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COVID-19 Vaccine Briefing: Tailored outreach vaccination delivery services for socially excluded groups in the UK

Version 2 - This guidance is correct as of 21st June 2021. However, as information is subject to updates, please use the hyperlinks to confirm the information is accurate.

Contents

Summary

Why a tailored outreach COVID-19 vaccination model is needed

People from socially excluded groups, including people experiencing homelessness, people seeking asylum, migrants in vulnerable circumstances, Gypsy, Roma and Traveller communities and street sex-workers, are more likely to be exposed to COVID-19 and experience adverse health outcomes from the virus than the general population. Yet these groups are more likely to face barriers to accessing the COVID-19 vaccine.

Recommendations for outreach vaccination service delivery

- Engage with housing providers, voluntary, community and social enterprise (VCSE) organisations supporting socially excluded groups, and people with lived experience of healthcare exclusion to identify possible outreach sites; promote outreach vaccine clinics, encourage engagement, and inform a culturally appropriate service.
- Do not turn away or signpost elsewhere people who do not have an NHS number. Instead, record the vaccination on paper and then document it more formally later. Ensure all staff and volunteers understand the process for booking in and delivering the vaccine to people without an NHS number.
- Take GMS1 (Family doctor services registration) forms on outreach and support unregistered patients to complete these at the time of vaccination.
- Provide COVID-19 vaccine information and consent forms in appropriate formats, languages, and literacy levels.
- Use interpreters where required.
- Ensure the environment in which the vaccine is being offered is accessible and feels safe and welcoming.
- Keep a list of all patients vaccinated on each outreach visit, including contact details with preferred language and any literacy needs for communication about the second dose.
- Revisit the same outreach site at least 8 weeks later to deliver the second COVID-19 vaccine dose to those who have received the first dose and to offer the first dose to any unvaccinated individuals.
- Where possible, contact patients to remind them to attend for the second vaccine dose and include the date, time and location of the outreach clinic where they can access this.
- Work with local VCSE organisations and relevant accommodation providers to advertise return outreach clinics and facilitate attendance by patients who are due the second dose.
- Consider opportunistically offering the second vaccine dose to hard-to-reach patients and individuals likely to move, such as asylum seekers, in the 4-12 weeks after the first vaccine dose.
- Collect data on vaccine uptake, barriers to access, and reasons for refusal.
- Evaluate the effectiveness of COVID-19 vaccine outreach delivery models.
- Share information gained, examples of good practice and lessons learnt to inform ongoing activities to reduce inequalities in COVID-19 vaccine access.

Background

This briefing document presents the case for outreach and bespoke vaccination delivery services for socially excluded groups, including people experiencing homelessness, people seeking asylum, migrants in vulnerable circumstances, Gypsy, Roma and Traveller communities and sex workers. The Joint Committee on Vaccination and Immunisation (JCVI) recognises the need to tailor vaccine delivery in order to increase access to the COVID-19 vaccine. It states, *"implementation should also involve flexibility in vaccine deployment at a local level with due attention to mitigating health inequalities, such as might occur in relation to access to healthcare and ethnicity…".*[1] Referring to the accommodation of people experiencing rough sleeping in emergency accommodation the JCVI

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[1] https://www.gov.uk/government/publications/priority-groups-for-coronavirus-covid-19-vaccination-advice-from-the-jcvi-30-december-2020/joint-committee-on-vaccination-and-immunisation-advice-on-priority-groups-for-covid-19-vaccination-30-december-2020

[wrote](#) on 1 March 2021: *"this provides a unique opportunity to in-reach vaccination to a population that is otherwise often unable to access basic healthcare."* This briefing is intended to inform stakeholder design and delivery of vaccination programmes to populations that are unlikely to access mainstream vaccination services.

Why socially excluded populations are at increased risk of exposure and adverse health outcomes from COVID-19

Doctors of the World's (DOTW) [Rapid Needs Assessment of Excluded People in England During the 2020 COVID-19 Pandemic](#) revealed that socially excluded populations are:

- at increased risk of being exposed to COVID-19 due to crowded and shared living conditions, or reduced access to hygiene and sanitation facilities;
- more likely to have poorly managed chronic health problems that increase their risk of morbidity or mortality from COVID-19;
- are less likely to access timely healthcare if they become unwell with COVID-19;
- are less able to self-isolate and protect themselves and others from further transmission.

