COVID-19 vaccination programme

JCVI Cohort 6 - Homelessness and rough sleeping

Mobilisation support pack

Version 1.0, 12 March 2021

Contents

Introduction and context (1/2)

- Objective: To vaccinate people experiencing homelessness and rough sleeping alongside cohort 6, including temporary hotels and hostels for people experiencing homelessness, and to maximise the opportunity to register people with a GP practice. **When identifying who is eligible for vaccination, the JCVI guidance and the COVID-19 Green Book must be followed.**
- This pack will support vaccination teams to mobilise services for people experiencing homelessness and rough sleeping (https://www.gov.uk/government/publications/health-matters-rough-sleeping/health-matters-rough-sleeping) alongside JCVI priority cohort 6, delivered through a range of models to maximise uptake of the vaccine for this group of people.
- 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*.'

- The following housing circumstances are examples of homelessness:
  - People without shelter of any kind, sleeping rough including people in buildings or other places not designed for habitation
  - People living in hostels, shelters and refuges

- This pack should be read alongside the standard operating procedure (SOP) *COVID-19 Local Vaccination Services (LVS) deployment in Community Settings.* The SOP includes the operating model for local vaccination services (LVS) and for providing LVS in outreach settings, and guidance and advice (eg cold chain management) for roving vaccinators.

Introduction and context (2/2)

- Given the high risk of exposure in hostels, hotels, residential rehabilitation settings, refuges and other settings of multiple occupancy, including people living on the streets, where a significant number of people would be considered Clinically Extremely Vulnerable (JCVI priority group 4) / Clinically Vulnerable (JCVI priority group 6), vaccination of the whole resident population is recommended, where appropriate.
- 'Trauma Informed Care' and 'psychologically informed approaches' have in recent years become accepted as good practice in working with people experiencing homelessness. Vaccination teams do not need to become expert in these approaches, although they may wish to understand more ahead of vaccinating people. ANEEMO offers a free course COVID-19 Support | aneemo and Homeless Link has this briefing: https://www.homeless.org.uk/sites/default/files/site-attachments/TIC%20PIE%20briefing%20March%202017_0.pdf
- People experiencing homelessness and rough sleeping have a higher risk of poorer outcomes from COVID-19 compared to the general population. This population group has high rates of undiagnosed co-morbidity and poor health outcomes and reduced access to healthcare, including primary care.
- Almost half of this population are, in practice, unable to access primary care, through a combination of either being unregistered or no longer based near where they are registered. These risks are compounded by challenges in adhering to recommended physical distancing and infection prevention and control measures, along with often poor symptom recognition or disclosure and barriers in engaging with contact tracing activities
- The Faculty of Inclusion Health has published the Standards for Inclusion Health for Commissioners and Providers here including Street Outreach Guidelines. These should be considered in planning and mobilising vaccine delivery. Public Health England has published a bite-sized session to give health and care professionals an overview of inclusion health. It includes key evidence, data and signposting to resources: https://portal.e-lfh.org.uk/Component/Details/688646

