Dear Colleague

COVID-19BOOSTER VACCINATION PROGRAMME FOR AUTUMN 2022

ACTION REQUIRED

COVID-19 AUTUMN BOOSTER VACCINATION PROGRAMME 2022

Chief Executives must ensure this information is drawn to the attention of all staff involved in the COVID-19 vaccination programme.

The SPPG must ensure this information is cascaded to all General Practitioners, practice managers and community pharmacies for onward distribution to all staff involved in the COVID-19 vaccination programme.

The RQIA must ensure this information is cascaded to all Independent Sector Care Homes for onward distribution to all staff involved in the COVID-19 vaccination programme.

Frontline Health and Social Care Worker COVID-19 Vaccination Programme - including Independent Sector

Chief Executives should ensure all frontline staff are actively encouraged to receive the COVID-19 vaccine to help protect their families, themselves, their patients and the wider population.
The RQIA should actively encourage all Independent Sector Care Home staff to receive the COVID-19 vaccine when community pharmacy teams visit each Care Home.

Introduction

1. Over the last 2 years, through a combination of vaccine-induced immunity and immunity generated following natural infection (natural immunity), large proportions of the Northern Ireland population have developed at least partial immunity against COVID-19. As NI transitions from a period of pandemic emergency response to pandemic recovery, the focus will increasingly be on protecting those in society who continue to be more at risk of severe COVID-19. To achieve this, a planned and targeted booster vaccination programme in the autumn is considered more appropriate than a reactive vaccination strategy.

2. Although there are uncertainties regarding the size and timing of potential future waves of COVID-19, winter remains the season when the threat from COVID-19 is greatest. Over winter 2022 to 2023, it is anticipated that other winter respiratory viruses such as influenza virus and respiratory syncytial virus (RSV) will return and could co-circulate with SARS-CoV-2 (COVID-19). An overlap in waves of infection due to different respiratory viruses would pose increased risks to the health of individuals and to the health service.

3. We do not underestimate the challenges involved in delivering the COVID-19 autumn booster vaccination programme to tens of thousands of people over a short period of time, while achieving as high an uptake rate as possible. Where possible, it is recommended that for those eligible, co-administration of the COVID-19 and Influenza vaccinations should be encouraged and both vaccinations should be recorded promptly on the Vaccine Management System (VMS).

Eligibility

4. The primary objective of the 2022 COVID-19 autumn booster programme 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 to 2023. In order to optimise protection over the winter months, JCVI have advised that the autumn programme should be completed by early December 2022. All staff involved in the COVID-19 vaccination programme should familiarise themselves with the Chapter 14a of the Green Book - which can be viewed here – https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1098808/Greenbook-chapter-14A-17August2022.pdf
5. In their statement of 15 July, the Joint Committee on Vaccinations and Immunisations (JCVI) advised that for the 2022 autumn programme, the following groups should be offered a COVID-19 booster vaccine:

- residents in a care home and staff working in care homes,
- 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 the Green Book),
- persons aged 5 to 49 years who are household contacts of people with immunosuppression, and
- persons aged 16 to 49 years who are carers (as set out in the Green Book)


6. Following review of vaccine products which may be available for use in the autumn booster programme, in their updated statement of 15 August, JCVI advised the following principles for vaccine deployment:

I. Timeliness of vaccination is more important than the type of booster vaccine used. The key priority of the autumn programme should be for eligible individuals to be offered a booster vaccine dose to increase their immunity against severe COVID-19 (hospitalisation and death) ahead of winter 2022 to 2023, as described in the previous advice of 15 July 2022.