On 16 February 2021, the government introduced the [COVID-19 Population Risk Assessment](#) tool to identify clinically extremely vulnerable people using risk factors including ethnicity and deprivation. This increases the number of people from socially excluded groups who fall within the [JCVI priority group](#) for vaccinations and should be immediately offered the vaccine.

On 24 February 2021, NHS England stated in a [communication to CCG accountable officers](#) that inclusion health populations *"are at increased risk of severe disease and higher mortality and should be considered a priority for vaccination"*. Annex 1 presents evidence to justify this statement, which can be used by local stakeholders when planning vaccination roll-out and by health professionals exercising clinical judgement when prioritising patients for the COVID-19 vaccine. In a [letter to the Secretary of State for Health](#), dated 1 March 2021, the JCVI advised that *"local teams exercise operational judgment and consider a universal offer to people experiencing homelessness and rough sleeping, alongside delivery of the programme to priority group 6, where appropriate"*.

An inclusive and equitable approach to COVID-19 vaccine roll-out is necessary to ensure pre-existing health inequalities experienced by socially excluded groups are not further exacerbated.

Why tailored outreach vaccination delivery should run in parallel to an inclusive mainstream delivery approach

[DOTW's briefing on access to the COVID-19 vaccine](#) outlines the need for mainstream vaccine delivery programmes to ensure vaccination services are accessible to socially excluded populations. In England, Scotland and Wales, everyone is entitled to register with a GP and receive the COVID-19 vaccine free of charge irrespective of immigration status. To facilitate this, [NHS England](#) and [NHS Scotland](#) have launched GP Access cards to increase GP registration amongst people who frequently face [barriers to registration](#), including people with no fixed address and migrant populations. GP registration would ensure individuals are included in GP practices' patient lists and have an NHS number and are therefore invited for a vaccination when they are deemed eligible in line with the [JCVI recommendations](#).

However, it is recognised that for some people from socially excluded populations, a more tailored approach to COVID-19 vaccine delivery is needed. In order to access a COVID-19 vaccination using the current mainstream delivery model, not only must an individual be registered with a GP but they must also:

- be identified on the GP system as eligible to receive the vaccination – which relies on up-to-date medical records, documented clinical diagnoses and recorded risk factors required for Population Risk Assessment, including Body Mass Index, ethnicity and postcode;
- receive the vaccine invitation;
- be able to read and understand the vaccine invitation and have the language, literacy and digital skills to engage with the booking system;
- be able to access the vaccination centre;
- feel confident that accessing the vaccine is free and independent of immigration control activities;
- believe they would benefit from having the vaccination.

These factors are discussed in more detail below.

Be identified as eligible to receive the vaccination on the GP record system

Even if registered with a GP, people from socially excluded populations [may not engage with mainstream healthcare services](#) due to:

- lack of trust;
- fear of or history of experienced stigma or discrimination;
- concerns related to NHS Overseas Visitor Charging and NHS data sharing with the Home Office.

Therefore, they may have undiagnosed long-term conditions and undocumented risk factors that would put them at increased risk of significant illness from COVID-19. Without documentation of these risks in GP records or [NHS Digital datasets,](#) people who are eligible to receive the vaccine based on clinical condition would go unrecognised.

Mobile populations, including people in temporary asylum accommodation and people from Gypsy, Roma and Traveller communities, are often registered as temporary patients. Temporary patients are unlikely to receive a new patient health check and less likely to have a complete or up to date medical history on record that would

enable identification of vaccine eligibility. Temporary patients are at risk of being excluded from vaccine delivery plans.

Receive the vaccine invitation

GP-led vaccination services offer appointments through letter, telephone, text and online. Many socially excluded populations are mobile populations with frequent changes of postal address and digital exclusion is a barrier to communication via telephone, text messaging and email.

Be able to understand the vaccination invite and engage with the booking service

People from socially excluded populations may not have the literacy or language requirements necessary to understand COVID-19 vaccine communications or book a vaccination appointment. Digital exclusion is an additional barrier to accessing the online National Booking Service or telephone booking services.

Be able to access the vaccination centre

People from socially excluded populations often experience deprivation and do not have access to personal transport or the finances for public transport. In addition, many may face challenges navigating to a new place because of literacy or language barriers and digital exclusion prohibits their access to online public transport timetables and route planning apps. Distrust of an unknown provider is also a deterrent for some.