Mobilisation

- Systems should work with CCGs, local authorities, providers commissioned to deliver COVID-19 vaccinations, Voluntary, Community, Social and Enterprise organisations and other partners to establish the most effective ways to serve people experiencing homelessness and rough sleeping, and determine the most appropriate vaccination delivery model for them (see slide 6 on delivery models) and to identify and encourage those individuals to access vaccination services.
- The Oxford/AstraZeneca vaccine is recommended for vaccination at residential settings including hostels, hotels, residential rehabilitation settings, refuges and other settings of multiple occupancy, including people living on the streets. Our position statement on the vaccination of care home residents using AZ provides guidance on the safe and aseptic movement of this vaccine and should be followed. The position statement on the use of the COVID-19 Oxford/AstraZeneca vaccine to visit housebound patients, which provides guidance on safe transport and use of punctured vials, may also be relevant.
- Where it isn't possible for residents of hostels / hotel accommodation for people experiencing homelessness and rough sleeping to attend vaccination sites, PCN groupings, and in some cases community pharmacies (when requested by NHS England), may need to deliver vaccinations in those settings.
  - The £10 residential settings supplement for delivering vaccinations in settings such as hostel/hotel accommodation for people experiencing homelessness, where it would not be possible for these patients to attend vaccination sites, has applied since 15 February (see our 13 February 2021 letter). This is payable to PCN groupings or community pharmacy contractors.
  - This supplement also applies to vaccinations administered in accommodations for asylum seekers or refugees, again from 15 February, and where it is not possible for these patients to attend vaccination clinics.
  - Outcomes for Health (Pinnacle) Point of Care system will be updated to include an additional field relating to the collection of data to support payment of the £10 residential settings supplement in due course. We will let you know when this has happened and advise you on next steps.
  - We have also recently made an extra £4.2m of funding available to support and enable locally led community engagement in all areas with health inequalities, with each STP receiving a notional allocation of £100,000. This announcement set out that people experiencing homelessness and asylum seeker, refugee and migrant populations may need additional routes to access the vaccine. You can find the letter here https://www.england.nhs.uk/coronavirus/publication/supporting-ccgs-to-address-vaccine-inequalities/
- Alternatively commissioners may wish to deploy dedicated LVS outreach teams to vaccinate this group of people.

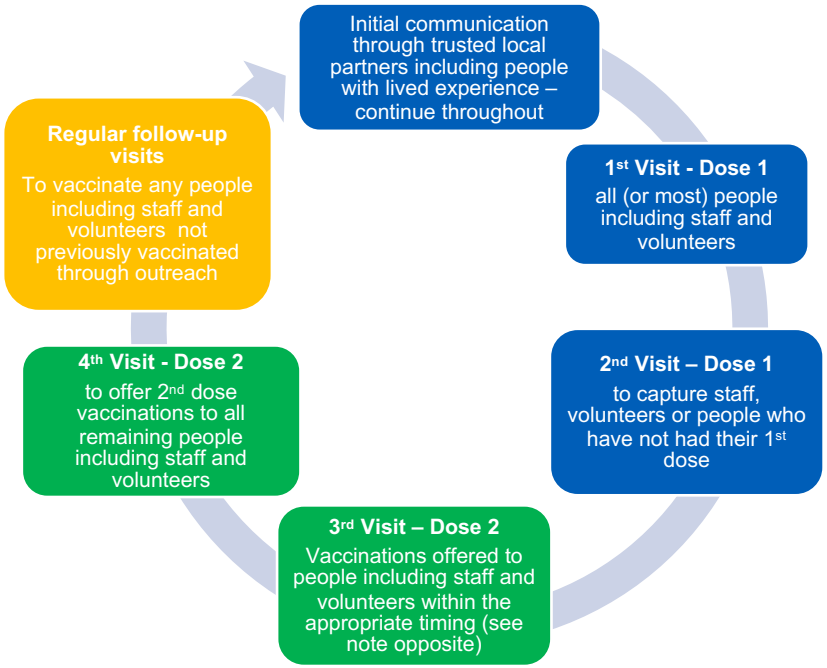
Delivery model (1/4)

