Official
Publication approval reference: C1597

23 February 2022

Planning parameters for 2022/23

For 2022/23, there are three key priorities: i) continued access to COVID-19 vaccination; ii) delivery of the autumn COVID-19 vaccination campaign if advised by JCVI; and iii) development of detailed contingency plans to rapidly increase capacity, if required. Across each of these, the focus must remain on increasing uptake in all communities and addressing unwarranted variation.

The included in this document, and the supporting information letter give systems the basis on which to develop detailed operational plans for the next six months, and provisional plans to provide autumn boosters should we be instructed to do so. This provides an opportunity for systems to rethink network design to best meet the needs of their population, albeit with ongoing uncertainties. Because the autumn booster campaign will only be decided later in the year, we will use the provisional plans for September 2022-April 2023 to work with systems and with government to ensure we have the right financial and commercial mechanisms in place to best support system delivery.

Systems need to continue to strengthen their local partnerships, especially with local authorities, working together to design and deliver a continued offer for the year ahead, with clear ownership at each level, drawing on the insight, experience and expertise of all partners.

A vaccine modelling pack has been developed for each ICS. Systems should use this information, together with local data, insights and analysis to inform their approach.

Delivery plans will need to adhere to the following parameters.

Overall delivery mix	Systems are responsible for designing the overall mix of delivery models to meet the needs of the local population. In determining the right combination, systems will need to co-produce an approach will ensure equality of access for all their communities, striking the right balance between high throughput sites with targeted approaches. As well as confirming the approach to delivering an uninterrupted vaccination offer to September 2022, systems are asked to work with their providers to set out their initial thoughts on the delivery approach for the remainder of the year. This will include a description of the location, size and throughput of services, but will not be provider specific. This information will help inform discussions around contract options that will be shared shortly. Systems also need to ensure their approach includes, and can quickly mobilise to support, vulnerable groups not able to attend vaccination sites, including care home residents, housebound populations, carers and homeless populations, with minimal impact on day to day delivery of NHS services. Systems must review their network to ensure sufficient and appropriate provision for unvaccinated populations and consider how to ensure continued

	access, including mobile, pop-up or outreach services, and ensure equity in vaccination take up across all communities.
Local vaccination services - PCN groupings and Community Pharmacy	We expect the existing General Practice COVID-19 vaccination Enhanced Service and CP Local Enhanced Service will be extended until the end of September 2022, although it is anticipated a proportion of LVS sites will deliver significantly fewer vaccinations or hibernate over the next few months with the ability to increase capacity if required. The contract is currently being discussed with professional bodies in the usual way. PCN groupings continuing to deliver post April 2022 will need to do so without impacting the 2022/23 core services, for example by drawing down additional workforce capacity. Systems should work with PCN groups to regularly review their capacity to deliver and be ready to flex delivery through other sites in case needed. We will design the contractual model for LVS sites over the coming weeks, taking into account feedback from systems and engagement with professional bodies.
NHS Trusts	As a minimum, **all acute trusts** are expected to deliver vaccinations to their staff as well as specific groups of patients, including the severely immunosuppressed, eligible clinical at-risk children's groups (5-11 and 12-15 with underlying health conditions), inpatients (including those with an extended length of stay), and those attending allergy clinics and maternity services (where applicable). Patients being discharged to care homes should be offered a vaccination where possible. **All non-acute trusts** must offer vaccination to their staff and should either vaccinate themselves or direct staff elsewhere. Trusts with community, mental health, learning disability and autism services should arrange for eligible patients to be vaccinated at the point of care, particularly during an extended inpatient stay. All Trusts are expected to use the national protocol as the legal mechanism for administration of vaccine to enable greater use of the non-registered workforce to make best use of people's skills. Trusts can access both paid and unpaid workforce via their lead employer. Where agreed locally, NHS Trusts may also provide vaccinations to the following: • Non-Trust frontline health and social care workers • Local communities using the National Booking Service • HCW clinics to validate MHRA approved vaccinations or provide additional doses (further information here) • Clinical trials participants (further information here)
Vaccination Centres (VC)	VCs are expected to be assured for all vaccine types, all vaccine cohorts, including children aged 5-11s, are part of the NHS estate and are accessible and convenient for the local population. Nationally set governance and operating procedures remain in place.