II. Simplicity is central to an efficient vaccination programme. Deployment of a single type of vaccine throughout the autumn booster programme promotes simplicity and is therefore desirable. If sufficient doses of mRNA bivalent Original ‘wild-type’/Omicron BA.1 vaccine become available to complete the autumn booster programme, JCVI considers that it is expedient to aim to offer authorised bivalent vaccines throughout the autumn programme, subject to operational considerations. Where substantial delays might be incurred in deploying a bivalent vaccine, the principle of timeliness should take priority and an alternative UK-approved booster vaccine offered, such as a monovalent Original ‘wild-type’ mRNA vaccine. Individuals offered vaccination should be advised that timely boosting is desirable to increase protection over the winter, and therefore to accept whichever booster vaccine is offered.

III. When there are constraints to vaccine supply or deployment, priority for vaccination should be given to those at higher individual clinical risk of severe COVID-19, such as those of older age.
IV. Vaccination of health and social care workers closer to the winter months would optimise the benefits to the HSC arising from vaccine-induced protection against Omicron symptomatic illness and transmission, as such protection is likely to be of relatively short duration. Operational flexibility is however appropriate in delivery of vaccines to health and social care workers.

V. The autumn booster vaccine dose should be offered at least 3 months after the previous dose. Operational flexibility may be applied to maximise timely delivery of the autumn programme and in consideration of individual circumstances.


7. Based on the current delivery schedules for bivalent vaccines, there is expected to be sufficient bivalent vaccines available between mid-September and early December 2022 to enable all eligible individuals aged 18 years and over to receive a bivalent vaccine. This will however mean that GPs, community pharmacies and Trusts will need to ensure they have sufficient bivalent vaccines available to match their planned vaccination clinics.

8. If supplies of the COVID-19 bivalent vaccines are constrained, GPs should offer vaccination to their patients aged 65 years and older and those in an ‘at risk’ group aged 18 to 64 years of age before those aged 50 to 64 years of age not in an at risk group. Community pharmacies should prioritise vaccination of care home residents and staff, then adults aged 65 years and over and frontline health and social care workers, followed by those aged 50 to 64 years and carers.

COVID-19 vaccines available in 2022/23

9. All of the available boosters provide good protection against severe illness from COVID-19. Timeliness of vaccination is more important than the type of booster vaccine used. The key priority of the autumn programme should be for eligible individuals to be offered a booster vaccine dose to increase their immunity against severe COVID-19 (hospitalisation and death) ahead of winter 2022 to 2023.

10. ‘Bivalent’ vaccines have been developed by global manufacturers since the emergence and dominance of the Omicron variant. These vaccines contain two different antigens (substances that induce an immune response) based on two different COVID-19 strains, or variants. The original mRNA vaccines contain one antigen (monovalent), based on the original ‘wild-type’ strain.
11. JCVI has reviewed data from studies undertaken by Pfizer-BioNTech and Moderna on bivalent Original ‘wild-type’/Omicron BA.1 mRNA vaccines, and from the COV-BOOST clinical trial. These studies indicate that neutralising antibody levels against Omicron after vaccination with a bivalent or monovalent-Omicron vaccine are marginally higher than after vaccination with a monovalent wild-type vaccine. Reactogenic events were similar to those observed in clinical studies of antecedent wild-type mRNA vaccines. There is no data on the clinical efficacy of these variant vaccines against currently circulating strains, or on their durability of protection.

12. On 15th August, JCVI published advice on which vaccines are available for use in this year’s autumn booster programme.

For adults aged 18 years and above:

- Moderna mRNA (Spikevax) bivalent Omicron BA.1/Original ‘wild-type’ vaccine;
- Moderna mRNA (Spikevax) Original ‘wild-type’ vaccine;
- Pfizer-BioNTech mRNA (Comirnaty) Original ‘wild-type’ vaccine; and
- in exceptional circumstances, the Novavax Matrix-M adjuvanted wild-type vaccine (Nuvaxovid) may be used when no alternative clinically suitable UK-approved COVID-19 vaccine is available. **It is intended to make this vaccine available via Trusts only and anyone requiring it should be referred to a Trust in the normal way.**

For people aged 12 to 17 years:

- Pfizer-BioNTech mRNA (Comirnaty) Original ‘wild-type’ vaccine.

