

[redacted] - FOISA Section 38(1)(b)

Population Health / Public Health Capabilities

11 June 2024

## Minister for Public Health and Women's Health

### FVCV 2024-25: JCVI ADVICE ON WINTER 2024 COVID-19 VACCINATION PROGRAMME AND CONSIDERATIONS ON FUTURE COVID-19 VACCINATION

#### Priority and Purpose

1. **Urgent: [redacted] – FOISA Section 30(b)** advice regarding the COVID-19 vaccination programme for winter 2024-25 and our proposal regarding frontline Health and Social Care Workers (HSCWs), and note that unpaid carers and household contacts will no longer be eligible for COVID-19 vaccination.

#### Recommendation

2. **[redacted] – FOISA Section 29(1)(a)**

#### Context and Issues

3. The JCVI COVID-19 subcommittee met on 27 February 2024 and we received the final draft statement from Scottish Government (SG) Senior Medical Officer (SMO) **[redacted] – FOISA Section 38(1)(b)** on 22 May (**Annex A**).
4. The primary aim of the national COVID-19 vaccination programme remains the prevention of severe illness (hospitalisations and deaths) arising from COVID-19. As currently available COVID-19 vaccines provide limited protection against mild and asymptomatic disease, the focus of the programme is on offering vaccination to those most likely to directly benefit from vaccination, particularly those with underlying health conditions that increase their risk of hospitalisation following infection. For winter 2024-25 the JCVI advise that a COVID-19 vaccine be offered to:
  - a. Those aged 65 years and over
  - b. Residents in care homes for older adults
  - c. Those aged 6 months to 64 years in a clinical risk group, as defined in tables 3 and 4 of the COVID-19 chapter of the Green Book (*this includes pregnant women at any stage of pregnancy*)
5. For the first time since the beginning of the pandemic, the JCVI does not advise an offer of vaccination to frontline HSCWs, staff working in care homes for older adults, unpaid carers and household contacts of people with immunosuppression.
6. The statement does however go on to offer further flexibility on the frontline HSCW group:
  - a. *JCVI does not consider aspects of occupational health programmes in their cost effectiveness methodology. Health and social care service providers may wish to consider whether vaccination provided as an occupational health programme*

*is appropriate. Ahead of such considerations, health departments may choose to continue to extend an offer of vaccination to frontline health and social care workers and staff working in care homes for older adults in autumn 2024.*

7. As such, we have assessed the options relating to the frontline HSCW group with senior clinical colleagues, including CMO, CPO, DCMOs, and SG policy teams including health workforce, social care workforce, carers, care homes and delayed discharge / winter resilience teams. We have also sought input from senior colleagues at Public Health Scotland (PHS).

8. [redacted] – FOISA Section 30(b)

#### Options Considered and Advice

[redacted] – FOISA Section 29(1)(a)

[redacted] – FOISA Section 29(1)(a)

9. [redacted] – FOISA Section 30(b)

10. [redacted] – FOISA Section 30(c)

11. [redacted] – FOISA Section 29(1)(a)

12. [redacted] – FOISA Section 29(1)(a)

13. [redacted] – FOISA Section 30(b)

14. [redacted] – FOISA Section 29(1)(a)

- a. [redacted] – FOISA Section 29(1)(a)
- b. [redacted] – FOISA Section 30(c)
- c. [redacted] – FOISA Section 29(1)(a)
- d. [redacted] – FOISA Section 30(c)

15. [redacted]- FOISA Section 30(c)

16. [redacted] – FOISA Section 30(c)

17. [redacted] – FOISA Section 30(b)

- a. [redacted] – FOISA Section 30(b)
- b. [redacted] – FOISA Section 30(b)

18. [redacted] – FOISA Section 30(c)

[redacted] – FOISA Section 29(1)(a)

19. [redacted] – FOISA Section 29(1)(a)

20. [redacted] – FOISA Section 29(1)(a)

- a. [redacted] – FOISA Section 29(1)(a)
- b. [redacted] – FOISA Section 29(1)(a)
- c. [redacted] – FOISA Section 30(c)
- d. [redacted] – FOISA Section 29(1)(a)
- e. [redacted] – FOISA Section 30(c)
- f. [redacted] – FOISA Section 30(b)

21. [redacted] – FOISA Section 29(1)(a)

### **Contribution to the Government's Three Missions**

22. Contributes to 'Community: Prioritising our public services', by helping to deliver efficient and effective public services.

### **Delivery**

23. The JCVI statement confirms the age-based cohorts for COVID-19 and flu now align since the removal of the healthy 50-64 flu group, with all those aged 65 and over being offered both vaccines. This will simplify operational delivery and messaging for these groups. However, with COVID-19 eligibility for unpaid carers ending, good public communications will be needed to maintain uptake of flu vaccinations for this group and to help address concerns that carers are being deprioritised from the programme.