Feel confident that accessing the vaccine is free and independent of immigration control activities

The COVID-19 vaccination is exempt from NHS charging and there are no processes in place by which patient data is shared between vaccination or GP services and the Home Office for immigration decision-making or enforcement. But lack of awareness about vaccine entitlement, distrust and fear remain barriers to access for many migrants in vulnerable circumstances. [Research by the Joint Council for the Welfare of Immigrants (JCWI)](#) showed 43% of migrants surveyed would be fearful of seeking healthcare for fear of having their status tested, or being charged. Of those with refugee status, 56% would be wary of accessing healthcare because of fears about data-= sharing between the NHS and Home Office, rising to 81% for those with no official status. This fear extends to [accessing COVID-19 vaccinations](#).

Believe they would benefit from having the vaccine

Illiteracy, language barriers and digital exclusion mean many socially excluded populations have less access to reliable information about COVID-19 and the COVID-19 vaccine than the general population. While conspiracy theories and myths exist across all of society, misconceptions are more likely to perpetuate in communities without ready access to the facts. This skepticism, coupled with a [distrust](#) in institutions and mainstream health service providers, may increase the risk of vaccine hesitancy in excluded populations. While data specifically examining COVID-19 vaccine uptake amongst migrants and people experiencing homelessness is not yet available, there is UK [evidence](#) that people from lower socioeconomic and minority ethnic groups are more likely to be

COVID-19 vaccine hesitant. A scoping exercise by DOTW UK which included surveys and interviews with people from health inclusion populations and supporting organisations identified the following as potential facilitators of vaccine uptake: access to reliable information from trusted sources that accounts for language and literacy needs and addresses specific concerns around vaccine safety and effectiveness; the opportunity to discuss concerns with health professionals prior to vaccination; vaccine endorsement by community and religious leaders and peers; reassurance that data collected for vaccination purposes won't be shared with the Home Office; and easily accessible and welcoming vaccination services.

For all the above reasons, tailored vaccination delivery services in partnership with VCSE sector providers should run in parallel to an inclusive mainstream delivery approach. Approval of the AstraZeneca vaccine has made an outreach delivery model possible as it can be safely transported between sites.[2] Recent authorisation of the one dose Janssen vaccine for adults over 18 will also be advantageous in efforts to vaccinate populations on outreach where timely delivery of a second vaccine dose can be challenging. Mobile devices with access to the vaccine recording system Pinnacle enable live documentation of vaccination. Pinnacle shares this vaccination information with the clinical IT systems EMIS and Systm1 so the registered GP of anyone vaccinated on outreach would be notified of the vaccination event.

What an outreach vaccination delivery model could look like

Outreach models whereby healthcare teams are mobilised to deliver vaccinations in locations that are better at reaching individuals from socially excluded populations are necessary. This could include delivering services:

- from hostels and hotels housing people experiencing homelessness and asylum seekers, including initial accommodation centres;
- curbside from outreach vans to reach rough sleepers and street sex workers;
- on Traveller sites;
- from VCSE/community locations frequented by people from socially excluded groups.

Local authorities and local VCSE organisations supporting socially excluded populations can help inform decisions on outreach sites.

Vaccinating unregistered patients and those without NHS numbers

If a person who is not registered with a GP is encountered on outreach, they should be assessed for eligibility for the vaccine and, if appropriate, they should be offered the vaccine there and then.

NHS England clearly states that unregistered patients should not be turned away or signposted elsewhere. Vaccination can be offered without an NHS number and should not be a barrier to uptake. Public Health England's Migrant Health Guide outlines how individuals without an NHS number can access the COVID-19

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https://www.england.nhs.uk/coronavirus/publication/standard-operating-procedure-covid-19-local-vaccination-services-deployment-in-community-settings/

vaccine, including requesting to book a vaccination appointment as an unregistered patient through a local GP practice and via local outreach services.   If someone is denied care because they do not have an NHS number, they can contact NHS England's customer contact centre.

Outreach services can vaccinate people registered with any GP practice – they do not have to be patients of the providers delivering vaccines.

If a vaccination service comes across a patient who is not registered with a GP, the patient should be encouraged to register with a GP. This will help to ensure vaccines requiring a second dose are delivered within the recommended timeframe and will improve healthcare access and benefit individuals in the long term.

