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COVID-19 - SARS-CoV-2

NOTIFIABLE

The virus

COVID-19 disease first emerged as a presentation of severe respiratory infection in Wuhan, China in late 2019 (WHO, 2020). By January 2020, lower respiratory samples taken from affected patients were sequenced and demonstrated a novel coronavirus (SARS-CoV-2) (Huang *et al*, 2020). The first two cases in the UK were seen in late January (Lillie *et al*, 2020). In March 2020, the World Health Organization (WHO) declared a SARS-CoV-2 pandemic (WHO Director-General, 2020).

SARS-CoV-2 is a member of the family of Coronaviridae and genus Betacoronavirus (Zhu *et al*, 2020). Phylogenetic analysis of SARS-CoV-2 has shown that it is genetically distinct from the SARS coronavirus (Dhama, *et al*, 2020), but appears to share strong sequence similarity to bat coronaviruses in China (Lam *et al*, 2020).

As with other coronaviruses, SARS-CoV-2 is an RNA virus which encodes four major structural proteins, spike (S), membrane (M), envelope (E) and a helical nucleocapsid (N) (Dhama *et al*, 2020). The S glycoprotein is considered the main antigenic target and consists of an S1 and S2 subunit (Kaur *et al*, 2020). The S1 subunit has two functional domains: the N terminal domain (NTD) and receptor binding domain (RBD) which contains the receptor binding motif (RBM) (Kaur *et al*, 2020). The RBM binds to angiotensin converting enzyme 2 (ACE2) on host cells and is endocytosed with subsequent release of the viral genome into the cytoplasm (Amanat *et al*, 2020).

SARS-CoV-2 is primarily transmitted by person to person spread through respiratory aerosols, direct human contact and fomites (Kaur *et al*, 2020). Estimates of the basic reproduction number [R] were initially between 2 and 3 although a recent estimate was as high as 5.7 (Sanche *et al*, 2020). This high transmissibility indicates that stringent control measures, such as active surveillance, physical distancing, early quarantine and contact tracing, are needed in order to control viral spread. Perinatal transmission has been reported although the exact transmission route has not been elucidated (ECDCa, 2020).

After the initial exposure, patients typically develop symptoms within 5-6 days (incubation period) although about 20% of patients remain asymptomatic throughout infection (Cevik *et al*, 2020). Polymerase chain reaction (PCR) tests can detect viral SARS-CoV-2 RNA in the upper respiratory tract for a mean of 17 days, although transmission is maximal in the first week of illness. Symptomatic and pre-symptomatic transmission (1-2 days before symptom onset), is thought to play a greater role in the spread of SARS-CoV-2 than asymptomatic transmission.

During late 2020 and 2021, a range of SAR-CoV-2 variants have emerged, some of which have been associated with increased transmission. These more transmissible variants have become established globally and replaced the original Wuhan strain, being associated with successive waves of infections in many countries. The first widely

distributed variant, designated Alpha, first emerged in Kent in late 2020 and led to a second wave in the UK in early 2021. Emergence of the Delta variant, first seen in India, was then associated with further waves of infection in many countries in 2021. Information on variants under investigation is posted each week at: <https://www.gov.uk/government/publications/investigation-of-sars-cov-2-variants-technical-briefings>

Many countries, including the UK, experienced increases in the incidence of Omicron in late 2021 and early 2022. Successive sub-lineages (BA.1, BA.2, BA.4, BA.5) of the Omicron variants have also circulated during 2022, often associated with an increase in incidence rates. UK data confirms observations from other countries that the severity of infection due to Omicron is low, with an estimated reduction in risk of hospitalisation of 50-70% (<https://www.gov.uk/government/publications/investigation-of-sars-cov-2-variants-technical-briefings>).

The disease

In adults, the clinical picture varies widely. A significant proportion of individuals are likely to have mild symptoms and may be asymptomatic at the time of diagnosis.

Symptoms are commonly reported as a new onset of cough and fever (Grant *et al*, 2020), but may include headache, loss of smell, nasal obstruction, lethargy, myalgia (aching muscles), rhinorrhoea (runny nose), taste dysfunction, sore throat, diarrhoea, vomiting and confusion; fever may not be reported in all symptomatic individuals. Patients may also be asymptomatic (He *et al*, 2020).

Progression of disease, multiple organ failure and death will occur in some individuals (Pachetti *et al*, 2020).

Early evidence confirmed that increasing age and male gender are significant risk factors for severe infection. However, there are also groups of patients with underlying comorbidities, where infection may result in increased risk of serious disease (Docherty *et al*, 2020). In a large review of primary care records pseudonymously linked with SARS-CoV-2 status, comorbidities including diabetes, cancer and poorly controlled asthma were associated with increased risk of death (Williamson *et al*, 2020).

Infection fatality ratios (IFR) for COVID-19 during the first wave in the UK, derived from combining mortality data with infection rates in seroprevalence studies, showed markedly higher IFR in the oldest age groups (Table 1) (Ward *et al*, 2020).

In Europe and the UK, deaths attributed to SARS-CoV-2 were reported disproportionately from residential care homes (ECDCb, 2020, Graham *et al*, 2020). Other notable risk groups include healthcare workers (Nguyen *et al*, 2020) who may acquire infection both in the hospital or within the community setting (Bielicki *et al*, 2020). Early evidence suggested that deprivation and being from black and asian minority ethnic group resulted in a higher risk for death from SARS-CoV-2 infection (Williamson *et al*, 2020), although the contribution of each of the possible underlying factors to these differences is unclear.

Table 1: UK Infection fatality ratio and estimated total numbers of deaths (February to July 2020)

Category	Population Size	SARS-CoV-2 antibody prevalence% (95% CI) ¹	Confirmed COVID-19 deaths ²	Infection fatality ratio % (95% CI) ²	Estimated number of infections (95% CI)
Total	56,286,961	6.0 (5.7, 6.8)	30180	0.9 (0.9, 0.9)	3,362,037 (3,216,816; 3,507,258)
Sex					
Male	27,827,831	6.5 (5.8, 6.6)	18575	1.1 (1.0, 1.2)	1,729,675 (1,614,585; 1,844,766)
Female	28,459,130	5.8 (5.4, 6.1)	11600	0.7 (0.7, 0.8)	1,633,785 1,539,821; 1,727,749)
Age (years)					
15-44	21,335,397	7.2 (6.7, 7.7)	524	0.0 (0.0, 0.0)	1,535,884 (1,436,941; 1,634,826)
45-64	14,405,759	6.2 (5.8, 6.6)	4657	0.5 (0.5, 0.5)	895,238 (837,231; 953,244)
65-74	5,576,066	3.2 (2.7, 3.7)	5663	3.1 (2.6, 3.6)	181,044 (153,426; 208,661)
75+	4,777,650	3.3 (2.5, 4.1)	19330	11.6 (9.2, 14.1)	166,077 (131,059; 200,646)

- 1 All estimates of prevalence adjusted for imperfect test sensitivity and specificity (see text for details). Responses have been re-weighted to account for differential sampling (geographic) and for variation in response rate (age, gender, ethnicity and deprivation) in final column to be representative of the England population (18+).
- 2 Infection fatality ratios were calculated excluding care home residents. Confirmed COVID-19 death counts were obtained from <https://fingertips.phe.org.uk/static-reports/mortality-surveillance/excess-mortality-in-England-week-ending-17-jul-2020.html>. Deaths in care homes by age on 12 June 2020 were obtained from www.ons.gov.uk. Total deaths in care home residents up to 17 July 2020 were obtained from www.ons.gov.uk. The age stratified estimates of COVID-19 deaths were then estimated using the total deaths from 17 July and the age distribution from 12 June. We assumed that age distribution of deaths did not change between 12 June and 17 July 2020.

Children

In general children appear to exhibit mild disease. Although cough and fever are the main symptoms in children (Ladhani *et al*, 2020), a UK study tracking children of healthcare workers has shown that of those who were seropositive, gastrointestinal symptoms were also commonplace (Waterfield *et al*, 2020). Initial evidence suggested that children had a lower susceptibility to SARS-CoV-2 infection, and they were unlikely to be key drivers of transmission at a population level (Viner *et al*, 2020). However, a prospective study found higher secondary attack rates where the household index case was a child (Lopez Bernal *et al*, 2020).

Following the large scale vaccination of adults in the UK, recent rates of reported cases in children have exceeded those in adults.

A spectrum of multi system inflammatory disease similar to Kawasaki disease (KD) was initially identified in children admitted during the SARS-CoV-2 pandemic, temporally associated with severe acute respiratory syndrome attributed to SARS-CoV-2 (Paediatric multisystem inflammatory syndrome temporally associated with SARS-CoV-2 infection (PIMS-TS)) (Whittaker *et al*, 2020). This severe presentation in children is extremely rare, but appears to encompass a wide range of features, including fever, gastrointestinal symptoms, rash, myocardial injury and shock (Swann *et al*, 2020).

Pregnant women and neonates

The risks to pregnant women and neonates following COVID-19 infection have worsened over the course of the pandemic: the maternal mortality ratio as a result of COVID-19 significantly increased from 1.4 per 100,000 live births in the wildtype SARS-CoV-2 dominant period to 5.4 per 100,000 live births in the Delta dominant period. (Knight *et al*, 2021). During the Delta dominant period, six neonatal deaths were recorded. No neonatal deaths were reported in previous waves. The proportion of pregnant women hospitalised with symptomatic COVID-19 that experienced moderate to severe infection increased from the first wave (wildtype) to subsequent Alpha and Delta dominant periods, and the proportion admitted to intensive care units also increased (Vousden *et al*, 2021a, <https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports>). Pregnant and recently pregnant women with COVID-19 are more likely to be admitted to an intensive care unit, have invasive ventilation or extracorporeal membrane oxygenation in comparison to non-pregnant women of reproductive age (Allotey *et al*, 2021).

UK studies have suggested a high rate of stillbirth in infected women (Allotey *et al*, 2020, Gurol-Urganci *et al*, 2021), and this appears to have increased during the Delta period (Vousden *et al*, 2021a). Vertical transmission appears rare (Gale *et al*, 2021). However, the risk of preterm birth is increased two to threefold for women with symptomatic COVID-19 (Vousden *et al*, 2021a,b), usually as a result of a medical recommendation to deliver early to improve maternal oxygenation.¹

Pregnant women are more likely to have severe COVID-19 infection if they are overweight or obese, are of black and asian minority ethnic background, have co-morbidities such as diabetes, hypertension and asthma, or are 35 years old or older (Vousden *et al*, 2021a, Allotey *et al*, 2020).

1 NICE Guideline 25, 2019 <https://www.nice.org.uk/guidance/ng25>

COVID-19 vaccines

The recognition of the pandemic has accelerated the development and testing of several vaccines using platforms investigated during previous emergencies such as the SARS pandemic (Amanat *et al*, 2020) and Ebola in West Africa. Candidate vaccines include nucleic acid vaccines, inactivated virus vaccines, live attenuated vaccines, protein or peptide subunit vaccines, and viral-vectored vaccines.

Most vaccine candidates focus on immunisation with the spike (S) protein, which is the main target for neutralising antibodies. Neutralising antibodies that block viral entry into host cells through preventing the interaction between the spike protein Receptor Binding Motif (RBM) and the host cell Angiotensin-converting enzyme 2 (ACE2) are expected to be protective (Addetia *et al*, 2020, Thompson *et al*, 2020).

In the UK four primary vaccines targeting the S protein of the original SARS-CoV-2 strain have been authorised for supply; two use an mRNA platform (Pfizer BioNTech COVID-19 BNT162b2 vaccine (Comirnaty® and Moderna mRNA-1273 COVID-19 vaccine/Spikevax®) and two use an adenovirus vector (AstraZeneca COVID-19 ChAdOx1-S vaccine/Vaxzevria® and COVID-19 vaccine Janssen Ad26.COVS-2 [recombinant]). One other vaccine is now approved for use in the UK, Nuvaxovid® is the COVID-19 vaccine developed by Novavax. This vaccine uses a recombinant S protein (grown in baculovirus infected insect cells) as an antigen with the Matrix-M™ adjuvant. The latter adjuvant includes two saponins derived from tree bark.

COVID-19 Vaccine Janssen and Nuvaxovid® are currently approved for primary immunisation in those aged 18 and older. As there are relatively few indications for these vaccines in the current programme, supplies of Nuvaxovid® are currently only available at a limited number of sites. Vaccines targeting newer variants of SARS-CoV-2 are now in development as booster doses (see below).

The Pfizer BioNTech and Moderna COVID-19 vaccines are nucleoside-modified messenger RNA (mRNA) vaccines. mRNA vaccines use the pathogen's genetic code as the vaccine; this then exploits the host cells to translate the code and then make the target spike protein. The protein then acts as an intracellular antigen to stimulate the immune response (Amanat *et al*, 2020). mRNA is then normally degraded within a few days. Both the Moderna mRNA-1273 and the Pfizer BioNTech COVID-19 BNT162b2 vaccines have been generated entirely in vitro and are formulated in lipid nanoparticles which are taken up by the host cells (Vogel *et al*, 2020, Jackson *et al*, 2020). The Pfizer vaccine was tested in healthy adults between the ages of 18-55 and 65-85 years in phase 1 studies and the BNT162b2 vaccine product at a 30 microgram dose was chosen by Pfizer as the lead candidate in phase 2/3 trials (Walsh *et al*, 2020). The Moderna mRNA-1273 vaccine was tested at three dose levels in those aged 18-55 years and the 100 microgram dose chosen for phase 3 study (Jackson *et al*, 2020).

AstraZeneca COVID-19 vaccine uses a replication deficient chimpanzee adenovirus (ChAd) as a vector to deliver the full-length SARS-CoV2 spike protein genetic sequence into the host cell (Van Doremalen *et al*, 2020). The adenovirus vector is grown in a human cell-line (HEK293) (see chapter 1). ChAd is a non-enveloped virus; the glycoprotein antigen is not present in the vector, but is only expressed once the genetic code within the vector enters the target cells. The vector genes are also modified to render the virus replication incompetent, and to enhance immunogenicity (Garafalo *et al*, 2020). Once the vector is in the nucleus, mRNA encoding the spike protein is produced that then enters the cytoplasm. This then leads to translation of the target protein which acts as an intracellular antigen.

Vaccine effectiveness

Pfizer BioNTech COVID-19 BNT162b2 vaccine (Comirnaty®)

Two doses of Pfizer BioNTech COVID-19 mRNA vaccine BNT162b2 successfully reduced the levels of detectable viral RNA in Rhesus macaques when followed by intra-nasal and intra-tracheal challenge with SARS-CoV-2 (Vogel *et al*, 2020). In phase 1/2 human trials, after prime and boost vaccination, neutralising antibodies were comparable or higher than in convalescent patients. Neutralising antibody responses were generally higher in the 18 to 55 year age group compared to the 65 to 85 year age group, but responses were comparable to levels in convalescent patients in both age groups.

A phase 3 study was conducted in around 44,000 individuals aged 12 years and above with a second dose delivered between 19 and 42 days. Initial analysis conducted as part of a phase 3 study demonstrated a two-dose vaccine efficacy of 95% (with credibility intervals from 90.3% to 97.6%) in those aged 16 years and above. Efficacy was consistent across age, gender, and ethnicity, and in the presence of co-morbidities (including asthma, obesity, diabetes, hypertension and lung disease). In naïve participants aged between 65 and 75 years, and in those aged 75 years and over, the efficacy was 94.7% (95% CI 66.7-99.9%) and 100% (95% CI -13.1-100%) respectively. Efficacy remained high when the analysis included those with evidence of prior immunity. Published efficacy between dose 1 and 2 of the Pfizer BioNTech vaccine was 52.4% (95% CI 29.5-68.4%). Based on the timing of cases accrued in the phase 3 study, most vaccine failures in the period between doses occurred shortly after vaccination, suggesting that short term protection from dose 1 is very high from day 10 after vaccination (Polack *et al*, 2020). Using data for those cases observed between day 15 and 21, efficacy against symptomatic COVID-19 after the first dose was estimated at 89% (95% CI 52-97%). (<https://www.fda.gov/media/144246/download>)

The Pfizer BioNTech COVID-19 vaccine BNT162b2 received approval to supply in the UK from the Medicine and Healthcare products Regulatory Agency (MHRA) on 2 December 2020.

