To: ICB Chief Executive Designates

CC:
- CCG Accountable Officers
- All GP practices
- All Community Pharmacies
- Primary Care Networks
- All Trust Chief Executives
- All Local Government Chief Executives
- All Health and Justice healthcare providers
- NHS England & NHS Improvement Regional Directors and Regional Directors of Commissioning
- All Directors of Public Health

NHS England and NHS Improvement
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22 June 2022

Dear colleagues

Next steps for COVID-19 vaccination

Firstly, thank you for delivering a successful vaccination programme over the last two years. Over 124 million COVID-19 vaccinations have been administered, alongside the biggest ever flu vaccine uptake and continued delivery of routine immunisation programmes. You have saved lives and protected our communities.

Following the publication of interim advice from the Joint Committee on Vaccination and Immunisation (JCVI) for the autumn, we are writing to set out next steps for COVID-19 and routine vaccination and how we want to work with you to develop a future vaccination and immunisation strategy.

DELIVERY OF COVID-19 AND ROUTINE VACCINATION

We continue to plan in the context of the Government's *Living with COVID-19* strategy and maintain our focus on the restoration and improvement of all routine immunisation programmes and the delivery of COVID-19 and flu. The next steps for COVID-19 vaccination need to be considered in two phases:

- Completion of the Spring Booster campaign and vaccination offer to the end of August

- Planning for the delivery of an integrated autumn /winter campaign and responding to outbreaks (surge).

Completion of Spring Booster Campaign and vaccination offer to end of August

Operational flexibility was included in the Green Book to ensure timely protection for the most vulnerable during spring.

The NHS will invite and vaccinate those eligible for a spring booster by the end of June. This includes those who turn 75 years old, are admitted to an older adult care home or become immunosuppressed in June. They will all be invited for a Spring Booster throughout this month.

The ability to book an appointment post 30 June for those eligible for a Spring Booster (e.g. those who became eligible on or before 30 June) will be maintained, however systems are asked to ensure clinical conversations take place at the point of care about the optimal timing of a booster dose prior to an autumn vaccination programme. It is expected that there will be a minimum interval of 91 days between an individual's last dose and an expected autumn vaccination offer. Updated national communications will be issued to support this. Those who enter care homes or turn 75 after 30 June are not eligible for further vaccination until the autumn programme begins. However, newly immunosuppressed individuals should continue to be offered vaccination through the summer period.

Acute trusts must continue to provide or support the vaccination of newly immunosuppressed individuals, pregnant women, and healthcare workers yet to complete a primary course and first booster.

As we set out in our letter on 23 February, systems, working across their partnerships, must continue community engagement to improve confidence and promote uptake, supported by appropriate access. The configuration of the network will vary by system as it should be co-designed to meet local population needs, however, a reduction in demand will necessitate systems agreeing sites that need to pause or hibernate until the autumn /winter campaign.

With the continued decline of MMR uptake rates and the loss of the UK's measles elimination status in 2019, systems should continue to work with partners to identify opportunities to bring forward and expedite planned catch up campaign for MMR, Td/IPV, Men ACWY, HPV and other routine vaccines. Local commissioners should consider how vaccination centres, workforce and engagement activities can be used throughout the summer to support this.

Planning for the delivery of an integrated autumn vaccination campaign and responding to outbreaks (surge)

To support operational planning, JCVI have provided interim advice, which states:

"As with the 2021 autumn COVID-19 booster programme, the primary objective of the 2022 autumn booster programme will be to augment population immunity and protection against severe COVID-19 disease, specifically hospitalisation and death, over winter 2022 to 2023.

The following advice should be considered as interim and for the purposes of operational planning for autumn 2022. The JCVI's current view is that in autumn 2022, a COVID-19 vaccine should be offered to:

- *residents in a care home for older adults and staff working in care homes for older adults*
- *frontline health and social care workers*
- *all those 65 years of age and over*
- *adults aged 16 to 64 years in a clinical risk group.*

Vaccination of other groups of people remains under consideration within JCVI's ongoing review."

