Royal College of General Practitioners

COVID-19 Vaccination FAQs

7th January 2021

1. Which health and care staff are eligible for a vaccination

The Joint Committee on Vaccination and Immunisation (JVCI) advises that the first priorities for the COVID-19 vaccination programme should be the prevention of mortality and the maintenance of the health and social care systems. As the risk of mortality from COVID-19 increases with age, prioritisation is primarily based on age. The first 4 categories are:

1. residents in a care home for older adults and their carers
2. all those 80 years of age and over and frontline health and social care workers
3. all those 75 years of age and over
4. all those 70 years of age and over and clinically extremely vulnerable individuals

JCVI recommend that within group 2, you should give priority to frontline staff "at high risk of acquiring infection, at high individual risk of developing serious disease, or at risk of transmitting infection to multiple vulnerable persons or other staff in a healthcare environment"

This includes but is not limited to:

- staff working on the vaccination programme
- staff who have frequent face-to-face contact with patients and who are directly involved in patient care in either secondary or primary care, mental health, urgent and emergency care and community settings
- those working in independent, voluntary and non-standard healthcare settings such as hospices, and community-based mental health or addiction services
- laboratory, pathology and mortuary staff
- those working for a sub-contracted provider of facilities services such as porters or cleaners
- temporary, locum or 'bank' staff, including those working in the COVID-19 vaccination programme, students, trainees and volunteers who are working with patients
- frontline social care workers directly working with vulnerable people who need care and support irrespective of where they work (for example in hospital, people's own homes, day centres, or supported housing); or who they are employed by (for example local government, NHS, independent sector or third sector).

This does not include family members or informal carers who do not fall into one of the prioritisation categories unless they are in receipt of a carer's allowance, or those who

are the main carer of an elderly or disabled person whose welfare may be at risk if the carer falls ill.

2. Who should have which vaccine?

There are very few individuals who cannot receive a COVID-19 vaccination.

Vaccine trials have only just begun in children and there are, therefore, very limited data on safety and immunogenicity in this group. Children and young people have a very low risk of COVID-19, severe disease or death due to SARS-CoV-2 compared to adults and so COVID-19 vaccines are not routinely recommended for those under 16.

Immunosuppressed individuals may have a reduced dose response but they should be given the standard dose at the standard intervals.

The vaccine should not be given to those who have had a previous systemic allergic reaction (including immediate-onset anaphylaxis) to a previous dose of the same COVID-19 vaccine or any component (excipient) of the COVID-19 vaccine.

The Pfizer-BioNTech vaccine contains polyethylene glycol (PEG), which is from a group of known allergens commonly found in medicines and also in household goods and cosmetics. Known allergy to PEG is extremely rare but would contraindicate this vaccine. Patients with a history of unexplained anaphylaxis or of anaphylaxis to multiple classes of drugs may have a PEG allergy. The AstraZeneca vaccine does not contain PEG and is a suitable alternative, but it does contain ethanol.

Anaphylaxis and other significant adverse reactions should be recorded on https://coronavirus-yellowcard.mhra.gov.uk/

3. Do all patients have to wait 15 minutes after their vaccination?

For the Pfizer-BioNtech vaccine, recipients should be monitored for 15 minutes after vaccination, with a longer observation period if they had a localised reaction to their first dose.

For the AstraZeneca there is not a requirement for 15 minutes observation unless this is indicated after clinical assessment.

As syncope (fainting) can occur following vaccination, all patients receiving a vaccination should either be driven by someone else and should not drive or operate machinery for 15 minutes after vaccination.

4. Is it safe to give the COVID-19 vaccination to patients on warfarin?

Individuals with bleeding disorders or on anticoagulation may be vaccinated. A fine needle (23 or 25 gauge) should be used for the vaccination, followed by firm pressure applied to the site (without rubbing) for at least 2 minutes. The individual/carer should be informed about the risk of haematoma from the injection.

5. Can we give the COVID-19 vaccination to patients with allergies?

Anaphylaxis is a very rare, though recognised event in vaccinations. There have been a small number of cases of anaphylaxis and possible allergic reactions following immunisation with the Pfizer-BioNTech vaccine.

The British Society for Allergy and Clinical Immunology (BSACI) has advised that individuals with a history of immediate onset-anaphylaxis to multiple classes of drugs or an unexplained anaphylaxis should not be vaccinated with the Pfizer-BioNTech vaccine. The AstraZeneca vaccine can be used as an alternative (if not otherwise contraindicated).

Individuals with a localised urticarial skin reaction to the first dose of a COVID-19 vaccine should receive the second dose of vaccine with 30 minutes observation in a setting with full resuscitation facilities (e.g. a hospital).

