Official
Publication approval reference: C1327

To:

- ICS and STP leads
- All CCG Accountable Officers
- All NHS Foundation Trust and Trust Chief Executives
- All COVID-19 vaccination sites
- All PCNs and all GP practices
- All Community Pharmacy
- All Local Authority Chief Executives

Copy to:

- Chairs of ICS and STPs
- All CCG Chairs
- Chairs of NHS trusts and foundation trusts
- NHS Regional Directors
- NHS Regional Directors of Commissioning

1 July 2021

Dear colleagues

COVID-19 Vaccination Autumn / Winter (Phase 3) planning

We communicated earlier in the year that local systems would likely need to prepare for the possibility of a COVID-19 vaccine booster campaign in the autumn or winter. Over the past few months, we have been working with regions and systems to learn lessons from Phases 1 and 2 and we have used these to inform the basic principles set out below for Phase 3, which are designed to support your planning locally.

The Joint Committee on Vaccination and Immunisation have now published their interim guidance on booster vaccinations which states:

'JCVI advises that any potential booster programme should begin in September 2021, in order to maximise protection in those who are most vulnerable to serious COVID-19 ahead of the winter months. Influenza vaccines are also delivered in autumn, and JCVI considers that, where possible, a synergistic approach to the delivery of COVID-19 and influenza vaccination could support delivery and maximise uptake of both vaccines.

Any potential COVID-19 booster programme should be offered in two stages:
Stage 1. *The following persons should be offered a third dose COVID-19 booster vaccine and the annual influenza vaccine, as soon as possible from September 2021:*
• adults aged 16 years and over who are immunosuppressed;
• those living in residential care homes for older adults;
• all adults aged 70 years or over;
• adults aged 16 years and over who are considered clinically extremely vulnerable;
• frontline health and social care workers.

Stage 2. *The following persons should be offered a third dose COVID-19 booster vaccine as soon as practicable after Stage 1, with equal emphasis on deployment of the influenza vaccine where eligible:*
• all adults aged 50 years and over
• adults aged 16 – 49 years who are in an influenza or COVID-19 at-risk group. (please refer to the Green Book for details of at-risk groups)
• adult household contacts of immunosuppressed individuals'

We still expect readouts from several clinical trials over the course of the summer and, therefore, plans will need to flex as new information becomes available.

Therefore, the core planning scenario systems should prepare for is to **deliver booster doses of COVID-19 vaccine to the individuals outlined in the JCVI interim guidance above between 6 September and 17 December 2021 (15 weeks), as quickly and safely as possible in two stages using supply available to us over that period**. The JCVI have advised adults who are severely immunosuppressed should be offered COVID-19 boosters at the start of the booster campaign. Alongside this, local systems will need to deliver existing requirements for the flu programme (co-administered in a single appointment where supply and eligibility of cohorts align), continue to deliver routine vaccination programmes for children and for adults, maintain an "evergreen" offer to all adults who have not yet taken up the earlier offer of a first dose of COVID vaccination, and complete any second doses not yet delivered.

We are working with systems to pilot a 'make every contact count' approach to winter vaccination. This means building in the offer – where practical and appropriate – for those attending vaccination clinics to also have other health checks, such as blood pressure or atrial fibrillation checks.

1. **Delivery model**: So far, the COVID-19 vaccination programme has in weeks where vaccine supply has permitted, delivered a maximum of around 3.5m vaccine appointments per week. Phase 1 was predominantly delivered through general practice and Phase 2 has seen increased participation from community pharmacy and increasing contribution from vaccination centres, as well as the popular convenience of pop-ups, walk in and roving models. This mix of delivery models, with tailoring to local community needs in partnership with local authorities, has played a critical role in reaching underserved communities. We are thankful for the efforts of all those involved and are conscious of the pressures being faced which will inevitably continue into autumn / winter. To build on the strengths of Phase 1 and 2, and ensure Phase 3 is delivered sustainably, we therefore recommend systems should deploy delivery models which:

    (i) **spread capacity across community pharmacy, vaccination centres and general practice.** Although general practice delivered the majority of vaccines in phase 1, spreading capacity across all delivery models will provide resilience and ease pressure on other services and workforces. For most areas it may be hard for general practice to deliver more than around 75% of vaccinations, based on learnings from Phase 1. In the majority of cases, local systems should therefore prudently plan for a minimum of 40% of COVID-19 booster vaccination through general practice and a maximum of

75%, drawing on the expertise of Local Authorities and subject to any agreement with local PCNs. Recognising their contribution in Phases 1 and 2**,** we intend to add an additional 1000 community pharmacy sites in the run up to September to support Phase 3 delivery, subject to interest and system need. Please note the capacity required to deliver 3.5m vaccinations a week consistently over this period and ensure that your delivery mix can support that.

(ii) **consider the best delivery access for your population requirements**, making the most of community pharmacy**,** pop ups, mobile units and other approaches. Convenience builds uptake through ease of access via locations as well as opening hours. In doing this, systems should identify from the start how to maximise uptake of the vaccine in underserved communities, building on learning in Phases 1 and 2.

We intend to publish the general practice and community pharmacy service specifications for Phase 3 in the first part of July with a view to confirming those who would like to opt in in mid to late July. Existing delivery models, including through PCN groupings, will continue to play a vital role in COVID-19 vaccine delivery due to supply considerations.