- People experiencing homelessness and rough sleeping should have inclusive access to the vaccination programme through all relevant routes. All of vaccination sites should ensure that their practice is trauma informed, accessible and inclusive, including having arrangements for people not registered with a GP and / or an NHS number.
- PCN groupings and Community Pharmacy Contractors can administer vaccines from locations other than those which have been specifically designated for COVID-19 vaccination in specific circumstances as set out in guidance. Our letter of 7 January outlining the additional operational flexibilities offered by the Oxford/AstraZeneca vaccine provides the framework for this to take place.
- There are a number of models that could be used to vaccinate people experiencing homelessness and rough sleeping:-
  - ✓ Supporting people to go to an existing vaccination site, for example a PCN led or community pharmacy LVS, or a vaccination centre. Community pharmacy may be most appropriate for those people who are in receipt of a regular prescription (a script)
  - ✓ Holding dedicated clinics targeted at people experiencing homelessness and rough sleeping at an existing vaccination site (see example Case Studies)
  - ✓ Holding temporary vaccination clinics at an alternative location to the designated sites, similar to the vaccination in care homes model, which deploys a small roving vaccination team to visit the location to administer the vaccine. These clinics could be on a one-off or rolling basis (e.g. weekly) depending on demand / uptake.
    - ➢ Note that for PCN groupings the commissioner will need to approve and confirm the arrangements in writing, including clarifying who the PCN grouping can vaccinate at the temporary vaccination clinic.
    - ➢ Community Pharmacy Contractors must be approved by their Regional team Commissioner to provide vaccinations at a venue other than the Designated Site with their LES agreement.
    - ➢ See Appendix H of the SOP for more information on temporary vaccination clinics. It should also be read in conjunction with our letter 'Further opportunities for PCN and Community Pharmacy COVID-19 vaccination sites to partner with community venues to delivery temporary vaccination clinics'.
  - ✓ Roving vaccination model to visit any homelessness or rough sleeping setting. A list of these settings is included on slide 9 (box 2). This would follow a similar operating model to that for visiting residential settings or settings of multiple occupancy as detailed in Appendix G of the SOP. For accommodation settings, this will require a dedicated room for the purpose of the vaccinations.
    - ➢ Prior communication with local housing authorities, support services and providers to determine the optimal arrangements required.
    - ➢ Providers should be aware that the level of staff knowledge or capacity will be very different from that of staff working in care homes with less resource available to support vaccination teams.
  - ✓ A mobile vaccination model to visit hostels / hotels / communal accommodation. This will entail the vaccination service being delivered from a suitable vehicle.

Delivery model (2/4)

- This proposed vaccination visit schedule in most cases includes a suggested programme of follow-up visits to capture individuals including staff and volunteers not previously vaccinated and applies to roving and mobile vaccination delivery models.
- As many people experiencing homelessness are likely to be offered the AstraZeneca vaccine, optimal timing of the 2nd dose is 8-12 weeks after the first dose. Local decision making should be undertaken on whether a shorter schedule may be offered in cases where the individual is unlikely to return for receipt of the 2nd dose at 12 weeks and where they may be lost to follow-up.
- The initial step should be to communicate through trusted local leaders and organisations, including people with lived experience, information about the safety and efficacy of the vaccine. Resources to support this are available from Groundswell and doctorsoftheworld.

Vaccination visit schedule



- ✓ 1st visit dose 1 – all (or most) people, staff and volunteers. It is important with this group to provide a date and time for the 2nd visit at this 1st appointment
- ✓ 2nd visit – to capture staff, volunteers or people who were unavailable initially, or chose not to accept the initial offer and who have not had their 1st dose
- ✓ 3rd visit – dose 2: vaccinations offered within the 77-84 day window following the 1st dose. Individuals who have not had their 1st dose should also be offered the vaccine at this visit
- ✓ 4th visit – to capture outstanding 2nd doses

Delivery Model (3/4)

Support can be drawn from the following:

- Locally – hospital or community support; nurse and pharmacy support within CCGs including existing inclusion health specialist practices, outreach screening and immunisation teams, drug and alcohol services etc
- Voluntary sector staff and volunteers providing support both in temporary accommodation sites and outreach care
- Local authorities including public health teams, social care, housing and homelessness teams, community champions
- Nationally – further resources are on the FutureNHS workspace (if you are not currently a member, please email P C N-manager@future.nhs.uk). The Homelessness and Inclusion Health workspace has additional resources [https://future.nhs.uk/HomelessHealthCOVID19/grouphome]
- Groundswell have produced a film about what works and key messages along with two print resources: https://groundswell.org.uk/2021/covidvaccine-resources/

Delivery Model (4/5)
Initial deployment considerations

Liaison with Local Authority (public health, social care, housing and homelessness – in two tier areas, the lower tier has housing responsibility) and Voluntary Sector organisations providing accommodation and / or support to people experiencing homelessness and rough sleeping

Identification of relevant sites: -
Accommodation including shelters, hostels, hotels and refuges.
Touch points including day centres, soup kitchens, specialist homeless health service, or other site recommended by an outreach support provider or housing advice service

Estimate the number of people in this cohort. A partnership approach with the local housing authority, service providers and the VCS will be most effective. Local Authorities hold some data on; number of people being temporarily accommodated; estimates on those continuing to sleep rough; refuges.

