EXECUTIVE COUNCIL

PUBLIC

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Responsible Director:	Director of Health and Social Services
Report Author:	Chief Medical Officer
Portfolio Holder:	MLA Ian Hansen
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List of Documents:	Appendix A - JCVI COVID-19 vaccination priority list Appendix B – WHO SAGE Roadmap For Prioritizing Uses Of COVID-19 Vaccines In The Context Of Limited Supply

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1. Recommendations

Honourable Members are asked to acknowledge and support:

(a) the KEMH Phase One COVID-19 vaccination policy (as mirrored from having regard to the UK Joint Committee on Vaccination and Immunisations recommended COVID-19 vaccination priority groups, and following WHO guidance)

Honourable Members are recommended to:

(b) decide and agree the suggested options for the Phase Two approach to vaccination (Phase Two alpha + beta groups) to be included in this vaccination round

(c) task the CE to identify other critical workers who might not have already been captured in the Phase One programme, or the Phase Two Alpha and Beta groups, who should be vaccinated during this round.

2. Additional Budgetary Implications

2.1 Managing the COVID-19 pandemic continues to cause additional costs, particularly for the KEMH. Extra staffing and equipment have been sourced to ensure that we can mount an effective response to COVID, should it enter the Islands, and continue to screen for latent COVID in our community.

2.2 The costs related to the vaccination programme will be put to the COVID budget line, as significant amounts of consumables are needed (needles and syringes etc.) as well as some medical staffing expenses.

3. Executive Summary

3.1 The global pandemic of the SARS-CoV-2 virus, which causes COVID-19 disease, continues to cause international havoc, and at the time of writing is responsible for over 2million worldwide deaths so far. Over 94 million people have been infected with the virus, many of which will have long-term consequences of the disease, leading to chronic illness, which in turn will reduce economic output by diminishing the workforce availability and will also cause increasing need for long-term social care support.

3.2 The development of SARS-CoV-2 vaccines will become a game-changer in the way we will control regulations around the pandemic response. If we can protect our most vulnerable in society, and in due course vaccinate the whole population, we will be in a position where we might be able to look at relaxing some of our strict measures that we currently have in place, which have been necessary to protect our population and resources. Vaccination could be seen as the beginning of the end of the pandemic, although the actual end might be years away in reality.

3.3 This report outlines a two-phased approach to vaccinate our population, as proposed by the KEMH, which in large part follows the JCVI's well-evidenced vaccination plan for the UK, with minor adjustments to suit local circumstances.

3.4 It should be noted that all countries who are in a position to start SARS-CoV-2 mass vaccination are following a similar pattern, i.e. vaccinating the most at risk and vulnerable first, along with front line healthcare workers, who themselves are critical for the provision of care for not just COVID patients, but general medical support to the country.

3.5 Two phases are suggested. The first phase is uncomplicated and straightforward and consists of a plan to vaccinate the most vulnerable in order of age grouping (as we know increasing age is a direct risk factor for COVID-19), and frontline health and social care workers and all allied health professionals who have patient contacts. We propose vaccinating all those aged >50 years, and all those who are younger who have been identified on the high or moderate risk registers, and health and social care staff in phase one. (NB Our risk criteria is similar to the UK risk grouping and included searches for patients: over 70's, pregnant, those on Immunosuppressants, asthmatics (well controlled vs oral steroids in last 2 yrs), COPD patients, diabetics (well controlled vs medicated), transplant patients, and those with asplenia, immunoglobulinaemia,

atrial fibrillation, heart disease (highlighting those with co-morbidities), Chronic Kidney Disease (3b or worse), obesity (weight over 20 stone and or BMI>40), long term prednisolone, HIV, lymphoma, myeloma and leukaemia.)

3.6 It should be noted that our vaccination policy towards health staff mirrors that laid out by the JCVI, CDC, ECDC and WHO. It is well recognised that the Health Department works as a team and it is not just frontline healthcare workers who are bedside workers. Ancillary staff, such as those in administration roles, all enter patient care areas and come into contact with patients. In a place as small as the Falklands, the administration staff often have cross-over roles where they work on reception, often chaperone medical staff in clinics, or work on the ward in an administrative or supportive role (e.g. minders for patients). In a major incident they become bedside scribes and runners. It is for this reason we propose inclusion of all health care staff in the Phase One (group two) section of the vaccination plan.