Following a study in over 2000 children aged 12-15 years, which generated additional safety and efficacy data, the approval of a 30 microgram dose was extended to those in this age group in June 2021.

In September 2021, the MHRA approved the use of a 30 microgram dose of Pfizer BioNTech vaccine as a third or reinforcing dose, at least eight weeks after completion of a primary course of either an mRNA or adenovirus vectored vaccine.

Trials have now been concluded in children aged 5-11 years, using a 10 microgram dose of the vaccine formulated for children. These trials have shown equivalent antibody response and slightly lower reactogenicity than the full adult/adolescent dose (30 micrograms) in those aged 16-25 years. In December 2021, MHRA approved the paediatric formulation of the 10 microgram dose for primary vaccination of children aged 5-11 years.

AstraZeneca COVID-19 vaccine (Vaxzevria®)

AstraZeneca COVID-19 vaccine elicited increased neutralisation antibodies in Rhesus macaques as well as a reduction in detectable virus in the lower respiratory tract following challenge with SARS-CoV-2 (Van Doremalen *et al*, 2020). In phase 1/2 human trials AstraZeneca COVID-19 vaccine was compared with a meningococcal conjugate vaccine

(MenACWY) control in healthy adults aged between 18-55 years (Folegatti *et al*, 2020). Preliminary findings showed that neutralising antibodies were induced at day 14 and 28 after the first vaccination and titres increased after a second dose. Specific T cell responses were also induced after a single immunisation and were maintained after the second dose. Final data showed that IgG spike antibody responses and neutralising antibody 28 days after the second dose were similar across the three age cohorts (18–55 years, 56–69 years, and ≥ 70 years). More than 99% (208/209) of the participants had neutralising antibody responses two weeks after the second dose. Peak T-cell responses were seen 14 days after the first dose and were broadly equivalent in the three age groups (Ramasamy *et al*, 2020). In analysis of over 11,000 patients in the phase 3 study, overall vaccine efficacy against symptomatic disease was 70.4% (95% CI: 54.8–80.6%) (Voysey *et al*, 2020). There were ten cases hospitalised for COVID-19, of which two were severe, all in the control group, suggesting very high protection against severe disease. High protection against hospitalisation was seen from 21 days after dose 1 until two weeks after the second dose, suggesting that a single dose will provide high short term protection against severe disease (Voysey *et al*, 2020). An exploratory analysis of participants who had received one standard dose of the vaccine suggested that efficacy against symptomatic COVID-19 was 73.00% (95% CI: 48.79-85.76%).

The AstraZeneca COVID-19 vaccine received approval to supply in the UK from the MHRA on 30 December 2020.

In September 2021, the MHRA approved the use of AstraZeneca vaccine as a third or reinforcing dose, at least eight weeks after completion of a primary course of AstraZeneca vaccine.

Moderna COVID-19 vaccine (Spikevax®)

In phase 1 testing of the Moderna mRNA-1273 vaccine, all patients seroconverted to IgG by Enzyme-Linked Immunosorbent Assay (ELISA) after the first dose of vaccine. Pseudo-neutralisation and wild virus neutralisation responses were detected in all participants after two 100 microgram doses of the Moderna mRNA-1273. Phase 3 placebo controlled testing in over 30,000 volunteers, showed a vaccine efficacy of 94.1% (95% CI: 89.3-96.8%). Efficacy was similar in those over 65 years. Vaccine efficacy against severe COVID-19 was 100% (95% CI: 87.0-100%) (Baden *et al*, 2020).

The cumulative case numbers in the phase 3 study showed a clear divergence between the vaccine and placebo groups from about 14 days after the first dose. Re-analysis of the phase 3 data from 15 days after the first dose to the time of the second dose, suggested that efficacy of a single dose was 92.1% (95% CI 68.8%-99.1%).

The Moderna vaccine (Spikevax®) was approved for use in the UK in January 2021. Following a study in over 3000 children aged 12-17 years, which generated additional safety and efficacy data, the approval was extended to those in this age group in August 2021.

Novavax COVID-19 vaccine (Nuvaxovid®)

In the phase 2 study, a dose of 5 micrograms of the recombinant S protein combined with 50 micrograms of Matrix-M™ adjuvant were chosen (Mallory *et al*, 2021). Large vaccine efficacy studies in the UK (Heath *et al*, 2021) and the USA (Dunkle *et al*, 2021) showed an efficacy of 90% against symptomatic infection with 100% against severe disease.

The vaccine was approved in the UK in February 2022.

Real world effectiveness

Vaccine effectiveness data from the UK has now been generated with successive SARS-CoV-2 variants. A single adult dose of either the Pfizer BioNTech or the AstraZeneca vaccines were shown to provide modest protection against symptomatic disease due to Alpha variant; with single vaccinated cases around 40% less likely to require hospital admission or to die (Lopez Bernal *et al*, 2021a). This was consistent with protection of around 80% against hospitalisation as seen in local studies (Vasileiou *et al*, 2021, AvonCAP, 2021). Protection against infection was also seen in healthcare workers, where a single dose of Pfizer BioNTech vaccine provided more than 70% protection against both symptomatic and asymptomatic infection (Hall *et al*, 2021a), and in care home residents where a single dose of either Pfizer BioNTech or AstraZeneca vaccines reduced the risk of infection by around 60% (Shrotri *et al*, 2021). The observed reduction in both symptomatic and asymptomatic infections suggested that vaccination has potential to reduce transmission; this was supported by a Scottish study that showed a 30% reduction in risk of infection in the household members of vaccinated compared to unvaccinated healthcare workers after a single dose of the Pfizer BioNTech vaccine. (Shah *et al*, 2021).

Higher levels of protection against symptomatic disease due to Alpha variant were observed after the second dose for both Pfizer BioNTech (Lopez Bernal *et al*, 2021b) and AstraZeneca vaccines.

Following the introduction of the Delta variant to the UK in April 2021, further updates to the analysis of real world effectiveness have been undertaken (Lopez Bernal *et al*, 2021b). Protection against symptomatic infection with the Delta variant was slightly lower than against Alpha, particularly after a single dose. Protection against hospitalisation, however, was maintained with two doses of the AstraZeneca and Pfizer BioNTech vaccines providing over 90% short term protection against this outcome. (Stowe *et al*, 2021).

Since the emergence of the Omicron variant, vaccine effectiveness data confirms that protection against symptomatic disease from current vaccines is lower than for Delta. (Andrews *et al*, 2021b). Vaccination does provide higher levels of protection against hospitalisation due to Omicron. A summary of the most recent data on real world effectiveness for each variant is now published and updated regularly. <https://www.gov.uk/government/publications/covid-19-vaccine-surveillance-report>.

Duration of protection

Israel was the first country to demonstrate waning protection from Pfizer BioNTech vaccine showing a decline in protection, even against severe disease, at around 6 months (Goldberg *et al*, 2021). In the USA, protection against hospitalisation for Pfizer BioNTech and Moderna vaccines remained high (around 84%) between 3 and 6 months (Tenforde *et al*, 2021).

Updated UK analysis to late August 2021 suggests that protection against symptomatic infection due to the Delta variant appears to decline after the second dose, although remains above 50% overall after 5 months. (Andrews *et al*, 2021a) Levels of protection from AstraZeneca are lower than that seen after Pfizer BioNTech and remain around 20% lower after 5 months. In contrast, protection against hospitalisation and death from Delta variant appears to be well sustained, remaining around 85% at six months after primary vaccination with both AstraZeneca and Pfizer BioNTech vaccines. The decline in protection appears to be mainly driven by older people (over 65 years) and those with clinical risk factors (including immunosuppression). For Omicron, protection from primary vaccination appears to decline to very low levels by six months after all three vaccines used in the UK.

Safety

Pfizer BioNTech COVID-19 BNT162b2 vaccine (Comirnaty®)

Local reactions at the injection site are fairly common after Pfizer BioNTech COVID-19 vaccine, primarily pain at the injection site, usually without redness and swelling. Systemic events reported were generally mild and short lived (Walsh *et al*, 2020). In the final safety analysis of over 21,000 participants 16 years and older, the most common events were injection site pain (>80%), fatigue (>60%), and headache (>50%). Myalgia, arthralgia and chills were also common with fever in 10-20%, mainly after the second dose. Most were classified as mild or moderate. Lymphadenopathy in the axillary, supraclavicular or cervical nodes on the same side as the injection was reported in less than 1% (Polack *et al*, 2020). Four cases of Bell's palsy were reported in vaccine recipients in the trial. Although within the expected background rate, this will be monitored closely post-implementation.

Side effects were less common in those aged over 55 than those aged 16 to 55 years. Severe systemic effects, defined as those that interfere with daily activity, included fatigue in 4% and headache in 2%. There was no signal to suggest that prior vaccination led to enhanced disease with only 1 case of severe COVID-19 in the 8 vaccine failures (Polack *et al*, 2020).

Recently a number of cases of myocarditis and pericarditis have been reported after Pfizer BioNTech vaccine. The reported rate appears to be highest in those under 25 years of age and in males, and after the second dose. Onset is within a few days of vaccination and most cases are mild and have recovered without any sequelae. The MHRA has advised the benefits of vaccination still outweigh any risk in most individuals.

A very small number of cases of Guillain-Barre Syndrome (GBS) have been reported after Pfizer-BioNTech vaccination but these reports have not reached the number expected to occur by chance in the immunised population.

Safety data reported from other countries after routine use of the paediatric dose of Pfizer BioNTech vaccine confirms the finding of lower rates of all reactions when compared to a full dose in older children and young people.

Moderna COVID-19 vaccine (Spikevax®)

A high proportion (more than 75%) of vaccine recipients had localised pain at the injection site after both dose 1 and dose 2 of the Moderna mRNA-1273 vaccine. Redness and swelling were also seen after the second dose and local pain tended to last longer (around 3 days). Mild systemic effects were also common, including headache, fatigue, joint and muscle aches and chills. Systemic events were more severe after dose 2 and fever was only seen after dose 2, and both local and systemic reactions were less common in older participants (Baden *et al*, 2020). Adverse events were less common in those with pre-existing SARS-CoV-2 antibody. Axillary lymphadenopathy on the same side as the injection site was detected in more than one in ten recipients.

Bell's palsy was reported by three participants in the vaccine group and one participant in the placebo group. As for the Pfizer BioNTech vaccine, this will be monitored closely post-implementation. There were no cases of severe COVID-19 disease in the vaccine group, and thus no signal for enhanced disease (Baden *et al*, 2020).

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AstraZeneca COVID-19 vaccine (Vaxzevria®)

From early phase trials, mild pain and tenderness at the injection site was common with AstraZeneca COVID-19 vaccine occurring in 88% of 18-55 year olds, 73% of 56-69 year olds and 61% of people aged 70 years or over; similar levels were reported after each dose. Short lived systemic symptoms including fatigue and headache were also common but decreased with age, being reported in 86%, 77%, and 65% of those aged 18-55, 56-69 and 70 years or over respectively; most of these were classified as mild or moderate. These reactions were unusual after the second dose (Ramasamy *et al*, 2020). Mild fever (>38°C) was recorded in the first 48 hours for around a quarter of younger participants but was not reported in those over 55 years of age or in any age group after the second dose (Ramasamy *et al*, 2020). Fever can be modified by the prophylactic use of paracetamol, which does not affect the immune response to this vaccine (Folegatti *et al*, 2020). In the phase 3 study, injection site reactions, mild fever, headache, myalgia and arthralgia occurred in more than 10% of vaccinees. Less than 1% reported lymphadenopathy or an itchy rash. Only one serious adverse event was reported as possibly linked to the vaccine; this was a case of transverse myelitis which occurred 14 days after dose 2. There was no signal to suggest that prior vaccination led to enhanced disease (Voysey *et al*, 2020).

A very rare condition involving serious thromboembolic events accompanied by thrombocytopenia, has been reported after AstraZeneca vaccination. The condition presents with unusual venous thrombosis, including cerebral venous sinus thrombosis, portal vein thrombosis, and sometimes arterial thrombosis, with low platelet count and high D-dimer measurements. The condition has similarities to heparin-induced thrombocytopenia and thrombosis (HITT or HIT type 2) and patients usually have positive antibody to platelet factor 4. The majority of the events occurred between 5 and 16 days following vaccination (Greinacher *et al*, 2021).

The current reported rate of this event in the UK is around 15 cases per million after the first dose, although a higher incidence is seen in younger individuals. After the second dose the reported rate is much lower, particularly in younger individuals. Overall, the Joint Committee on Vaccination and Immunisation (JCVI), MHRA and the WHO remain clear that the benefits of vaccination outweigh this small risk for adults aged 40 years and over, adults who are clinically extremely vulnerable and those with underlying clinical risks as defined in table 3.

GBS has been reported very rarely within six weeks of AstraZeneca vaccination, and rates appear to be higher than the background rates. This risk would equate to about 5.6 extra cases of GBS per million doses in the six weeks following the first dose of AstraZeneca vaccine, based on a unpublished UK study. There was no evidence of a higher rate of reporting in individuals who had had a previous episode of GBS.

A small number of cases of capillary leak syndrome have been reported across Europe within 4 days of AstraZeneca vaccination. Around half of those affected had a history of capillary leak syndrome.

Cases of thrombocytopenia (without accompanying thrombosis) have been reported rarely in the first four weeks after receiving AstraZeneca vaccination. Some of these cases have occurred in individuals with a history of immune thrombocytopenia (ITP)

Novavax COVID-19 vaccine (Nuvaxovid®)

Side effects after the vaccine are similar to other COVID-19 vaccines, with slightly lower rates of local reactions and systemic effects when compared to mRNA vaccines. Around 50% of dose 1 and 70% of dose 2 recipients reporting pain and /or tenderness at the injection site and around 40-50% report systemic symptoms including fatigue, malaise, headache and muscle pain, with rates of fever below 10%. Overall, there was a higher incidence of adverse reactions in younger age group (18-64 years).

Small numbers of cases of myocarditis or pericarditis were reported across the trials and in post-marketing follow up. Myocarditis and pericarditis have now been added to the list of side effects after the vaccine.

Reinforcing immunisation

Studies of boosting in the UK have shown that a third adult dose of AstraZeneca, Novavax, Moderna and Pfizer BioNTech vaccines successfully boosted individuals who had been primed with two doses of Pfizer BioNTech or AstraZeneca vaccine around 3 months earlier (Munro *et al*, 2021). Levels of IgG and neutralising antibody, including against Delta variant, were generally higher where an mRNA vaccine was used as either a heterologous or homologous boost, or where AstraZeneca was used as a heterologous boost after a primary course of Pfizer BioNTech. Although levels of antibody were lowest after an AstraZeneca boost in those primed with the same vaccine, levels are as good or better than those seen after the second dose; these antibody levels correlate with high levels of protection against severe disease and death. This finding was confirmed in a study where a third dose of AstraZeneca was given at a later time point (Flaxman *et al*, 2021).

All boosters led to short term local and systemic reactions, similar to those seen after the primary course, including local pain, fatigue, headache and muscle pain. Rates of reactions were higher with heterologous than homologous boosters and in those aged under 70 years when compared to older recipients. Rates of local and systemic symptoms were higher where a full dose of Moderna was used to boost those who had received either AstraZeneca or Pfizer BioNTech for the primary course and when AstraZeneca was used to boost those who had Pfizer BioNTech as a primary course, when compared to Novavax or Pfizer BioNTech after either primary vaccination.

A separate study using a half dose of Moderna (50 micrograms) in those who had received a primary course of Moderna (100 micrograms) showed good immunogenicity and a rate of reactions similar to the second dose of Moderna. (Choi *et al*, 2021). The half dose of Moderna is expected to have a lower rate of side effects (including myocarditis) than a full dose.

In Israel, administration of a booster dose of Pfizer BioNTech to adults who had received a primary course of the same vaccine, has been associated with a major reduction in the risk of both confirmed and severe disease due to COVID-19. (Bar-On *et al*, 2021).

