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Independent report

Priority groups for coronavirus (COVID-19) vaccination: advice from the JCVI, 2 December 2020

Updated 3 December 2020

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Introduction

This advice is provided to facilitate the development of policy on COVID-19 vaccination in the UK.

The Joint Committee on Vaccination and Immunisation (JCVI) advises that the first priorities for any COVID-19 vaccination programme should be the prevention of COVID-19 mortality and the protection of health and social care staff and systems. Secondary priorities could include vaccination of those at increased risk of hospitalisation and at increased risk of exposure, and to maintain resilience in essential public services. This document sets out a framework for refining future advice on a national COVID-19 vaccination strategy.

This advice has been developed based on:

- a review of UK epidemiological data on the impact of the COVID-19 pandemic so far (see reference 1)
- data on demographic and clinical risk factors for mortality and hospitalisation from COVID-19 (see references 2 to 3)
- data on occupational exposure (see references 4 to 7)
- a review on vaccine inequalities associated with COVID-19 (see reference 8)
- Phase 1, 2 and 3 data on the Pfizer/BioNTech mRNA vaccine and headline phase III results on the AstraZeneca vaccine, Phase 1 and 2 data on other developmental COVID-19 vaccines (see references 9 to 18)
- mathematical modelling on the potential impact of different vaccination programmes (see reference 19)

Considerations

Pfizer/BioNTech vaccine

The committee has reviewed unpublished Phase 1, 2 and 3 safety and efficacy data for the Pfizer/BioNTech mRNA vaccine. The vaccine appears to be safe and well-tolerated, and there were no clinically concerning safety observations. The data indicates high efficacy in all age groups (16 years and over), including encouraging results in older adults. The committee advises that this vaccine be used in the first phase of the programme, according to the priority order set out below. While there is some evidence to indicate high levels of short-term protection from a single dose of vaccine, a two-dose vaccine schedule is currently advised in accordance with regulatory approval.

This statement will be updated following consideration of Phase 3 safety and efficacy data on other COVID-19 vaccines.

Direct protection versus transmission reduction

JCVI has considered a number of different vaccination strategies, including those targeting transmission and those targeted at providing direct protection to persons most at risk.

In order to interrupt transmission, mathematical modelling indicates that we would need to vaccinate a large proportion of the population with a vaccine which is highly effective at preventing infection (transmission). At the start of the vaccination programme, good evidence on the effects of vaccination on transmission will not be available, and vaccine availability will be more limited. The best use of available vaccine will also, in part, be dependent on the point in the pandemic the UK is at.

Given the current epidemiological situation in the UK, all evidence indicates that the best option for preventing morbidity and mortality in the initial phase of the programme is to directly protect persons most at risk of morbidity and mortality.

Age

Current evidence strongly indicates that the single greatest risk of mortality from COVID-19 is increasing age and that the risk increases exponentially with age (see references 1 to 3). Mathematical modelling indicates that the optimal strategy for minimising future deaths or quality adjusted life year (QALY) losses is to offer vaccination to older age groups first. These models assume an available vaccine is both safe and effective in older adults (see reference 19). Data also indicate that the absolute risk of mortality is higher in those over 65 years than that seen in the majority of younger adults with an underlying health condition (see below). Accordingly, the Committee's advice largely prioritises based on age.

Age-based programmes are usually easier to implement and therefore achieve higher vaccine uptake. An age-based programme is also likely to increase uptake in those with clinical risk factors as the prevalence of these increases with age.

Older adults resident in care homes

There is clear evidence that those living in residential care homes for older adults have been disproportionately affected by COVID-19 (see references 20 to 23) as they have had a high risk of exposure to infection and are at higher clinical risk of severe disease and mortality. Given the increased risk of outbreaks, morbidity and mortality in these closed settings, these adults are considered to be at very high risk. The committee's advice is that this group should be the highest priority for vaccination. Vaccination of residents and staff at the same time is considered to be a highly efficient strategy within a mass vaccination programme with the greatest potential impact (see below).

Health and social care workers

Frontline health and social care workers are at increased personal risk of exposure to infection with COVID-19 and of transmitting that infection to susceptible and vulnerable patients in health and social care settings. The committee considers frontline health and social care workers who provide care to vulnerable people a high priority for vaccination. Protecting them protects the health and social care service and recognises the risks that they face in this service. Even a small reduction in transmission arising from vaccination would add to the benefits of vaccinating this population, by reducing transmission from health and social care workers to multiple vulnerable patients and other staff members. This group includes those working in hospice care and those working temporarily in the COVID-19 vaccination programme who provide face-to-face clinical care.

