Community Pharmacy Bulletin

23 July 2021

NHS England and NHS Improvement – South West

Contents

Coming Up

	July	August	September
Week 1	Public Health England COVID-19 Vaccination Campaign evaluation survey on PharmOutcomes closes 5 July 2021 --- CPCS GP Referral pathway engagement deadline to claim for payment 5 July 2021 --- Pharmacy Leadership Diversity Webinar 7 July 2021 7.00pm	Public Health England COVID-19 Vaccination Campaign materials to be removed from display 1 August 2021 --- PSNC Covid -19 Cost Claims workshop 2 August 2021 7.30pm --- Expressions of Interest for Chrismas and New Year Applications 2 August 2021	
Week 2	Snapshot wellbeing survey of the primary care workforce closes 12 July 2021		

	July	August	September
Week 3	Staff Vaccination Survey 12 July 2021, 9am --- PSNC Covid -19 Cost Claims workshop 14 July 2021 7.30pm		
Week 4	CPCS Technical Toolkit and IT supplier webinar for contractors 22 July 2021 7.00pm – 8.30pm --- Community Pharmacy Assurance Framework (CPAF) screening questionnaire ends 24 July 2021	Aligning the Upper Age for NHS Prescription Charge Exemptions with the State Pension age consultation closes 26 August 2021 11.45pm	Supplenmentary Application for Christmas Eve (24 December 2021) deadline 25 September 2021 --- Core and Supplenmentary Applications for Boxing Day (26 December) deadline 27 September 2021
Week 5	Support development of weight management referral tool focus group meeting 26 July 2021 10.00am --- Rural Regulations Workshop 26 July 2021 2.00pm --- PSNC Webinar on Dispensing Controlled Drugs 27 July 2021 7.00pm --- National Inclusive Pharmacy Practice Round Table 29 July 2021 10.00am – 13.00pm	August Bank Holiday 30 August 2021	

Headlines from the Week

NHS England

- None

NHS England South West Regional Team

- COMMUNITY PHARMACY COVID UPDATE 121: Arrangements for Primary Care from 19 July 2021 (sent 20 July 2021)
- URGENT - Community Pharmacy details for Phase 3 of the vaccination programme (sent 22 July 2021)
- URGENT INFORMATION - CPCS IT Provision for all Community Pharmacies (sent 22 July 2021)

PSNC Bulletin

- Face coverings in pharmacies after C-19 restrictions eased
- Less than one week left to complete CPAF 2021/22

Staff Isolation: Approach Following Updated Government Guidance

Please see the attached letter, 'C1354 Staff Isolation Approach Following UKSHA Changes to Government Website', which gives guidance for allowing essential frontline staff to return to work following a negative PCR if they have been asked to isolate due to potential contact with COVID-19.

Transition to New Covid Test Kits for Pharmacies

(taken from Primary Care Bulletin – 22 July 2021 (Issue 144))

NHS Test and Trace are moving to new COVID-19 test kits over the coming weeks. Innova COVID19 Test kits which are nose and throat tests will be replaced with Orient Gene tests from week commencing 26 July for a short period of time.

Orient Gene Kits are a rapid nose-only test for COVID-19 for use at home and are different to the Innova tests which are nose and throat tests.

From the 2 August, Orient Gene kits will be replaced by Acon Flex Flow kits which are also nose-only tests. As we transition between products Pharmacies should continue to work through existing stock levels and are reminded that people collecting for themselves should only be provided with one box of test kits.

Please continue to report test collections every week using the NHSBSA's Manage your Service (MYS) portal. We thank you for your continued support in delivering this service.

GP and Pharmacy PPE Engagement Panels

(taken from Primary Care Bulletin – 22 July 2021 (Issue 144))

The Department of Health and Social Care (DHSC) is recruiting panel members for GP and Pharmacy personal protective equipment (PPE) engagement panels to gather feedback on the quality and quantity of PPE provided to meet service needs.

The purpose of the panels is to provide end-user customers the opportunity to discuss their (COVID) PPE provision experiences, in order to improve the service of the DHSC PPE cell. The meeting will take place for one hour on a monthly basis.

If you would like to express an interest in joining, please email NonAcutePPECustomerDemand@dhsc.gov.uk with your name, role and panel preference.

Working safely during COVID-19: Guidance from Step 4 (Community Pharmacy and Optometrists)

(taken from Primary Care Bulletin – 22 July 2021 (Issue 144))

A new update to the guidance relating to those providing services in retail spaces and those providing close contact services was published yesterday. This is particularly relevant to community pharmacies and optometrists who will often have both healthcare and retail spaces within their premises. There are a number of priority recommendations, key amongst which is to undertake a risk assessment so that contractors can identify the actions they need to take to ensure that their staff and patients/customers are protected and able to access services. The full guidance, including a list of the priority recommendations, is available for you to review and action as appropriate to your premises.

Contractual Terms of Service

(taken from Primary Care Bulletin – 22 July 2021 (Issue 144))

In response to the pandemic, a number of contractual dispensations were put in place to support contractors to maintain core services and meet the needs of their patients in 2020/21. For clarity, pharmacy contractors are reminded that all contractual Terms of Service will need to be completed in 2021/2 included the following:

- The Community Pharmacy Assurance Framework screening questionnaire will need to be completed via the NHS BSA MYS portal by 24 July 2021.
- Updating of practice leaflets where and when required.
- The NHSE&I determined national clinical audit, details of this audit for this year are still to be announced, and the contractor chosen clinical audit.
- The Community Pharmacy Patient Questionnaire (CPPQ) for 2021-2022.
- The annual complaints return for 2021-2022.
- The health campaigns still to be announced for 2021-2022

Further details on the contractual Terms of Service can be found online.

In addition, contractors are advised that routine provider assurance post payment verification sampling will resume, as will the requirement to return NMS quarterly returns to the NHS Business Services Authority for quarter 2 onwards.

Tripartite Annual Seasonal Flu Letter

The attached letter "BW556 Annual National Flu Programme 2021 to 20222 provides details on the national influenza immunization programme 2021-2022

Medicine Supply Notifications (MSNs)

Please find attached Medicine Supply Notifications for:

- Tier 2 medicine supply notification for Locorten Vioform® (flumetasone/clioquinol) 0.02% w/v / 1% w/v ear drops solution
- A Tier 2 medicine supply notification for Catapres® (clonidine) 100 microgram tablets
- A Tier 2 medicine supply notification for Nexium® (esomeprazole) 10mg gastro-resistant granules sachets

The table below provides a summary of the attached MSNs:

Medicine	Out of stock until	Alternatives
Locorten Vioform® (flumetasone/clioquinol) 0.02% w/v / 1% w/v ear drops solution	April 2022	• Betnesol-N® (Betamethasone sodium phosphate 0.1%, Neomycin sulphate 0.5%) eye/ear/nose drops • Otomize® (Dexamethasone 0.1%, neomycin sulphate 0.5%, glacial acetic acid 2%) ear spray • Otosporin® (Hydrocortisone 1%, neomycin sulphate 3400 units/mL, polymyxin B sulphate 10,000 units/mL) ear drops • Sofradex® (Dexamethasone 0.05%, framycetin sulphate 0.5%, gramicidin 0.005%) ear/eye drops • Canesten® (clotrimazole) 1% solution Please see MSN for further details.

Medicine	Out of stock until	Alternatives
Catapres® (clonidine) 100 microgram tablets	Very limited supplies until w/c 4 October 2021.	• Clonidine 25 microgram tablets • Clonidine 50 microgram /5ml oral solution sugar free • Unlicensed imports have been sourced. Please see MSN for further details.
Nexium® (esomeprazole) 10mg gastro-resistant granules sachets	w/c 16 August 2021	• Lansoprazole 15mg & 30mg orodispersible tablets • Omeprazole (10mg, 20mg and 40mg) dispersible gastro-resistant tablets • Omeprazole (2mg/ml or 4mg/ml) oral suspension sugar free (licensed) • Omeprazole (2mg/ml or 4mg/ml) oral solution (unlicensed) • Please see MSN for further details.

Please note that supply issues that have been categorised as tier 1 or 2, DHSC and the MSRG have requested that the NHSE&I commissioning routes are used to reach community pharmacy and GP Practices. More serious supply issues are communicated via the Central Alerting System for action.

If you have any stock queries please contact: DHSCmedicinesupplyteam@dhsc.gov.uk.

There have also been changes to the resupply dates of the medicines listed below. These communications were previously circulated via the NHSE&I commissioning routes.

