensuring that people understand the benefits and potential risks associated with immunisation hence we need to continue improving how this information is shared with staff and the public.	Thank you for your comments. Although the evidence for individual studies and age groups did not strongly favour the use of education, the committee agreed with your comments about the importance of people being providing with information on the benefits and risks of vaccination to enable them to make informed decisions. For this reason, they used their experience and the qualitative evidence from the barriers and facilitators review to make recommendations in the section on initial invitations on how and when to provide this information. Due to the limited effectiveness of these interventions, the committee mostly recommended information-based rather than education-based interventions as these are less resource and cost-intensive. The importance of providing this information is included in the recommendations, such as using relevant literature to support discussions in appointments, providing links to trusted information in vaccine invitations and providing

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					information and education to children, young people and their parents or carers for school aged vaccinations. Further information on the decisions behind these recommendations is provided in the committee discussion section of the education evidence review E.
London School of Hygiene and Tropical Medicine (LSHTM)	General	General	General	A summary table with strength of evidence for the range of interventions (education, call recall, …) might help the reader and be a good way of communicating key findings and recommendations.	Thank you for your comments. Each evidence review includes a summary of the evidence table. This provides a summary of the results for a particular intervention type (such as reminders), , and includes the number of studies and participants for each outcome as well as the quality of each outcome. We do not produce summary tables that span reviews. Instead, the rationales in the guideline are intended to give the reader an idea of the strength of the evidence.
London School of Hygiene and Tropical Medicine (LSHTM)	General	General	General	There is no reference to the potential to using Opt-out for consent on school vaccinations, though there have been some trials/evaluation in the UK (e.g. Leicestershire Partnership NHS Trust Year 9 – Teenage Booster and Men ACWY Opt out Pilot Service Evaluation). It would be good to recommend the need for further research on this subject.	Thank you for your comments. The committee discussed school aged research recommendations, but they decided that research should be prioritised to address the research gaps they had already identified, such as HPV vaccination for boys, school vs GP catch up campaigns and incentives for school-aged vaccinations. They therefore declined to make this additional research recommendation .
London School of Hygiene and Tropical Medicine (LSHTM)	Guideline	006	002	The implication from the current structure and wording of recommendations 1.1.7 and 1.1.8 is that, while needs and barriers of the local population should always be identified (recommendation 1.1.7), that the introduction of targeted interventions should be considered only in areas of low vaccine uptake (recommendation 1.1.8). Perhaps these recommendations would benefit from re-structuring and wording. Usually, you identify low uptake	Thank you for your comments. The committee have combined the two recommendations. The new recommendation includes the need for NHS commissioners and providers to identify local population needs, barriers to vaccine uptake and areas or populations with low vaccine uptake. This should ensure that commissioners and providers identify the needs of the whole local area, identify barriers to vaccination for that area and then focus specifically on the areas which have low uptake to

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				and then potential causes and solutions, rather than the other way around (as currently inferred by the recommendations). For instance: 1.1.7 NHS commissioners and providers should ensure that they identify areas or populations with low vaccine uptake. 1.1.8 In areas or populations with low vaccine uptake, commissioners and providers should ensure that they identify local population needs and barriers to vaccine uptake and consider targeted interventions which: • overcome these local barriers to vaccination address identified inequalities in vaccine uptake between different population groups.	determine which populations would benefit the most from interventions to increase uptake.
London School of Hygiene and Tropical Medicine (LSHTM)	Guideline	006	002	Recommendation 1.1.7 lacks specificity. It asks NHS commissioners and providers to identify local population needs and barriers but gives no further details on how this could be achieved. This is likely to hinder the implementation of the recommendation. Furthermore, if individuals are uncertain of how to identify needs/barriers this has knock on implications for the development of appropriate interventions as per recommendation 1.1.8. Notably, in Evidence Review D it states that this process 'would likely' be guided by population health data and a health needs assessment, with input from the local	Thank you for your comments. The committee decided to provide additional information about identifying local population needs and barriers to vaccination. An additional sentence has been added to the recommendation to indicate that local needs and priorities should be identified using data from the Joint Strategic Needs Assessment. This should include input from service users and local communities to provide a clear insight to the needs of the local population. More information is available in the rationale section of the guideline.

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				community. Perhaps these additional details could form part of the recommendation. While input from the local community is detailed in recommendation 1.1.9 this is central in identification of population needs and barriers and hence may be better situated as a subcomponent of the recommendation regarding needs identification and intervention.	
London School of Hygiene and Tropical Medicine (LSHTM)	Guideline	006	009	1.1.9 It would be good to add more detail about how (include links to other documents e.g. the WHO TIP guide) to conduct operational research that increases awareness of barriers to immunisation and helps design tailored services.	Thank you for your comments. The committee was aware of the WHO TIP approach but as there is limited evidence of its effectiveness for vaccination uptake in the UK they decided against referring directly to it in the recommendations, Instead they designed a research recommendation aimed at examining the effectiveness of the use of the TIP approach to increase vaccine uptake in the UK.
Meningitis Now	Guideline	General	General	We are pleased to see that the guideline addresses many of the priorities and practical issues that are likely to increase vaccine uptake including integrating and sharing record keeping systems. Named vaccination leads, people's awareness of vaccination status, accessibility of services, reminders and invitations and community engagement. We think the latter is pivotal when it comes to improving vaccine uptake in harder to reach groups e.g. gypsy and traveller communities.	Thank you for your comments and support for this guideline.
Meningitis Now	Guideline	General	General	We note that there is little mention of campaigns and awareness raising in relation to promoting vaccine uptake, however, appreciate this may lay outside the scope for this guideline.	Thank you for your comments. The committee reviewed the evidence for education and information about vaccination as a means of increasing vaccine uptake however, this

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					clearly showed that these interventions had a limited effect at increasing uptake Despite this, the committee thought it was important to provide people with information about vaccinations so they can make informed decisions. For this reason, they used their experience and the qualitative evidence from the barriers and facilitators review to make recommendations on how and when to provide this information. Due to the limited effectiveness of these interventions, the committee mostly recommended information-based rather than education-based interventions as these are less resource and cost-intensive.
Meningitis Now	Guideline	008	005	We agree that other practitioners, who do not administer vaccines, are educated about vaccines. Does this include GP receptionists? If not, we would like them to be mentioned in this list. Some of the people we speak to have been given incorrect information about eligibility when trying to book appointments at their GP surgery. This has either prevented or delayed them getting a vaccine e.g. MenACWY vaccine for those have missed this at school but remain eligible until their 25th birthday.	Thank you for your comments. The training for other practitioners does include GP receptionists. This is covered in more detail in the training and education section of the rationale in the guideline, which explains that both staff in GP practices and those who work in social care would benefit from this type of training.
Meningitis Now	Guideline	010	009	We agree that keeping records up to date is vital. Many parents and adolescents we speak to are uncertain of their MenACWY vaccine status and not always able to obtain this information from their GP surgery.	Thank you for your comments and support for this guideline.

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Ministry of Defence - Defence Public Health Network	Guideline	002	Box	We would like to add UK and overseas Defence Medical Services providers and commissioners to the list "Who is it for?"	Thank you for your comment. The committee have added this group to the list as requested.
Ministry of Defence - Defence Public Health Network	Guideline	006	014	Recommendation 1.1.9 and 1.1.10 could be challenging in practice. -The makeup of the local community served by DMS/DPHC facilities is highly mobile and therefore local needs may change regularly. - Where a DPHC facility provides families care there may be limited trained staff to give childhood immunisations, especially outside of the immunisation clinic or outside usual opening hours (also recommendation 1.1.11). - Where alternative community locations are considered, particularly overseas, issues pertaining to security for uniformed personnel and their families and commissioning arrangements between DMS and local providers may have additional complexities. - Provision of a convenient location may also be challenging in practice as the number of sites that provide DMS care is limited and some Service Personnel may travel some distance to their nearest medical facility. Should this be mentioned, or less so as only likely to impact service personnel as families practices tend to be very close to those who are eligible to register there.	Thank you for your comments. This guideline is aimed at the NHS in general, and the issues for DMS commissioners are likely to only impact service personnel. DMS commissioners will therefore need to decide how these recommendations can be best implemented to address the specific set of challenges that are faced by people in the military.

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Ministry of Defence - Defence Public Health Network	Guideline	007	004	This could be challenging in practice if DMS commissioners at a national level need to link with providers at every regional/local level.	Thank you for your comments. This guideline is aimed at the NHS in general, and the issues for DMS commissioners are likely to only impact service personnel. DMS commissioners will therefore need to decide how these recommendations can be best implemented to address the specific set of challenges that are faced by people in the military.
Ministry of Defence - Defence Public Health Network	Guideline	007	017	Whilst we agree that reviewing lessons learnt through audit and evaluation from initiatives to improve uptake of routine and COVID-19 vaccinations is vital, it is important to note that the barriers to uptake of any vaccine during the pandemic and specifically of COVID-19 vaccine may have been different to the barriers seen for other vaccines and at different times. The lessons from COVID-19 and routine vaccination in this pandemic period are not necessarily transferrable for all cause vaccine hesitancy and this should be noted as a footnote.	Thank you for your comment. The committee recognise that not all interventions and lessons learned from COVID-19 will be transferrable. For this reason, the second part of the recommendation suggests that providers should identify any that could be used to increase the uptake of routine vaccination programmes, rather than applying all interventions to routine vaccination programmes.
Ministry of Defence - Defence Public Health Network	Guideline	008	006	We agree with this recommendation, but why for dental practices is the recommendation limited to only NHS practices, could DMS and potentially private dental practices be included?	Thank you for your comments. It may also be helpful for practitioners in dental practices not providing NHS services to be provided with education about vaccination. NICE cannot make specific recommendations for dental practitioners that do not provide NHS services, but this recommendation has been rephrased as dental services. This means that people who work in dental practices not providing NHS services could also be considered for education about vaccinations if providers considered this to be helpful.
Ministry of Defence - Defence	Guideline	010	007	The link advices that GPs should "offer … access to online systems or apps to allow them to view and check their NHS vaccination records". This recommendation	Thank you for your comments. This guideline is aimed at the NHS in general, and compatibility between DMS and NHS records are a specific issue that may need to be

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Public Health Network				may be challenging if DMS records (historical and current) are not compatible with the software/app used for NHS vaccination records and therefore information viewed is inaccurate. These challenges may also apply to recommendations 1.2.7-1.2.9	addressed by DMS commissioners. There is also a new recommendation in section 1.2 on identifying eligibility, giving vaccinations and recording vaccination status. This highlights the importance of ensuring that compatible systems or processes are in place so that vaccination records can be shared effectively and in a timely way between different parts of the health and care system. This may provide an opportunity for DMS records to be linked with those used by the NHS.
Ministry of Defence - Defence Public Health Network	Guideline	011	017	We agree with this list, but it could also include on admission to further and higher education including military establishments. It could be considered that this is covered by on registration with a new GP?	Thank you for your comments. The committee were aware that there are many different ways that people can be identified as eligible for vaccination. They therefore decided to make a list of some of the possible ways in which people can be identified, but this does not exclude other methods not included in the examples. The committee agree that in many cases your examples could be covered by registration with a new GP.
Ministry of Defence - Defence Public Health Network	Guideline	015	008	We agree with this recommendation, commissioning teams should also ensure that transient populations including service family children, are included in that system and that there is coordination between the systems in different NHS regions and with DMS overseas systems.	Thank you for your comments. This committee thought that it was important that vaccination information can be shared between different providers and settings. They therefore made a new recommendation about the coordination of reporting systems and the importance of ensuring that compatible systems or processes are in place to enable the effective and timely transfer and sharing of vaccination records between different parts of the health and care system. This should help where there are transient populations where healthcare may take place in different locations and settings.
Ministry of Defence - Defence	Guideline	021	025	Is there any guidance on who should fund the prize and what types of prizes could/should be offered. From a Public Health perspective, it could be reputationally	Thank you for your comments. The committee have not made recommendations on who should fund the prizes. There was no evidence on the best type of incentive and

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Public Health Network				damaging to offer a prize that counteracts another Public Health campaign, i.e. on healthy eating.	the committee thought that the most acceptable and effective incentive is likely to vary depending on the local population. They therefore decided to leave this decision up to local providers. They also developed a research recommendation aimed at determining what the most effective incentive may be so that more specific recommendations can be made in future guideline updates.
Ministry of Defence – Defence Public Health Network	Guideline	010	019	This could be a challenge for children of service personnel (and other transient members of the population) who move frequently between DMS and NHS practices and between Local Authority CHIS. Where data is not transferred between CHIS, recalls for already received vaccinations can create frustration and a barrier to further engagement on vaccination as there is lack of clarify of what has been received and hasn't. This is a frequently cited frustration in the Army Parents Network. The challenge of linkage of information between DMS and CHIS providers would also be flagged under recommendation 1.2.19.	Thank you for your comments. This guideline is aimed at the NHS in general, and compatibility between DMS and NHS records are a specific issue that may need to be addressed by DMS commissioners. As for the previous comment on compatibility of systems, the new recommendation about ensuring that systems used by different parts of the health and care system are compatible, or that there are compatible processes, may provide an opportunity for DMS records to be linked with those used by the NHS.
Ministry of Defence – Defence Public Health Network	Guideline	019	015	We agree with the recommendation but would recommend it is made clearer whose responsibility it is to contact with the individual who does not respond to the reminder. In the case of DMS maternity care, Maternity care may be provided by the hospital and an NHS GP, but all other care a DMS GP. Source – maternity passport. This is because not all military practices have a midwife service and so dual registration is required.	Thank you for your comments. The roles of the vaccination lead would include determining who should contact people who do not respond to reminders. This is covered in the named vaccination leads section of the guideline.

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MSD	Guideline	General	General	MSD is very impressed with the high-quality draft guidelines and evidence review pack. The key areas we would like to see change and as a company are committed to support are: - Increase vaccination rates across all ages and addressing barriers - Digital data connectivity that would support capturing missed opportunities/people - Ensure high quality data that could be achieved with guidance and auditing We would like to encourage the use of the NHS patient screening digital tool to help to reduce time and resource impact to highlight a potential name for vaccination within a practice. Hepatitis C elimination work provided lots of positive learnings including but not limited to prison interventions and people who has first-hand experience.	Thank you for your comments. The committee agreed that it is important to increase vaccine uptake across all age groups and recognised a key barrier to this the lack of digital data connectivity. In response to stakeholder comments the committee added a recommendation to try to ensure that compatible systems are in place to enable the effective and timely transfer and sharing of vaccination records between different parts of the health and care system. If implemented this would help to facilitate the accurate and timely update of vaccination records across different providers and make it easier to identify eligible people. However, the committee recognised that developing and implementing a compatible system could be time consuming and costly and that it may be more effective, at least in the short term, to develop compatible processes to facilitate information transfer. The committee also agreed about the importance of ensuring that records are accurate, complete and up to date and made a series of recommendations to address these issues. The committee recommended a number of ways that people could be identified as eligible for vaccination, including the use of electronic patient records, patient hand-held records and different settings for opportunistic identification. However, there was no evidence on the use of specific screening tools like the one you suggest to systematically identify eligible people for vaccination and so the committee did not make a recommendation for this.

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					However, this would not prevent such a tool being used at the practice level if it proved useful. Hepatitis C screening and vaccination is not part of the routine schedule and the committee therefore did not review the evidence for this programme.
MSD	Guideline	004	008	This point could benefit from including a recommendation of within a timeframe, a week, month of becoming eligible. The process could be automated by the IT providers. A good example of the automation process is a software developed for the hepatitis C. Further information on this tool is summarised in the comment number 19 (referring to the page 11 lines 4-5 in the guideline).	Thank you for your comments. Information about timescales for reporting different vaccinations is included in section 1.2 on keeping records up to date. The recommendation you refer to covers having named leads for different process to do with vaccination, but not how these processes are carried out. The committee agreed that it is important that vaccination information can be shared between different providers and settings. They therefore made a new recommendation to try to ensure that compatible systems are in place to enable the effective and timely transfer and sharing of vaccination records between different parts of the health and care system. if implemented this would help to facilitate the accurate and timely update of vaccination records across different providers and make it easier to identify eligible people. This could also facilitate the implementation of the automated systems of data transfer you mention. However, the committee recognised that developing and implementing a compatible system could be time consuming and costly and that it may be more effective, at least in the short term, to develop compatible processes to facilitate information transfer.
MSD	Guideline	004	011 - 012	In line with this and Section 1.2.3 states that GPs should update their records monthly against records received,	Thank you for your comments. The committee discussed your suggestion but noted that the named vaccination

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				could there be a requirement to link the Vaccination Lead to the local School Age Immunisation Service (SAIS) providers so that there is a link and standardized approach between all SAIS providers and GP practices in their areas? This would ensure the consistency and quality of the data and reporting and ensure that GP practices are aware of any individual who has missed vaccinations from the school's programme and are able to provide it through primary care which is of particular importance with the backlog from Covid-19. Suggestion to mention a frequency at which these tasks are done (i.e., regular/monthly invitations and reminders are sent).	leads cover all organisations that commission, provide or organise vaccination services and this would therefore already cover local School Age Immunisation Services which would be expected to have their own named lead. In addition, the recommendation already mentions one responsibility of the named lead as being ensuring that there is coordination between providers and other services involved in organising vaccinations. In response to your comment and other stakeholders the committee have added 'reporting' to this point. Recommendations in other sections cover the processes for ensuring that records are up to date and that data is transferred between providers. These recommendations include times and frequencies as you suggest. The committee were aware that there is an issue with the consistency of reporting and the transfer of records between different providers. This lack of integrated record keeping makes coordination between different parts of the health system more difficult. They therefore made a new recommendation to try to ensure that compatible systems are in place to enable the effective and timely transfer and sharing of vaccination records between different parts of the health and care system. If implemented this would help to facilitate the accurate and timely update of vaccination records across different providers and make it easier to identify eligible people. However, the committee recognised that developing and implementing a compatible system could be time consuming and costly and that it may

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					be more effective, at least in the short term, to develop compatible processes to facilitate information transfer. In addition, the recommendations already covered catch ups sessions within schools for children and young people who miss their school aged vaccinations, but the committee have added a new recommendation to cover situations where children and young people are not up to date with any vaccinations that are not part of the school-aged programme. In this case their parents should be directed to their GP to carry out the overdue vaccinations.
MSD	Guideline	005	003 - 004	Follow-up mechanism to check and support a person: suggestion to have a feedback mechanism where a secondary or tertiary care provider has recommended a vaccination for a patient to confirm that they have received the vaccine or not. Ensuring that agreed pathways are in place would make it easier to follow and achieve the desired outcome.	Thank you for your comments. The committee decided against including a specific recommendation for follow-up after people have been signposted to vaccination services from secondary or tertiary care providers. Instead, they have added a recommendation that compatible systems or processes should be in place to ensure that updates to vaccination records can be transferred between different healthcare providers accurately and in a timely manner. This means that it should be easier for other healthcare providers, including secondary or tertiary care providers, to track whether someone has been vaccinated following signposting to other services.
MSD	Guideline	005	014	If incentives will be applied to improving vaccination uptake, could commissioners ensure incentives apply to all vaccination programmes to avoid variation in uptake across the vaccination schedule. The guideline does discuss that this might not be a feasible approach and the practices will have to manage their vaccination activities. The suggested approach may lead to deprioritizing the non-incentivized vaccination	Thank you for your comments. The committee were aware that incentives for some vaccination schemes can sometimes have a detrimental impact on other vaccinations. For this reason, they included a recommendation to take into account that using incentives to prioritise certain vaccinations could have unintended consequences on the uptake of other vaccinations when designing incentive schemes for providers. This is intended

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				programmes. Considering the impact of Covid-19 on specific immunisation programmes, could incentives be aligned to programmes facing the lowest coverage rates and backlogs.	to raise commissioners' awareness of the potential impact of incentives schemes. More information about this can be seen in the rationale section of the guideline. The committee were unable to recommend specific incentives or targets for these incentives as this is beyond the scope of their remit. However, where such incentives already exist, such as the quality outcomes framework payments the committee agreed that it is important that providers are aware of them, especially if they are new or short-term payments, so they can take advantage of them.
MSD	Guideline	006	001	This guideline should provide a bit more information and guidance on how to achieve this. Some good ideas are provided in the table in the Burgess at al 2021 article which could help providers understand how to achieve this more clearly. Ref: 1. Burgess, R.A., et al., The COVID-19 vaccines rush: participatory community engagement matters more than ever. The Lancet, 2021. 397(10268): p. 8-10.	Thank you for your comments. The Burgess et al 2021 article was not included in the evidence base for this guideline as the design did not meet the inclusion criteria for any of the reviews. However, many of the themes that are covered in the article are similar to those discussed by the committee when considering the importance of determining local needs. Taking your comment into account the committee decided to provide additional information about identifying local population needs and barriers to vaccination. An additional sentence has been added to this recommendation to cover the use of data from the Joint Strategic Needs Assessment (JSNA) and other data sources to help identify local needs and priorities. This should include input from service users and local communities to provide a clear insight to the needs of the local population. This importance of involving people in the local community is also covered by another recommendation in this section in relation to the barriers they face to vaccine uptake and making services

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					accessible. More information is available in the rationale section of the guideline.
MSD	Guideline	006	007 - 008	NHS commissioners should leverage work undertaken by local authorities to address inequalities in immunisation uptake. Lessons can be learned and adapted from engagement efforts during COVID. Here are few post-Covid examples, more details can be shared if needed: • Gained agreement with NHSEL and PHE to restart awareness of Shingles NIP. • Project with NHSEL and PHE to gain an understanding of immunisations in the BAME community. Project included Ashfield feedback and 4 London CCGs. Information helped inform the London recommendations to strengthen the Shingle Programme in London. • Supported the update of the London Shingles toolkit. Letter also sent to every London Practice encouraging uptake of programme. Both contained links to MSD assets. Health care practitioners (HCP's) would benefit from a training in 'community engagement' conversations with their patients to enable this. This is what was observed to be lacking across various practices. Should this be called out in the guideline – the industry could support with a training. MSD supported Irish HCPs with trainings materials to overcome the HPV VCR decline. In the London BAME project, there was a lack of data on ethnicity captured at a practice level record system. This	Thank you for your comments. The committee also thought that there are things from COVID-19 vaccination programmes that can be beneficial for routine vaccination programmes. There was not sufficient evidence from the COVID-19 evidence review to make specific recommendations on what this should be. However, the committee decided to make a recommendation about evaluating initiatives from COVID-19 programmes and identifying whether any of these could be applied to routine vaccination programmes to increase uptake. The committee also made recommendations on training and education for healthcare practitioners. This includes the ability to have effective and sensitive conversations, which should help with community engagement and addressing vaccination concerns. We do not have the evidence to indicate whether a lack of ethnicity data is a common issue on practice records. However, there is a recommendation which highlights population groups that are known to have low vaccine uptake, and this includes people from some ethnic minority groups. This should highlight to commissioners and providers the importance of considering this group when planning interventions to increase vaccine uptake.

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				could be called out under the named vaccination lead responsibility. Ref: Commission on Race and Ethnic Disparities – Commission on Race and Ethnic Disparities: The Report – March 2021 (publishing.service.gov.uk) Sherman, S.M., et al., A survey of knowledge, attitudes and awareness of the human papillomavirus among healthcare professionals across the UK. Eur J Public Health, 2020. 30(1): p. 10-16. DOI: 10.1093/eurpub/ckz113	
MSD	Guideline	006	009	Commissioners should hold providers to account to agreed national SLAs and operating standards including accurate record keeping and patient data transfer.	Thank you for your comments. The committee thought that this is something that commissioners should already be doing and therefore did not need a specific recommendation. They also thought that there is information about quality of services, and how to improve them, throughout the guideline. They therefore decided against making this type of recommendation.
MSD	Guideline	006	019 - 022	A great example on how to support this recommendation - MSD and other organizations have been doing community outreach as part of our Hepatitis C POC testing in communities (hep C Elimination) and how effective this is to reach people. Mobile outreach has been hugely successful in reaching underserved and marginalised populations. Where we have had the most success, there have been people with lived in experience supporting HCPs with client engagement (ex PWIDs/ homeless/ prisoners) either	Thank you for your comments. The committee agree that in some areas mobile outreach may prove to be an effective method of increasing vaccine uptake. However, the committee thought that the most effective interventions are likely to vary between areas and there was not sufficient evidence on outreach programmes to recommend them as a general intervention. Instead, the committee recommended that the needs of local communities are identified, and interventions are designed based on local needs and barriers to vaccination. This could include versions of outreach programmes.

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				through the Hep-C Trust peer programme, or via local peers/mentors. Also, it would be good to include some examples of how the fragmented system means people are often sent to different services for vaccines vs where they are managed (for example - this is a key issue in HIV whereby on diagnosis, people are recommended to have a series of vaccinations, however, the majority of HIV clinics are no longer funded to do this work - so patients have to travel to a GP who they may not have disclosed their HIV to - in order to get their vaccines. However, the vaccines uptake in people living with HIV is not audited or data is not published. This recommendation and related activities have a high need to be better managed / coordinated centrally. Ref: BHIVA guidelines: https://www.bhiva.org/vaccination-guidelines Some vaccinations for people with HIV may be available from the HIV clinic, but for others will require the GP. In some cases, people may need to have disclosed their HIV status to the GP to be eligible for free vaccination. Ref: https://www.aidsmap.com/about-hiv/what-vaccinations-are-recommended-people-hiv It will also be important to assess the feasibility of providing vaccines in different settings and by different healthcare professionals. In addition to the note above regarding the commissioning differences that exist, the current system for routine vaccinations uses several different data systems that are not connected. The	The committee thought it is important for there to be more coordination between the records used by different providers and have added a recommendation to reflect this. This should help to manage vaccinations when a person has to receive vaccinations from different providers, or if different settings are to be used to provide vaccinations. This should ensure the accurate and timely update of vaccination records, more similar to that used for the reporting of COVID-19 vaccinations.

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				Committee should consider how the system can adopt a similar approach to Covid-19 vaccination where a single system (PINNACLE) allows for all vaccinations to be recorded and stored on a single data system no matter where you receive your vaccine.	
MSD	Guideline	007	010 - 014	Could the providers be required to conduct an annual audit for every national immunisation programme? The Immunisation programme coverage reports are published annually but are often delayed. Ensuring the Immunisation dashboards are kept up to date and standardized i.e., learnings from Covid-19 activities. More timely summaries or real time data would provide more up to date information to the involved parties and public. This would help to evaluate the effectiveness of interventions, activities, and plan further steps to improve uptake and address inequalities in delivery.	Thank you for your comments. The evidence for audits was inconclusive and so the committee did not make recommendations for annual audits of all immunisation programmes. They did recommend the use of quarterly audits for providers to monitor their own activity and there was a recommendation about evaluating COVID-19 initiatives. If an annual audit for COVID-19 was shown to be successful, then this is something that could be applied to routine vaccination programmes. Currently real-time data for vaccination programmes would be labour and time-intensive and so the committee did not consider this to be a realistic target at this time.
MSD	Guideline	008	001 - 003	It is important to point here about ensuring the practitioner is CONFIDENT in discussing concerns, we hear it time and time again that someone may be trained but that does not mean they are confident. Especially it is important when speaking with someone who is vaccine hesitant.	Thank you for your comments. The committee thought that the key aspects of education are covered in the recommendation. They decided against specifying the need for confidence as this is difficult to evaluate.
MSD	Guideline	008	005 - 006	Could they be more explicit here and add that in addition, all practice staff need some vaccination training as well. Previously the SIT teams have conducted an "assurance audit" to check that practices had procured enough Flu vaccines for their eligible patients. Could they be required to conduct an audit for every national immunisation programme? This way ensuring that they	Thank you for your comments. Education for practice staff is included within the training recommendations in section 1.1. The recommendations in the audit and feedback section are aimed at highlighting the importance of completing regular audits and reviewing vaccination activity for all routine vaccinations. This should help to ensure that all vaccination programmes are reviewed and assessed regularly.

