Access to vaccination for displaced population groups

Colleagues have raised questions about opportunistic vaccination of our SW homeless and migrant communities following the end of the evergreen campaign. Supporting access to vaccination in population groups with unmet health needs.

SW C19 clinical steering group supporting statement:

As part of the access and inequalities outreach work, we encourage teams to continue to work with local partners to support vaccination of clinically vulnerable individuals within displaced population groups and across difficult to reach communities.

Clinically, we know homelessness is a marker for poorer health outcomes and opportunities to explore wider care needs of this group of patients should be available to those accessing our SW vaccination sites. Our migrant communities may also have poorer associated health outcomes and should be supported with access to vaccination and health services.

Clinical assessment of both these patient groups should consider the JCVI recommendations as per chapter 14a of the Green Book. All eligibility groups are listed in the inclusion criteria of the National Protocol / Patient Group Direction (NP/PGD). Displaced population groups are not specific cohorts within the legal mechanisms, only individuals which fit the JCVI eligibility can be vaccinated using the NP/PGD. Clinical judgement and interpretation of the eligibility criteria should also be considered. For example, a homeless individual / migrant living in close contact to someone with immunosuppression would be eligible for vaccination.

In cases where an individual is considered higher risk of more severe infection with COVID-19 due to identified unmet health needs clinical teams working under the PGD/NP may not be able to confirm a clinical indication for vaccination against the eligibility criteria. Clinical assessment on an individual basis in these cases would need to be supported through a prescriber led service. Vaccination using a patient specific direction (PSD), or prescription could be supported at clinical discretion. Appropriate access to services in these cases could subsequently support MECC opportunities to address any wider health needs of the individual.

UKHSA supporting information following the end of the evergreen programme (30th June):

The JCVI evaluate all the evidence that then informs the recommendations they make to DHSC as to who should be vaccinated, and they also consider the value to be gained from continuing the offer of COVID-19 vaccine to all.

Following the end of the parallel evergreen programme on the 30th June 2023 the JCVI recommendation was to concentrate vaccination efforts on the groups at highest risk and this came after a long period when everyone over 18 years could have COVID vaccination and teams could focus on provision of vaccine to individuals with unmet health needs.

Please see the JCVI November 2022 statement 'considerations' section which discusses ending the evergreen offer:

Since April 2022, uptake of the initial booster dose of COVID-19 vaccine has been less than 0.1% per week in all eligible people under 50 years of age. Based on the current data,

keeping the booster (third dose) offer open to these groups is considered of limited ongoing value and the overall impact on vaccine coverage is negligible.

The offers of primary course vaccination have been widely available since 2021. Uptake of these vaccine offers have plateaued in recent months across all age groups. Since the beginning of 2022, less than 0.01% of eligible individuals per week over the age of 12 years, received a first COVID-19 vaccine dose. A more targeted offer of primary course vaccination during vaccination campaign periods will enable these efforts to be more focused and allow more efficient use of NHS resources.

Although the COVID-19 vaccination programme has been very successful overall, there are some socioeconomic and ethnic groups where vaccine coverage remains lower. Addressing health inequalities is a long-term effort that is relevant to all UK immunisation programmes. Building trust, and specifically vaccine confidence, requires steady determined investments of time, resources and persons. Appropriate and adequate communication should be provided in advance of changes to the primary course vaccination offer to optimise uptake among those who are eligible but have yet to accept the offer of vaccination.

Some worked practical examples:

Scenario 1:

A homeless patient attending a substance misuse service regularly for supervised consumption of methadone requesting vaccination in a community pharmacy?

Clinical assessment should review whether vaccination can be supported using the JCVI eligibility criteria. Social history should also be explored to see if the individual could be vaccinated as a carer/close contact aligning the eligibility criteria using clinical judgement.

An individual in this group with a higher risk of more severe infection from COVID 19 and poorer health outcomes should be assessed for potential unmet health needs. If the patient doesn't have a confirmed clinical history to support indication for vaccination against the JCVI eligibility criteria using the national legal mechanisms (PGD/NP), then vaccination needs to be supported by a prescriber led model.

Scenario 2:

A migrant patient living in asylum seeker accommodation with other clinically vulnerable individuals?

Firstly, clinical assessment should review whether vaccination can be supported using the JCVI eligibility criteria. Secondly, consider if social history supports vaccination in specific social housing settings. Consider, for example, if the individual could be vaccinated as a carer/close contact. The Green Book Covid-19 chapter 14a, defines household contacts as individuals who **expect to share living accommodation on most days (and therefore continuing close contact is unavoidable**) **with people who are immunosuppressed** (immunosuppression definition as per tables 3 or 4).

An individual in this group with a higher risk of more severe infection from COVID 19 and poorer health outcomes should be assessed for potential unmet health needs. If the outreach team is working under the PGD the patient should be clinically assessed against the JCVI eligibility criteria to support vaccination. A prescriber led model as described above would need to be used in

circumstances where registered staff cannot identify a clinical indication which aligns to the eligibility criteria.

In outbreak management situations the health protection team (HPT) may also assess the setting to support vaccination. Local risk assessments and supporting recommendations made by HPT would require individual assessment on a case-by-case basis. Access to vaccination in this situation is outside of the national vaccination programme and would be supported using a PSD/prescription.