A full copy of the interim advice can be found here.

Systems should develop plans to deliver autumn COVID-19 vaccination on a minimum scenario for cohorts 1-6 and a maximum scenario of cohorts 1-9 without disruption to core health and care services, subject to final JCVI advice. For 2022/23, information on the flu immunisation programme has been published in our letter of 22 April 2022 available here.

Systems should maximise opportunities to co-promote and co-administer where possible and clinically advised (e.g. COVID-19, flu and pneumococcal), especially where this improves patient experience and uptake**.** Local commissioners may use vaccination centres to deliver other routine immunisations if appropriate.

All vaccination sites will be expected to create opportunities to improve population health, delivering as a minimum health promotion advice, and offering health checks where possible. These should be locally determined to address local need.

Differences in uptake between and within communities remain and we must continue to prioritise building confidence, maximising convenience and addressing unwarranted variation. Systems will be provided with standardised uptake for their local populations through the Vaccine Equalities Tool which should be used to prioritise activity, and support an accessible network design and focused community engagement.

Surge

When developing plans for autumn, systems should also consider how they would rapidly deploy additional COVID-19 vaccination in the event of a surge. These plans will need to limit the impact on primary care, routine and elective NHS activities, including other routine immunisation programmes. We recognise this is a challenge and to support this work we will share further guidance shortly.

Workforce

Systems should ensure plans maximise the use of the national protocol and reduce the pull on registered healthcare professionals. Throughout the summer, further steps should be taken to engage staff in retention activities to ensure that there is sufficient capacity for autumn delivery, with well-developed models for stepping up workforce in the event of surge.

Vaccine supply and consumables

Following your feedback, changes have now been made to enable the deselection of consumables from orders and to support systems during the low demand period. Sites can now also order smaller pack sizes through the ordering platform. Vaccine continues to be accessible through the supply planner and ordering platform on Foundry and weekly stocktakes are required.

Maximum caps and existing pharmaceutical standards also continue to apply. Legislation enabling mutual aid arrangements has been extended to April 2024 and current MHRA rules regarding movement and remanufacturing of vaccine must be adhered to, with all stock movement correctly recorded. Systems should not plan to have a dependency on additional movement of vaccine between sites and should consider operational and expiry wastage when determining the number and type of sites.

We will continue to operate a fixed delivery schedule for supply, delivering to agreed and assured locations. For maximum flexibility and resilience, as many sites as possible should be assured for all adult and children vaccine types, including any new vaccines as and when they are introduced.

We will continue to work with sites to further improve allocation and supply processes, including the development of an auto-allocation approach to provide additional certainty and to support planning.

Primary care

New contracts and full details about an expressions of interest process for community pharmacy and an opt-in process for general practice involvement in the COVID-19 vaccination programme from autumn 2022 will be published shortly.

Finance

Variations to the COVID-19 vaccination contracts for general practice and community pharmacy will be published shortly, along with specifications for Vaccination Centres, Hospital Hubs and the 2022/23 flu service.

The national allocation for the COVID-19 vaccination programme covers the whole of the 2022/23 financial year. The existing financial framework – a mix of item of service and reimbursement – remains in place to the end of August.

From September, to give greater flexibility to systems to meet the needs of local communities, we will be issuing fixed allocations. These will be based around a fixed unit payment across all delivery models, with an additional supplement for people who are housebound. Regions will therefore receive an allocation, shown at ICB level, made up of three parts as follows:

(i) core activity, based on total expected doses at the standard rate per dose;

(ii) funding to design an accessible network and deliver engagement activities to increase uptake across communities, shaped by indicators of rurality, ethnicity, and deprivation;

(iii) funding to maintain a degree of ‘surge’ capacity based on population size.

Because the programme allocation for the year is fixed, the value of (ii) and (iii) will be influenced by the spend in the period to August.

