

COVERING LETTER FROM DCMO AND NHSE/I CMO

Information for clinical staff regarding immunosuppressed patients

We are writing to update you on the latest Government guidance for the clinically extremely vulnerable (CEV), particularly immunosuppressed patients. The aim is to support clinicians in their ongoing dialogue with these patients around infection risks, including Covid-19 risks.

As you will be aware, shielding was paused on the 1st April, and since then individuals have been able to follow the same guidance as the rest of the population. This will remain the case when restrictions are lifted on 19 July for Step 4 of the Government's roadmap, although the Government continues to advise the most vulnerable to think about extra steps they may wish to take to protect themselves.

This will be particularly important for those CEV individuals who are immunosuppressed. Although the vast majority of the population will be well protected by the vaccine, including the clinically extremely vulnerable, no vaccine is 100% effective and there is emerging evidence to suggest that some immunocompromised and immunosuppressed individuals may not respond as well to the COVID-19 vaccine as others.

Such patients will have been at long-term risk of infectious disease and, pre-pandemic, and should in most cases be familiar with making individual risk assessments in consultation with their clinicians to deal with possible encounters with a wide variety of infections, not least influenza and other respiratory viruses. Advice regarding Covid-19 should be considered as part of this ongoing dialogue around general infection risk for those patients.

We therefore enclose the initial government advice, which provides an overview of the latest guidance for the CEV, and information we have to date regarding vaccine efficacy and antibody testing and treatments. Alongside this letter, the Department of Health and Social Care will work with stakeholders to help raise awareness with patients.

The Department of Health and Social Care will aim to update advice in September 2021, particularly with regard to booster vaccines and vaccine efficacy study findings, and we will write to you again at that point.



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GOVERNMENT GUIDANCE ON ADVISING PATIENTS WHO ARE IMMUNO-SUPPRESSED

General advice

Clinicians may wish to emphasise the following points within the [general advice to clinically extremely vulnerable \(CEV\) people from 19 July](#). The Government highlights that those who are CEV may wish to take the following actions:

Consider the risks of close contact with others:

- in crowded spaces, where there are more people who might be infectious
- in enclosed indoor spaces where there is limited fresh air
- when COVID-19 disease levels are high in the general community

Take steps to reduce the risk of catching or spreading COVID-19. For example, they could:

- meet outside if possible – the particles containing the virus that causes COVID-19 are quickly blown away which makes it less likely that they will be breathed in by another person
- make sure the space is well ventilated if you meet inside; open windows and doors or take other action to let in plenty of fresh air – please see [the COVID-19: ventilation of indoor spaces guidance for more information](#)
- consider whether you and those you are meeting have been vaccinated – you might want to wait until 14 days after everyone's second dose of a COVID-19 vaccine before being in close contact with others
- wash your hands regularly and avoid touching your face
- consider continuing to practice social distancing if that feels right for you and your friends
- asking friends and family to take a lateral flow test before visiting you
- ask home visitors to wear face coverings

This advice will be particularly appropriate to those who are immunosuppressed, especially if they have only received one dose of vaccination, or as a precautionary measure for those who have received both vaccinations, given that research in this area is still underway.

If clinicians want to provide patients with further information, or give general advice for immunosuppressed people, [a useful summary is provided here](#).

Vaccine efficacy

PHE data released on 9 July shows for those who are immunosuppressed, vaccine effectiveness against symptomatic infection is 4% after a first dose. However, this rises to 74% after a second dose, which amounts to broadly similar protection levels to those who are not in a risk group.¹ It should be noted however that these figures are based on very small numbers of events in a subgroup which covers a broad definition of immunocompromise. The analysis also only looked at symptomatic disease. Further work is therefore needed to evaluate vaccine efficacy in specific groups, and to evaluate vaccine efficacy against severe outcomes.

It is also important to note that these are aggregated data for immunocompromised patients as a whole. Within this group there will be substantial variation in the degree of immunosuppression: in some individuals, any vaccine hypo-responsiveness might have been transient related to ongoing or recent chemotherapy that is time limited, suggesting that they might respond to a booster at a later time point. In other cases where immunosuppression is more intrinsic to the underlying condition, such as those with haematological malignancies², any reduced ability to respond to vaccines might persist. Measurement of antibody levels post-vaccination appears to correlate in general with the likelihood of vaccine protection against infection, but unless T-cell responses are also measured, likely clinical protection against severe disease cannot be fully assessed.

The OCTAVE-DUO study is seeking answers to these issues by evaluating boosters for the immunosuppressed and should be able to report to JCVI by late August or early September. Notwithstanding, taken as a single group of patients, the aggregated estimate of vaccine effectiveness against infection is very reassuring for most patients, after two doses. These figures underline just how vital it is that everyone takes advantage of both doses to secure high levels of protection.

All clinically extremely vulnerable individuals, not just those who are immunosuppressed, have always been and remain a high priority group of individuals for COVID-19 vaccination (Cohorts 4 and 6). [Interim advice from the JCVI](#), indicates that in the Autumn a programme of booster vaccinations may be offered to individuals over the age of 16 who are immunosuppressed and to adult household contacts. It remains important that clinicians in all areas of healthcare promote vaccination amongst this group and their adult household contacts, and that each contact is used to ensure that these groups are fully up to date with their vaccinations.

Where therapy with immunosuppressive drugs is being considered or may be required at short notice (i.e. from past history of acute flare ups requiring intervention), then full vaccination should be encouraged, and implemented in such a way as to promote optimal immune response. More information can be found [here](#).

¹ <https://www.gov.uk/government/publications/phe-monitoring-of-the-effectiveness-of-covid-19-vaccination>

² Further information on the vaccine and blood cancer can be found on the [Blood Cancer UK website](#)

Antibody testing and treatments

It may be possible to give someone an indication of their mitigated, but not eliminated, risk against COVID-19 disease based on past infection status or vaccination status, as identified by antibodies or medical records. Presence of detectable circulating antibodies will almost certainly result in a mitigation of severe disease on re-exposure but cannot at present be used to assure protection from infection. Antibody titres almost certainly wane over time, so risk assessment cannot be extrapolated forwards indefinitely. T-cell derived response is equally important in response to SARS-CoV-2, particularly for moderation, but is far more challenging to assess. A wholly T-cell driven response to SARS-CoV-2 is rare, so antibody testing remains the most accessible marker of immune response. Guidance will shortly be made available on gov.uk to assist primary healthcare workers in discussions with patients regarding antibody status and immune response.

In addition to the work on vaccination, work is ongoing to identify effective specific treatments for patients who have been infected with SARS-CoV-2 to speed up recovery times and prevent complicated disease. It will also help identify and clarify the use cases for long-term and post-exposure prophylaxis for patients who cannot respond to vaccines or who have specific medical contraindications to all COVID-19 vaccines.