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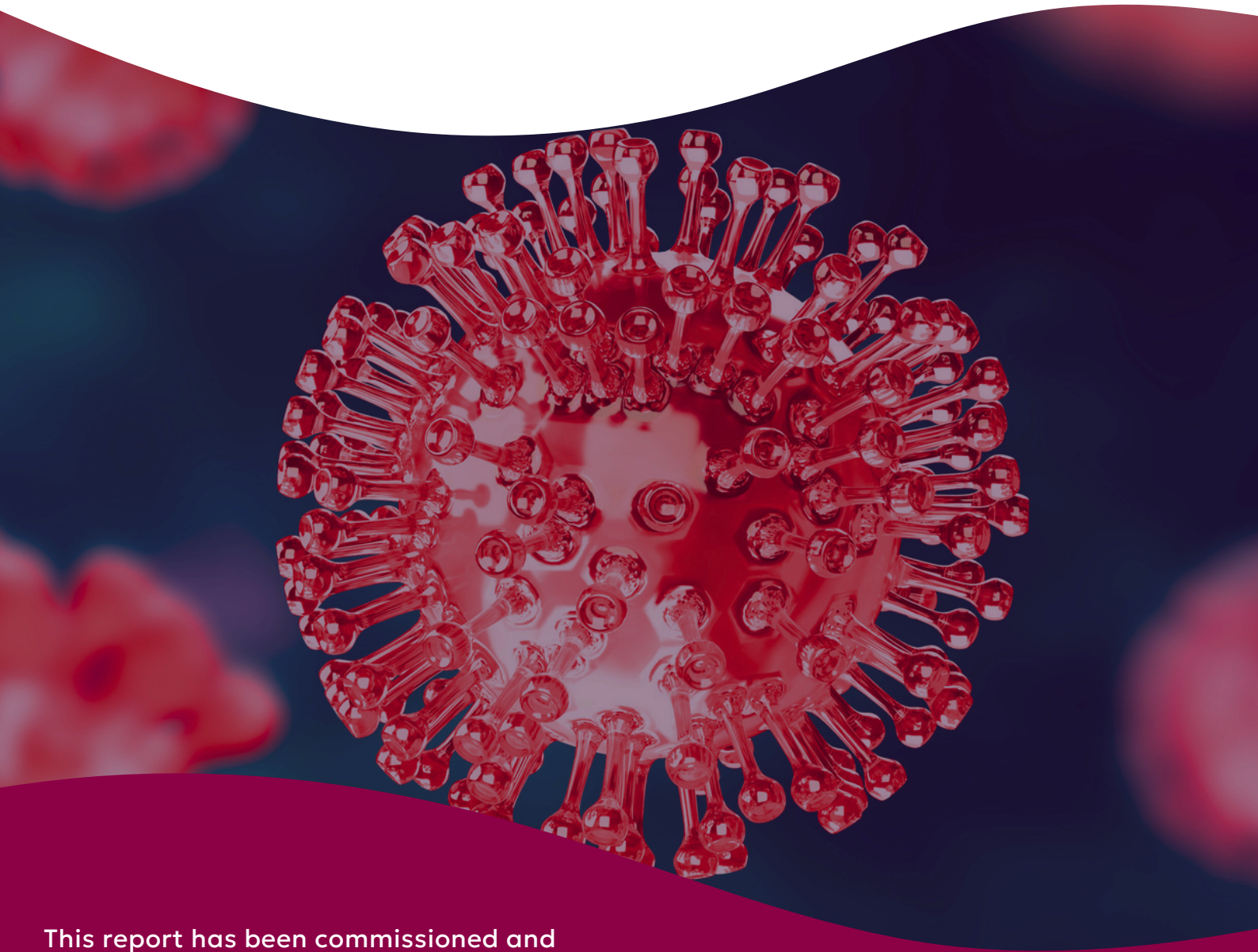
Beyond the pandemic: Strengthening access to COVID-19 therapies for high-risk patients in England

Policy Report
September 2025



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Executive Summary

Despite significant evolution in national policy toward endemic COVID-19 management, access to COVID-19 treatments for high-risk patients remains inconsistent across England[1]. This report – based on Kintiga's original policy analysis and reinforced through qualitative interviews with key stakeholders – highlights the enduring disparities across England and proposes pragmatic recommendations for actions at both national and local levels.