3.7 The second phase looks at ways to prioritise the remaining vaccine for those who are either most as risk as a result of their jobs, or who have high-contact jobs, e.g. bio-security officers or shop assistants respectively.

3.8 Unfortunately we are not going to be in a position to cover the whole population twice, so will prioritise vaccination accordingly until we receive more vaccine.

3.9 We are confident that we will receive enough doses in the first delivery of the AstraZeneca vaccine to undertake vaccination for all of those listed in Phase One, and will likely have enough left for some people in Phase Two.

3.10 Elected members are asked to acknowledge the Phase One vaccination programme, and to approve the prioritisation of the Phase Two vaccination programme.

4. Background

4.1 The U.K. Government has issued a commitment that it will support all United Kingdom Overseas Territories with vaccination of their populations.

4.2 Two vaccines have been offered for this purpose; 1) the PfizerBioNTech vaccine, which requires transportation and storage at a super-cool temperatures of between -55 and -85 centigrade, and 2) the Oxford/AstraZeneca vaccine that is more easily transported and stored at temperatures between +2 – +8 centigrade.

4.3 Due to the strict time constraints and difficulties of moving the Pfizer vaccine, it became obvious to the PH teams at the KEMH and PHE/UKOT's that the AZ vaccine would be the best choice for our remote Islands where we have regular flight delays and disruptions.

4.4 As the aim of the COVID-19 vaccination programme is to protect those most at risk from severe illness or death, the Joint Committee on Vaccination and Immunisation (JCVI) have prioritised the eligible groups according to risk. The COVID-19 UK national vaccine programme has started with those in the first priority groups, and is then moving into the subsequent priority groups as more vaccine becomes available. In

the Falkland Islands we will largely follow this approach, though we ought to be able to cover all the priority groups in a much shorter timeline than the UK is able to achieve.

4.5 Please note, the UK's MHRA has agreed vaccination of all people aged 16 and over, excluding pregnant women (unless benefit clearly outweighs the risks) and those who have a **true** allergy to the constituents of the vaccine (which is expected to be very low). It has been suggested to capture herd, or population immunity, 70% of the population should have immunity to COVID-19 disease, either by vaccination or by catching the illness.

4.6 FIG has been advised that we expect to take receipt of up to 5,200 doses of the AZ vaccine by the end of February 2021.

4.7 It must be noted that here in the Falklands we will be using a syringe and needle delivery system for the AZ vaccine that will see some wastage of this total dosing. This is because there is a worldwide shortage of the dose-sparing systems (where there is a needle pre-fixed to the syringe). It is perfectly acceptable to use a standard system, and indeed across the UK many centres have to do just this, due to a shortage of the dose-sparing systems.

4.8 We are not clear exactly what the wastage will be, but it is expected to fall between 10-20%, i.e. meaning in reality we can deliver between 4,160 and 4,680 doses in total. The lack of clarity on this is because all vaccine manufacturers add a little extra to each vial, to ensure that a 10-dose vial, when given with the recommended delivery system, will definitely deliver 10 doses. We do not know what excess, if any, AZ have added to vials. We have asked for clarity around this, but have not yet received a response.

4.9 The FI priority listing for **Phase One** vaccination falls into 10 groups and is listed as follows:

Priority group	**Inclusion criteria**	**Number of patients (BFSAI figures in red)**	**Running total (including BFSAI)**	**Total vaccine doses needed**	**Groups included**
1	Residents and Nurses at Liberty Lodge, Residents in Sheltered Accommodation and Community Support Staff	86 (24 patients, and 62 staff) (0)	86	172	
2	Patients aged 80 + and all KEMH staff (and all MPC medical staff, including SAR/MIR/RIC/RRH medics, First responders, Med centre staff, swabbing	177 (51 patients and 132 staff) (64)	327	654	Groups 1 & 2