In the UK, early data showed a major increase in levels of protection after the first booster dose against both symptomatic disease and hospitalisation due to the Delta variant (Andrews *et al*, 2021c). Vaccine effectiveness data for Omicron confirms that protection against symptomatic disease soon after an mRNA booster dose increases to around 70-75% regardless of the primary vaccine series. Levels of protection after an AstraZeneca booster in those who received the same vaccine as a primary course are only slightly lower than those seen after the mRNA boosters. (Andrews *et al*, 2021b). More recent analysis confirms that protection after an mRNA booster has declined substantially by three months after the dose was given. For the small number of individuals who received AstraZeneca as a booster, levels of protection against symptomatic Omicron infection appear to be similar or slightly lower than those after an mRNA booster.

Protection against hospitalisation after an mRNA booster reaches over 90% in the two weeks after vaccination but also declines over time. Data real world effectiveness for more severe outcomes is published and updated regularly. <https://www.gov.uk/government/publications/covid-19-vaccine-surveillance-report>.

Following implementation of booster doses, the nature of adverse events reported has been similar to that reported after the first two doses of the COVID-19 vaccines. Reports of suspected adverse events following COVID-19 boosters given at the same time as seasonal flu vaccines are also similar to that when the vaccines are given individually. There have been a small number of reports of suspected myocarditis and pericarditis following booster doses with Pfizer/BioNTech Moderna COVID-19 vaccines; reports after booster doses remain very rare.

Variant vaccines

Although current vaccines offer lower levels of protection against mild disease caused by variants with mutations on the spike protein, protection against more severe COVID-19 appears to be relatively less affected. Higher levels of antibody against the original spike protein do appear to provide higher levels of protection against symptomatic infection due to distant variants. There is no evidence, as yet, that vaccines based on the whole virion offer better or broader protection.

Following the recognition of the Omicron variant becoming the dominant global circulating strain during 2022, many vaccine manufacturers have rapidly developed second generation vaccines that may have broader coverage against SARS-CoV-2 variants. Those approved or approaching licensure have been developed as boosters and have either replaced the spike protein from the original vaccine strain with an Omicron BA.1 strain, or developed a bivalent formulation containing the spike protein sequences from both the ancestral strain and an Omicron variant. Those which use a well established format, such as mRNA vaccines, are being licensed on the basis of immunobridging - i.e. by showing non-inferiority of the neutralising antibody response to the ancestral strain, with potentially higher neutralising antibody response to the variant strain. Other manufacturers have investigated the impact of proteins from alternative variants and/or the role of adjuvants in providing broader protection against a range of strains. Bivalent original and Omicron BA.1 mRNA vaccines are becoming available in the autumn of 2022.

So far, the emergence of new variants has been too rapid to enable incorporation of a new strain in time to respond to any increase in disease. Rates of infection in the summer of 2022 were largely driven by infection with Omicron BA.4 and BA.5 and so the degree of cross protection from the BA.1 containing vaccines is being rapidly investigated.

Moderna bivalent (Spikevax® bivalent Original/Omicron vaccine) was approved by MHRA for use as a booster in August 2022. This vaccine contains 25 micrograms of mRNA directed against the ancestral strain and 25 micrograms of mRNA against Omicron BA.1. A similar formulation manufactured by Pfizer BioNTech (Original/Omicron BA.1 Comirnaty®) containing 15 micrograms of mRNA directed against the ancestral strain and 15 micrograms of mRNA against Omicron BA.1 was approved by the MHRA in September 2022. Other booster formulations directed to sub-variants of Omicron (such as BA.4 and BA.5) or to other variants (such as Beta) may be submitted for approval during the autumn.

Around one month after a booster of the Moderna bivalent vaccine, neutralising antibody against the Omicron (BA.1) strain was around 1.6 times the level in those who received a 50 microgram dose of the original Moderna vaccine. Neutralising antibody levels against the ancestral strain were also slightly higher with the bivalent vaccine compared to the original vaccine (geometric mean ratios 1.22 in naive participants), as were the levels of binding antibodies against the alpha, beta, delta and gamma variants (geometric mean ratios between 1.10 and 1.17). The bivalent vaccine did effectively boost neutralising antibody to BA.4/BA.5, but geometric mean levels were lower than against Omicron BA.1 (<https://www.fda.gov/media/159492/download>). Reactogenicity was similar between the original and bivalent vaccine.

For Pfizer BioNTech, a booster of the bivalent vaccine produced neutralising antibody response against the Omicron (BA.1) strain around 1.56 times the level in those who received a 30 microgram dose of the original Pfizer BioNTech vaccine. Neutralising antibody levels against the ancestral strain were similar to those after the original vaccine. Neutralising antibody against BA.4/BA.5 was detected after the bivalent vaccine although geometric mean levels were around 3 fold lower than against Omicron BA.1. (<https://www.fda.gov/media/159496/download>). Reactogenicity was similar between the original and bivalent vaccine.

Storage

The adult/adolescent formulation of Pfizer BioNTech COVID-19 vaccine (Comirnaty®) is supplied frozen in packs of 195 vials. The shelf life is 9 months when stored at -80°C to -60°C. Frozen vials should be transferred to thaw at 2°C to 8°C; a 195 vial pack may take 3 hours to thaw. Alternatively, frozen vials may also be thawed for 30 minutes at temperatures up to 25°C for immediate use. After thawing, undiluted vaccine can be stored for up to 31 days at 2°C to 8°C.

The paediatric formulation Pfizer BioNTech COVID-19 vaccine (Comirnaty®) is supplied frozen in 10-vial packs. The shelf life is 12 months when stored at -90°C to -60°C. The vaccine can be thawed at 2°C to 8°C for 4 hours or individual vials can be thawed at room temperature (up to 30°C) for 30 minutes. Unopened vials can be stored for up to 10 weeks at 2°C to 8°C. Prior to use, the unopened vial can be stored for up to 12 hours at temperatures up to 30°C.

The bivalent Pfizer BioNTech booster formulation is supplied frozen in 10 vial packs and should be stored - 90°C to -60°C. Packs can be thawed at 2 °C to 8 °C for 6 hours or individual vials can be thawed at room temperature for 30 minutes. Once thawed, the vaccine should not be re-frozen, but can be stored and transported at 2 °C to 8 °C for 10 weeks (within the overall shelf life).

The AstraZeneca vaccine should be stored at 2°C to 8°C and has a shelf life of 6 months. The vaccine does not contain any preservative. After first opening the vial, it should be used within 6 hours. The vaccine may be stored between 2°C and 25°C during this period. After this time, the vial must be discarded.

Moderna COVID-19 vaccine vials should be stored frozen (between -25° to -15°C for the original vaccine and -50° to -15° C for the bivalent vaccine) and have a shelf life of 9 months at these temperatures. Once thawed, the vaccine may be stored refrigerated at 2°C to 8°C protected from light for up to 30 days if not punctured. The unopened vials are stable for 24 hours at 8° to 25°C.

Novavax COVID-19 vaccine can be stored for 9 months at 2°C to 8°C, if protected from light. The vaccine is stable up to 12 hours at 25°C.

Presentation

A pack of the adult/adolescent Pfizer BioNTech COVID-19 vaccine (Comirnaty®) contains 195 vials with a purple cap; each vial contains a minimum of 6 doses per vial (1170 doses per pack). A pack of the Pfizer BioNTech COVID-19 vaccine (Comirnaty®) paediatric contains 10 vials with an orange cap, each containing sufficient for 10 doses. Both are supplied with 0.9% sodium chloride diluent for injection in plastic ampoules. After dilution, the adult/adolescent vaccine should be kept at 2°C to 25°C and used within 6 hours; the paediatric vaccine should be kept at 2°C to 30°C and used within 12 hours. Any unused vaccine should be discarded.

The Pfizer BioNTech bivalent booster (Comirnaty Original/Omicron BA.1®) comes in packs of 10 vials with a grey cap. The vaccine does not require dilution and each vial contains 6 doses. After the first puncture the vaccine can be stored at 2°C to 30°C and used within 12 hours.

The AstraZeneca vaccine is supplied in packs of 10 vials. Each vial contains 8 or 10 doses of vaccine, and is a colourless to slightly brown, clear to slightly opaque liquid.

Moderna COVID-19 vaccine is supplied in multidose vials containing 10 primary doses of 0.5ml or 20 booster doses of 0.25ml. The bivalent Moderna Original/Omicron booster is supplied in multidose vials containing either 5 or 10 doses of 0.5ml.

Novavax COVID-10 vaccine is supplied in a multidose vial which contains 10 doses of 0.5 ml. Each vial contains a colourless to slightly yellow, clear to mildly opalescent fluid. The multidose vial should be gently swirled and inspected for particles, and used within 6 hours of first puncture.

Dosing and schedule

All COVID-19 vaccines

For both adenovirus vector and mRNA vaccines, there is evidence of better immune response and/or protection where longer intervals between doses in the primary schedule are used. (Amirthalingam *et al*, 2021, Payne *et al*, 2021, Voysey *et al*, 2021).

Based on this evidence, longer intervals are likely to provide more durable protection. JCVI is currently recommending a minimum interval of eight weeks between doses of all the available COVID-19 vaccines where a two-dose primary schedule is used for adults and for children at high risk (see section on children). Operationally, using the same minimum interval for all products will simplify supply and booking, and will help to ensure a good balance between achieving rapid and long-lasting protection.

For those under 18 who are not in a high risk group a 12 week interval is preferred. This is based on precautionary advice from the JCVI based on emerging evidence of a lower rate of myocarditis in countries that use schedules of 8 to 12 weeks. The intervals may be shortened to eight weeks when rapid protection is required, for example high incidence or circulation of a new variant in a vulnerable population.

The main exception to the eight week lower interval would be those about to commence immunosuppressive treatment. In these individuals, the minimal intervals outlined below may be followed to enable the vaccine to be given whilst their immune system is better able to respond.

In August 2021, JCVI recommended a third primary dose of vaccination for individuals who were severely immunosuppressed when they received their first or second dose of COVID-19 vaccination (see below).

Pfizer BioNTech COVID-19 vaccine (Comirnaty®)

For those aged 12 years and above, the dose of Pfizer BioNTech COVID-19 vaccine is 30 micrograms contained in 0.3ml of the diluted vaccine. After dilution each multidose vial can be used to deliver six doses of 0.3ml. JCVI have advised that those aged 12 years may also commence or complete with a paediatric dose (off-label) to align with peers in the same academic year (see the section on age specific recommendations on vaccine type).

For children aged 5-11 years, the dose of Pfizer BioNTech COVID-19 vaccine is 10 micrograms. The paediatric formulation Comirnaty® 10 micrograms is supplied in a multidose vial, with each vial containing 10 doses of 0.2 mL (after dilution with 1.3ml of saline). The paediatric formulation should be used, although 10 micrograms (0.1ml) of the diluted adult/adolescent vaccine may be an alternative when protection is required rapidly and the paediatric formulation is not available. The use of a fractional adult/adolescent vaccine would be off-label and can be considered on a case by case basis.

The primary course should be administered in two doses, a minimum of 21 days apart.

A booster dose of Pfizer BioNTech COVID-19 vaccine is 30 micrograms contained in 0.3 ml of the diluted vaccine.

Pfizer BioNTech bivalent vaccine (Comirnaty® Original/Omicron BA.1)

A booster dose of the bivalent Pfizer BioNTech vaccine contains 15 plus 15 micrograms in 0.3ml of the undiluted (ready to use) vaccine.

AstraZeneca COVID-19 vaccine (Vaxzevria®)

The dose of AstraZeneca COVID-19 vaccine is 0.5ml.

The primary course should be administered in two doses, a minimum of 4 weeks apart.

Moderna COVID-19 vaccine (Spikevax®)

For primary vaccination, including third doses for those with severe immunosuppression, the dose of Moderna COVID-19 vaccine is 100 micrograms in 0.5ml. The dose for reinforcing vaccination (booster doses) of the original Moderna COVID-19 vaccine is 50 micrograms in 0.25ml.

The primary course should be administered in two doses, a minimum of 28 days apart.

Moderna bivalent COVID-19 vaccine (Spikevax® bivalent Original/Omicron)

A booster dose of the bivalent vaccine contains 25 plus 25 micrograms in 0.5ml.

Novavax COVID-19 vaccine (Nuvaxovid®)

The dose of Novavax COVID-19 vaccine is 0.5 mL each. The primary course is two doses, a minimum of 3 weeks apart.

Administration

Vaccines are routinely given intramuscularly into the upper arm or anterolateral thigh. This is to reduce the risk of localised reactions, which are more common when vaccines are given subcutaneously (Mark *et al*, 1999; Zuckerman, 2000; Diggle and Deeks, 2000).

Pfizer BioNTech COVID-19 vaccine (Comirnaty®) and the equivalent bivalent booster vaccine, should be administered to those aged 5 years and above as an intramuscular injection into the deltoid muscle. A 1ml syringe with a 23g x 25mm needle will be provided for administration. A separate needle and syringe should be used for each individual. The vial should be discarded if the solution is discoloured or visible particles are observed.

AstraZeneca COVID-19 vaccine (Vaxzevria®) is administered as a single dose of 0.5ml intramuscular injection into the deltoid muscle. A 1ml syringe with a 23g/25g x 25mm needle will be provided for administration. The vaccine should be inspected visually for particulate matter and discolouration prior to administration. The vial should be discarded if the solution is discoloured or visible particles are observed. The vial should not be shaken. A separate needle and syringe should be used for each individual. It is normal for liquid to remain in the vial after withdrawing the final dose.

Moderna COVID-19 vaccine (Spikevax®) and the equivalent bivalent booster vaccine should be administered as an intramuscular injection into the deltoid muscle. A 1ml syringe with a 23g x 25mm needle will be provided for administration. A separate needle and syringe should be used for each individual. It is normal for liquid to remain in the vial after withdrawing the final dose.

Novavax COVID-19 vaccine should be administered by intramuscular injection, preferably in the deltoid muscle of the upper arm. A separate needle and syringe should be used for each individual. A 1ml syringe with a 23g/25g x 25mm needle will be provided for administration.

Individuals with bleeding disorders may be vaccinated intramuscularly if, in the opinion of a doctor familiar with the individual's bleeding risk, vaccines or similar small volume intramuscular injections can be administered with reasonable safety by this route. If the individual receives medication/treatment to reduce bleeding, for example treatment for haemophilia, intramuscular vaccination can be scheduled shortly after such medication/treatment is administered. Individuals on stable anticoagulation therapy, including individuals on warfarin who are up-to-date with their scheduled INR testing and whose latest INR is below the upper level of the therapeutic range, can receive intramuscular vaccination. A fine needle (23 or 25 gauge) should be used for the vaccination, followed by firm pressure applied to the site without rubbing for at least 2 minutes (Advisory Committee on Immunization Practices 2019). The individual/parent/carer should be informed about the risk of haematoma from the injection.

Disposal

Equipment used for vaccination, including used vials, ampoules or syringes, should be disposed of by placing them in a proper, puncture-resistant 'sharps box' according to local authority regulations and guidance in Health Technical Memorandum 07-01: Safe management of healthcare waste (Department of Health, 2013).

AstraZeneca COVID-19 vaccine (Vaxzevria®) contains genetically modified organisms (GMOs). Sharps waste and empty vials should be placed into yellow lidded waste bins and sent for incineration; there is no need for specific designation as GMO waste. An appropriate virucidal disinfectant should be available for managing spills in all settings where vaccination is administered. Potentially contaminated gloves and aprons can be disposed in yellow/black striped bags for offensive waste.

The COVID-19 immunisation programme

The main objective of the COVID-19 immunisation programme is to protect those who are at highest risk from serious illness or death. The JCVI ranked the eligible groups according to risk. For the first phase this was based on the risk of COVID-19 specific mortality, with the second phase concerned with prevention of hospitalisation.

Phase 1 recommendations for primary vaccination

Evidence from the UK indicates that the risk of poorer outcomes from COVID-19 infection increases dramatically with age in both healthy adults and in adults with underlying health conditions. Those over the age of 65 years have by far the highest risk, and the risk increases with age. Residents in care homes for older adults have been disproportionately affected by the COVID-19 pandemic. Table 2 sets out JCVI advice on priority groups for primary COVID-19 vaccination. Table 3 sets out JCVI advice on clinical and other risk groups for COVID-19 vaccination.