There is evidence that infection rates are higher in residential care home staff (see references 20 to 23), than in those providing domiciliary care or in healthcare workers. Care home workers are therefore considered a very high priority for vaccination.

Prioritisation amongst health and social care workers

Frontline health and social care workers at high risk of acquiring infection, at high individual risk of developing serious disease, or at risk of transmitting infection to multiple vulnerable persons or other staff in a healthcare environment, are considered of higher priority for vaccination than those at lower risk. This prioritisation should be taken into account during vaccine deployment.

Clinically extremely vulnerable (shielding patients)

Individuals considered extremely clinically vulnerable have been shielding for much of the pandemic (see reference 24) . This means that available data are likely to underestimate the risk in this group. Many of those who are clinically extremely vulnerable are in the oldest age groups and will be among the first to receive vaccine. Considering data from the first wave in the UK, the overall risk of mortality for clinically extremely vulnerable younger adults is estimated to be roughly the same as the risk to persons aged 70 to 74 years.

Given the level of risk seen in this group as a whole, [JCVI](#) advises that persons aged less than 70 years who are clinically extremely vulnerable should be offered vaccine alongside those aged 70 to 74 years of age. There are 2 key exceptions to this, pregnant women with heart disease and children (see below).

Many individuals who are clinically extremely vulnerable will have some degree of immunosuppression or be immunocompromised and may not respond as well to the vaccine. Therefore, those who are clinically extremely vulnerable should continue to follow government advice on reducing their risk of infection. Consideration has been given to vaccination of household contacts of immunosuppressed individuals.

However, at this time there are no data on the size of the effect of COVID-19 vaccines on transmission. Evidence is expected to accrue during the course of the vaccine programme, and until that time the committee is not in a position to advise vaccination solely on the basis of indirect protection. Once sufficient evidence becomes available the committee will consider options for a cocooning strategy for immunosuppressed individuals, including whether any specific vaccine is preferred in this population.

Pregnancy

There are no data as yet on the safety of COVID-19 vaccines in pregnancy, either from human or animal studies. Given the lack of evidence, [JCVI](#) favours a precautionary approach, and does not currently advise COVID-19 vaccination in pregnancy.

Women should be advised not to come forward for vaccination if they may be pregnant or are planning a pregnancy within three months of the first dose.

Data are anticipated which will inform discussions on vaccination in pregnancy. [JCVI](#) will review these as soon as they become available.

Children

Following infection, almost all children will have asymptomatic infection or mild disease. There is very limited data on vaccination in adolescents, with no data on vaccination in younger children, at this time. The committee advises that only those children at very high risk of exposure and serious outcomes, such as older children with severe neuro-disabilities that require residential care, should be offered vaccination.

Clinicians should discuss the risks and benefits of vaccination with a person with parental responsibility, who should be told about the paucity of safety data for the vaccine in children aged under 16 years. More detail on vaccination in children is set out in the Green Book – Immunisation Against Infectious Disease (<https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book>).

Underlying health conditions

There is good evidence that certain underlying health conditions increase the risk of morbidity and mortality from COVID-19. When compared to persons without underlying health conditions, the absolute increased risk in those with underlying health conditions is considered generally to be lower than the increased risk in persons over the age of 65 years (with the exception of the clinically extremely vulnerable).

The committee's advice is to offer vaccination to those aged 65 years and over followed by those in clinical risk groups aged 16 years and over.

The risk groups identified by the committee are set out below:

- chronic respiratory disease, including chronic obstructive pulmonary disease (COPD), cystic fibrosis and severe asthma
- chronic heart disease (and vascular disease)
- chronic kidney disease
- chronic liver disease
- chronic neurological disease including epilepsy
- Down's syndrome
- severe and profound learning disability
- diabetes
- solid organ, bone marrow and stem cell transplant recipients
- people with specific cancers
- immunosuppression due to disease or treatment
- asplenia and splenic dysfunction
- morbid obesity
- severe mental illness

Individuals within these risk groups who are clinically extremely vulnerable are discussed separately (see above). Further advice on risk groups, including clear definitions, are set out in the Green Book – Immunisation Against Infectious Disease (<https://www.gov.uk/government>

/collections/immunisation-against-infectious-disease-the-green-book).