24. The JCVI flu statement for 2024-25 states that due to the waning profile of adult flu vaccines, the optimum period for vaccination is October to the end of November in order to give greater protection over the height of the flu season which we typically see around December and January. They advise that the child flu programme begin in early September, as the waning of these vaccines is less pronounced.

25. Under our delivery model, flu and COVID-19 vaccines are offered and co-administered at the same winter appointment. [redacted] – FOISA Section 30(c)

### **COVID-19 Vaccines**

26. The statement notes that Moderna and Pfizer vaccines should be deployed this winter, with further information to be made available via the COVID-19 Green Book Chapter. We are anticipating updated mRNA vaccines targeting a prominent recent strain.

27. The statement notes that Novavax Nuvaxovid or HIRPA Bimervax can be used for those where mRNA products are not considered clinically suitable. UKHSA has no contract for either of these products and as such, we are piloting small batch, local level procurement of Novavax this spring. If this is successful then we may choose to locally procure non-mRNA vaccine for winter. More advice would be provided if there is any change in position.

### **Bute House Agreement Implications**

28. None

### **Verity House Agreement Implications**

29. None

### **Financial Considerations**

30. Delivery funding for this winter programme, including the frontline HSCW group has already been approved for 2024-25 under the FVCV budget which included an allocation of £76m across Boards to cover workforce, venues and other non-pay costs to support delivery of all vaccine programmes. Although this is a 5% reduction on the allocation from the previous year, the flu cohorts have reduced in size for winter 24-25 by approx. 750,000 with the removal of the healthy 50-64 year olds, and we are encouraging Boards to make other efficiencies in their delivery models. We will continue to work with Boards through the Programme to ensure vaccines are delivered in the most effective and efficient way.
31. COVID-19 vaccines have already been pre-procured as part of the UK government's pandemic emergency response and that this equates to sufficient vaccine, available at no additional cost, to complete the winter 2024-25 campaign.

### **Legal Considerations**

32. [redacted] – FOISA Section 36(1)

### **New Deal for Business Implications**

33. None

### **Sensitivities**

34. We would expect unpaid carer representatives to challenge their exclusion and that of the household contacts group this winter, particularly if Ministers approve the inclusion of the frontline HSCW group. Unpaid carers perform a similar role to care staff and argue for similar treatment. If they are unwell and unable to look after their dependants, they may need emergency social care support, placing additional burden on services. The need for NHS service resilience during the winter period could therefore be reinforced to them to bring more clarity as to why the decision has been made. The difference is that that there is no flexibility for the unpaid carer or household contact groups within the JCVI statement, although carers organisations have noted that Scotland is not obligated to follow JCVI advice and can make its own policy decisions. We would propose to engage soon with carers groups to seek to mitigate their fears. Previous engagement has shown they are willing to listen to our advice, especially when SG clinical colleagues present evidence on reduction in severity of COVID-19-related illness and vaccine efficacy and transmission. Both unpaid carers and household contacts remain eligible for the flu vaccine this winter.

### **Quality Assurance**

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35. This submission has been approved by the Chief Medical Officer and Simon Cuthbert-Kerr, Deputy Director, Public Health Capabilities.

**Conclusion and next Steps**

**36. [redacted] – FOISA Section 30(b)**

37. We are seeking clarity from the Department of Health & Social Care (DHSC) on timelines for publication of the statement, but as Westminster is in an election cycle it may be that Ministerial agreement and subsequent publication is not seen until after the general election. We would therefore also not be able to publish our intentions until the JCVI statement was in the public domain, although due to the tight delivery timescales, planning would have to continue based on the unpublished statement.

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Population Health + Public Health Capabilities

<b>Cabinet Secretaries and Ministers Copy List</b>	<b>For Action</b>	<b>For Information Portfolio interest</b>	<b>For Information Constituency interest</b>	<b>For Information General awareness</b>
Cabinet Secretary for NHS Recovery, Health and Social Care		X		
Minister for Social Care, Mental Wellbeing & Sport		X		

<b>Officials Copy List</b>
Permanent Secretary DG Health and Social Care  Chief Medical Officer Chief Pharmaceutical Officer Interim Chief Nursing Officer Graham Ellis, DCMO Marion Bain, DCMO Chief Operating Officer National Clinical Director <b>[redacted] - FOISA Section 38(1)(b)</b>  Director of Population Health Director of Health Workforce  Simon Cuthbert-Kerr Derek Grieve Ian Turner Rachael McGruer

**Officials Copy List**

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**PLEASE NOTE THE FOLLOWING STATEMENT IS THE FINAL DRAFT STATEMENT AS IT HAS NOT YET BEEN PUBLISHED – THIS IS BEING SHARED IN STRICT CONFIDENCE AT THIS STAGE**

## **JCVI FVCV WINTER ADVICE STATEMENT 2024-25**

9 April 2024

Advice from the Joint Committee on Vaccination and Immunisation (JCVI) on the COVID-19 vaccination programme has continued to adapt as the country has transitioned from pandemic response to recovery. In 2024, the current situation is one of very high levels of population immunity against the SARS-CoV-2 virus and the emergence of new Omicron sub-variants that are not associated with increased disease severity compared with earlier variants.