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				would have to review the details of all vaccination programmes.	
MSD	Guideline	008	013	Practice staff as well and Practice Nurses and GPs need to have an annual update to help them keep up with the changing recommendations for each vaccination programme.	Thank you for your comments. The committee discussed this and decided that it was important to highlight that education should be ongoing so that all staff are aware of changes in policy. This has now been added to the recommendation.
MSD	Guideline	008	020	This could go further and focus more on 'community engagement', so go a level deeper than just barriers and benefits and risk which does little the change behaviour – how do they engage with positive stories around vaccination as well.	Thank you for your comments. This recommendation is aimed at people who are in contact with people who are eligible for vaccination but who do not administer vaccines, such as GP receptionists or people who work in social care. The committee did not think it was necessary for these people to have an in-depth knowledge of vaccination, such as methods of community engagement. Instead, by knowing where to signpost people for further information, they will be able to direct people to healthcare practitioners who will have a more detailed knowledge of issues relating to vaccinations.
MSD	Guideline	009	013	It might be worthwhile having standardised /universal myth busters which practitioners can share with patient.	Thank you for your comments. The committee thought that it is important that practitioners can answer people's questions and concerns about vaccination, or signpost them to relevant sources of information. This should include the ability to highlight when someone's concerns are based on misinformation and either provide them with correct information or direct them to reliable sources of information.
MSD	Guideline	009	014	Suggestion to add "Be confident to offer...".	Thank you for your comments. The committee thought that the key aspects of education are covered in the recommendation. They decided against specifying the need for confidence as this is difficult to evaluate.

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MSD	Guideline	009	016 – 017	There has always been a long debate amongst Practice Nurses about how much time they are given for vaccination appointments and travel health appointments including vaccinations for travel abroad. We suggest considering advocating a minimum standard of the time required for each appointment depending on the type of vaccination appointment being scheduled. Another point to take into consideration is available vaccination time. Working parents prefer evening and weekend appointments for vaccination and other health care matters. NHS commissioners and providers to review evening/weekend appointment options to help boost vaccine uptake.	Thank you for your comments. The committee considered appointment length but decided that they could not recommend what this should be. The research questions in this review did not look at appointment times and so the committee did not have any evidence on which to make a recommendation on appointment length. The committee also discussed the need for alternative times for appointments to make them more accessible for some people, such as in the evening and at weekends. A recommendation about the importance of tailoring vaccination service times to meet local needs was therefore included in the guideline.
MSD	Guideline	010	016	This is important to transfer the vaccination records of those that have received a vaccine in another setting such as from the School Age Immunisation Service providers.	Thank you for your comments.
MSD	Guideline	010	020	School Age Immunisation Providers are required to share the details of vaccines given with their local Child Health System within 2 days of administration as per the Service Specification. However, notification to GPs is not specified. Does the CHIS notification to GPs time requirement need to be included in this guideline? Could there be a requirement for this data transfer process be audited by the NHS Commissioners on a regular 6 to 12 months basis?	Thank you for your comments. There is a recommendation in this section (1.2 – recording vaccination offers and administration) which highlights that CHIS should send GPs details of vaccinations to vaccination records within 2 weeks or as specified in the CHIS contract if this is shorter.
MSD	Guideline	011	004 - 005	The provided list of opportunities is appreciated but should not be limited to it. The guideline should allow other HCPs to identify the population at risk. The NIP and guidance around it must be disseminated to all	Thank you for your comments. This recommendation provides a list of examples of opportunities to identify people who are eligible for vaccination. However, the list is

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				specialities that may have at risk individuals not just primary care and paediatrics – so the Royal colleges will need to be included and the HSA has a role to play here. There is a PSI (Patient Search Identification) tool - as referenced page 8 of the report referenced below - which is a software tool for GPs has been developed as part of the NHS England and NHS Improvement deal with industry and which is currently been piloted. This allows GP practices to search through their records for people who have READ codes indicating past infection with hepatitis C (people who were diagnosed many years ago many have not been offered treatment), and other risk factors. The people identified can then be contacted by their GP and offered a test. Software like this could be explored to find patients who may have missed vaccinations they are eligible for Ref: Routemap to eliminating hepatitis C in London: The Opportunity Supporting reference of how to utilise existing GP clinical systems for proactive case-finding to identify eligible cohorts is below. Ref: Setting up a vaccination programme for immunocompromised patients	not intended to be exhaustive and so other opportunities can also be used for opportunistic identification. Although search tools may be a useful way of identifying people who should be invited for vaccinations, these are not a method of opportunistic identification. For this reason, they have not been included in the opportunistic identification recommendations.
MSD	Guideline	011	006	While engaging with the outlines groups proactively ask around ethnicity to support at risk populations	Thank you for your comments. As this is an example of opportunistic identification, people should be offered vaccination if identified as eligible. The information that must be included at patient registration in general practice is out of scope for this guideline.

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MSD	Guideline	011	012	The NHS recommends the hepatitis B vaccine for anyone with multiple sexual partners, particularly men who have sex with men and sex workers. The hepatitis A and HPV vaccines are recommended for men who have sex who have multiple sexual partners. People living with HIV, people who inject drugs, people travelling to countries where the viruses are often found, and people whose work could bring them into contact with an infection are also recommended to get vaccinated. BHIVA Guidelines (2018) recommend Hep B vaccination - where eligible - should be offered before starting prEP. Some areas are also including offer of a HPV vaccination at this early prEP screening stage. The Green book also recommends Hepatitis A and HPV vaccine for MSMs and high-risk individuals. A flag from Hep-C elimination experience - D&A services have a lot of targets to hit and are rightly focused on the addiction elements - how do you keep this high on their agenda? Ref: NHS Vaccination webpage NHS Hepatitis B vaccine overview https://www.bhiva.org/file/5b729cd592060/2018-PrEP-Guidelines.pdf page 66	Thank you for your comments. This guideline is for routine vaccinations and hepatitis A and B and HPV vaccinations for adults are not part of the routine vaccination schedule. These vaccines are therefore beyond the scope of this guideline.
MSD	Guideline	012	001	The prisons have a '2nd reception', this space may be the most appropriate time and place for these conversations. The first reception is too chaotic with	Thank you for your comments. The committee thought it was important to highlight that people in prisons and young offenders institutions should be identified for vaccination.

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				other priorities, and prisoners often feeling anxious having come from police custody.	As this is provided as an example of one setting where opportunistic vaccination would be useful, they did not go into detail about how or where this should take place as this could vary between settings.
MSD	Guideline	014	002 - 003	If the vaccination was declined, then it could be helpful to know why it was declined, what was discussed (exception, hesitant or against). This information will help to facilitate further steps including how to approach this conversation next time. We suggest considering what is going to happen after the decline? Any follow up? Any flags in the system to have that conversation during next appointment?	Thank you for your comments. There is a recommendation in section 1.3 on reminders and escalation of contact that indicates that if a reason for declining vaccination is given, then this should be recorded. The committee did not recommend further actions as this may vary between people, as some will not want to be asked about vaccination again,
MSD	Guideline	014	019	When and how this will be ensured? Further recommendations and guidance will be required on how can a practice receive this info by phone or secure email from the patient? How easy is to transfer data from one provider/centre to another?	Thank you for your comments. The committee did not specify how this should happen as it may depend on where the person received their vaccination. However, the committee has made a new recommendation about the coordination of reporting systems which says that compatible systems or processes should be in place to enable the effective and timely transfer and sharing of vaccination records between different parts of the health and care system. This should help with the transfer of data between providers and centres.
MSD	Guideline	014	020 - 022	It is important that data is aligned and updated across multiple platforms that are in use. We suggest to consider to recommend a way an individual can take their vaccination record around with them - maybe changing the NHS COVID APP to encompass all vaccines in the NIP or a similar solution to the maternity red book. The NHS app and Covid-19 vaccination status is a great example on how data can be updated across multiple platforms. Can the NHS App be updated to	Thank you for your comments. The committee thought that it was important for people to be able to access their own vaccination records, including using online records or with an app, similar to the use of the NHS app to access COVID-19 vaccination records. For this reason, they included two recommendations in section 1.2 on identifying people eligible for vaccination which say that people should be given access to this type of information.

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				include all routine vaccinations in a new digital vaccination record card?	
MSD	Guideline	015	004 - 006	This recommendation could be a challenge from a prison perspective and a process would need to be pre-agreed locally by the GP footprint (PCN or CCG) where there is a prison within their geography. Prison SystmOne does not speak to any system outside of the prison. Transfer of data and a process to support it needs to be considered.	Thank you for your comments. The committee thought that it was important that vaccination information can be shared between different providers and settings. They therefore made a new recommendation about the coordination of reporting systems, highlighting the importance of compatible systems or processes being in place to enable the effective and timely transfer and sharing of vaccination records between different parts of the health and care system. This should help to ensure the accurate and timely update of vaccination records.
MSD	Guideline	015	008 - 010	GP clinical systems could be used more smartly to automate the identification of eligible cohorts and recall process. Further information on the potential tool is summarised in the comment number 19 (referring to the page 11 lines 4-5 in the guideline).	Thank you for your comments. The committee thought it is important that these systems are used for call-recall. However, as the evidence reviews did not include the most effective search tools for this process, the committee could not make recommendations on how this should be done.
MSD	Guideline	018	010 – 014	There are additional available resources l that would be very beneficial to add: MSD Connect, HPVWise and similar resources supported by other organizations. Ref: Information for UK member of the public (msdconnect.co.uk) Join the fight against certain HPV cancers (hpvwise.co.uk)	Thank you for your comments. The committee did not review individual resources and so could did not think they could recommend other sources of information. However, they have recommended that information should be from trusted sources of information so these could be included.
MSD	Guideline	019	027	If someone declines a vaccine and a reason is noted could this be escalated to someone else in the practice like a GP to explore why the patient has declined this vaccine and what information may lead to them consenting to have a vaccine? Same as per the	Thank you for your comments. With the stages of reminders and escalation of contact, the person who has declined vaccination should have additional opportunities to discuss the reasons that they have declined and be provided with further information to address any concerns.

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				comment number 23 (referring to the page 14 lines 2-3 in the guideline).	
MSD	Guideline	022	027	Suggestion is to provide clarification how that data is getting captured and how catch-up program setting implemented? If a vaccine was administered in a pharmacy setting to ensure that the vaccination status and relevant information are recorded.	Thank you for your comments. The committee discussed this and were confident that this information should be identified through CHIS. The guideline has recommendations about the various processes for recording and transferring vaccine uptake data so any vaccinations for children and young people in this group should be captured.
MSD	Guideline	024	015	Several organisations have conducted research and reports in this area, including understanding opportunities to improve uptake of at-risk groups. This includes the International Longevity Centre (ILC-UK) who have worked with several at-risk charities through a programme of work that can be found here: https://ilcuk.org.uk/wp-content/uploads/2021/09/ILC-REDUCING-THE-RISK-Improving-vaccine-uptake-across-at-risk-groups-in-the-UK.pdf	Thank you for your comments. These research recommendations are based on areas where the committee thought that more evidence was needed. Although there may be some evidence already available, the committee thought that more was needed for committees to be able to make strong recommendations on those areas in future.
MSD	Guideline	028	018 - 019	The ability of providers to do this is totally dependent on the quality of data in the Electronic Patient Record which as we understand is currently inadequate. For the recommendation to be effectively implemented and the increase in the uptake observed, the data connectivity, record quality and data set completeness has to be ensured and accountability for those activities taken.	Thank you for your comments. The committee thought that it was important that vaccination information can be shared between different providers and settings. They therefore made a new recommendation about the coordination of reporting systems and the importance of ensuring that compatible systems or processes are in place to enable the effective and timely transfer and sharing of vaccination records between different parts of the health and care system. This should help to improve the quality of vaccination records which should help with identification.
MSD	Guideline	029	001	Suggestion to include the word "systematic" identification here as well so that patients with an underlying condition that puts them "at risk" could be	Thank you for your comments. As opportunistic identification is meant for all people who are seen in these

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				identified systematically and then referred to their GP or provider for vaccination?	locations, the committee did not think that it needs to be specified as systematic.
MSD	Guideline	033	010	Some simple Vaccination Audit tools could be developed to help practices audit their performance in delivering the national immunisation programmes.	Thank you for your comments. The committee agreed that having vaccination audit tools would be helpful. However, as our evidence reviews , did not look at the effectiveness of specific audit tools the committee were unable to recommend one in particular and it is beyond our remit to develop such a tool ourselves. .
MSD	Guideline	034	026	Could NICE recommend something like the Healthcare Practice and Quality Improvement programmes as they have in the US supported by ACIP? Here is a link to their programmes. There is a IQIP programme for providers. These types of programmes could help address the lower performing practices. Ref: Pink book | Immunization Strategies | Epidemiology of VPDs | CDC	Thank you for your comments. The committee did not review any evidence for quality improvement programmes such as these. For this reason, they could not make recommendations on these types of programmes. However, they did make recommendations on audits and feedback that can be used for continuous improvement.
MSD	Guideline	035	025	These practice staff need to understand the eligibility criteria for all national immunisation programmes. Could there be some type of qualification such as voluntary certificate in Vaccination and Immunisation for non-clinical practice staff so that they can increase their knowledge and advocacy of vaccination programmes?	Thank you for your comments. The content of the education for people who do not administer vaccines may vary depending on who is receiving the education. The committee therefore decided against recommending specific materials, training or qualifications. Instead, they have added an additional statement to this recommendation that education should be tailored to the level and content of the individual's role, as different staff may need different levels of understanding.
MSD	Guideline	036	024	Could NICE make a recommendation for an "ideal" appointment time based on which vaccines are being given. Some Practice Nurses are expected to deliver vaccinations within too short a time period so would appreciate help in negotiating additional time to	Thank you for your comments. The committee considered appointment length but decided that they could not recommend what this should be. The research questions in this review did not look at appointment times and so the

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				complete the additional tasks expected such as like record keeping etc.	committee did not have any evidence on which to make a recommendation on appointment length.
MSD	Guideline	038	011	Could there be a recommendation for pictorial consent forms with few words but enough information to overcome any literacy challenges or language barriers?	Thank you for your comments. The committee were aware that there are a number of accessibility considerations when providing information about vaccinations. For this reason, they made recommendations in the section about invitations and reminders that state that information should be provided in a person's preferred format and take into account any literacy needs. This would include formats such as easy read materials.
MSD	Guideline	038	029	Could NICE recommend that NHS Commissioners could provide extra resources to address backlog in vaccination cohorts and record keeping to help practices make a step change to improve their future performance?	Thank you for your comments. NICE is unable to recommend additional funding be provided for these activities as funding levels are not within our remit.
MSD	Guideline	040	003	Could this word "could" be changed to "should" allowing the patient more information about their eligibility for vaccines that they have not yet received?	Thank you for your comments. This has been updated to should.
MSD	Guideline	044	023	Potentially involving their community leaders in these activities. Industry and other key stakeholders could provide some support with how to approach these situations.	Thank you for your comments. The committee thought that is important to engage with people from communities both to identify local needs and barriers to vaccination but also to develop effective local interventions aimed at increasing vaccine uptake. This is discussed in the section on making vaccination services accessible and tailoring to local needs.
MSD	Guideline	047	021	Suggestion to add "and other HPV related cancers and disease (including warts). Please consider adding this publication to support HPV vaccination impact to reduce the cervical cancer in women in their 20s who were offered the vaccine at age 12 to 13 years. Ref: Falcaro, M., et al., *The effects of the national HPV vaccination programme in England, UK, on cervical*	Thank you for your comments. This section is based on the findings from the qualitative barriers and facilitators review, which specifically mentioned people not being aware of the link between the HPV vaccination and cervical cancer.

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				cancer and grade 3 cervical intraepithelial neoplasia incidence: a register-based observational study. Lancet, 2021. **398**(10316): p. 2084-2092.	
MSD	Guideline	051	005	The reason why there are recommended to receive vaccines from an initial age is because the vaccine is more effective the sooner it is given to the newly eligible patient. Suggesting to add "However, the shingles vaccine is more effective the sooner it is given to the newly eligible patient".	Thank you for your comments. The committee did not discuss this, but were satisfied that the important information for this guideline is to highlight the more time-sensitive nature of reminders for babies and children compared to older people who are eligible for vaccination.
National Childbirth Trust	Guideline	General	General	The issue of greater levels of vaccine hesitancy and lack of trust in the service among women of Black, Asian and minority ethnic background is largely omitted in this guideline, which we feel is a major error. Whether this poor coverage results from overt racism, cultural insensitivity or problems of direct communication, there is clear need to engage more effectively with different ethnic communities to improve their maternity outcomes and help reduce inequalities.	Thank you for your comment. NICE looked for evidence for these groups during the development of the guideline and evidence for ethnic minorities was included where it was identified. However, there was a lack of evidence on what interventions are effective at increasing vaccine uptake (our primary outcome of interest) in these groups and limited qualitative evidence was identified that met the inclusion criteria for the review looking at barriers to and facilitators for vaccine uptake. The barriers identified included misinformation, a lack of information, a lack of trust in the government and other public bodies and concerns about vaccine safety and effectiveness amongst other things. (These findings are presented in evidence review B.) However, these findings were not specific to Black, Asian and Minority Ethnic

					communities but were also identified as barriers to vaccine uptake by other groups of people. The committee therefore made a series of recommendations aimed at promoting identification of local needs and barriers to uptake and then responding in a way that is tailored to address these needs and inequalities in uptake between population groups but without naming the groups of people specifically. Another recommendation covers seeking input from local people about their needs and tailoring service hours and locations to meet them. Other relevant recommendations are aimed at identifying if people have language needs or literacy issues; providing information about the vaccination process for people who come from outside the UK; providing information in in an appropriate format and language; ensuring that vaccination staff are able to engage with people's concerns about vaccination and give them tailored responses; exploring why people decline vaccinations or do not respond to invitations and trying to address any issues raised; and ensuring that there is time during consultations to have a discussion where any concerns can be identified and addressed. The committee envisaged that these recommendations would enable specific populations with low vaccine uptake to be identified at the individual or community level and provide opportunities for them to be addressed, However, in response to your comment and feedback from other stakeholders the committee have now included an information box that lists population groups which are known to have or be at risk of low vaccine uptake to highlight the importance of thinking about these groups when commissioners and providers assess local needs and tailor their services to meet them. This includes people

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					from some ethnic minority groups; people from some religious communities (for example, Orthodox Jewish communities) and people who live in an area of high deprivation amongst other groups. To try to help fill the gaps in the evidence base, the committee made research recommendation asking what the most effective and acceptable interventions are to increase uptake in populations or groups with low routine vaccine uptake in the UK. The text accompanying this research recommendation in evidence review B mentions some of the particular groups of interest. In response to your comment, the committee have added ethnic minorities to this text. In addition, the committee recognised that it is important to directly engage, and work more effectively, with people from communities most likely to be vaccine hesitant to improve their maternity and neonatal outcomes, and to reduce inequality. However, there was very limited evidence identified as part of the qualitative review for pregnant women and none that specifically looked at the barriers affecting pregnant women from the communities you mention. In addition, there were very few quantitative studies that looked at interventions to increase vaccine uptake in these groups (please see evidence review F). As a result, the committee made a research recommendation to stimulate more research in this area. In response to stakeholder comments, the committee have added pregnant women from ethnic minorities as a group of interest in the PICO for this research recommendation.

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National Childbirth Trust	Guideline	General	General	We suggest that caregivers offer a general introduction to women in early pregnancy to the taking of medication of any sort in pregnancy. This should emphasise the evidence-based policy change over recent years from a 'don't take anything' approach to 'seek advice and, if necessary, alternative treatment, but do take medicines and vaccines prescribed to benefit you and/or your baby'. Benefits for the baby should always be emphasised as often women may be focusing on possible risks without even thinking about the advantages.	Thank you for your comments. The guideline includes recommendations about pregnant women, including using antenatal visits to offer vaccination and check whether women are up to date with their vaccinations. NICE also has an antenatal care guideline (https://www.nice.org.uk/guidance/ng201) which provides recommendations on discussions about other medications during pregnancy. The committee recognised the importance of trust in overcoming vaccine hesitancy and this was also raised as a facilitator in evidence review B. The committee therefore made recommendations to ensure that invitations for vaccinations come from trusted sources, such as midwives and health visitors during routine antenatal visits.
National Childbirth Trust	Guideline	General	General	As far as is possible, vaccinations and any discussion about them should be offered within the usual routines of antenatal care and in a practice model of continuity of carer. Women's hesitancy is often linked with lack of trust or respect for providers of health advice and receiving the vaccine directly from a trusted caregiver can make the difference. In the evidence review there was high-quality evidence of this. Healthcare professionals who may play a role in talking to women about vaccinations in pregnancy should have access to easily understandable information about vaccines in order to confidently proactively initiate conversations with women.	Thank you for your comments. The committee recognised the importance of trust in overcoming vaccine hesitancy and this was also raised as a facilitator in evidence review B. The committee therefore made recommendations to ensure that invitations for vaccinations come from trusted sources, such as midwives and health visitors during routine antenatal visits. The guideline recommends that people should be able to access information about vaccinations in a format that is most suitable to them, and this will also apply to women who are being offered vaccinations during pregnancy. In addition, based on your comment and other similar ones the committee have added the use of suitable literature to facilitate discussions to the recommendation in the section about appointments and consultations.

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National Childbirth Trust	Guideline	General	General	The issue of greater levels of vaccine hesitancy and lack of trust in the service among women of Black, Asian and minority ethnic background is largely omitted in this guideline, which we feel is an error. Whether this poor coverage results from overt racism, cultural insensitivity or problems of direct communication, there is clear need to engage more effectively with different ethnic communities to improve their maternity outcomes and help reduce inequalities	Thank you for your comment. NICE looked for evidence for these groups during the development of the guideline and evidence for ethnic minorities was included where it was identified. However, there was a lack of evidence on what interventions are effective at increasing vaccine uptake (our primary outcome of interest) in these groups and limited qualitative evidence was identified that met the inclusion criteria for the review looking at barriers to and facilitators for vaccine uptake. The barriers identified included misinformation, a lack of information, a lack of trust in the government and other public bodies and concerns about vaccine safety and effectiveness amongst other things. (These findings are presented in evidence review B.) However, these findings were not specific to Black, Asian and Minority Ethnic communities but were also identified as barriers to vaccine uptake by other groups of people. The committee therefore made a series of recommendations aimed at promoting identification of local needs and barriers to uptake and then responding in a way that is tailored to address these needs and inequalities in uptake between population groups but without naming the groups of people specifically. Another recommendation covers seeking input from local people about their needs and tailoring service hours and locations to meet them. Other relevant recommendations are aimed at identifying if people have language needs or literacy issues; providing information about the vaccination process for people who come from outside the UK; providing

					information in in an appropriate format and language; ensuring that vaccination staff are able to engage with people's concerns about vaccination and give them tailored responses; exploring why people decline vaccinations or do not respond to invitations and trying to address any issues raised; and ensuring that there is time during consultations to have a discussion where any concerns can be identified and addressed. The committee envisaged that these recommendations would enable specific populations with low vaccine uptake to be identified at the individual or community level and provide opportunities for them to be addressed, However, in response to your comment and feedback from other stakeholders the committee have now included an information box that lists population groups which are known to have or be at risk of low vaccine uptake to highlight the importance of thinking about these groups when commissioners and providers assess local needs and tailor their services to meet them. This includes people from some ethnic minority groups; people from some religious communities (for example, Orthodox Jewish communities) and people who live in an area of high deprivation amongst other groups. To try to help fill the gaps in the evidence base, the committee made research recommendation asking what the most effective and acceptable interventions are to increase uptake in populations or groups with low routine vaccine uptake in the UK. The text accompanying this research recommendation in evidence review B mentions some of the particular groups of interest. In response to your comment, we have added ethnic minorities to this text.

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					In addition, the committee recognised that it is important to directly engage, and work more effectively, with people from communities most likely to be vaccine hesitant to improve their maternity and neonatal outcomes, and to reduce inequality. However, there was very limited evidence identified as part of the qualitative review for pregnant women and none that specifically looked at the barriers affecting pregnant women from the communities you mention. In addition, there were very few quantitative studies that looked at interventions to increase vaccine uptake in these groups (please see evidence review F). As a result, the committee made a research recommendation to stimulate more research in this area. In response to stakeholder comments, the committee have added pregnant women from ethnic minorities as a group of interest in the PICO for this research recommendation.
National Childbirth Trust	Guideline	001	006	'Who is it for?' As 'midwives' are mentioned specifically in the guideline text (p13 and on), we believe they should be listed among the groups in 'Who is [the guideline] for?'. (Pregnant and breastfeeding women are an important group for whom to ensure optimum vaccine uptake, and may need additional support from a midwife).	Thank you for your comments. Midwives have been added to the list of people who the guideline is for as requested.
National Childbirth Trust	Guideline	013	005	As far as is possible, vaccinations and any discussion about them should be offered by a midwife within the usual routines of antenatal care and in a practice model of continuity of carer. Women's hesitancy is often linked with lack of trust or respect for providers of health advice and receiving the vaccine directly from a trusted caregiver can make the difference. In the evidence	Thank you for your comments. Based on the evidence and their experience, the committee thought it was important to highlight the opportunity for midwives to offer vaccinations to pregnant women. However, they were aware that not all midwives would be able to administer the vaccine and therefore stated in the second part of recommendation that

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				review there was high-quality evidence of this. Healthcare professionals who may play a role in talking to women about vaccinations in pregnancy should have access to easily understandable information about vaccines in order to confidently proactively initiate conversations with women.	they could also signpost women to services where they can access vaccinations.
National Childbirth Trust	Guideline	016	012	The heading '**Vaccinations for babies, infants and preschool-aged children, and adults'** should also include 'pregnant women' as they are specifically mentioned in the 'visual summary' four lines later.	Thank you for your comments. The committee were confident that this section title also incorporates pregnant women.
National Childbirth Trust	Guideline	019	001	We suggest that midwives or other caregivers offer a general introduction to women in early pregnancy to the taking of medication of any sort in pregnancy. This should emphasise the evidence-based policy change over recent years from a 'don't take anything' approach to 'seek advice and, if necessary, alternative treatment, but do take medicines and vaccines prescribed to benefit you and/or your baby'. Benefits for the baby should always be emphasised as often women may be focusing on possible risks without even thinking about the advantages. See https://www.gov.uk/government/publications/safer-medicines-in-pregnancy-and-breastfeeding-consortium/safer-medicines-in-pregnancy-and-breastfeeding-consortium-information-strategy	Thank you for your comments. The guideline includes recommendations about pregnant women, including using antenatal visits to offer vaccination and check whether women are up to date with their vaccinations. NICE also has an antenatal care guideline which provides recommendations on discussions about other medications during pregnancy. The committee recognised the importance of trust in overcoming vaccine hesitancy and this was also raised as a facilitator in evidence review B. The committee therefore made recommendations to ensure that invitations for vaccinations come from trusted sources, such as midwives and health visitors during routine antenatal visits.
National Pharmacy Association	Guideline	003	General	Consider adding content that would consider those who would require further guidance and support in reaching their decision to be vaccinated or allow immunisation of	Thank you for your comments. The guideline already has recommendations about ensuring that healthcare practitioners are able to elicit and address concerns raised

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				their dependents. This may need to be tailored to allow for different healthcare settings.	by individuals, using tailored responses. It also includes information about considering people who have additional needs, including the need to provide information in different formats, such as easy read materials, and languages. Opportunities for discussion are covered by the recommendations on consultations, in the invitation information and during the reminders process if people remain unvaccinated. The committee envisaged that these conversations would be tailored to the needs of the individual, but they were unable to provide further guidance about how to tailor this information or about.
National Pharmacy Association	Guideline	004	011	This line may require some further detail as to the mechanisms that would be employed for effective coordination between providers, given that the pandemic has provided a wider range of healthcare settings.	Thank you for your comments. This recommendation is aimed at ensuring that there is a named lead who will make sure that certain essential processes are carried out rather than to cover in detail how they are to be carried out. Where the committee were able to provide details about how these processed should be performed they are covered in later sections of the guideline. However, the committee did not have any information about how the coordination between providers and other services involved in organising vaccinations should be carried out and this would have to be determined by commissioners and providers themselves depending on how their services are organised locally. However, to facilitate this co-ordination the committee made a new recommendation to try to ensure that compatible systems are in place to enable the effective and timely transfer and sharing of vaccination records between

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					different parts of the health and care system. if implemented this would help to facilitate the accurate and timely update of vaccination records across different providers and make it easier to identify eligible people. However, the committee recognised that developing and implementing a compatible system could be time consuming and costly and that it may be more effective, at least in the short term, to develop compatible processes to facilitate information transfer. In addition they also recommended that the named vaccination leads should have access to the relevant information and facilities they need to carry out their role.
National Pharmacy Association	Guideline	005	014	Some providers may not benefit from incentive schemes, and such schemes may lead to patient adverse behaviours. The NPA suggests further discussion/ debate on the use of incentive schemes for public health services such as vaccinations.	Thank you for your comments. The qualitative review on barriers and facilitators highlighted that some parents are not in favour of provider incentive schemes because they think this is a conflict of interest, while the quantitative evidence suggested that this can be an effective method of increasing vaccine uptake. The committee noted that some providers would be able to meet targets more easily than others due to the characteristics of their local populations. This may be discouraging for these providers as they may need to expend a lot more effort to obtain a lower vaccination rate than providers in other areas with higher baseline rates of uptake (see evidence review G for more details of the committee discussion about this topic). The committee were unable to recommend specific incentives or targets for these incentives as this is beyond the scope of their remit. However, such incentives already exist, such as the quality outcomes framework payments and the committee agreed that it is important that providers

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					are aware of them, especially if they are new or short-term payments, so they can take advantage of them. They also made a recommendation to highlight potential issues that need to be considered when incentive schemes are developed. The committee also thought that more evidence on the effectiveness and acceptability of these schemes would be useful and so they made a research recommendation to examine this.
National Pharmacy Association	Guideline	009	016	Include provision for a discussion to raise any concerns re: side-effects, not engaging with the relevant vaccination programme. Suggest the inclusion of literature (available in different languages), to support discussion for patient to be able to arrive to an informed decision.	Thank you for your comments. The opportunity to have discussions about vaccination and raise concerns has been covered through the guideline. However, the committee decided to highlight the importance of using suitable literature to facilitate discussions in vaccination appointments and added this to the recommendation. Further information about the importance of suitable literature has also been added to the rationale for this recommendation.
National Pharmacy Association	Guideline	010	009	Allow Community Pharmacy to have read/write access to patients medical records to ensure that records are comprehensive and complete at all times.	Thank you for your comments. The committee thought that it was important that vaccination information can be shared between different providers and settings. They therefore made a new recommendation about the coordination of reporting systems and the importance of ensuring that compatible systems or processes are in place so that vaccination records can be shared effectively and in a timely way between different parts of the health and care system. This includes other vaccination providers such as community pharmacies. This should help to ensure the accurate and timely update of vaccination records.
National Pharmacy Association	Guideline	011	021	Suggest removal of medicines use review, but add when people visit community pharmacies for all their healthcare needs, including the supply of their	Thank you for your comments. Based on this comment and other comments, this has now been updated to a medication review.