For people aged 5 to 11 years:

- Pfizer-BioNTech mRNA (Comirnaty) Original ‘wild-type’ vaccine paediatric formulation.

13. JCVI will consider further bivalent vaccines for use in the programme if they are approved by the MHRA or EMA as applicable in Northern Ireland, and a further update will be provided in due course.

14. At this time the Moderna mRNA (Spikevax) bivalent Omicron BA.1/Original ‘wild-type’ vaccine is temporarily authorised for use in Northern Ireland under Regulation 174 of the Human Medicines Regulations 2012. If the European Medicines Agency (EMA) grants a marketing authorisation for the Spikevax bivalent Original/Omicron BA.1 booster vaccine it would apply in Northern Ireland and the Regulation 174 authorisation would no longer be in place. Supply of this product will be subject to the same requirements in Great Britain and Northern Ireland. Further information on the regulatory approval including Regulation 174 Information for Healthcare Professionals and Patient Information Leaflet is available at
In line with JCVI advice, sufficient doses of a mRNA bivalent Original ‘wild-type’/Omicron BA.1 vaccine should be available to complete the autumn booster programme although this will involve deliveries of the bivalent vaccine(s) into NI throughout the course of the programme. Therefore GPs, Community Pharmacies and Trusts should plan on the basis of using a mRNA bivalent Original ‘wild-type’/Omicron BA.1 vaccine for the vast majority of patients and only use the original wild type vaccine for those aged 18 years and over if there is a significant delay in bivalent vaccine supplies or in exceptional circumstances. Individuals offered vaccination should be advised that timely boosting is desirable to increase protection over the winter, and therefore to accept whichever booster vaccine is offered.

COVID-19 vaccines can be ordered from Movianto in the normal way. First deliveries of the Spikevax mRNA bivalent ‘wild type’/Omicron BA.1 vaccine have been received and initial deliveries will be prioritised for those community pharmacies vaccinating in care homes, followed by other providers in Trusts, GPs and other community pharmacies.

Rapid vaccine response measures may be required should there be substantial changes in population immunity against the dominant circulating variant, including any new variant of concern. The maintenance of sufficient surge capacity to enable a proportionate response to emergent circumstances is an integral component of the autumn booster programme.

Deployment plans

There will be an estimated 1.073m people eligible for the COVID-19 autumn booster vaccination, which will officially commence on 19th September, subject to vaccine supply. The programme will be implemented using a combination of GPs, community pharmacies and Trusts, with the majority of vaccinations expected to be administered by GPs and community pharmacies. It is essential that booster doses are recorded promptly on the Vaccine Management System to ensure patients do not receive multiple vaccinations from different providers.

GPs

GPs are being asked to invite for vaccination:

- all eligible patients aged 50 years or older (i.e. those born before 31 March 1973);
- patients aged 18-49 years in clinical at risk groups (see Annex 1) All secondary care staff involved in the patient care of these individuals should also actively encourage their patient at every contact to receive a COVID-19 booster vaccine; and
• issue a letter to their immunosuppressed patients advising their household contacts aged 18-49 years that they are eligible for vaccination.

20. GPs are also asked to identify their housebound patients and refer to Trust vaccination teams as soon as possible to enable Trusts to arrange their vaccination.

21. In addition GPs are asked to identify and inform their patients aged 5-17 years who are in a clinical at-risk group or are the household contacts of an immunosuppressed individual and advise them to receive their vaccination via a Trust led clinic. This is due to the fact that at present none of the licensed bivalent booster vaccines for those aged 5-11 or 12 to 17 years of age can be deployed at GP/community pharmacy level. This position might change if additional COVID-19 vaccines are approved.

22. Due to a limited supply of the Moderna mRNA (Spikevax) bivalent Omicron BA.1/Original ‘wild-type’ vaccine at the beginning of the programme GPs and community pharmacies will be advised of their quota total available for them to order. In order to help minimise vaccine waste, GPs and community pharmacies are advised to only order enough vaccine for the number of patients that are likely to attend for vaccination.

