



Royal College of
General Practitioners

COVID-19 Vaccination FAQs

17th May 2021

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

The Joint Committee on Vaccination and Immunisation (JCVI) advises that the first priorities for the COVID-19 vaccination programme should be the prevention of mortality and the maintenance of the health and social care systems. As the risk of mortality from COVID-19 increases with age, prioritisation is primarily based on age. The first 6 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
5. all those 65 years of age and over
6. all individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality

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.

It is worth maintaining a priority list of patients who can be called at short notice at the end of each clinic to save discarding part-used vials.

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 other children with severe neuro-disabilities who tend to get recurrent respiratory tract infections and who frequently spend time in specialised residential care settings.

Immunosuppressed individuals may have a reduced dose response but they should be given the standard dose at the standard intervals. The small number of patients who are about to receive planned immunosuppressive therapy should be considered for vaccination prior to commencing therapy (ideally at least two weeks before), when their immune system is better able to make a response. Where possible, it would also be preferable for the 2-dose schedule to be completed prior to commencing immunosuppression.

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 and Moderna vaccines 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.





Serious thromboembolic events with concurrent thrombocytopenia have occurred very rarely following vaccination with AstraZeneca vaccine. This includes venous thrombosis, sometimes involving unusual sites such as cerebral venous sinus thrombosis (CVST), splanchnic vein thrombosis, or arterial thrombosis, combined with thrombocytopenia.

It is currently estimated that the overall incidence of CVST following the AstraZeneca vaccine is around 4 per million first doses administered. Suspected cases have been reported in patients of all ages and genders and currently, no specific predisposing factors have been identified.

All those who have received a first dose of the AstraZeneca vaccine should continue to be offered a second dose of AstraZeneca vaccine, irrespective of age. There is no data on the effectiveness of mixing COVID-19 vaccines.

The relative balance of benefits and risks the benefits of prompt vaccination with the AstraZeneca vaccine far outweighs the risk of adverse events for individuals 30 years of age and over, and those aged under 30 who have underlying health conditions which put them at higher risk of severe COVID-19 disease.

None of the three vaccines contain animal products.


JCVI advises that, in addition to those aged under 30, unvaccinated adults aged 30 to 39 years who are not in a clinical priority group at higher risk of severe COVID-19, should be preferentially offered an alternative to the AstraZeneca COVID-19 vaccine, only where no substantial delay or barrier in access to vaccination would arise.


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

For the Pfizer-BioNtech and Moderna vaccines, recipients should be monitored for 15 minutes after vaccination, with a longer observation period (usually 30 minutes) if they had a localised reaction to their first dose. For the AstraZeneca vaccine, 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.

The right premises are crucial in order to provide a separate space from business as usual, sufficient space to allow for social distancing and the post-vaccine 15-minute wait period, with clear signage, and sufficient parking as well as volunteers to manage the flow through the site.





Taking up offers from **volunteers** is felt to be very important and helpful in efficient vaccine delivery.

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 or Moderna vaccines. The AstraZeneca vaccine can be used as an alternative (if not otherwise contraindicated).

Individuals with a systemic allergic 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. Anaphylaxis and other significant adverse reactions should be recorded on <https://coronavirus-yellowcard.mhra.gov.uk/>

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: <ul style="list-style-type: none">• 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.

GP leadership within vaccination sites and PCNs is important as they bring the experience that GPs have in delivering mass vaccination programmes.

It is important that all staff have received appropriate training before starting work in a Covid-19 vaccination service.



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?

Inactivated, recombinant viral or bacterial vaccines or toxoids are safe during pregnancy or whilst breast-feeding. There have been no specific safety concerns identified with any brand of coronavirus (COVID-19) vaccines in relation to pregnancy.

JCVI has therefore advised that pregnant women in the same age or clinical risk as the general population invited for vaccination should also be invited for vaccination.

Real-world data from the United States shows that around 90,000 pregnant women have been vaccinated, mainly with mRNA vaccines including Pfizer-BioNTech and Moderna, without any safety concerns being raised. These are the preferred vaccines to offer to pregnant women. Inactivated adenovirus vector vaccines similar to the AstraZeneca Covid-19 vaccination have been used safely around the world to vaccinate pregnant women against other diseases, so it is likely that this is also safe, but there is not yet sufficient data to recommend its routine use.





Women who are planning pregnancy, are in the immediate postpartum, or are breastfeeding can be vaccinated with any vaccine, depending on their age and clinical risk group.

Clinicians should discuss and document the risks and benefits of vaccination with the woman, who should be told about the limited evidence of safety for the vaccine in pregnancy.


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


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 (i.e. seasonal flu and Covid-19), vaccination may 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.

Boxed text: GPs should be **proud** of their involvement in the Covid vaccination programme and it is important to remember this when managing the stresses of supply problems and the impact of mass vaccination centres on booking appointments

References (accessed 15th April 2021)

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