Original MSN reference	Date of original MSN/SDA	Supply issue	Resupply date originally communicated	Updated resupply date as of w/c 19 July 2021
MSN/2021/021	09/04/2021	Diamorphine 5mg and 10mg injections	w/c 19th April 2021	5mg - End of July 2021 10mg - w/c 19th July 2021

Please note that supply issues that have been categorised as tier 1 or 2, DHSC and the MSRG have requested that the NHSE&I commissioning routes are used to reach community pharmacy and GP Practices. More serious supply issues are communicated via the Central Alerting System for action.

If you have any stock queries, please contact: DHSCmedicinesupplyteam@dhsc.gov.uk

---

Useful Information

NHS England & Improvement – South West Region Community Pharmacy Contract Management Team contact information

Team Member	Telephone	Address
Jenny Collins	07979 308749	**South West Region Postal Addresses**
Sharon Greaves	07900 715295	
Les Riggs	07730 371074	NHS England and Improvement – South West Peninsula House

Mary Cotton	07920 288191	Kingsmill Road Tamar View Industrial Estate Saltash, PL12 6LE Or NHS England and Improvement – South West Sanger House, 5220 Valiant Court Gloucester Business Park, Brockworth Gloucester, GL3 4FE Or NHS England and Improvement – South West Jenner House, Avon Way Langley Park Chippenham, SN15 1GG *Please note all our offices are currently closed, please do not send post and use email wherever possible* Email: england.pharmacysouthwest@nhs.net
Michele Toy	07568 431890	
Sarah Lillington	07920 834445	
Sharon Hodges	07702 411295	
Tracey Howes	07730 380479	
Chris Yengel	07769 963478	
Kath Hughes	07730 374739	
Hayley Colledge	07900 713005	
Lesley St Leger	07730 381871	
William Anderson	07783 821721	
Stacey Burch	07730 391418	

NHS England & NHS Improvement Regional Controlled Drugs Accountable Officer

Name	Telephone number	Main contact details
Jon Hayhurst	07718130490	• Reporting incidents and concerns www.cdreporting.co.uk • Advice and support • Authorised witnesses for destruction england.southwestcontrolleddrugs@nhs.net

Webpages

Please see our websites for more information and any blank templates, forms and documents:

Cornwall & Isles of Scilly, Devon, Bristol, Dorset, North Somerset, Somerset and South Gloucestershire

BaNES, Gloucestershire, Swindon or Wiltshire

Interpretation and Translation Services

Official

Publication approval reference: C1354

To:

- ICS and STP leads
- All CCG Accountable Officers
- All NHS Foundation Trust and Trust Chief Executives, Medical Directors, Chief Nursing Officers and Chief People Officers/HR Directors
- All PCNs and all GP practices
- All Community Pharmacy
- All NHS primary care dental contract holders
- All Primary Care Optometrists and Dispensing Opticians
- All Pathology Incident Directors

Copy to:

- Chairs of ICS and STPs
- All CCG Chairs
- Chairs of NHS trusts and foundation trusts
- All Local Authority Chief Executives
- NHS Regional Directors
- NHS Regional Directors of Commissioning

19 July 2021

Dear colleague

Staff isolation: approach following updated government guidance

Guidance for allowing essential frontline staff to return to work following a negative PCR if they have been asked to isolate due to potential contact with COVID-19

The government has announced that as of today, Public Health England will update their guidance on self-isolation for health and care staff. It sets out that if there is a risk that staff absence would lead to potential patient harm then staff who are fully vaccinated (14 days post second dose) may be brought back to work ahead of the self-isolation period following the completion of a local risk assessment.

This is on the basis that the following safeguards are implemented: an immediate negative PCR test prior to returning to work, provision of subsequent negative daily LFD tests for a minimum of 7 days (with test results reported to Test and Trace via the web portal and to their duty manager or an identified senior staff member), appropriate use of IPC measures, including social distancing in the workplace when not undertaking clinical work and the use of PPE in line with the current UK IPC Guidance. Employers should take all reasonable steps to ensure the vaccine status of the employee and compliance with these safeguards. Staff should access testing through normal mechanisms.

It is important to note that any staff who are able to return to work following these risk assessments must adhere to legal isolation requirements at all other times i.e. when not at or travelling to work.

To help with local decision-making processes and support appropriate flexibility we suggest that the local risk assessment takes account of the following considerations:

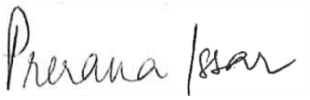
- The balance of risk between staff absence and the potential impact on patient safety – this needs to consider the risk to patients as a consequence of staff shortages versus risk associated with exposure to potential nosocomial or other transmission, which can affect patients and staff which could exacerbate staff shortages.
- Cases where the contact was a member of the staff member's household should not be eligible for this process. Across the NHS, the risk assessment process should involve (as appropriate) the organisation's medical and nursing leadership, local DIPC and local Director of Public Health (DPH) with each local organisation deciding on the most appropriate level of senior approval required for individual cases.
- In small primary care organisations, the risk assessment process should involve the senior clinical leadership, commissioner and local DPH.
- Staff who would normally care for highly vulnerable patients such as those who are immunocompromised could be re-deployed to another area, and staff may need to be deployed outside of designated green areas.
- In primary care it would apply where the immediate or system-wide impact of absence could lead to adverse patient outcomes judged to outweigh the risk of potential exposure to COVID-19.

We are clear that the aim is to support organisations to reduce the pressure we know is being experienced. However, this flexibility should not be seen as a means to bring back all staff that are absent. These guidelines give employers the 'right to allow' not to 'compel' staff to return to work. Local organisations will need to determine how to record and govern decision making to ensure appropriate application.

We recognise how hard everyone is working and that there is exceptional pressure once more in the system. We believe that the changes and processes outlined should be helpful. Where staff can work from home or care can be delivered online or by phone this should continue to be the preferred option.

These guidelines will be kept under review as the arrangements for self-isolation change over the coming months. Please see the Public Health England website for the latest guidance at any point.

Yours sincerely



Ruth May
Chief Nursing Officer, England

Professor Stephen Powis
National Medical Director

Prerana Issar
Chief People Officer for the NHS

Department of Health & Social Care

Public Health England

NHS

17 July 2021

Dear Colleague,

The national influenza immunisation programme 2021 to 2022

1. Last year saw the roll out of the biggest NHS influenza vaccination programme ever, with the aim of offering protection to as many eligible people as possible during the COVID-19 pandemic. We would like to extend a huge thank you to all those involved for your hard work during very challenging times which led to the best influenza vaccine uptake rates ever achieved.

2. As a result of non-pharmaceutical interventions in place for COVID-19 (such as mask-wearing, physical and social distancing, and restricted international travel) influenza activity levels were extremely low globally in 2020 to 2021. As a result, a lower level of population immunity against influenza is expected in 2021 to 2022. In the situation where social mixing and social contact return towards pre-pandemic norms, it is expected that winter 2021 to 2022 will be the first winter in the UK when seasonal influenza virus (and other respiratory viruses) will co-circulate alongside COVID-19. Seasonal influenza and COVID-19 viruses have the potential to add substantially to the winter pressures usually faced by the NHS, particularly if infection waves from both viruses coincide. The timing and magnitude of potential influenza and COVID-19 infection waves for winter 2021 to 2022 are currently unknown, but mathematical modelling indicates the 2021 to 2022 influenza season in the UK could be up to 50% larger than typically seen[1] and it is also possible that the 2021 to 2022 influenza season will begin earlier than usual. Influenza vaccination is therefore an important priority this coming autumn to reduce morbidity and mortality associated with influenza, and to reduce hospitalisations during a time when the NHS and social care may also be managing winter outbreaks of COVID-19.

Eligibility

3. The national influenza immunisation programme aims to provide direct protection to those who are at higher risk of influenza associated morbidity and mortality. Groups eligible for influenza vaccination are based on the advice of the Joint Committee on

[1] Modelling on influenza activity in the 2021/22 season. University of Warwick [unpublished]. Referenced in JCVI statement (30/06/2021) JCVI interim advice: potential COVID-19 booster vaccine programme winter 2021 to 2022

PHE Gateway Ref: GOV-8073
NHS England Publishing Approval Reference: PAR556

Vaccination and Immunisation (JCVI) and include older people, pregnant women, and those with certain underlying medical conditions.

4. Since 2013, influenza vaccination has been offered to children in a phased roll-out to provide both individual protection to the children themselves and reduce transmission across all age groups to protect vulnerable members of the population.

5. The expanded influenza vaccination programme that we had last year will continue in 2021 to 2022 as part of our wider winter planning when we are likely to see both influenza and COVID-19 in circulation. This means that as a temporary measure the offer for 50 to 64 year olds will continue this year to protect this age group, as hospitalisation from COVID-19 also increases from the age of 50 years onwards.