Delivering the vaccine to an individual who is not registered with a GP and / or does not have an NHS number may present a number of logistical challenges, particularly with regard to recording the vaccine given. The following measures will address some of these challenges and reduce the risk of patients missing their second dose (not applicable to the Janssen vaccine which is given as a single dose):

- **Take** GMS1 (Family doctor services registration) forms **on outreach and seek consent to fully register a patient in order to generate an NHS number.** Note, this needs to be registration as a permanent patient (not a temporary patient) as temporary registration does not generate an NHS number for new NHS patients or link existing NHS patients with their NHS number.
- **Previously** NHS England stated that vaccinations for people without an NHS number could be recorded locally via a paper system at the time of delivery and then documented more formally later.[3] Documentation of vaccination details in Systm1/EMIS at time of vaccination was recommended so there was an electronic record pending upload onto the Pinnacle Outcomes4Health system. From April 2021 the system has changed to allow vaccination events to be uploaded to Pinnacle Outcomes4Health with "unknown" NHS number. The central system then tries to match an NHS number, or issue a new number. Outcomes4Health has issued a guide for providers detailing this update.
- **Use Systm1/EMIS for details of vaccinations delivered already.** If an individual is uncertain of their COVID-19 vaccine status or a second dose is potentially due and documentation can't be found on Pinnacle Outcomes4Health then outreach services should try searching on Systm1/EMIS for a vaccination record.

Increasing vaccine uptake at time of outreach

To increase uptake of vaccines on outreach, delivery programmes should:

- Provide COVID-19 vaccine information and consent forms in appropriate formats, languages, and literacy levels. This may include providing vaccination information sessions before delivering the vaccine. Annex 2 includes a list of COVID-19 resources for patients.
- Use interpreters where required.

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[3] Communication in the NHSE & NHSI Primary care Bulletin, 28 January 2021.

- Partner with housing providers and VCSE organisations working with and trusted by socially excluded populations, in addition to community leaders, representatives and peer advocates from targeted population groups in order to promote outreach vaccine clinics, encourage engagement and inform a culturally appropriate service.
- Ensure the environment in which the vaccine is being offered is accessible and feels safe and welcoming. This includes ensuring all staff and volunteers understand the process for booking in and delivering the vaccine to people without an NHS number.
- Identify what time of day would be most appropriate to engage targeted populations with recognition of their life circumstances. For example, sex-workers often work unsociable hours and the Manchester charity MASH accounted for this by offering vaccines to sex-workers from its drop-in van that travels around the city every weekday night.

Delivering the second dose of the COVID-19 Pfizer-BioNTech, Oxford-AstraZeneca and Moderna vaccine

The COVID-19 chapter of the Green Book states that *"operationally, it is recommended that the second dose of all vaccines should be routinely scheduled between four and 12 weeks after the first dose"*. Government guidance is that the second COVID-19 vaccine should be given 12 weeks after the first dose unless the individual belongs in the top nine priority groups, in which case the dose interval should be reduced to 8 weeks to ensure "the strongest possible protection from the virus at an earlier opportunity". The COVID-19 risk experienced by Inclusion Health populations justifies consideration of individuals in these populations as belonging to the top nine priority groups irrespective of their age.

Everyone given the vaccine (with the exception of individuals receiving the single dose Janssen vaccine) should be informed of the need of a second vaccine dose and the benefits of this. It should be clearly explained when this dose is due and how it can be accessed. Actions that could be taken to reduce the risk of a missed second dose include:

- Outreach delivery service to keep a list of all patients vaccinated on each outreach visit, including contact details with preferred language and any literacy needs for communication about the second dose.
- Revisit the same outreach site at least 8 weeks later. Where possible, plan this in advance so at the time of delivery of the first vaccine dose the individual can be informed of the date and time that the outreach vaccination clinic will return to deliver the second dose.
- Where possible, contact patients to remind them to attend for the second vaccine dose and include the date, time and location of the outreach clinic where they can access this.
- Work with local VCSE organisations to advertise outreach clinics and facilitate attendance by people who are due the second dose.

