NHS England

# COVID-19 and flu vaccinations for Inclusion Health Populations in London for 2023-2024

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## Aim:

This paper outlines the evidence and highlights the importance of concerted efforts around COVID-19 and flu vaccination to target people who are socially excluded (also referred to as 'inclusion health groups'). It builds on a previous guidance by JCVI on the impact of COVID-19 vaccines prioritisation on health inequalities: *'social exclusion is associated with the poorest health outcomes, putting those affected beyond the extreme end of the gradient of health inequalities.'* Social exclusion is the basis for the concept of 'inclusion heath', which typically encompasses populations such as people experiencing homelessness, Gypsy, Roma, and Traveller communities, vulnerable migrants and sex workers.

This winter we are facing both COVID-19 and flu with increased risk of morbidity, mortality and hospitalisation. Flu and COVID Vaccinations offer an important public health intervention which reduce reduce the risk of serious illness and relieving some of the NHS resources during winter. Although these two diseases are caused by different viruses, they are spread from person-to-person in similar ways. COVID-19 and flu cause more harm to people who already experience poor health and who are more vulnerable because of wider social factors including poverty and poor living or working conditions. Those experiencing homelessness have a higher prevalence of chronic diseases, and a higher mortality rate from respiratory infections. This is further aggravated by living in congregate and communal settings which enhance viral transmission.

Vaccines are available for COVID-19 and flu, and these offer good protection from serious illness and death. In order to deliver the vaccine efficiently within existing resources, this means offering the vaccine universally to health inclusion groups. Some of the asylum seekers have been accommodated in hotels, which would enable vaccine delivery effectively.

## Guidelines on COVID-19 Vaccination Programme

**The SAGE report on 5th July 2021:**

'High levels of transmission of COVID-19 can occur in institutional settings including hospitals, care homes, prisons, and homeless shelters with infection seeded back into the community'.

Therefore, appropriate controls will need to be maintained and/or enhanced in these settings. These factors are also likely to contribute to a greater risk of being exposed to flu and a greater risk of becoming severely unwell or dying.

**JCVI statement on the COVID-19 vaccination programme for autumn 2023, 26 May 2023[1]**

**(https://www.gov.uk/government/publications/covid-19-autumn-2023-vaccination-programme-jcvi-advice-26-may-2023/jcvi-statement-on-the-covid-19-vaccination-programme-for-autumn-2023-26-may-2023)**

*The UK COVID-19 vaccination programme is entering its third autumn season in 2023. The primary aim of the programme remains the prevention of severe illness (hospitalisations and*

*deaths) arising from COVID-19. During the current phase of pandemic recovery, and while the virus continues to circulate and cause illness, the objective is to continue to focus the offer of vaccination on those at greatest risk of serious disease and who are therefore most likely to benefit from vaccination. For autumn 2023, JCVI has begun to include cost effectiveness considerations in the development of its advice.*

*JCVI advises that for the 2023 autumn booster programme, the following groups should be offered a COVID-19 vaccine:*

- *residents in a care home for older adults*
- *all adults aged 65 years and over*
- ***persons aged 6 months to 64 years in a clinical risk group,** as defined in tables 3 and 4 of the COVID-19 chapter of the Green book* [2]
- ***frontline health and social care workers***
- *persons aged 12 to 64 years who are household contacts, as defined in the Green book, of people with immunosuppression*
- *persons aged 16 to 64 years who are carers, as defined in the Green book, and staff working in care homes for older adults*

***Green book: Clinical Risk Groups***

| 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. |
| Immunosuppression | 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).<br>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.<br>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.<br>Anyone with a history of haematological malignancy, including leukaemia, lymphoma, and myeloma.<br>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. |

*The COVID-19 clinical risk groups as defined in the Green book are recognised to be highly heterogenous, with absolute risks of serious disease varying substantially both within and between clinical risk groups. The relative importance of clinical risk groups in the development of severe COVID-19 may also be changing as population immunity changes. However, further discrimination or stratification of risk at this time would increase the complexity of the programme and would likely impact negatively on vaccine uptake. Therefore, for autumn 2023 it is considered appropriate to offer vaccination to all people in a clinical risk group aged 6 months and over. This includes those who are pregnant, regardless of their stage of pregnancy.*

## Health and social care staff

### JCVI states

*While vaccines are still only available through nationally funded mass vaccination programmes, JCVI considers it is appropriate to continue the offer of vaccination in HSCWs for autumn 2023. When COVID-19 vaccines become available outside of nationally funded programmes, any decision on whether to continue to offer vaccination to HSCWs would be expected to become a policy decision for DHSC and/or individual employers.*

## Guidelines on the flu immunisation programme

JCVI guidance recommends:

- Adults aged 65 years and over
- At risk adults (including pregnant women) aged less than 65 years of age