Clinical	Monitoring requirements for current vaccines remain unchanged. For those with a history of allergy or other clinical concerns a 15 minute observation will need to be observed. The current dosing requirements will continue. Covid-19 vaccination information for clinicians is included in the green book.
Finance and contracting	Funding is available to allow essential spending commitments to be made to March 2023 and systems should ensure that commitments are made in line with expected volumes and planned delivery. Financial commitments should also be considered in the context of flexibility, scaling down at pace if required, to ensure value for money for the taxpayer. Current financial and contractual processes and principles, for the initial planning period, remain in place up to the end of September 2022 and include: • Item of Service and additional reasonable costs for primary care providers contracted through the ES and LES. Specific items may be adjusted within these parameters to reflect the changing delivery landscape. More detail will be available by early March. • Reimbursement of incremental costs for other providers. Systems should continue to apply the existing principles of value for money. Procurement and reimbursement arrangements for the autumn COVID-19 vaccination campaign from September 2022, if advised by the Joint Committee of Vaccination and Immunisation (JCVI), will be finalised in collaboration with systems over the next few weeks to ensure that they adequately reflect the needs and flexibilities needed to deliver. Programme budgets will continue to support systems in the planning and commissioner management of these services. Costs for programme support should be funded from this budget, recognising the direction of travel toward ensuring ICBs have sufficient capacity to effectively support delivery.
Workforce	The vaccination workforce will continue to be deployed using a single, agile approach owned by the system. To facilitate this, the lead employer model continues to be the recommended approach. Each system must ensure that it has a mechanism for sharing staff across all vaccine services, to prevent impacting other core NHS services including other vaccination programmes and balances the use of paid staff and volunteers. To reduce the pull on the existing NHS workforce, the nationally procured contracts will remain in place for NHS Volunteer Responders, as is currently delivered through Royal Voluntary Service and St John Ambulance. The use of volunteers should be maximised and the extended offers from national partner organisations should be taken up by all systems, including for the vaccination of children. The national workforce hotline will continue to be in place to enable the escalation of staffing capacity challenges.

	National protocols and workforce model: the national protocols continue to be the default legal mechanism for delivery; both unregistered vaccinators and vaccinator volunteers should be deployed to reduce the pull on registered workforce. Systems should ensure they are working with local communities as part of recruitment and retention to ensure the workforce reflects the communities they serve. Military teams should not be part of any plans. **Training:** the lead employer continues to be responsible for ensuring the workforce are trained and competent and will need to put in place processes if additional training is required. The workforce should be upskilled to support wider vaccination and immunisation programmes, with funding available to support this through the lead employer. Staff should be upskilled to support Making Every Contact Count (MECC) where appropriate. **Retainment of workforce:** retention funding has been extended until the end of September 2022 to support the ability to recall staff when seasonal vaccination or surge is required. **Reporting and capacity:** existing reporting requirements for lead employers will continue.
Estates	Systems should make best use of **NHS estates** wherever possible and ensure **maximum accessibility** for their local communities, adhering to **value for money** principles. Systems should use data, analytics and insight, including the SHAPE tool, to inform network designs, ensuring the coverage of sites is maintained to ensure a viable, accessible and appropriate offer for the local community, including children. Consideration should be given to analysis of which sites have historically performed most strongly for each cohort, avoiding excess over-capacity and duplication of provision by multiple sites serving the same population without a clear rationale. Operational plans will need to include the decommissioning of sites when they are deemed surplus to requirements as well as detail the sequence in which any hibernating sites would open to support surge. Prioritisation of estates should be: NHS estate, other public sector estate and, only where required, commercial estate. On this basis systems should work to transfer commercial sites into NHS estate wherever viable. Where NHS estate is exhausted, systems should continue to work with their Local Authority partners to identify and commission public sector estate. Only where the need has been evidenced, the NHS estate is fully utilised/not suitable, public sector estate is exhausted or timeframes do not align (ie temporary use of Pop-Ups) will use of commercial estate be supported. Commercial premises should not be considered where the site is expected to hibernate during periods of lower throughput, although co-location with other health services which can make use of the space during the dormant periods may be acceptable, where costs are borne by those services for those periods.