The 2025 10-Year Health Plan for England does not explicitly set out future COVID-19 services, but its focus on community-based care, digital delivery, and stronger data infrastructure could support more flexible, local responses in any future waves.[2] However, the absence of clear, dedicated pandemic provisions may risk gaps in maintaining specialist COVID-19 treatment pathways or rapid surge capacity. While the plan's broader reforms could enhance resilience, ensuring consistent access to COVID-19 care, particularly for high-risk patients, remains a potential challenge as services become more locally managed.

Key findings (as reaffirmed by patient group representatives, clinicians, and commissioners) include:

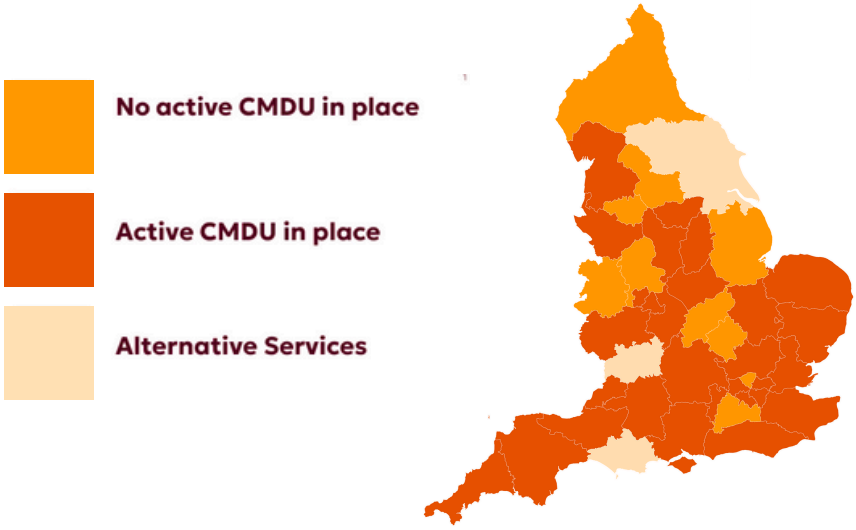
- Persistent regional variation in service models, with 74% of ICBs retaining COVID Medicines Delivery Units (CMDUs).
- Widespread confusion regarding access pathways and inconsistent ICB communication.
- Undermining of equity through digital exclusion, lack of access to free testing for infection, and systemic de-prioritisation of COVID-19.[3]

Stakeholders stressed an urgent need for renewed national coordination, comprehensive and robust communication with high-risk populations, and local accountability mechanisms to ensure timely and equitable access to treatments.

[1] NHS England. Innovation Scorecard: COVID-19 Therapeutics Dashboard. (n.d.). Available at: https://app.powerbi.com/view?r=eyJrIjoiZmM0OGE5ODQtZmNiYS00NGU2LTg1NGItNDc2OWI0Zjk2ZmU4IiwidCI6ImNmNmQwNDg yLTg2YjEtNGY4OC04YzBjLTNiNGRlNGNiNDAyYyJ9
[2] Department of Health and Social Care, 10 Year Health Plan for England: fit for the future, 2025. Available at: https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future
[3] Kintiga, Beyond the pandemic: Addressing disparities in timely access to COVID-19 therapeutics, 2025.