	staff etc.)				
3	Patients aged 75+	78 (1)	406	812	Groups 1 – 3
4	Patients aged 70+	107 (15)	528	1056	Groups 1 – 4
5	Patients aged 65+	126 (14)	668	1336	Groups 1 – 5
6	High Risk patients under 65	169 (88)	925	1850	Groups 1 – 6
7	Moderate Risk Patients under 65	206 (0)	1131	2262	Groups 1 – 7
8	Patients aged 60+ (Minus 59 civilians already identified in the risk lists)	154 (59)	1344	2688	Groups 1 – 8
9	Patients aged 55+ (Minus 49 civilians already identified in the risk lists)	202 (100)	1646	3292	Groups 1 – 9
10	Patients aged 50+ (Minus 63 civilians already identified in the risk lists)	282 (126)	2054	4108	Groups 1 – 10

4.10 As you can see from the table above, even with expected wastage by using a standard syringe and needle delivery system, we will still be able to vaccinate everyone in the Phase One programme.

4.11 **Please note**, these figures have been gathered from the current EMIS records on file at the KEMH, which have been carefully sifted through and analysed to gather these data. It also includes known people from MPC who fall into the priority groups 1-10 of Phase One. There may be a few others who as yet have not been identified, however this figure is not expected to be more than 10-20.

4.12 Black, Asian and Minority Ethnic (BAME) individuals have not been selected out and prioritised individually. Although there has been some discussion around prioritising this group, as yet, the JCVI have not indicated that there is enough evidence to pull this group forward as a separate section to immunise.

4.13 As mentioned we expect to be able to deliver between 4160 and 4680 doses, meaning that we will have enough vaccine left to from the Phase One process to vaccinate between 26 and 286 people from phase two (even more if we can secure the dose sparing syringe and needle systems, which we are trying to do, but it is unlikely we will be successful in obtaining any).

4.14 The priority grouping for the **Phase Two** vaccination programme can be more flexible. The KEMH PH team and PHE recommend that those who are aged 50 or under and who will be most at risk of catching COVID-19 disease (by the nature of their lifestyle or work) should be prioritised in phase two.

4.15 Here in the Falklands it seems sensible to prioritise those who have direct contact with arrivals into the country who have not yet quarantined. This would include Customs and Immigration staff, Bio-Security staff, Penguin Travel Drivers, and Malvina staff

working in the quarantine section of the hotel, who have not already been caught in the Phase One programme (by nature of their age or medical situation).

4.16 Also in Phase Two, it seems reasonable to include critical non-healthcare workers, e.g. police, fire, courts and teachers.

4.17 As yet it is unclear how far down the Phase Two lists we can get as we don't have staffing numbers for all groups, and we have a flexible "expected wastage" of vaccine. **We suggest prioritising those who have the most direct contact with new arrivals (as listed above), followed by the groups whose jobs are seen as most vital within the community**, e.g. perhaps there is only one person in the Islands who is qualified to undertake that particular role. The KEMH staff do not know this type of specific information, so CMT advice may be necessary.

4.18 Suggested vaccination priority grouping for Phase Two is as follows:

1. **Phase Two Alpha group -** Customs and Immigration staff, Bio-Security staff, Penguin Travel drivers and Malvina staff working in the quarantine area. **It is expected we will have enough vaccine to cover these groups in this vaccination round.**
2. **Phase Two Beta group -** All other staff considered critical non-healthcare workers, starting with police staff, courts staff, fire fighters and teachers. **It is expected that we will have enough vaccine to cover some of these groups in this vaccination round.**
3. Other critical, or single-handed, workers in the community. More work into the inclusion and prioritisation of this group is needed.

5. Delivery of the programme – details

5.1 Please note that this is the plan as it currently stands. Slight alterations to the detail are to be expected as we gain more clarity around the date of vaccine delivery and around how many people fall into exactly which group and where they are currently residing.

5.2 As we do not know when we will get further vaccine supplies we will be conserving our initial supply so as to ensure everyone who is vaccinated can get two doses of the vaccine. The scientific evidence is clear that it is important that everyone who is vaccinated receives a second dose within 12 weeks so as to maximise the chance of them developing longer term immunity.