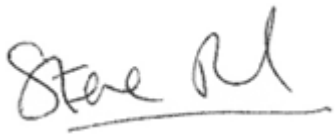
FUTURE VACCINATION AND IMMUNISATION STRATEGY

Following the recent Secretary of State reform announcement on ambitions for a new approach to vaccination, we are developing an integrated vaccination and immunisation strategy, building on the learning from COVID-19 and the foundations of our other

immunisation programmes. Working in partnership with all providers, local authorities, voluntary and community sector leaders and communities themselves, we now need to design a future model that will maximise uptake, reduce unwarranted variation and help people protect themselves and their families.

Over the next few weeks we will be in touch with you to hear your views on the core elements of our future vaccination and immunisation service and understand what opportunities and challenges exist at a local, regional and national level, to help us realise this ambition.

Yours sincerely



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Annex 1 – High-level principles to inform autumn 2022 System planning – COVID-19 Vaccination Programme

These success criteria are guiding principles within a broader review to support Regions in providing the capacity they need. They should not be viewed as a set of criteria which need to be 'ticked off'. There will be a need for Systems to strike a balance across these criteria, however safety / clinical quality, coverage access and addressing inequalities should always be prioritised. It is then for each System to flex between the other principles in order to provide a network that is fit for purpose for their population needs.

#	Criteria	Principle	What good looks like
1	Safety and Clinical Quality	• All Locations to adhere to the existing and any emerging clinical standards that need to be achieved to ensure the safety and quality of services	• All Locations have met the national pharmaceutical assurance and quality criteria, including adherence to policy relating to movement of vaccine • All Locations to comply with regulatory guidance e.g. Medicines, CQC • All Locations have effective systems in place for clinical incident reporting and review and escalate them in accordance with the national Incident Reporting SOP • All Locations have implemented and embedded procedures for maintaining safe staffing • All Locations to have a process is in place to assure continued clinical competency when sites are stood up for surge/booster. Link here • There is evidence of learning culture –QI approach – governance processes and embedded learning and PDSA. Evidence of QI lead for site/provider, lesson learnt, safety culture and participant experience/feedback • Within the operational locations ensure that there are effective assurance and governance systems in place with clear and clearly understood lines of accountability for all aspect of programme delivery • All sites to comply with the national complaints process, ensuring posters are displayed in all sites identifying the lead provider • At the outset make provisions of building in evaluation and getting feedback from participants and staff

			• All Locations to have reasonable adjustments to cater to participant and population needs, Link here • All Locations comply to national Infection Prevention and Control guidance Link here • All Locations to ensure training, operational policies, guidance and referral/advice pathways for the management of safeguarding are up to date • All Locations have met the standards within relevant clinical checklists (including Children checklist A, B & C for ages 5-17 Link here • All Locations to have suitably qualified and trained staff and equipment to manage medical emergencies Link Here • All systems to have a clear process for access to allergy clinics for people who have severe allergies and anaphylaxis
2	Coverage/ Access	• Systems can ensure participants can access a vaccination Location with suitable travel time and operating times with options for walk-in.	• Map of proposed Locations (e.g. using SHAPE tool) with a narrative on travel times and opening times • Plan for mobile units / roving options to supplement static network • A schedule of actual / proposed pop-ups and outreach services aligned to static Locations • System can ensure participants can access a vaccination Location with suitable travel and opening times, whilst maintaining VFM estates and vaccine wastage principles • Tiered travel times provided for inner cities / urban / rural communities.
3	Addressing Inequality	• Systems ensure equity of access, to improve uptake, and to reduce variation across communities • The delivery model must include an agreed engagement strategy applicable to all Locations that supports vaccination and tailored delivery approaches for under-served communities (especially	• Systematic and continuous engagement and outreach plans to improve confidence in areas/groups of low uptake (e.g. vaccine hesitancy and underserved communities), supported by operational delivery reflecting community need • EHIA (Equality and Health Inequalities Impact Assessment) • System plan can evidence EHIA recommendations in location and delivery model mix, with reasonable adjustment in place to equity of access • Plans should set out how they will identify and invite the existing and newly diagnosed immunosuppressed population