6. As a temporary measure, the programme will also be extended this year to 4 additional cohorts in secondary school so that all those from years 7 to year 11 will be offered vaccination. Vaccinating children reduces transmission of influenza and JCVI have recommended that expanding into secondary schools would be cost-effective, particularly if COVID-19 is still circulating[2].

7. Therefore, those eligible for NHS influenza vaccination in 2021 to 2022 are:

    - all children aged 2 to 15 (but not 16 years or older) on 31 August 2021
    - those aged 6 months to under 50 years in clinical risk groups
    - pregnant women
    - those aged 50 years and over
    - those in long-stay residential care homes
    - carers
    - close contacts of immunocompromised individuals
    - frontline health and social care staff employed by:
        - a registered residential care or nursing home
        - registered domiciliary care provider
        - a voluntary managed hospice provider
        - Direct Payment (personal budgets) and/or Personal Health Budgets, such as Personal Assistants.

8. All frontline health and social care workers are expected to have influenza vaccination to protect those they care for.

9. The influenza chapter in ‘Immunisation against infectious disease’ (the ‘Green Book’), which is updated periodically, gives detailed descriptions of the groups outlined above and guidance for healthcare workers on administering the influenza vaccine.

[2] Draft minute of the meeting of the Influenza sub-committee of the Joint Committee on Vaccination and Immunisation held on 26 August 2020

Vaccines for the national immunisation programme

10. Influenza viruses change continuously and the World Health Organization (WHO) monitors the epidemiology of influenza viruses throughout the world, making recommendations about the strains to be included in vaccines, with recommendations now confirmed for 2021 to 2022[3].

11. Every year JCVI reviews the latest evidence on influenza vaccines and recommends the type of vaccine to be offered to patients[4]. Providers should ensure that they have ordered adequate supplies of the recommended vaccines for their different adult patient groups, as set out in 2 letters from NHS England and Improvement (NHSEI) on 3 February and on 1 April 2021[5].

12. In summary the recommended vaccines are:

    - for those aged 65 years and over – the adjuvanted quadrivalent influenza vaccine (aQIV), with the cell-based quadrivalent influenza vaccine (QIVc) or the recombinant quadrivalent influenza vaccine (QIVr) offered if aQIV is unavailable
    - for under-65s (including those at risk, pregnant women and 50 to 64 year old cohort) offer QIVc or QIVr, as an alternative if these are not available, the egg-grown quadrivalent influenza vaccine (QIVe) should be considered for use

13. Public Health England (PHE) procures vaccines for the children's programme and these can be ordered through Immform. The live attenuated influenza vaccine (LAIV) should be offered to eligible children aged 2 years and over, unless contraindicated. QIVc, which is now licensed for all children aged 2 years and above, will be available to order for children in at risk groups who are contraindicated to receive LAIV, and as an alternative offer for children aged 2 and over whose parents object to LAIV on the ground of its porcine gelatine content. Children in clinical risk groups aged 6 months to less than 2 years should be offered QIVe.

14. LAIV is offered to children as it is generally more effective in the programme than the injected vaccines. It is also easier to administer and considered better at reducing the spread of influenza to others, who may be vulnerable to the complications of influenza.

15. In order for providers to receive payment for administration and reimbursement of vaccine they will need to use the specific influenza vaccines recommended in the NHSEI letters referred to in paragraph 11.

---

[3] WHO Consultation and Information Meeting on the Composition of Influenza Virus Vaccines for Use in the 2021 to 2022 Northern Hemisphere Influenza Season
[4] Joint Committee on Vaccination and Immunisation: Advice on influenza vaccines for 2021 to 2022
[5] NHS England: Achievements and developments during 2020 to 2021 flu season

16. Last season due to supply constraints the alternative offer for children whose parents/guardians objected to LAIV on grounds of porcine gelatine content was only able to be made from November onwards. This season no supply constraints are anticipated and the alternative offer should be made routinely from the start of the season where applicable.

Achieving high vaccine uptake levels

17. Last season saw the most successful programme ever. Despite the challenges due to the COVID-19 pandemic, at the end of February 2021 NHS services had vaccinated a record 80.9% of those aged 65 years and over in England. This is the highest uptake ever achieved for this group and exceeds the WHO uptake ambition of 75%. For frontline healthcare workers, 2 and 3 year olds, and at risk groups the highest ever recorded levels of influenza vaccine uptake were also achieved. [6].

18. All providers should have planned their influenza vaccine ordering to at least equal the high levels of uptake achieved in 2020 to 2021. The ambitions we are setting for the 2021 to 2022 programme are set out below. We want to build on the momentum of last year's achievements and the successful roll-out of the COVID-19 vaccination programme, achieving even higher uptake this year. You many need to order additional vaccine to support you in reaching these ambitions.

19. The high ambitions reflect the importance of protecting against flu this winter and should be regarded as a minimum level to achieve. The different ambitions across the cohorts reflect what is regarded as achievable so, for instance, for those aged 65 and over the high ambition reflects the already high uptake levels achieved last year whereas for school-aged children the large expansion into secondary school this year will be challenging in itself.

Table 1. Vaccine uptake ambitions in 2021 to 2022

Eligible groups	Uptake ambition
Routine programme for those at risk from influenza	
Aged 65 years and over	At least 85%
Aged under 65 'at risk', including pregnant women	At least 75% in all clinical risk groups
Aged 50 to 64 years	At least 75%
Children's programme	

6 Seasonal flu vaccine uptake in GP patients: winter season 2020 to 2021
Seasonal flu vaccine uptake in children of school age: winter season, 2020 to 2021
Seasonal flu vaccine uptake in healthcare workers: winter season, 2020 to 2021

Preschool children aged 2 and 3 years old	At least 70% with most practices aiming to achieve higher.
School-aged children	At least 70% to be attained across all eligible school years.
Reducing levels of inequality	
All ages	No group or community should have a vaccine uptake that is more than 5% lower than the national average. See paragraph 18 for more details.
Health and social care workers	
Frontline health care workers	100% offer with an 85% ambition
Frontline social care workers	100% offer with an 85% ambition

* In addition to occupational health schemes, all frontline social care workers can access a free vaccination from their GP or local pharmacy through the complementary scheme.

20. In 2020 to 2021, published monthly data included a breakdown by ethnic group for the first time, and this was included in the 2020 to 2021 annual report[7] and this will continue in 2021 to 2022. Other inequalities work led by PHE will continue to monitor and enhance the tools available and will include data on Index of Multiple Deprivation (IMD) which can be used to provide the best measure of relative deprivation as a snapshot in time (see Appendix I). We need to ensure those who are living in the most deprived areas, from ethnic minority and other underserved communities, have equitable uptake compared to the population as a whole. It will therefore require high quality, dedicated and interculturally competent engagement with local communities, employers, faith and advocacy groups. Providers are expected to ensure they have robust plans in place for tackling health inequalities for all underserved groups to ensure equality of access.

21. GP practices and school-based providers must actively invite 100% of eligible individuals (for example, by letter, email, phone call, text) and ensure uptake is as high as possible. The benefits of influenza vaccination among all eligible groups should be communicated and vaccination made as accessible as possible. Community pharmacy service providers do not have a fixed patient list from which to undertake call and recall activities. However, they should proactively offer influenza vaccination to any patient they identify as being eligible to receive it should the patient present in the pharmacy for any reason.

22. NHSEI will be recommissioning of a National Call and Recall service for the 2021 to 2022 season. This national call and recall service will supplement rather than replace

[7] Seasonal influenza vaccine uptake in GP patients: winter season 2020 to 2021 (24/06/2021) https://www.gov.uk/government/statistics/seasonal-flu-vaccine-uptake-in-gp-patients-winter-2020-to-2021

local contractual call and recall mechanisms which must still continue as contracts dictate.

Frontline health and social care workers

23. All frontline health and social care workers should receive a vaccination this season. This should be provided by their employer, in order to meet their responsibility to protect their staff and patients and ensure the overall safe running of services. Employers should commission a service which makes access easy to the vaccine for all frontline staff, encourage staff to get vaccinated, and monitor the delivery of their programmes.

24. For healthcare workers providers should use the current definition as set out in chapter 12 of the Green Book.

25. As in previous years, NHS Trusts should complete a self-assessment against a best practice checklist which has been developed based on 5 key components of developing an effective flu vaccination programme. The completed checklist should be published in public board papers at the start of the flu season. (See Appendix H.)

26. Where employee led occupational health services are not in place NHS England and Improvement (NHSEI) will continue to support vaccination of social care and hospice workers employed by registered residential or domiciliary care providers as well as those employed through Direct Payment and/or Personal Health Budgets to deliver domiciliary care to patients and service users. Vaccination will be available through community pharmacy or their registered general practice. This scheme is intended to complement, not replace, any established occupational health schemes that employers have in place to offer flu vaccination to their workforce.