Table 2 – Phase 1 priority groups for primary vaccination advised by the Joint Committee on Vaccination and Immunisation

Priority group	Risk group
1	Residents in a care home for older adults Staff working in care homes for older adults
2	All those 80 years of age and over Frontline health and social care workers
3	All those 75 years of age and over
4	All those 70 years of age and over Individuals aged 16 to 69 in a high risk group ¹
5	All those 65 years of age and over
6	Adults aged 16 to 65 years in an at-risk group (Table 3)
7	All those 60 years of age and over
8	All those 55 years of age and over
9	All those 50 years of age and over

¹ Previously known as clinically extremely vulnerable

People at high risk (priority groups 4 and 6)

People previously defined as clinically extremely vulnerable (CEV) were considered to be at high risk of severe illness from COVID-19 (<https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19#cev>); and these patients were flagged on the GP system. A hospital clinician or GP was able to add a patient to the list, based on their clinical judgement, because they considered them to be at very high risk of serious illness from COVID-19.

All patients who were on the CEV list also fell into the broader disease categories outlined in table 3, but were vaccinated with priority group 4 because of more recent treatment, more advanced condition or co-morbidities. Since the shielding programme has ended groups 4 and 6 have been formally merged.

In December 2021, following the recognition of pregnancy as a risk factor for severe COVID-19 infection and poor pregnancy outcomes during the Delta wave, pregnancy was added to the the clinical risk groups (table 3 and table 4)

Table 3: Clinical and other risk groups for individuals aged 16 years and over eligible for COVID-19 immunisation.

Clinical risk groups	
Chronic respiratory disease	Individuals with a severe lung condition, including those with poorly controlled asthma ¹ and chronic obstructive pulmonary disease (COPD) including chronic bronchitis and emphysema; bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD).
Chronic heart disease and vascular disease	Congenital heart disease, hypertension with cardiac complications, chronic heart failure, individuals requiring regular medication and/or follow-up for ischaemic heart disease. This includes individuals with atrial fibrillation, peripheral vascular disease or a history of venous thromboembolism.
Chronic kidney disease	Chronic kidney disease at stage 3, 4 or 5, chronic kidney failure, nephrotic syndrome, kidney transplantation.
Chronic liver disease	Cirrhosis, biliary atresia, chronic hepatitis.
Chronic neurological disease	Stroke, transient ischaemic attack (TIA). Conditions in which respiratory function may be compromised due to neurological or neuromuscular disease (e.g. polio syndrome sufferers). This group also includes individuals with cerebral palsy, severe or profound and multiple learning disabilities (PMLD) including all those on the learning disability register, Down's syndrome, multiple sclerosis, epilepsy, dementia, Parkinson's disease, motor neurone disease and related or similar conditions; or hereditary and degenerative disease of the nervous system or muscles; or severe neurological disability.
Diabetes mellitus and other endocrine disorders	Any diabetes, including diet-controlled diabetes, current gestational diabetes, and Addison's disease.

1 Poorly controlled asthma is defined as:

- ≥2 courses of oral corticosteroids in the preceding 24 months OR
- on maintenance oral corticosteroids OR
- ≥1 hospital admission for asthma in the preceding 24 months

<https://www.brit-thoracic.org.uk/covid-19/covid-19-information-for-the-respiratory-community/#jcvi-advice-on-covid-19-booster-vaccination-for-adults-in-clinical-at-risk-groups-and-adults-with-asthma>

Immunosuppression	<p>Immunosuppression due to disease or treatment, including patients undergoing chemotherapy leading to immunosuppression, patients undergoing radical radiotherapy, solid organ transplant recipients, bone marrow or stem cell transplant recipients, HIV infection at all stages, multiple myeloma or genetic disorders affecting the immune system (e.g. IRAK-4, NEMO, complement disorder, SCID).</p> <p>Individuals who are receiving immunosuppressive or immunomodulating biological therapy including, but not limited to, anti-TNF, alemtuzumab, ofatumumab, rituximab, patients receiving protein kinase inhibitors or PARP inhibitors, and individuals treated with steroid sparing agents such as cyclophosphamide and mycophenolate mofetil.</p> <p>Individuals treated with or likely to be treated with systemic steroids for more than a month at a dose equivalent to prednisolone at 20mg or more per day for adults.</p> <p>Anyone with a history of haematological malignancy, including leukaemia, lymphoma, and myeloma.</p> <p>Those who require long term immunosuppressive treatment for conditions including, but not limited to, systemic lupus erythematosus, rheumatoid arthritis, inflammatory bowel disease, scleroderma and psoriasis.</p> <p>Some immunosuppressed patients may have a suboptimal immunological response to the vaccine (see Immunosuppression and HIV).</p>
Asplenia or dysfunction of the spleen	This also includes conditions that may lead to splenic dysfunction, such as homozygous sickle cell disease, thalassemia major and coeliac syndrome.
Morbid obesity	Adults with a Body Mass Index (BMI) ≥ 40 kg/m ² .
Severe mental illness	Individuals with schizophrenia or bipolar disorder, or any mental illness that causes severe functional impairment.
Younger adults in long-stay nursing and residential care settings	<p>Many younger adults in residential care settings will be eligible for vaccination because they fall into one of the clinical risk groups above (for example learning disabilities). Given the likely high risk of exposure in these settings, where a high proportion of the population would be considered eligible, vaccination of the whole resident population is recommended.</p> <p>Younger residents in care homes for the elderly will be at high risk of exposure, and although they may be at lower risk of mortality than older residents should not be excluded from vaccination programmes (see priority 1 above).</p>
Pregnancy	All stages (first, second and third trimesters)
Other risk groups	
Household contacts of people with immunosuppression	Individuals who expect to share living accommodation on most days (and therefore for whom continuing close contact is unavoidable) with individuals who are immunosuppressed (defined as immunosuppressed in tables 3 or 4).
Carers	Those who are eligible for a carer's allowance, or those who are the sole or primary carer of an elderly or disabled person who is at increased risk of COVID-19 mortality and therefore clinically vulnerable. ¹

1 Those clinically vulnerable to COVID-19 are defined by the JCVI priority groups: a) children of any age with severe neuro-disability, severe or profound and multiple learning disabilities (including Down's syndrome and those on the learning disability register) or immunosuppression (as defined in table 4), b) adults who have underlying health conditions leading to greater risk of disease or mortality as defined in table 3, c) those of advanced age.

The examples above are not exhaustive, and, within these groups, the prescriber should apply clinical judgment to take into account the risk of COVID-19 exacerbating any underlying disease that a patient may have, as well as the risk of serious illness from COVID-19 itself. A list of eligible diagnoses, and the appropriate clinical codes, can be found in the link at the end of the chapter.

Recommendations by staff groups

The objective of occupational immunisation of health and social care staff is to protect workers at high risk of exposure who may also expose vulnerable individuals whilst providing care. There is limited evidence that vaccination leads to a reduction in transmission, and even a small effect may have major additional benefit for staff who could expose multiple vulnerable patients and other staff members. Potential exposure to COVID-19, and therefore the priority for vaccination, may vary from workplace to workplace. Therefore, it is recommended that these staff groups are offered primary vaccination against COVID-19 as outlined below.

Frontline healthcare staff

This includes the following groups:

Staff involved in direct patient care

This includes staff who have frequent face-to-face clinical contact with patients and who are directly involved in patient care in either secondary or primary care/community settings. This includes doctors, dentists, midwives and nurses, paramedics and ambulance staff, pharmacists, optometrists, occupational therapists, physiotherapists and radiographers. It should also include those working in independent, voluntary and non-standard healthcare settings such as hospices, and community-based mental health or addiction services. Staff working on the COVID-19 vaccination programme, temporary staff, students, trainees and volunteers who are working with patients must also be included.

Non-clinical staff in secondary or primary care/community healthcare settings

This includes non-clinical ancillary staff who may have social contact with patients but are not directly involved in patient care. This group includes receptionists, ward clerks, porters and cleaners.

Laboratory and pathology staff

Hospital-based laboratory and mortuary staff who frequently handle SARS-CoV-2 or collect or handle potentially infected specimens, including respiratory, gastrointestinal and blood specimens should be eligible as they may also have social contact with patients. This may also include cleaners, porters, secretaries and receptionists in laboratories. Frontline funeral operatives and mortuary technicians/embalmers are both at risk of exposure and likely to spend a considerable amount of time in care homes and hospital settings where they may also expose multiple patients.

Staff working in non-hospital-based laboratories and those academic or commercial research laboratories who handle clinical specimens or potentially infected samples will be able to use effective protective equipment in their work and should be at low risk of exposure, and of exposing vulnerable patients.

Frontline social care workers

This includes front-line social care workers who provide care closely and regularly to those who are clinically vulnerable. Those clinically vulnerable to COVID-19 are defined by the

JCVI priority groups: a) children of any age with severe neuro-disability, severe or profound and multiple learning disabilities (including Down's syndrome and those on the learning disability register) or immunosuppression (as defined in table 4), b) adults who have underlying health conditions leading to greater risk of disease or mortality as defined in table 3, c) those of advanced age. This includes:

- those working in long-stay residential and nursing care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality
- social care staff directly involved in the care of clinically vulnerable patients or clients
- others involved directly in delivering social care such that they and clinically vulnerable patients/ clients are at increased risk of exposure

Young people age 16-17 years, who are employed in, studying or in training for health and social care work should be offered a full course of primary vaccination alongside their colleagues, if a suitable vaccine is available (see section on age specific recommendations). Younger people who are taking part in health and social care work as volunteers, interns or for the purposes of work experience, should make all efforts to avoid exposure to infection; they should be offered vaccination in line with other under 16s (see below).

Phase 2 advice

The objectives of the second phase of the COVID-19 immunisation programme was to protect those who are at risk from serious illness or death, and to protect the NHS by reducing the risks of hospitalisation and critical care admission. Phase 2 of the programme was accompanied by continued efforts to maximise coverage amongst those prioritised in Phase 1 but who remained unvaccinated, and to complete delivery of second doses to all those given first doses in Phase 1.

There is good evidence that the risks of hospitalisation and critical care admission from COVID-19 increase with age. JCVI therefore advised that the offer of vaccination during Phase 2 was age-based starting with the oldest adults first. As there is an increased risk of hospitalisation in males, those from certain ethnic minority backgrounds, those who are obese or morbidly obese, and those from socio-economically deprived areas, JCVI advises that specific focus should be used to promote and deliver vaccination to the following groups:

All those aged 40-49 years

All those aged 30-39 years

All those aged 18-29 years

Young people aged 16-17 years

Young people aged 16-17 years at higher risk

Young people aged 16 to 17 years who are in a recognised clinical risk group (see table 3) and those who work in health and social care should receive two doses of vaccine at an interval of at least eight weeks. This includes those aged 16 to 17 years who expect to share living accommodation on most days (and therefore for whom continuing close contact is unavoidable) with individuals of any age who are immunosuppressed (defined as immunosuppressed in tables 3 or 4).

Other young people aged 16-17 years

Initially JCVI advised that young people aged 16-17 years who are not in a risk group should receive their first dose of vaccine. A second dose of vaccine is now advised at an interval of 12 weeks. The longer interval in this age group reflects the strong evidence of high levels of protection against severe disease from the first dose, although the interval could be shortened to eight weeks when rapid protection is required, for example high incidence or circulation of a new variant in a vulnerable population. Emerging evidence also suggests that countries with longer schedules (eight to twelve weeks) may have a lower rate of myocarditis after the second dose. Although this latter evidence is limited, JCVI have taken a precautionary approach to mitigate the very rare risk of post-vaccine myocarditis. Young people should be fully informed about the benefits and risks of the second dose and able to discuss the optimal timing for them.

Children and young people aged 12-15 years

Children and young people at higher risk of severe COVID-19

Children and young people aged 12 to 15 years who are in recognised risk groups (table 4) should receive two doses of Pfizer BioNTech vaccine at an interval of at least eight weeks. Although children are at low overall risk from the complications of COVID-19 infection, the JCVI has reviewed available evidence on children who may be at higher risk. Initially, based on clinical reviews and analysis of primary care data (Williamson *et al*, 2021), JCVI advised that children with severe neuro-disabilities, immunosuppression, Down's Syndrome, profound and multiple learning disabilities (PMLD), severe learning disabilities or those who are on the learning disability register, should be offered COVID-19 vaccination. Analysis under an expert group commissioned by the Deputy Chief Medical Officer has also identified a number of distinct diagnostic groups with a high absolute risk (greater than 100/million) of paediatric intensive care admission over the 2020-21 period. These groups included children with haematological malignancy, Sickle cell disease, Type 1 diabetes, and congenital heart disease (Harwood *et al*, 2021, Smith *et al*, 2021, Ward *et al*, 2021). For most other diagnostic groups, such as renal and liver disease, the numbers of cases admitted or the size of the population were too small to generate a robust estimate of risk. The exception to this was asthma where the rate of admission was only slightly raised above the rate in healthy children, suggesting that, in line with the evidence from adults, only poorly controlled asthma constitutes a clinical risk for the complications of COVID-19 infection. In addition to these distinct diagnoses, the analysis suggested that the admission rate was high in a pooled group of children with chronic conditions. This basket of chronic conditions included any health problem requiring follow-up by health services in most affected children, as used for a Royal College of Paediatrics and Child Health review of mortality in 2013.¹ The conditions included involved diagnoses in each of the main organ systems and therefore, based on this analysis, JCVI decided that vaccine should be offered to similar groups as those prioritised for adult vaccination with the exception of obesity and mental illness. JCVI decided that most major underlying health conditions would reasonably apply to children and young people (summarised in Table 4). Children aged over 12 years with these conditions are often severely affected by other respiratory infections and should therefore be offered a course of COVID-19 vaccination. These individuals will be eligible for a booster in the autumn programme (see below).

1 <https://www.rcpch.ac.uk/sites/default/files/CHR-UK - Retrospective Epidemiological Review of All-cause Mortality in CYP.pdf>

In December 2021, following the recognition of pregnancy as a risk factor for severe COVID-19 infection and poor pregnancy outcomes over the Delta wave, pregnancy was added to the clinical risk groups for young people aged 5-15 years (table 4).

Individuals aged 12 to 15 years who are contacts of immunosuppressed individuals

Those aged 12 years and above who expect to share living accommodation on most days (and therefore for whom continuing close contact is unavoidable) with individuals **of any age** who are immunosuppressed (defined as immunosuppressed in tables 3 or 4) should be offered two doses of vaccine eight weeks apart. These individuals will be eligible for a booster in the autumn programme (see below).

Other children and young people aged 12-15 years

In September 2021, the Chief Medical Officers recommended that all young people aged 12 to 15 years can receive their first dose of COVID-19 vaccine. <https://www.gov.uk/government/publications/universal-vaccination-of-children-and-young-people-aged-12-to-15-years-against-covid-19>

JCVI have now advised that a second dose of vaccine should be offered after an interval of 12 weeks. This interval reflects the strong evidence of high levels of protection against severe disease from the first dose, although could be shortened to eight weeks when rapid protection is required, for example high incidence or circulation of a new variant in a vulnerable population. Emerging evidence also suggests that countries with longer schedules (eight to twelve weeks) may have a lower rate of myocarditis after the second dose. Although this latter evidence is limited, JCVI have taken a precautionary approach to mitigate the very rare risk of post-vaccine myocarditis.

Children aged 5-11 years¹

Children at higher risk of severe COVID-19

Children and young people aged 5 to 11 years who are in recognised risk groups (table 4) should receive two doses of the paediatric dose (10 micrograms) of Pfizer BioNTech vaccine at an interval of at least eight weeks. Children in these risk groups will continue to become eligible when they turn 5 years of age, as will those aged 5-11 years who become at risk. Those with severe immunosuppression (box 2) will be eligible for a three dose primary course. Children in this group will also be eligible for a booster dose in the autumn programme (see section on the autumn programme).

Children aged 5-11 years who are contacts of immunosuppressed individuals

Individuals aged 5-11 years who expect to share living accommodation on most days (and therefore for whom continuing close contact is unavoidable) with individuals of any age who are immunosuppressed (defined as immunosuppressed in tables 3 or 4) should be offered two doses of the paediatric dose (10 micrograms) of Pfizer BioNTech vaccine at an interval of at least eight weeks. Children in this groups will continue to become eligible when they turn 5 years of age, as will those aged 5-11 years when a close contact becomes immunosuppressed. Children in this group will also be eligible for a booster dose in the autumn programme (see section on the autumn programme).

