Immunisations for migrants in vulnerable circumstances

Guidance for ICS' and providers of vaccination services in the North East and Yorkshire and Humber Region

Date: June 2023 (updated April 2025)

1. Introduction

This document is to support ICS' and providers of vaccination services (including primary care and school-aged immunisation teams) to develop and deliver strategies/action plans to improve uptake of immunisations for vulnerable migrants. It has been developed by a task and finish group under the North East and Yorkshire and Humber (NEYH) Migrant Health Network. The task and finish group had representation from NEYH NHS England (NHSE) Screening and Immunisation Teams, integrated care boards (ICBs), Office for Health Improvement and Disparities (OHID), local authority and the voluntary, community and social enterprise (VCSE) sector. It was established to facilitate improvements in uptake of immunisations for vulnerable migrant groups.

This guidance has been endorsed by the boards responsible for immunisation within the following ICB areas:

- Humber and North Yorkshire ICB Vaccination Board
- Humber and North Yorkshire Inequalities Group
- North East and North Cumbria ICB Vaccination Board
- South Yorkshire ICB Vaccination Board
- West Yorkshire Vaccine Inequalities Group

For further details contact your NHSE Screening and Immunisation Team:

- Humber and North Yorkshire: england.nyahsit@nhs.net
- North East and North Cumbria: england.cane.screeningimms@nhs.net
- South Yorkshire: england.sybsit@nhs.net
- West Yorkshire: england.wysit@nhs.net

2. Migrants in vulnerable circumstances and immunisation[1]

The Migrant Health Guide (OHID, GOV.UK) defines migrants in vulnerable circumstances as:

- Asylum seekers (a person who has applied for permission to stay in the UK)
- Unaccompanied asylum seeker children
- Refugees (a person given permission to stay in the UK)
- Trafficked migrants (someone who has been moved to the UK to be exploited through forced labour, slavery, or prostitution)
- Undocumented migrants, i.e., those with refused asylum and others with NRPF
- Low paid migrant workers.

People belonging to inclusion health groups, tend to have very poor health outcomes, often much worse than the general population and a lower average age of death. This contributes considerably to increasing health inequalities. NICE and UKHSA (formerly PHE) have identified vulnerable migrants as having low vaccine uptake.

Many vulnerable migrants who come to the UK arrive from a country with a high burden of infectious diseases. There are several reasons why they are at an increased risk of infectious diseases whilst living in the UK. Vaccination rates in their country of origin are often lower because of inadequate healthcare support, war/disruption, and social and cultural barriers. They are more likely to be economically disadvantaged, live in over-crowded conditions, and live and meet socially with other at-risk groups. Risk factors do not only relate to their country of origin but also their journey to the UK where they may have been living in overcrowded and unsanitary conditions and then once here, they find navigating health systems confusing and don't always feel able to access health services through fear of discrimination and being judged[2]. There is also the issue of vaccine hesitancy and a lack of understanding amongst professionals of their needs and few dedicated pathways to support better uptake.

[1] Everyone is entitled to register with a GP practice. They should not have to show proof of address or immigration status. More information - GP Access Cards - Doctors of the World

[2] A national qualitative study of barriers and facilitators to vaccine delivery and uptake in adult migrants through UK primary care was published in 2022 to explore views around barriers/facilitators to catch-up vaccination in adult migrants. The primary care staff highlighted several barriers with themes including lack of training and knowledge of guidance among staff; unclear or incomplete vaccine records; and lack of incentivisation (including financial) and dedicated time and care pathways. They reported that any focus was on children and that adult migrants were reported as being excluded from many vaccination initiatives.

3. Primary care vaccinations: Contractual requirements and incentives

The aim of immunisation is to improve population health and outcomes and reduce inequalities. This is particularly important for the migrant population.

To mitigate against potential outbreaks and the impact of vaccine preventable diseases (VPDs), it is essential that the vaccination history for this population is assessed as soon as possible to bring individuals up to date in line with the UK schedule. As of 1st April 2021, all NHS-funded vaccinations, except for both adult and childhood seasonal flu programmes and where applicable COVID vaccination, became essential services. This means practices are required to provide or offer these vaccines– whether directly, via PCN collaboration or via a sub-contracting arrangement – to all eligible patients in accordance with the GMS contract, the Statement of Financial Entitlement and any other technical specifications and the Green Book . Following the assessment of individual vaccination history, a bespoke offer should be made via call/recall, opportunistically or on request to complete individual vaccination schedules in a timely manner (see other sections for more details about how this can be done).