2. **Workforce**: We recognise the need to ensure sufficient workforce is in place to deliver Phase 3 alongside the national flu vaccination programme and the continuation of routine immunisation programmes. Therefore, as in Phases 1 and 2, **we expect providers will be able to access centrally sourced workforce for Phase 3, including non-registered trained vaccinators through the lead employer model, using the national protocol as appropriate and national agreements with volunteering organisations**. Providers should seek to maximise the use of volunteers wherever possible. Workforce and training guidance for phase three will be released shortly and we ask systems to continue to tell us if there is more we can do to help.

3. **Estates**: Phases 1 and 2 have made use of a mix of commercial, NHS and other public sector and community estates to meet population requirements. Many commercial estates used in Phases 1 and 2 are now returning to their business as usual function, and therefore **systems should plan to maximise existing NHS estate use or commissioned provider premises, while recognising that in some cases commercial estate will remain the best value for money solution**. Regions and systems will be offered the flexibility to retain commercial estates into Phase 3, where there are demonstrable benefits for coverage, access and uptake amongst underserved communities and where there is evidenced value for money in leasing arrangements. The following prioritised principles will apply to the Estates strategy from 1 September 2021 onwards:

(i) Maximise use of existing NHS estate and commissioned provider premises first, including uptake of vacant available estate across England. This will include the use of Community Pharmacies and GP Surgery premises as well as property held by the NHS Property Companies, and where viable, Secondary Care and Mental Health estate. This may require additional

planning and onboarding of sites to ensure that capacity needs can be met from a larger number of smaller premises.

(ii) Use available Local Authority estate to backfill gaps in NHS coverage.

(iii) Use private / commercial estate where required to target gaps in coverage, meet specific capacity shortfalls, or to better target underserved groups / cohorts.

4. **Vaccinating healthcare and social care workers**: As in Phase 1, we are expecting trusts to lead on vaccinating their staff with COVID-19 boosters through Hospital Hubs, as well as supporting the delivery of vaccinations to primary and social care staff as needed in the local system. The Government is shortly to consult on mandatory COVID-19 vaccination for all patient facing health and care staff.

5. **Changes to national processes and Phase 3 constraints**: System and regional engagement over the past few months has identified challenges and requirements for phase 3. We are taking the following actions to address these:

   (i) **Move to a "capped pull" ordering model** to support sites to have visibility and influence over the supply of COVID-19 vaccine. This will also allow sites to align COVID-19 vaccine with their flu vaccine supply for joint clinics to support co-administration, where timing of cohort phasing and eligibility of the programmes align.

   (ii) **Onboard additional primary care sites**. We anticipate being able to onboard additional community pharmacy sites in the run up to September. These will provide reach into underserved communities, increase weekend and evening vaccination capacity, and ease workforce pressures across primary care teams.

   (iii) **Work towards an infrastructure that enables point of care recording of both a co-administered and individual vaccination event,** recognising that this is likely to roll out across platforms as phase 3 progresses.

6. Co-administration: The JCVI have advised that 'early evidence on the concomitant administration of COVID-19 and influenza vaccines used in the UK supports the delivery of both vaccines where appropriate'. Co-administering flu and COVID-19 vaccines in the same appointment will allow more efficient use of resources and a better service for patients, as well as potentially helping to improve uptake of both vaccines. This will only be possible once the final results of the relevant clinical trials are published (expected later this summer), and where supply, regulation, and alignment of cohorts allows, particularly in primary care. If the ongoing clinical study finds that co-administration is safe and effective, **we intend to optimise for full co-administration of flu and COVID-19 vaccines in Trusts, residential care homes, to housebound patients and in other residential settings**. **We will actively enable and encourage co-administration in all other settings where possible (Local Vaccination Sites (LVS) and Vaccination Centres (VC))** by seeking flexibility to pool flu vaccine between practices, adding additional CP sites that can deliver flu vaccination to the COVID-19 vaccine supply network, and providing a tech and data infrastructure that is interoperable between the two programmes.

7. **Financial resources:** Consistent with Phase 1 & 2 of the programme, we have split the regional funding for phase 3 into two elements: regional programme resource funding and regional delivery funding.

   (i) Regional programme resource funding – Regional allocations were communicated on 30 June.

   (ii) Regional delivery funding - We expect to share initial indicative delivery costs shortly with regional finance teams. The costs will be dependent on the final delivery model (e.g. coadministration, childhood immunisation, etc.) and we will be refining these as the programme assumptions mature.

8. **Children's COVID-19 vaccination:** MHRA have approved the Pfizer vaccine for use in those aged 12+, and the JCVI is examining the evidence. The JCVI will advise the Government on next steps in due course.

Next steps

Systems should **work with local providers, local authorities and regional teams to review their current Autumn/Winter plans**, to ensure alignment with the content of this letter. We will make additional information available as soon as it becomes available to us.

Thank you for your continued efforts in delivering the COVID-19 vaccination programme. We are grateful to everyone in the programme for their dedication in making the COVID-19 vaccination rollout a success.

Emily Lawson
SRO Vaccine Deployment
Chief Commercial Officer
NHS England and NHS Improvement

Dr Nikki Kanani
Medical Director for Primary Care

Professor Keith Willett
NHS Strategic Incident Director