Analysis of access routes to COVID-19 services: availability of active CMDUs

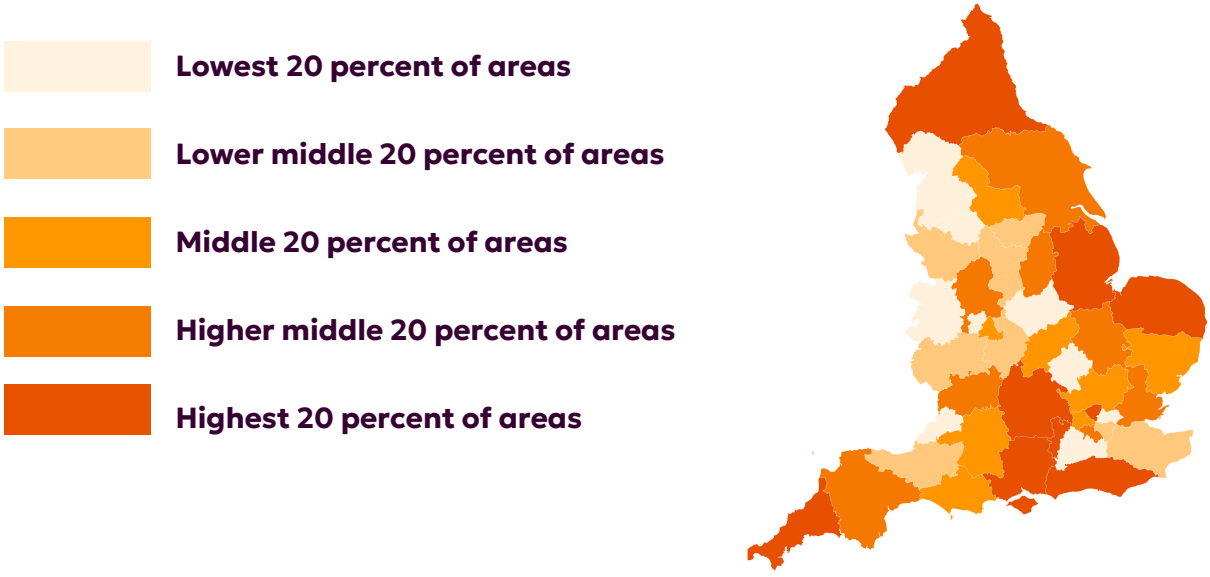
Availability of COVID Medicines Delivery Units (CMDUs)



- Out of the 42 ICBs analysed, 31 (74%) ICBs currently have an active CMDU in place, while others rely on alternative services, such as community pharmacies.
- 11 ICBs do not have an active CMDU in place, with three ICBs (Dorset, Gloucestershire, and Humber and North Yorkshire) using alternative service arrangements, such as community pharmacies and specialist units, as an access route.

Uptake of NICE recommended COVID-19 antivirals across England

ICB use of COVID-19 antivirals - ADD per 100,000 population



1 Revisiting the Original Findings

Kintiga's preliminary research analysed all 42 Integrated Care Boards (ICBs) in England against the NHS Commissioning Framework for COVID-19 therapeutics. The research identified concerning gaps in access, communication, and medicine uptake:

- **CMDU presence:** 31 of 42 ICBs (74%) had an active CMDU in place.
- **Public-facing guidance:** 24% of ICBs had no clear COVID-19 treatment access information available on their websites.
- **Antiviral uptake:** Use of COVID-19 antiviral treatments varied significantly, with some regions persistently under-prescribing.

These disparities were not simply technical or transitional—they represent real barriers to care for immunocompromised patients during time-critical windows of eligibility.

2 Revisiting the Original Findings

2.1 CMDUs: Obsolete or Essential?

Stakeholders interviewed expressed a range of insights concerning the use of CMDUs. Malcolm Qualie, former NHS England commissioner, describes CMDUs as largely redundant in the current phase of endemic COVID-19 care. He emphasised the sufficiency of the GP–pharmacy model, which is now the dominant route for access.

> *"CMDUs served a purpose, but they're no longer necessary in most areas."*
>
> **Malcolm Qualie, Former NHS Commissioner**

However, Gail Fortes Mayer (Strategic Commissioner, Black Country ICB) offered a more nuanced view. CMDUs, she explained, are increasingly unsustainable financially – but their outright removal could harm access unless replaced by robust home-care or shared regional models. Black Country ICB still runs a CMDU, but Fortes Mayer anticipates regional consolidation in the future due to funding cuts and service overlaps.