Agree delivery team and the resources they will need, drawing on: existing outreach teams; specialist health care practices; Voluntary Community and Social Enterprise partners; Substance Misuse services.

Embed 'Every Contact Counts' principles and consider what other health care including health checks, immunisations and screening could be offered.

Check mobile data access including access to Pinnacle for mobile and outreach teams – sites unlikely to have wi-fi

Work with local community leaders and partners to agree the best approach for engaging and communicating with this cohort and encouraging uptake of vaccine (outreach).

Work with partners to register people with General Practice prior to or at point of vaccination.

Work with local authorities and partners to explore the potential to provide emergency, safe accommodation for people living on the streets which enables the individual to move on from homelessness

Establish a paper based recording system for those who are not registered with a GP / with an NHS number. Where possible register individuals prior to vaccination or at point of vaccination.

For those individuals that refuse to provide personal information, this should not preclude them from being offered the vaccine.

Agree best approach to follow-up for 2nd dose vaccination with individuals and draw on their engagement with any relevant homelessness service to maximise 2nd dose take-up where appropriate.

Data – ensure minimum data recording on GP record is updated to include capture of: ethnicity; housing status; GP registration (existing, new or refused).

Vaccine supply and re-supply: to minimise wastage direct communication between medicines lead / vaccine supply and mobile / outreach teams to be able re-stock whilst on site where take up is higher than anticipated

Delivery Model (5/5)
Vaccine delivery for mobile and outreach

Vaccine information communicated through hostels, hotels and through outreach teams to individuals.

Paper based method for recording vaccination available and 'patient held' paper record with details in case they are moved to a different area

In the case of a positive outbreak, a risk assessment should be undertaken with the site lead in accordance with the guidance

Paper based recording either uploaded to pinnacle, system1 with trigger for follow up and NIMS. Where no GP reg or NHS number, paper records must include clear contact

Local plan for mobilisation of outreach and mobile delivery agreed

LVS / PCN, Local Authority and VCSE Partners agree sites and locations to prioritise

Trusted support organisations provide information to people in accommodation, other sites and through outreach on the streets

Sites, Local Authorities and community leaders provide estimates on numbers of people and agree schedule

Outreach and mobile teams equipped including with information, consent forms including easy read / translated resources

Check in with sites and street outreach teams identification or reports of any onset of new illness

① Delivery of first vaccinations with regular repeat visits to pick up new people. Visits scheduled at different times of the day

Connection with medicines/ vaccination supply team to check number of vaccines to be delivered and establish process for re-supply for mobile and outreach teams at short notice

Liaison with Local Authority (public health, social care, housing and homelessness) and Voluntary Sector organisations providing accommodation and / or support to people experiencing homelessness and rough sleeping

Where possible and appropriate, support sites to discuss with people in advance and register with GP Practice

Teams have sufficient equipment for safe delivery including PPE

Check all IT required for the day is available and working.

③ ④ 4-cycle visit schedule to be undertaken to capture individuals and staff not previously vaccinated.

② Follow-up for 2nd vaccinations also picking up new people. Repeat visits scheduled on different days and times

Initial health checks where possible to identify individuals with possible contra-indications

Consent process (1/2)