Individuals with non-allergic reactions to the first dose of a COVID-19 vaccine can receive the second dose in any vaccination setting.

Have a look at this RCGP webinar for further advice on the practical management of vaccination-related anaphylaxis, with input from Dr Paul Turner, co-chair of the Anaphylaxis Working Group at Resuscitation UK.

6. What is the best way to staff the clinics? Who can give the vaccine?

The clinics can be staffed by a range of clinicians and non-clinicians. The balance between ensuring a smooth and regular flow of patients must be balanced against the need for social distancing and the risk of transmission of COVID-19 between staff and patients.

There are three legal mechanisms for delivering the COVID-19 vaccinations by different members of staff:

	Description	Details
Patient Specific Directions	An instruction from a prescriber for medicines to be supplied and/or administered to a named patient	A registered healthcare professional must carry out the clinical assessment.
Patient Group Directions	May be used by chiropodists, podiatrists, dental hygienists, dental therapists, dieticians, midwives, nurses, occupational therapists, optometrists, orthoptists, orthotists and prosthetists, paramedics, pharmacists, physiotherapists, radiographers and speech and language therapists.	Supply and/or administration of a medicine must not be assigned or delegated to any other person under a PGD, regardless of their professional group or level of training.
National Protocol	A new legal mechanism which has been put in place following amendment of the Medicines Regulations to allow registered and non-registered healthcare professionals to safely administer a licensed or temporarily authorised COVID-19 or influenza vaccine.	Tasks can be split into: • Clinical assessment and consent • Preparation and drawing up of vaccine • Administration • Record keeping The clinical assessment must be carried out by a registered healthcare professional.

7. Do we need written consent from patients?

All patients who are able to give informed consent are required to do so, in order to receive the vaccination. There is no legal requirement for consent for immunisation to be in writing, but a signature serves to record the decision and the discussions that have taken place with the patient or the person giving consent on the patient's behalf.

Those being vaccinated should be able to understand, retain, and communicate:

- the anticipated benefits of vaccination in the simplest of terms,
- the likely side effects from vaccination and any individual risks they may run should be addressed, and
- the disadvantages of not consenting to the vaccination.

Consent can be withdrawn at any point, even between giving consent and the vaccination being given. Consent should be sought on the occasion of each immunisation.

EBSCO and Professor Glyn Elwyn have produced a decision grid to support shared decision making for consenting to the Covid-19 vaccine. Practices may wish to use this as part of their processes.

8. Is the COVID-19 vaccine safe in pregnancy?

Vaccination in pregnancy should be considered where the risk of exposure to COVID-19 infection is high and cannot be avoided. Clinicians should discuss the risks and benefits of vaccination with the woman, who should be told about the absence of safety data for the vaccine in pregnant women. There is no known risk associated with giving non-live vaccines whilst breastfeeding.

9. Can patients who are Clinically Extremely Vulnerable stop shielding after their vaccination?

Initial analysis of the Pfizer-BioNTech vaccine-conducted as part of a phase 3 study demonstrated a two-dose vaccine efficacy of 95% (with credibility intervals from 90.3% to 97.6%) in those aged 16 years and above. Efficacy was consistent across age, gender, and ethnicity, and in the presence of co-morbidities (including asthma, obesity, diabetes, hypertension and lung disease). In analysis of over 11,000 patients in the phase 3 study, overall AstraZeneca vaccine efficacy against symptomatic disease was 70·4% (95·8% CI 54·8–80·6).

Immunocompromised persons, including individuals receiving immunosuppressant therapy, may have a diminished immune response to the vaccine. For any individual, one cannot guarantee that they are protected by being vaccinated and this should not change their risk level or their perception of risk, so they should continue shielding until this is brought to an end.

10. When should the doses be given?

The requirement for a gap of seven days between seasonal flu vaccination and COVID-19 vaccination has been removed. Although no data for co-administration of COVID-19 vaccine with other vaccines exists, based on experience with other vaccines any potential interference is most likely to result in a slightly attenuated immune response to

one of the vaccines. There is no evidence of any safety concerns, although it may make the attribution of any adverse events more difficult.

Because of the absence of data on co-administration with COVID-19 vaccines, it should not be routine to offer appointments to give this vaccine at the same time as other vaccines. Based on current information about the first COVID-19 vaccines being deployed, scheduling should ideally be separated by an interval of at least 7 days to avoid incorrect attribution of potential adverse events.

However, if patient presents requiring two vaccines, vaccination should proceed to avoid any further delay in protection and to avoid the risk of the patient not returning for a later appointment. In such circumstances, patients should be informed about the likely timing of potential adverse events relating to each vaccine.

Booster doses of COVID-19 vaccine are not yet recommended because the need for, and timing of, boosters has not yet been determined.

References (accessed 7th January 2021)

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