5.3 **Stanley vaccination plan -** We plan to vaccinate the Stanley based population in the FIDF hall over a period of 4-5 days. Individuals above the age of 50 will be invited to attend in specified slots, of approximately one hour's duration, according to their age. Where we have identified a large number of people within a specific age grouping we will use an additional criteria such as letter of surname so as to be able to manage patient flow. These individuals will NOT receive an individual invitation to the vaccination programme. We anticipate, that with clear messaging that they will all be in a position to receive the vaccine, that there will not be a need for people to rush in anticipation of wanting to be "first in the queue".

5.4 Individuals under the age of 50, with significant underlying health conditions will have been identified in advance and given an individual letter of appointment. Individuals under the age of 50 who have not been specifically invited will not be offered a vaccination at this stage of the programme.

We are currently undertaking a public information strategy to encourage people to register with KEMH if they are not already registered. We intend to vaccinate everyone who is resident in the FI (and likely to be so for the second dosage) at the time of the vaccination programme.

5.5 We are aiming to have 9 vaccination stages set up in the FIDF hall at any one time and people will be given their consent forms and information leaflets on arrival. We are liaising with other agencies, such as PWD, on issues such as traffic management. Housebound patients, and those resident at Liberty Lodge, will be vaccinated by the Community Support Team in line with our well established annual flu vaccination programme.

5.6 **Camp vaccination plan**

It should be noted that the post Christmas period, through until mid-April, is the busiest farming time for the agricultural population. It might be impossible for farmers to leave their farms due to shearing pressures (shearing times are inflexible – more so than ever this year due to limited professional shearers being available, and the season is expected to take a little longer than usual in any case). Some cannot easily leave their farms unattended.

East Falkland population

- Where possible, people from East Falkland will be encouraged to travel to Stanley for vaccination. Flexibility will be offered for this group, i.e. we will offer an arrangement whereby people from East Falkland, who are willing and able to travel to Stanley, can let KEMH staff know which day they would like to attend, with a rough arrival time, and they will be slotted into the Stanley programme.
- Those who cannot travel to Stanley will be seen by a mobile team (a doctor, nurse and admin team member) who will travel by vehicle on a pre-planned route.
- Depending on who needs to be visited, it is likely that the land-based mobile team will travel to the North Camp one day, perhaps agreeing a time to be at a particular settlement, e.g. San Carlos, and farmers from the surrounding, close farms, can meet for their vaccinations at a set time, followed by a visit to Goose Green and North Arm on days 2 and 3. MPC will be included in the East Falkland mobile team if MPC cannot undertake their own vaccination of their people in Phase One.
- This leaves the flexibility of a day to visit other settlements if needed, or if there are delays or breakdowns.

West Falkland and the Island population

FIGAS is under a great deal of pressure this year with the TRIP scheme being a huge success, however medical teams flying to patients will be much easier for FIGAS to manage than patients coming into Stanley. Also, more can be achieved in a more efficient way, by working like this. FIGAS have already said they would fully support

us where possible, and if given enough time to plan. Following initial discussion with FIGAS manager, he feels the schedule is achievable.

- Looking at estimates, it would seem there is approximately 60 people on West Falkland or the Islands who would reach the criteria for COVID-19 vaccination in Phase One.
- Mainland West Falkland is relatively easy to organise. Each day a doctor and a nurse will be delivered to one of the main settlements on West Falkland, e.g. Fox Bay day one, Port Stephens Day two, Hill Cove day three and Port Howard day four. Farmers from mainland West Falkland will be contacted in advance to be asked which settlement they want to be seen at and estimated timings can be given to FIGAS, as they are when undertaking normal Camp visits.
- A second doctor and nurse team will fly with FIGAS to the Islands to visit those patients who fall into the Phase One vaccine group. The exact planning of which Islands get a visit on what days will lie firmly with FIGAS.
- These mobile teams will have the necessary administrative paperwork needed to undertake COVID-19 vaccination and on their return to Stanley each day they will hand over the completed documentation to the administrative team to be filed onto EMIS and documented properly.

Giving the vaccine in Camp

Each year dozens of vaccinations and injections (including biological agents) are given to patients in Camp. The AstraZeneca vaccine is seemingly very safe with a very low side effect profile, however patients will be given the vaccine and asked to wait for a full 15 minutes with the medical team before leaving. A doctor and a nurse, who have received recent anaphylaxis training, will be in attendance and will have appropriate medical kit with them to treat an emergency.