### **Advice on autumn 2024 vaccination**

The primary aim of the national COVID-19 vaccination programme remains the prevention of severe illness (hospitalisations and deaths) arising from COVID-19. As currently available COVID-19 vaccines provide limited protection against mild and asymptomatic disease, the focus of the programme is on offering vaccination to those most likely to directly benefit from vaccination, particularly those with underlying health conditions that increase their risk of hospitalisation following infection. For autumn 2024, the JCVI advises that a COVID-19 vaccine should be offered to:

- adults aged 65 years and over
- residents in a care home for older adults
- persons aged 6 months to 64 years in a clinical risk group, as defined in tables 3 and 4 of the COVID-19 chapter of the Green Book.

The vaccine should usually be offered no earlier than around 6 months after the last vaccine dose, although operational flexibility around the timing of vaccination in relation to the last vaccine dose is considered appropriate (with a minimum interval of 3 months between doses). More information on operational flexibility will be provided in the COVID-19 chapter of the Green Book.

The Committee does not advise an offer of COVID-19 vaccination within the autumn 2024 national COVID-19 vaccination programme for frontline health and social care workers, staff working in care homes for older adults, unpaid carers, and household contacts of people with immunosuppression.

JCVI does not consider aspects of occupational health programmes in their cost effectiveness methodology. Health and social care service providers may wish to consider whether vaccination provided as an occupational health programme is appropriate. Ahead of such considerations, health departments may choose to continue to extend an offer of vaccination to frontline health and social care workers and staff working in care homes for older adults in autumn 2024.

### **Considerations- Number needed to vaccinate (NNV)**

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An estimate of how many individuals need to be vaccinated, by age group, to prevent one hospitalisation, ICU admission, and one death (the number needed to vaccinate) provides a quantified assessment of the potential benefits of population vaccination. This assessment continues to indicate that the greatest benefits are obtained with programmes targeting the oldest age cohorts, especially those with underlying health conditions. Analyses of NNV were used to inform a bespoke cost-effectiveness assessment of autumn 2024 vaccination. Further details are provided at appendix 1.

### **Cost effectiveness assessment**

A bespoke, non-standard method of cost effectiveness assessment was developed to reflect the ongoing uncertainties around COVID-19 and the availability of pandemic pre-procured COVID-19 vaccines. This cost effectiveness assessment was one of the factors considered by JCVI in the formulation of its advice for autumn 2024. Cost effectiveness was considered by age group and clinical risk group.

Using an estimated item of service fee per vaccine set by NHS England and assuming co-administration with influenza vaccines in autumn 2024, the bespoke cost effectiveness assessment for autumn 2024 indicated that vaccination was likely to meet acceptable cost effectiveness criteria when offered to the following groups:

- all adults aged 70 years and over
- adults aged 65 years and over in a clinical risk group (excluding immunosuppression)
- immunosuppressed individuals aged 15 years and over

Given the high proportion of older adults with underlying health conditions and the higher uptake seen in universal age-based programmes, JCVI considers that for autumn 2024, it is appropriate to offer vaccination to all adults aged 65 years and over. While not a fully incremental assessment as would be standard, this approach is considered appropriate as it reflects the uncertainties in the cost effectiveness assessment estimates.

Further details regarding the cost effectiveness assessment of COVID-19 vaccination in autumn 2024 will be published by the Department of Health and Social Care (DHSC) in due course. This interim non-standard analytical approach to cost effectiveness is specific to COVID-19 and is applicable only during this transition phase of pandemic recovery.

Cost effectiveness analyses indicate that COVID-19 vaccination of clinical risk groups under the age of 65 years is unlikely to be cost effective. However, COVID-19 clinical risk groups as defined in the Green Book (tables 3 and 4) are highly heterogenous, with the absolute risk of serious disease varying substantially both within and between clinical risk groups. The relative importance of different underlying health conditions in susceptibility to severe complications of COVID-19 may also be changing as population immunity changes.

Therefore, for autumn 2024, the JCVI considers it appropriate to offer vaccination to all people in a clinical risk group aged 6 months and over. This includes women who are pregnant regardless of their stage of pregnancy, whilst recognising that the risk of severe COVID-19 in both pregnant women and neonates is currently substantially lower than previously seen in these groups (references 1 and 2).