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				medicines, seeking advice, and through any pharmacy public health services.	
National Pharmacy Association	Guideline	012	020	Please see recent DOTW-NHS-NPA toolkit for those who have insecure NHS status. Such individuals may not have health records as they may not be registered with a GP, but would be still be vaccinated through other routes.	Thank you for your comments. This recommendation is only for people who do not have a documented vaccine history. If they have been vaccinated through other routes, and this is documented then they can continue with the routine vaccination schedule as normal.
National Pharmacy Association	Guideline	015	019	All healthcare settings be able to provide people who have come from outside the UK with details of the NHS vaccine schedule and so on.	Thank you for your comments. The committee did not specify who should provide this information so that it can be provided by a range of healthcare settings.
National Pharmacy Association	Guideline	017	029	Remove the words- if space allows. The following information is critical to vaccine compliance, and all information ought to be provided to the patient at each opportunity. Also include contact details for any further queries……	Thank you for your comments. While it would be useful to provide this information every time an invitation is sent, the committee noted that it would not always be possible, for example if the invitation is sent as a text message. This has been clarified further in the rationale section for this recommendation. The committee agreed that it is important that people can discuss their concerns and so the earlier recommendation covering what to include in the invitation also refers to providing contact details for a healthcare practitioner.
National Pharmacy Association	Guideline	019	021	Include community pharmacists. They have played a key role in encouraging patients to receive their covid-vaccination. They are the trusted healthcare professional on the high street.	Thank you for your comments. The people included in the list of people who could be part of the multidisciplinary approach are examples, but the list is not meant to be exhaustive. The recommendation says that other relevant healthcare practitioners should be involved which would include community pharmacists.
National Pharmacy Association	Guideline	020	006	Please refer to chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/viewer.html?pdfurl=https%3A%2F%2Fwww.npa.co.uk%2Fwp-	Thank you for your comments. It is not possible to open this link but as the committee did not review the effectiveness of different toolkits they were unable to make recommendations on this.

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				content%2Fuploads%2F2021%2F12%2F211207-Community-Pharmacy-Toolkit-Open-access-vaccination-clinic-.pdf&clen=2389559	
National Pharmacy Association	Guideline	026	001	Add in the role of community pharmacy within vaccination and immunisation programmes. Community Pharmacy inhabits the deprived areas of the population, and hence, buck the inverse care law i.e. they are easily accessible to the local population.	Thank you for your comments. The protocols for the research recommendations about increasing vaccine uptake include interventions relating to improving access. This would include the opportunity for vaccination within community pharmacies.
National Pharmacy Association	Guideline	031	030	It would be helpful to add in some key learns from the current Covid vaccination campaigns and deliveries, where innovative mechanisms have been adopted for a wider reach of the general population.	Thank you for your comments. The committee agreed that it is important that key learning is taken from COVID-19 vaccination campaigns, This is discussed in the audits and feedback section of the guideline.
National Pharmacy Association	Guideline	035	010	PHE is now UKHSA	Thank you for your comment. We are aware of this change but at the time of consultation it was unclear how to refer to the documents as they retained the PHE name. We have now been provided with some suitable wording and have updated this as requested.
National Pharmacy Association	Guideline	036	021	Allow sufficient time to have discussion with those who are concerned about vaccinations.	Thank you for your comments. The committee also thought that it is important to allow sufficient time for discussions about vaccinations. They therefore decided to highlight this in the recommendations.
National Pharmacy Association	Guideline	040	019	Add in the newly published Community Pharmacy toolkit that addresses the point raised.	Thank you for your comments. As the committee did not review the effectiveness of different toolkits they were unable to make recommendations on this.
National Pharmacy Association	Guideline	046	030	There are in the region of 1.6 million visits to community pharmacy daily. Therefore, we can deduce that the most of the population will have regular contact with the community pharmacist at least monthly.	Thank you for your comments. The committee thought that community pharmacy can have an important role to play in providing vaccinations in the community. Throughout the guideline this service has been named as an opportunity to

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					provide information, take part in opportunistic identification and administer vaccinations.
NHS England Screening and Immunisation Team	Guideline	General	General	Generally, there is an underestimate of cost/ impact/ effort to do the recommendations in the "How the recommendations might affect practice" sections across the guidelines.	Thank you for your comment. The committee were aware that a lot of the health services are under pressure and that there are workforce shortages, and noted that the majority of recommendations are things that should already be current practice and are aiming to reduce variation rather than create additional services.
NHS England Screening and Immunisation Team	Guideline	030	019 – 022	Rec 1.1. 5 to 1.1.6 We are concerned that it shouldn't be underestimated the variety of knowledge and therefore the time that it would take to ensure this communication is accurate and useful. It may also sit within different teams and organisations.	Thank you for your comments. Although this may take coordination of different teams and organisation the committee thought this was an important role so that all providers can benefit from the available funding streams to help increase vaccination uptake.
NHS England Screening and Immunisation Team	Guideline	034	017 – 018	Rec 1. 1. 14 to 1.1.16 How the recommendations might affect services: There may be an administrative cost associated with compiling these feedback reports, but this will be small. Comment: It is thought that the impact of the cost has been underestimated. The compilation of useful audit and feedback reports is not just an administrative role and can take considerable input from other members of the Screening and Immunisation Team.	Thank you for your comment. The committee have now altered the wording to be clear this isn't only an administrative role and that these tasks should already be within the remit of existing roles.
NHS England Screening and Immunisation Team	Guideline	037	019 - 020	Rec 1.2.1 to 1.2.5 There seems to be a recommendation missing capturing the importance of informing CHIS in a timely manner of vaccinations given and children leaving the practice. Ensuring CHIS is accurate is important for scheduling accuracy and understanding the reporting of uptake. The ability to	Thank you for your comments. There is a recommendation in the section about recording vaccination offers which includes that providers should ensure that vaccinations are reported promptly to GP practices and to CHIS. The committee decided against recommending that CHIS are

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				forward accurate information for children moving in to new areas. Once source of accurate uptake and unvaccinated population, which would be useful in the event of outbreaks allowing focused work.	informed of children leaving the practice as often this is not known until they are registered with a new practice.
NHS England Screening and Immunisation Team	Guideline	037	022 - 025	Rec 1.2.1 – 1.2.5 How recommendations might affect Practice: Keeping records up to date, How the recommendations might affect Practice – this should be incorporated with the importance of feedback immunisation records back to CHIS departments for this kind of task to be effective. For children moving in with incomplete CHIS records, this task would not be useful. Another way of ' filing gaps' would be checking of the red book where possible. As we start to encourage vaccinations to be administered in settings outside of the Practice, we must also encourage the importance of timely information sharing.	Thank you for your comments. The committee were aware that not all people will have complete records, or CHIS records for children. They therefore highlighted the importance of opportunistic identification, including the use of patient-held records to obtain a vaccination history. This would include checking the red book for children.
NHS England Screening and Immunisation Team	Guideline	054	014	Rec 1. 2 20 to 1.3. 22 Offsetting the cost of the extra work against the saving from fewer outbreaks is (sadly) very idealistic. Given the very separate funding streams, then the cost to the work with unregistered children would be a barrier – no matter how much is saved down stream	Thank you for your comment. The committee recognised that the funding streams are separate, however the benefits of reaching those unregistered people is broader than just that associated with increased vaccine uptake and preventing outbreaks, for example other healthcare needs. There is potential that this identification can be done opportunistically when the local authorities, health visitors or others are already in contact with those unregistered individuals which would reduce the additional resources required. NICE cannot make recommendations on changes to funding streams as it is out of our remit.
NHSEI	Guideline	004	009	GP contract also extends this to telephone call with clinician for those who don't respond to the call/ recall already	Thank you for your comments. As the vaccination lead role is for a range of providers, the recommendation does not include specific information about the GP contract.

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					However, the vaccination lead is not always expected to carry out the roles themselves, but to ensure that there is someone who can do this. The process of invitations and reminders is covered in more detail in later sections of the guideline (see the section on reminders and escalation of contact for vaccinations for babies, infants and preschool-aged children, and adults). In the case reminders for people who are eligible for vaccination, this could include the GP phoning someone who has not responded to previous invitations as covered by the recommendations and the GP contract. Although this is already covered by the GP contract, as you note, for some vaccinations the committee agreed that it was important to include it in recommendations to highlight that this is good practice.
NHSEI	Guideline	004	012	Presumably this is referring to access to vaccine supply which for school flu and rest of imms done by UKSHA via ImmForm	Thank you for your comments. This refers to any situation where there are different providers involved in providing the same vaccinations in various settings, such as GP practices and pharmacies for adult vaccinations or schools and GPs for school aged vaccinations. Another recommendation about vaccine supply and minimising wastage between different providers is in section 1.1 on making vaccination services accessible.
NHSEI	Guideline	004	016	1.1.3 We are concerned that this statement is too broad and non-specific, it would need further clarification/exact definition to be practicable.	Thank you for your comments. This recommendation relates to services that can provide opportunistic identification for people who are eligible for vaccinations. The exact approach each service uses may vary depending on the organisation and so the committee could not specify exactly what this approach should be. It might be as simple as asking a parent if their child's vaccinations are up to date when they start at school and directing them

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					to their GP if they are not up to date or suggesting they check their records or with their GP if the parent is unsure.
NHSEI	Guideline	005	005	Some of this is part of the core GMS contract, QoF and II and PCN contracts – NHSEI centrally negotiated. Some could be locally negotiated via CCG LES	Thank you for your comments and this information. While these are from different contracts, the committee thought it was important that awareness should be raised of all payment schemes available to healthcare professionals and providers. This should ensure that everyone can make use of all the resources available to them to help increase vaccination uptake.
NHSEI	Guideline	006	007	1.1.8 This would require national input to ensure the same granularity and sophistication of data available for Covid vaccination is available for other immunisations	Thank you for your comments. The committee thought that this could be achieved as part of a system wide approach to addressing uptake which would involve a range of services including GPs, nurseries, schools and community leaders. This has been added to the recommendation and is explained further in the rationale.
NHSEI	Guideline	006	007	Identified inequalities depends on the data – there is currently an absence of data around immunisation at a granular level which makes identification of HI challenging.	Thank you for your comments. This is something that the committee hope can be addressed with the addition of this recommendation.
NHSEI	Guideline	006	014 - 015	As outlined in the revised NHS GP contract already This is unsuitable for the majority of vaccination programmes. NHS currently commissions inactivated flu and COVID only	Thank you for your comments. This recommendation is suggesting examples of potential local options for clinics that would happen occasionally, rather than permanent settings.
NHSEI	Guideline	006	017	Community pharmacy does not vaccinate under 18s. Also, there are wrap around services for some immunisations out with imms to ensure they are not lost	Thank you for your comments. This recommendation provides examples of places where vaccinations could be provided but the options are not limited to those locations. There is a separate section of the guideline for school-aged children and young people which covers opportunities to provide vaccinations for people under 18.

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NHSEI	Guideline	006	019	1.1.10 There are too many national barriers in place to enable vaccination outside of healthcare settings, current rules re movement of vaccines do not allow for this level of flexibility with the exception of covid vaccination. Perhaps a separate vaccination service is required altogether which would require national implementation.	Thank you for your comments. This recommendation is suggesting examples of potential local options for clinics that would happen occasionally, rather than permanent settings. The committee agree that a separate national vaccination service may be beneficial in future.
NHSEI	Guideline	006	019	Helpful to consider this- that said, this would also require a level of digital transformation across service providers/ settings to ensure timely recording of uptake and coverage	Thank you for your comments. The committee agreed that updates to vaccine reporting systems is needed to improve the recording of uptake. A new recommendation has therefore been added to the guideline to highlight the need for effective systems and the importance of ensuring that compatible systems or processes are in place so that vaccination records can be shared effectively and in a timely way between different parts of the health and care system.
NHSEI	Guideline	006	023	1.1.11 Community pharmacy could be key to opportunistic promotion/delivery of vaccination to children/adults however the infrastructure is not in place to enable this.	Thank you for your comments. The committee also thought that community pharmacies could be beneficial for opportunistic identification and providing vaccinations. While current infrastructure may make this more difficult, the committee thought that some changes, such as better coordination of records between different parts of the health care system, could help to facilitate this. If changes are made based on different recommendations in the guideline, the committee think that it is possible for community pharmacies and other settings to become an important part of vaccination programmes.
NHSEI	Guideline	006	023	GPs should be doing this and as already demonstrated via PCN arrangements his already as identified in the GP contract	Thank you for your comment. The committee thought this was an important aspect of the GP contract to help improve

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					access to vaccination services and so they decided this should be included in the recommendations.
NHSEI	Guideline	007	004	1.1.12 Mutual aid only available in extreme situations for flu vaccine but many rules do not allow for this to happen for other vaccines, this requires national input.	Thank you for your comment. The committee thought that it was important to highlight what would be best practice and therefore something that should be aimed for. As this guideline is recommending that providers increase accessibility by using alternative locations for vaccination services then it is important to minimise any potential wastage of vaccines from these sites.
NHSEI	Guideline	007	006	Contractual obligations for patient registration and with regards to vaccination and immunisations itself	Thank you for your comments. The committee were aware that contractual obligations and best practice are not always followed for patient registration in particular, and this is why they chose to specifically refer to registration within the recommendations.
NHSEI	Guideline	007	010	'NHS commissioners / NHS England' - I cannot think of any immunisations that anyone other than an NHS commissioner commissions (there are private OH providers and hospital OH providers to their staff. Is this guidance covering that? I cannot think of any LA commissioned imms service	Thank you for your comments. This guidance covers vaccinations on the NHS routine UK immunisation schedule. We have specified NHS commissioners and providers in places at the request of NHS England, but as you note, in reality everywhere we refer to commissioners they will undoubtedly be NHS commissioners.
NHSEI	Guideline	007	010 - 012	NHS Commissioners will be reviewing performance against contractual obligations at regular points and will be holding performance and contract meetings with providers.	Thank you for your comments. The committee agree that this is a helpful way to use the data provided by quarterly audits and feedback.
NHSEI	Guideline	007	011	Feedback to who on what? Audit of what? Which are the standards that we would be auditing against?	Thank you for your comments. This is intended to be feedback and audits of vaccine uptake data. This has now been clarified in the recommendation.

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NHSEI	Guideline	007	015	1.1.16 the same level/sophistication of data collection used for Covid vaccination would be required for section 7a programmes to be able to monitor and address inequalities and then evaluate interventions. Could a national audit schedule for immunisations similar to screening audits be developed? National provision of data would be required in a much timelier way in order to address issues as they are happening.	Thank you for your comments. The committee agreed that a national audit schedule, and associated funding, could be a helpful way to evaluate interventions and improve vaccine uptake. However, this is not something that they think needs a specific recommendation within this guideline.
NHSEI	Guideline	007	015	'commissioners' - UKHSA are responsible for evaluating the effectiveness of all NHS routine immunisation programmes. This includes evaluations of national catch up campaigns	Thank you for your comments. The committee thought that all commissioners should have the ability to do this on a local level so that they can provide feedback to local providers and help with continuous improvement.
NHSEI	Guideline	007	018	We are still in the pandemic – this guidance says it is out with those programmes so this recommendation is the reason we were suggesting that this guideline isn't well timed as this work could be done ahead of its circulation for consultation – it also is worded to assume that the learning is only in one direction	Thank you for your comments. The committee are aware that COVID-19 interventions are not yet finished and may continue to develop, or new interventions introduced. For this reason, the recommendation suggests that this should be done to increase vaccine uptake in the future, rather than as an immediate action.
NHSEI	Guideline	008	002	Who is to ensure? Contractually this obligation is with the provider themselves	Thank you for your comments. This is for the vaccination leads to ensure. This has now been clarified in the recommendation
NHSEI	Guideline	008	003	To what standard? Is this to National Minimum Standards or shortened version of this if not clinically administering vaccines? Should this include how to discuss immunisations with parents/	Thank you for your comments. The content of the education for people who do not administer vaccines is stated in the recommendation that follows this one. This education is intended to provide a general understanding of vaccination, rather than meet professional requirements, such as those for the National Minimum Standards. The committee have added an additional statement to this

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					recommendation, indicating that the level and content of the information should be tailored to the individual's role, as different staff may need different levels of understanding. For more detailed discussions, such as those that would take place with parents, the committee thought that this group of people should be able to signpost people to relevant healthcare practitioners, rather than have an in depth knowledge of how to have these conversations themselves.
NHSEI	Guideline	009	003	Not just mandatory training- there is also a clinical supervision element to this. NHS providers are commissioned on the basis that they ensure their staff are competent and confident in administering vaccines which include the two day training and clinical supervision in practice. *Training is a function provided by UKSHA	Thank you for your comments. This recommendation is aimed at highlighting what types of education and support people should be given to develop their understanding of how to discuss vaccination and help people make informed decisions. The committee discussed how it is the responsibility of employers to ensure that staff are competent to deliver vaccines. This is a separate consideration to the training needed to have effective discussions about vaccination.
NHSEI	Guideline	009	016	1.1.20 The team discussed the difference between delivering adult immunisations versus children's immunisations with added complexity for children's immunisations. It was suggested that perhaps some guidance for best practice would be valuable in relation to delivering immunisations to children and babies.	Thank you for your comments. Best practice for delivering immunisations is important but beyond the scope of this guideline, which is aimed at increasing vaccine uptake.
NHSEI	Guideline	010	009	Is there a reason for this standard – is that as specified in contract?	Thank you for your comments. The GP contract provides information about the importance of keeping vaccination records up to date. The time frame provided in the recommendation was based on discussions from the committee who thought that this would ideally take place

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					within a week, but that it could take longer if there were a number of records to update. For this reason, they decided that 2 weeks was a reasonable and achievable timescale. More information about their discussions can be seen in the committee discussion section of the identification evidence review (Evidence review A).
NHSEI	Guideline	010	010	1.2.1 The team discussed that there was no guideline to ensure effective data transfer from GP surgeries to CHIS which is problematic if services use different IT suppliers in order to ensure greater reliability of COVER data. Also, that IT and paperwork transactions differ in local CHIS areas and this can lead to GPs not transacting correctly with their CHIS because the processes are not properly known and understood by the GP Practices. This leads to delayed/incomplete/incorrect data transfers, which in turn leads to incorrect or delayed follow-up of unvaccinated children. The advice in this part of the NICE guidance should be: "GPs need to be familiar with the specific administrative processes needed for transactions with their local CHIS. The CHIS should clearly publish it's transactional processes for their GPs so that they are clearly understood, and these processes should be reviewed and updated annually by the CHIS. GP Practices should review their internal transactional processes in line with their local CHIS published guide and have these signed off as part of their internal GP Practice clinical governance."	Thank you for your comments. The committee agreed that a lack of integrated record keeping systems can cause issues with the recording and reporting of vaccination status. A new recommendation has therefore been added to the guideline to highlight the need for effective systems and the importance of ensuring that compatible systems or processes are in place so that vaccination records can be shared effectively and in a timely way between different parts of the health and care system.

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NHSEI	Guideline	010	010	1.2.1 "GP practices should ensure that their vaccination records are updated within 2 weeks in response to new information about a person's 12 vaccination status." – can this be clearer to imply vaccines given and subsequent records should be updated within 24 hours, and where relevant CHIS notified within 2 working days (I don't think its actually stated anywhere)? Most are extracted, but some still do email this info over. This I think is then different to the rational listed later in the document to ensure records are accurate/new registration and need to update records. It is important that there isn't a delay in updating the info – as all parties might get chase dup unnecessarily.	Thank you for your comment. The committee discussed the time frame for updating and reporting records and decided that 2 weeks is realistic given the time demands placed on GPs. They were also aware that at times multiple records for the same vaccination can be sent through which can be very time consuming. The consensus of the committee was that 2 weeks is a realistic target until record keeping systems improve. The committee also thought that 5 days, rather than 2 days, for reporting vaccinations to GPs and CHIS was realistic. They added the statement that this should either be within 5 working days or in line with required standards if these are shorter, to emphasise that the expected time may be shorter in some areas.
NHSEI	Guideline	010	011 - 013	What this template would this be? Clinicians update records directly on clinical systems	Thank you for your comments. This recommendation is aimed at ensuring that the most up to date template that is available on the clinical system is used. The recommendation has now been reworded to make this clearer, along with a statement about the importance of also using up-to-date SNOMED codes.
NHSEI	Guideline	010	014	CQRS is used to validate general practice submissions for payment – they have to record all their vaccines in order to be paid for each vaccine given	Thank you for your comments. This recommendation is aimed at ensuring that when vaccination records are updated, they are done so as accurately as possible.
NHSEI	Guideline	010	019	1.2.4 – to also include that CHIS services update their records within 5 days of notification, and CHIS have to inform the GP's of children who are due immunisations on a weekly basis using an electronic process rather than monthly. This will include children having a first invitation, a first reminder or a second reminder.	Thank you for your comments. The committee discussed whether to change the timeframes for updating of CHIS records. However, they thought that giving GPs a monthly update is more realistic than weekly as more frequent updates may make it hard for GPs to dedicate sufficient time to updating their records. Monthly updates are also likely to mean that there will be enough children identified

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					that catch-up sessions can be arranged. However, the committee were aware that there are times where the service specification will be less than a month. The recommendation was therefore updated to: 1.2.6 CHIS should give GP practices a monthly update (or as specified in the CHIS contract if shorter) on children who are not up to date with their vaccinations.
NHSEI	Guideline	012	005 - 007	This relates to occupational health as opposed to the routine immunisation schedule	Thank you for your comments. Although these reviews are not directly aimed at assessing vaccination status, the committee thought this to be a good opportunity where opportunistic identification could take place for looked-after children and young people.
NHSEI	Guideline	012	027	Primary responsibility for the offer and administration will sit with the GP, although can be offered, where commissioned in maternity. They should be referred back to the GP if maternity can't administer	Thank you for your comments. Although the main responsibility lies with the GP, the committee thought it was important to highlight the opportunity for midwives to be an additional way to offer vaccinations to pregnant women. They were aware that not all midwives would be able to administer the vaccine and therefore included a recommendation that they should signpost women to services where they can access vaccinations.
NHSEI	Guideline	012	028	As recommended by the NHS immunisation schedule	Thank you for your comments. The committee did not include this information as this guideline is aimed at increasing vaccination uptake specifically for vaccines on the routine immunisation schedule and so it applies to all recommendations in this guideline.
NHSEI	Guideline	014	011	This is an ongoing challenge in immunisations (and not as advanced as screening). The role, responsibilities and expectations of both CHIS and the GP here could support this aspect moving forward.	Thank you for your comments. The committee were aware that updating patient-held records at the time of vaccination can be difficult. However, they thought this is something important that should be aimed for. They also included the opportunity to update records at subsequent appointments

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					if it was not possible to update patient-held records at the time of vaccination.
NHSEI	Guideline	014	027 - 029	This is not the responsibility of the CHIS. CHISs support this process but they are not accountable or commissioned as the primary service to report updated vaccination status to the GP. For example, School providers are contracted to report immunisation status to the GP and CHIS as a dual reporting process. Responsibility rests with the Commissioned provider	Thank you for your comments. The committee discussed this further and thought that CHIS are commissioned to do this in some local areas while in other places CHIS may support other providers to do this. To clarify that this will not always be the role of CHIS, the beginning of the recommendation has been updated to say that this should happen where it is commissioned locally.
NHSEI	Guideline	015	007	Call/recall is mixed method- overall responsibility is with the commissioned provider. However, CHISs also support this process, where this has been commissioned.	Thank you for your comments. The committee also thought that this is the responsibility of a range of providers and so they made the recommendations with this in mind.
NHSEI	Guideline	015	008	Who should ensure? Providers? CHISs?	Thank you for your comments. This may vary depending on the vaccination and so, to ensure it is relevant to all vaccinations on the routine schedule, the committee did not specify who should do this. It is the responsibility of the vaccination leads specified in section 1.1 to ensure that invites and reminders are being sent, so the committee do not think that this process will be overlooked by not specifying a team responsible for this.
NHSEI	Guideline	015	011	1.3.2 would need to be taken into consideration by PHC team as currently GP's do not have access to letters in alternative formats/languages and the interpreting services is currently only commissioned for clinical care.	Thank you for your comments. The committee were aware that materials are not always available in different formats and languages. For this reason, the recommendation says that these materials should be provided if it is possible to do so. However, the committee agree that this is something that PHC teams could take into consideration.