For people who may experience challenges presenting for timely receipt of a second vaccine dose, e.g., people experiencing homelessness with a history of poor healthcare engagement, there is an arguable case for opportunistic vaccination earlier than the 12-week advice. This approach is supported in a JCVI communication dated 1 March 2021. Their patient records could be flagged so that if they are encountered on outreach after 28

days, they could be offered the vaccine at this time to reduce risk of missing the second dose at 12 weeks. Similarly, there is a case for a shorter interval between doses for mobile populations including asylum seekers in temporary accommodation and people from Gypsy, Roma and Traveller communities who may move location in the four to 12 weeks post first vaccine dose.

Advice regarding administration of Oxford AstraZeneca vaccines to under 40s

On 7 May 2021 the [JCVI updated its guidance](#) to advise that unvaccinated adults aged under 40 years who are not in a clinical priority group at higher risk of severe COVID-19 disease, *"should be preferentially offered an alternative to the AstraZeneca COVID-19 vaccine, where possible and only where no substantial delay or barrier in access to vaccination would arise."*

In line with JCVI guidance partners responsible for COVID-19 vaccine roll-out must make every effort to remove barriers to accessing vaccination for individuals under 40 years who are at higher risk of acquiring and/or suffering complications of COVID-19 including people from certain ethnic minority backgrounds and people experiencing socioeconomic deprivation. DOTW have produced briefings on [GP registration](#) and [COVID-19 vaccination](#) which offers guidance to support this.

Based on the JCVI guidance DOTW UK recommends that providers of outreach services establish a pathway for people identified as eligible for the COVID-19 vaccine who are aged under 40 years to receive an alternative vaccine to AstraZeneca. This could involve making an appointment on their behalf and where possible arranging support with transport if needed. Of note while there are additional logistical challenges to using Pfizer- BioNTech in temporary vaccination settings there is [guidance](#) to support its safe transport, storage, preparation and administration in these circumstances. Pfizer BioNTech vaccines have been successfully administered in care-home settings. Therefore, delivery of Pfizer BioNTech vaccines should be considered when planning in-reach vaccinations in accommodation settings where the majority of the population are under 40 years of age e.g. hotels housing asylum seekers.

If personal factors or system barriers prevent timely access to an alternative to the AstraZeneca vaccine then an appropriate health professional should have a conversation with the individual on the risks and benefits of receiving the AstraZeneca vaccine. This is considered acceptable within JCVI guidance which recognises that due to its storage and transport requirements, the AstraZeneca vaccine may be the only vaccine practical to offer in some settings. In such circumstances JCVI advises that *"the benefits of receiving the AstraZeneca vaccine outweigh the risks, and individuals in this event should be offered the AstraZeneca vaccine."*

Data collection and evaluation

Data collection on the proportion of people from socially excluded populations taking up the COVID-19 vaccination offer, barriers to access, and reasons for refusal, in addition to evaluation of the effectiveness of COVID-19 vaccine delivery models for socially excluded groups, is recommended to inform ongoing efforts to ensure equitable vaccine access.

Case studies

In recognition of their increased vulnerability to morbidity and mortality from COVID-19, several areas in the UK, including [Oldham](), [Shrewsbury](), [Manchester](), [Redbridge](), [Liverpool](), [Brighton](), [Watford](), [Plymouth](), [Leeds and Bradford](), have already started vaccinating some health inclusion populations. The following case study highlights examples of good practice and identifies lessons learnt to inform outreach vaccination delivery design and implementation.

Case study: Leeds and Bradford's outreach COVID-19 vaccination service for socially excluded populations

Bevan Healthcare CIC provides responsive NHS General Practice services designed to meet the needs of socially excluded populations in Bradford and Leeds. Recognising the COVID-19 vaccine access barriers faced by many of its patients, Bevan Healthcare worked closely with the local Clinical Commissioning Groups (CCGs) and Primary Care Networks (PCNs) to source a regular AstraZeneca vaccine supply to deliver to socially excluded populations at high risk of COVID-19. With an existing outreach healthcare service, access to a clinic bus equipped for vaccine storage, and good relationships with local VCSE organisations and housing providers serving socially excluded populations across the city, Bevan Healthcare CIC was able to quickly operationalise remote delivery of vaccines to socially excluded populations clinically judged to be most at risk of COVID-19.

Learning points:

- Engagement with local partners including housing providers and VCSE organisations was key to identifying outreach sites, advertising the outreach vaccine clinic, and supporting residents/service users to engage with the service.