Other children aged 5-11 years

In February 2022, the JCVI advised a one-off, non-urgent programme to offer vaccination to all children aged five to 11 years of age who are not in a clinical risk group. The immediate benefits of vaccination in this age group are likely to be small because children are at low risk

¹ Including some children aged 12 years - see section on age specific recommendations on vaccine type

from COVID-19 infection, and by February 2022 almost all children in this age group will already have been infected with COVID-19. Although Omicron infection appears to be particularly mild, and the vaccine induced protection against mild Omicron infection is short lived, the offer is intended to increase and broaden protection against severe COVID-19 in advance of a potential future wave of COVID-19. As this offer is non-urgent, JCVI has recommended that delivery of paediatric non-COVID-19 immunisation programmes across all ages should receive due attention. Coverage in these other programmes has fallen behind during the pandemic, and may thus be increasing health inequalities, so it is important that COVID-19 vaccination does not further impact on these programmes.

Two doses of the paediatric vaccine (see the section on age specific recommendations on vaccine type) should be offered with an interval of at least 12 weeks between doses. This one-off programme applies to those aged 5 to 11 years, including those who turn five years of age before the end of August 2022. Subject to further clarification, on-going eligibility in 2022/23, after the one off-programme, is expected to be for children in the academic years where children are aged 11 or 12 years. Use of the paediatric formulation is advised for commencing (and for completing) vaccination for children in the relevant academic year.

Table 4: Clinical and other risk groups for children and young people aged 5-15 years

Chronic respiratory disease	Including those with poorly controlled asthma ¹ that requires continuous or repeated use of systemic steroids or with previous exacerbations requiring hospital admission, cystic fibrosis, ciliary dyskinesias and bronchopulmonary dysplasia
Chronic heart conditions	Haemodynamically significant congenital and acquired heart disease, or less severe heart disease with other co-morbidity. This includes: <ul style="list-style-type: none"> • single ventricle patients or those palliated with a Fontan (Total Cavopulmonary Connection) circulation • those with chronic cyanosis (oxygen saturations <85% persistently) • patients with cardiomyopathy requiring medication • patients with congenital heart disease on medication to improve heart function • patients with pulmonary hypertension (high blood pressure in the lungs) requiring medication
Chronic conditions of the kidney, liver or digestive system	Including those associated with congenital malformations of the organs, metabolic disorders and neoplasms, and conditions such as severe gastro-oesophageal reflux that may predispose to respiratory infection
Chronic neurological disease	This includes those with <ul style="list-style-type: none"> • neuro-disability and/or neuromuscular disease that may occur as a result of conditions such as cerebral palsy, autism, epilepsy and muscular dystrophy • hereditary and degenerative disease of the nervous system or muscles, other conditions associated with hypoventilation • severe or profound and multiple learning disabilities (PMLD), Down's syndrome, including all those on the learning disability register • neoplasm of the brain
Endocrine disorders	Including diabetes mellitus, Addison's and hypopituitary syndrome
Immunosuppression	Immunosuppression due to disease or treatment, including: <ul style="list-style-type: none"> • those undergoing chemotherapy or radiotherapy, solid organ transplant recipients, bone marrow or stem cell transplant recipients • genetic disorders affecting the immune system (e.g. deficiencies of IRAK-4 or NEMO, complement disorder, SCID) • those with haematological malignancy, including leukaemia and lymphoma • those receiving immunosuppressive or immunomodulating biological therapy • those treated with or likely to be treated with high or moderate dose corticosteroids • those receiving any dose of non-biological oral immune modulating drugs e.g. methotrexate, azathioprine, 6-mercaptopurine or mycophenolate • those with auto-immune diseases who may require long term immunosuppressive treatments <p>Children who are about to receive planned immunosuppressive therapy should be considered for vaccination prior to commencing therapy.</p>
Asplenia or dysfunction of the spleen	Including hereditary spherocytosis, homozygous sickle cell disease and thalassaemia major
Serious genetic abnormalities that affect a number of systems	Including mitochondrial disease and chromosomal abnormalities
Pregnancy	All stages (first, second and third trimesters)

1 Poorly controlled asthma is defined as:

- ≥2 courses of oral corticosteroids in the preceding 24 months OR
- on maintenance oral corticosteroids OR
- ≥1 hospital admission for asthma in the preceding 24 months

<https://www.brit-thoracic.org.uk/covid-19/covid-19-information-for-the-respiratory-community/#jcvi-advice-on-covid-19-vaccination-for-children-aged-12-15-years-in-clinical-at-risk-groups>

Other risk groups

Household contacts of people with immunosuppression	Individuals who expect to share living accommodation on most days (and therefore for whom continuing close contact is unavoidable) with individuals who are immunosuppressed (defined as immunosuppressed in tables 3 or 4).
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Third primary dose for those aged 12 years or over

Some individuals who are immunosuppressed due to underlying health conditions or medical treatment may not mount a full immune response to primary COVID-19 vaccination. Preliminary results from UK studies of real-world vaccine effectiveness (VE) in persons who are immunosuppressed suggest only a modest reduction in VE against symptomatic COVID-19 (Whitaker *et al*, 2021). Immunogenicity studies measuring binding or neutralising antibody and/or cellular responses have suggested that, amongst the immunosuppressed group, some individuals with more severe forms of immunosuppression make low or no detectable responses. A few published studies describing the effect of a third dose of mRNA vaccine in persons who are immunosuppressed report increased immune responses in varying proportions of persons. (Hall *et al*, 2021b, Kamar *et al*, 2021, Werbel *et al*, 2021).

Although there are no known correlates of protection against infection, symptomatic disease and severe COVID-19 (hospitalisation and deaths), JCVI considers that a small group of immunosuppressed individuals should be offered a third primary vaccination.

JCVI advises that a third vaccine dose be offered to individuals aged 12 years and over who had severe immunosuppression in proximity to their first or second COVID-19 doses in the primary schedule (Box 1). Most individuals whose immunosuppression commenced at least two weeks after the second dose of vaccination do not require an additional primary vaccination at this stage. Individuals who had received brief immunosuppression (≤ 40 mg prednisolone per day) for an acute episode (for example, asthma / COPD / COVID-19) and individuals on replacement corticosteroids for adrenal insufficiency are not considered severely immunosuppressed sufficient to have prevented response to the primary vaccination.

In general, vaccines administered during periods of minimum immunosuppression are more likely to generate better immune responses. Therefore the third dose should be given ideally at least 8 weeks after the second dose, with special attention paid to current or planned immunosuppressive therapies. Where possible the third dose should be delayed until two weeks after the period of immunosuppression, in addition to the time period for clearance of the therapeutic agent. If not possible, consideration should be given to vaccination during a treatment 'holiday' or when the degree of immunosuppression is at a minimum. Advice for patients on chemotherapy is available at <https://www.ukchemotherapyboard.org/publications>

Those aged 12 years and above in this group will also require booster doses, in line with the rest of the eligible population, to extend protection from their primary course. Following the recognition of the Omicron variant in South Africa, JCVI advised that the first reinforcing dose should be offered from three months after the third primary dose. Individuals in this group are also eligible for the spring booster dose (see section on the spring booster campaign 2022).

Eligible individuals who have not yet received their third dose are advised to receive their third dose immediately to avoid further delay (at least eight weeks after the second primary dose). A booster dose should then be given at least three months later (ideally in line with the clinical advice on optimal timing in relation to the degree of immune suppression). A further booster should then be given during the spring campaign, provided there is at least three months from the previous dose.

Individuals who completed primary vaccination later, and so received their first booster (fourth dose) during the spring campaign, do not need an additional spring dose but are expected to next become eligible during the autumn booster campaign.

Third primary dose for those aged 5-11 years

JCVI advises that a third vaccine dose be offered to individuals aged 5-11 years who had severe immunosuppression in proximity to their first or second COVID-19 doses in the primary schedule (Box 2). Most individuals whose immunosuppression commenced at least two weeks after the second dose of vaccination do not require an additional primary vaccination at this stage, although specialist advice may need to be sought. Children who had received brief immunosuppression ($\leq 2\text{mg/kg}$ prednisolone per day) for an acute episode of asthma and children on replacement corticosteroids for adrenal insufficiency are not considered severely immunosuppressed sufficient to have prevented response to the primary vaccination.

In general, vaccines administered during periods of minimum immunosuppression are more likely to generate better immune responses. Therefore the third dose should be given ideally at least 8 weeks after the second dose, with special attention paid to current or planned immunosuppressive therapies. Where possible the third dose should be delayed until two weeks after the period of immunosuppression, in addition to the time period for clearance of the therapeutic agent. If not possible, consideration should be given to vaccination during a treatment 'holiday' or when the degree of immunosuppression is at a minimum. Such holidays should be taken only on advice of the patient's specialist.

This group became eligible for primary vaccination in early 2022, so were not eligible for boosting in the spring campaign. Individuals in this group will become eligible for boosting in the autumn campaign (see below).

Box 1: Criteria for a third primary dose of COVID-19 vaccine in those aged 12 years and above
Individuals with primary or acquired immunodeficiency states at the time of vaccination due to conditions including:

- acute and chronic leukaemias, and clinically aggressive lymphomas (including Hodgkin's lymphoma) who were under treatment or within 12 months of achieving cure at the time of vaccination
- individuals under follow up for a chronic lymphoproliferative disorders including haematological malignancies such as indolent lymphoma, chronic lymphoid leukaemia, myeloma, Waldenstrom's macroglobulinemia and other plasma cell dyscrasias (Note: this list is not exhaustive)
- adults and children aged 12 years and over with immunosuppression due to HIV/AIDS with a current CD4 count of <200 cells/ μ l
- Primary or acquired cellular and combined immune deficiencies – those with lymphopaenia ($<1,000$ lymphocytes/ μ l) or with a functional lymphocyte disorder
- those who had received a stem cell transplant or chimaeric antigen receptor (CAR)-T cell therapy in the 24 months before vaccination
- those who had received a stem cell transplant more than 24 months before vaccination but had ongoing immunosuppression or graft versus host disease (GVHD)
- persistent agammaglobulinaemia (IgG <3 g/L) due to primary immunodeficiency (e.g. common variable immunodeficiency) or secondary to disease / therapy

Individuals on immunosuppressive or immunomodulating therapy at the time of vaccination including:

- those who were receiving immunosuppressive therapy for a solid organ transplant at the time of vaccination
- those who were receiving or had received in the previous 3 months targeted therapy for autoimmune disease, such as JAK inhibitors or biologic immune modulators including B-cell targeted therapies (including rituximab but in this case the recipient would be considered immunosuppressed for a 6 month period), T-cell co-stimulation modulators, monoclonal tumour necrosis factor inhibitors (TNFi), soluble TNF receptors, interleukin (IL)-6 receptor inhibitors., IL-17 inhibitors, IL 12/23 inhibitors, IL 23 inhibitors. (Note: this list is not exhaustive)
- those who were receiving or had received immunosuppressive chemotherapy or radiotherapy for any indication in the 6 months before vaccination

Individuals with chronic immune-mediated inflammatory disease who were receiving or had received immunosuppressive therapy prior to vaccination including:

- high dose corticosteroids (equivalent to ≥ 20 mg prednisolone per day) for more than 10 days in the month before vaccination
- long term moderate dose corticosteroids (equivalent to ≥ 10 mg prednisolone per day for more than 4 weeks) in the 3 months before vaccination
- non-biological oral immune modulating drugs, such as methotrexate >20 mg per week (oral and subcutaneous), azathioprine >3.0 mg/kg/day; 6-mercaptopurine >1.5 mg/kg/day, mycophenolate >1 g/day) in the 3 months before vaccination
- certain combination therapies at individual doses lower than above, including those on ≥ 7.5 mg prednisolone per day in combination with other immunosuppressants (other than hydroxychloroquine or sulfasalazine) and those receiving methotrexate (any dose) with leflunomide in the 3 months before vaccination

Individuals who had received high dose steroids (equivalent to >40 mg prednisolone per day for more than a week) for any reason in the month before vaccination

Box 2: Criteria for a third primary dose of COVID-19 vaccine in children aged 5-11 years**Individuals with primary or acquired immunodeficiency states at the time of vaccination due to conditions including:**

- acute and chronic leukaemias, and clinically aggressive lymphomas (including Hodgkin's lymphoma) who were under treatment or within 12 months of achieving cure at the time of vaccination
- individuals under follow up for a chronic lymphoproliferative disorders including haematological malignancies
- children with immunosuppression due to HIV/AIDS (children with a current CD4 count of <500 cells/ μ l in those aged 5 years and <200 cells/ μ l in those aged 6-11 years)
- Primary or acquired cellular and combined immune deficiencies – those with lymphopaenia (<1,000 lymphocytes/ μ) or with a functional lymphocyte disorder
- those who had received a stem cell transplant or chimaeric antigen receptor (CAR)-T cell therapy in the 24 months before vaccination
- those who had received a stem cell transplant more than 24 months before vaccination but had ongoing immunosuppression or graft versus host disease (GVHD)
- persistent agammaglobulinaemia (IgG < 3g/L) due to primary immunodeficiency (e.g. common variable immunodeficiency) or secondary to disease / therapy

Individuals on immunosuppressive or immunomodulating therapy at the time of vaccination including:

- those who were receiving immunosuppressive therapy for a solid organ transplant at the time of vaccination
- those who were receiving or had received in the previous 3 months targeted therapy for autoimmune disease, such as JAK inhibitors or biologic immune modulators including B-cell targeted therapies (including rituximab but in this case the recipient would be considered immunosuppressed for a 6 month period), T-cell co-stimulation modulators, monoclonal tumour necrosis factor inhibitors (TNFi), soluble TNF receptors, interleukin (IL)-6 receptor inhibitors., IL-17 inhibitors, IL 12/23 inhibitors, IL 23 inhibitors. (Note: this list is not exhaustive)
- those who were receiving or had received immunosuppressive chemotherapy or radiotherapy for any indication in the 6 months before vaccination

Individuals with chronic immune-mediated inflammatory disease who were receiving or had received immunosuppressive therapy prior to vaccination including:

- high dose corticosteroids (equivalent to \geq 1mg prednisolone per kg per day) for more than 10 days in the month before vaccination
- long term moderate dose corticosteroids (equivalent to \geq 0.5 mg prednisolone per kg per day for more than 4 weeks) in the 3 months before vaccination
- any dose of non-biological oral immune modulating drugs (with the exception of hydroxychloroquine and sulfasalazine), such as methotrexate, azathioprine, 6-mercaptopurine or mycophenolate in the 3 months before vaccination. (Note: this list is not exhaustive)

Individuals who had received high dose steroids (equivalent to >2mg prednisolone per kg per day for more than a week) for any reason in the month before vaccination

Reinforcing immunisation

Initial recommendations for reinforcing immunisation

In September 2021, JCVI advised that the following groups should be offered a COVID-19 booster vaccine.

This included:

- those living in residential care homes for older adults
- all adults aged 50 years or over
- frontline health and social care workers
- all those aged 16 to 49 years with underlying health conditions that put them at higher risk of severe COVID-19 (table 3)
- all carers aged 16 years and above
- all those aged 16 years and above who are household contacts of immunosuppressed individuals (defined as immunosuppressed in tables 3 or 4) of any age

The first groups to receive boosters were therefore those prioritised in phase 1 of the COVID-19 programme (table 2, groups 1-9), with the booster offered six months from the completion of the primary course. JCVI also advised that operational flexibility should permit boosting of all adults, regardless of age, in certain closed settings or in populations such as those experiencing homelessness.

Additional surge recommendations following the emergence of the Omicron variant

Following the emergence of the Omicron variant in November 2021, JCVI advised accelerating the booster deployment in order of age and risk status. Individuals aged over 50 years and in risk groups were offered booster vaccination first, followed by those aged 18-49 years who were not in high risk groups, in descending age order. Reinforcing doses should not be given within three months of completion of the primary course.