27. Since last year, the Community Pharmacy Seasonal Influenza Advanced Service Framework enables community pharmacies to vaccinate both residential care or nursing home residents **and** staff in the home setting in a single visit.

28. Good practice guidance material can be found at Increasing Health and Social Care Worker Flu Vaccinations: Five Components and marketing resources will be available to download and order from the PHE Campaign Resource Centre.

Influenza and COVID-19 vaccination

29. At present, the Green Book chapter on the COVID-19 vaccine states that administration of the COVID-19 vaccine should ideally be scheduled with an interval of at least 7 days to another vaccination (including influenza) in order to avoid incorrect attribution of potential adverse events[8]. Booster vaccines for COVID-19 are currently under

[8] COVID-19: the Green Book, chapter 14a

consideration, with trials underway to ascertain whether co-administration of COVID-19 and influenza vaccines will be permissible, subject to the advice of JCVI. Early evidence on the concomitant administration of COVID-19 and influenza vaccines used in the UK, supports the delivery of both vaccines at the same time where appropriate[9].

30. Planning for influenza vaccination should continue as usual for this autumn, with further advice issued should co-administration with COVID-19 vaccination be recommended so that where appropriate both vaccines could be given at the same time.

Timing

31. Vaccination should be given in sufficient time to ensure patients are protected before influenza starts circulating. If an eligible patient presents late for vaccination it is generally appropriate to still offer it. This is particularly important if it is a late influenza season or when newly at risk patients present, such as pregnant women who may not have been pregnant at the beginning of the vaccination period. The decision to vaccinate should take into account the fact that the immune response to vaccination takes about 2 weeks to fully develop.

32. Last year the school age immunisation national service specification had a requirement that, to provide early protection, the provider would complete the influenza vaccination as early as possible after the influenza vaccine became available and at the latest by 15 December for all eligible children. In order to facilitate the service expansion alongside the continuation and catch up of the routine school age immunisation programmes this season the completion date for school age influenza vaccinations has been extended until the end of January 2022 although providers are encouraged to complete as soon as possible.

33. Parents of any child at risk from influenza because of an underlying medical condition can choose to receive influenza vaccination in general practice, especially if the parent does not want their child to have to wait for the school vaccination session (which may be one of the later sessions). GP practices should invite these children for vaccination, making it clear that parents have the option to have their child vaccinated in general practice.

List of appendices

34. Detailed planning information is set out in the following appendices:

[9] National Immunisation Schedule Evaluation Consortium (NISEC) data [unpublished], referenced in the JCVI Interim Statement regarding a potential COVID-19 Booster vaccine programme for winter 2021 to 2022 (30/06/2021)

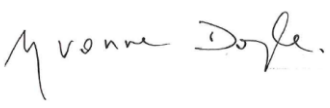
Conclusion

35. We would like to take this opportunity to thank you all for your hard work in delivering the influenza immunisation programme. We have some of the best influenza vaccine uptake rates in Europe and we achieved record levels in 2020 to 2021. This winter, it remains a key intervention to reduce pressure on the NHS and social care.

36. This Annual Influenza Letter has the support of the Chief Pharmaceutical Officer, the NHS Chief Nursing Officer for England and the Public Health England Chief Nurse.

Yours sincerely,

Prof Chris Whitty
Chief Medical Officer for England



Prof Yvonne Doyle
Public Health England Medical Director & Director for Health Protection

Prof Stephen Powis
NHS England & NHS Improvement, National Medical Director

Any enquiries regarding this publication should be sent to: immunisation@phe.gov.uk. For operational immunisation queries, providers should contact their local screening and immunisation team.

Links to other key documents

Green Book Influenza Chapter

Joint Committee on Vaccination and Immunisation

National Institute for Health and Care Excellence (NICE) guidelines on increasing influenza vaccine uptake

NHS England Public Health Commissioning information

General practice specifications for seasonal influenza immunisation

Community Pharmacy Seasonal Influenza Vaccination Advanced Service

Immform Survey User guide for GP practices, local NHS England teams, and NHS Trusts

Flu vaccine uptake figures

Flu immunisation PGD templates

ImmForm website for ordering child flu vaccines

National Q&As training slide sets

e-learning programme

Vaccine Update – PHE monthly newsletter

PHE Flu Immunisation Programme home page

PHE Campaign Resource Centre – Help Us Help You campaign

Distribution list

General practices
Community pharmacies
Clinical commissioning groups clinical leads
Clinical commissioning groups accountable officers
General Practitioners Committee
Pharmaceutical Services Negotiating Committee
NHS England & NHS Improvement regional directors
NHS England & NHS Improvement regional medical directors
NHS England & NHS Improvement regional chief nurses
NHS England & NHS Improvement regional directors of commissioning
NHS England & NHS Improvement regional directors of primary care & public health
NHS England & NHS Improvement heads of public health commissioning
NHS England & NHS Improvement heads of primary care
Sustainability and Transformation Partnership (STP) primary care leads
Integrated Care System (ICS) primary care leads
PHE centre directors
Screening and immunisation leads
Chief executives of NHS trusts and foundation trusts
Heads of nursing of NHS trusts and foundation trusts
Heads of midwifery of NHS trusts and foundation trusts
Chief pharmacists of NHS trusts and foundation trusts
Directors of public health
Local authority chief executives
NHS regional chief pharmacists
Chairs of health and wellbeing boards

For information

Allied Health Professionals Federation
Community Practitioners and Health Visitors Association
Nursing and Midwifery Council
Royal College of Midwives
Royal College of Nursing
Academy of Medical Royal Colleges
Royal College of Anaesthetists
Royal College of Physicians
Royal College of Surgeons
Royal College of Obstetricians and Gynaecologists
Royal College of General Practitioners
College of Emergency Medicine
Faculty of Occupational Medicine
Royal College of Pathologists
Royal College of Ophthalmologists
Royal College of Paediatrics & Child Health
British Medical Association
Royal Pharmaceutical Society
Association of Pharmacy Technicians UK
Company Chemist's Association
National Pharmacy Association
Local Government Association
Association of Directors of Adult Social Services
Council of Deans of Health
General Medical Council
General Pharmaceutical Council
Faculty of Public Health
Association of Independent Multiple Pharmacies
UK Homecare Association (UKHCA)
Skills for Care
Association of Directors of Adult Social Services
Care Association Alliance
Care Provider Alliance
Hospice UK
Voluntary Organisations Disability Group
National Care Forum (NCF)
National Care Association (NCA)
Care England
Local Government Association
Unison

Appendix A: Groups included in the national influenza immunisation programme

1. In 2021 to 2022, influenza vaccinations will be offered under the NHS influenza immunisation programme to the following groups:

    - all children aged 2 to 15 (but not 16 years or older) on 31 August 2021
    - people aged 50 years or over (including those becoming age 50 years by 31 March 2022)
    - those aged from 6 months to less than 50 years of age, in a clinical risk group such as those with:
        - chronic (long-term) respiratory disease, such as asthma (requires continuous or repeated use of inhaled or systemic steroids or with previous exacerbations requiring hospital admission), chronic obstructive pulmonary disease (COPD) or bronchitis
        - chronic heart disease, such as heart failure
        - chronic kidney disease at stage 3, 4 or 5
        - chronic liver disease
        - chronic neurological disease, such as Parkinson's disease or motor neurone disease
        - learning disability
        - diabetes
        - splenic dysfunction or asplenia
        - a weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment)
        - morbidly obese (defined as BMI of 40 and above)
    - all pregnant women (including those women who become pregnant during the influenza season)
    - household contacts of immunocompromised individuals, specifically individuals who expect to share living accommodation on most days over the winter and, therefore, for whom continuing close contact is unavoidable
    - people living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality. This does not include, for instance, prisons, young offender institutions, university halls of residence, or boarding schools (except where children are of primary school age or secondary school Years 7 to 11)
    - those who are in receipt of a carer's allowance, or who are the main carer of an older or disabled person whose welfare may be at risk if the carer falls ill
    - health and social care staff, employed by a registered residential care or nursing home or registered domiciliary care provider, who are directly involved in the care of vulnerable patients or clients who are at increased risk from exposure to influenza

- health and care staff, employed by a voluntary managed hospice provider, who are directly involved in the care of vulnerable patients or clients who are at increased risk from exposure to influenza
- health and social care workers employed through Direct Payments (personal budgets) and/or Personal Health Budgets, such as Personal Assistants, to deliver domiciliary care to patients and service users

2. Organisations should vaccinate all frontline health and social care workers, in order to meet their responsibility to protect their staff and patients and ensure the overall safe running of services.
3. The list above is not exhaustive, and the healthcare professional should apply clinical judgement 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.
4. Healthcare practitioners should refer to the influenza chapter in ‘Immunisation against infectious disease’ (the ‘Green Book’) for further detail about clinical risk groups advised to receive influenza immunisation and for full details on advice concerning contraindications and precautions for the influenza vaccines.