- All patients who are able to give informed consent are required to do so to receive the vaccination. Those being vaccinated should be able to understand, retain, use or weigh, and communicate the anticipated benefits of vaccination in the simplest of terms, the likely side effects from vaccination and any individual risks they may face should be addressed, and the disbenefits of not consenting to the vaccination.
- Chapter 2 of The Green Book states that consent must be obtained before administration of all vaccines. This applies where the patient is able to give informed consent. The guidance is based both on the current legal position and the standards expected of health professionals by their regulatory bodies. Follow guidance set out in Section 4.5 and Appendix D of the SOP.
- To provide informed consent, people need to receive information about the vaccine both in advance of and at their vaccination appointment.
- This information should meet individual communication needs, for instance, through providing information in translation, 'Easy Read' versions, visual prompt cards, explanations via video, or verbal explanations. Explanations should use short sentences, repeat key information and avoid jargon. 'Easy read' information and consent forms developed by Public Health England are here.
- To support people to understand the information and come to an informed decision, time should be taken to explain all the benefits and risks and deal with any queries and concerns. Trusted community members/leaders, Peers and Experts by Experience should be engaged early, as appropriate, and provided with relevant information to support them in this role.
- Discussions ahead of vaccination visits (where possible) should also be used to check whether the person has any contraindications to vaccination and to identify any medical, communication or support needs they may have which may need to be addressed prior to receiving the vaccine.
- Staff and volunteers should have the information about the Oxford/AstraZeneca vaccine, what administering the vaccine will involve, and when it will happen. It would be advisable for staff leading the conversations to have completed the COVID-vaccination e-learning core knowledge for the Oxford/AstraZeneca vaccine training: https://portal.e-lfh.org.uk/Component/Details/675208.

Consent process (2/2)

- There is no legal requirement for consent to immunisation to be in writing and a signature on a consent form is not conclusive proof that consent has been given, but serves to record the decision and the discussions that have taken place with the patient.
- The giving and obtaining of consent is viewed as a process, not a one-off event. Consent should still be sought on the occasion of each immunisation visit. Consent must be given voluntarily and freely.
- Where possible, the informed consent of the individual should be recorded at the point of vaccination on the Outcomes4Health / Pinnacle Point of Care system within the pre-populated fields and the individual should be provided with written information about the vaccination.
- Where an individual lacks the mental capacity and a best interests decision has been made, the decision maker should make a record of their best interests decision. If a capacity assessment is done and the decision is that the individual did have capacity to consent this should also be documented.
- Relevant consent forms, other supporting forms and associated information can be found on the GOV.UK website.

Further information is in the Standard Operating Procedure for COVID-19 local vaccination services deployment in community settings: https://www.england.nhs.uk/coronavirus/publication/standard-operating-procedure-covid-19-local-vaccination-services-deployment-in-community-settings/

Capacity (1/3)

- Some people who will be offered the vaccine may lack mental capacity to make decisions about vaccination. This could include some (but not all) people with mental health difficulties, dementia, learning disabilities, autistic people and people with acquired brain injury. These people, if they are aged 16 or over, are protected by the empowering, decision-making framework set out under the The Mental Capacity Act 2005 (MCA).
- These legal requirements should be familiar to everyone involved in the care and treatment of these people, as they will be used to consider for other, similar decisions, including a decision to test a person for COVID-19, or administer the flu vaccine to help protect them from illness over the winter. The principle of best interests decision making under the MCA is the same for the COVID-19 vaccination.
- The MCA requires the assumption of capacity unless "it is established" that an individual lacks the mental capacity to consent. Therefore, all adults are considered to have mental capacity to consent to the COVID-19 vaccination, unless there is evidence to suggest that they lack mental capacity to make this specific decision.
- If someone has mental capacity, they are able to understand information about the vaccine, retain the information, weigh up the information and communicate their decision about having it.
- A person is not to be treated as unable to make a decision merely because they make an 'unwise decision' (Section 1.4 of the MCA) or one with which others disagree. Furthermore, a lack of capacity cannot be established merely because of 'a condition' or an aspect of behaviour, which might lead others to make unjustified assumptions about the person's capacity (Section 2(2)(b) of the MCA).
- When determining if someone with mental health needs or a learning disability has mental capacity, it is important that information is provided in a way that the individual can understand and that the person is supported to communicate their decision (e.g. in writing, verbally, signing or non-verbally).

Capacity (2/3)

- Never assume someone lacks capacity to consent for vaccination based on the fact they use alcohol or drugs (or they have mental health problems).
- Professionals should be aware that intoxication with drugs or alcohol is not necessarily a barrier to a person making an informed decision about vaccination. People who are dependent on drugs or alcohol can often tolerate large quantities of substances and often have the capacity to make specific health decisions, provided an individual can understand, retain, weigh-up and communicate their decision. If intoxication is thought to be impairing someone's capacity to make a decision, it is reasonable to approach them again when less intoxicated. Certain times of the day or certain situations maybe better for some individuals.
- For people with fluctuating capacity, conversations about the vaccine should take place at the optimal time for the person, when they are most likely to be able to demonstrate their mental capacity to decide about the vaccine.