### **Those living and working with vulnerable people**

In the current era of high population immunity to COVID-19 and all cases due to Omicron sub-lineages of the SARS-CoV-2 virus, additional doses of available COVID-19 vaccines

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provide moderate protection against severe COVID-19 for a few months (references 3 and 4). However, protection against mild symptomatic infection is much more limited both in terms of peak protection and duration of protection (weeks). Whilst there is an absence of good scientific data on the added protection against transmission of infection from one person to another in the era of highly transmissible Omicron sub-variants, it is expected that any such protection would be extremely limited. Therefore, the indirect benefits of vaccination (vaccinating an individual in order to reduce the risk of severe disease in other people) are less evident now compared with previous years. These considerations informed the advice relating to frontline health and social care workers, unpaid carers, and household contacts of people with immunosuppression. A specific cost effectiveness analysis was not undertaken for these cohorts.

### **Post-COVID syndromes**

There remains considerable uncertainty regarding the impact of additional vaccine doses, beyond primary vaccination, on the risk, progression and/or outcome of post-COVID syndromes (reference 5). Long-term sequelae following SARS-CoV-2 infection are highly heterogeneous and determining the proportion of cases in which symptoms can be firmly attributed to SARS-CoV-2 infection is complex. The rate of self-reported long-term symptoms following COVID-19 is lower with infection from Omicron sub-lineages of SARS-CoV-2 compared with previous variants (reference 6). Better data are needed on the impact of additional vaccine doses on the occurrence and severity of post-COVID syndromes in the current era of Omicron sub-variants and high population immunity.

### **Vaccine products for autumn 2024 programme**

The cost effectiveness assessment for the autumn 2024 programme considered the unique situation that COVID-19 vaccines have already been pre-procured as part of the government's pandemic emergency response. There will be sufficient pre-procured COVID-19 vaccine doses, available at no additional cost, to complete the autumn 2024 campaign. Other authorised vaccines which may offer similar protection and would therefore be considered suitable, but which would incur additional costs, are therefore less cost effective.

For the autumn 2024 COVID-19 programme, the following COVID-19 vaccines are advised (please refer to the COVID-19 chapter of the Green Book for more details):

For all individuals aged 18 years and over:

- Moderna mRNA (Spikevax) vaccine. Dose: 50 micrograms
- Pfizer-BioNTech mRNA (Comirnaty) vaccine. Dose: 30 micrograms

For young people aged 12 to 17 years:

- Pfizer-BioNTech mRNA (Comirnaty). Dose: 30 micrograms

For children aged 5 to 11 years:

- Pfizer-BioNTech mRNA (Comirnaty). Dose: 10 micrograms

For children aged 6 months to 4 years:

- Pfizer-BioNTech mRNA (Comirnaty). Dose: 3 micrograms

Novavax Matrix-M adjuvanted COVID-19 vaccine (Nuvaxovid) may be used as a booster dose for persons aged 12 years and above when alternative products are considered not clinically suitable.

HIPRA bivalent COVID-19 vaccine (Bimervax) may be used as a booster dose for persons aged 16 years and above when alternative products are considered not clinically suitable.

### Future programmes

Infection with SARS-CoV-2 continues to occur throughout the year. The current trend indicates intermittent waves occurring every few months which are consistently peaking at lower amplitude. Winter remains the period of greatest threat from COVID-19 both in relation to the risk of infection to individuals and the pressures on health systems. JCVI will continue to review the optimal timing and frequency of COVID-19 vaccination beyond autumn 2024. Transition to a routine vaccination programme will require the COVID-19 programme to meet standard cost-effectiveness criteria, in line with other vaccination programmes. Should population immunity to SARS-CoV-2 be maintained, it is anticipated that most people will experience relatively mild symptomatic or asymptomatic infections. In such a scenario, future routine COVID-19 immunisation may be a cost-effective intervention for only a relatively small population group who remain at high risk of severe complications from SARS-CoV-2 infection.

### References

1. Intensive Care National Audit & Research Centre data (unpublished)
2. UK Obstetric Surveillance System (in press, Nature Communications)
3. [The impact of vaccination and SARS-CoV-2 variants on the virological response to SARS-CoV-2 infections during the Alpha, Delta, and Omicron waves in England - ScienceDirect](#)
4. [Weekly Flu and COVID-19 Report w8 \(publishing.service.gov.uk\)](#)
5. [Effect of covid-19 vaccination on long covid: systematic review - PubMed \(nih.gov\)](#)
6. [Self-reported long COVID after infection with the Omicron variant in the UK - Office for National Statistics \(ons.gov.uk\)](#)