The national flu immunisation programme 2023-2024[3]
https://www.gov.uk/government/publications/national-flu-immunisation-programme-plan/national-flu-immunisation-programme-2023-to-2024-letter)

The below groups will be eligible for a flu vaccine from 1 September 2023:

- those aged 65 years and over
- those aged 6 months to under 65 years in clinical risk groups (as defined by the Green Book, chapter 19 (Influenza))[4]
- pregnant women
- all children aged 2 or 3 years on 31 August 2023
- primary school aged children (from Reception to Year 6)
- those in long-stay residential care homes
- carers in receipt of carer's allowance, or those who are the main carer of an elderly or disabled person
- close contacts of immunocompromised individuals
- frontline workers in a social care setting without an employer led occupational health scheme including those working for a registered residential care or nursing home, registered domiciliary care providers, voluntary managed hospice providers and those that are employed by those who receive direct payments (personal budgets) or Personal Health budgets, such as Personal Assistants

*The list above is not exhaustive, and the medical practitioner should apply clinical judgment to take into account the risk of influenza exacerbating any underlying disease that a patient may have, as well as the risk of serious illness from influenza itself. Influenza vaccine should be offered in such cases even if the individual is not in the clinical risk groups specified above*

Green book: clinically at risk groups who should receive the influenza vaccine

| Clinical risk category | Examples (this list is not exhaustive and decisions should be based on clinical judgement) |
|---|---|
| Chronic respiratory disease | Asthma that requires continuous or repeated use of inhaled or systemic steroids or with previous exacerbations requiring hospital admission.<br>Chronic obstructive pulmonary disease (COPD) including chronic bronchitis and emphysema; bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD).<br>Children who have previously been admitted to hospital for lower respiratory tract disease.<br>See precautions section on LAIV. |
| 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 (included in the DES directions for Wales) | Stroke, transient ischaemic attack (TIA). Conditions in which respiratory function may be compromised due to neurological or neuromuscular disease (for example polio syndrome sufferers). Clinicians should offer immunisation, based on individual assessment, to clinically vulnerable individuals including those with cerebral palsy, severe or profound and multiple learning disabilities (PMLD), Down's syndrome, multiple sclerosis, 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 and adrenal insufficiency | Type 1 diabetes, type 2 diabetes requiring insulin or oral hypoglycaemic drugs, diet-controlled diabetes. Addison's disease, secondary or tertiary adrenal insufficiency requiring steroid replacement. |
| Immunosuppression (see contraindications and precautions section on live attenuated influenza vaccine) | 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, people living with HIV (at all stages), multiple myeloma or genetic disorders affecting the immune system (for example IRAK-4, NEMO, complement disorder, SCID). Individuals who are receiving immunosuppressive or immunomodulating<br>biological therapy including, but not limited to, anti-TNF- alemtuzumab,<br>ofatumumab, rituximab, patients receiving protein kinase inhibitors or<br>PARP inhibitors, and individuals treated with steroid sparing agents such as<br>cyclophosphamide and mycophenolate mofetil.<br>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 (any age), or for children under 20kg, a dose of 1mg or more per kg per day.<br>Anyone with a history of haematological malignancy, including leukaemia, lymphoma, and myeloma and those with systemic lupus erythematosus and rheumatoid arthritis, and psoriasis who may require long term immunosuppressive treatments.<br>Some immunocompromised patients may have a suboptimal immunological response to the vaccine. |





| Clinical risk category | Examples (this list is not exhaustive and decisions should be based on clinical judgement) |
|---|---|
| Asplenia or dysfunction of the spleen | This also includes conditions such as homozygous sickle cell disease, hereditary spherocytosis, thalassemia major and coeliac syndrome that may lead to splenic dysfunction. |
| Pregnant women | Pregnant women at any stage of pregnancy (first, second or third trimesters). See precautions section on live attenuated influenza vaccine. |
| Morbid obesity (class III obesity)* | Adults with a Body Mass Index ≥40 kg/m². |

* Many of this patient group will already be eligible due to complications of obesity that place them in

**London Offer**

**To maximise efficiency of the vaccination programme and to mitigate risk of morbidity, mortality and hospitalisation, London will continue to offer COVID and flu vaccinations to health inclusion populations and front line social care workers with the aim of saving lives and addressing health inequalities.**

## Definitions of Inclusion health groups

Inclusion health is a term used to describe people who are socially excluded and experience multiple risk factors for poor health such as poverty, violence and complex trauma. This can include people who experience homelessness, drug and alcohol dependence, Gypsy, Roma and Traveller communities, sex workers, victims of modern slavery, refugees, asylum-seekers and undocumented migrants.