Individuals without Mental Capacity to consent

- If intoxication is thought to be impairing someone's capacity to make a decision, it is reasonable to approach them again when less intoxicated. For individuals in whom capacity to consent to vaccination is likely to vary, an alternative time of day / setting may be more appropriate
- Record management systems should be used to record if the person did not have mental capacity and that consent was provided by a third party (i.e. a Deputy or Attorney) or obtained via a valid ‘best interests’ decision.
- Where it has been established that the person lacks capacity to consent, a best interests decision should be taken in line with the best interest checklist in Section 4 of the MCA.
- If the person has a valid Advanced Decision (i.e. witnessed, in writing, and stating that it applies even if their life is at risk) to refuse all vaccines, or specifically to refuse the COVID-19 vaccine, then this must be followed

Capacity (3/3)

Declining the vaccine

- If someone has mental capacity, then they have the right to decline the vaccine. They do not need to give a reason.
- Anyone who declines the vaccine should be made aware that they can change their mind at any point and request the vaccine at a later date.
- It is important that when offering the vaccine on subsequent occasions, conversations are conducted with the individual respectfully, recognising that it is the person's right to make their own decision.
- Importantly, the Mental Health Act cannot be used to enforce vaccination as the vaccine does not constitute treatment for a mental health problem. In addition, where someone has mental capacity, restraint must never be used to administer the vaccine.

Vaccine handling and preparation

- The vaccine programme will be delivered to sites and on the street through Primary Care using the Oxford/AstraZeneca vaccine.
- PCNs should follow the relevant vaccine Specialist Pharmacy Service's (SPS) SOPs. The lead GP must be familiar with the relevant legislation (see Chief Pharmaceutical Officer's letters) and be sure that all those involved in storing, handling, preparing and administering the vaccine are competent to do so.
- Letters published 8 December and 31 December set out the principles and expectations necessary to maintain integrity, and therefore safety, quality and effectiveness, of the COVID-19 vaccines.
- This means systems and processes must be in place to maintain product integrity, medicines governance, and risk management of COVID-19 vaccines, recognising the significant additional considerations and conditions that may apply compared to other vaccination programmes.
- It is critical that the products are handled correctly in accordance with the detailed SOPs on the Specialist Pharmacy Service's website. Providers should initially contact the Lead Responsible CCG Chief Pharmacist, who will then contact the relevant Specialist Pharmacy Services Regional Quality Assurance Specialist or Regional Chief Pharmacist for additional guidance and support.
- Regulatory compliance by the doctor/GP under reg.3 of the Human Medicines Regulations 2012 means they have to understand the process being done in their name and be accountable for it.
- PHE has published information for healthcare professionals and SOPs specific to the vaccines have been published.
- PHE has also published COVID-19: vaccinator training recommendations, Immunisation training standards for healthcare practitioners, and COVID-19 specific vaccine e-learning.
- **Further information is in the Standard Operating Procedure for COVID-19 local vaccination services deployment in community settings:** https://www.england.nhs.uk/coronavirus/publication/standard-operating-procedure-covid-19-local-vaccination-services-deployment-in-community-settings/