Mitigating inequalities

Multiple social and societal drivers are recognised to contribute towards increased risk from COVID-19. JCVI considered it important to understand the factors underlying health inequalities in COVID-19 giving due consideration to relevant scientific evidence, ethical principles and vaccine programme deliverability. The issues considered are set out in annex A (<https://www.gov.uk/government/publications/priority-groups-for-coronavirus-covid-19-vaccination-advice-from-the-jcvi-2-december-2020/annex-a-covid-19-vaccine-and-health-inequalities-considerations-for-prioritisation-and-implementation>).

There is clear evidence that certain black, Asian and minority ethnic (BAME) groups have higher rates of infection, and higher rates of serious disease, morbidity and mortality. There is no strong evidence that ethnicity by itself (or genetics) is the sole explanation for observed differences in rates of severe illness and deaths. What is clear is that certain health conditions are associated with increased risk of serious disease, and these health conditions are often overrepresented in certain BAME groups. It is also clear that societal factors, such as occupation, household size, deprivation, and access to healthcare can increase susceptibility to COVID-19 and worsen outcomes following infection. These factors are playing a large role in the inequalities being seen with COVID-19.

Good vaccine coverage in BAME groups will be the most important factor within a vaccine programme in reducing inequalities for this group. Prioritisation of persons with underlying health conditions will also provide for greater vaccination of BAME communities who are disproportionately affected by such health conditions.

The committee's advice is for NHS England and Improvement, the Department of Health and Social Care, Public Health England and the devolved administrations to work together to ensure that inequalities are identified and addressed in implementation. This could be through culturally competent and tailored communications and flexible models of delivery, aimed at ensuring everything possible is done to promote good uptake in BAME groups and in groups who may experience inequalities in access to, or engagement with, healthcare services. These tailored implementation measures should be applied across all priority groups during the vaccination programme.

Occupational vaccination (other than frontline health and social care workers)

The committee considered evidence on the risk of exposure and risk of mortality by occupation. Under the priority groups advised below, those over 50 years of age, and all those 16 years of age and over in a risk group, would be eligible for vaccination within the first phase of the programme. This prioritisation captures almost all preventable deaths from COVID-19, including those associated with occupational exposure to infection. As such, JCVI does not advise further prioritisation by occupation during the first phase of the programme.

Occupational prioritisation could form part of a second phase of the programme, which would include healthy individuals from 16 years of age up to 50 years of age, subject to consideration of the latest data on vaccine safety and effectiveness.

The impact of vaccine delivery on non-pharmaceutical interventions

In a situation of constrained vaccine supply, population level protection will not be achievable immediately.

Once we have evidence of the impact of the programme on morbidity and mortality amongst vulnerable persons, the initial phase of the vaccination programme could allow the subsequent relaxation of non-pharmaceutical interventions in some sectors of the population. Government advice on non-pharmaceutical interventions should continue to be followed.

Vaccine priority groups: advice on 2 December 2020

Phase 1 – direct prevention of mortality and supporting the NHS and social care system

JCVI advises that the first priorities for the COVID-19 vaccination programme should be the prevention of mortality and the maintenance of the health and social care systems. As the risk of mortality from COVID-19 increases with age, prioritisation is primarily based on age.

The order of priority for each group in the population corresponds with data on the number of individuals who would need to be vaccinated to prevent one death, estimated from UK data obtained from March to June 2020 (see reference 3).

This priority list is as follows:

1. residents in a care home for older adults and their carers
2. all those 80 years of age and over and frontline health and social care workers
3. all those 75 years of age and over
4. all those 70 years of age and over and clinically extremely vulnerable individuals^[footnote 1]
5. all those 65 years of age and over
6. all individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality
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

It is estimated that taken together, these groups represent around 99% of preventable mortality from COVID-19.

JCVI advises that implementation of the COVID-19 vaccine programme should aim to achieve high vaccine uptake. An age-based programme will likely result in faster delivery and better uptake in those at the highest risk. Implementation should also involve flexibility in vaccine deployment at a local level with due attention to:

- mitigating health inequalities, such as might occur in relation to access to healthcare and ethnicity

- vaccine product storage, transport and administration constraints
- exceptional individualised circumstances
- availability of suitable approved vaccines, for example for specific age cohorts

JCVI appreciates that operational considerations, such as minimising wastage, may require a flexible approach, where decisions are taken in consultation with national or local public health experts. To be assured that outcome is maximised however, JCVI would like to see early and regular comprehensive vaccine coverage data so that the Committee can respond if high priority risk groups are unable to access vaccination in a reasonable time frame.

The next phase – further reduction in hospitalisation and targeted vaccination of those at high risk of exposure and/or those delivering key public services

As the first phase of the programme is rolled out in the UK, additional data will become available on the safety and effectiveness of COVID-19 vaccines. These data will provide the basis for consideration of vaccination in groups that are at lower risk of mortality from COVID-19.