To support practices to deliver these services/programmes effectively and in a timely manner as possible, in accordance with the national routine schedule, the following contract changes were made to the GP Contract in 2023/24 and further changes have been made in the GP Contract in 2025/26:

- Item of Service (IoS) fee is per dose administered (not completed course, which applied pre-2021). A single item of service fee applies for all doses delivered in those vaccination programmes funded through the GMS contract. An IoS fee will be payable for vaccinations administered for medical reasons and incomplete or unknown vaccination status ('evergreen offer') for the 8 programmes outlined in the SFE Part 5 Vaccinations and Immunisation, section 19.

- As the vaccination and immunisations repayment (clawback) mechanism for practice performance below 80% coverage for routine childhood programmes has been removed there are no financial risk to practices.

- The QOF indicators 2025-26 are intended to support optimal performance of immunisation. The QOF indicators are to help ensure everyone is up to date with their recommended planned vaccinations as part of our routine national vaccination programmes and to prevent outbreaks of vaccine-preventable diseases. The QOF indicator thresholds for childhood vaccinations are therefore set according to the requirements of herd immunity. For 2023/24 changes to the childhood vaccination and immunisation indicators within QOF will see the lower thresholds reduced and the upper thresholds raised to 96% (see table 1 below). Practices should continually use their overall practice level data to monitor progress as well as any Personalised Care Adjustment (PCA) adjusted uptakes against these targets (see below).

- Introduction of a new PCA update for patients who registered at the practice too late (either too late in age, or too late in the financial year) to be vaccinated in accordance with the UK national schedule (or, where they differ, the requirements of the relevant QOF indicator). The application of a PCA (via SNOMED coding) to a patient record means the patient is removed from the denominator of the indicator, so this will not affect the practices overall performance in relation to QOF.

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

- From April 2024, practices can use the PCN DES to work more collaboratively within core hours, offering more flexibility and increased access to maximise uptake.

Table 1: The QOF indicators for childhood vaccination & immunisation in 2025/26

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

4. Supporting vaccination

The Migrant Health Guide provides various information regarding immunisations and migrants including links to:

- The UKHSA migrant immunisation information leaflet
- The UK immunisations schedule
- the immunisation algorithm for advice on immunising individuals with uncertain or incomplete immunisation status
- An animation about keeping up to date with vaccinations for migrants

The above guidance is aimed at the needs of migrants more broadly, but it is important to be aware of additional considerations when supporting the needs of more vulnerable migrants such as the impact of them living in poor housing conditions and undiagnosed health conditions which may not make them automatically eligible for COVID and flu vaccinations.

Whilst COVID commissioning and delivery models don't always/necessarily translate to other routine programmes, the principles can be considered. The COVID pandemic provided valuable lessons around immunisations and inclusion health groups including vulnerable migrants. Doctors of the World produced a helpful paper titled 'COVID-19 Vaccine Briefing: Tailored outreach vaccination delivery services for socially excluded groups in the UK'. The paper talks about why a tailored and bespoke model is needed to increase vaccine confidence and uptake. Co-designing and co-delivering services have also shown to be effective in providing more appropriate services.

5. Principles

5.1 Understand the characteristics and needs of vulnerable migrants locally

Identify your vulnerable migrant populations and work with your local authority migration leads and public health leads as well as specialist providers including VCSEs to understand their characteristics and needs.

5.2 Map existing service models across the ICB to see how effective they are at immunising migrants in line with the national schedule (including adults who have not received childhood immunisations)

Identify the models and interventions that are most effective and work collaboratively across the integrated care system (ICS) to ensure immunisations are delivered as part of a wider package of health support. This may be through a range of models, for example in primary care, GP practices can be part of the Safe Surgeries initiative (Doctors of the World) which means they are supported to ensure their services are inclusive to the needs of migrants. Where contracting constraints allow, more bespoke outreach models may be appropriate, for example the provision of primary care services in sites accommodating asylum seekers.