Talking about the use of CMDUs more broadly, Miranda Scanlon, a transplant patient and advocate with Kidney Research UK, added that in some areas CMDUs remain vital due to GP or pharmacy-based alternatives being poorly understood or unavailable. She reported that her own recent access came via a direct CMDU call on a holiday weekend and expressed that such a pathway that would likely be inaccessible elsewhere.

2.2 Drivers of Regional Variation

Asking about structural drivers of regional variation, both Qualie and Fortes Mayer pointed to demographics, socioeconomic inequalities, and historic care models. However, both also affirmed Kintiga's findings that communication failures are a major contributor to disparities in the delivery and uptake of COVID-19 medicines.

3 Patient Perspective: On the Ground Realities

3.1 Testing and Treatment Breakdown

Susan Walsh, CEO of Immunodeficiency UK, described testing access as "the first and largest barrier." In rural or underserved areas, pharmacies often lack stock or are unaware of eligibility schemes. Without timely tests, high-risk individuals miss the five-day window and become ineligible.

> *"Patients are ping-ponged between GPs, NHS 111 and CMDUs—with no clear route in."*
>
> **Susan Walsh, Immunodeficiency UK**

This perspective was echoed by Miranda Scanlon, noting that even among patients who are aware of the system, delays in test availability, prescribing confusion, and pharmacy shortages render the system ineffective. For those unable to tolerate Nirmatrelvir/ritonavir due to kidney issues, access to alternative COVID-19 treatments is inconsistent and geographically limited.

3.2 Systemic Communication Failures

Both Scanlon and Walsh reported that proactive outreach from NHS bodies has disappeared. Patients are now reliant on Facebook groups and peer networks rather than official sources.

> *"We've gone from centralised letters and shielding support to total radio silence."*
>
> **Susan Walsh, Immunodeficiency UK**

For digitally excluded patients, this void is even more severe. Many lack smartphones or the confidence to navigate fragmented NHS web pages. A simple outreach programme in the form of a letter delivered to the homes of high-risk individuals – similar to outreach for cervical screening campaigns – could dramatically improve awareness and access, while being a low-cost fix for the NHS. Letters could comprise of a one-sided A4 sheet of information sheet about COVID-19 medicines, patient eligibilities, contact numbers and key services in that area.

3.3 Emotional and Mental Health Toll

The sense of being "forgotten" and "abandoned" was a consistent theme. High-risk patients report anxiety attending clinical appointments where masking is no longer enforced, and widespread belief that "COVID is over" erodes both personal safety and public policy attention.

3.4 Recommendations for a Fairer Future

For National Bodies (Department for Health and Social Care, NHS England)

- **Reinstate annual communications** to high-risk patients outlining eligibility, access routes, and treatment guidance.
- **Mandate public-facing guidance** for every ICB on COVID treatment access (including printable options).
- **Streamline test and treatment logistics,** including pre-identified pharmacy stock and rapid dispatch systems.
- **Fund multilingual awareness campaigns,** targeted at digitally excluded and underserved communities.
- **Monitor and publish national uptake data** by region, pathway, and demographic.

For ICBs

- **Assign clear pathway leads** for COVID and respiratory therapeutics.
- **Train primary care and 111 staff** on eligibility and referral processes.
- **Review service models, i**ncluding CMDU consolidation and telemedicine-based prescribing.
- **Enable postal or phone-based access** alongside digital tools.
- **Collect local data** on access, equity, and patient outcomes to inform planning and commissioning.

Conclusion

The move from crisis to endemic-scale COVID-19 care cannot justify eroding access for those most at risk, which is currently how the situation is perceived. While national frameworks and treatments exist, their real-world implementation remains fragmented. Without renewed central leadership, better communication, and a recommitment to equity, high-risk patients will continue to be underserved – and ultimately unprotected. Addressing these gaps would not only safeguard vulnerable groups but also support the ambitions of the 2025 10-Year Health Plan to build a more preventive, community-based, and digitally enabled health system. By ensuring consistent, equitable access to COVID-19 therapeutics, policymakers, commissioners, and care providers can deliver immediate benefits while advancing the Plan's longer-term goals for resilience, integration, and health equity during a period of significant NHS change.