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NHSEI	Guideline	015	019	1.3.4 – can this be strengthened to require GP's to check if they do need an immunisation on registration? I think its implied but could be more specific? GPs often do not think this is their responsibility.	Thank you for your comments. In the recommendation in section 1.2 on identifying people eligible for vaccination, registration in general practice is one of times listed when opportunistic identification of people eligible for vaccination should take place.
NHSEI	Guideline	017	019	Detail the relationship between CHIS (as per national spec) and the GP in letter invitations (and text if appropriate) for child imms. CHIS notify/remind and best practice for parent to then be able to easily book an appointment at the GP.	Thank you for your comments. This is a general recommendation for what should be included for all vaccines, so the committee did not specify details about CHIS. However, the recommendation includes the need for the invite to include details on how to contact a healthcare practitioner and how to book an appointment so the relevant information should still be provided to parents and carers of children any young people who are eligible for vaccinations.
NHSEI	Guideline	018	005	Do you mean UKHSA? Think we should be signposting to NHS website - formerly NHS choices	Thank you for your comments. The recommendation includes a link to a NHS webpage on vaccination.
NHSEI	Guideline	018	017	Why only pertussis- surely this would be flu vaccine during the flu season.	Thank you for your comments. The flu vaccine was out of scope for this guideline and so the committee could not make recommendations on this.
NHSEI	Guideline	018	017	1.3.13 – in regard to sending reminders - update to say Providers (such as GP practices and CHIS)	Thank you for your comments. CHIS have been added to the recommendation.
NHSEI	Guideline	019	015	1.3.16 reference could be made to the use of an interpreter in phone calls to patients who do not speak English as a first language, if required.	Thank you for your comments. The committee thought it was important that people are contacted in a way that is most appropriate to them. They included a recommendation in section 1.2 on keeping records up to date about the importance of recording people's preferred method of contact and any additional language needs. This

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					should help to ensure that any contact made by phone calls includes consideration of their language needs.
NHSEI	Guideline	020	002 - 009	1.3.20-1.3.22 These guidelines are restricted by the national specifications limiting practices to vaccinate only their registered population.	Thank you for your comments. The committee are aware that there are some barriers to vaccination associated with non-registered populations. However, they thought that the recommendations should highlight what commissioners should be aiming for in terms of providing vaccination for these groups of people so that they can have the opportunities to access vaccinations.
NHSEI	Guideline	020	009	Where this is commissioned. This is not specifically a CHIS role and will depend on local arrangements. The CHIS will be expected to identify this cohort and discuss alternative provision with the NHSE/I commissioner, but they wouldn't routinely be expected to send out invitations.	Thank you for your comments. This recommendation has been reworded to clarify that CHIS will identify these children and send invitations when they are commissioned to do so. If this is not commissioned, it is recommended that this cohort is highlighted to the service commissioner
NHSEI	Guideline	020	016 - 017	NHSE/I commission school aged providers to deliver routinely in schools. They also provide community clinics for any catch-up elements or for those who are not in mainstream education	Thank you for your comments. These recommendations are about vaccinations that are not provided in schools. Recommendations for school age-children and young people are included in a later section in the guideline.
NHSEI	Guideline	021	020	Incentives? What kind of incentive? – could consider rather than should, particularly in schools with lower uptake	Thank you for your comments. There was no evidence on the best type of incentive and the committee thought that the most acceptable and effective incentive is likely to vary depending on the local population. They therefore decided to leave this decision up to local providers. There is more discussion about specific nature of the incentive used in the study that informed this recommendation and other possible forms the incentive could take in evidence review J. In addition, the rationale mentions a prize draw as an example. They also developed a research

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					recommendation aimed at determining what the most effective incentive may be so that more specific recommendations can be made in future guideline updates.
NHSEI	Guideline	021	025	Envisage it would be a challenge to fund incentives despite potential savings from not having to 'chase' none returns. Would it be per school/year group/geographical area. Potential for negative media/parental response if private providers with school aged immunisation contracts were offering incentives.	Thank you for your comment. The committee noted that incentives would not have to be expensive or complicated – e.g. they could be a school-based benefit. The negative response is considered to be associated with incentivising vaccination, and should be managed by the incentive being for consent form return and not for vaccination itself.
NHSEI	Guideline	022	018	This is already a requirement of NHSEI as commissioner of School age imms services	Thank you for your comment and this information.
NHSEI	Guideline	022	025	The team would like to add to 1.3.35 that sometimes children receive vaccination in non-mainstream education provider institutes.	Thank you for your comments. This section has been updated and now says schools where vaccinations are not provided, rather than non-mainstream schools.
NHSEI	Guideline	022	07	Think this needs to be more explicit- up to date with their adolescent routine immunisations- providers are not commissioned to administer outside of those school aged programmes. Adolescent programmes currently include DT/aIP, HPV, Men ACWY and MMR. Anything outside of this will be signposted back to the GP	Thank you for your comments. The committee agreed that children and young people who are not up to date with vaccinations that are not part of the school-aged programme should be signposted to their GP. An additional recommendation has been added to the guideline to reflect this.
NHSEI	Guideline	024	005	We weren't aware of the eligibility for shingles dropping (as commissioners) – when do you think this will come into effect and to what age group?	Thank you for your comment. We are not aware of the date that this is expected to change but have provided a link to the Green book so that people can check what age group this includes at the time they are using the guideline. We

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					found the information about this change in the JCVI minutes but have no other information. See the JCVI minutes from 22 June 2021, point 53 for more information.
NHSEI	Guideline	024	009	Some NHS documents are using the term "pregnant people"	Thank you for your comments. We have used the term pregnant women as this is still common terminology in many NHS documents. This is included in 'Terms used in this guideline' for clarity.
NIHR Applied Research Collaboration (ARC) North Thames	Equality Impact Assessment	005	Point 3.1	No specific recommendations were made for either health and social care professionals nor carers. This is also somewhat surprising given these groups' important positions to offer and administer vaccinations and the risk thereby of exposing individuals to viruses/diseases if not themselves vaccinated. For example, in the case of the COVID-19 vaccines some 'vaccine hesitancy' from members of these groups have been reported in research. Therefore, we strongly suggest that such considerations and the evidence base for these groups be further taken on-board in the development of recommendations.	Thank you for your comments. No evidence was identified concerning specific interventions to increase routine vaccine uptake in these groups as part of our review work. However, the recommendations in the guideline are aimed at ensuring that everyone is up to date with their routine vaccinations, including health and social care practitioners and carers. The recommendation covering opportunistic identification and vaccination includes many occasions when a person could be identified, and these would apply to the groups you mention as well as the general public. In particular, this recommendation includes checking vaccination status when people start a job and during subsequent occupational health checks for people who work in a clinical setting. In response to your feedback the committee have expanded this to include social care settings. This would therefore cover checks on vaccination status for both healthcare and social care staff.
NIHR Applied Research Collaboration (ARC) North Thames	Equality Impact Assessment	003, 004, 007	Point 3.1 and 3.4	The committee did not make any separate recommendations for ethnic minority or religious groups. This is somewhat surprising when we know how health inequalities adversely affect ethnic minority groups (and for some more than others and in particular for Black ethnic groups), coupled with the potential exacerbation of inequalities in the lower vaccine uptake rates,	Thank you for your comments. NICE looked for evidence for these groups during the development of the guideline. Religious groups were included as subgroup of interest in the review protocols and evidence for ethnic minorities was included where it was identified. However, there was a lack of evidence on what

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				including for COVID-19 vaccines, demonstrated for these groups. Without interventions tailored and targeted to address barriers to uptake as relating specifically to respective ethnic minority and religious groups, it is a concern that more universally applicable interventions alone will fail to provide the accommodation and encouragement that might be needed to achieve sufficiently high uptake rates in these groups to help close the inequality gap compared with the higher uptake rates in the ethnic majority population. Indeed, failure to make separate recommendations/assess evidence for ethnic minority or religious groups could lead to widening inequalities. Contemplating this alongside Point 3.4 stating that no difficulties in practice for specific groups to access services compared with other groups were associated with the recommendations, it might appear that the *full* extent of the considerations we raise in the present comment have not been adequately reflected upon. In terms of a response to NICE's question of which areas will have the biggest impact on practice and for whom, we strongly suggest that our above considerations and the evidence base for these groups be further taken on-board in the development of recommendations.	interventions are effective at increasing vaccine uptake (our primary outcome of interest) in these groups and limited qualitative evidence was identified that met the inclusion criteria for the review looking at barriers to and facilitators for vaccine uptake. The barriers identified included misinformation, a lack of information, a lack of trust in the government and other public bodies and concerns about vaccine safety and effectiveness amongst other things. (These findings are presented in evidence review B.) However, these findings were not specific to Black, Asian and Minority Ethnic communities, and people from religious communities but were also identified as barriers to vaccine uptake by other groups of people. The committee therefore made a series of recommendations aimed at promoting identification of local needs and barriers to uptake and then responding in a way that is tailored to address these needs and inequalities in uptake between population groups but without naming the groups of people specifically. Another recommendation covers seeking input from local people about their needs and tailoring service hours and locations to meet them. Other relevant recommendations are aimed at identifying if people have language needs or literacy issues; providing information about the vaccination process for people who come from outside the UK; providing information in in an appropriate format and language; ensuring that vaccination staff are able to engage with people's concerns about vaccination and give them tailored

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					responses; exploring why people decline vaccinations or do not respond to invitations and trying to address any issues raised; and ensuring that there is time during consultations to have a discussion where any concerns can be identified and addressed. The committee envisaged that these recommendations would enable issues like to ones you raise to be identified at the individual or community level and provide opportunities for them to be addressed. However, in response to your comment and feedback from other stakeholders the committee have now included an information box that lists population groups which are known to have or be at risk of low vaccine uptake to highlight the importance of thinking about these groups when commissioners and providers assess local needs and tailor their services to meet them. This includes people from some ethnic minority groups; people from some religious communities (for example, Orthodox Jewish communities) and people who live in an area of high deprivation amongst other groups. To try to help fill the gaps in the evidence base, the committee made a research recommendation asking what the most effective and acceptable interventions are to increase uptake in populations or groups with low routine vaccine uptake in the UK. The text accompanying this research recommendation in evidence review B mentions some of the particular groups of interest including people from religious communities and immigrants. In response to your comment, the committee have added ethnic minorities

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					to this text and have included both people from ethnic minorities and religious communities as groups of particular interest in the draft PICO that accompanies the research recommendation. In addition,
NIHR Applied Research Collaboration (ARC) North Thames	Evidence review K	General	General	In relation to COVID-19, only a call for evidence was circulated and no systematic review of the evidence was carried out. The decision was justified based on the recent roll-out of the COVID-19 vaccination programme and the expected limited published evidence available at the time the call for evidence was made. However, we have seen a very rapid emergence of COVID-19 evidence due to the policy urgency of tackling the impacts of the pandemic on population groups and society as a whole. Some of this evidence might be accessible as pre-print versions of prospective journal publications, which would also seem within NICE's scope of asking for unpublished in addition to published evidence. Therefore, it is possible that even a relatively simple systematic search on an established health database and pre-print server would have revealed missing studies. As we believe the choice of methods for COVID-19 evidence might have introduced selection bias and the risk that relevant studies have been missed, we would therefore suggest that this limitation is more explicitly acknowledged. To widen the knowledge and learning on the pandemic and its impacts on vaccination, we would also strongly recommend the inclusion as well as future commissioning of relevant systematic reviews here.	Thank you for your comments. Part of the reason that a call for evidence was used rather than a systematic review was that COVID-19 research was still at an early stage at the time that the guideline was being developed. Some of the evidence provided was submitted as pre-prints which have since been published. Although it is notable that this evidence was qualitative in nature and that no quantitative evidence that met our inclusion criteria was submitted, supporting our argument about the limited published evidence. Another reason that a systematic review was not conducted for COVID-19 evidence was that the vaccination is not on the UK routine schedule and therefore was out of scope for this guideline. However, given the important nature of the COVID-19 vaccination programme and the rapid changes to how vaccines were provided, it was decided that it could not be overlooked. We do not believe that the recommendations in the guideline have been biased by the process used to collate COVID-19 evidence as this only informed one recommendation about evaluating COVID-19 initiatives to identify if they could be used to increase the uptake of routine vaccinations. It is not NICE's intention at this time to look further at the effects of COVID-19 on routine vaccinations. However, this may change if information

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					becomes available that would alter the existing recommendations. We will pass your comment onto the NICE surveillance team who monitor new evidence to decide when a guideline should be updated.
NIHR Applied Research Collaboration (ARC) North Thames	Evidence review K	006	Table 1	Outcomes. The primary outcome for 'all intervention types except interventions that target the recording and identification of eligibility and status' is defined (i.e. COVID-vaccine uptake). However, no primary outcome was identified/reported for 'interventions that target the recording and identification of eligibility and status'. If also identified, we suggest that this is reported.	Thank you for your comments. Unlike the other types of interventions there was no single outcome identified as the primary outcome for interventions that targeted recording and identification of eligibility and status.
NIHR Applied Research Collaboration (ARC) North Thames	Evidence review K	008	004 – 008	The main reasons for excluding evidence are stated. However, as standard procedure, we also suggest that the number of responses (n) excluded for each separate reason are provided.	Thank you for your comments. Although this section provides a summary of the excluded studies, there is more detailed information about the number of studies excluded and reasons for exclusion in the excluded studies section (Appendix E).
NIHR Applied Research Collaboration (ARC) North Thames	Evidence review K	017	003 – 008	PHE 2021 reference. All the organisations that were involved in this work have not been stated. Missing organisations are: Greater London Authority; London School of Hygiene and Tropical Medicine (LSHTM); and NIHR ARC North Thames, UCL. In the description of the evaluation, please could also mentioning of 'borough' (n=2 times) be amended to 'local authorities' in London. Please could it be confirmed that these amendments are made.	Thank you for your comments. These details have been amended as suggested.
NIHR Applied Research Collaboration	Evidence review K	009 – 010	Table 3	PHE 2021 reference. All the organisations that were involved in this work have not been stated. Missing organisations are: Greater London Authority; London School of Hygiene and Tropical Medicine (LSHTM); and NIHR ARC North Thames, University College London	Thank you for your comments. We have added the missing organisations and updated the setting and population.

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(ARC) North Thames				(UCL). Also the setting and population are listed as 'healthcare providers', when in fact a more correct description would be local authorities and directors of public health in London. Please could it be confirmed that these errors are corrected.	
NIHR Applied Research Collaboration (ARC) North Thames	Evidence review K	023	Appendix B	There is a discrepancy in the flow chart, i.e. it is stated that there were 22 submissions following the COVID-19 call for evidence, but then as many as 39 submissions were screened in the next stage. Therefore, it is unclear where the additional 17 submissions emanated from and we suggest that this is reflected in the flow chart.	Thank you for your comments. The number of submissions are greater than the number of responses because some of the responses contained multiple references and, in some cases, the same documents were submitted by more than one respondent. This has been added to the flow chart for transparency.
NIHR Applied Research Collaboration (ARC) North Thames	Evidence review K	037	001	PHE 2021 reference. Bibliographic reference for this response has been added twice.	Thank you for your comments. The duplicate reference has been removed.
NIHR Applied Research Collaboration (ARC) North Thames	Evidence review K	038	Study characteristics table	In the description of the PHE 2021 evaluation, please could mentioning of 'borough' be amended to 'local authorities' in London (under subsections 'Data collection' (n=3 times); 'Method and process of analysis' (n=1); 'Population and sample collection' (n=1); and 'Inclusion Criteria' (n=1)). Please could it be confirmed whether this amendment is made.	Thank you for your comments. These details have been amended as suggested.
NIHR Applied Research Collaboration (ARC) North Thames	Evidence review K	038	Study setting	This is listed as 'healthcare providers', when in fact a more correct description would be local authorities and directors of public health in London.	Thank you for your comments. These details have been amended as suggested.

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NIHR Applied Research Collaboration (ARC) North Thames	Evidence review K	039	Ethical issues and overall risk of bias	To note that this was a service evaluation, with no ethic permissions sought. However, in accordance with General Data Protection Regulation, names were anonymised.	Thank you for your comments. The ethical issues and overall risk of bias have been left with the details as we were aware of them at the time of the review. This reflects the information that was available to the committee at the time at which they made their decisions.
NIHR Applied Research Collaboration (ARC) North Thames	Guideline	024 - 028	Recommendations for research	Recommendations for research The assessment of effectiveness and acceptability are common outcomes listed for the majority of the research recommendations. However, we wondered whether the longevity/sustainability of interventions should also be considered for the development of future recommendations? (i.e. that an intervention has an effect immediately post-treatment does not necessarily mean that it would have a longer-term effect improving conditions and, as such, without this information it is uncertain whether the intervention should feature as a recommendation).	Thank you for your comments. The committee agreed that both the short-term and long-term impacts of vaccination programmes are important. The committee have not specified a timeframe for any of the research recommendations so that interventions can be evaluated over a range of time periods.
NIHR Applied Research Collaboration (ARC) North Thames	Guideline	046 - 047	030 - 032, 001 - 004	It is stated that "not everyone has regular contact with a particular provider, and medical records that would be used to generate invitations may not show who a person has most contact with. The committee were also aware that in some areas, standardised invitations from a more centralised service are used, which may be difficult to personalise. Therefore, the committee agreed that using the name of a provider or service that is known to the person in the invitation and any subsequent reminders might be useful". However, it is not suggested how the name of the provider or service might be identified in practice. We suggest further information on this could be	Thank you for your comments. The vaccination lead, which is recommended in section 1.1 of the guideline, is responsible for ensuring that there are processes in place for people to be identified and invited for vaccination. These people should therefore be able to ensure that people are contacted by the service that they see and communicate with most frequently.

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				added to assist practitioners and to optimise the prospect of the recommendation being adhered to.	
NIHR Applied Research Collaboration (ARC) North Thames	Guideline	18	20-21	Recommendation 1.3.13. It is stated as a recommendation that healthcare providers should "confirm that the person has received the reminder". However, it is not suggested how this might be done in practice. We suggest that further information on this could be added to assist practitioners and to optimise the prospect of the recommendation being adhered to.	Thank you for your comments. The committee thought that this could be best achieved via a phone call to the person who has not received their vaccination, based on a system of escalating reminders. More information about this is provided in the Reminders and escalation of contact section of the rationale.
NIHR Applied Research Collaboration (ARC) North Thames	Guideline	025	004 - 007	4 Tailoring Immunisation Programmes. Research on the effectiveness of the World Health Organisation 'Tailoring Immunisation Programme' approach has been added as a key recommendation for research. However, it is unclear why this approach should be considered at the expense of other approaches and/or whether other approaches were considered?	Thank you for your comments. The committee were aware that the TIP programme has already been used in some areas in the UK but there is limited evidence about the effectiveness of this programme, and no UK-based evidence. The committee therefore thought that this was an important area for research.
NIHR Applied Research Collaboration (ARC) North Thames	Guideline	027	007 - 009	Incentives for school-based vaccinations. It is stated that this recommendation relates to a 'school-based population'. However, what about those that are outside mainstream schools? Are they not captured by this recommendation? We suggest more clarity on this aspect.	Thank you for your comments. This has been reworded to a school-aged population so that it does not exclude people outside mainstream schools.
NIHR Applied Research Collaboration (ARC) North Thames	Guideline	033	013 – 016	It is stated that "the evidence from studies on the effects of audit and feedback was inconclusive and varied in quality due to limitations with the design of some studies. These studies frequently included additional interventions such as provider education or bonuses, which made the effects of audit and feedback harder to isolate". We wondered if research into this should not therefore feature as a separate recommendation for future research?	Thank you for your comments. The committee thought that the effects of audits and feedback are an important consideration but decided that there are some other areas that should be prioritised for research.

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NIHR Applied Research Collaboration (ARC) North Thames	Guideline	034	019, 024	It is stated that "evaluating initiatives used to increase vaccine uptake during the coronavirus pandemic … is likely to be a one-off activity". However, in order to assess the longer-term impacts of these initiatives as the pandemic continues and post-pandemic, we feel that a caveat might be added here relating to potential cost implications of such prolonged activities.	Thank you for your comment. We have now noted that repeated evaluations would be associated with additional costs in the section on 'How the recommendations might affect services' that accompanies the audit recommendations.
NIHR Applied Research Collaboration (ARC) North Thames	Guideline	035	002 – 004	It is stated that "there was very limited evidence for the effect of provider education or information alone on vaccine uptake. However, this intervention was a component of several multicomponent studies that showed increased vaccine uptake". We wondered if research into this should not therefore feature as a separate recommendation for future research?	Thank you for your comments. The committee thought that the effects of provider education and information is an important consideration but decided that there are some other areas that should be prioritised for research.
NIHR Applied Research Collaboration (ARC) North Thames	Guideline	051	006 - 008, 017 - 018	Some potential reporting inconsistencies in the following sentences might add confusion on the part of readers: "There was qualitative evidence to show that if a person does not respond after being sent a reminder, an escalating system of contact can be effective in increasing uptake" **vs.** "the evidence did not show that using escalating reminders was more effective than other forms of reminders". We suggest that the appropriate amendments are made to correct these potential reporting inconsistencies.	Thank you for your comments. The first of these sentences refers to qualitative evidence and the paragraph goes onto explain that quantitative evidence shows that escalating reminders are more effective than usual care. The second is a discussion of how the evidence suggests escalating reminders are not more effective than other types of reminders.
NIHR Applied Research Collaboration (ARC) North Thames	Methods	010 - 011	Pairwise meta-analysis	The effectiveness and relevance of interventions might differ considerably depending on contextual factors and population groups. When there are ten or more studies available for a meta-analysis, this is commonly reflected in the estimation and display of prediction intervals. However, no mention of this is made in this subsection. Therefore, we suggest clarification on whether prediction	Thank you for your comments. Our methods do not include the use of prediction intervals and they are not mentioned in the methods or evidence reviews for this reason.

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				intervals were considered and, if not, to add this as a potential limitation (particularly with the view that NICE indicate their interest in detecting variations and the range of potential impacts of interventions on population groups in practice).	
NIHR Applied Research Collaboration (ARC) North Thames	Methods	015 - 016	Table 4	Methodological limitations. For 'not serious' it is stated that "if the theme was identified in studies at low risk of bias, the outcome was not downgraded", while for 'serious' it is stated that "if the theme was identified only in studies at moderate or high risk of bias, the outcome was downgraded one level". However, these definitions still leave it somewhat uncertain/open for further interpretations what might have happened if some studies were of low risk of bias while the remainder of moderate or high risk. We therefore suggest clarification of these definitions for the avoidance of any confusion.	Thank you for your comments. This clarifies that it is only when all studies are at moderate or high risk of bias that a theme is considered at serious risk of bias. If there are a mix of studies at low, moderate and high risk of bias that contribute to a finding then the finding is rated as low risk of bias.
NIHR Applied Research Collaboration (ARC) North Thames	Methods	007	015 - 016	It is stated that "full literature searches … were completed for *all* review questions". However, we suggest that this is amended as it is incorrect in the case of the COVID-19 call for evidence, where a full literature search was not conducted.	Thank you for your comments. The COVID-19 review was not a full evidence review but a call for evidence. COVID-19 vaccinations are not part of the routine vaccination schedule and so were out of scope for inclusion in the guideline.
NIHR Applied Research Collaboration (ARC) North Thames	Methods	008	016	Machine learning algorithm. We suggest further reflections around the reasons for choosing a machine learning algorithm to select studies as a relatively novel technique and the potential drawbacks of this approach in terms of missed studies compared to human selection.	Thank you for your comments. Although this algorithm was used to prioritise the order of the papers in the evidence sift, it was not used in practice to reduce the numbers the numbers of papers to sift. This was because the papers identified in the searches spanned different review questions making it hard to train the algorithm successfully. Therefore, it will not have influenced the study selection for this guideline.

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NIHR Applied Research Collaboration (ARC) North Thames	Methods	009	010 - 012	The sentence explaining the category 'moderate quality' seems a bit self-contradictory: "It is possible that additional relevant and important data would be identified from primary studies compared to that reported in the review, but unlikely that any relevant and important studies have been missed by the review". Would not the fact that studies might contain 'additional relevant and important data' in itself classify these studies as 'relevant and important'? We suggest clarification to avoid any confusion on the part of readers and guideline implementers.	Thank you for your comments. This refers to whether additional information might have been available had data been directly extracted from the primary study, rather than using what was reported in the published evidence syntheses. It doesn't refer to the evidence syntheses having missed any important or relevant studies.
NIHR Applied Research Collaboration (ARC) North Thames	Methods	010	003 - 005	Data synthesis for intervention studies. In meta-analyses to combine results of quantitative intervention studies, it is not clear whether different study designs were combined or separate analyses were to be undertaken depending on study design (e.g. randomised controlled trials (RCTs) vs. non-RCTs). For replication purposes, we suggest that this point is clarified.	Thank you for your comments. This document contains the general methods that were used in the reviews. Where reviews contained multiple study types we did not combine RCT and non-RCT data. Additional methods information and any methods used that were specific to a particular review are stated in the methods and processes section of that evidence review.
NIHR Applied Research Collaboration (ARC) North Thames	Methods	010	004 - 005	For the subsection 'data synthesis for intervention studies', it is stated that "where possible, meta-analyses were conducted to combine the results of quantitative studies for each outcome". However, there is no mentioning of how data synthesis for intervention studies proceeded if meta-analyses were not feasible. We suggest clarification on this point.	Thank you for your comments. Where meta-analyses were not possible, outcomes were presented as individual study results in the forest plots and GRADE tables.
NIHR Applied Research Collaboration (ARC) North Thames	Methods	011	031	It is stated that "fixed-effects models were the preferred choice to report". We suggest further clarification as to why this was the case (e.g. compared to random effects models as a common choice in the wider literature).	Thank you for your comments. The Guideline Updates Team standard methods include the use of fixed effects models unless there is a high level of heterogeneity in the results.