Appendix B: Service specifications

1. The general practice specification for seasonal influenza immunisation sets out all eligible groups for vaccination (apart from those aged 2 and 3 on 31 August 2021). It includes eligible frontline health and care workers working in residential care and nursing homes, domiciliary care providers, the voluntary managed hospice sector, and those employed through Direct Payment (personal budgets) and/or Personal Health Budgets, such as Personal Assistants. The specification will be published on the NHS GP Contract web page.

2. There is a separate Enhanced Service (ES) specification for the childhood seasonal influenza vaccination programme, covering the vaccination of children aged 2 and 3 years on 31 August 2021. The specification will be published on the NHS GP Contract web page.

3. General practices are reminded that they are required to operate a proactive call and recall system to contact all at risk patients. Various methods for this should be considered such as letter, email, phone call, text or social media and during face to face interactions if the opportunity arises, to encourage people to attend for their vaccination.

4. Community pharmacies offering an influenza vaccination service for adults will be required to do so in accordance with the Community Pharmacy Seasonal Influenza Vaccination Advanced service specification for 2021 to 2022 which will be published on the Community Pharmacy Seasonal Influenza Vaccine Service web page.

5. The school age immunisation service specification has a requirement that, to provide early protection, the provider will complete influenza vaccination as early as possible after the influenza vaccine becomes available and at the latest by 31 January 2022 for all eligible children. School aged immunisation services must offer the vaccine to 100% of eligible children.

Appendix C: Recommended influenza vaccines

1. The Joint Committee on Vaccination and Immunisation (JCVI) has reviewed the latest evidence on influenza vaccines and recommended the following for the 2021 to 2022 season (summarised in table on next page).[10] Providers should ensure that they have ordered adequate supplies of the recommended vaccines for their different adult patient groups, as set out in 2 letters from NHS England and Improvement (NHSEI) on 4 February and on 1 April 2021[11].

2. **Aged 65 years and over.** These patients should be offered an adjuvanted quadrivalent influenza vaccine (aQIV). Where this is not available a cell-based quadrivalent influenza vaccine (QIVc) and the recombinant quadrivalent influenza vaccine (QIVr) are considered acceptable alternatives and are preferable to standard egg-culture influenza vaccines. Doses of QIVr are available to order in limited quantities and will be reimbursed.

3. JCVI recommended the high dose quadrivalent influenza vaccine (QIV-HD) is offered alongside aQIV because of the additional benefit from the use of aQIV and QIV-HD in those aged 65 years and over, compared with standard dose egg-culture inactivated trivalent and quadrivalent vaccines. However, QIV-HD is not currently available in the UK market.

4. **Aged 18 to 64 years (including at risk adults, pregnant women, and 50 to 64 year olds cohort).** This group should be offered QIVc or QIVr as there is a clear benefit to offering quadrivalent vaccines compared to trivalent influenza vaccines. There is also a potential advantage to using vaccines that do not use egg in the manufacturing process due to the possible impact of ‘egg-adaptation’ on the effectiveness of influenza vaccines, particularly against A(H3N2) strains. The egg grown quadrivalent influenza vaccine (QIVe) should be considered for use where QIVc or QIVr are not available because any impact of egg adaptation will likely be limited to seasons in which the influenza season is dominated by well-matched H3N2 strains.

5. **Children aged 2 years to less than 18 years.** These children should be offered the live attenuated influenza vaccine (LAIV). JCVI recommended that at risk children for whom LAIV is not suitable should be offered QIVc (now licensed from the age of 2), or QIVe, in that order of preference. However, please note that PHE has only procured LAIV and QIVc for this age group.

---

[10] Joint Committee on Vaccination and Immunisation: Advice on influenza vaccines for 2021 to 2022
[11] 2021 to 2022 influenza season: letter and NHS England: Achievements and developments during 2020 to 2021 flu season

6. **At risk children aged 6 months to 2 years of age**. These children should be offered QIVe, which has been procured by PHE for this age group. Please note that neither LAIV or QIVc are licensed for children under 2 years of age.

7. **Children whose parents decline LAIV:** If the parent of an eligible child refuses LAIV because of its porcine gelatine content (and they understand that it is the most effective product in the programme), a policy decision has been made that they can request an alternative injectable vaccine. PHE has procured QIVc for these children which will be available for use from the start of the season.

Table 2. Summary table of which influenza vaccines to offer

Eligible group	Type of influenza vaccine
At risk children aged from 6 months to less than 2 years	Offer QIVe. LAIV and QIVc are not licensed for children under 2 years of age.
At risk children aged 2 to under 18 years*	Offer LAIV. If LAIV is contraindicated (or it is otherwise unsuitable) offer: • QIVc
Aged 2 and 3 years on 31 August 2021 Primary school aged children and those in Year 7 to 11 in secondary school (aged 4 to 15 on 31 August 2021)	Offer LAIV If LAIV is contraindicated (or it is otherwise unsuitable) offer: • QIVc*
Aged 18 to 64 (including at risk, pregnant women, and 50 to 64 year olds cohort)	Offer: • QIVc or • QIVr Or offer QIVe (if QIVc or QIVr are not available).
Aged 65 years and over**	Offer aQIV. Or offer QIVc or QIVr if aQIV is not available. It is recommended that aQIV is offered ‘off-label’ to those who become 65 before 31 March 2022.

* QIVe is suitable to offer to these children but as a second option. QIVe has not been procured by PHE for this age group.
** JCVI recommended use of QIV-HD in this age group but this is not currently available in the UK market.

Appendix D: Vaccine supply and ordering

Vaccine supply for adult's programme

1. Providers remain responsible for ordering vaccines directly from manufacturers. Further guidance on additional support for the expanded flu programme next season, including on access to supply, may be released ahead of the season starting.

2. Providers should ensure they are able to offer the most effective vaccine for each eligible group consistent with national guidance. Provided a patient is offered a recommended vaccine for their age, providers are not expected to have to offer a choice between vaccines.

3. Influenza vaccines generally start to be distributed from September each year. However, vaccine manufacture involves complex biological processes. There is always the possibility that initial batches of vaccine may be subject to delay, or that fewer doses than planned may be available initially. Providers should remain flexible when scheduling vaccination sessions, and be prepared to reschedule if necessary.

Vaccine supply for children's programme

4. Public Health England procures and supplies the vaccines for the children's programme. This includes the live attenuated influenza vaccine (LAIV) administered as a nasal spray which is suitable for use in children aged 2 to less than 18 years except where contraindicated. Children in at-risk groups for whom LAIV is unsuitable, and healthy children whose parents object to LAIV on the ground of its porcine gelatine content should be offered the injectable cell-based Quadrivalent Influenza Vaccine (QIVc) if aged 2 years to less than 18. Children aged 6 months to less than 2 years should be offered QIVe. Centrally supplied children's vaccines can be ordered through the ImmForm website.

5. Timing of vaccine availability should be taken into account when vaccination sessions are being arranged.The latest and most accurate information on availability of centrally supplied influenza vaccines for the children's programme will be made available on the ImmForm news page.

6. As usual, ordering controls will be in place for Fluenz® Tetra in 2021 to 2022 to enable PHE to manage vaccine availability and demand appropriately across the programme. The latest information on ordering controls and other ordering advice for PHE supplied influenza vaccines will be featured on the ImmForm news page both prior to and during the influenza vaccination period. Information will also be featured in Vaccine Update and disseminated via the National Immunisation Network as appropriate. It is strongly advised that all parties involved in the provision of influenza vaccines to children ensure they remain up to date with this information at all times until the end of the 2021 to 2022 programme.

Vaccines available in 2021 to 2022

7. The vaccines that are available for the 2021 to 2022 influenza immunisation programme are listed here: www.gov.uk/government/publications/influenza-vaccine-ovalbumin-content

8. None of the influenza vaccines contain thiomersal as an added preservative. Some influenza vaccines are restricted for use in particular age groups. The Summary of Product Characteristics (SmPC) for individual products **should always** be referred to when ordering vaccines for particular patients.

Appendix E: Training resources, PGDs, protocols and patient facing information

1. Healthcare practitioners should refer to the influenza chapter in 'Immunisation against infectious disease' (the 'Green Book') for further detail about clinical risk groups advised to receive influenza immunisation and advice on contraindications and precautions for the influenza vaccines.