5.3 Make use of existing assets to improve uptake

Make use of existing mechanisms and community assets. VCSEs are often trusted and skilled at engagement and have established relationships with different groups, especially those who experience health inequalities. Having peer advocates is important for this population; trusted relationships and feeling safe are key. Local authorities have mechanisms in place to engage with communities, and each ICB has established structures around VCSE partnerships (see West Yorkshire, South Yorkshire, Humber and North Yorkshire and North East and North Cumbria).

5.4 Work in partnership with people with lived experience

NHSE have published statutory guidance for the NHS around working in partnership with people and communities. We cannot assume what the needs and experiences are of vulnerable migrants. Working in partnership with people with lived experience will enable a far greater understanding of the barriers and enablers to good uptake. They could co-design interventions to improve uptake.

6. Examples of practice to improve uptake

Case study 1: Learning from COVID: A peer support model to improve COVID and flu vaccine confidence in Wakefield contingency/initial asylum seeker accommodation

Summary:
- Peer advocates were identified amongst those who had the best English language/interpretation skills.
- Advocates received training on basic motivational interviewing skills and vaccine effectiveness and safety. VSCE were key to the success of this model.
- Monthly vaccine confidence workshops were co-produced and co-delivered with peer advocates acting as interpreters.
- Monthly sessions have been in place since May 2021, the evaluation of Wakefield's roving vaccination model is available at request.
- COVID and Flu were co-administered in Flu season over two sites.

Key lessons:
- Rapport building takes time - interpretation services and translation apps were crucial for communication and responding to anxiety.
- WhatsApp is highly effective in disseminating information with this population.
- Working with trusted VCSE partners was essential in developing peer support and advocacy.
- Consistency, flexibility, and patience of vaccination practitioners were key to improving uptake.

For further information contact: Pat McCusker, COVID Response Manager for Vulnerability and Health Inequality, pmccusker@wakefield.gov.uk / healthprotection@wakefield.gov.uk

Case study 2: Working with VCSEs to deliver COVID vaccinations to migrants in vulnerable circumstances: St Augustine's, Calderdale

Summary:
- 3 pop-up clinics at St Augustine's in collaboration with North Halifax PCN and Calder & Ryburn PCN.
- Over 110 centre members vaccinated.
- Video Q&A session with centre members and Calderdale public health ahead of the first clinic.
- Posters, flyers and WhatsApp messages in several languages before each clinic and reminders.
- Short videos by members of staff explaining why they had their first jab, what it was like and why it was important to get vaccinated - subtitled in the centre members' 5 main languages.
- Volunteer interpreters in our centre members' major languages present at each clinic.
- Model used more recently to offer Flu and COVID boosters.

Key lessons:
- Working with trusted staff, peers and organisations is crucial to successful delivery.
- Having the service delivered in an environment that is people are familiar with and feel at ease is important.
- Translation of relevant information into the key languages spoken by people attending, use of different communication formats and media and the provision of translators on the day were all important.
- Collaboration across different organisations and bespoke delivery is important. With Calderdale public health, we have been able to take the learning from COVID and adapt it to provide booster sessions for Flu and COVID. Now the model is in place, it can be mobilised to respond to current need.

For further information contact: Laurence Larroche, Senior Health Caseworker, St Augustine's Centre, laurence.larroche@staugustinescentrehalifax.org.uk

Cast study 3: Inreach/outreach COVID vaccination model, The Whitehouse Centre, Locala, Huddersfield

Summary:
-The Whitehouse Centre is a specialist primary care provider for asylum seekers and refugees.
- We have found delivering vaccinations somewhere convenient for the individuals (either where they are socialising or living) has shown better uptake.
-COVID sessions were held at Huddersfield Mission and all the contingency accommodation sites (hotels). There was larger uptake there than in vaccination sites or the GP practice.
-Providing information on the vaccinations and what they were for in individuals own language helps to address any confusion and fear.
-We identified peers to work with the service and encourage others to have the vaccination.

