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Independent report

JCVI statement on COVID-19 vaccination in autumn 2026 and spring 2027

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Introduction

The aim of the COVID-19 vaccination programme is to prevent serious disease (hospitalisation and/or mortality) arising from COVID-19.

In formulating their advice for COVID-19 vaccination in autumn 2026 and spring 2027, the Joint Committee on Vaccination and Immunisation (JCVI) considered the latest COVID-19 epidemiology, vaccine coverage and safety data.

Advice on COVID-19 vaccination in autumn 2026 and spring 2027

Using the standard cost-effectiveness assessment, with an example price of £25 for the combined cost of vaccine and delivery, JCVI advises that vaccination should be offered to the following groups in autumn 2026 and spring 2027:

- adults aged 75 years and over
- residents in a care home for older adults
- individuals aged 6 months and over who are immunosuppressed (as defined in the 'immunosuppression' sections of tables 3 or 4 in the COVID-19 chapter of the green book (https://www.gov.uk/government/publications/covid-19-the-green-book-chapter-14a))

Timing of vaccination

The vaccine should usually be offered no earlier than around 6 months after the last vaccine dose, although operational flexibility around the timing of vaccination in relation to the last vaccine dose is considered appropriate (with a minimum interval of 3 months between doses). More information on operational flexibility will be provided in the COVID-19 chapter of the green book.

Considerations

The most recent cost-effectiveness assessment for COVID-19 immunisation was carried out in October 2024 (Keeling MJ and others, 2025) (https://www.sciencedirect.com/science/article/pii/S0264410X25002452); an example price of £25 for the combined cost of vaccine and delivery was used. Since then, no new COVID-19 vaccines have been approved for use in the UK and recent epidemiological trends (see below) were considered too uncertain to reliably inform a new model.

This year, an updated cost-effectiveness analysis for the COVID-19 vaccination programme has not been undertaken due to a lack of new data to input into the model, and uncertainty associated with recent epidemiological trends (see below). Given this, JCVI agreed that, at this time, it remained appropriate to base its advice for autumn 2026 and spring 2027 on the cost-effectiveness assessment carried out in October 2024 with an example price of £25 for the combined cost of vaccine and delivery.

Consistency in vaccine eligibility over the medium term will allow for clear public health messaging regarding the campaign, which in turn facilitates vaccine confidence and uptake.

Epidemiology

For the first time since SARS-CoV-2 (the virus which causes COVID-19) was detected in the UK, there was no significant COVID-19 wave over the winter (mid-November 2024 to February 2025). The largest peak in the second half of 2024 occurred in July with a slightly smaller peak in October, after which incidence remained at low levels until the end of the year. This is a change from the previous epidemiological trend where waves of COVID-19 were seen every 3 to 4 months throughout the year. There continues to be no evidence of seasonality in COVID-19 epidemiology.

It should be noted that seasonal respiratory viruses, including respiratory syncytial virus (RSV), influenza and rhinovirus, all had higher rates of positivity than SARS-CoV-2 over winter 2024 to 2025.

More information can be found in a report on the epidemiology of COVID-19 in England by the UK Health Security Agency (UKHSA) (https://www.gov.uk/government/publications/epidemiology-of-covid-19-in-england), which summarises trends in COVID-19 epidemiology from July to December 2024, and in the national influenza and COVID-19 surveillance reports (https://www.gov.uk/government/statistics/national-flu-and-covid-19-surveillance-reports-2024-to-2025-season).

While no significant waves have been observed in the past 8 months, it is difficult to predict whether this trend will continue. As such, JCVI considers it appropriate to offer vaccination to the same groups in autumn 2026 and

spring 2027 as are advised for vaccination in autumn 2025 and spring 2026 (https://www.gov.uk/government/publications/covid-19-vaccination-in-2025-and-spring-2026-jcvi-advice). Over the next 2 years, epidemiological trends will be closely monitored to inform vaccine eligibility decisions going forward.

Viral evolution

Viral evolution of SARS-CoV-2 appears to have slowed down in the past year. Circulating sub-variants are relatively closely related within the JN.1 variant family (World Health Organization, 2025) (https://www.who.int/news/item/15-05-2025-statement-on-the-antigen-composition-of-covid-19-vaccines). This has meant a better match between available COVID-19 vaccines and the circulating viral variants than in some previous years. For example, in autumn 2023 the bivalent Original/Omicron BA.4-5 mRNA and monovalent XBB vaccines were deployed in the autumn 2023 campaign. However, by early December 2023 the XBB lineage had been replaced by the BA.2.86/JN.1 lineage which had a number of accumulated mutations, making the virus more distant from the XBB vaccine. In contrast, the monovalent JN.1 vaccine was deployed in the autumn 2024 programme when the major circulating variants were XEC and KP.3.1.1, both of which are subvariants of JN.1. This meant the vaccine was a better match for the variants causing illness at the time.

Eligible cohorts

Older adults and individuals who are immunosuppressed continue to be at the highest risk of serious disease (hospitalisation and/or mortality). The highest rates of severe hospitalisation and mortality are observed in adults aged 75 years and over. More than half of adults aged 75 years and over have a clinical comorbidity, which is important to consider when determining eligibility for a universal, age-based programme.

JCVI recognises that more recent data is needed to assess whether any other population groups under the age of 75 years with specific clinical comorbidities are at similar risk of serious disease as those aged 75 years and over.

High rates of hospitalisation and mortality are also observed in individuals who are immunosuppressed, particularly those aged 50 years and over.

Currently available vaccines provide limited protection against mild infection and no evident protection against transmission of SARS-CoV-2 from one individual to another. Hence, direct protection, via vaccination, of those

individuals at highest risk of severe outcomes following SARS-CoV-2 infection is considered the most effective method of protection.

Vaccine products

Safety

The Medicines and Healthcare products Regulatory Agency (MHRA) monitors vaccine safety and adverse events. No significant changes in the safety profile of currently available COVID-19 vaccines have been notified to JCVI. The safety profile of all COVID-19 vaccines currently licensed in the UK is acceptable.

Advice on vaccine products

The committee's advice on vaccine products for use in the autumn 2026 and spring 2027 immunisation programmes remains the same as for autumn 2025 and spring 2026.

JCVI does not have a preference for a specific COVID-19 vaccine product in the adult population. JCVI advises a preference for having vaccine products based on more than one vaccine platform in the programme, such as mRNA and protein-based vaccines.

It is expected that COVID-19 vaccines will continue to be updated to match circulating variants on a yearly basis. JCVI advises that, when possible, the latest updated vaccine should be used in a vaccination campaign, provided this does not delay the start of the campaign.

For children and young people who are immunosuppressed, JCVI continues to advise the use of the Pfizer-BioNTech COVID-19 mRNA (Comirnaty) vaccine, with the vaccine dose appropriate to the child's age:

- 12 to 17 years: 30 micrograms
- 5 to 11 years: 10 micrograms
- 6 months to 4 years: 3 micrograms