The committee is currently of the view that the key focus for the second phase of vaccination could be on further preventing hospitalisation.

Vaccination of those at increased risk of exposure to SARS-CoV-2 due to their occupation could also be a priority in the next phase. This could include:

- first responders
- the military
- those involved in the justice system
- teachers
- transport workers
- public servants essential to the pandemic response.

Priority occupations for vaccination are considered an issue of policy, rather than for JCVI to advise on. JCVI asks that DHSC consider occupational vaccination in collaboration with other government departments.

Wider use of COVID-19 vaccines will provide a better understanding of whether they can prevent infection and onward transmission in the population. Data on vaccine impact on transmission, along with data on vaccine safety and effectiveness, will potentially allow for consideration of vaccination across the rest of the population.

As trials in children and pregnant women are completed, we will also gain a better understanding of the safety and effectiveness of the vaccines in these persons.

Further work

JCVI will continually monitor data on vaccines in development. As more Phase 3 data becomes available on candidate COVID-19 vaccines the committee will be able to prepare

further advice for policy makers in the UK.

JCVI will review data on vaccine coverage, in particular focussing on inequalities, and the impact of actions being undertaken to mitigate inequalities. Vaccine safety will be continually monitored by the MHRA and PHE, and JCVI will regularly review data on vaccine safety as the programme rolls out. Vaccine efficacy and any potential impacts on transmission will be monitored by PHE. Data will be considered at the earliest opportunity to facilitate discussions on prioritisation after the first phase of the programme.

Background

JCVI met to consider COVID-19 vaccination on:

- 7 May
- 3 June
- 6 July
- 1 September
- 29 November
- 30 November
- 1 December 2020

Between 24 September 2020 and 19 November 2020, a JCVI COVID-19 sub-committee met weekly to consider key issues in greater depth. The advice provided is to support the government in development of a vaccine strategy for the procurement and delivery of a vaccination programme to the population.

SARS-CoV-2 (COVID-19)

COVID-19 disease first emerged as a cause of severe respiratory infection in Wuhan, China in late 2019. The first 2 cases in the UK were seen in late January 2020. In March 2020, the World Health Organisation (WHO) declared a SARS-Cov-2 pandemic.

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, but may include headache, loss of smell, nasal obstruction, lethargy, myalgia, rhinorrhoea, taste dysfunction, sore throat, diarrhoea, vomiting and confusion. Fever may not be reported in all symptomatic individuals. Progression of disease, multiple organ failure and death will occur in some individuals.

As with other Coronaviruses, SARS-CoV-2 is an RNA virus which encodes four major structural proteins. Most vaccine candidates focus on immunisation with the spike glycoprotein, which is the main target for neutralising antibodies following infection. Neutralising antibodies that block viral entry into host cells by preventing interaction between the spike protein and the host cell are expected to be protective.

Pfizer/BioNTech vaccine

The Pfizer/BioNTech vaccine is a lipid nanoparticle-formulated mRNA vaccine. The mRNA

encodes the SARS-CoV-2 full length spike protein. The mRNA in the vaccine is translated and transcribed by the body to produce the spike protein. The protein then acts as an intracellular antigen to stimulate the immune response. The mRNA in the vaccine is normally degraded within a few days and cannot incorporate into the host genome. Data from the Pfizer/BioNTech vaccine trials undertaken in over 40,000 individuals indicate high vaccine efficacy, with no serious safety concerns observed.

AstraZeneca COVID-19 vaccine

AstraZeneca COVID-19 vaccine uses a replication deficient chimpanzee adenovirus as a vector that encodes the full-length SARS-CoV2 spike protein. Chimpanzee adenoviruses are non-enveloped viruses, meaning that the glycoprotein antigen is not present on the surface of the vector, but is only expressed at high levels once the vector enters the target cells. Genes are inserted to render the virus replication incompetent, and to enhance immunogenicity. Once the vector is in the nucleus, mRNA encoding the spike protein is produced that then enters the cytoplasm. This leads to translation of the target protein which acts as an intracellular antigen. Headline data from vaccine trials undertaken indicate high vaccine efficacy, with no serious safety events related to the vaccine.

After [JCVI](#) has been given the opportunity to review Phase 3 data on this vaccine, this statement will be updated.

Other vaccines in development

Other COVID-19 vaccines are in development, with some in late stage trials. When sufficient data on vaccine safety and efficacy are available, these will be considered by [JCVI](#) and this statement will be updated.

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