In late December, JCVI advised that those aged 16-17 years, children and young people aged 12-15 who are at higher risk from COVID-19 (table 4) or those aged 12-15 years who are household contacts of immunosuppressed individuals of any age (defined as immunosuppressed in tables 3 or 4) should also be offered a booster. This group will include high risk individuals who received primary vaccination as part of the 5-11 year cohort who have now turned 12 years of age. Reinforcing doses should not be given within three months of completion of the primary course. These children will also be eligible for boosting in the autumn campaign (see below).

Additional considerations around reinforcing doses

In December 2021, following the recognition of pregnancy as a risk factor for severe COVID-19 outcomes and poor pregnancy in the Delta wave, pregnancy was added to the clinical risk groups. Women who are currently pregnant and who are also in a COVID-19 clinical risk group should already have been called for their booster. Younger women who may have received primary vaccination more recently, can be boosted from three months after completion of their primary course. Given that the booster programme is progressing at full pace to vaccinate all over 18s, JCVI agreed that actively identifying and calling in pregnant women aged under 40 years for boosting is unlikely to make a substantial difference to the timing of boosting in this group. They therefore agreed that boosters could be provided opportunistically or in line with their age cohort.

JCVI advised that those aged 5 years and over with severe immunosuppression (Boxes 1 and 2) who have not yet received their third dose should be given their third dose now to avoid further delay. Subsequent boosters should be scheduled for at least three months, in line with the clinical advice on optimal timing in immunosuppressed individuals.

Boosters in children and young people aged 5 to 15 years who are not at high risk are not currently recommended by JCVI.

The spring booster campaign 2022

In February 2022, recognising the small decline in observed vaccine effectiveness against hospitalisation for COVID-19 after the booster dose, JCVI recommended a spring booster campaign for individuals at higher risk of severe COVID-19. Many of the oldest adults received their booster vaccine dose in September or October 2021, and protection against severe disease is expected to continue to wane gradually by the autumn. As a precautionary strategy, an extra spring dose is being advised, to sustain protection whilst JCVI continues to review the epidemiological situation, ahead of an expected booster programme in autumn 2022.

The committee recommended that a booster dose should be given around 6 months after the last vaccine dose to:

- adults aged 75 years and over
- residents in a care home for older adults, and
- individuals aged 12 years and over who are immunosuppressed (defined as immunosuppressed in tables 3 or 4).

The vast majority of people aged over 75 will reach an interval of around six months from their previous dose between March and June 2022. Although vaccination should ideally be offered around six months from any previous dose, operational flexibility may be used. For example, individuals in care homes or housebound patients may be offered the booster alongside other residents providing there is at least three months from the previous dose. Immunosuppressed individuals who have received an additional primary dose may have received the booster (fourth) dose more recently. These latter individuals and other eligible people who received their last vaccine more recently should also be offered the booster during the spring campaign providing there is at least three months from the previous dose. This will ensure they have additional protection against a potential summer wave and will align with their peers to facilitate an autumn programme.

Someone in an eligible group who has received a full course of primary vaccination (two or three doses) but had not received their first booster by March 2022, may be given the spring booster in the campaign provided there is at least three months from the previous dose. An additional dose is not then recommended before the autumn. The vaccines offered should follow the age-appropriate advice for reinforcing doses (see below).

The autumn booster campaign 2022

Following on from the spring campaign, the JCVI has recommended a move to regular, planned and targeted boosting as the most important strategy to control COVID-19. For the 2022 autumn booster programme, the primary objective is to augment immunity in those at higher risk from COVID-19 and thereby optimise protection against severe COVID-19, specifically hospitalisation and death, over winter 2022/23.

The following groups should be offered a COVID-19 booster vaccine in the autumn of 2022:

- residents in a care home for older adults and staff working in care homes for older adults
- frontline health and social care workers
- all adults aged 50 years and over
- persons aged 5 to 49 years in a clinical risk group, as set out in Tables 3 and 4
- persons aged 5 to 49 years who are household contacts of people with immunosuppression (as defined in Tables 3 and 4)
- persons aged 16 to 49 years who are carers (as defined in Table 3).

The booster should ideally be offered from September, allowing a minimum of three months from the previous dose. The programme should prioritise delivery to those aged over 75 years and in care homes for older adults but recognising the need for operational flexibility based on the likely delivery models. The aim should be to complete the campaign before December to provide additional protection in time for the expected winter peak of other seasonal viruses. Mop-up opportunities should then be offered up to the end of January.

Someone in the eligible groups above who has received a full course of primary vaccination (two or three doses) but has not received a booster before September 2022, may be given the autumn booster in the campaign provided there is at least three months from the previous dose. Additional doses are not then required. Children in high risk groups who turn five years of age after August 2022 will become eligible for primary vaccination and can also receive a booster during the autumn programme, provided there is at least three months since their second (or third) primary dose.

JCVI considered evidence around the differences in neutralising antibody after the bivalent vaccines compared to the original boosters. The committee considered that the improvement in neutralising antibody levels were modest and likely to translate to only small improvements in protection against the BA.1 strain, with no clear advantage against other variants. This marginally improved protection against one variant was considered insufficient to justify any substantial delay in offering boosters to those at highest risk. On this basis the committee concluded that Moderna or Pfizer BioNTech bivalent vaccine should be offered in the autumn booster programme, but only if the supply was sufficient to avoid delays in the planned implementation timetable. Individuals should be clearly advised that boosting is required to ensure timely protection over the winter, and therefore to accept whichever booster vaccine they were offered. Otherwise, the vaccines offered should follow the age-appropriate advice for reinforcing doses as outlined below.

Age specific recommendations on vaccine type

Children aged 5-11 years (including some who have turned 12 years)

For children aged 5-11 years, a childhood dose of Pfizer BioNTech (Comirnaty® 10 micrograms) is recommended. The paediatric formulation should be used, although 10 micrograms (0.1ml) of the diluted adult/adolescent vaccine may be an alternative when protection is required rapidly and the paediatric formulation is not available. The use of a fractional adult/adolescent vaccine would be off-label and can be considered on a case by case basis.

In the USA, the safety experience with the paediatric Pfizer BioNTech vaccine (Comirnaty® 10mcg) suggests a lower rate of reactions than after the adult dose in older children, with a very low rate of reported myocarditis (1-2 cases per million doses). JCVI have therefore advised that the lower dose of vaccine is therefore preferred for those aged 12

years alongside those aged 11 years in the same academic year (year 7 in England and Wales, year 8 in Northern Ireland and year S1 in Scotland). Using the same vaccine dose for pupils in the same academic year should help simplify any school-based immunisations and increase overall safety.

Children aged 5-11 years who have commenced immunisation with the paediatric dose of Pfizer BioNTech and then turn 12 years of age should also complete vaccination with the paediatric dose. An adult/adolescent dose is an acceptable alternative if this is the only supply available. Children aged 5-11 years who are given a fractional dose of the adult preparation may complete with the paediatric formulation or vice versa.

Children and young people aged 12-17 years

An adult/adolescent (30 micrograms) dose of the Pfizer BioNTech vaccine (Comirnaty®) has approval for use from 12 years old and currently has the most extensive safety data in those aged 12-17 years. This vaccine is therefore the preferred vaccine for children and young people. Although Moderna vaccine is also approved in children, Pfizer is currently preferred due to a lower reported rate of myocarditis.¹ Children aged 12 years of age who have commenced vaccination with the 30 microgram dose who are being vaccinated alongside their peers from the same same academic year may complete with the 10 microgram dose (see above).

AstraZeneca vaccine is no longer being supplied for routine use in the UK. When mRNA vaccines are not considered clinically suitable, Novavax COVID-19 vaccine may be used for primary vaccination of adults and children aged 12 years and over.

Healthy adults aged 18 years and over

Evidence suggests that the risk of serious COVID-19 disease is strongly related to age, and the risk of COVID-19 mortality, hospitalisation and ICU admission is lower in younger adults. Based on current supply, a full dose mRNA vaccine (Pfizer BioNTech 30 micrograms or Moderna 100 micrograms) is recommended for primary vaccination. This advice may change if there is a change in the epidemiology or an interruption in the supply of the mRNA vaccines.

AstraZeneca vaccine is no longer being supplied for routine use in the UK. When mRNA vaccines are not considered clinically suitable, Novavax COVID-19 vaccine may be used for primary vaccination of adults.

Pregnant women in eligible groups

Pfizer BioNTech and Moderna vaccines are the preferred vaccines for eligible pregnant women (for those under 18 years, Pfizer BioNTech vaccine (Comirnaty®) is preferred), because of more extensive experience of their use in pregnancy. When mRNA vaccines are not considered clinically suitable, Novavax COVID-19 vaccine may be used for primary vaccination of pregnant women, including to complete a course or as a booster, although experience in pregnancy is relatively limited.

Third primary doses for those aged 5 years and over with severe immunosuppression

For those aged over 18 years, JCVI advises a preference for full dose mRNA vaccines - 30 micrograms of Pfizer BioNTech (Comirnaty®) or 100 micrograms of Moderna (Spikevax®) - for the third primary dose. Pfizer BioNTech (Comirnaty®) is preferred for 5-17 year olds.

AstraZeneca vaccine is no longer being supplied for routine use in the UK. When mRNA vaccines are not considered clinically suitable, Novavax COVID-19 vaccine may be used for a

1 <https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-adverse-reactions/coronavirus-vaccine-summary-of-yellow-card-reporting>

third dose primary vaccination of those aged 12 years and over, although this is currently off-label in those who received a different priming vaccine.

Reinforcing vaccination

The JCVI have advised that the following vaccines are suitable for boosting irrespective of the vaccine used for the primary course:

Adults aged 18 or over (including pregnant women)

- A full 0.3ml dose (30 micrograms) of adult/adolescent Pfizer BioNTech vaccine (Comirnaty®)
- A full 0.3ml booster dose of bivalent (15/15 micrograms) Pfizer BioNTech vaccine (Comirnaty® Original/Omicron BA.1)
- A half 0.25ml dose (50 micrograms) of the Moderna COVID-19 vaccine (Spikevax®)
- A full 0.5ml dose of the bivalent (25/25 micrograms) of the bivalent Moderna COVID-19 vaccine (Spikevax® bivalent original/Omicron)

Children and young adults aged 12-17 years (including pregnant women)

- A full 0.3ml dose (30 micrograms) of adult/adolescent Pfizer BioNTech vaccine (Comirnaty®)
- A full 0.3ml booster dose of bivalent (15/15 micrograms) Pfizer BioNTech vaccine (Comirnaty® Original/Omicron BA.1)

Children aged 5-11 years

- A full 0.2ml dose (10 micrograms) of paediatric Pfizer-BioNTech vaccine (Comirnaty®10) - off label indication

AstraZeneca vaccine is no longer being supplied for routine use in the UK. When mRNA vaccines are not considered clinically suitable, Novavax COVID-19 vaccine may be used for vaccination of those aged 12 years and over, including to complete a course or as a booster, although the latter is currently off-label.

Other considerations

Previous incomplete vaccination

If the course is interrupted or delayed, it should be resumed using the same vaccine but the first dose should not be repeated. Evidence suggests that those who receive mixed schedules, including mRNA and adenovirus vectored vaccines, make a good immune response, (Liu *et al*, 2021) although rates of side effects with a heterologous second dose are higher. (Shaw *et al*, 2021). Accumulating evidence now supports the use of heterologous schedules for primary immunisation, and these are now recognised by the European Medicines Agency. <https://www.ema.europa.eu/en/news/ema-ecdc-recommendations-heterologous-vaccination-courses-against-covid-19> For individuals who started the schedule and who attend for vaccination where the same vaccine is not available or suitable, or if the first product received is unknown or not available, one dose of the locally available product should be given to complete the primary course. Individuals who experienced severe expected reactions after a first dose of AstraZeneca or Pfizer BioNTech vaccines should be informed about the higher rate of such reactions when they receive a second dose of an alternate vaccine. (Powell *et al*, 2021)

Children aged 5-12 years who have commenced immunisation with the paediatric dose of Pfizer BioNTech should complete vaccination with the paediatric dose (although an adult/adolescent dose is an alternate in those who turn 12 years of age between doses). Those who present for the second dose over the age of 12 years should be given an adult/adolescent dose of vaccine.

Individuals vaccinated overseas or as part of clinical trials

Individuals who have been vaccinated abroad are likely to have received an mRNA or vector vaccine based on the spike protein, or an inactivated whole viral vaccine. Specific advice on vaccination of those who received COVID-19 vaccine overseas is available from UKHSA.

<https://www.gov.uk/government/publications/covid-19-vaccinations-received-overseas>.

Individuals who have participated in a clinical trial of either primary or booster COVID-19 vaccination should be provided with written advice on whether and when they should be safely vaccinated in the routine programme. Advice should also be provided from the trial investigators on whether any individual could receive additional doses for the purposes of vaccine certification. Trial participants who are eligible for boosters should be offered vaccination in line with the general population, at least three months after the dose considered as the final primary dose or the final revaccination (if the latter is required for certification purposes).

Co-administration with other vaccines

Initially data on co-administration of COVID-19 with other vaccines was limited. In the absence of such data first principles would suggest that interference between inactivated vaccines with different antigenic content is likely to be limited (see Chapter 11). Based on experience with other vaccines, any potential interference is most likely to result in a slightly attenuated immune response to one of the vaccines. There is no evidence of any safety concerns, although it may make the attribution of any adverse events more difficult. Similar considerations apply to co-administration of inactivated (or non-replicating) COVID-19 vaccines with live vaccines such as MMR. In particular, live vaccines which replicate in the mucosa, such as live attenuated influenza vaccine (LAIV) are unlikely to be seriously affected by concomitant COVID-19 vaccination.

A UK study of co-administration of AstraZeneca and Pfizer BioNTech COVID-19 vaccines with inactivated influenza vaccines confirmed acceptable immunogenicity and reactogenicity (Lazarus *et al*, 2021). In contrast, a study of co-administration of Novavax COVID-19 vaccine with inactivated influenza, did show some attenuation of the antibody response to COVID-19 (Toback *et al*, 2022). Although the clinical significance of this is unclear, administration of Novavax COVID-19 vaccine should be separated from administration of influenza vaccine by at least 7 days.

With the exception of this, as COVID-19 vaccines are considered inactivated (including the non-replicating adenovirus vaccine), where individuals in an eligible cohort present having recently received one or more inactivated or another live vaccine, COVID-19 vaccination should still be given. The same applies for most other live and inactivated vaccines where COVID-19 vaccination has been received first or where a patient presents requiring two or more vaccines. It is generally better for vaccination to proceed to avoid any further delay in protection and to avoid the risk of the patient not returning for a later appointment. This includes but is not limited to vaccines commonly administered around the same time or in the same settings (including pneumococcal polysaccharide vaccine in those aged over 65 years, pertussis-containing vaccines and influenza vaccines in pregnancy, and LAIV, HPV,

MenACWY and Td-IPV vaccines in the schools programmes). In addition to influenza and Novavax vaccine, the other current exception is the shingles vaccines, where a seven day interval should ideally be observed. This is based on the potential for an inflammatory response to COVID-19 vaccine to interfere with the response to the live virus in the older population and because of the potential difficulty of attributing systemic side effects to the newer adjuvanted shingles vaccine.

A UK study of co-administration of AstraZeneca and Pfizer BioNTech COVID-19 vaccines with inactivated influenza vaccines confirmed acceptable immunogenicity and reactogenicity (Lazarus *et al*, 2021). Where co-administration does occur, patients should be informed about the likely timing of potential adverse events relating to each vaccine. If the vaccines are not given together, they can be administered at any interval, although separating the vaccines by a day or two will avoid confusion over systemic side effects.

Monoclonal antibodies to SARS-CoV-2 have recently been licensed for the treatment and prophylaxis of COVID-19 infection. Primate data suggests that administration of the AstraZeneca combination monoclonal antibody product did not interfere with the subsequent response to active vaccination. Based on this limited evidence, therefore, no specific interval is required between receipt of these products and COVID-19 vaccination, or vice versa. As the use of these products is likely to be prioritised to those who are less able to respond to vaccination, for example immunosuppressed individuals, additional doses of vaccine may be required as outlined above.

Specific population groups

Pregnancy

There is no known risk associated with giving inactivated, recombinant viral or bacterial vaccines or toxoids during pregnancy or whilst breastfeeding (Kroger *et al*, 2013). Since inactivated vaccines cannot replicate, they cannot cause infection in either the mother or the fetus. Although AstraZeneca COVID-19 vaccine contains a live adenovirus vector, this virus is not replicating so will not cause infection in the mother or the fetus. As with most pharmaceutical products, large clinical trials of COVID-19 vaccine in pregnancy have not been carried out.