2. Information for healthcare practitioners about the childhood influenza programme and the inactivated influenza vaccines, and links to training slide sets and influenza e-learning programme will be available on the Annual flu programme webpage and the e-learning for healthcare Flu Immunisation web page.

3. PHE will develop PGDs that will be available prior to commencement of the programme at Immunisation patient group direction (PGD) templates and Community Pharmacy Seasonal Influenza Vaccine Service.

4. PHE will support development of national protocols if pandemic operational delivery models are to be utilised for the delivery of seasonal influenza vaccination in the 2021 to 2022 season.

5. Resources for the PHE public facing marketing campaign to encourage take-up amongst eligible groups and for adaptable assets for NHS and social care organisations to use in their own staff vaccination campaigns will be available from the PHE Campaign Resource Centre.

6. Template letters for practices to use will be available on the Annual flu programme web page.

Appendix F: Children's influenza vaccination programme

1. A recommendation to extend influenza vaccination to children was made in 2012 by JCVI to provide both individual protection to the children themselves and reduce transmission across all age groups[12]. Implementation of the programme began in 2013 with pre-school children offered vaccination through GP practices and pilots for school aged children.

2. Research into the first 3 years of the childhood programme compared the differences between pilot areas, where the entire primary school age cohort was offered vaccination, to non-pilot areas. Findings include reductions in: GP consultations for influenza-like illness, swab positivity in primary care, laboratory confirmed hospitalisations and percentage of respiratory emergency department attendances[13].

3. In 2015 to 2016 the programme began nationally in a phased roll-out starting with the youngest school-aged children first and was fully implemented for all primary school aged children in 2019 to 2020. There was then to be a pause in the programme to fully assess the impact before deciding whether to extend into secondary school. However, because of the COVID-19 pandemic, last year the vaccine was offered to those in Year 7 in secondary school to offer wider protection.

4. This year as part of our wider winter planning and an expanded flu vaccination programme, an offer will be extended to all secondary school aged children in Years 7 to 11, in addition to all children aged 2 to 3 in General Practice and all primary school aged children in Reception Year to Year 6.

5. In 2021 to 2022 the following children will be offered vaccination as follows:

    - all those aged 2 and 3 years old on 31 August 2021 (date of birth on or after 1 September 2017 and on or before 31 August 2019) will be offered vaccine in general practice
    - all primary school-aged children in Reception Year to Year 6 (ages 4 to 10 on 31 August 2021) will be offered through a school age immunisation service
    - all secondary school aged children in Years 7 to Year 11 (ages 11 to 15 on 31 August 2021) will be offered through a school age immunisation service

[12] Joint committee on Vaccination and Immunisation. Statement on the annual influenza vaccination programme – extension of the programme to children. JCVI (2012). 25 July 2012.
[13] Pebody, R. et al. 21 June 2018. Uptake and impact of vaccinating primary school-age children against influenza: experiences of a live attenuated influenza vaccine programme, England, 2015 to 2016. Eurosurveillance. Volume 23, Issue 25.

6. Some school aged children might be outside of the age ranges outlined in the above paragraph (for example, if a child has been accelerated or held back a year). It is acceptable to offer and deliver immunisations to these children with their class peers.

7. At-risk children who are eligible for influenza vaccination via the school-based programme because of their age will be offered immunisation at school. However, these children are also eligible to receive vaccination in general practice if the school session is late in the season, parents prefer it, or they missed the session at school. GP practices should invite children in at-risk groups for vaccination, so that parents understand they have the option of taking up the offer in either setting.

8. Children in at-risk groups for whom LAIV is contraindicated or unsuitable will be offered an inactivated influenza vaccine.

9. LAIV is offered to children as it is more effective in the programme than the injected vaccines. This is because it is easier to administer and considered better at reducing the spread of influenza to others, who may be vulnerable to the complications of influenza. Where parents object to LAIV on the ground of its porcine gelatine content, an alternative injected vaccine (QIVc) will be available.

Appendix G: Pregnant women

Rationale

1. All pregnant women are recommended to receive the inactivated influenza vaccine irrespective of their stage of pregnancy.

2. There is good evidence that pregnant women are at increased risk from complications if they contract influenza[14,15]. In addition, there is evidence that having influenza during pregnancy may be associated with premature birth and smaller birth size and weight[16, 17] and that influenza vaccination may reduce the likelihood of prematurity and smaller infant size at birth associated with an influenza infection during pregnancy[18]. Furthermore, a number of studies show that influenza vaccination during pregnancy provides protection against influenza in infants in the first few months of life[19, 20,21,22,23].

3. A review of studies on the safety of influenza vaccine in pregnancy concluded that inactivated influenza vaccine can be safely and effectively administered during any trimester of pregnancy and that no study to date has demonstrated an increased risk of either maternal complications or adverse fetal outcomes associated with inactivated influenza vaccine.[24]

When to offer the vaccine to pregnant women

14 Neuzil KM, and others. (1998) Impact of influenza on acute cardiopulmonary hospitalizations in pregnant women. American Journal of Epidemiology. 148:1094-102
15 Pebody R and others. (2010) Pandemic influenza A (H1N1) 2009 and mortality in the United Kingdom: risk factors for death, April 2009 to March 2010. Eurosurveillance 15(20): 19571.
16 Pierce M, and others (2011) Perinatal outcomes after maternal 2009/H1N1 infection: national cohort study. BMJ. 342:d3214.
17 McNeil SA, and others. (2011) Effect of respiratory hospitalization during pregnancy on infant outcomes. American Journal of Obstetrics and Gynecology. 204: (6 Suppl 1) S54-7.
18 Omer SB, and others (2011) Maternal influenza immunization and reduced likelihood of prematurity and small for gestational age births: a retrospective cohort study. PLoS Medicine. 8: (5) e1000441.
19 Benowitz I, and others (2010) Influenza vaccine given to pregnant women reduces hospitalization due to influenza in their infants. Clinical Infectious Diseases. 51: 1355-61.
20 Eick AA, and others. (2010) Maternal influenza vaccination and effect on influenza virus infection in young infants. Archives of Pediatrics and Adolescent Medicine. 165: 104-11.
21 Zaman K, and others. (2008) Effectiveness of maternal influenza immunisation in mothers and infants. New England Journal of Medicine. 359: 1555-64.
22 Poehling KA, and others. (2011) Impact of maternal immunization on influenza hospitalizations in infants. American Journal of Obstetrics and Gynecology. 204:(6 Suppl 1) S141-8.
23 Dabrera G, and others. (2014) Effectiveness of seasonal influenza vaccination during pregnancy in preventing influenza infection in infants, England, 2013 to 2014. Eurosurveillance. Nov 13;19.
24 Tamma PD, and others. (2009) Safety of influenza vaccination during pregnancy. American Journal of Obstetrics and Gynecology. 201(6): 547-52.

4. The ideal time for influenza vaccination is before influenza starts circulating. However, even after influenza is in circulation vaccination should continue to be offered to those at risk and newly pregnant women. Clinicians should apply clinical judgement to assess the needs of an individual patient, taking into account the level of flu-like illness in their community and the fact that the immune response following influenza vaccination takes about 2 weeks to develop fully.

Data review and data recording

5. Uptake of vaccine by pregnant women, along with other groups, will be monitored. GPs will need to check their patient database throughout the duration of the influenza vaccination programme in order to identify women who become pregnant during the season. GPs should also review their records of pregnant women before the start of the immunisation programme to ensure that women who are no longer pregnant are not called for vaccination (unless they are in other clinical risk groups) and so that they can measure the uptake of influenza vaccine by pregnant women accurately.

Maternity services

6. All pregnant women are able to access influenza immunisation from their GP practice or a community pharmacy. In addition, Maternity Service Providers may also vaccinate pregnant women via a national Service Specification as commissioned by NHSEI.

7. Midwives need to be able to explain the benefits of influenza vaccination to pregnant women and offer them the vaccine, or signpost women back to their GP or community pharmacy if they are unable to offer the vaccine.

8. Where maternity providers or pharmacies provide the influenza vaccine, it is important that the patient's GP practice is informed in a timely manner (within 48 hours) so their records can be updated accordingly, and included in vaccine uptake data collections. Maternity providers should ensure they inform GPs when a woman is pregnant or no longer pregnant.

Appendix H: Healthcare worker flu vaccination best practice management checklist

For public assurance via trust boards by December 2021.