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NIHR Applied Research Collaboration (ARC) North Thames	Methods	012	010, 18	For the avoidance of any confusion, we suggest clarification in the wording of subheadings. I.e. it is unclear whether the subheading 'data synthesis for mixed methods studies and reviews' (line number 10) would refer to other reviews that were included, while the subheading 'data synthesis for mixed methods sections of reviews' (line number 18) might then refer to NICE's own evidence reviews?	Thank you for your comments. This has been re-worded to clarify that the second heading is for mixed methods sections of NICE evidence reviews, rather than the analysis of primary studies.
NIHR Applied Research Collaboration (ARC) North Thames	Methods	014	Table 3	Imprecision. Downgraded twice if the sample size of the study was sufficiently small that it is not plausible any realistic effect size could have been detected. However, it is unclear how the threshold for 'sufficiently small' was defined in this context? An illustrative example might help to clarify.	Thank you for your comments. The sample size was considered sufficiently small if less than 200 people were included in the analysis. This is stated in the footnotes of GRADE tables in the evidence reviews.
NIHR Applied Research Collaboration (ARC) North Thames	Methods	014	Table 3	Publication bias. There are known issues with conducting only visual inspection of funnel plots to determine publication bias. Were any formal statistical tests considered to detect the presence of any publication bias?	Thank you for your comments. Only visual inspections of the funnel plots were used to assess publication bias.
NIHR Applied Research Collaboration (ARC) North Thames	Methods	015	006 - 007	Upgrading was considered when "data from studies showed an effect size sufficiently large that it could not be explained by confounding alone". However, it is unclear how a threshold for 'sufficiently large' might have been determined here? An illustrative example might help to clarify.	Thank you for your comments. In practice we very rarely use the considerations listed in that paragraph to upgrade a study, but if we had done this for the vaccines guideline it would have been based on the effect size being several magnitudes bigger than seen for other similar interventions for the same outcome (i.e., 20 fold increase in effect rather than 2 fold). .
Patient information Forum (PiF)	Guideline	General	004	Overall PIF is very supportive of the draft recommendations. However, we would like to see a much greater emphasis on the provision of health literate information in accessible formats that clearly	Thank you for your comments and this information. The committee agree with your comment about the importance of providing trusted information to help people make informed decisions about their health and the problems

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				explains the benefits and risks of vaccination. Trusted information on vaccination needs to be embedded throughout the vaccination pathway. This would be inline with the Nice Guideline on Shared Decision Making published in June 2021. Providing accurate, easy to understand information is more important in the field of vaccination given the political context vaccination programmes operate in. The anti-vax movement is organised and active in disseminating disinformation on vaccines. This has been very evident during the Covid-19 pandemic but the movement was already in existence. At least one PIF member charity was subjected to an organised online campaign to discredit its information after recommending routine infant vaccinations to parents via its social media channels. The anti-vax movement is skilled in creating accessible material on vaccination and this needs to be countered to increase uptake of vaccines. A PIF advisory group member recently carried out a literature review of videos on Covid-19 and vaccination hosted on YouTube. The recommendations of that review are summarised here: https://pifonline.org.uk/blogs/judging-the-quality-of-youtube-videos-on-covid-19-lessons-learnt/	posed by misinformation. They have included a number of recommendations in the guideline to try to address these issues. The recommendations on what vaccination invitations should contain in section 1.3 include instructions for accessing videos and information from trusted sources and contact details for someone who could answer questions and address concerns. Section 1.1 on appointments and consultations also covers using suitable literature to facilitate discussions about vaccinations. In the rationale accompanying this recommendation it is made clear that the choice of literature should be based on people's individual needs, such as whether it is needed in a different language or whether easy read materials are required. There are also recommendations about ensuring that information, invitations and reminders are in a format and language appropriate for the person and to take into account if they have any specific communication needs (such as requiring different languages, formats, easy read documents). In addition, the recommendations for education for healthcare practitioners include training on how to have effective conversations, which should include discussing vaccinations with people who have vaccine hesitancy. The committee recognised that some people with long term medical conditions need specialist information on vaccination and could benefit from being signposted to relevant charities. However, this information was too specific to go in the general information supplied with a

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					vaccination invitation but could be passed on by healthcare practitioners when they have discussions with people about their concerns.
				PIF echoes comments in the guideline to signpost the public to 'trusted' sources of information on vaccination. Some people with long term medical conditions need specialist information on vaccination and should be signposted to relevant charities. Macmillan, for example, provides information on vaccination for people with cancer. PIF operates a quality mark for health information, the PIF TICK. Almost 100 organisations, including many of the leading national health charities, are involved in PIF TICK. An organisation's information production process is assessed against 10 criteria before PIF TICK is awarded. We recommend that relevant PIF TICK members are signposted to those who need specific advice on vaccination. We note the need to tailor information to the needs of specific communities. We recommend that the principles of the PIF TICK criteria are used to create information, based on thorough identification of need and working with communities to develop evidence based, accessible information based on that need.	The committee agreed with the need to tailor the information provided to the needs of the individual. This may occur during conversations with healthcare practitioners or by choosing to share suitable literature. However, the guideline does not cover the process used to develop this literature because the committee did not review evidence on this specifically, and the evidence they did review for information/ education only provided limited information about the contents of these interventions and their development. The committee are therefore unable to provide any specific guidance on methods to develop the information, such as those based on the principles of the PIF TICK criteria. The committee agreed with your point about digital exclusion. Taking this into account, they added an extra point to a recommendation in the section about making services accessible to ensure that a range of options for booking appointments are available, such as telephone booking and online systems and noted that some individuals may need additional support to use these systems. This should ensure that people should not be

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				We note that the guideline identifies specific groups who may face barriers to access services and information and support on vaccination. It also identifies the needs of the housebound. PIF recommends that the needs of people who are digitally excluded are also considered as lack of digital access is a barrier to accessing information and services.	excluded because of a lack of access to digital content. In addition, in the section about keeping records up to date there is also a recommendation that GP practices should keep a record of people's preferred methods of contact, such as letters or emails. This should ensure that people are not sent digital information if this is accessible to them.
Patient information Forum (PiF)	Guideline	004	012	Named vaccination leads should ensure that: health literate trusted information is provided to meet the needs of all groups in the community with particular emphasis on groups at risk of health inequality. This information should be co-produced in line with best practice guidance.	Thank you for your comments. The recommendation on named vaccination leads is intended as an overview of the processes that this person should ensure are carried out. More detail about the processes themselves is provided later in the guideline, including providing information in a language and format that meets people's communication needs. The committee were unable to provide details about how this literature should be produced as they did not look

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					at any evidence concerning this matter. However, they did include recommendations about identifying local needs and targeting interventions to address these needs in areas or populations with low uptake which would include those with groups at risk of health inequalities.
Patient information Forum (PiF)	Guideline	006	008	Suggest extra bullet point: produce information campaigns tailored to community needs.	Thank you for your comments. The education evidence review (evidence review E) considered the evidence for the use of information and education , but these made limited difference to vaccine uptake and therefore the least resource intensive forms were recommended by the committee. (i.e., providing information with the invitation for vaccination rather than as part of an information campaign). If, by working with the community, commissioners and providers, found that campaigns might be useful in their local area] then they could still use this type of intervention, but the evidence was not sufficient to make a general recommendation on this.
Patient information Forum (PiF)	Guideline	006	019	Include information hubs within pop up vaccination services.	Thank you for your comments. The committee could not list all possible locations for vaccination clinics within the recommendation. However, this does not exclude information hubs because they would fall under the definition of sites outside healthcare settings that could address specific barriers to uptake.
Patient information Forum (PiF)	Guideline	009	009	Training should include the provision of risk benefit information and signposting to trusted sources of information.	Thank you for your comments. The committee thought that it was important for practitioners to be able to signpost people to relevant sources of additional information if needed, and so this is included in the third bullet point of the recommendation for training and education for people who administer vaccines.

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Patient information Forum (PiF)	Guideline	009	013	Suggest having a shared decision making discussion using the BRAN model (Benefits, Risks, Alternative, Nothing) so concerns can be identified and addressed.	Thank you for your comments. The committee thought that vaccination should take place based on a discussion involving shared decision making. The recommendations about appointments and consultations include a reference to NICE's shared decision-making guideline so that any concerns that someone has about vaccination can be discussed effectively.
Patient information Forum (PiF)	Guideline	011	002	Add digital accessibility issues to literacy and language needs as these are important to access both health services and information and support. Translated materials should include culturally appropriate visual health information in different formats to tackle literacy and language barriers.	Thank you for your comments. The committee discussed the importance of providing information about vaccination that is in an appropriate format for the person and that the information meets their communication needs. This is highlighted in the recommendations in section 1.3 on invitations, reminders and escalation of contact. Issues with digital accessibility have also been considered. A recommendation has been included in section 1.1 on making vaccination services accessible which indicates that a range of booking options should be provided, including both telephone booking and online systems.
Patient information Forum (PiF)	Guideline	011	015	When having a conversation with anyone trying to conceive	Thank you for your comments. The committee agreed that this is an important opportunity and have added this to the recommendation.
Patient information Forum (PiF)	Guideline	011	017	and university. Health packs and apps should be promoted to freshers as part of induction.	Thank you for your comments. The committee were aware that there are many different ways that people can be identified as eligible for vaccination. They therefore decided to make a list of some of the possible ways in which people can be identified, but this does not exclude other methods not included in the examples.
Patient information Forum (PiF)	Guideline	012	010	for other people not registered with GP services for example the homeless, Roma community and migrant workers and asylum seekers.	Thank you for your comments. The committee were aware that there are many different ways that people can be identified as eligible for vaccination. They therefore decided to make a list of some of the possible ways in which people

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					can be identified, but this does not exclude other methods not included in the examples. One of the examples that the committee decided to include was when new migrants, including asylum seekers, arrive in the country.
Patient information Forum (PiF)	Guideline	013	015	and trusted sources of information including the NHS, WHO, PIF TICK accredited organisations	Thank you for your comments. The committee thought that at this stage it would be most important for non-healthcare practitioners to refer people to vaccination services. These services can then provide people with more information about vaccination and links to trusted sources.
Patient information Forum (PiF)	Guideline	014	003	Provide follow up information on the benefits of vaccination and record this. Qualitative evidence showed that some people underestimate the severity of certain diseases measles / shingles - and improved understanding of these issues may motivate people to have the vaccines". Use visual engaging techniques to aid understanding followed by a short quiz to assess whether information is retained / pros and cons weighed up and informed decision is made (accepted or declined). A quiz has the benefit of essentially *checking informed consent* which is not only important from a healthcare perspective but also medico-legally.	Thank you for your comments. A recommendation in section 1.1 on appointments and consultations highlights that there should be sufficient time for appointments to allow discussion about vaccinations, and this is expected to include information about the benefits of vaccination. An additional recommendation in section 1.3 on initial invitations also includes information about vaccination that should be sent when someone is invited for a vaccination. The committee decided not to specify specific follow-up information that should be provided if a person declines vaccination as this may vary between people and might be annoying to some people as well as a waste of resources. Instead, they decided to include a recommendation to highlight to people that they can still get a vaccination at a later date even if they decline the vaccination initially.
Patient information Forum (PiF)	Guideline	015	013	Information should be health literate, written in plain language and co-produced and user tested. It is important to check the tone as well as the clarity of information.	Thank you for your comments. The committee believe that this recommendation in combination with the recommendation about providing people with information that meets their communication needs and the recommendations about what a vaccination invite should contain, will help to provide people with clear information to help them understand what vaccine they are being offered,

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					as well as the benefits and risks associated with vaccination.
Patient information Forum (PiF)	Guideline	016	011	with supporting information.	Thank you for your comments.
Patient information Forum (PiF)	Guideline	017	003	Provide supporting information on benefits and risks. Link to the Accessible Information Standard and the Nice guidelines on patient experience.	Thank you for your comments. There is further information about what should be included in the vaccine invitation later in this section of the guideline.
Patient information Forum (PiF)	Guideline	017	007	Provide supporting information on benefits and risks for mother/birth person and baby.	Thank you for your comments. There is a recommendation later in this section of the guideline that specifies what information should be provided about vaccination. This includes the risks and benefits of vaccination both to the mother and the baby.
Patient information Forum (PiF)	Guideline	017	019	The benefit of the vaccine should be clearly expressed to people. The 'why should I do this'	Thank you for your comments. The committee thought that it was important to highlight the risks and benefits of vaccination. However, there was no evidence on how this content should be phrased and so the committee could not make recommendation on this. Instead, they made a research recommendation which can be seen in the section labelled key recommendations for research.
Patient information Forum (PiF)	Guideline	017	General	Delete if 'space allows' Risks and benefits should be included in line with NICE Guidelines on Share Decision Making and the PIF TICK criteria. How can someone make a choice about the vaccine if they don't understand the risks and benefits?	Thank you for your comments. While it would be useful to provide this information every time an invitation is sent, the committee noted that it would not always be possible, for example if the invitation is sent as a text message. This has been clarified further in the rationale section for this recommendation. However, this recommendation also refers to information being included on how to contact a healthcare practitioner if a person has any questions. This will help people to understand the risks and benefits as well as address any concerns.

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					The committee agreed that it is important to provide information to allow people to make informed decisions about vaccination. The recommendation covering what should ideally be included in the invitation therefore includes the risks and benefits of vaccination.
Patient information Forum (PiF)	Guideline	018	009	Consider needs of under-represented communities, for example black and minority ethnic girls in the case of HPV and co-create culturally appropriate information.	Thank you for your comments. Based on your feedback and other comments the committee have added a list of key barriers to uptake and population groups who often have low uptake.
Patient information Forum (PiF)	Guideline	018	014	Include PIF TICK organisations for specific groups, for example Macmillan for cancer patients, Tommy's for pregnant women.	Thank you for your comments. As there are a number of potential sources of information depending on which vaccine is being offered, the committee decided against naming them all. Instead, the recommendation indicates that information from trusted sources should be included. This will therefore include PIF TICK organisations.
Patient information Forum (PiF)	Guideline	019	004	offers of supporting information	Thank you for your comments, Later recommendations in this section on escalation of contact include having conversations to identify concerns and trying to address any issues raised. The recommendations for invitations in the earlier section cover the information to include with invitations and how to contact a healthcare practitioner to discuss concerns.
Patient information Forum (PiF)	Guideline	019	014	Provide trusted information and disinformation busters in form of FAQs.	Thank you for your comments. The committee thought that it was important that people are provided with opportunities to access trusted information. This is covered in the invitations and reminders section of the guideline.
Patient information Forum (PiF)	Guideline	020	014	Add in 'Homeless people'.	Thank you for your comments. The committee discussed this and decided to highlight homeless people as one of the groups who are not registered with a GP practice but should be offered vaccinations. A link to the NICE

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					homeless guideline which is due to publish in March has also been added to the end of this recommendation.
Patient information Forum (PiF)	Guideline	021	024	Tackle practical concerns like needle phobia.	Thank you for your comments. Based on this and other comments the committee have added an additional point to the recommendation about training and education for people who administer vaccines. This explains that people should know how to overcome individual barriers to vaccination, including needle phobia.
Patient information Forum (PiF)	Guideline	021	026	Hyperlinks to online consent forms should be embedded with invitations sent to patients to make completion of consent easier.	Thank you for your comments. The committee have added a recommendation that the invitation, information and consent form should be available in both digital and non-digital formats. This ensures that people can access online consent forms, but that people who cannot access digital content will not be excluded.
Patient information Forum (PiF)	Guideline	028	General	Rationale discusses the needs of the housebound. Digital exclusion can be an equal barrier to accessing services and information and should be covered more widely in this guideline.	Thank you for your comments. The committee discussed this and agreed that people should not be excluded because of a lack of access to digital content. An additional point has been added to the recommendation in the section about making services accessible to say that commissioners should 'Provide a range of accessible options for booking appointments, such as telephone booking and online systems, taking into account that some individuals may need additional support to use these systems'. In the section about keeping records up to date there is also a recommendation that GP practices should keep a record of people's preferred methods of contact, such as letters or emails. This should ensure that people are not sent digital information if this is not a preferred method of contact for them.
Pfizer	Guideline	004	004	Rec 1.1.1 – We support this recommendation to introduce a named vaccination lead as an important	Thank you for your comments and support of having named vaccination leads. The committee discussed the

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				opportunity to integrate vaccination within healthcare decision making for patients. Vaccination leads can play a key role in orientating an organisation around the importance of vaccination. However, in the introduction of named vaccination leads, we are concerned that this recommendation may imply that the responsibility for ensuring vaccination is prioritised sits with only one person and could be viewed as a "tick-box" exercise. The recommendation also does not address the potential role of a named vaccination lead in ensuring that adult vaccination is given the same priority as childhood vaccination. The responsibilities listed are welcome and they should help coordinate and synchronise efforts to improve vaccination uptake. However, in order to deliver on these responsibilities, it will be important to ensure the named vaccination lead is supported through various measures such as: • Appropriate access to vaccination records; • Technological capability to monitor, identify and communicate with members of the public eligible for vaccination; and,	role of the vaccination lead and how they are intended to have responsibility for ensuring that all the necessary processes are in place to facilitate vaccination. They agreed that this would by necessity involve working with other people thus ensuring that that the responsibility for ensuring vaccination is prioritised does not sit with one person alone. As such, they did not think that this would result in this becoming a tick box exercise. They agreed that adult and child vaccinations are both important but decided that this is not something that needs to be specifically stated in the recommendations covering vaccination leads. The committee discussed the importance of vaccination leads having access to the necessary information and facilities to ensure they can successfully complete their role. They decided that this is something that should be highlighted in the recommendations and in response to your comment they added a new recommendation in the vaccination lead section to ensure that this happens. The committee noted that if vaccinations are provided in the emergency department, then the relevant parts of this recommendation would also apply. Otherwise, in addition there is a separate recommendation for secondary and tertiary care providers who do not routinely provide vaccinations and emergency departments are listed as settings for opportunistic identification of vaccination status. In response to your comment the committee added emergency departments to the recommendation for training

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				• Adequate measures and protocols for coordination between service providers. As such, the introduction of vaccination leads should come in tandem with additional other measures to support leads and ensure they can efficiently meet and exceed vaccination targets. An additional idea that could be led and delivered by named vaccination leads would be to set up vaccine clinics in hospitals which could help to vaccinate people with comorbidities that are eligible for certain vaccines, to enable them access to vaccines without having to navigate primary care.	for healthcare practitioners who do not administer vaccinations. The committee have also added a cross reference from the section about people who are not registered with a GP to direct people back to the recommendations on opportunistic identification. As part of the committee's discussions about the evidence using different settings for vaccination, the committee explored the possibility of having drop-in immunisation clinics within or alongside hospitals. This was not considered further as it was likely to be associated with substantial resource implications, especially if these clinics were to be set up in every hospital (see evidence review D for more details and a costing exercise). However, where vaccinations are already available in a hospital setting, including an emergency department, then they could be used for opportunistic vaccination This action is covered by a general recommendation in the section on identifying people eligible for vaccination and opportunistic vaccination, which also covers discussing any outstanding vaccinations. If, however, vaccinations are not available then the healthcare practitioners can encourage them to book an appointment for a vaccination elsewhere.
Pfizer	Guideline	004	016	Rec 1.1.3 – We support the recommendation to introduce a named vaccination lead within social care providers and providers of other non-healthcare services. In implementing this, appropriate mechanism and protocols should be in place to ensure that these individuals have the latest vaccination information and	Thank you for your comments and support of this recommendation. The committee made recommendations for health and social care practitioners and other related staff (for example, receptionists in primary care) who do not provide vaccinations to be given training about vaccination. This included a summary of what this training should contain, although the content and depth of the information would need to be tailored to the person's role. However,

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				are adequately trained to provide vaccination education for individuals who may ask for more information. Moreover, all measures that place a responsibility on social care providers to identify those eligible for vaccinations should be supported with ongoing communications channels with general practice to monitor and follow up with individuals as appropriate.	they did not make similar recommendations for people who do not work in healthcare or social care. This is because they thought that these people should be identifying people opportunistically and signposting them to the relevant services rather than providing them with up-to-date vaccine information. It is then the responsibility of people who work in healthcare services to provide more detailed information and discussions about vaccinations. For a similar reason, the committee did not make recommendations about follow-up for the people who provide opportunistic identification services as it is expected that they will be signposting individuals to the vaccination services who will then provide further information, offer vaccinations and carry out any follow-up. However, there is already a recommendation in the section on reminders and escalation of contact for vaccinations for babies, infants and preschool-aged children, and adults that includes considering a multidisciplinary approach to address issues raised by people are overdue their vaccinations and that this might involve a range of other practitioners. This could include social care staff and social workers.
Pfizer	Guideline	005	005	We would recommend consideration be given to introduce accountable targets for adult vaccination where they do not currently exist in order to help to increase uptake in all adult programmes. Adult vaccination coverage is significantly lower than coverage for infant, child and adolescent vaccination and a lack of targets and incentives for programme delivery and a lack of parity in ambition are likely to be factors. Every	Thank you for your comments. NICE cannot recommend specific targets for vaccination uptake as this is beyond the scope of our remit. However, section 1.1 on audits and feedback recommendations that there should be quarterly cycles of feedback and audits of vaccine uptake data, and this should be used to help with continuous improvement. The aim of these recommendations is to help raise awareness of local data, which can be used to try and

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				vaccination programme in the NIP should have accountable and incentivised targets. Although a QOF target was recently introduced for shingles, there is no equivalent for adult/at risk pneumococcal vaccination, for example.	increase vaccination uptake. In addition, there is information provided under terms used in this guideline section about a definition of low uptake that refers to the Public Health Outcomes Framework and the performance indicators that are set out in the S7A NHS public health functions agreement. (See annex B in the current version at publication (2019/2021).)
Pfizer	Guideline	006	004	Rec 1.1.8 – We strongly support efforts to introduce local targeted interventions in areas of low vaccine uptake to overcome identified local barriers to vaccination and address identified inequalities in vaccine uptake between different population groups. One way to support this could include embedding vaccination information easily within the NHS App and creating a public facing version of the 'green book' for adult vaccination. The App could be expanded to include wider details of people's vaccination status for eligible vaccines, building from the success of the COVID-19 vaccination certificates in the App. The App could have the ability to send eligibility reminders for vaccines and include information on the different vaccinations available. We are aware that some of this functionality exists, but it appears inconsistent and patchy, and more work is needed to ensure that this is adopted and in place for all individuals. Additionally, more emphasis is then needed to go into advertising to ensure the public are aware of this functionality within the App/the App in general.	Thank you for your comments. Although the evidence for individual studies and age groups did not strongly favour the use of information and education, the committee thought it was important to provide people with information on the benefits and risks of vaccination. For this reason, they used their experience and the qualitative evidence from the barriers and facilitators review to make recommendations on what information should be provided. However, without stronger evidence, the committee did not think they could make recommendations on how this information should be provided. For this reason, they could not recommend interventions such as adding information to the NHS App. Providing people with app-based records of their vaccination history is something that the committee thought is important. They made a recommendation that people should have access to online systems or apps to access their vaccination status. This should increase people's awareness of whether they have had a vaccination, or are overdue for a vaccination. The committee were aware that transient populations can be at risk of low vaccination uptake, and they highlighted

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				There are also challenges in London and cities with regards to high population mobility and the impact of this on the reliability of the data when it comes to vaccination. It also presents challenges in following up with patients. Without better data targeted interventions to improve uptake may be held back. One way to mitigate this and improve efforts in high population density areas could be to accompany final guidelines with additional resource to these areas to carry out more regular needs assessments and mapping of local populations. Another suggestion could build on some local councils efforts to address COVID vaccine hesitancy through Q&A sessions for the local community. Perhaps a similar concept could be trialled in popular community spots at relevant times to 'myth bust' and share information around other vaccines.	these as one of the populations to consider in the guideline. They also added a recommendation that providers should ensure that people's contact details are kept up to date, so even if someone changes address it should still be possible to invite them for vaccinations. Interventions such as Q& A sessions may be a useful way to address vaccine hesitancy and increase vaccination uptake. However, the committee were aware that the most effective interventions are likely to vary between areas, depending on the local populations. For this reason, they recommended that commissioners and providers should identify local population needs and barriers to vaccination, and use this information to develop the most effective interventions.
Pfizer	Guideline	006	009	Rec 1.1.9 – We support measures to ensure that vaccination services are fit for the local community. We know that service engrained in the communities they serve can help improve vaccination uptake. The more touchpoints for vaccination, outlined in the guidance, is welcomed. Within the guidelines, we believe that community pharmacy as a location can be further utilised to improve vaccination uptake and coverage. Throughout COVID-19, pharmacists have demonstrated their importance to large-scale vaccination programmes. Moreover, they	Thank you for your comments. The committee also thought that pharmacists can play an important role in increasing vaccine uptake. For this reason, they named them as one of the groups that the guideline is made for. Pharmacies have been listed as one of the alternative locations for vaccinations in the section on making vaccination services accessible, and as one of the settings to provide opportunistic identification. Pharmacists have also been identified as one of the groups who should be offered education about vaccinations so that they can provide information and advice when needed. Although the committee cannot make recommendations about changes

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				play a vital role in helping to vaccinate at risk and hesitant communities. There is opportunity to further their role in adult vaccination, building on best practice from influenza and COVID-19 vaccination campaigns. Beyond the pandemic, community pharmacy should be solidified as a key component of vaccination infrastructure with support afforded to them accordingly. Potentially, mechanisms could be introduced within primary care contracts to increase the use of community pharmacy in delivering adult vaccination programmes.	to primary care contracts, they believe that this guideline highlights the important role that the pharmacy profession can play in increasing vaccination uptake.
Pfizer	Guideline	007	015	Rec 1.1.16 - Building on the best practice and collaboration fostered during the COVID-19 pandemic, now is the time to ensure the UK has a robust vaccination ecosystem to protect against future public health threats and existing VPRDs. Vaccination should be the core of a UK prevention strategy, aligning with the NHS Long Term plan's goal of embedding preventative healthcare throughout the system. Ensuring older adults and those living with certain chronic medical conditions are protected against influenza and pneumococcal disease should be prioritised to help alleviate health system capacity, impacted in the context of the current pandemic and beyond as the health system addresses the care backlog. As a result of the pandemic, there is an increased awareness of the importance of adult vaccination.	Thank you for your comments. the committee agree that it is important to build on the effective interventions and collaboration that has been developed during the COVID-19 pandemic. This is why the committee have made recommendations on the importance of evaluating initiatives using during the pandemic and identifying those that can be applied to the routine vaccination programmes. The committee also agree that adult vaccinations should be promoted throughout the year, and this guideline has a number of recommendations aimed at increasing awareness of vaccination and uptake. The committee also thought that the use of digital tools such as the NHS App are important. For this reason, they included recommendations about providing people with online access and app-based access to their vaccination records. The committee did not make recommendations on specific interventions, such as online consultations and Q&A sessions because there was not sufficient evidence

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				Moreover, there is an increased understanding of the impact of diseases caused by respiratory pathogens, which often peak during the winter season, and how these put pressure on healthcare system resources. During the pandemic, health systems have prioritised vaccination as a key healthcare measure to protect the public with influenza vaccination for example at record levels. Going forward adult vaccination should be prioritised to protect adults and reduce mortality but also help alleviate anticipated pressures on the health system. As vaccination programmes against VPRDs such as influenza and COVID-19 are expanded, pneumococcal disease should be prioritised to help alleviate health system capacity in the context of the current pandemic. Community-acquired pneumonia (CAP) in particular is associated with significant resource use and long hospital stays. It remains a serious condition in adults, impacting productivity and family life, and resulting in substantial morbidity and mortality, with possible long-term consequences. In particular, measures should be in place on the importance of adult vaccination all year long rather than just in advance of the winter season. Pneumococcal vaccination for example can be administered all year long, ensuring patients have adequate time to be protected.	for this. However, their recommendations that provider interventions should be based on local population needs means that these types of interventions can be considered if it is thought that they would tackle local barriers to vaccination.

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				Additionally, vaccines can play an important role in mitigating the threat of antimicrobial resistance. By increasing our use of vaccines to prevent infections such as CAP, and only using antibiotics when absolutely necessary, we can ensure that antibiotics are available for many years to come. One specific learning from the pandemic that could be applied to assist uptake of other vaccines has been the significant strides taken in the use of digital tools in supporting patient care. The most high profile has been the NHS COVID-19 App, but there has also been greater uptake of the general NHS App and use of other digital platforms such as online and video consultations for patient and clinician engagement. Digital can play a key role in supporting the uptake of future adult vaccinations and the NHS App provides a good platform this. The App could be expanded to include wider details of people's vaccination status for eligible vaccines, building from the success of the COVID-19 vaccination certificates in the App. The App could have the ability to send eligibility reminders for vaccines and include information on the different vaccinations available. Alongside this for those without the App, further work is needed to ensure that GP systems are able to send out text and other reminders for vaccination to patients.	

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				Another specific option tried and tested by local councils in response to COVID vaccine hesitancy was Q&A sessions for the local community. Perhaps a similar concept could be trialled in popular community spots at relevant times to 'myth bust' and share information around other vaccines.	
Pfizer	Guideline	008	002	Rec 1.1.17 - We support measures to provide education for health and social care practitioners who do not administer vaccines but are in contact with people eligible for vaccination and would recommend this is expanded further to include midwives since they support and can provide information to pregnant women. This would be a welcome step in improving a culture of promoting vaccination with an onus on all healthcare providers to inform and education patients, whether this be through reminders or administering vaccines. In doing this, priority should be given to healthcare setting that are recognised for their role in a local community such as community pharmacies.	Thank you for your comments. The committee agreed that other healthcare staff should also receive education. This recommendation has now been updated to say that health and social care practitioners and other related staff should receive this education. This widens the group of people who should be offered education about vaccinations.
Pfizer	Guideline	008	013	Rec 1.1.18 – As outlined in the guidelines, education material should look beyond simply whether an individual is eligible, seeking to utilise these healthcare professionals as recognised sources of vaccination information, eligibility, and service provision. Education materials should also be tailored for those within "at-risk" groups, highlighting the importance of vaccination as it relates to their medical circumstances.	Thank you for your comments. This recommendation is aimed at people who are in contact with people who are eligible for vaccination but who do not administer vaccines, such as GP receptionists or people who work in social care. The committee did not think it was necessary for these people to have an in-depth knowledge of vaccination, such as detailed knowledge of at-risk groups. Instead, by knowing where to signpost people for further information, they will be able to direct people to healthcare practitioners

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				Additionally, we would suggest NICE guidance for 'at risk' individuals should also refer to immunisation and the benefits this could afford to patients in those 'at risk' categories. This would help to encourage awareness and uptake of vaccination via the patient pathway for diseases that put patients in 'at risk' groups.	who will have a more detailed knowledge of issues relating to vaccinations.
Pfizer	Guideline	011	004	Rec 1.2.6 – We firmly support the approach found within the guidelines that every opportunity should be utilised to identify and communicate with individuals eligible for vaccination. Expand the list included within the guidelines, touchpoints should also be made: • Following receipt of a COVID-19 vaccine • As part of winter influenza vaccination planning In particular, to improve adult vaccination coverage, an adult's vaccination status should be checked, with relevant information provided, when children receive their recommended vaccines. This measure will hopefully identify those deemed at-risk and therefore eligible for a recommended vaccine such as pneumococcal.	Thank you for your comments. The committee were aware that there are many different ways that people can be identified as eligible for vaccination. They therefore decided to make a list of some of the possible ways in which people can be identified, but this does not exclude other methods not included in the examples. Although influenza vaccination planning is not specifically included in the recommendation, other recommendations such as 1.2.9 and 1.2.12 on the use of vaccination records and prompts from electronic medical records, mean that people could still be identified when attending a GP surgery for their flu vaccination.
Pfizer	Guideline	012	011 – 019	We strongly support these recommendations based on learnings from the COVID-19 pandemic and support steps to ensure personal vaccination records are readily accessible for all other vaccinations. A lifelong, easily	Thank you for your comments. The committee also discussed the importance of providing people with access to online systems and apps that allow them to access their vaccination records and included this in the

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				accessible personal immunisation record should be available to people who want it and it is no longer acceptable that this is only delivered through the red book/e red book for children or for pandemic vaccination. The existing NHS app should be expanded to include people's vaccination status for all vaccines, and the app could have the ability to send eligibility reminders for vaccines and include information on the different vaccinations available.	recommendations. More information about their discussions are available in the rationale section of the guideline and the committee discussion section of the identification evidence review (Evidence review A).
Pfizer	Guideline	015	008	Rec 1.3.1 – In improving vaccination coverage, it will be important that coordinated systems and protocols are in place at the local level for providers to send out invitations and reminders. As such, we support this recommendation within the guidelines. However, we believe it is important for this to go as far as possible to ensure all patients are reached, and most importantly feel informed to receive their vaccination. In the context of the current vaccination landscape, and rise in vaccination misinformation, NHS England public health commissioning teams and screening and immunisation teams should ensure their communications through invitations and reminders provide the appropriate information on each recommended vaccine along with links to NHS resources. We support measures within the guidelines to ensure reminders are given in a format and language appropriate for the person and their family members or	Thank you for your comments. The committee also thought that, alongside invites and reminders, it is important to provide information that explains why that vaccine is important. For this reason, the committee included two recommendations in section 1.3 on initial invitations which state the important information that should be included alongside vaccine invitations, with the aim of increasing people's awareness of the benefits of the vaccination that they are being invited for.