		those with historically low uptake or who have not taken up the vaccine offer)	
4	Balancing wider NHS activity	• Systems have a sustainable network that does not hinder wider NHS services and does not rely too heavily on general practice. Additionally, activity should support wider recovery	• Capacity plans and identified Locations have an appropriate split across delivery models • System plan describes plans for MECC at all locations (e.g., hypertension management) and other opportunities for health promotion to maximise VfM • Plans consider opportunities to promote and offer other vaccinations
5	Capacity	• Plan to have sufficient capacity to provide a credible offer for 100% of the population across the specified time period	• Credible capacity for care homes, specifically called out in the capacity plans • Demand generation initiatives to maximise throughput / utilisation • Narrative on how design optimises towards high performing Locations and takes into consideration minimum order quantities of the vaccines • An approach to temporary pausing further Locations if over-capacity is identified • List of proposed Locations and site level capacity by delivery model • Evidence of expected cohort coverage by Location • Delivery models need to include detail on mobile outreach • Systems to provide demand and capacity profile over the course of the delivery period
6	Contract	• Locations and associated services should be contracted on the basis of fully delivering all aspects of agreed planned and surge capacity	• Each Location must commit with the system to a minimum weekly volume they're delivering from the beginning of autumn • All Local Vaccination Services should draw down additional workforce in a way that will maximise uptake of planned and surge vaccination delivery (and be able to demonstrate they are doing so)

7	Planning	• Systems should undertake integrated planning that aligns behavioral insights regarding access, demand, capacity, supply and workforce – and ensure there is national and local visibility of each element	• Ensure there is national and local visibility of capacity • Having processes in place to ensure supply follows demand effectively • Access: Confirm access times based upon behavioural insights and previous activity • Demand: Visible demand profile matched by clear capacity plan • Supply: Describe approach to allocation at a system level, and how this supports effective delivery • Workforce: Describe the approach to ensuring, based upon capacity and demand requirements, sufficient workforce is mobilised
8	Ramp-up to Surge	• Systems have an agile and robust plan in place to rapidly increase capacity to respond to a surge scenario. • Surge activity and associated additional capacity should limit impact on routine NHS activities	• System plan demonstrates how it will implement the surge planning guidance • Systems have identified 'Surge locations' and roving options to meet surge capacity requirements; and can demonstrate how it has arrived at its optimum capacity/location network • All systems have a Rapid Deployment Plan to expand capacity for all age cohorts and vaccine types • All systems have existing Estate plans and existing Workforce Plans with capacity aligned to regional scenario assumptions • Plan to mobilise care homes within the current delivery model parameters, whilst upskilling care home staff to deliver vaccines • Systems need to ensure that they are balancing COVID-19 response with routine elective capacity and reducing the impact of COVID-19 on other NHS services
9	Value for Money	• Systems to spend taxpayer money in a way that maximises value for money in line with the success criteria. National and regional teams will support systems on cost estimates of their plans to enable a rounded value for money assessment.	• System identify the cost per vaccine for each pillar within their System • System plan identifies that Locations are placed to support multiple offers e.g. walk in, booked appointments and facilitate roving teams to minimise on numbers of locations and vaccine utilisation • System plan describes other health activities e.g. MECC to maximise on VfM

			• System plan describes use of available workforce e.g. volunteers and SJA to reduce agency and other spend on workforce in line with clinical guidance
10	Workforce	• Systems ensure efficient use of the workforce, optimising the unregistered and volunteer workforce, to ensure sustainability and flexibility to ensure sufficient capacity to deliver planned and surge requirements.	• Confirmation of the lead employer for each system • Sufficient workforce recruited, trained and retained to deliver vaccination demand and surge, including plan for retention when demand is low • Optimised use of the workforce, including adoption of the national protocol as default legal mechanism of delivery • Narrative on opportunities for co-administration of vaccines