A	Committed leadership	Trust self-assessment
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	
A3	Board receive an evaluation of the flu programme 2020 to 2021, including data, successes, challenges and lessons learnt	
A4	Agree on a board champion for flu campaign	
A5	All board members receive flu vaccination and publicise this	
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	
A7	Flu team to meet regularly from September 2021	
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	
B3	Board and senior managers having their vaccinations to be publicised	
B4	Flu vaccination programme and access to vaccination on induction programmes	
B5	Programme to be publicised on screensavers, posters and social media	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	
C2	Schedule for easy access drop in clinics agreed	
C3	Schedule for 24 hour mobile vaccinations to be agreed	
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	
D2	Success to be celebrated weekly	

Appendix I: Data collection

Introduction

1. PHE publish the national Official Statistics on vaccine coverage that are used to formally evaluate the programme year-on-year and these data collections are managed through the ImmForm website.

2. PHE coordinates the data collection and will issue details of the collection requirements and guidance on the data collection process. This guidance and flu vaccine uptake data will be available at Vaccine uptake guidance and the latest coverage data.

3. In addition to the established ImmForm data collections, as was the case in the 2020 to 2021 season, NHSEI will also collect vaccination data for internal operational management purposes. Further information will be provided on this ahead of the flu season.

4. Queries concerning data collection content or process should be emailed to influenza@phe.gov.uk. Queries concerning ImmForm login details and passwords should be emailed to helpdesk@immform.org.uk.

Reducing the burden from data collections

5. Considerable efforts have been made to reduce the burden of PHE data collections and these are regularly submitted for approved to the Data Coordination Board (DCB) or been through a full burden assessment by the former Review of Central Returns (ROCR) and Burden Advice and Assessment Service (BAAS) functions within NHS Digital. Over 95% of GP practices benefited from using automated IT data returns for final data collections extracted directly from GP system suppliers (GPSS) in 2020 to 2021 survey. GP practices that are not able to submit automated returns should discuss their arrangements with their GPSS. If automated returns fail for the monthly data collection GP, practices will be required to manually submit the mandatory data items on to ImmForm to meet contractual obligations.

Data collections for 2021 to 2022

6. Monthly data collections (for Healthcare workers, School aged children and eligible GP registered patients) will take place over 6 months during the 2021 to 2022 flu immunisation programme. Subject to the approval from the Data Coordination Board the first data collection will be for vaccines administered by the end of September 2021 (data collected in October 2021), with the subsequent collections monthly thereafter, and with the final data collection for all vaccines administered by the end of February 2022 (final data collected in March 2022).

7. Data will be collected and published monthly using NHS geographies and by local authority (LA) level.

8. During the data collection period, those working in the NHS with relevant access rights are able, through the ImmForm website, to:

   - validate the data on point of entry and correct any errors before the end of the data submission period
   - view vaccine uptake data by eligible groups for areas they are responsible for
   - compare themselves with other anonymous general practices or areas

9 The data and tools provided by ImmForm are a trusted source of information. These can be used to facilitate the local and regional management of the flu vaccination programme, enhance the monitoring of inequalities and the impact of interventions to address these.

10 For the 2021 to 2022 season, in addition to the routine data items covering vaccine uptake in pregnant women, PHE will be running a new data collection to evaluate vaccine coverage in women who have delivered in the previous month. This is similar to how the pertussis vaccination programme is evaluated and will take place year-round to evaluate coverage year-on-year, rather than just in season. This will also allow for a direct comparison between flu and pertussis vaccination coverage in pregnancy.

11. The NHS is also reviewing the technology and data used to capture flu administration. All NHS Trusts are required to record flu vaccinations, for staff and patients, using the same Point of Care recording system which they use for COVID-19 vaccinations. Changes or additions to other NHS flu data collections will be outlined in the applicable service specifications.

Monitoring on a weekly basis

11. Weekly uptake data will be collected from GP practices that have fully automated extracts provided by their GPSS. These data will be published in the PHE weekly flu report.

12. During the data collection period, those working in the NHS with relevant access rights are able, through the ImmForm website to view this data as per the monthly collections described above.

Appendix J: Antiviral medicines

1. Antiviral medicines (AVMs) have an important role to play in managing symptoms of influenza for specified groups of patients, especially for people who may not get vaccinated against seasonal influenza.

2. AVMs can only be prescribed by GPs and non-medical prescribers in primary care during the influenza season, once a Central Alerting System (CAS) Alert has been cascaded to GP practices and community pharmacies by the Chief Medical Officer (CMO) and Chief Pharmaceutical Officer authorising the prescribing and supply of AVMs at NHS expense, informed by surveillance data from Public Health England, that indicates that influenza activity has risen above baseline levels, across a number of indicators.

3. Antiviral medicines may be prescribed for patients in ‘clinical at-risk groups’ as well as individuals who are at risk of severe illness and/or complications from influenza if not treated.

4. More information on clinical at-risk groups and patients eligible for treatment in primary care at NHS expense with either oseltamivir or zanamivir can be found on the Influenza: treatment and prophylaxis using anti-viral agents web page.

5. Once PHE informs DHSC that the level of seasonal influenza activity is below threshold levels at the end of the influenza season, another CMO CAS Alert is cascaded to stop the prescribing and supply of AVMs.

6. The statutory prescribing restrictions that apply to primary care do not apply in secondary care. Hospital clinicians can continue to prescribe antiviral medicines for patients whose illness is confirmed or clinically suspected to be due to influenza, in accordance with PHE guidance for the treatment of complicated influenza.

7. The Department of Health and Social Care works with manufacturers of AVMs from summer and throughout the influenza season to monitor supplies of AVMs to ensure adequate stocks are available in the supply chain to meet demand.

Department of Health & Social Care

NHS

Medicine Supply Notification

MSN/2021/037

Catapres® (clonidine) 100microgram tablets

Tier 2 – medium impact*

Date of issue: 21/07/2021

Summary

- Very limited supplies of Catapres® (clonidine) 100microgram tablets are available until w/c 4th October 2021.
- Clonidine 25 microgram tablets remain available and able to support a full increase in demand.
- Clonidine 50 microgram /5ml oral solution sugar free remain available and able to support a full increase in demand.
- The above preparations have different licensed indications (migraine or recurrent vascular headache and menopausal hot flushes) to Catapres® 100 microgram tablets (see supporting information below).
- Unlicensed imports of clonidine 100 microgram tablets can be sourced. Lead times vary.

Actions Required

For patients with insufficient supplies until the re-supply date, clinicians should consider the following options:

- prescribe clonidine 25 microgram tablets and counsel patients on the equivalent number of tablets required (see supporting information below); or
- prescribe clonidine 50 microgram /5ml oral solution sugar-free and counsel patients on the equivalent volume of liquid required (see supporting information below); or
- consider prescribing unlicensed imports (see supporting information below).

Supporting Information

Clonidine alternative preparations:

- Catapres® (clonidine) 100 microgram tablets are licensed for the treatment of all grades of essential and secondary hypertension. Initial treatment dose is 50 - 100 micrograms three times daily, which is increased gradually, with most patients controlled on divided daily doses of 300 - 1200 micrograms.
- Despite difference in licensed indication(s), there are no known differences in bioavailability between clonidine 25 microgram tablets or clonidine 50 microgram /5ml oral solution sugar free and Catapres® 100 microgram tablets, and they can be considered interchangeable.
- When switching patients to clonidine 25 microgram tablets or clonidine 50 microgram /5ml oral solution sugar free, clinicians should consider the quantity of tablets or volume of liquid required to deliver the equivalent dose and check patient's understanding (see Table 1).
- For patients prescribed a high dose of clonidine, prescribers should work with local pharmacies to establish availability of clonidine 100 microgram tablets for the period of the shortage and signpost patients accordingly.

*Classification of Tiers can be found at the following link: **A Guide to Managing Medicines Supply and Shortages.**

Table 1: Clonidine 100microgram tablets equivalent conversion

Preparation	Equivalent dose to clonidine 100 microgram
Clonidine 25 microgram tablets	4 tablets
Clonidine 50 microgram / 5ml oral solution sugar-free	10ml

Please refer to the BNF and SPCs below for further information:

- Clonidine hydrochloride BNF
- Clonidine 25mcg tablets
- Clonidine 50mcg/5ml oral solution sugar free

Guidance on ordering and prescribing unlicensed imports

The following specialist importers have currently confirmed they can source unlicensed clonidine 100 microgram tablets (please note, there may be other companies that can also source supplies):

- Alium Medical
- Mawdsleys
- Target Healthcare
- UL Global Pharma

Any decision to prescribe an unlicensed medicine must consider the relevant guidance and NHS Trust or local governance procedures. Please see the links below for further information:

- The supply of unlicensed medicinal products, Medicines and Healthcare products Regulatory Agency (MHRA)
- Professional Guidance for the Procurement and Supply of Specials, Royal Pharmaceutical Society
- Prescribing unlicensed medicines, General Medical Council (GMC)

Enquiries

If you have any queries, please contact DHSCmedicinesupplyteam@dhsc.gov.uk

Department of Health & Social Care

NHS

Medicine Supply Notification

MSN/2021/038

Nexium® (esomeprazole) 10mg **gastro-resistant granules sachets**

Tier 2 – medium impact*
Date of issue: 21/07/2021

Summary

- Nexium (esomeprazole) 10mg gastro-resistant **granules sachets** are out of stock until w/c 16th August 2021.
- Alternative liquid or dispersible tablet formulations of a proton-pump inhibitor (PPI) remain available.
- Unlicensed imports of esomeprazole 10mg gastro-resistant granule sachets can be sourced.