Post vaccination

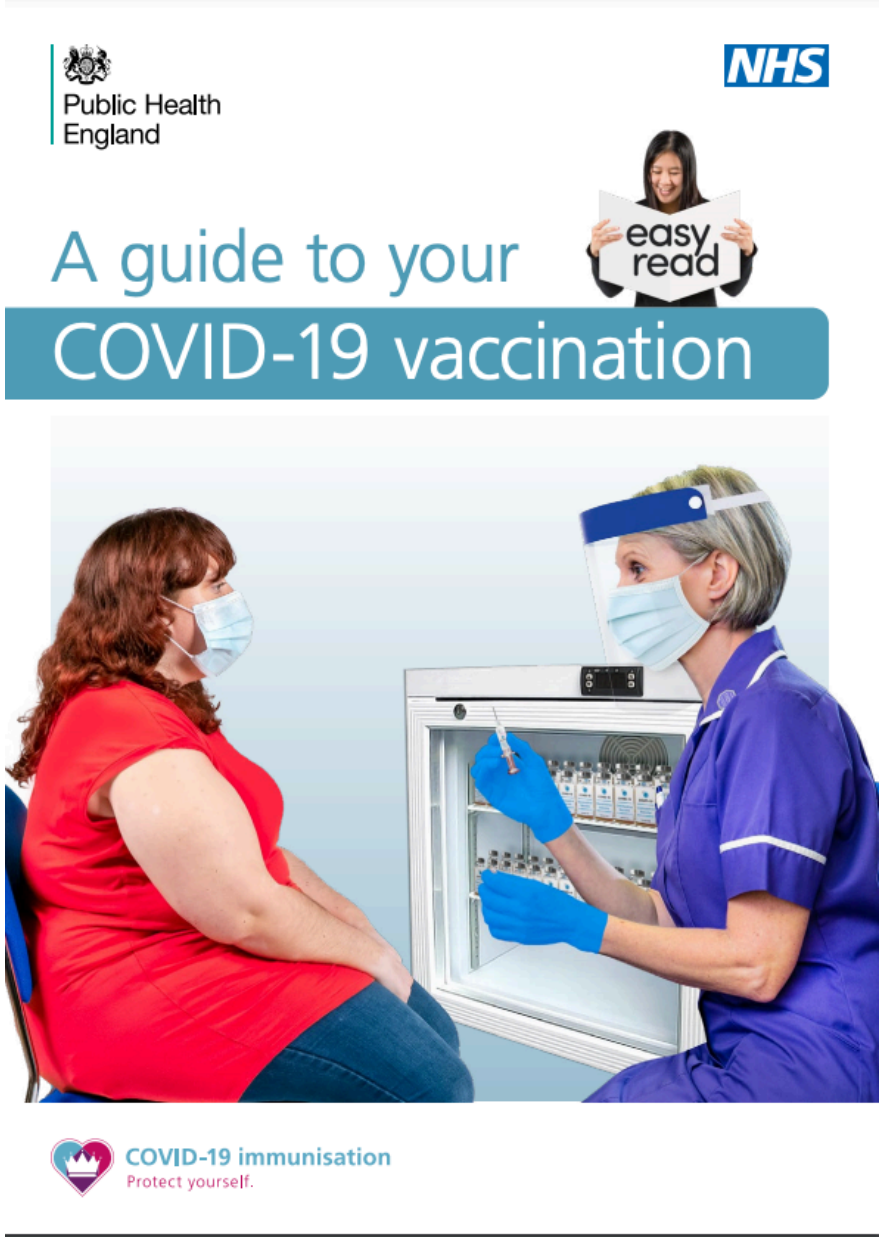
- Post-observation periods should follow normal arrangements for observation after vaccination and pharmacovigilance, as set out in the Green Book.
- The Oxford/AstraZeneca vaccine is recommended for visits to residential settings and outreach delivery and temporary vaccination clinics. The position statement on the use of the COVID-19 Oxford/AstraZeneca vaccine to visit housebound patients, which provides guidance on safe transport and use of punctured vials may also be relevant.
- For the Oxford/AstraZeneca COVID vaccine there is no requirement for 15 minutes observation unless this is indicated after clinical assessment or where the patient has experienced an adverse reaction to a previous vaccination dose.
- The individual / their carer / support worker should be made aware of possible side effects as set out in the patient leaflets (available online).
- The Public Health England (PHE) Immunisation Department is conducting enhanced surveillance of COVID-19 cases in vaccinated individuals in England. Clinicians who are seeing patients face to face are encouraged to report any confirmed cases in partially or fully vaccinated individuals if they tested positive within the preceding 7 days. This provides an opportunity to get early and complete samples from these cases. Further information is available here.
- Immediate post-vaccination adverse events should be recorded by the vaccinator on the Pinnacle Point of Care system and be notified as part of Yellow Card arrangements.
- The registered GP Practice would normally be the first contact for advice around adverse reaction. Outreach and mobile teams should follow up with sites to check for adverse reactions and liaise with appropriate professionals.