Key lessons learned:
- Providing vaccinations in a setting where individuals are socialising or living results in better uptake than providing them at the GP practice.
- Providing information on the vaccinations and what they are for, in their own language has proven to help uptake.
- Finding an 'advocate' within the cohort of patients who is willing to work with the service to encourage others to have the vaccination was our biggest success. Encouragement coming from a peer that they knew and trusted worked well.

For further information contact: Kim Stott, Business Manager, Locala, kim.stott@locala.org.uk

Case study 4: Learning from COVID by extending the uptake of MMR vaccinations in ethnically marginalised groups in Gateshead

Summary:
- We have used learning from COVID to inform people about MMR and how the vaccines work.
- We use our health champions model under the umbrella of Making Every Contact Count.
- We ask what the issues, worries or needs are relating to health and their communities, identify the information to use which community leaders then cascade. They can translate it and use in a different format (e.g., a quiz) that is most appropriate for their community members.
- Training took place for health champions based on issues raised by migrant communities.
- The slides were shared so they could translate and adapt as required for their audiences.
- The slides include a template which allows people to input a video onto the slides so it can have a translator talking as the slides are delivered.
- We hold a monthly sessions online to discuss current issues relating to health and wellbeing and this helps us to adopt what topics the leaders require training input for and what myths need debunking.

Embedded document below: Gateshead slides presented to health champions

Understanding Vaccines Gateshead sl

Key lessons:
- Information needs to come from a trusted source such as NHS or public health directly to someone within the community who is trusted by the community members.
- Starting at the beginning of what is a vaccine and how it works relating to each disease is necessary to myth bust and gain confidence in the vaccine.

For further information contact: Louise Harlanderson, Public Health Programme Lead, Gateshead Council LouiseHarlanderson@gateshead.gov.uk

Case study 5: Understanding barriers / hesitancy issues that might be preventing vulnerable migrants from seeking or consenting to immunisations in North Yorkshire

Summary:
-One of the key ways to improve uptake of immunisations amongst vulnerable migrants is to understand potential barriers or hesitancy issues that might be preventing them from seeking or consenting to immunisations.
-North Yorkshire public health team worked on a brief project to improve our understanding of the issues. We approached colleagues who already had relationships with these populations and gave them some generic questions to understand migrants' attitudes towards immunisations, any access barriers that they are facing and general healthcare issues relevant to immunisations.
-We worked with colleagues in Early Help, Stronger Communities and Primary Care to try to gather as much information as we could from various sources. We gathered feedback in several ways; we arranged meetings with colleagues and discussed the issues they had picked up on, we received feedback in writing from colleagues who had visited migrant families and we also did a brief desktop exercise to identify what recent research evidence is telling us about some of the issues.

Key lessons:
This approach allowed us to gather a lot of information around vaccine hesitancy and other barriers to immunisation to inform our approach, e.g., access to interpreters, trusted peers etc. Going forward, and in collaboration with our behavioural science colleagues, we are going to use the information we gathered, as well as some further engagement work, to co-develop and co-produce appropriate materials in various formats. We are hoping that this will make a difference in the uptake of immunisations amongst our migrant populations.

For further information contact: Dora Machaira, Public Health Manager, North Yorkshire Council dora.machaira@northyorks.gov.uk

Information and resources

- BMA guidance: Refugee and asylum seeker health toolkit (bma.org.uk)
- Doctors of the World: Translated health information
- Doctors of the World: Vaccine Confidence Toolkit - Doctors of the World
- NEY migrant health information
- NHS England: Working in partnership with people and communities: statutory guidance, 2022
- UKHSA: Animation about keeping up to date with vaccinations for migrants
- UKHSA: Migrant immunisation information leaflet
- UKHSA: The UK immunisations schedule
- UKHSA: Immunisation algorithm for advice on immunising individuals with uncertain or incomplete immunisation status

Gateshead resources:

Facebook: https://www.facebook.com/BetterHealthGateshead/

Twitter: https://twitter.com/BHGateshead

Instagram: https://www.instagram.com/betterhealthgateshead/

YouTube: https://www.youtube.com/@BetterHealthGateshead

Facebook Group: https://www.facebook.com/groups/gatesheadmecc

Gateshead: How to engage asylum seekers and refugees | Local Government Association

Public library on Knowledge Hub (you don't need a membership or log in):https://khub.net/web/making-every-contact-count-gateshead/public-library