- Vaccination staff are actively engaged in identifying people on outreach who are not registered with a GP/do not have an NHS number and support them in registering with a GP. This enables individuals to access healthcare more effectively in the future with benefits beyond the vaccination programme.

- The provision of free hot drinks and food at the vaccination site encouraged people to approach the outreach team, thus facilitating discussions about the vaccine and the opportunity to explain the benefits, explore reasons for vaccine hesitancy and dispel any myths.

- Seeing people queuing to receive the vaccine from the outreach bus appeared to reassure and encourage others to have the vaccine.

- When delivering the vaccine outreach service to asylum seekers housed in hotels, people who spoke the same language were placed in groups and a remote interpreter was kept on the phone line to

facilitate communication with each person in this group. This was coordinated by hotel support staff and proved to be an effective and efficient means of overcoming language barriers to access.

- Outreach delivery from hostels/hotels accommodating people experiencing homelessness and asylum seekers yielded much higher numbers of vaccinations than through provision of an advertised drop-in vaccination clinic from the Leeds city centre GP clinic.

- Use of the outreach van enabled the vaccination team to drive through the city centre and identify people living on the street and offer them the vaccine.

Annex 1: Evidence-based prioritisation of socially excluded groups

On 24 February 2021, NHS England stated in a [communication to CCG accountable officers](#) that inclusion health populations *"are at increased risk of severe disease and higher mortality and should be considered a priority for vaccination"*. The following paragraphs present evidence to justify this statement, which can be used by local stakeholders when planning vaccination roll-out and by health professionals exercising clinical judgement when prioritising patients for the COVID-19 vaccine.

People experiencing homelessness

While data quality is limited, available evidence suggests a much higher diagnosis rate of COVID-19 amongst people experiencing homelessness than in the general population.[4] COVID-19 outbreaks in homeless settings can lead to increased spread of infection among people experiencing homelessness, even if incidence remains low in the general population.[5]

In addition to increased risk of being exposed to COVID-19, people experiencing homelessness are also more likely to be clinically vulnerable to the infection. People experiencing homelessness have a significantly lower life expectancy than the general population – 45 years for men and 43 years for women, compared to 76 years and 81 years respectively.[6] They also have high rates of diseases that have been identified as putting people at high risk of serious illness from COVID-19. The average number of long-term conditions is reported as being 2.8 per patient experiencing homelessness.[7] One UK study estimates the prevalence of chronic obstructive pulmonary disease, a condition that places you in the clinically extremely vulnerable group, to be 14% in the homeless population.[8] People experiencing homelessness have higher rates of liver disease, cardiovascular disease, poorly controlled diabetes and severe mental illness than the general population – all conditions identified in the Green Book clinical risk groups.[9] Studies have shown that people experiencing homelessness suffer premature aging and exhibit levels of multimorbidity and frailty equivalent to people 30-40 years their senior.[10][11]

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[4]

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

[5] https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30396-9/fulltext

[6]

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/2019registrations

[7] https://bjgpopen.org/content/1/3/bjgpopen17X100941

[8] https://bmjopen.bmj.com/content/9/4/e025192

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4520328/

[10] https://bjgpopen.org/content/1/3/bjgpopen17X100941

[11] https://www.emerald.com/insight/content/doi/10.1108/HCS-05-2020-0007/full/html

The JCVI advises that local teams exercise operational judgment and consider a universal offer to people experiencing homelessness and rough sleeping, alongside delivery of the programme to priority group 6, where appropriate. [12]The NHS have issued a mobilisation support pack in response to this recommendation.[13]

People from Gypsy, Roma and Traveller Communities

People from Gypsy, Roma and Traveller communities often live in crowded accommodation with shared toilet, washing and kitchen facilities.[14] Inability to socially distance or isolate increases the risk of exposure to the COVID-19 virus. This is a particular concern as this population is at increased risk of adverse health outcomes from COVID-19. The health status of people from Gypsy, Roma and Traveller communities is much poorer than the general population and their life expectancy is 10-25 years less.[15] People from Gypsy, Roma and Traveller communities are significantly more likely to have a long-term condition and research shows an increased prevalence of symptoms of lung disease, including chronic bronchitis and asthma, in the Gypsy and Traveller population in England – conditions listed as rendering a person clinically vulnerable to COVID-19.[16]