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				carers. However, this should go further as it related to at-risk patients who are recommended certain vaccines. Vaccination communications, through invitations and reminders, should take into account the specific reasons as to why an individual is deemed at-risk and the importance of receiving their vaccine as a form of protection. This measure could go some way to improving adult vaccination rates for at-risk groups. For examples, pneumococcal vaccination uptake amongst 'at risk' groups varies greatly.	
Pfizer	Guideline	016	010	Rec 1.3.6 – We support this recommendation for NHS England public health commissioning teams and screening and immunisation teams to consider sending invitations and reminder for different vaccinations together. Vaccination, particularly for adults, should be viewed holistically with information provided on all available and recommended vaccines. This will allow for patients to make decisions with information about various recommended vaccines and the protection they afford. As vaccination programmes against vaccine preventable respiratory diseases such as influenza and COVID-19 are expanded, other vaccines against diseases such as pneumococcal disease should be prioritised in tandem to help alleviate health system capacity.	Thank you for your comments. The committee agree that people should be provided with information on all the vaccines that they are eligible for. This is covered in more detail in section 1.3 on invitations, reminders and escalation of contact.

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Royal College of General Practitioners	Guideline	004	009	Can the committee recognise that the GP contract determines when to call and recall patients for their vaccinations and whilst having a named individual is important, there are some situations that primary care will not be able to send reminders to their patients. For example, the GP can proactively call & recall a 70-year-old for shingles vaccination but cannot do so for the 71-79-year olds because the contract does not allow call & recall for this cohort – it allows for 'opportunistic' vaccination only. It is one thing to be eligible for vaccination and another for the GP Contract to allow a patient to be called and recalled. It is important that this nuanced is recognised in the guidance.	Thank you for your comments. Information has been added to the rationale section about invitations for babies, infants and preschool-aged children, and adults to clarify that the current GP contract states that call-recall activity is limited for some vaccinations and that these people should instead be identified opportunistically. However, the committee agreed that there are times when it would be beneficial to go beyond the specifications of the contract if this results in increased vaccine uptake and that by recommending what they think is best practice this could facilitate changes to the GP contract in the future. They also noted that interventions that involved inviting people for vaccinations (call) and reminding them (recall) were among the most effective types of interventions identified in the evidence reviews in terms of increasing vaccine uptake.
Royal College of General Practitioners	Guideline	004	010	Can the committee consider amending the line "vaccines are administered and recorded" to increase it's accuracy as follows? "vaccines are administered according to the product licence and recorded in the personal electronic notes of the individual that has received the vaccination/s"	Thank you for your comments. The committee declined to make this change because this recommendation is about the responsibilities of named leads rather than how the vaccine is administered and recorded. This information is covered later in the guideline in section 1.2 on Recording vaccination offers and administration. There is a separate recommendation there aimed at ensuring that patient held records are updated. The committee did not add the requested text about ensuring that vaccines are administered according to the product licence because this point applies to every treatment administered/ offered by a prescriber and is part of their expected professional duties.
Royal College of	Guideline	009	004	PHE needs to be changed to UKHSA. This occurs throughout the document.	Thank you for your comments. This has been updated throughout the guideline.

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General Practitioners					
Royal College of General Practitioners	Guideline	010	019 – 020	The new GP contract in England states that primary care should also inform CHIS if three invitations for vaccination are made (the 3rd on the phone, direct), and a child still remains unvaccinated. Please can this be added to the guidance?	Thank you for your comments. The committee discussed this and agreed that the guideline should highlight what should be done if a child remains unvaccinated after three invitations. They therefore added a new recommendation to the section about keeping records up to date which highlights that GP practices should inform CHIS if a child remains unvaccinated after three invitations for vaccination are made.
Royal College of General Practitioners	Guideline	012	024 - 026	Can the committee consider reviewing or removing this recommendation? It is impossible in practice to achieve this recommendation due to how primary care works. Temporary patients attend for 10-minute urgent consultations only. By definition, they are temporary and require short term health care management, rather than long term care, which is given by their registered GP. Without access to their regular GP records, to enable a vaccination status review will require significant administrative burden and time to process the temporary resident checks prior to the person being seen. This could cause unintended consequences of delaying the appointment whilst waiting for a "vaccination history" from their routine GP provider which would be potentially detrimental to care. Could the recommendation instead focus on the need for GP IT system integration, to make it easy for GP practices to check the vaccination status of temporary residents?	Thank you for your comments. The committee discussed this and were aware that it can be difficult to obtain the vaccination status of temporary residents. However, they were also aware that this can be a barrier to vaccination and can leave this group of people at risk of being under vaccinated. With no clear system in place to identify the vaccination status of these people, the committee thought it would be beneficial for GP practices to have their own processes in place where possible. While this may be difficult to achieve with the systems that are currently available, the committee thought that this is something that should be aimed for in the future.
Royal College of	Guideline	012	027 - 029	Can the committee consider rewording this statement to make it clearer?	Thank you for your comments. The committee discussed this and were satisfied that this was describing opportunistic identification. To clarify this they have added

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General Practitioners				This statement does not appear to take into consideration the differentiation in the GP Contract of "call/recall" and "opportunistic" vaccination. In this recommendation you appear to be describing opportunistic vaccination, for those who are overdue their vaccination, which can only be completed when a patient is with the clinician in an appointment. This is when prompts and reminders can be used. For the call and recall, prompts and reminders do not work and instead searches of the system are required to identify eligible populations. Can we suggest "for opportunistic vaccination, providers should use prompts and reminders to identify those who are overdue vaccinations".	that this should happen when a person is eligible and due or overdue for vaccination. This should distinguish this scenario from one where a provider is searching the system for people for call/recall.
Royal College of General Practitioners	Guideline	017	014 - 017	Patient confidentiality is paramount and recommending that reminders be sent without consent to carer and family members is not allowed under GMC rules on confidentiality. Can the committee consider adding "if the person has consented, consider sending the vaccination invitation…"?	Thank you for your comments. The section labelled 'Terms used in this guideline' states that family members or carers are people who have legal responsibility for decision making for an individual who is eligible for vaccination but cannot make this decision for themselves (such as those with lasting power of attorney). Since invitations will only be sent to the relevant carers or family members of these people issues of confidentiality will not apply here. The committee therefore did not make the changes you suggested.
Royal College of General Practitioners	Guideline	018	017 – 021	The recommendation states that the GP surgery / provider should confirm that the person has received the reminder. This is not possible unless the person calls the GP surgery to acknowledge the receipt. Can this sentence be removed?	Thank you for your comments. The committee thought that this could be best achieved via a phone call to the person who has not received their vaccination, based on a system of escalating reminders. More information about this is provided in the Reminders and escalation of contact section of the rationale.

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Royal College of General Practitioners	Guideline	019	023 - 026	Home visits in primary care are offered to housebound patients. For those who have difficulty with transportation, could the recommendation instead consider help with social care funded transportation to vaccination services rather than a home visit? In rural areas, a home visit may take 30-45 minutes taking a clinician away from face-to-face care for an extended period where at least four patients could otherwise be seen. Innovative approaches to vaccination, especially in times of extreme workforce challenges should be considered as alternatives to home visits in the first instance.	Thank you for your comments. Although this could be a helpful way for some people to access vaccinations, we did not find any evidence to support a recommendation that would involve the costs associated with funding travel to vaccination services. However, the committee did make a recommendation for alternative settings for vaccinations and these could include using mobile vaccination units and using sites outside healthcare settings such as community or faith centres. Other recommendations are aimed at ensuring that the locations are tailored to local needs.
Royal College of General Practitioners	Guideline	021	025 - 026	We question the need for incentivising people to return of consent forms to win a prize. Consent should be based on fully informed consent and patient/ parent choice and not the hope of "winning" money or prizes. If this approach is taken, it is essential that individuals have an equal chance of "winning" whether they agree to vaccination or not and this should be explicitly written on the form for transparency and to prevent unintended coercion.	Thank you for your comments. The recommendations are for the use of incentives for consent form return rather than consent itself. The committee thought that this was an important distinction as the young person will be eligible for the incentive just by returning the form, whether or not they consent to vaccination. Individuals should have an equal chance of winning whether or not their consent form says they consent to vaccination.
Royal College of Nursing	Guideline	General	General	We welcome the guidelines including the visuals and evidence. They give an overview of all vaccine programmes. It is useful to see the rationale and evidence for a range if interventions. There are three clear overarching recommendations with sections included.	Thank you for your comments and support for this guideline.
Royal College of Nursing	Guideline	General	General	Given what we have learnt about the COVID vaccine programme and data can this not state that having much clearer electronic links between CHIS, GP and other	Thank you for your comments. The committee agreed with your comment that it is important that vaccination information can be shared between different providers and

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				service providers need to be built in. This will help in identifying eligible groups and missed vaccines as well as call and recall	settings. They therefore made a new recommendation about the coordination of reporting systems to help ensure compatible systems are in place to enable the effective and timely transfer and sharing of vaccination records between different parts of the health and care system. However, the committee recognised that developing and implementing a compatible system could be time consuming and costly and that it may be more effective, at least in the short term, to develop compatible processes to facilitate information transfer.
Royal College of Nursing	Guideline	007	015 - 018	Audit and feedback It would be useful here to be explicit that vaccine and immunisation programmes need to be considered together. While the COVID programme through necessity has needed a clear programme of work. The Green Book is the key document but there are other letters and pieces of information. All guidance and documentation, strategic planning to be available in one place and this should be in the same platforms as other programmes. This will help to ensure lessons learnt are see across the programmes	Thank you for your comments. The committee agree that it may be useful if there is coordination of guidance and documentation linked to different immunisation programmes. However, it is beyond the remit of NICE to recommend this level of strategic change.
Royal College of Nursing	Guideline	009	003	We appreciate that there is limited actual evidence but could the guideline make it explicit that the National Minimum Standards provides a benchmark of the content for immunisation training?	Thank you for your comments. Although this is not mentioned directly in the recommendations, the rationale for this section explains that the National Minimum Standards sets out the content that should be covered by people who administer vaccines.
Royal College of Nursing	Guideline	019	027 - 029	section 1.3.19	Thank you for your comments. The committee had to prioritise which sections of the guideline they thought would most benefit from the inclusion of the visual summaries.

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				The escalation approach for Call and recall is useful. Could there be another visual to show this specifically? We agree that the final contact refusal should be documented. Should this include that individuals / parents be informed that this is being recorded? Is there something about getting people who refuse to sign something to accept their responsibility in this? It is something many practices seem to want to adopt. Is there any evidence to support individuals or parents to sign to say they refuse but understand they can get back in touch and when further vaccines are due the surgery will contact them. We have a number of nurses asking what would be the best way to manage this. This will need to be in the visual as well.	There was no evidence to indicate whether people signing to say that they had declined vaccination was effective and so the committee could not make recommendations on this.
Royal College of Nursing	Guideline	021	021	Should this include nationally available resources where available an appropriate to avoid duplication	Thank you for your comments. The committee discussed how there are national resources available but none that they were aware of that have been evaluated for effectiveness. Our research questions for this guideline did not include the effectiveness of specific educational materials and so the committee did not feel they could recommend any specific resources.
Royal College of Nursing	Guideline	022	021	The RCN are developing a revised consent tool online which should be available by the time these are published.	Thank you for your comment and this additional information.
Royal College of Nursing	Visual summaries	General	General	These are really useful.	Thank you for your comment and support of the visual summaries.
Royal College of Paediatrics	Guideline	General	General	We welcome the publication of this document which attempts to increase the uptake of immunisation. However, we are disappointed that, while we have a good understanding of the characteristics of groups who	Thank you for your comments. The committee also noted the shortage of evidence for interventions to increase uptake in groups with low vaccination. They agreed that more evidence is needed and therefore included a number

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and Child Health				are not vaccinated, there is very little progress in terms of evidence for effective interventions.	of research recommendations in the guideline, which can be seen in the 'Recommendations for research' section including one focusing on interventions to increase uptake in populations with low uptake and the acceptability of these interventions.
Royal College of Paediatrics and Child Health	Guideline	General	General	We welcome the emphasis on using any opportunity to pass on information about vaccination AND administer vaccines in non-traditional settings. Our members see children with chronic conditions and are in an ideal position to provide advice about vaccination, to reassure parents of the safety of vaccines in complex conditions and to ensure false contraindications to vaccination are not applied. We were glad to see encouragement of the administration of vaccines in secondary and tertiary care.	Thank you for your comments and support for this guideline.
Royal College of Paediatrics and Child Health	Guideline	General	General	We can find no mention of contraindications in the document. There are very few true contraindications to vaccination, yet significant numbers of people are denied vaccination because of conditions/events that are wrongly considered to be contraindications. We believe that there should be a section devoted to this and emphasising how rare contraindications truly are. We would suggest that a contraindication should not be assigned to a vaccine without confirmation by an expert.	Thank you for your comments. Taking your comment into account the committee have added a recommendation in section 1.2 which aims to address this issue by directing healthcare providers to consult the Green book or specialist advice when uncertainties exist around contraindications and allergies. This should reduce the risk of people not being offered vaccinations when they are actually eligible. The committee have also added information to the recommendation in section 1.3 about what the vaccination invite should contain. This now mentions contacting a healthcare professional to discuss concerns, including possible contraindications or allergies that could affect people's ability to be vaccinated. This should give people the opportunity to address any questions over eligibility.

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Royal College of Paediatrics and Child Health	Guideline	009	001	We would like to flag the statement that social care practitioners are administering vaccines. We were not aware that this was the case.	Thank you for your comments. This was an error and has been updated to say healthcare practitioners, with no reference to social care.
Royal College of Paediatrics and Child Health	Guideline	010	013 - 014	We are not aware of exact details of what is included in the templates, but we are aware that there is not always consistency in the codes used for different vaccines. We feel it might be worthwhile specifying the need for consistent coding.	Thank you for your comments. The committee decided that it was important to add the need to use the most up-to-date SNOMED codes when recording vaccinations.
Royal College of Paediatrics and Child Health	Guideline	012	027	Some practices flag the records of family members, particularly of mothers, when a child is incompletely vaccinated. This allows the practitioner to raise the issue, if appropriate. We think this should be mentioned as a possibility.	Thank you for your comments. The committee agreed that this is a useful way to identify babies and children who are overdue for their vaccinations, and to facilitate discussions with their parents or carers. Based on your comments they have added an additional recommendation in section 1.2 on identifying people eligible for vaccination highlighting that prompts should be used on the records of parents or carers.
Royal College of Paediatrics and Child Health	Guideline	014	003	Where there is a contraindication to one or more vaccines being given, it is important that, not only is this recorded, but also whether it is temporary or likely to be permanent. If the former, there should be a review at intervals as to whether the contraindication still stands.	Thank you for your comments. The committee did not add this requirement to the recommendation because they envisaged that if a person was contraindicated then they would not be offered the vaccination and therefore not be covered by this recommendation. However, they recognised that there could be confusion around contraindications and included a recommendation about consulting the Green book and seek expert help if needed to determine if a person is really contraindicated. They also added references to contraindications to recommendations covering staff education and information to go in the vaccination invitation. If people are only temporarily contraindicated then they can still be identified

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					opportunistically or by when reminders are sent out for overdue vaccinations and offered vaccinations at these times.
Royal College of Paediatrics and Child Health	Guideline	019	001	Immunisation during pregnancy is extremely important, yet uptake falls far short of what we would like. We believe that vaccination should be mentioned at the first appointment that a pregnant woman has after pregnancy has been confirmed, whether that be with primary care or the booking visit in maternity care. The vaccine can be given any time from 16 weeks gestation onwards, so although the advice should be repeated after the 20-week scan, if should not be the first time it is given. Even though the prime responsibility for vaccinating pregnant women often lies with the maternity service, if a woman is seen in primary care and vaccination is overdue, the default should be for it to be offered and administered there and then, unless there is a medical reason not to.	Thank you for your comment. NICE has an antenatal care guideline that covers information to be provided and discussed with pregnant women in detail. In particular, there is a recommendation with a bullet list of information to be provided at the first antenatal (booking) appointment (and later if appropriate). This includes immunisation for flu, pertussis (whooping cough) and other infections (for example, COVID-19) during pregnancy, in line with the NICE guideline on flu vaccination and the Public Health England Green Book on immunisation against infectious disease.
Royal College of Paediatrics and Child Health	Guideline	019	015	We feel that this should apply to any circumstance where there is a gap in vaccinations, including, for example, 'at-risk' groups with chronic conditions.	Thank you for your comments. This recommendation covers all of the adults who would be invited for vaccinations on the routine schedule. People who would be invited for selective immunisation programmes or for additional vaccinations for people with underlying medical conditions are out of scope for this guideline.
Royal College of Paediatrics and Child Health	Guideline	019	027	As well as recording the fact that someone has declined a vaccine, the practitioner should offer to talk again.	Thank you for your comments. The committee thought it was important to highlight that if someone declines vaccination, they should know that they can change their mind. This could include a vaccination appointment which provides an opportunity for discussion of any concerns.
Royal College of Physicians	Guideline	General	General	The Royal College of Physicians and Surgeons of Glasgow although based in Glasgow has a membership	Thank you for your comments and support for this guideline.

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and Surgeons of Glasgow				of 15,000 and represents Fellows and Members throughout the UK. While NICE has a remit for England, many of the recommendations are applicable to all devolved nations including Scotland. They should be considered by the relevant Ministers of the devolved governments and in the NHS environment in each country. The College welcomes this guidance on Vaccine Uptake in the General Population. It considers that all members of the public should be given the option of immunisation against various diseases and be given information to give informed consent. The guideline hits the right balance in addressing how to improve uptake. There has been much talk of vaccine hesitancy with regards vaccine confidence; but recent PHE and other research shows vaccine confidence (non-COVID) is high, and drop off in vaccine uptake is more about access and systems.	
Royal College of Physicians and Surgeons of Glasgow	Guideline	001	006	We are concerned that a large number of vaccination programmes are excluded from this guideline. The general principles are the same for all programmes. However, the guideline does not include selective immunisation programmes eg Influenza. These are the ones where it is most challenging to achieve uptake (and conversely given they are selective; the patients generally stand to benefit more).	Thank you for your comments. Influenza vaccination was out of scope for this guideline update as this is already covered by NICE guideline on flu vaccination: increasing uptake (NG103). The flu guideline includes a section on increasing uptake among eligible groups in primary and secondary care. The current guideline only covers the uptake of vaccinations that are on the NHS routine schedule. However, NICE is aware of the overlap between different vaccination programmes that you mention and is planning on looking at how to integrate the guidance on vaccinations in the future. In response to your comment,

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					we have added cross references to the flu guideline to the start of each section of the routine vaccination guideline.
Royal College of Physicians and Surgeons of Glasgow	Guideline	004	002	It is on note that there are various systems for giving immunisation within the UK. Within England, during the pandemic there have been a variety of systems not confined to Primary Care. These may be in an alternative separate system, eg primary care service other than general practice, secondary care or commercial system. There needs to be coordination between these systems for arrangement of the service and recording the service. The primary recording system should be in the Primary Care Record. During the pandemic, those at high risk often had difficulty getting a COVID-19 immunisation from secondary care because it was not the "normal" method. However. it was the easiest for the patient. This applies to patients with malignancy, in chemotherapy or those with significant disease requiring immunosuppression.	Thank you for your comments. The committee also agreed that it was important that vaccination information can be shared between different providers and settings. They therefore made a new recommendation to try to ensure that compatible systems are in place to enable the effective and timely transfer and sharing of vaccination records between different parts of the health and care system. If implemented this would help to facilitate the accurate and timely update of vaccination records across different providers and make it easier to identify eligible people. However, the committee recognised that developing and implementing a compatible system could be time consuming and costly and that it may be more effective, at least in the short term, to develop compatible processes to facilitate information transfer. Other recommendations cover ensuring that the GP record is accurate and is kept up to date. Although many vaccination programmes are delivered by GP practices, the committee were aware of the alternative settings used during the COVID-19 pandemic, and the success of providing these different locations and times for vaccinations. For this reason, they made recommendations on making vaccination services more accessible by tailoring opening hours and locations to local needs. This should ensure that there are a wider range of settings provided for vaccination programmes in the future.

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				Whilst the general principles of ensuring good vaccine uptake are the same across the UK, service delivery is increasingly different in Scotland. As part of the 2018 GMS contract, Scottish Government and SGPC agreed that vaccinations would move away from a model based on delivery in general practice to one based in Boards/HSCPs. This vaccine transformation programme was due to be completed March 2021, now postponed to March 2022. From April 2022 general practice will not be involved in vaccine delivery. As GPs historically have been the main provider of choice in the rest of the UK, the NICE guidance assumes most delivery is within the GP setting. However, during the COVID-19 pandemic this was not the case and may not be the same in all areas of the four countries of the UK including England. http://www.healthscotland.scot/health-topics/immunisation/vaccination-transformation-programme	While NICE has a remit for England, many of the recommendations are applicable to all devolved nations and so they can all choose to use recommended products and services. However, if different models of routine vaccine delivery prove effective in Scotland and other counties within the UK then they would be of interest in the future when this guideline is updated.
Royal College of Physicians and	Guideline	006	001	One of our reviewers felt that accessibility and tailoring patient needs was a crucial element. Providers need to assess uptake by small areas such as local geography, ethnicity and deprivation. This should be in all areas, not	Thank you for your comments. The committee recognised the importance of accessibility and tailoring to local and needs and for this reason they included an entire section of the guideline on this topic. The recommendations in this

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Surgeons of Glasgow				just those with low uptake. This is because even at local authority the overall uptake can hide variation at more local level. In infectious diseases this can lead to pockets of susceptible people where infection can rapidly spread. Examples, might be religious communities, travelling people and homeless people etc. Paras 1.1.10 and 11 should be recommended more strongly than 'consider' (especially as the evidence is quoted in p31).	section cover identifying local population needs, and in areas of low uptake introducing targeted interventions to overcome local barriers to uptake and inequalities between populations. The committee also recognised about the importance of identifying areas or populations with low uptake and added this to the first recommendation within this section to make it clear that the low uptake may be limited to a particular population within an area. They also included an information box, in response to stakeholder comments, that highlights some population who are known to have to be at risk of low vaccine uptake. The committee was not able to make the requested recommendations stronger because the use of alternative settings and extended hours for vaccination could be costly and they would need to be chosen to address local barriers to uptake rather than, for example, just displacing vaccinations from GPs to other settings. For more costly interventions to be strongly recommended the committee need to have clear high-quality evidence supporting their effectiveness. In this case the evidence quality was moderate to very low and the included studies covered a limited range of alternative settings. The committee therefore lack the evidence to make a stronger recommendation here. Furthermore, in some places the use of alternative settings may not be the most effective way to address local barriers to vaccination. In these places, other interventions may be more cost-effective methods of increasing vaccination uptake.
Royal College of	Guideline	007	009	Audit is really important and links to above. There is no mention of the essential regular vaccine uptake	Thank you for your comments. The committee also thought that audits are important to ensure the quality and

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Physicians and Surgeons of Glasgow				surveillance and analysis of local uptake, including inequalities etc. Unless this is done on a regular basis at local level, it is difficult to know where to target the initiatives as above. Audit should include waiting times for all vaccinations. There should be a target of no wait for any routine vaccinations: yet often there is a wait for preschool booster. Also audit of non-attenders is important. It is necessary why people don't go to an appointment.	effectiveness of routine vaccination programmes. For this reason, they included a section in the guideline about audits and feedback which recommends quarterly cycles of feedback and audits of data. They also recommended that this data is used to review current and past activity to help with continuous improvement. As mentioned in the rationale, this could also be compared with other providers to identify if a particular intervention is the most effective. However, the evidence for audits and feedback was inconclusive and so the committee did not think they could be more specific on what should be monitored beyond vaccine uptake data.
Royal College of Physicians and Surgeons of Glasgow	Guideline	009	003	It is noted that while mandatory training is important it was a significant barrier to providing services in a Pandemic. It is important to prioritise what is absolutely mandatory, what is desirable and what is deliverable.	Thank you for your comments. The committee thought that it is important for people who provide routine vaccinations to complete the necessary training before administering vaccinations. Vaccinations that are not on the routine schedule, such as those delivered during a pandemic, are out of scope of this guideline. As such, the recommendations in this guideline do not mean that anyone who provides vaccinations under different circumstances, such as in reaction to a pandemic, have to complete all of the same training as those who regularly provide routine vaccinations.
Royal College of Physicians and Surgeons of Glasgow	Guideline	010	005	We strongly support identifying eligible people and subsequent opportunistic vaccination. Online systems and apps would indeed be a major step forward. However, some at risk groups do not have access to these eg elderly people and those who are homeless. We should endeavour to have a life-long immunisation record, much as is being developed for	Thank you for your comments. The committee were aware that not all people would have access to online systems. For this reason, they decided to include a recommendation which lists other opportunities to identify people eligible for vaccination. This includes health service contact with people who are homeless, at arrival in prisons and in other healthcare settings such as drug and alcohol services.