23. Individuals aged 50 years and over will also have the option to receive their autumn booster vaccination via a participating community pharmacy.

Community Pharmacies

24. Community pharmacies will be responsible for the vaccination of all care home residents and staff, including mop-up visit. Many care homes will already have effective medicines management arrangements with community pharmacies and it is anticipated that these existing partnerships will continue through the offer of COVID-19 vaccination to care homes.

25. For care homes operated by HSC Trusts, Trusts are asked to ensure that local arrangements are made with community pharmacies offering the COVID-19 vaccination service.

26. In addition community pharmacies can offer vaccination to anyone aged 50 years or older, frontline health and social care staff, pregnant women and carers (as set out in the Green Book definition).

Trusts

27. Trusts will continue to run a small number of vaccination centres and mobile clinics/pop up clinics to vaccinate anyone who attends for their relevant dose. This includes those who to date have not received their primary course of vaccination.
28. In addition to this, Trusts are asked to vaccinate:

- Frontline Health and Social Care Workers- (different booking systems may operate in each Trust);
- Housebound patients (via District Nursing Teams and based on referral from GP);
- Pregnant women via maternity services;
- Those aged 5-17 years of age in clinical at risk groups (self-booking online);
- Those aged 5-17 years of age who are the household contacts of the Immunosuppressed (self-booking online following receipt of a GP letter to the household of the immunosuppressed person); and
- Those aged 16-17 years of age who self-identify as a carer.

Pregnant Women

29. In December 2021, data from studies from the UK Obstetric Surveillance System (UKOSS) and the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) indicated that clinical outcomes following COVID-19 in pregnant women had worsened over the course of the pandemic, and the majority of pregnant women admitted to hospital with COVID-19 were unvaccinated. In view of this data, women who are pregnant are considered to be in a clinical risk group within the COVID-19 vaccination programme.

30. Unvaccinated women who become pregnant are strongly encouraged to come forward for vaccination via Trust led vaccination clinics or a participating community pharmacy. **Women who are pregnant and have previously been vaccinated should be offered a booster dose this autumn.**

Household contacts of immunosuppressed persons and carers

31. The effectiveness of currently available COVID-19 vaccines to protect against non-severe infection and virus transmission due to the Omicron variants is of relatively short-duration. Nonetheless, for household contacts of immunosuppressed persons and carers of vulnerable persons, such protection over the winter months, when indoor virus transmission is likely to be greater, is considered to confer worthwhile benefits. Those offered vaccination should understand that these benefits relate mainly to the potential for short-term indirect protection of the person they care for or their household contact who is immunosuppressed.

32. For carers, direct protection against severe illness and hospitalisation could also mean that they are better able to continue providing the vital care that is required of them over the winter. In Northern Ireland, the definition of a carer is: **Carers are people who, without payment, provide help and support to a family member or a friend who may not be able to manage without this help because of frailty, illness or disability. Carers can be adults caring for other**
adults, parents caring for ill or disabled children or young people who care for another family member.

33. As there is no central list of carers in Northern Ireland individuals will have to self-identify as a carer based on the definition above. Vaccinators will not be expected to query anyone who shows up for vaccination and self identifies as a carer. It is expected that most carers will seek their booster dose via community pharmacies or Trust led clinics although some GPs may invite those carers registered with their practice in for vaccination.

**Frontline Health and Social Care workers**

34. In line with the Green Book definition in Chapter 14a on COVID-19 - [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1098808/Greenbook-chapter-14A-17August2022.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1098808/Greenbook-chapter-14A-17August2022.pdf) Trust employed frontline health and social care workers will be invited to book their vaccination at a Trust vaccination site shortly, while non-Trust employed frontline health and social care workers, such as Dentists and Domiciliary Care workers etc., will be eligible to receive their booster vaccination via a Trust run vaccination clinic or a local community pharmacy.