Developmental and reproductivity testing of the Pfizer BioNTech, Moderna and AstraZeneca vaccines in animals have not raised any concerns. Adenovirus vectors, similar to those used in the AstraZeneca COVID-19 vaccine, have been widely used to vaccinate women against Ebola without raising any concern; formal trials of these vaccines in pregnancy are due to proceed.

A large amount of observational data from women vaccinated in pregnancy in the USA have not shown an increase in adverse pregnancy outcomes.¹ JCVI has therefore advised that women who are pregnant should be recommended to receive primary immunisation, and that pregnancy is considered a clinical risk group for the autumn booster programme. Although data systems and collection periods differ between the UK countries, around 150,000 women in England, 25,000 in Scotland and 4,500 in Wales have received at least one dose of COVID-19 vaccine whilst pregnant. Initial analysis of birth outcomes in women who had received at least one dose of the vaccine and delivered between January to November in England showed a similar or higher rate of good birth outcomes than in unvaccinated women. <https://www.gov.uk/government/publications/covid-19-vaccine-weekly-surveillance-reports>.

1 <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/vsafepregnancyregistry.html>

Routine questioning about last menstrual period and/or pregnancy testing is not required before offering the vaccine. Women who are planning pregnancy or in the immediate postpartum should be vaccinated with a suitable product for their age and risk status.

If a woman finds out she is pregnant after she has started a course of vaccine, she should complete vaccination at the recommended interval.

Termination of pregnancy following inadvertent immunisation should not be recommended. Surveillance of the inadvertent administration of COVID-19 vaccines in early pregnancy is being conducted for the UK by the UK Health Security Agency Immunisation and Vaccine Preventable Diseases Division, to whom such cases should be reported.¹ This surveillance is being undertaken to document safety in women who unknowingly receive a vaccine in early pregnancy to provide better information to inform women and health professionals. As above, any women who are inadvertently vaccinated in early pregnancy should complete vaccination at the recommended interval.

Breastfeeding

There is no known risk associated with being given a non-live vaccine whilst breastfeeding. JCVI advises that breastfeeding women should be offered any suitable COVID-19 vaccine. Emerging safety data is reassuring: mRNA was not detected in the breast milk of recently vaccinated women (Golan *et al*, 2021) and protective antibodies have been detected in breast milk (Gray *et al*, 2021)

The developmental and health benefits of breastfeeding are clear and should be discussed with the woman, along with her clinical need for immunisation against COVID-19.

Children

SARS-CoV-2 vaccine trials have been conducted in those aged 12-15 years using the adult/adolescent dose of both Pfizer BioNTech and Moderna vaccines. A 10 microgram dose of Pfizer BioNTech vaccines formulated for children, has been approved by the MHRA for use in children aged 5-11 years.

Children and young people have a very low risk of COVID-19, severe disease or death due to SARS-CoV-2 compared to adults. Vaccination of school children aged 12-15 years may help to avoid school absences and disruption to face-to-face education.²

Children under 16 years of age are at low risk of COVID-19 mortality, and risk of hospital admission is largely confined to those in clinical risk groups. Some children, such as those with profound and multiple LD (PMLD) and severe LD, and including children with Down's syndrome and cerebral palsy are at higher risk of hospitalisation for COVID-19 (Williamson *et al*, 2021). Analysis undertaken by an expert group recently concluded that rates of intensive care admission exceeded 100 per million over the first year of the pandemic in children with a broad range of underlying conditions. Children aged over 5 years with these conditions are therefore recommended to have two doses of Pfizer BioNTech COVID-19 vaccine (see section on children and tables 3 and 4).

1 <https://www.gov.uk/guidance/vaccination-in-pregnancy-vip>

2 <https://www.gov.uk/government/publications/universal-vaccination-of-children-and-young-people-aged-12-to-15-years-against-covid-19>

Immunosuppression and HIV

Individuals who have immunosuppression and HIV infection (regardless of CD4 count) should be given COVID-19 vaccine in accordance with the recommendations and contraindications above. Although AstraZeneca COVID-19 vaccine contains a live adenovirus vector, this virus is not replicating and is considered safe in immunosuppressed people. Other adenovirus vector vaccines have been trialled in populations with high prevalence of HIV and shown no serious adverse events (Kennedy *et al*, 2017). Although individuals with stable treated HIV infection were not excluded from the phase 3 trial of the Pfizer and Moderna mRNA vaccines, data on safety and effectiveness in this group have not been presented. A study of the AstraZeneca vaccines in people living with HIV infection is underway.

Individuals with immunosuppression may not make a full immune response to vaccination. As there is limited evidence on the response in immunosuppressed individuals there is also very little evidence upon which to base advice on the optimal timing of delivery. A recent study suggested immune responses were better, however, in patients with cancer who received their chemotherapy at least two weeks earlier (Monin-Aldama *et al*, 2021). Specialists may advise their patients based on their knowledge and understanding of their immune status and likely immune response to vaccination, but should also consider the risk from COVID-19 and the patient's likelihood of exposure. The small number of patients (aged 5 years or above) who are about to receive planned immunosuppressive therapy should be considered for vaccination prior to commencing therapy (ideally at least two weeks before), when their immune system is better able to make a response. Where possible, it would also be preferable for the 2-dose schedule to be completed prior to commencing immunosuppression. This would entail offering the second dose at the recommended minimum for that vaccine (three or four weeks from the first dose) to provide maximum benefit that may not be received if the second dose was given during the period of immunosuppression. Any decision to defer immunosuppressive therapy or to delay possible benefit from vaccination until after therapy should not be taken without due consideration of the risks from COVID-19 and from their underlying condition.

Emerging evidence suggests that many patients with immunosuppression do derive protection after two doses of vaccination. (Whitaker *et al*, 2021). As for immunocompetent individuals, however, protection from primary vaccination does decline over time. As those with immunosuppression remain at higher risk of serious complications from COVID-19 infection, this group of individuals were eligible for a booster in the spring and will be eligible for a booster in the autumn campaign. To reduce the risk of exposure, household contacts of individuals with immunosuppression are also eligible for primary vaccination and boosting in the autumn campaign (if aged 5 years and over).

Some individuals with more severe immunosuppression do not make a good immune response to a complete primary course of vaccine. This includes, but is not limited to, individuals on immunosuppression for solid organ transplants (Prendecki *et al*, 2021), those with haematological cancers who are within six months of completing curative therapy (Lim *et al*, 2021), and those on certain monoclonal antibody therapies (Mahil *et al*, 2021). JCVI has therefore recommended that some individuals require an additional primary dose (see Boxes 1 and 2).

Post-vaccination testing for spike antibody may also be considered by specialists managing individuals with severe immunosuppression. Low levels of detectable antibody may indicate poor protection against mild infection, although protection against severe disease may still

be present due to T and B cell immunological memory. Taking into account their underlying immune defect, individuals may be advised to take additional precautions to avoid exposure and information about access to early antiviral therapy.

Individuals who receive bone marrow transplants, and many individuals who receive CAR-T therapy for certain conditions, may lose immunological memory from vaccination prior to the treatment and the development of the underlying condition. After treatment and recovery, these individuals should be considered for a full course of revaccination for **all** vaccines used in the routine programme (see chapter 7). Specialist advice should be followed on which vaccines can be safely given and on the optimal timing for commencing revaccination.

Contraindications

There are very few individuals who cannot receive the Pfizer BioNTech, Moderna, AstraZeneca or Novavax COVID-19 vaccines. Where there is doubt, rather than withholding vaccination, appropriate advice should be sought from the relevant specialist, or from the local immunisation or health protection team.

The following are relative contra-indications to receiving a COVID-19 vaccine:

- individuals who have had a previous systemic anaphylaxis reaction to a COVID-19 vaccine
 - individuals who received Astra-Zeneca or Novavax vaccines may be given an alternate vaccine in any setting, with observation for 30 minutes
 - there is now evidence that many individuals with initial apparent allergic reaction to an mRNA vaccine can tolerate a second dose of the same vaccine. Where there were no objective signs of anaphylaxis and symptoms rapidly resolved (with no more than 1 dose of IM adrenaline), a further dose of the same vaccine can be given in any vaccination setting. If the reaction might have been anaphylaxis, obtain expert advice; if a decision is made to administer the same vaccine, then this should be done under medical supervision in the hospital setting. See flowchart, page 31 for further information.
- individuals with a prior allergic reaction to any component (excipient) of the COVID-19 vaccine e.g. polyethylene glycol
 - published data now show that some individuals with prior allergic reaction to PEG-containing medicines (eg. PEG-asparaginase) can tolerate the Pfizer BioNTech vaccine (although the historical reaction may have been due to a non-PEG component) (Mark *et al*, 2021). Expert advice should be obtained and if a decision is made to administer an mRNA vaccine, then this should only be done in hospital under medical supervision

Precautions

Minor illnesses without fever or systemic upset are not valid reasons to postpone immunisation. If an individual is acutely unwell, immunisation may be postponed until they have fully recovered. This is to avoid confusing the differential diagnosis of any acute illness (including COVID-19) by wrongly attributing any signs or symptoms to the adverse effects of the vaccine.

Individuals with a past history of COVID-19 infection

There is no convincing evidence of any safety concerns from vaccinating individuals with a past history of COVID-19 infection, or with detectable COVID-19 antibody.

Vaccination of individuals who may be infected or asymptomatic or incubating COVID-19 infection is unlikely to have a detrimental effect on the illness, although individuals with

suspected COVID-19 infection should not attend vaccination sessions to avoid infecting others. As clinical deterioration can occur up to two weeks after infection, vaccination of adults and high risk children should ideally be deferred until clinical recovery to around four weeks after onset of symptoms or four weeks from the first confirmed positive specimen to avoid confusing the differential diagnosis. There is no need to defer immunisation in individuals after recovery from a recent episode with compatible symptoms who were not tested unless there are strong clinical and epidemiological features to suggest the episode was COVID-19 infection. The four week interval may be reduced to ensure operational flexibility when rapid protection is required, for example high incidence or circulation of a new variant in a vulnerable population. Currently, the JCVI consider that, in care home residents and the housebound, there may be an advantage in offering vaccination to some individuals with recent confirmed COVID-19, without a four-week deferral, where individuals are clinically stable and when infection control procedures can be maintained. These populations are likely to be highly vulnerable and will facilitate vaccination without the need for multiple visits.

In younger people, after natural infection or a single dose of vaccine, protection from serious complications of COVID-19 infection is likely to be high for a period of months. Limited evidence suggests that countries with longer intervals between primary doses (eight to twelve weeks) may have a lower rate of myocarditis after the second dose. Based on extrapolation from this limited evidence, JCVI have taken a precautionary approach to mitigate the very rare risk of post-vaccine myocarditis. Therefore vaccination should ideally be deferred until twelve weeks from onset (or sample date) in children and young people under 18 years who are not in high risk groups. This interval may be reduced to eight weeks in healthy under 18 year olds when rapid protection is required, for example high incidence or circulation of a new variant in a vulnerable population. Current advice in PIMS-TS cases also suggests that an interval of 12 weeks should be observed, although earlier administration can be considered in those at high risk of infection and/or who are fully recovered. There is no need to defer immunisation in individuals after recovery from a recent episode with compatible symptoms who were not tested unless there are strong clinical and epidemiological features to suggest the episode was COVID-19 infection.

Having prolonged COVID-19 symptoms is not a contraindication to receiving COVID-19 vaccine but if the patient is seriously debilitated, still under active investigation, or has evidence of recent deterioration, deferral of vaccination may be considered to avoid incorrect attribution of any change in the person's underlying condition to the vaccine.

Individuals with a history of allergy

A very small number of individuals have experienced anaphylaxis when receiving a COVID-19 vaccine. Anyone with a history of allergic reaction to an excipient in the COVID-19 vaccine should not receive that vaccine (except with expert advice), but those with any other allergies (such as a food allergy) – including those with prior anaphylaxis – can have the vaccine.

The Pfizer BioNTech and Moderna mRNA vaccines contain polyethylene glycol (PEG). PEGs (also known as macrogols) are a group of known allergens commonly found in medicines, many household products and cosmetics. Medicines containing PEG include some tablets, laxatives, depot steroid injections, and some bowel preparations used for colonoscopy. Known allergy to PEG is rare. Evidence now shows that PEG allergy is implicated in only a minority of allergic reactions reported after COVID-19 vaccines.

The rate of anaphylaxis reported to date after the AstraZeneca vaccine is in line with the expected rate of anaphylaxis to non-COVID vaccines. The AstraZeneca and Novavax vaccines do not contain PEG but do contain a related compound called polysorbate 80. Rarely, people with PEG allergy may also be allergic to polysorbate 80. However, polysorbate 80 is widely used in medicines and foods, and is present in many medicines including monoclonal antibody preparations. Some injected influenza vaccines (including the main vaccine used in over 65 year olds) contain polysorbate 80. Individuals who have tolerated injections that contain polysorbate 80 (including the adjuvanted influenza vaccine, Fludax[®] and the GlaxoSmithKline vaccine Fluarix[®]) are likely to tolerate the AstraZeneca and Novavax vaccines. Advice on the management of patients with allergy is summarised in table 5.

Following COVID-19 vaccine administration, individuals should be observed for any immediate reactions whilst they are receiving any verbal post vaccination information and exiting the centre. Facilities for management of anaphylaxis should be available at all vaccination sites (see chapter 8). Advice has also been issued by the Resuscitation Council.¹

There is no routine requirement for observation following COVID-19 Vaccine AstraZeneca. According to the Summaries of Product Characteristics, it is recommended that all recipients of the Pfizer BioNTech, Moderna and Novavax vaccines are kept for observation and monitored for a minimum of 15 minutes. In recognition of the need to accelerate delivery of the programme in response to the emergence of the Omicron variant, the UK Chief Medical Officers recommended suspension of this requirement for the two mRNA vaccines (Pfizer BioNTech and Moderna) in both children and adults. The suspension of the observation period in individuals without a history of allergy has since been agreed by the Commission on Human Medicines and also applies to the Moderna and Pfizer BioNTech bivalent vaccines.²

The MHRA will continue to closely monitor anaphylaxis post-COVID-19 vaccination; reporting of adverse events via the Yellow Card Scheme is strongly encouraged (www.mhra.gov.uk/yellowcard).

Vaccinated individuals should be informed about how to access immediate healthcare advice in the event of displaying any symptoms. In some settings, for example domiciliary vaccination, this may require a responsible adult to be present for at least 15 minutes after vaccination. Patients with a personal history of allergy should be managed as in table 5. No specific management is required for patients with a family history of allergies.

As fainting can occur following vaccination, all those vaccinated with any of the COVID-19 vaccines should not drive for 15 minutes after vaccination.