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				COVID which should be part of the Primary Health Record. There should be more included on trusted healthcare provider (eg Blood Borne Viruses Services etc). Populations that are at risk and vaccine uptake needs to be maximised for those in Custodial Care (eg prison, asylum seekers, secure psychiatric units, long term residential health care) and those who are homeless and drug users.	
Royal College of Physicians and Surgeons of Glasgow	Guideline	010	009	The important recommendations for keeping records up-to-date are challenging. As crucial as identifying those who has been vaccinated, is identifying the correct cohort (up to date medical records) who need and should be vaccinated. Denominator inflation is a real issue in interpreting vaccine uptake (eg easier to get on a practice list than to get off). If the correct information is not available, then contacting to remind people is not possible.	Thank you for your comments. Although there may be challenges in keeping the records up-to-date, the committee thought this is an important aspect of increasing vaccine uptake. This process may be helped by the recommendation to ensure that GP practices have up to date contact details for people, including phone numbers and email addresses. This way it should be possible to contact people who are eligible for vaccination even if they change address and do not update this information.
Royal College of Physicians and Surgeons of Glasgow	Guideline	011	004	The examples given are good but they exclude homeless people, new migrants and people whose first language is not English.	Thank you for your comments. The committee were aware that there are many different ways that people can be identified as eligible for vaccination. They therefore decided to make a list of some of the possible ways in which people can be identified, but this does not exclude other methods not included in the examples. These examples include any health service contact with people who are homeless and when new migrants arrive in the country.
Royal College of Physicians	Guideline	014	001	Recording vaccination offers must made as easy as possible. While drop down electronic methods are	Thank you for your comments. The committee also thought that recording vaccinations, or offers of vaccinations, should be made to be relatively simple. A recommendation

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and Surgeons of Glasgow				excellent, some will still require other methods of (non-electronic) recording.	was included that is aimed at ensuring that, where possible, electronic health record templates are used. Another recommendation indicates that people should ensure that templates are up to date, which should ensure accurate recording using the most up to date methods.
Royal College of Physicians and Surgeons of Glasgow	Guideline	017	029	1.3.12 is important as it will allay vaccine misinformation. An invitation is not enough, it must be backed up by fact.	Thank you for your comments and support for this recommendation.
Royal College of Physicians and Surgeons of Glasgow	Guideline	019	007	We very much support 1.3.15. In order to do that it is important these infants are correctly identified with the correct contacts for them. We should tailor reminders to the person's preferred mode of communication, but we could still do a lot more. Many people get far more reminders about their dental appointment or the car going in to the garage than a routine immunisation appointment. Non-attenders are a real issue and cause inefficiency and are often because people forget or the appt is not suitable to them (hence the importance of item 1 on accessibility, as well as choice).	Thank you for your comments. The committee agreed that it is important that people are sent reminders and that they are in a format that is most appropriate to them. However, they were also aware that sending multiple reminders will take up time and resources, and people who do not want vaccinations may find this annoying. For this reason, the committee included the section on escalation of contact but did not choose to recommend ongoing reminders if a person does not want vaccination. More information about this is available in the rationale section of the guideline.
Royal College of Physicians and Surgeons of Glasgow	Guideline	020	001	There is no specific advice for those who are homeless or who live on the streets.	Thank you for your comments. The committee discussed this and decided to highlight homeless people as one of the groups who are not registered with a GP practice but should be offered vaccinations. A link to the NICE guideline on Integrated health and care for people experiencing

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					homelessness which published in March 2022 has also been added to the end of this recommendation.
Royal College of Physicians and Surgeons of Glasgow	Guideline	021	004	Routine vaccinations at school require parental consent. The return of consent forms determines uptake. In most instances consent forms are not returned because they didn't get out of the schoolbag, got mislaid, the dog ate it etc. 1.3.28 says 'providers should offer incentives' - much stronger wording than 1.1.10 and 11. There should be pilots of online consent form return. Nearly everything to be signed for at school is now online. The requirement to complete all fields and drop downs would also improve quality of returns.	Thank you for your comments. The committee discussed online consent forms and agreed that this is a useful way to obtain consent for school aged vaccinations. For this reason, they added a recommendation to section 1.3 on routine vaccinations at school that providers should ensure that the invitation, information and consent form is available in a digital format with non-digital options available where needed. This may help address issues with paper-based consent forms while also ensuring that people who do not have access to digital content are not excluded from access to vaccinations.
Royal College of Physicians and Surgeons of Glasgow	Guideline	022	025	There should be specific mention of student (university and college) vaccinations and recommendations for new students.	Thank you for your comments. As these people are not school children they would no longer be covered by these recommendations. However, the recommendation on opportunistic vaccination in section 1.2 lists one of the opportunities to identify people who are overdue vaccinations as on admission to further and higher education. This should mean that these people will be given the opportunity to catch up any vaccinations.
Royal College of Physicians and Surgeons of Glasgow	Guideline	023	012	The housebound is not an inclusive term. It may include people with protected characteristics and should relate to those who have difficult receiving messages and communication and who are unable to attend a site such as their GP surgery or similar. This can include older people, those with a physical, sensory or mental disability. These people are often most at risk of diseases preventable by immunisation.	Thank you for your comments. The term housebound was used to maintain consistency with NHS documents and websites. In this guideline, housebound refers to people who are unable to leave their home environment through physical or psychological illness. More information about this is available in the section named 'Terms used in this guideline'.

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				Many services are only geared to someone who can attend a specific site and who may not because of protected characteristics.	
Royal Pharmaceutical Society	Guideline	General	General	In general, we welcome the content of this guideline. However, we are aware that pharmacists, especially those working in primary care (GP practice, Community and Care Homes) could be better utilised to identify and provide vaccinations in the general population. We would welcome more inclusion of the pharmacy profession within this guideline.	Thank you for your comments. The committee also thought that pharmacists can play an important role in increasing vaccine uptake. For this reason, they named them as one of the groups that the guideline is made for. Pharmacies have been listed as one of the alternative locations for vaccinations in the section on making vaccination services accessible, and as one of the settings to provide opportunistic identification. Pharmacists have also been identified as one of the groups who should be offered education about vaccinations so that they can provide information and advice when needed. We believe that this guideline highlights the role that the pharmacy profession can play in increasing vaccination uptake.
Royal Pharmaceutical Society	Guideline	General	General	There may be an issue in some places with healthcare professionals offering incentives like chocolates or vouchers in return for people getting vaccinated. Vaccines are medicines and not normal items of commerce and we believe that this approach may actually erode trust in healthcare professionals in the longer term. As is mentioned in this guidance document we believe we should be informing people professionally so they can make educated decisions and provide informed consent to being vaccinated and incentives should not be used.	Thank you for your comments. The recommendations are for the use of incentives for consent form return rather than vaccinations. The committee thought that this was an important distinction as the young person will be eligible for the incentive just by returning the form, whether or not they consent to vaccination. The guideline also recommends a range of information and education to be provided to children, young people and their parents or carers, so this is not intended to replace providing people with the information they need to make an informed decision.
Royal Pharmaceutical Society	Guideline	004	004	We believe that the vaccination lead should also be responsible for vaccine orders and storage governance	Thank you for your comments. An additional point has been added to the recommendation to clarify that vaccination leads are also responsible for ensuring that

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					best practice is followed for vaccine ordering, storage, distribution, and disposal as covered in the Green book.
Royal Pharmaceutical Society	Guideline	005	001	Secondary and tertiary care providers would find it hard to identify people who are unvaccinated without access to GP records and health care to health care professional referral might be more effective than "signposting". It is important that whoever gives vaccines records it on a central database so there is one single national record (ideally covering all the home nations).	Thank you for your comments. These providers are not necessarily expected to have access to GP records. As these providers are likely to be providing opportunistic vaccination services, they may just be asking people if they've had the relevant vaccinations or using other records, such as those held by the patient. Information about ways that people can be identified opportunistically can be found in section 1.2 on identifying people eligible for vaccination. However, the committee recognised that this process could be improved if compatible systems are in place to allow vaccination records to be shared between different parts of the health and care system. They therefore made a new recommendation to address this issue. If implemented this would help to facilitate the accurate and timely update of vaccination records across different providers and make it easier to identify eligible people. However, the committee recognised that developing and implementing a compatible system could be time consuming and costly and that it may be more effective, at least in the short term, to develop compatible processes to facilitate information transfer.
Royal Pharmaceutical Society	Guideline	006	002	Any "local problem" is likely to be mirrored throughout the country. There are national / societal barriers to vaccine uptake so the research on barriers to vaccine uptake should also be undertaken at a national level. As well as incentives to vaccine uptake the advantages and disadvantages of disincentives to vaccinations should be explored e.g., look at what other countries	Thank you for your comments. Although there are likely to be some needs that are mirrored across the country, the committee thought it was most important to identify needs on a local level so that smaller population groups with specific needs will not be overlooked when vaccination services are being put in place in their local areas. This section is not focused on providing information for research but rather on making local services accessible and tailored

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				have done. Different approaches need to be explored in a scientific way to gain evidence for or against such an approach.	to local needs, which may differ across the country. However, the committee also included a research recommendation to identify the most effective and acceptable interventions to increase vaccine uptake in populations with low uptake in the UK. This could cover the kind of approaches that you suggest. However, please note that evidence review G already includes evidence on disincentives (or penalties) to vaccinations taken from other countries. The committee discussion of this evidence and the acceptability of using such methods is covered in the section on the committee's discussion and interpretation of the evidence.
Royal Pharmaceutical Society	Guideline	007	004	A coordinated approach is extremely important which means a move away from competition between different service providers and having a "place-based" approach to vaccination.	Thank you for your comments and support for this guideline.
Royal Pharmaceutical Society	Guideline	010	009	In this section about keeping records up to date there should also be a recommendation that vaccine records are shared electronically and easily accessible to anyone providing care to that individual patient across health and social care.	Thank you for your comments. The committee also thought that it was important for vaccine information to be updated and shared wherever possible. For this reason, they included the section in the guideline on recording vaccination offers and administration. This highlights the importance of recording vaccination information accurately and consistently and using electronic health records to support recording of vaccination status.
Royal Pharmaceutical Society	Guideline	011	021	Medicines use reviews are being phased out and will no longer be part of the community pharmacy contractual framework from April 2022. We would suggest using the term medicine review instead	Thank you for your comments. Based on this comment and other comments, this has now been updated to a medication review.

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Royal Society for Public Health (RSPH)	Guideline	006	010 - 013	RSPH welcomes the inclusion of "input from people in the local community about the accessibility of services" clause. We would recommend the extension of the clause to include a reference to the 'community champions' approach. Evidence review (PHE 2021) shows that community champions can be used flexibly to support community engagement in the pandemic response. Evidence highlights the value of volunteers with credibility in the community who can tap into existing social networks. This helps bridge gaps between services and communities. See: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1011854/A_rapid_scoping_review_of_community_champion_approaches_for_the_pandemic_response_and_recovery_V8.pdf	Thank you for your comments. The committee were aware that there are a number of different people and groups in the community who could provide information on the accessibility of services. As they had not reviewed evidence on which groups could provide the most information, they decided to include a reference to the NICE guideline on community engagement. This has a section on involving people in peer and lay roles to represent local needs and priorities, which has more detailed recommendations on who should be involved in community engagement.
Royal Society for Public Health (RSPH)	Guideline	008	013 – 020	While the draft guidance does not pertain to COVID-19 vaccinations, the COVID-19 pandemic has led to a marked increase in the dissemination of, and public exposure to, vaccination misinformation which has translated into vaccine hesitancy, particularly amongst minority groups. We are concerned that the focus of the training and education curricula (outlined in guidance 1.1.18) is on promoting knowledge transfer from practitioners to patients. While line 18 indicates that practitioners should be educated on the barriers to vaccination, we believe that practitioners should also be equipped with a basic understanding of behaviour change in order to effectively manage patient conversations on vaccine	Thank you for your comments. The recommendation about education for people who administer vaccines includes the ability to have effective conversations, part of which involves talking to people with vaccine hesitancy. This is covered in more detail in the rationale section. The recommendation for staff who are in contact with people who are eligible for vaccines but do not administer them is intended to be a more general understanding of vaccination. The committee were confident that these people should be able to signpost people to relevant healthcare practitioners or other sources of information, rather than have an in depth knowledge of how to have these conversations themselves.

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				hesitancy and concern. It is imperative that all health system contact points, irrespective of a practitioner's role in directly administering vaccines, are utilised and maximised to address public vaccine concern and hesitancy, and in doing so, reduce the spread of vaccination misinformation and close the vaccination uptake gap. In 2021, RSPH held conversations with stakeholders including Lambeth Council and South East London Clinical Commissioning Group on the educational tools available to promote vaccine uptake in key communities. The stakeholders felt that there was a need for a qualification that provided practitioners with skills development, motivational techniques and a person-centred approach to conversations about vaccinations. Following this, RSPH developed an Ofqual certified Level 2 Award: Encouraging Vaccine Uptake, which has since been commissioned by several local authorities and NHS trusts. The training course consists of 7 hours of centre-led practitioner learning and is assessed via a workbook, facilitating the reflective learning required. The objective of the course is to provide learners with the knowledge, skills and understanding to: • Promote the importance of vaccinations; • Identify sources of vaccination concern and explore them through brief conversations; • And use behaviour change models and motivational techniques to support individuals in making a decision around receiving a vaccination.	

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				Evaluation of the course to date has shown that the content greatly improves participants' knowledge of sources of vaccine concern and hesitancy and their confidence in engaging with individuals about vaccination programmes. As such, RSPH recommends that: • Line 18 within guidance 1.1.18 is updated to '*awareness of barriers to vaccination and common sources of vaccine misinformation, concern and hesitancy'* thereby placing greater emphasis on the public health importance of recognising the sources and consequences of vaccine misinformation; • Line 20 within guidance 1.1.18 is updated to read *'where to signpost people for further reliable information and vaccination*' to make explicit the importance of differentiating reliable sources from unreliable sources; • And an addition bullet, '*What can impact behaviour change and how to explore these factors with a patient*' is incorporated into guidance 1.1.18 to ensure practitioners receive basic education and skills training on behaviour change to have effective conversations.	
Royal Society for Public Health (RSPH)	Guideline	011	025	RSPH advises that clause 1.2.6 is extended to read "when new migrants, including refugees, asylum seekers and migrants in irregular situations, arrive in the country and when they access healthcare services". Removing identity checks and assurance that the health service will refuse to engage with law enforcement on immigration	Thank you for your comments. The committee were aware that there are many different ways that people can be identified as eligible for vaccination. They therefore decided to make a list of some of the possible ways in which people can be identified, but this does not exclude other methods not included in the examples. There are additional

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				are shown to be key to encourage individuals to attend appointments. It would also be worthwhile reiterating the flexible approach to the location of vaccine delivery, including in community centres, local parks, and other services that the migrant/refugee populations might access within the "How the recommendations might affect services" section beginning on line 13 page 32.	recommendations on the information that should be given to these groups of people about how and where vaccinations are delivered in the section of the guideline for invitations, reminders and escalation of contact.
Royal Society for Public Health (RSPH)	Guideline	036	001 – 006	We agree that healthcare practitioners not involved in administrating vaccines should be provided with the educational resources and time to learn about vaccinations, however we would like to challenge the use of website links and booklets as the medium for education delivery as stated on page 36, line 3. Both Evidence Reviews E and H demonstrate that the information provided by the practitioners to the patients are an important factor affecting vaccine uptake. Evidence Review E shows that practitioner education might have limited impact on vaccine uptake, with the exception of RCTs cited on p.28 such as Jacobson 1999; on p.29 Thomas 2003; and on p.44 such as Kriss 2017, Dixon 2019, Thomas 2003. However, the evidence review as it currently stands does not provide sufficient analysis on the quality, content and methods of training packages for practitioners. Evidence from the health education sectors, including NICE guidelines on other health education areas, suggest that structured and guided educational delivery methods can positively impact practitioner information retainment and confidence. We would therefore expect	Thank you for your comments. The committee recognised the importance of providing healthcare practitioners who are not involved in administrating vaccines with education about vaccinations. However, the evidence review was not able to analyse the quality, content and methods of specific training packages for practitioners because there were very few studies using these interventions that met the inclusion criteria for this review and they provided limited information about how the interventions were carried out and what they contained. The section on ' How the recommendations might affect services' that accompanies this recommendation mentions that the costs associated with delivering the training could be contained by providing materials (such as a booklet or accessible webpage) rather than delivering education in person. However, the recommendation for education for health and social care practitioners and other related staff who do not provide vaccinations does not specify the format of this education. In addition, the committee have clarified that the level and the content of this education should be tailored to the person's role because GP receptionists will need a different level of training compared to healthcare practitioners. Therefore the format of the education is not confined to specific non-interactive formats by the recommendation

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				the guidance to suggest, while there would be some cost implications, that practitioner education and training includes an interactive element and assessment should be preferred where possible. An example of low-cost and interactive training is the RSPH's Ofqual certified Level 2 Award: Encouraging Vaccine Uptake, which has since been commissioned by several local authorities and NHS trusts. The training course consists of 7 hours of centre-led practitioner learning and is assessed via a workbook, facilitating the reflective learning required. The objective of the course is to provide learners with the knowledge, skills and understanding to: • Promote the importance of vaccinations; • Identify sources of vaccination concern and explore them through brief conversations; • And use behaviour change models and motivational techniques to support individuals in making a decision around receiving a vaccination.	and interactive training can be used where it is appropriate and cost-effective. This may involve the use of the training programme you mention for people in roles who need that level of information.
SAPHNA	Evidence review A	006	005	data accuracy, such as Methods of recording (electronic, such as e-red books, mobile apps or paper, such as red books nb ELECTRONIC RED BOOKS ARE NOW BEING USED eRedbook - The Digital Red Book For Parents	Thank you for your comments and this information. The guideline covers a number of methods of record keeping, such as electronic patient records and patient held records (which could include the eRedbook) and recommends the wider availability of apps for people to keep track of their vaccination status. These can also be used to help identify people who are eligible for vaccination. In the discussion section of review A we specifically mention that the patient held records could include the digital red book.

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SAPHNA	Evidence review B	012	007	No evidence ages 5-11? years	Thank you for your comment. The NHS routine UK immunisation schedule lists the vaccinations that are covered by this guideline. There are no vaccinations on this schedule for children between the ages of around 3 years to 12 years (although vaccinations may be administered to children who missed them at the normal ages.) Therefore, we divided our analyses into 0-5 year olds and 11 to 18 year olds, allowing for variations between the routine schedules among the countries included in the evidence review.
SAPHNA	Evidence review C	007	General	Reminders should include use of partner agency comms e.g for school aged children use of school's communications to students, parents and staff	Thank you for your comments. A recommendation in section 1.3 on routine vaccinations at school highlights that school age immunisation providers and schools should work together to carry out vaccinations. This should include working together to send out information, invitations and reminders about vaccination.
SAPHNA	Evidence review C	012	025	Needs to include those electively home educated (significantly increasing population)	Thank you for your comments. There was limited evidence identified for the vaccination of home educated children and this concerned barriers to and facilitators for uptake in Christian home-schooling families in Pennsylvania. (Please see evidence review B for more details.) No evidence for interventions to improve uptake was identified for this group. However, in section 1.3 of the guideline there is a recommendation aimed at children and young people who do not attend schools where vaccinations are provided. This will include those who are electively home educated.
SAPHNA	Evidence review D	042	008 - 015	opportunistic vaccinations: should include 'home' visits by healthcare professionals e.g nurses for looked after children, young carers, young offenders.	Thank you for your comments. The recommendation in the guideline for opportunistic vaccination includes home visits for healthcare or social care, as well as during a looked-after child or young person's health plan, and within 7 days

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				As well as fridges, staff need cool bags to facilitate the ongoing cold chain	of arrival in young offender institutions as opportunities to identify people who are overdue for vaccinations. The barriers to opportunistic vaccination mentioned in evidence review D were not intended to be exhaustive but were examples that came up during committee discussions. The committee did not make recommendations on vaccine storage but did recommend that vaccination leads ensure that best practice is followed for vaccine ordering, storage, distribution and disposal.
SAPHNA	Evidence review D	043	009 - 043	Where school nurses are/were previously the Provider, they do and can offer home based immunisations for those children out of school for whatever reason. This should be integral and specific within service specifications. The circa 30% cuts to school nursing services have had a significant impact on the ability to target these children, offer flexibility and/or work with those contra-indicated, dissenters etc in a tailored way. The HCP Commissioning guidance should be strengthened as current language/narrative too loose. There should be specific measures introduced e.g number of cyp awareness and understanding of childhood immunisations Healthy child programme 0 to 19: health visitor and school nurse commissioning - GOV.UK (www.gov.uk)	Thank you for your comments. NICE cannot determine the contents of service specifications. However, there is a recommendation in section 1.3 on vaccinations for school-aged children to ensure that they are invited for vaccination at another setting if they do not attend schools where vaccinations are provided and another that covers catch up sessions and alternative provisions for those children and young people who miss being vaccinated at school. This could be due to being absent due to sickness or exclusion. This should ensure that children who are out of school are still able to access their routine vaccinations.
SAPHNA	Evidence review D	044	038	'The committee recommended that school nursing teams offer catch-up vaccination sessions 39 to children or young people who are not up to date, and noted that this often happens in 40 usual practice already, so is	Thank you for your comments. The term 'school nursing teams' referred to the teams providing school-aged immunisations rather than school nurses specifically, although this could involve school nurses if they provide the vaccinations for the children and young people in their

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				unlikely to have substantial implications on resource use.' This is incorrect. Only some school nursing services provide school aged immunisations, increasingly it is imms teams/private providers. School nurse delivered programmes have been found to have increased uptake? Immunisations for school aged children should, in SAPHNA's opinion, therefore, be provided by school nurses who are known, trusted, and respected by cyp, parents, schools etc. This specific and local knowledge mitigates many barriers to immunisation uptake.	school. The evidence identified in this review concerned the provision of vaccinations within schools rather than who provided them. To avoid confusion this has been reworded to say school age immunisation teams, or services in both the evidence review and guideline.
SAPHNA	Evidence review D	045	004	'in the case of school nursing community clinics there was now an online appointment system that would make this easier for some 5 people'; this is incorrect, we still have some school nursing services without this facility which requires a recommendation in itself re the provision of such though a hybrid model, including telephone, should be offered c/o digital literacy and poverty	Thank you for your comments. We have amended this text to reflect that this service is available in some places, but not all currently. The committee discussed your suggested recommendation and agreed that while an online appointment system is helpful for many people it would not be appropriate for everyone. Based on your feedback an additional recommendation has been added in the section about vaccinations for school-aged children and young people about using a digital format for invitation, information and consent forms. This also contains the need for non-digital options to be available. This should ensure that people who do not have access to digital content will not be excluded from obtaining information about vaccinations or consenting to vaccinations.
SAPHNA	Evidence review D	045	013	NHS England » Accessible Information Standard this is adult focused and requires children specific evidence re communication NHS England » Communications plan About Me first	Thank you for your comment. Although the recommendation at the start of the invitation, reminders and escalation of contact section mentions the Accessible Information Standard and is therefore more adult focused, there is a separate recommendation in the section on vaccinations for school-aged children and young people

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					that refers to providing invitations and information in a format that is accessible to both parents and secondary school-aged children and young people. Another recommendation covers school based education and notes that it should be made available in an age appropriate format.
SAPHNA	Evidence review E	General	General	There is nothing about health education in this section? School nurses work with education colleagues and many deliver as part of RSE curriculum and assemblies, parents' events etc??? Huge regional variation and dependant on commissioning/service specifications	Thank you for your comments. There was limited evidence for interventions that involved school-based information or education. However, the qualitative evidence the importance of vaccination information to be provided in school and the involvement of school nurses and teachers in providing this information. NICE is not able to make recommendations on the school curriculum as this is beyond our remit. However, there is a recommendation in section 1.3 of the guideline on vaccinations for school-age children which stresses the importance of providers and schools working together to ensure that children and young people receive age-appropriate education about vaccinations.
SAPHNA	Evidence review F	005	016	There is a lack of evidence re teenage pregnancies. Stigma associated with teenage parents also a barrier to uptake.	Thank you for your comments. Given the lack of evidence about teenage pregnancies the committee did not think they could make specific recommendations on this group. However, they were confident that the recommendations made for pregnant women would apply in the same way for teenagers who are pregnant. There is also a recommendation for education of healthcare practitioners in section 1 of the guideline that covers training about how to have sensitive conversations about vaccination. This would

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				Page 7 need to include School nurses here 'recommendations to vaccinate from people/groups including Medical and other staff (for example, GPs, nurse, health visitors, midwives.}'. Page 8 need to include schools here: 'outreach interventions or mobile services: • home or domiciliary or day centre visits • support group meeting visits • residential or care home visits • special school visits. Also add 'Home visits' to 'opportunistic' Family nurse partnership impact? The Family Nurse Partnership | (fnp.nhs.uk) See Immunisations: applying All Our Health – GOV.UK (www.gov.uk) used by public health nurses, including school nurses supporting RSE curriculum pre-pregnancy and supporting teenage parents	include how to approach stigma, such as that which is potentially faced with teenage pregnancies. The interventions listed in the protocol were not intended to be exhaustive and the examples you list would have been included in the review had evidence been available. As we note in the review, there was very little evidence for interventions to increase pertussis uptake in pregnant women. The recommendations that were made for opportunistic identification include home visits for health and social care. No evidence was identified concerning the effectiveness of these programmes in increasing vaccine uptake and the committee did not otherwise review specific training resources for healthcare practitioners and so are unable to recommend any specific materials that should be used apart from the national minimum standards and core curriculum for immunisation training for registered healthcare practitioners which forms part of the mandatory training for health care practitioners who administer vaccines. However, All Our Health could be incorporated as part of the training if it is useful.
SAPHNA	Evidence review G	038	006	School nurses need to be included in these barriers re not enough time to discuss with parents/children Integrated Care Systems need to be given reference/consideration here?	Thank you for your comments. A lack of time for discussions was raised as a barrier to vaccinations in the qualitative review, however, this was not raised in relation to conversations with school nurses. It has therefore not been added to this review, although the committee

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					recognise that this barrier would apply to these discussions as well as those with GPs and practice nurses. We did not identify any UK based evidence for the effectiveness of integrated care systems in increasing routine vaccine uptake and the committee therefore did not make any recommendations for them.
SAPHNA	Evidence review H	045	017	? Young carers, Young offenders, CYP with SEND? Also 'Population groups with potential equality issues' Settings ? include Children's residential homes, Young offenders institutes/secure estate?	Thank you for your comments. Although these groups were not listed as subgroups of particular interest in the protocol they were still included in the evidence searches and covered by the equality impact assessment. No evidence that matched our inclusion criteria was identified for these specific groups. However, the committee did include many of these groups in their recommendations for opportunistic identification to ensure that they would have the opportunity to be vaccinated.
SAPHNA	Evidence review I	006	038	Confidence reduced re attendance at immunisation sites during COVID Limitation of education settings due to additional infection controls during COVID eg one way systems, reduced class numbers etc Venues offered eg fast food restaurants, night clubs, football stadium	Thank you for your comments and this information about barriers to vaccine uptake that you have encountered during the COVID-10 pandemic. Review K covers the COVID-19 call for evidence, the barriers that were identified in the submitted evidence and the committee's discussion.
SAPHNA	Evidence review J	048	046	Re incentive decision-assume young people have been consulted/involved in responding?	Thank you for your comments. We did not receive any comments from young people as stakeholders during consultation of this guideline. However our committee included a lay member who was a parent of a school aged child and another lay member who was in her early twenties and was recruited to represent the views of young

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				Page 49/line 6, anecdotal evidence during COVID would suggest e-consent has had a significantly positive impact, facilitating efficiency, effectiveness, safety.	people because people under 18 are not accepted as committee members. The incentives recommendations were based on qualitative evidence which evaluated consent form-based incentives given to young people in schools in the UK. This evidence is considered highly relevant and a good indication of how appropriate this type of intervention will be. In addition, the committee also drafted a research recommendation to investigate the effectiveness and acceptability of different types of incentives to increase school-aged vaccine uptake. The committee noted that in their experience the use of e-consent was likely to facilitate consent. They therefore added a recommendation to promote the use of digital formats for invitation, information and consent forms for school aged vaccinations, whilst ensuring that other non-digital options existed for people who could not access the digital ones. The committee discussed the use of Fraser or Gillick competence and decided that Gillick competence was the most appropriate term for this guideline as it does not solely refer to HPV. The committee agreed about the importance of school-based education about vaccinations and included a recommendation for providers, which could include school nurses, and schools to work together to deliver this. The recommendation for opportunistic identification includes a number of settings where vaccination status could be

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				16-34. 'Gillick' should be referred to as 'Fraser' and should also be used at each immunisation session with those deemed to have the ability to self-consent. This is used successfully with many of our most vulnerable yp by school nurses. https://learning.nspcc.org.uk/child-protection-system/gillick-competence-fraser-guidelines#heading-top Where commissioned and resourced to do so School nurses provide excellent prep health education re immunisations helping to self-empower YP and families. Health promotion re imms also integral part of any contact with CYP/parents 'making every contact count'/ 'all our health'. Line 39;'devisive issue'. Health professionals with skills, experience and training are well placed to assess Fraser competence and are wise to any CYP being 'divisive'. We would like this terminology removed as find it offensive to our professionalism and judgemental of the CYP. Page 50 line 1. Disagree. Fraser competence can and is successfully assessed/used at routine sessions. To	checked, These settings include admission to schools and special needs schools. We have rephrased the section of the evidence review to clarify that, despite immunisation nurses being well trained, the evidence showed that some people (especially some parents) are not comfortable with the concept of young people being able to self-consent for vaccination. The committee discussed the use of Gillick competence and catch-up sessions. They thought that, where possible, competence should be assessed at routine sessions. However, they were also aware that time pressures during these sessions also mean that this is not always possible, and in those circumstances, it would be appropriate to do Gillick competence assessments at catch-up sessions instead. This has been explained further in the rationale section of the guideline. In addition, the text referring to assessing Gillick competence has been moved out of the catch up recommendation. The committee were aware that it can be difficult to overcome inequalities issues in relation to Gillick competence in some settings, such as faith schools. This is why they thought that vaccination teams need a policy in place on Gillick competence. This should ensure that if a competence assessment is not deemed appropriate for a particular person or population, there should be other processes in place to help the young person access vaccination.