Common questions and answers

Question	Answer
What if patients don't have NHS Numbers?	If a patient has not been issued with an NHS number, then teams should still carry out the vaccination, record locally via a paper system and then ensure that the vaccination event is recorded on Pinnacle at later date. In preparation for being vaccinated where a resident is registered with a GP, they should access their NHS number, and if unknown it can be found through Find your NHS number - NHS (www.nhs.uk)
Will people experiencing homelessness need any special considerations regarding consent?	Warm up and preparation work should be carried out by the staff and volunteers in the relevant services / settings where appropriate. This should include completion of the consent form where possible. Consent will be confirmed on the day by the clinical team.
Is there a need for a different type of clinical review for people experiencing homelessness?	Before administering the vaccination, a clinical review should be undertaken to determine if the patient is fit to receive vaccination in much the same way that it would be done for any patient in the community.
What vaccine are we using?	The vaccine being used will be the Oxford/AstraZeneca vaccine. There are no concerns from a movement stability perspective of transporting the vaccine from service to service to support patients who are experiencing homelessness.

Resources (1/2)

- Public Health England has published e-learning and resources on homelessness and inclusion health, including key evidence, data and signposting to trusted resources: https://portal.e-lfh.org.uk/Component/Details/688646 and inclusion health guidance. This will support NHS staff to make services – including vaccination services – as inclusive as possible to promote health and wellbeing of individuals in inclusion health groups.
- PHE's leaflets (updated in light of various changes, eg the scheduling of the second vaccine dose and pregnancy and breastfeeding) are here and include different languages, large print versions and British Sign Language videos.
  - PHE easy read Covid vaccination leaflet
  - PHE easy read What to expect after the vaccine leaflet
  - PHE easy read Consent form for adults
- Consent forms are available for use with residents in multi-occupancy settings according to the 'consent' section of the Standard Operating Procedure. PHE easy read Consent form for adults is here.
- Additional training materials for COVID 19 vaccinators and volunteers provide top tips on communicating with people with a learning disability and autistic people and reasonable adjustments that should be considered
- To support vaccinating residents in multi-occupancy settings, take sufficient quantities to the care setting of:
  - ✓ Leaflet: what to expect after vaccination
  - ✓ If you need more forms when vaccinating at the PCN site and when roving, please print additional quantities from the link above.
  - ✓ If there is any chance you may vaccinate staff and volunteers as well as residents, then you should also take some of the leaflets for women of child-bearing age, and the 'guide for healthcare workers' leaflet.
  - ✓ Credit card sized patient record cards will come direct with the vaccine itself



Please ensure relevant staff familiarise themselves with the content of the leaflets.

Resources (2/2)

- The Chair of the Social Care Sector, Medical Director of Primary Care, and Deputy Chief Medical Officer have produced this video to answer questions about the vaccine for the workforce supporting and caring for vulnerable people.
- Standard operating procedure (SOP) *COVID-19 Local Vaccination Services (LVS) deployment in Community Settings*.
- Leaflet on why you are being asked to wait for COVID-19 vaccination
- What to expect after your COVID-19 vaccination
- General vaccine fact sheets here
- Q&A video for social care staff. Download this zip file with short videos (designed for social media) about JVCI, what vaccines are, and the Oxford vaccine
- Video on how the vaccine was made so quickly
- Groundswell information on the COVID-19 vaccine and GP registration for people experiencing homelessness
- Homeless Link information on Covid -19 and Homelessness
- Trauma informed approaches from ANEEMO and Homeless Link
- Doctors of the World Translated COVID-19 health information
- Case Studies – Queens Nursing Institute (QNI) on homeless and inclusion health in action can be found here - https://www.qni.org.uk/nursing-in-the-community/homeless-health-programme/homeless-health-practice-action/
- COVID-19 vaccine pregnancy information leaflet
- Useful tips on COVID-19 vaccine for people with dementia
- Covid Vaccine film produced by Skills for People and Learning Disability England