Actions Required

Primary care:

Prescribers should work with local Pharmacies to understand stockholdings and signpost patients accordingly. Where patients are unable to access supplies until the re-supply date, the following actions should be considered:

- prescribe alternative PPI preparations (see supporting information below); or
- for patients whose treatment was initiated in secondary care, refer to prescribing clinician for review and/or supply; or
- consider prescribing unlicensed imports. Prescribers should work with local pharmacy teams to ensure orders are placed within appropriate time frames as lead times may vary (see supporting information below).

Secondary care:

Trust/Health Board pharmacy procurement teams working with the local Medication Safety Officer (MSO) and clinical teams should:

- review local stock holding of Nexium 10mg gastro-resistant granules sachets; and
- work with their local Regional Pharmacy Procurement Specialists (RPPS) to share stock locally, to ensure continuity of care; or
- where stock is unavailable consider switching to alternative PPI preparations (see supporting information below); or
- consider prescribing unlicensed imports. Prescribers should work with local pharmacy teams to ensure orders are placed within appropriate time frames as lead times may vary (see supporting information below).

*Classification of Tiers can be found at the following link:
A Guide to Managing Medicines Supply and Shortages

Supporting information

Clinical Information

Table 1: Alternative dispersible or liquid PPI preparations

Medicine	Licensed age of patient group	Licensed for administration via enteral feeding tube	Additional information
Lansoprazole (15mg & 30mg) orodispersible tablets	Adults	Yes	N/A
Omeprazole (10mg, 20mg and 40mg) dispersible gastro-resistant tablets	Adults and Children over 1 year old	No	N/A
Omeprazole (2mg/ml or 4mg/ml) oral suspension sugar free (licensed)	Adults and Children	Yes	If the more complex reconstitution and administration instructions and/or presence of additional excipients, is not considered appropriate, an unlicensed oral solution of omeprazole is available.
Omeprazole (2mg/ml or 4mg/ml) oral solution (unlicensed)	N/A	Unlicensed product; has been used in practice down enteral feeding tube,	N/A

Please refer to the SPCs (linked) for further information on all preparations

Unlicensed Supply Information

Any decision to prescribe an unlicensed medicine must consider the relevant guidance and NHS Trust or local governance procedures. Please see the links below for further information:

- The supply of unlicensed medicinal products, Medicines and Healthcare products Regulatory Agency (MHRA)
- Professional Guidance for the Procurement and Supply of Specials, Royal Pharmaceutical Society
- Prescribing unlicensed medicines, General Medical Council (GMC)

The following specialist importers have currently confirmed they can source unlicensed supplies of Esomeprazole 10mg gastro-resistant granules sachets (please note, there may be other companies that can also source supplies):

- UL Global Pharma

Enquiries

Enquiries from NHS Trusts in England should in the first instance be directed to your Regional Pharmacy Procurement Specialist, who will escalate to national teams if required.

REGION	Full Name	Email
East Midlands	Andi Swain	andi.swain@nhs.net
East of England	James Kent	james.kent@nhs.net
London	Jackie Eastwood	jacqueline.eastwood@lpp.nhs.uk
North East	David Cook Umair Hamid	david.cook20@nhs.net umair.hamid2@nhs.net
North West	Glenn Harley	Glenn.Harley@liverpoolft.nhs.uk
South Central	Alison Ashman	Alison.Ashman@berkshire.nhs.uk
South East Coast	Richard Bateman	richard.bateman2@nhs.net
South West	Danny Palmer	Danny.Palmer@UHBristol.nhs.uk
West Midlands	Diptyka Hart	Diptyka.Hart@uhb.nhs.uk
Yorkshire & Humber	David Allwood	davidallwood@nhs.net

Scotland
nss.nhssmedicineshortages@nhs.scot

Wales
MedicinesShortages@gov.wales

Northern Ireland
RPHPS.Admin@northerntrust.hscni.net

All other organisations should send enquiries about this notice to the DHSC Medicine Supply Team quoting reference number MSN/2021/038.

Email: DHSCmedicinesupplyteam@dhsc.gov.uk

Department of Health & Social Care

NHS

Medicine Supply Notification

MSN/2021/036

Locorten Vioform® (flumetasone/clioquinol) 0.02% w/v / 1% w/v ear drops solution

Tier 2 – medium impact*
Date of issue: 21/07/2021

Summary

- Locorten Vioform® (flumetasone/clioquinol) 0.02% w/v / 1% w/v ear drops are out of stock until April 2022.
- There are no other combination products on market that contain a steroid and an antimicrobial agent with both antibacterial and antifungal properties.
- Alternative topical combination steroid and antibacterial preparations for the ear are available (see Supporting Information below).
- The only topical antifungal preparation on the market for use in the ear is Canesten® (clotrimazole) 1% solution.

Actions Required

Clinicians prescribing treatment should:

- not initiate any new patients on Locorten Vioform® ear drops;
- consider prescribing an alternative combination steroid and antibacterial ear drops (see Supporting Information below);
- consider whether there is also a clear clinical need to co-prescribe antifungal ear drops;
- counsel patients on how to administer two separate ear drops if both a steroid-antibacterial combination product and an antifungal is prescribed (see Supporting Information below).

Supporting information

Clinical Information

Locorten Vioform® is licensed for the treatment of inflammatory conditions of the external ear where a secondary infection is suspected, and otorrhoea.

It contains the steroid flumetasone and clioquinol, which has anti-fungal and anti-bacterial properties. There are no other steroid/antibacterial/antifungal combination ear drops on the market and flumetasone and clioquinol are not available as separate components. Whether there is a need for an antifungal in addition to a steroid and antibacterial agent needs to be clinically assessed and if deemed necessary, an alternative steroid-antibacterial and antifungal will need to be prescribed as separate ear preparations. The only licensed antifungal ear drops are Canesten® (clotrimazole) 1% solution (Table 2).

There are several steroid-antibacterial combination ear preparations available (Table 1).

*Classification of Tiers can be found at the following link: **A Guide to Managing Medicines Supply and Shortages**.

Table 1

Alternative steroid-antibacterial ear preparations	Components	Availability
Betnesol-N® eye/ear/nose drops	Betamethasone sodium phosphate 0.1%, Neomycin sulphate 0.5%	In stock – can support a full uplift
Otomize® ear spray	Dexamethasone 0.1%, neomycin sulphate 0.5%, glacial acetic acid 2%	In stock – can support a full uplift
Otosporin® ear drops	Hydrocortisone 1%, neomycin sulphate 3400 units/mL, polymyxin B sulphate 10,000 units/mL	In stock – can support a partial uplift
Sofradex® ear/eye drops	Dexamethasone 0.05%, framycetin sulphate 0.5%, gramicidin 0.005%	In stock – can support a full uplift

Table 2

Alternative antifungal ear drops	Components	Stock availability
Canesten® solution	Clotrimazole 1%	In stock- can support a full uplift

Counselling Points:

Clinicians should be aware of the following when counselling patients:

- Explain to patients the mechanism of action of the components being prescribed.
- Anecdotally, the administration of Canesten® solution into the ear can be painful; patients should be counselled appropriately.
- If prescribing both a combination steroid-antibacterial and antifungal ear drops, advise patients to allow a gap of 2-5 minutes before administering the second preparation; there is no guidance on optimal sequence, but the steroid preparation could be administered first in case of pain following use of Canesten® solution.

Further advice on the management of otitis externa can be found here:

- NICE CKS: Otitis Externa
- BNF treatment summary: Ear

Please refer to the SPCs for further information on all preparations:

- Locorten Vioform® ear drops
- SPC Betnesol-N® eye/ear/nose drops
- SPC Otomize® ear spray
- SPC Otosporin® ear drops
- SPC Sofradex® ear/eye drops
- SPC Canesten® solution

Enquiries

If you have any queries, please contact DHSCmedicinesupplyteam@dhsc.gov.uk