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				delay until catch-up sessions risks creating unnecessary delay and a further inequality as it is often our most vulnerable where consent is not available. The recommendation should be that appropriate time is allowed within routine imms sessions for Fraser competence to be assessed as required. Line 30 Disagree with this statement 'this was considered a key issue, as assessing for Gillick competence in this scenario could potentially damage the ability of the immunisation team to access the school for other vaccination campaigns. Whilst this is true and possible, the immunisation provider should, therefore, according to approved Fraser consent, offer the YP alternative options to access their immunisation should they wish to go against their parents wishes. To not do so is discriminatory against the CYP, risks causing additional health inequalities and? UN convention rights of the child? UN Convention on the Rights of the Child (UNCRC) – UNICEF UK	Where the text refers to school-based perks the committee mean that these would be school-based benefits aimed at the young person such as priority access to the lunch queue rather than benefits for the school itself as this would be unlikely to incentivise a young person to complete their consent forms.

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				Page 51 line 6, why would we reward the schools and not the student?	
SAPHNA	Evidence review K	General	General	Thank you for the hard work and option to consult on these guidelines. There is significant emerging evidence from COVID times re immunisations, best practice, policy etc and would be prudent to allow delay to capture some of the excellence and, conversely, learning lessons of what has not worked well?	Thank you for your comments. It was decided that the guideline should not be delayed as COVID-19 is not currently on the UK routine vaccination schedule and so is out of scope for it to be included in more detail in this guideline. However, the committee were aware that there may be opportunities for future learning from the COVID-19 programmes. For this reason, they included a recommendation in section 1.1 of the guideline under audits and feedback, recommending that COVID-19 initiatives are evaluated and if useful, applied to routine vaccinations. This means that any interventions that are identified as effective can be used to increase the success of routine vaccination programmes.
SAPHNA	Guideline	009	018	We need to also offer children and young people the 'opportunity to have a discussion where any concerns can be identified and addressed'. School nurses can where appropriately commissioned and resourced, offer this in 1:1, classroom, assemblies, via text/digital services etc Page 11/11 and at any contact with HV/SN services via the healthy child programme contacts. Healthy child programme 0 to 19: health visitor and school nurse commissioning - GOV.UK (www.gov.uk) Line 17, Young offenders/secure estate, line 15 woman/girls, page 12/7, and NEET	Thank you for your comments. The committee were aware of the importance of ensuring that children and young people understand the importance of vaccination and can address any concerns they may have. For this reason, they included two recommendations aimed at ensuring that they are provided with reliable sources of information to help them make informed decisions, and that school-based education is provided to help further their understanding of vaccination.

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Thames Valley Screening and Immunisation Team	Guideline	004	013	Given the work done throughout the pandemic to identify inequalities, we feel it would be beneficial for services to also nominate a named person to support the identification of patients with LD, SMI and vulnerable children/adults.	Thank you for your comments. The committee recognised that this is an important issue, but it is beyond the remit of this particular guideline. However, we will pass your comment onto the NICE surveillance team who can add it their log of things to consider for the learning disabilities guideline when it is updated. The guideline already includes a detailed recommendation about opportunistic identification of eligible people. This covers many situations that could be used to identify vulnerable people who are unvaccinated including during the annual learning disability health check; home visits for healthcare or social care; in prison and young offender's institutes and during contacts with homeless people.
Thames Valley Screening and Immunisation Team	Guideline	004	016	Throughout the pandemic there has been a greater system reliance of the voluntary/charity sector in the support and signposting of patients.	Thank you for your comment and this information. The committee recognise the importance of voluntary and charity sector services signposting people to vaccination services as well as the important role they can play in opportunistic vaccination. They believe that these processes have been covered within the recommendations in this guideline.
Thames Valley Screening and Immunisation Team	Guideline	006	006	Online booking systems for immunisations would avoid patients, their parents or carers, being held in long queue waiting times. Alternatively offering a separate telephone line specifically for immunisations booking would better support access. Waiting in telephone queues can be costly for callers, or difficult to manage if at work, causing greater health inequities.	Thank you for your comments. The committee discussed this and agreed that online booking systems can be helpful. They thought that, where possible, both online and telephone booking options should be provided so that people who cannot access digital content won't be excluded. An additional point has been added to the recommendation in the section about making services accessible to highlight the importance of providing a range of accessible options for booking appointments, such as telephone booking and online systems. This should also

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					take into account some people who may need additional support to use the booking systems. The committee did not make a recommendation for providing a separate telephone line for vaccine appointment booking as there was no evidence to support the effectiveness of this intervention and it would likely be costly to implement.
Thames Valley Screening and Immunisation Team	Guideline	006	014	The continuation of groups such as GP Patient Participation Groups will be key to tailoring services opening hours and locations to meet local needs.	Thank you for your comments. The committee made a recommendation that input from people in the local community should be used to identify local barriers to vaccination. Although GP Patient Participation groups are not specifically mentioned, these would fall under the remit of this recommendation. The information provided by these groups can then be used to tailor services to local needs.
Thames Valley Screening and Immunisation Team	Guideline	006	018	Promotion and provision in locations such as children and family centres should also be considered to support access to families that may struggle with engagement with health services. Consideration should be given wherever possible in providing reasonable adjustments.	Thank you for your comments. The committee also thought that children and family centres are good examples of alternative settings for vaccination clinics. These have been added to the recommendation.
Thames Valley Screening and Immunisation Team	Guideline	009	007	It would be helpful to have additional training or support available regarding behavioural insights and how to manage the vaccine hesitant. As we know from the GP National Patient Survey results, most patients have faith in the health professionals they see in Primary Care. This training would better equip staff with the information/tools needed to support hesitant patients and communities.	Thank you for your comments. The recommendation about education for people who administer vaccines includes the ability to have effective conversations, part of which involves talking to people with vaccine hesitancy. This is covered in more detail in the rationale section.
Thames Valley Screening and	Guideline	011	006	Wider availability of nationally produced information on routine immunisations, in a range of languages, to support those moving to the UK with missed/incomplete immunisations in addition to routine childhood	Thank you for your comments. Information that should be provided to people who move to the UK is covered in a recommendation in section 1.3. This should include providing information about how and where the vaccines

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Immunisation Team				immunisations, specifically highlighting that this service is free of cost.	are delivered as well as information about vaccines being free of charge. More information about this is included in the rationale section of the guideline and in the barriers and facilitators evidence review (Evidence review B). The importance of providing information in a range of languages is also highlighted in the recommendations.
Thames Valley Screening and Immunisation Team	Guideline	017	027	Guidance suggests 'if possible', could this be strengthened to best practice attainment statement	Thank you for your comments. The committee decided that this should stay as if possible, as not everyone will be able to access digital content. There has also been a point added to the recommendation for commissioners and providers in the section on making vaccination services accessible, highlighting that people should be provided with a range of accessible options for booking appointments which includes both telephone booking and online systems. This should mean that people who are able to use online booking systems will be able to access them, without restricting access for people who cannot use online systems.
Thames Valley Screening and Immunisation Team	Guideline	039	018	Inclusion of sex-workers	Thank you for your comments. The committee did not have any evidence for vaccination programmes and sex workers. However, they will still be included within the list of opportunities for opportunistic identification.
UK Health Security Agency	Guideline	001	006	It might be helpful to make it clearer upfront the scope of what is covered in the 'NHS routine immunisation schedule', i.e. more context about the age-range, type of vaccines, and settings in which they are delivered. This information appears piece-meal throughout the document but it might be more informative to have it right at the start of the document (such as bringing up	Thank you for your comments. The structure of NICE guidelines mean that the recommendations are presented before the context section. We did not want to be too specific about the vaccinations included in the routine schedule, or the ages at which they are given, in the recommendations to ensure that they remain relevant if there are any changes to the schedule between this being

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				the information on 'Context' from page 61 to the top of the document).	published and the next update of this guideline. Instead, a link to the routine immunisation schedule will be included in the introductory text on the main page for the guideline that provides information about what the guideline does and doesn't cover so that people can easily check which vaccines are within the scope of this guideline.
UK Health Security Agency	Guideline	006	017 - 018	We welcome the recommendation to offer vaccination in locations convenient to people and the mention of 'community pharmacies, clinics people regularly attend, or GP practices could be used'. However, we agree with the acknowledgement in the 'rationale and impact section', that the lack of integrated record-keeping makes it hard to identify people eligible for vaccination outside of general practice (see page 39, lines 24-26) and that perhaps more emphasis should be placed in the guidelines on the importance of record-keeping and on improving the effective transfer or sharing of records between parts of the health system.	Thank you for your comments. The committee agreed that issues with the lack of integrated record keeping makes coordination between different parts of the health system more difficult. They therefore decided to add an additional recommendation into the guideline about the importance of ensuring that compatible systems or processes are in place so that vaccination records can be shared effectively and in a timely way between different parts of the health and care system, including other vaccination providers such as community pharmacies.
UK Health Security Agency	Guideline	007	016 - 017	The guidelines state that they don't cover COVID-19 vaccinations, but COVID-19 vaccinations are subsequently mentioned in lines 16 -17. Perhaps this could be made clearer that this is included because of some of the learning from the innovations from the COVID-19 programme may be valuable and relevant for the rest of the routine immunisation programme, as outlined later in the 'rationale and impact sections'.	Thank you for your comments. The beginning of the guideline is clarifying that the recommendations are not giving guidance on providing COVID-19 vaccinations. This is intended to make it clear to anyone involved in COVID-19 vaccinations that this guideline will not provide any specific recommendations for their vaccination programmes. Although there are recommendations in relation to COVID-19 in this guideline, this is in relation to potential learning that can be used for the routine vaccination programme and there is a link to the rationale that explains this directly below the recommendation.

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UK Health Security Agency	Guideline	010	009	This section on 'Keeping records up to date' only mentions the roles and responsibilities of GPs and CHIS. But it should also reference the responsibility that all immunisation providers have to inform GPs of the administration of any vaccination. This is referred to in 'Visual Summary 1' where it says to: "Ensure that vaccinations are reported promptly (within 5 working days or in line with required standards if shorter) to GP practices and child health information services (CHIS), if relevant" and should therefore also be included as a bullet point in this section. We also felt that more emphasis could be placed on how important it is for the NHS Summary Care Record to be as comprehensive as possible and should include information on immunisations.	Thank you for your comments. The recommendation for vaccinations to be reported promptly that is included in the visual summary is included in the guideline under section 1.2 – identifying eligibility, giving vaccinations and recording vaccination status. The committee discussed the importance of the summary care record but were also aware that not all healthcare professionals had access to these records. For this reason they included a recommendation to highlight the importance of both this and other types of vaccination records to help identify people eligible for vaccination. More information about this is available in the rationale section of the guideline.
UK Health Security Agency	Guideline	011	017 - 018	We welcome the recommendation on opportunistic identification "on admission to day care, nurseries, schools, special needs schools, pupil referral units, and further and higher education". This could be further strengthened by asking childcare and education providers to prompt parents to check the vaccination status of their children and to signpost to immunisation services where possible.	Thank you for your comments. The committee were aware that there are many different ways that people can be identified as eligible for vaccination. They therefore decided to make a list of some of the possible ways in which people can be identified, but this does not exclude other methods not included in the examples.
UK Health Security Agency	Guideline	011	020 - 022	We welcome the recommendation on opportunistic identification when people visit a community pharmacy (lines 20 -22 say: "when people visit community pharmacies for health advice, a medicines use review or a new medicine service, or to collect prescriptions"). However, the system needs to be strengthened to ensure the data flows are available to improve the feasibility of pharmacists being able to effectively identify	Thank you for your comments. The committee thought that it was important that vaccination information can be shared between different providers and settings. They therefore made a new recommendation about the coordination of reporting systems and the importance of ensuring that compatible systems or processes are in place so that vaccination records can be shared effectively and in a timely way between different parts of the health and care

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				eligible patients which, for some vaccines, is not possible without access to the patient's care record.	system. This includes other vaccination providers such as community pharmacies. This should help to ensure the identification of people eligible for vaccination as well as the accurate and timely update of vaccination records.
UK Health Security Agency	Guideline	011	024	We welcome this recommendation to opportunistically assess when "any health service contact with people who are homeless". Again, the system needs to be strengthened to ensure that the integrated record-keeping is available and access to the patient's record by these services is possible, to enable this to happen.	Thank you for your comments. The committee thought that it was important that vaccination information can be shared between different providers and settings. They therefore made a new recommendation about the coordination of reporting systems which say that it should be ensured that compatible systems or processes are in place so that vaccination records can be shared effectively and in a timely way between different parts of the health and care system. This should help to ensure the identification of people eligible for vaccination as well as the accurate and timely update of vaccination records.
UK Health Security Agency	Guideline	015	007	Perhaps it would be better if this section on 'Invitations, reminders and escalation of contact' came before the section starting on page 11 line 3 'Identifying people eligible for vaccination and opportunistic vaccination'. Routine call / recall is an intervention which has an existing evidence base to support its effectiveness in improving uptake of immunisations. By placing this section first in the document, this would put more emphasis on assuring there was effective call and recall which is the main mechanism by which the majority of vaccination are currently delivered. At the moment it seems the guidelines are placing more emphasis on opportunistic identification of individuals than on this more robust, systematic and evidence-based process.	Thank you for your comments. The committee thought that this was the best order to present the recommendations as people need to be identified as eligible for vaccination before invitations and reminders can be sent.

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UK Health Security Agency	Guideline	015	011 - 018	In addition to these two paragraphs, it would be helpful to mention age appropriate materials for young people and also the consent process for them, including the potential for self-consent. There is a growing body of evidence relating to the impact, both positive and negative, of the consent process on uptake which may be of value as part of this consideration.	Thank you for your comments. The committee also thought that it is important for children and young people to receive age-appropriate information about their vaccinations, including the ability for them to self-consent. This is covered in recommendations in section 1.3 on routine vaccinations at school.
UK Health Security Agency	Guideline	016	018	Line 18 onwards The section on 'Initial Invitation' doesn't mention anything about consent. For invitations to young people and their parents it may be important to include something on this so that they understand the process. Consent forms produced by UKHSA are available from: www.gov.uk/government/collections/immunisation	Thank you for your comments. The vaccinations for young people usually take place as part of the school age immunisation programmes. There are recommendations about providing information about both the vaccines and the consent process in section 1.3 on vaccinations for school-aged children and young people.
UK Health Security Agency	Guideline	029	010 – 012	Checking for eligibility for vaccination may be difficult in non-healthcare settings where this is not usual practice and where information systems may not be accessible or have intraoperability.	Thank you for your comments. Although we are aware that this may not always be easy in some settings, there is still the option for these places to use opportunistic identification and signpost people to vaccine services. This does not necessarily need staff to have access to health care records, but could instead involve asking someone if they are up to date on their vaccinations.
UK Health Security Agency	Guideline	035	010 – 012	As Public Health England no longer exists it may be better to say: "The committee acknowledged that the former Public Health England's (now UKHSA) core curriculum for immunisation training for registered healthcare practitioners sets out content to be covered by practitioners who are administering vaccinations".	Thank you for your comment. We have updated the text as suggested in the guideline and evidence reviews.
UK Health Security Agency	Guideline	040	012 - 014	As Public Health England no longer exists it may be better to say: "The committee were aware of the guidance on vaccinating people with uncertain or	Thank you for your comment. We have updated the text in the guideline and evidence reviews to refer to UKHSA (previously known as Public Health England).

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				incomplete immunisation status, produced by the former Public Health England (now UKHSA)".	
UK Health Security Agency	Guideline	046	015 - 021	It should be noted that for pregnant woman there can be sensitivities about sending written invitations. This is because there can be confidentiality issues if, for instance, other household members see the letter but were unaware of the pregnancy. Or there may be instances where the records have not been updated to show that the pregnancy has ended (through miscarriage or termination).	Thank you for your comments. Although there can be confidentiality issues associated with vaccination, the committee recommended that people's preferred methods of contact are kept up to date. This means that people could specify that they prefer to be contacted by email or phone to avoid confidentiality issues associated with being contacted by mail.
UK Health Security Agency	Guideline	050	020 - 023	The statement about vaccination timing (between 16 and 32 weeks of pregnancy) for pregnant women needs to make it clear that this is for the pertussis vaccine. (This is because flu and COVID-19 vaccines, which pregnant women are eligible to receive, can be given at any stage of pregnancy).	Thank you for your comments. Pertussis has been added to the rationale as suggested.
UK Health Security Agency	Guideline	056	009 - 010	In this section on 'Routine vaccinations at school', is it worth mentioning that providers should encourage schools to use all their communication channels with parents to encourage the return of consent forms e.g. texting systems, parentmail, newsletters and websites.	Thank you for your comments. The committee has added a recommendation that invitations, information and consent forms should be sent out in both digital and non-digital formats. This should include the schools using different methods of contacting parents. The committee did not specify the ways that schools should contact parents and carers as this may vary between different schools.
UK Health Security Agency	Guideline	061	014 - 019	The vaccine coverage data in this section can be updated with more recent data: - 5-in-1 coverage of children measured at 5 years was 95.2% in 2020/2021 - 60.6% of Year 9 girls completed the 2-dose HPV (human papillomavirus) vaccination course in 2020/21 compared with 64.7% in 2019 to 2020, 83.9% in 2018 to 2019 and 83.8% in 2017 to 2018.	Thank you for your comment. We have decided against updating this information because the COVID-19 pandemic has had an extreme effect on vaccination uptake, and we do not think that this is representative of the normal situation. We do however, acknowledge the impact of COVID-19 on routine vaccinations in the COVID-19 call for evidence document introduction (document K).

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				Please note that the severe disruption caused by the COVID-19 pandemic in the past two school years. - Shingles vaccine uptake for the 70-year-old routine cohort was 26.5% in 2019/20 - Coverage of PPV in adults aged 65 years and over, vaccinated any time up to and including 31 March 2021, was 70.6% - Pertussis vaccine coverage in pregnant women was 67.8%in 2020/21 Please see link: https://www.gov.uk/government/collections/vaccine-uptake	
UK Health Security Agency	Visual Summary 2	General	General	The bottom right hand corner of the chart refers to the 'Department of Health's Green Book'. This reference should be "'Immunisation against infectious disease' (the 'Green Book')", produced by the UKHSA.	Thank you for your comment. We have made this correction.
UK Health Security Agency	Visual Summary 3	General	General	It would be helpful if the chart made clear, perhaps right at the top of the document, that pertussis vaccine (and flu) should be offered in every pregnancy.	Thank you for your comments. As the visual summary is a summary of sections of the guideline, we cannot add any additional information to it that is not included in the recommendations.
UK Health Security Agency	Visual Summary 3	General	General	The chart only refers to pertussis vaccine in pregnant women and omits to refer to flu vaccine (or COVID-19 vaccine). Although the guidelines don't cover flu vaccination, it may useful to refer to the fact that women can have their pertussis (or COVID-19) vaccine at the same time as the flu vaccine (just as the guidelines elsewhere mention that you can have pneumococcal vaccine and flu together – see page 16 line 11).	Thank you for your comments. As the visual summary is a summary of sections of the guideline, we cannot add any additional information to it that is not included in the recommendations. For this reason, we cannot include information on the flu or COVID-19 vaccinations for pregnant women. These vaccinations are both out of scope of the current guideline. The recommendation about pneumococcal and flu vaccines is referring to providing invitations and reminders for the two vaccinations at the same time, rather than giving someone both vaccinations at the same time.

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UK Health Security Agency	Visual Summary 3	General	General	It may be worth including in the table the opportunistic identification of pregnant women who have not had MMR – so that after the pregnancy they can be offered this to ensure they are covered against rubella for future pregnancies. If this is included, the chart will need to be clear that MMR cannot be given during pregnancy as it is a live vaccine. Please see measles chapter of the Green Book which says: "Since the cessation of antibody screening for rubella in pregnancy, it remains important to encourage MMR vaccination of women of child-bearing age – for example at opportunities such as family planning consultations. In addition, unvaccinated or partially vaccinated women who become pregnant should be offered missing doses post-partum, for example at the post-natal check or if they accompany their infant to their routine immunisations. If two doses of MMR are required, then the second dose should be given one month after the first. MMR vaccine can be given to individuals of any age, and should be offered opportunistically and promoted to unvaccinated or partially vaccinated younger adults – particularly those born before 1990. New GP registration, and entry into college, university or other higher education institutions, prison or military service also provides an opportunity to check an individual's immunisation history. Those who have not received MMR should be offered appropriate MMR immunisation". www.gov.uk/government/publications/measles-the-green-book-chapter-21	Thank you for your comments. As the visual summary is a summary of sections of the guideline, we cannot add any additional information to it that is not included in the recommendations. For this reason, we cannot include specific information about opportunistic identification of pregnant women who have not had the MMR vaccine, or the timings for when these vaccines should be provided. This summary is about the invitations, reminders and escalation of contact for pregnant women rather than opportunistic identification. However, visual summary 1 covers opportunistic identification and refers people to the section of the guideline which includes opportunities for opportunistic identification in more detail. These opportunities include when women have a newly confirmed pregnancy and at antenatal and postnatal reviews. Identifying people as eligible for vaccination at these times is not restricted to the pertussis vaccine. Due to space constraints in the visual summaries we are unable to present all the opportunities for opportunistic identification in visual summary 1. However, this summary refers people to the relevant section of the guideline which includes new GP registration, entry into college, university or other higher education institutions and prison as potential locations for opportunistic identification.

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UK Health Security Agency	Visual Summary 4	General	General	Under the first bullet of the top box entitled 'invitations' it may be helpful to elaborate a bit more on "Involve schools in sending invitations on behalf of providers" to include asking schools to use their existing communication channels to remind to parents to return consent forms such as texting services, newsletters and their website.	Thank you for your comments. As the visual summary is a summary of sections of the guideline, we cannot add any additional information to it that is not included in the recommendations. In response to stakeholder comments the committee have added a new recommendation that invitations, information and consent forms should be sent out in both digital and non-digital formats. This should include the schools using different methods of contacting parents. The committee did not specify the ways that schools should contact parents and carers as this may vary between different schools.
UK Health Security Agency	Visual Summary 4	General	General	It would be helpful if the third bullet of the top box entitled 'invitations' included a reference to the information for young people being age appropriate.	Thank you for your comments. The committee agree that it is important for information to be age appropriate. The guideline already recommends that the invitation is accessible to parents and secondary school-aged children and young people. This is intended to ensure that the invitation and information contained within it is written in such a way that it can be understood by people of all of these ages. In addition, it covers a requirement for school-based education about vaccines to be available in an age-appropriate format. However, due to space constraints we have to provide a summary of the recommendations, rather than the recommendations in full. The committee therefore decided to include information about ensuring that children and young people are provided with reliable information that will help them make informed choices about vaccination and that this is in an accessible format for parents and secondary school-aged children and young people. People can then choose to

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					access more information and additional recommendations by looking at the guideline. This will provide them with details on what types of information should be provided, which includes the importance of age appropriate education.
UK Health Security Agency	Visual Summary 4	General	General	It might be helpful to include more about the potential role of schools in the vaccination programme and how it provides an opportunity to integrate learning about the benefits of vaccination into the school curriculum including history and science. This would reflect the text in the guidelines on page 21, line 21 -24 which says: "Providers and schools should work together to ensure that school-based education about vaccines is available in an age-appropriate format to children and young people to increase their understanding about vaccinations".	Thank you for your comments. The committee agree that it is important for schools to be involved in the vaccination process and provide education about vaccinations. The visual summary is intended to represent the recommendations in summary form and due to space constraints we are unable to present all the recommendations for this section of the guideline in the visual summary. The committee decided to focus on including information about ensuring that children and young people are provided with reliable information that will help them make informed choices about vaccination. People can then choose to access more information and additional recommendations in the guideline. This will provide them with details on what types of information should be provided, which includes the provision of school-based education.
Unite - Community Practitioners' & Health Visitors Association	Guideline	007	006	It is important for individuals to know that access is not dependent on immigration status or providing proof of address. There is low trust as GP practices often discriminate and refuse services.	Thank you for your comments and support for this guideline.
University of Nottingham	Evidence review E	092	032 – 033	Evidence from only one trial involving lay educators was available. In view of the clear demographic clustering in vaccine hesitancy, future research should be conducted	Thank you for your comment. The committee discussed your suggestion but decided against making this research recommendation because they agreed that research

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				into methods for identifying, training lay educators and evaluating their effectiveness in hard to reach communities	should be prioritised to address the research gaps they had already identified.
University of Nottingham	Evidence review E	093	General	This section focuses on salient information that should appear in invitations/reminders from health care providers. Research is required to understand the information priorities when vaccine uptake is provided by lay or peer vaccine champions; and how community groups could be used to remind the public about routine vaccinations.	Thank you for your comment. The committee discussed your suggestion but decided against making this research recommendation because they agreed that research should be prioritised to address the research gaps they had already identified.
University of Nottingham	Evidence review H	030	016 – 017	In view of the central importance of cultural issues in driving vaccine uptake, the absence of evidence from the UK is a significant concern and the development and evaluation of behavioural and socio-cultural interventions in the UK should be a research priority.	Thank you for your comment. The committee discussed your suggestion but decided against making this research recommendation because they agreed that research should be prioritised to address the research gaps they had already identified. However, they agreed that the lack of UK specific research was problematic and as a result they specified that the research should be UK based for their existing research recommendations,
University of Nottingham	Evidence review H & E	General	General	The majority of research effort for both educational and multicomponent interventions necessarily focusses on knowledge or nudging of behaviour (eg reminders). Although important, these approaches alone are consistently associated with small effect sizes and ignore the psychological and socio-cultural determinants of vaccine uptake. There is a need to promote primary research in these areas and behavioural research which encourages innovation in therapeutic approaches (e.g., combining different intervention modalities e.g., motivational interviewing combined with language that supports beliefs of self-agency)	Thank you for your comment. The committee discussed your suggestion but decided against making this research recommendation because they agreed that research should be prioritised to address the research gaps they had already identified. This includes a research recommendation looking at relative effectiveness and acceptability of different styles of phrasing content in a vaccination invitation letter.

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University of Nottingham	Guideline	General	General	A distinction is not made between one-off versus repeat vaccinations. The barriers and facilitators are likely to differ between these two scenarios. Primary research is required into this and development of appropriate behavioural and socio-cultural interventions	Thank you for your comment. The committee discussed your suggestion but decided against making this research recommendation because they agreed that research should be prioritised to address the research gaps they had already identified.
University of Nottingham	Guideline	007	General	For audit and feedback to be helpful, clear targets need to be identified and communicated for each vaccine. Implementation of a traffic light system with an associated tool kit of remedial actions for each threshold would help providers easily and rapidly understand gaps in vaccine uptake and interventions they can implement	Thank you for your comments. NICE cannot recommend specific targets for vaccination uptake. However, the recommendations on audits and feedback are aimed at ensuring that data from the audits can be used to help with continuous improvement. While a system such as the traffic light system may be useful in future, the committee did not review evidence on these types of systems.