Refugees, asylum seekers and undocumented migrants

Many migrants in vulnerable circumstances live in shared accommodation where it is difficult to practice social distancing and isolation. There have been several well publicised outbreaks in government provided asylum seeker accommodation.[17][18]

Many refugees, asylum seekers and undocumented migrants are from Black, Asian or minority ethnic (BAME) groups. Evidence shows people from BAME groups are at greater risk of critical illness and death from COVID-19.[19] When compared to previous years, there has been a larger increase in deaths among people born outside the UK and Ireland, suggesting an increased COVID-19 mortality rate amongst the migrant population.[20]

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[12] https://www.gov.uk/government/publications/letter-from-the-health-and-social-care-secretary-on-covid-19-vaccination-phase-1-advice/letter-from-the-jcvi-to-the-health-and-social-care-secretary-on-further-considerations-on-phase-1-advice-1-march-2021

[13] NHS. COVID-19 vaccination programme. JCVI Cohort 6 – Homelessness and rough sleeping. Mobilisation Support Pack. Version 1.0. 12 March 2021.

[14] https://gov.wales/guidance-those-supporting-gypsy-and-traveller-communities-covid-19-html

[15] https://www.gypsy-traveller.org/wp-content/uploads/2019/07/Experiences-of-Gypsies-and-Travellers-in-primary-care-GP-services-FINAL-1.docx

[16] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2652907/#:~:text=Descriptive%20studies%20and%20practitioner%20accounts,and%20high%20child%E2%80%90accident%20rates.

[17] https://www.bbc.co.uk/news/uk-england-kent-56089779

[18] https://www.independent.co.uk/news/uk/home-news/asylum-seekers-accommodation-coronavirus-west-yorkshire-a9613111.html

[19] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

[20] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

Sex workers

Urban-based sex workers are at increased risk of contracting COVID-19.[21] Without access to financial aid, many sex workers are forced to continue engaging in sex work, exposing themselves to the COVID-19 virus in order to earn money to buy food or pay rent.[22] Increased prevalence of underlying health conditions among sex workers could increase their risk of severe illness from COVID-19.[23] Many street sex workers experience homelessness and a proportion are migrants. As such, they face the COVID-19 health risks discussed above.

Unrecognised vaccine eligibility

The evidence presented above suggests many people in socially excluded groups would fall into the JCVI priority group four or six for vaccination. However, many people from the groups presented are not registered with a GP or have limited engagement with healthcare services. Consequently, they may not have documentation of their risk factors in NHS data systems and, as such, may not be identified as eligible for the COVID-19 vaccine using the current system. To address the inequalities associated with the current methods of identifying eligible patients, it is proposed that local stakeholders and health professionals consider prioritising these high risk populations for COVID-19 vaccination and, where necessary, adapt an outreach delivery model to achieve this.

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[21] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7556610/

[22] https://www.doctorsoftheworld.org.uk/wp-content/uploads/2020/06/covid-full-rna-report.pdf

[23] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31033-3/fulltext?fbclid=IwAR26rPEDdcfWFgI_YMCYLK785iUPc28jPdIrsK16Gfm2P3gIntqkrWI1M6I

Annex 2: Translated and tailored COVID-19 vaccine resources

- Doctors of the World UK 'Translated Health Information for Patients' (up to 61 languages)
- PHE 'COVID-19 Vaccination Centre Toolkit video' (16 languages)
- Department of Health and Social Care 'Guidance on COVID-19 testing, treatment and vaccination free of charge' (40 languages)
- PHE 'COVID-19 vaccination: easy-read resources' (English)
- PHE 'COVID-19 vaccination: guide for older adults' (20 languages)
- PHE 'What to expect after your COVID-19 vaccination' (20 languages)
- PHE 'COVID-19 vaccination: Why you are being asked to wait' (20 languages)
- PHE 'COVID-19 vaccination: women of childbearing age, currently pregnant or breastfeeding' (23 languages)
- BBC 'Coronavirus vaccine Q&A in five South Asian languages' (5 languages)
- International Organization for Migration (UK) 'COVID-19 Vaccination' (10 languages)

Annex 3: NHS resources and guidance to support outreach delivery of COVID-19 vaccines

- [Standard operating procedure: COVID-19 local vaccination services deployment in community settings](#)

- COVID-19 vaccination programme. JCVI Cohort 6 – Homelessness and rough sleeping. Mobilisation Support Pack. Version 1.0. 12 March 2021.