	The use of high-cost commercial sites should be exceptional; however this should be balanced with high-utilisation and/ or appropriate access in areas of lower uptake.
Supply chain	The national supply chain will continue to deliver to agreed and assured locations. Current allocation processes based on a capped pull model will continue, with frontline stock monitored to ensure minimum wastage and maximum efficiency. Existing pharmaceutical standards continue to apply. Systems should have as many sites as possible assured for all vaccine types to allow flexibility and resilience. Vaccine specific consumables will continue to be supplied alongside vaccine ordered – Combined Needles and Syringes, Steret Wipes, Diluent, Diluent needles, patient information leaflets. For new sites, systems must first identify and use existing equipment already in the system before requesting new equipment. Pack sizes will continue to be supplied as offered by the manufacturers: • Comirnaty (30microgram/dose) – 1170 doses / pizza box • Comirnaty (10microgram/dose) – 100 dose per carton • SpikeVax – 100 full doses / pack For all LVSs: • Ordering through Foundry through the Ordering Platform and Supply Planner will continue on a four-week cycle • Central supply chain will continue to offer smaller ‘pack down’ sizes for Comirnaty (30microgram/dose) into 90 doses / “baby pack” up to multiples of 10 packs • Sites will be expected to continue to undertake weekly stocktakes to inform allocations decision making. For Vaccination Centres and Hospital Hubs/ Hospital Hubs+: • From by end of March, the Ordering Platform will be made available to access smaller ‘pack down’ sizes of vaccine from the SPLs. Further detail will be shared shortly.
Continuous engagement	Systems must continue engaging with their communities, informed by data and local intelligence, to build confidence and promote uptake. Systems are expected to work together, at every level, with all partners to continue confidence building, drawing on and developing existing local infrastructure, such as local voluntary, faith and community organisations as well as wider public and private sector partners. Local authority partners must co-develop and design the approach and be resourced to deliver. National messaging, communications and marketing campaigns will continue to be available to systems in 2022/23, with systems responsible for local communications across their partnerships.

Tech and data	The National Booking Service (NBS), GrabAJab website for walk-ins, 119 supported helpline and the Vaccination Data Resolution Service (VDRS) will all continue. Systems can continue to put forward PCN-led LVS to be included on NBS using existing routes.
Co-delivery with other vaccination programmes	Systems should plan to align Covid-19 vaccination with other vaccination programmes as far as possible, where clinically and operationally appropriate. This is supported through: • Permission of local movement of flu supplies • Converging national call/recall communications where adult, age-based cohorts align • POC systems will continue to support COVID-19 only, flu only and co-administration for HH, VC, CP and PCN groupings.
MECC	Systems should ensure that all vaccination sites are delivering the minimum level of MECC intervention (posters, leaflets and information) with a focus on the Core20 PLUS5 clinical areas from April 2022. Additionally, due to the excess mortality for conditions associated with hypertension, systems should ensure that vaccination sites that have capacity to undertake blood pressure checks to support hypertension case finding and management activities are embedded within wider system-commissioned hypertension diagnostic and management clinical pathways that are expect to be in place by September 2022. Additionally, systems should explore a wider range of evidence based MECC interventions alongside the Covid-19 vaccination as part of clinical pathway planning to address the Core20 PLUS5 clinical areas. The minimum level of MECC intervention (posters, leaflets and information) should be developed collaboratively with local authority partners and where appropriate signpost to LA commissioned advisory services around weight management, smoking cessation, alcohol consumption and mental wellbeing support. Further guidance to support development of hypertension case finding and management pathways, including approaches to data recording and contractual frameworks, will be provided shortly alongside training materials for the vaccine workforce. Nationally a series of operational principles to guide systems in delivering MECC approaches alongside the Covid-19 vaccination event will shortly be published building on learning to-date.