1 www.resus.org.uk/about-us/news-and-events/rcuk-publishes-anaphylaxis-guidance-vaccination-settings

2 <https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-adverse-reactions/coronavirus-vaccine-summary-of-yellow-card-reporting>

Table 5: Management of patients with a history of allergy

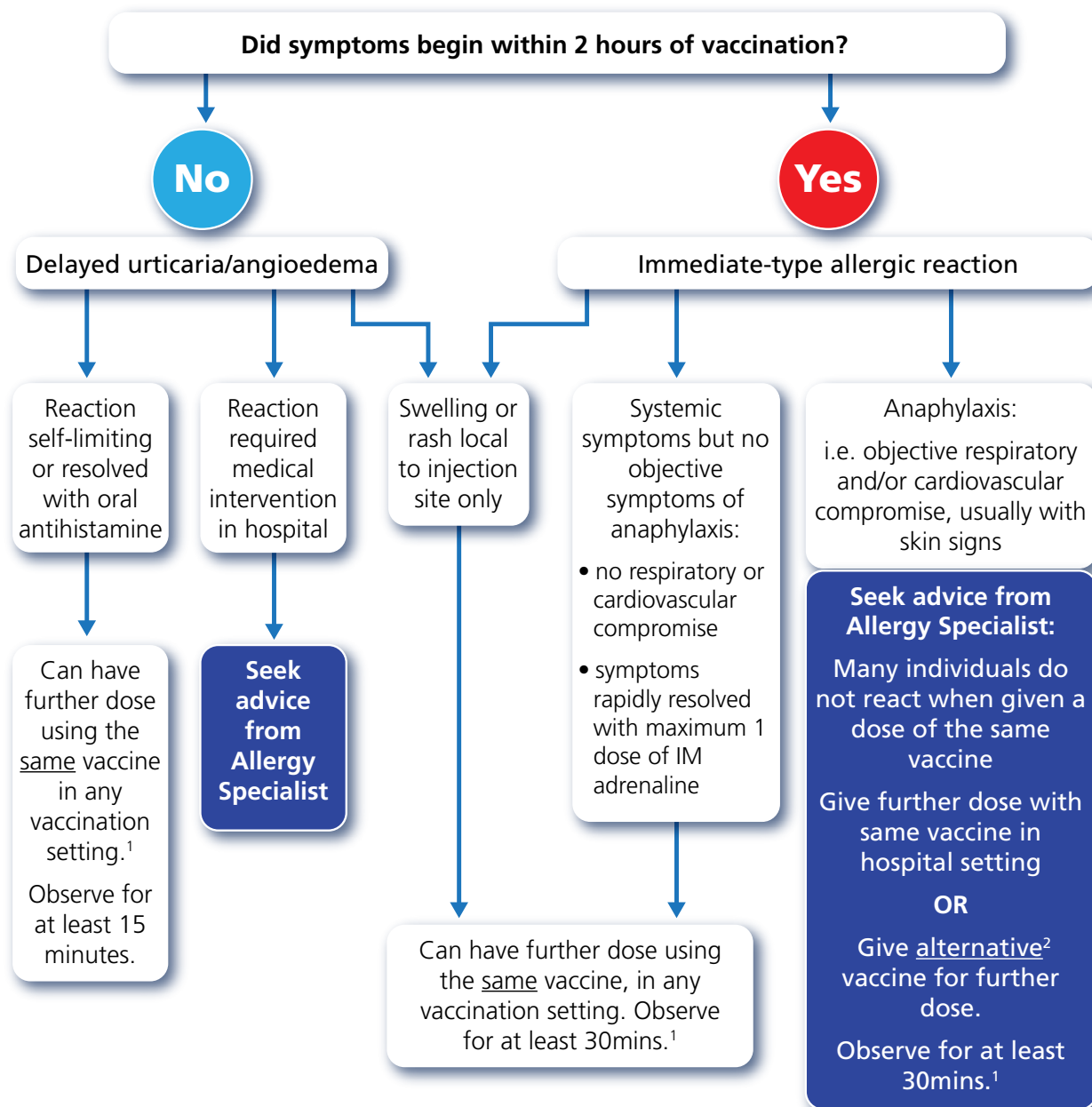
	Proceed with vaccination (no special precautions)	Special precautions	Vaccination contra-indicated
PATIENT CHARACTERISTICS	<ul style="list-style-type: none"> ● previous allergic reaction (including anaphylaxis) to a food, insect sting and most medicines (where trigger has been identified) ● previous non-systemic reaction to a vaccine ● hypersensitivity to non-steroidal anti-inflammatory drugs e.g. aspirin, ibuprofen ● mastocytosis 	<ul style="list-style-type: none"> ● prior non-anaphylaxis allergic reaction to COVID-19 vaccine ● history of immediate anaphylaxis to multiple, different drug classes, with the trigger unidentified (this may indicate PEG allergy) ● history of anaphylaxis to a vaccine, injected antibody preparation or a medicine likely to contain PEG (e.g. depot steroid injection, laxative) ● history of idiopathic anaphylaxis 	<ul style="list-style-type: none"> ● prior anaphylaxis reaction to COVID-19 vaccine ● prior systemic allergic reaction to a component of the vaccine <p>(for known PEG allergy see text above)</p>
ACTIONS	<ul style="list-style-type: none"> ● proceed with vaccination in any setting ● some individuals may be reassured by being observed for 15 minutes (may not be required if previously tolerated the same vaccine) ● some patients (e.g. those with mastocytosis) may benefit from pretreatment with anti-histamine to reduce allergic symptoms 	<ul style="list-style-type: none"> ● consider possibility of PEG allergy and seek allergy advice if needed ● a person has previously tolerated a dose of the same vaccine, it is safe to administer in any setting. <p>Otherwise</p> <ul style="list-style-type: none"> - consider giving vaccine and observe for 30 minutes 	<ul style="list-style-type: none"> ● refer to allergist or other appropriate specialist ● consider administration of the implicated mRNA vaccine under medical supervision in hospital, or, where reaction was to AstraZeneca or Novavax vaccines give alternative vaccine in any setting ● consider observation for 30 minutes

Patients with undiagnosed PEG allergy often have a history of immediate onset-unexplained anaphylaxis or anaphylaxis to multiple classes of drugs. Such individuals should not be vaccinated with the Pfizer BioNTech or Moderna vaccines, except on the expert advice of an allergy specialist or where at least one dose of the same vaccine had been tolerated previously. A non-mRNA vaccine (such as AstraZeneca or Novavax) can be used as an alternative (unless otherwise contraindicated), particularly if they previously tolerated the adjuvanted influenza vaccine. The vaccine should be administered in a setting with full resuscitation facilities (e.g. a hospital), and a 30 minute observation period is recommended. Advice for children with cancer who may be receiving PEG containing drugs is available at <https://www.cclg.org.uk/Coronavirus-advice>.

The British Society for Allergy and Clinical Immunology (BSACI) has advised that individuals who have a reaction to the first dose of a COVID-19 vaccine may be able to receive a second dose of vaccine, as in the flowchart below. Many individuals have tolerated subsequent doses of the same vaccine, and this is preferred as it avoids an individual being wrongly labelled as allergic for life.

Individuals with non-allergic reactions (vasovagal episodes, non-urticarial skin reaction or non-specific symptoms) to the first dose of a COVID-19 vaccine can receive the second dose of vaccine in any vaccination setting. Observation for 15 minutes is recommended.

Flowchart for managing patients who have allergic reactions to a previous dose of COVID-19 vaccine



1 Consider pre-treatment with non-sedating antihistamine, at least 30mins prior to vaccination.

2 If reaction was to AstraZeneca or Novavax vaccine, complete or boost with an mRNA vaccine. If reaction was to an mRNA vaccine, give any mRNA vaccine or Novavax vaccine in a hospital setting.

Thrombosis and thrombocytopenia syndrome (TTS) occurring after COVID-19 vaccination

A recently recognised condition involving serious thromboembolic events accompanied by thrombocytopenia, has been reported after AstraZeneca vaccination.

There is no evidence of any underlying risk factors in the individuals affected by this condition who have mainly been previously healthy. The condition is rare, tends to present with unusual forms of clotting and the mechanism is believed to be an idiosyncratic reaction related to an immune response to the AstraZeneca vaccine. This may be related to the

recipient's polymorphisms in genes encoding Fc receptors in the immune system and is an area of active research. Because of this likely immune mechanism, there is no reason to believe that individuals with a past history of clots or of certain thrombophilic conditions would be at increased risk of this very rare condition. Similarly, although pregnancy increases the risk of clotting conditions, there is no evidence that pregnant women, those in the post-partum or women on the contraceptive pill are at higher risk of the specific condition of thrombosis in combination with thrombocytopenia after the AstraZeneca vaccine. There have been no confirmed cases reported in pregnant women to date. Caution should be used, however, when vaccinating individuals who have a history of a previous episode of heparin induced thrombocytopenia and thrombosis (HITT or HIT type 2).

Individuals who experience a clotting episode with concomitant thrombocytopenia following the first dose of AstraZeneca vaccine should be properly assessed. If they are considered to have the reported condition, further vaccination should be deferred until their clotting has completely stabilised. A number of patients with confirmed TTS (n=23) in the UK have now tolerated a second dose of Pfizer BioNTech, with a smaller number having tolerated Moderna (n=2) or AstraZeneca (n=1) vaccines (Lacy J *et al*, 2021). A recent study documented decline in anti-PF4 antibody by 12 weeks following the first dose of vaccine; follow up of 5 patients with confirmed TTS who received Pfizer BioNTech for the second dose at an minimum interval of 10 weeks had no further episodes (Schönborn *et al*, 2021). Current evidence would therefore support a decision to complete the primary course or boost patients with a history of TTS with an mRNA vaccine, provided at least 12 weeks has elapsed from the implicated dose.

Individuals who have received the first dose of AstraZeneca vaccine without developing this rare condition are advised to receive the second dose of the same vaccine at the currently recommended interval. To date, there is no signal of an increased risk of this condition after the second dose and the rate of other reactions is lower at the second dose than after the first dose of this vaccine. Using an alternative product for the second dose is more likely to lead to common side effects.

Based on current evidence JCVI is advising a preference for an alternative vaccine for healthy people under 40 years of age, including health and social care workers, unpaid carers and household contacts of immunosuppressed individuals.

Individuals with past clotting episodes and those diagnosed with thrombophilia, whether or not they are on long term anti-coagulation, remain at risk of COVID-19 disease. There is no evidence that those with a prior history of thrombosis or known risk factors for thrombosis are more at risk of developing this immune-mediated condition of thrombosis in combination with thrombocytopenia after the AstraZeneca vaccine. For most of these individuals, the risk of recurrent thrombosis due to COVID-19 infection, remains far greater than the risk of this syndrome. Therefore individuals aged 40 years and over with such a history should be vaccinated with any of the available vaccines (provided they are not otherwise contra-indicated). The same consideration applies to those who experience common clotting episodes after the first dose of AstraZeneca vaccine but without concomitant thrombocytopenia.

Other rare conditions

Myocarditis and pericarditis

Cases of myocarditis and pericarditis have been reported rarely after COVID-19 vaccination. If an individual develops myocarditis or pericarditis following the first COVID-19 vaccination

they should be assessed by an appropriate clinician to determine whether it is likely to be vaccine related <https://www.gov.uk/government/publications/myocarditis-and-pericarditis-after-covid-19-vaccination/myocarditis-and-pericarditis-after-covid-19-vaccination-guidance-for-healthcare-professionals>. As the mechanism of action and risk of recurrence of myocarditis and pericarditis are being investigated, the current advice is that an individual's second or subsequent doses should be deferred pending further investigation and careful consideration of the risks and benefits. For those that experience myocarditis or pericarditis within two weeks of the first dose of an mRNA vaccine, testing for N antibody may indicate prior exposure to COVID-19. These individuals are likely to be well protected and therefore the benefit from a second or subsequent dose is likely to be more limited. Where N antibody is negative or in other circumstances where a further dose is considered necessary, for example in those higher risk of the complications of COVID-19 infection. A second or booster dose of Pfizer BioNTech vaccine should be considered once the patient has fully recovered. Emerging evidence suggests that an interval of at least 12 weeks should be observed from the previous dose. Pfizer BioNTech is preferred over Moderna due to a slightly higher rate of myocarditis reported after the latter vaccine; AstraZeneca should not be offered to those who have previously received an mRNA vaccine given the more serious nature of thrombosis and thrombocytopenia syndrome. As cases of myocarditis and pericarditis have been reported after Novavax vaccine and there is less overall safety experience, this vaccine should only be used with caution in those who have had myocarditis after a previous dose of an mRNA vaccine.

Guillain-Barré syndrome

Very rare reports have been received of GBS following COVID-19 vaccination, so healthcare professionals should be alert to the signs and symptoms of GBS to ensure correct diagnosis and to rule out other causes, in order to initiate adequate supportive care and treatment.

Individuals who have a history of GBS should be vaccinated as recommended for their age and underlying risk status. Cases of GBS reported following vaccination may occur by chance (the background rate of GBS is 2 per 100,000 per year in the population) and no causal mechanism with COVID-19 vaccination has been proven. There is evidence to suggest that having had a prior diagnosis of GBS does not predispose an individual to further episodes of GBS when immunised with other vaccines (Baxter *et al*, 2012) and for the Pfizer BioNTech COVID-19 vaccine (Ben David *et al*, 2021). In those who are diagnosed with GBS after the first dose of vaccine, the balance of risk benefit is in favour of completing a full COVID-19 vaccination schedule. On a precautionary basis, however, where GBS occurs within six weeks of an Astra Zeneca vaccine, for any future doses Pfizer or Moderna COVID-19 vaccines are preferred. Where GBS occurs following either of the mRNA vaccines, further vaccination can proceed as normal, once recovered.

Thrombocytopenia

Cases of thrombocytopenia (without accompanying thrombosis) have been reported rarely in the first four weeks after receiving AstraZeneca vaccination. Some of these cases have occurred in individuals with a history of immune thrombocytopenia (ITP). Previous ITP is not a contra-indication for vaccination but platelet monitoring is advised for patients with a history of ITP who receive AstraZeneca vaccine. Although evidence suggests a raised risk ITP after the AstraZeneca vaccine (Simpson *et al*, 2021), ITP has also been reported with other COVID-19 vaccines (Lee *et al*, 2021). Guidance produced by the UK ITP Forum Working Party therefore advises discussing the potential for a fall in platelet count in patients with a history of ITP receiving any COVID-19 vaccine and recommends a platelet

count check 2-5 days after vaccination (<https://b-s-h.org.uk/about-us/news/covid-19-updates/>). Individuals who experience ITP in the four weeks after the first dose of AstraZeneca vaccine should be assessed by a haematologist and the risk benefit of further vaccination and with which product should be considered on an individual basis. If receiving further vaccination, the platelet count should be monitored.

Capillary leak syndrome

Extremely rare reports of capillary leak syndrome have been reported after AstraZeneca and Moderna vaccines in individuals with a prior history of this condition. Individuals with a history of capillary leak syndrome, should be carefully counselled about the risks and benefits of vaccination and advice from a specialist should be sought.

Reporting anaphylaxis and other allergic reactions

Anaphylaxis is a very rare, recognised side effect of most vaccines and suspected cases should be reported via the Yellow Card Scheme (www.mhra.gov.uk/yellowcard). Chapter 8 of the Green Book gives detailed guidance on distinguishing between faints, panic attacks and the signs and symptoms of anaphylaxis. If a case of suspected anaphylaxis meets the clinical features described in Chapter 8, this should be reported via the Yellow Card Scheme as a case of 'anaphylaxis'. Cases of less severe allergic reactions (i.e. not including the clinical features of anaphylaxis) should not be reported as anaphylaxis but as 'allergic reaction'.

As these vaccines are labelled with a black triangle, all adverse reactions occurring in individuals of any age after vaccination should be reported to the MHRA using the Yellow Card Scheme. Anyone can report a suspected adverse reaction to the Medical and Healthcare products Regulatory Agency (MHRA) using the Yellow Card reporting scheme (www.mhra.gov.uk/yellowcard). Any adverse reaction should also be documented in accordance with local procedures.

Management of suspected cases and contacts

There is currently limited evidence to support the use of COVID-19 vaccines as post-exposure prophylaxis or to interrupt transmission during outbreaks. The use of vaccine to provide direct protection to vulnerable individuals in prolonged community outbreaks should be discussed with the local health protection teams.

Current recommendations for testing and contact tracing and guidance on infection control is regularly updated and can be found in the following links:

<https://www.gov.uk/coronavirus>

<https://www.gov.scot/collections/coronavirus-covid-19-guidance/>

<https://www.hps.scot.nhs.uk/a-to-z-of-topics/covid-19/>

<https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/>

<https://www.publichealth.hscni.net/covid-19-coronavirus/guidance-hsc-staff-healthcare-workers-and-care-providers>

Additional resources

Supplies

COVID-19 vaccines for those authorised by the NHS to deliver the programme will be made available for ordering on the ImmForm website <https://portal.immform.phe.gov.uk/> telephone 0207 183 8580 or through the Foundry ordering platform in England.

Arrangements in Scotland, Wales and Northern Ireland may be different, please contact Public Health Agencies in each respective administration for local details.

Key links

The full specification for those diagnoses, and associated clinical codes, eligible for COVID-19 vaccination has been developed and is available on the PRIMIS website <https://www.nottingham.ac.uk/primis/covid-19/covid-19.aspx>. Access to the link is available to NHS professionals and requires online registration.

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