35. Staff from across the Health and Social Care system (including Arm’s Length Bodies) should consider the Green Book guidance and decide if they fall into the definition of frontline staff. Care home staff will be offered vaccination at their place of employment when a community pharmacy team attend but in addition they can also avail of vaccination via a local community pharmacy.

36. We would like to re-emphasise the importance of vaccination for frontline Health and Social Care workers, including those working in the Independent Sector and would encourage them to take up the offer of vaccination as soon as possible to ensure they **protect their families, themselves and the vulnerable patients in their care.**

**Conclusion**

37. Rolling out the COVID-19 vaccination programme has required a huge amount of hard work and dedication so to all involved, please accept our sincere gratitude. We appreciate the long hours you have worked to ensure that we could provide the people of Northern Ireland with the best available protection from this virus. With a more severe flu season than normal being predicted and further waves of COVID-19 infection expected, we will have to continue to work hard to ensure those most at risk are protected against COVID and Influenza this winter.

38. The COVID-19 vaccination programme is a critical element of the system-wide approach for delivering robust and resilient health and care services during the winter. The autumn COVID-19 booster vaccination will help to increase the protection of those most at risk from the impact of this disease. A high uptake rate is expected to reduce GP consultations, unplanned
hospital admissions, pressure on Emergency Departments as well as staff sickness levels.

39. We would therefore urge that every effort is made by GPs, community pharmacies and Trusts to build on the success of the COVID-19 vaccination programme to date and encourage all those eligible to receive the autumn booster dose to do so when appropriate.

Yours sincerely

[Signatures]

Professor Sir Michael McBride
Chief Medical Officer

Ms Maria McIlgorm
Chief Nursing Officer

Mrs Cathy Harrison
Chief Pharmaceutical Officer
CIRCULATION LIST

Director of Public Health/Medical Director, Public Health Agency (for onward distribution to all relevant health protection staff)
Assistant Director Public Health (Health Protection), Public Health Agency
Director of Nursing, Public Health Agency
Assistant Director of Pharmacy and Medicines Management, SPPG (for onward distribution to Community Pharmacies)
Directors of Pharmacy HSC Trusts
Director of Social Care and Children, SPPG
Family Practitioner Service Leads, SPPG (for cascade to GP Out of Hours services)
Medical Directors, HSC Trusts (for onward distribution to all Consultants, Occupational Health Physicians and School Medical Leads)
Nursing Directors, HSC Trusts (for onward distribution to all Community Nurses, and Midwives)
Directors of Children’s Services, HSC Trusts
RQIA (for onward transmission to all independent providers including independent hospitals)
Joe Brogan, Assistant Director, Head of Pharmacy and Medicines Management, Strategic Planning and Performance Group (SPPG) (for onward distribution to SPPG Pharmacy and Medicines Management Team and community pharmacists)
Regional Medicines Information Service, Belfast HSC Trust
Regional Pharmaceutical Procurement Service, Northern HSC Trust
Professor Donna Fitzsimons, Head of School of Nursing and Midwifery QUB
Professor Sonja McIlfatrick, Head of School of Nursing, University of Ulster
Heather Finlay, CEC
Donna Gallagher, Open University
Professor Paul McCarron, Head of School of Pharmacy and Pharmaceutical Sciences, UU
Professor Colin McCoy, Head of School, School of Pharmacy, QUB
Professor Colin Adair, Postgraduate Pharmacy Dean, NI Centre for Pharmacy Learning and Development, QUB
Michael Donaldson, Head of Dental Services, SPPG (for distribution to all General Dental Practitioners)
Raymond Curran, Head of Ophthalmic Services, SPPG (for distribution to Community Optometrists)
Trade Union Side
Clinical Advisory Team
Louise McMahon, Director of Integrated Care, SPPG

This letter is available on the Department of Health website at


Working for a Healthier People

INVESTORS IN PEOPLE
COVID-19 vaccine should be offered to the eligible groups set out in the table below.