## Clinical vulnerability and health inequalities

- Inclusion health groups have some of the worst health inequalities.[5, 6] The average age of death for those experiencing homelessness is 45 years and those from GRT communities die 10-25 younger than the general population. [7,8]

- People experiencing homelessness experience tri-morbidity: increased levels of physical and mental ill-health and increased risk of substance misuse. They are more likely die at a significantly younger age than the general population. Therefore, those experiencing homelessness may be 'clinically at risk' groups or can be identified as 'extremely clinically vulnerable'. They are at high risk of becoming seriously unwell or dying from COVID-19 or flu. [9,10]

- Those experiencing homelessness have a higher prevalence of chronic diseases, and a higher mortality rate from respiratory infections. This is further aggravated by living in congregate and communal settings which enhance viral transmission.

- GRT communities are significantly more likely to have a long-term condition making them 'clinically vulnerable' to COVID-19 or flu including chronic bronchitis and asthma.[11]

- Many refugees, asylum seekers and undocumented migrants are from Black, Asian or minority ethnic (BAME) groups who are at greater risk of severe illness and death from COVID-19. They are more likely to have poorly managed ongoing health problems that increase their risk of serious illness or death from COVID-19. They also often live in shared accommodation with increased risk of transmission of COVID-19 and flu.[12]

- Higher levels of ongoing health problems among sex workers increases their risk of severe illness or death from COVID-19 or flu. Many sex workers are forced to continue engaging in sex work and expose themselves to the risk of infection in order to earn money to buy food or pay rent

- Health inclusion groups face barriers to health services and social care. They may not be registered with a GP or have any information recorded about their health problems.

## Unequal risk in inclusion health groups

Inclusion health groups are especially at high risk of exposure due to:

- being in congregate settings or living on the streets putting them at risk of infection
- poor symptom recognition
- difficulties with isolation
- challenges with vaccination uptake

## Barriers to vaccination

Despite being more vulnerable to COVID-19 and flu, people from inclusion health groups face many challenges accessing the COVID-19 and flu vaccines:

- They may be wrongly refused GP registration if they are unable to provide ID or proof of address
- The subsequent lack of GP records or other documentation of their risk factors for disease means they are not identified as 'at risk' and eligible for vaccination
- They may not receive vaccine invitations due to frequent moving or a lack of address
- They may be unable to read and understand the vaccine invitation or use the booking system because of a lack of language, literacy or digital skills
- They may face transport barriers and be unable to get to vaccination sites
- They may be uncertain about whether the vaccine is free and have concerns about whether attending for vaccination will have consequences for immigration control activities
- There may be ongoing distrust in vaccines and organisations and the people responsible for their delivery which is often rooted in historic injustice experienced by socially excluded groups

NHS England has identified that people in inclusion health groups "*are at increased risk of severe disease and higher mortality and should be considered a priority for vaccination*" against COVID-19.

The Joint Committee for Vaccination and Immunisation (JCVI) guidance recognises the need to consider the complex interplay of health and social risk factors for serious illness from COVID-19 and flu when prioritising patients for vaccination. The risk of developing severe COVID-19 continues to be strongly associated with increasing age and underlying health conditions.

The Green Book, whose chapters reflect the current policies and procedures for vaccination, gives the person prescribing flu or COVID-19 vaccines flexibility in determining eligibility, stating that the prescriber should apply clinical judgment to take into account the risk of COVID-19 or flu worsening any underlying disease that a patient *may* have, as well as the risk of serious illness from COVID-19 or flu.

Vaccination can be offered to people without an NHS number, and those who are not registered with a GP should not be turned away when trying to access vaccination.

## Recommended approaches to vaccination delivery

We have made good progress in London in vaccinating our most vulnerable communities, and these efforts need to be maintained to protect the most vulnerable in society.

Outreach delivery models: Tailored outreach vaccination approaches allow healthcare teams to deliver vaccinations in locations that feel safe and welcoming and can be more easily accessed by inclusion health groups. This may include delivering services from hostels, hotels or accommodation centres housing people experiencing homelessness or asylum seekers; curbside from outreach vans to reach rough sleepers and street sex workers; on Traveller sites or from community locations frequented by people from in inclusion health groups. A combination of local delivery models is recommended. Additional support can be sought from the specialist pan-London Find and Treat team based at UCLH.

Partnership working: It is important to work in partnership with ICS, rough sleeping and homelessness leads, LA, the voluntary sector, NHS and clinical providers to deliver the vaccine effectively. Peer advocacy has been shown to build trust in supporting health inclusion groups in receiving flu and COVID vaccinations in a timely manner, thereby protecting the health of inclusion groups.

Peer advocacy: peer advocates support sharing of information and building trust to encourage vaccination uptake. Include appropriate support from Groundswell Peer Advocates, SWARM, GRT and migrant community link workers.

Preparation and planning: good planning is required and multiple visits to allow information exchange and building trust between heath inclusion groups and clinical staff.

Holistic offer: vaccine uptake is enhanced if the offer includes facilitation to other health services such as a health check, GP registration etc.

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