It is perfectly reasonable to give the vaccine in the back of the plane, or Land Rover (as indeed most vaccines are already given this way in Camp) and it could be argued that this is safer because if the patient should have a serious reaction, moving them by plane to Stanley for urgent attention will be easier and quicker. In all cases, where possible, the vaccine should be given as close to the airstrip and plane as can be achieved. This is particularly true when vaccinating on remote Islands, as travelling to settlements might delay and complicate evacuation in an emergency.

6. Options and Reasons for Recommending Relevant Option

6.1 Honourable members are asked to acknowledge and support the Phase One vaccination programme in its entirety, without change.

6.2 Honourable members are asked to agree to the suggested Phase Two vaccination priority grouping as listed in step 1 (Phase Two Alpha) and 2 (Phase Two Beta) above, and include these groups in this vaccination round.

6.3 Honourable members are asked to task the CE, via discussion with HR, CMT and private companies, to identify other critical workers who might not have already been captured in the Phase One programme, to be included in this vaccination programme. It is suggested that vaccination of this group will be undertaken until the current supply of vaccine is used up and will be given in age-order.

6.4 It is clear that we will have enough vaccine to cover the large bulk of our population, and most importantly the high-risk groups, and that we will have some vaccine left over. The Phase Two group must be ordered in levels of priority and this paper serves to offer some guidance on how this can be done.

7. Resource Implications

7.1 Financial Implications - as listed above in section 2 it is clear that COVID-19 is costing the FIG substantial amounts of money, and the vaccination programme is no different. We have ordered in enough consumables (syringes, needles etc.) to ensure we can vaccinate our entire population twice. These orders have been in addition to our usual consumable supply.

7.2 Human Resource Implications – nil. The vaccination programmes can be delivered within the KEMH staffing establishment (including bank staff and past employees).

7.3 Other Resource Implications – there will be some disruption to the usual KEMH service during the vaccination programmes. Each person will receive two vaccines (an initial vaccine and a booster approximately 6 weeks later) to enable them to achieve a full immunological response to the vaccine, so the disruption to normal service will be repeated several times.

8. Legal Implications

8.1 The COVID-19 pandemic engages a number of fundamental rights and freedoms. In the context of vaccine delivery, the main considerations are the protection of right to life (section 2), and the protection from discrimination (section 16).

8.2 It is desirable to offer vaccination to as many persons as possible.

8.3 The Falkland Islands Government is expecting to receive a limited initial allocation of doses of the vaccine and it is important to prioritise delivery of the vaccine according to clinical benefit. This will be in accordance with section 2, and will not offend section 16. The Oxford/Astra-Zeneca vaccine is licensed for use only in relation to persons aged over 16. The prioritisation of persons is primarily based on age and clinical risk factors. This is based on evidence of the risks faced by persons in relation to COVID-19. It is also intended to prioritise health and care workers. Again, this is due to potential risks those staff would face if there was to be an outbreak of COVID-19, and also to ensure, so far as possible, the resilience of those staff – which would otherwise have a broader impact on overall population well-being.

9. Significant Risks

9.1 Not to undertake a structured SARS-CoV-2 vaccination plan will see the Falkland Islands population at considerable risk of the effects of COVID-19 disease. Priority must be given to the vaccination of those most at risk and those who deliver healthcare services to the Islands.

10. Consultation

10.1 This paper has been discussed, considered and agreed by the SPMG.

11. Communication

11.1 This plan will be shared with the media, BFSAI colleagues to ensure that the population understand what is happening and why. This is essential as we want to capture as many of the population as possible to ensure adequate long-term herd immunity.

Appendix:
A – Paper from JCVI re prioritisation groups – link
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

B – WHO SAGE Roadmap For Prioritizing Uses Of COVID-19 Vaccines In The Context Of Limited Supply – link

https://www.who.int/publications/m/item/who-sage-roadmap-for-prioritizing-uses-of-covid-19-vaccines-in-the-context-of-limited-supply