<table>
<thead>
<tr>
<th>Eligible groups</th>
<th>Further detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>All adults aged 50 years and over</td>
<td>Adults aged 50 years or older (i.e. those born before 31 March 1973)</td>
</tr>
<tr>
<td>Persons aged 5 to 49 years in a clinical risk group (as set out in the Green Book)</td>
<td>• Table 1 below shows the clinical risk groups for those aged 16 and over.</td>
</tr>
<tr>
<td></td>
<td>• Table 2 below shows the clinical risk groups for those aged 5 to 15 years.</td>
</tr>
<tr>
<td>Persons aged 5 to 49 years who are household contacts of people with immunosuppression</td>
<td>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 the Green Book).</td>
</tr>
<tr>
<td>Persons aged 16 to 49 years who are carers (as set out in the Green Book)</td>
<td>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 COVID19 mortality and therefore clinically vulnerable. Carers are people who, without payment, provide help and support to a family member or a friend who may not be able to manage without this help because of frailty, illness or disability. Carers can be adults caring for other adults, parents caring for ill or disabled children or young people who care for another family member.</td>
</tr>
<tr>
<td>Residents in a care homes and staff working in care homes</td>
<td>People living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to</td>
</tr>
</tbody>
</table>
follow introduction of infection and cause high morbidity and mortality.

| Frontline health and social care workers | • Frontline health care workers providing health-related services in acute HSC hospitals, mental health hospitals, community-based services, ambulance care, that are in direct contact with patients.  
• Frontline social care workers providing social care to patients or clients through the Trust, community-based services to individuals in their own home, in care homes or other long-term care facilities that is in direct contact with patients. |

Table 1: Clinical risk groups for individuals aged 16 years and over eligible for COVID-19 immunisation.

<table>
<thead>
<tr>
<th>Clinical risk groups</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic respiratory disease</td>
<td>Individuals with a severe lung condition, including those with poorly controlled asthma and chronic obstructive pulmonary disease (COPD) including chronic bronchitis and emphysema; bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD).</td>
</tr>
<tr>
<td>Chronic heart disease and vascular disease</td>
<td>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.</td>
</tr>
<tr>
<td>Chronic kidney disease</td>
<td>Chronic kidney disease at stage 3, 4 or 5, chronic kidney failure, nephrotic syndrome, kidney transplantation.</td>
</tr>
<tr>
<td>Chronic liver disease</td>
<td>Cirrhosis, biliary atresia, chronic hepatitis.</td>
</tr>
<tr>
<td>Chronic neurological disease</td>
<td>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.</td>
</tr>
<tr>
<td>Diabetes mellitus and other endocrine disorders</td>
<td>Any diabetes, including diet-controlled diabetes, current gestational diabetes, and Addison's disease.</td>
</tr>
</tbody>
</table>
| 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).

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.

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.

Anyone with a history of haematological malignancy, including leukaemia, lymphoma, and myeloma.

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.

Some immunosuppressed patients may have a suboptimal immunological response to the vaccine (see Immunosuppression and HIV). |
| 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/m². |
| 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 | 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.

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) |</p>
<table>
<thead>
<tr>
<th>Clinical risk groups for children and young people aged 5-15 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic respiratory disease</td>
</tr>
</tbody>
</table>
| Chronic heart conditions | Haemodynamically significant congenital and acquired heart disease, or less severe heart disease with other co-morbidity. This includes:  
  - 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  
  - 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:  
  - 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  
  - Children who are about to receive planned immunosuppressive therapy should be considered for vaccination prior to commencing therapy. |
| Asplenia or dysfunction of the spleen | Including hereditary spherocytosis, homozygous sickle cell disease and thalassemia major |
| Serious genetic abnormalities that affect a number of systems | Including mitochondrial disease and chromosomal abnormalities |
| Pregnancy | All stages (first, second and third trimesters) |