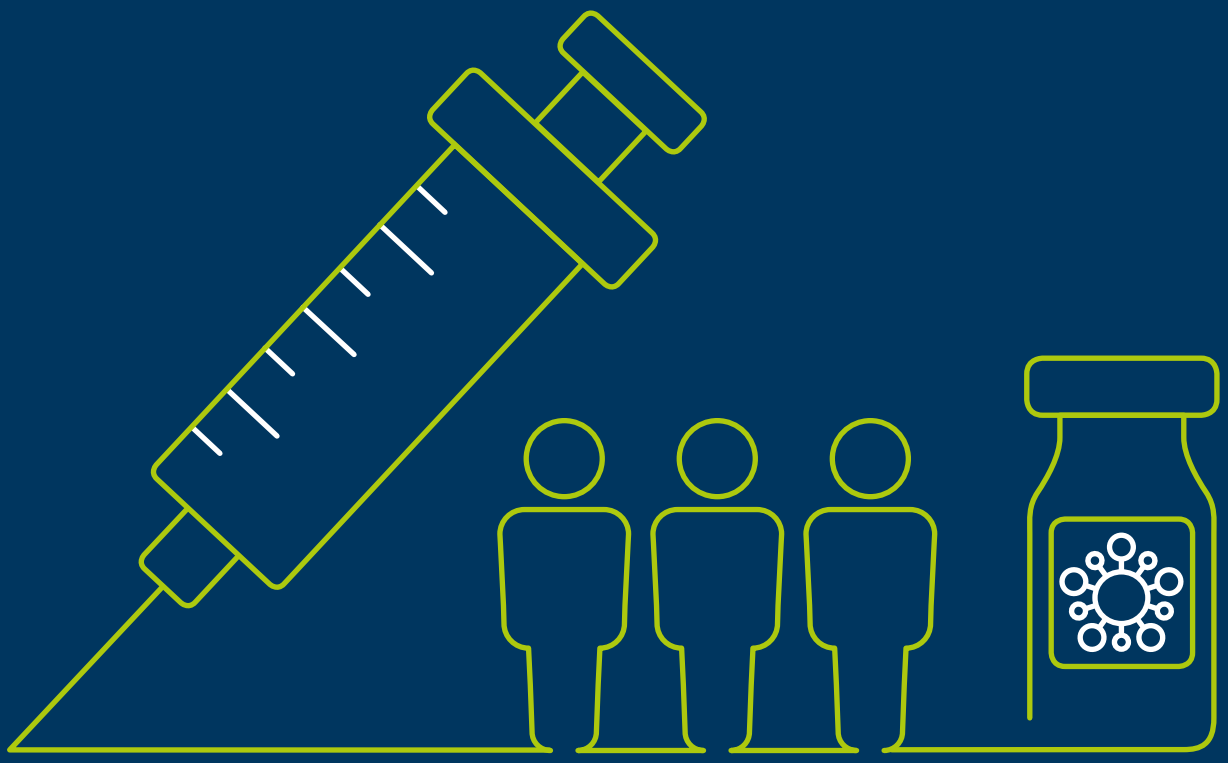
Delivering the COVID-19 vaccine across London

Evaluation report

July 2021



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Contents

Summary

Background

Successful rollout of the COVID-19 vaccination programme has been critical to the country's response to the pandemic, providing protection to those at greatest risk of poor outcomes from COVID-19 infection and enabling the easing of restrictions and increasingly a return to normality. This report presents findings from the evaluation, which focused on analysis of interventions to increase COVID-19 vaccine uptake in London and specifically sought to identify and explore reported barriers to vaccination, strategies and interventions to address these barriers, as well as the key features of strategies that were successful in achieving increased uptake.

The programme adopted a learning health system methodology, taking an agile approach to gathering and sharing insights as they emerged throughout the programme, so that decisions could be made, and actions implemented as appropriate within the rapidly changing COVID-19 environment. The formal evaluation consisted of a three-phase approach, adopting qualitative and quantitative components that allowed both a broad scope of the work going on as well as a deep dive into specific areas. The evaluation was supplemented by further insights gathered from a range of sources including virtual learning events and targeted interviews.

Key findings

The evaluation insights are divided into four distinct areas of focus:

- **Barriers** – understanding barriers to individuals wanting to take the COVID-19 vaccine
- **Demand** – reflections on activities to increase uptake of the vaccine and address vaccine confidence
- **Access** – reflections on activities to make the vaccine more easily accessible to people that wanted to have it
- **Legacy** – reflections on how we can take the lessons and apply them to the future, across the NHS, social care and local authority activities

A variety of barriers to both demand for the vaccine (e.g., concerns of side effects, loss of income) and access to the vaccine (e.g., booking systems, locations of clinics) were identified. Community engagement initiatives often provided a deeper understanding of key barriers, ensuring health care professionals were equipped with the information they needed to target their efforts and resources to the areas that required the most support.

Key **interventions focused on demand and increasing uptake** of the COVID-19 vaccine included the growth of community champions to listen to perspectives, share information about the vaccine with their local communities and create time for 1:1 conversations and motivational interviews. Other common interventions across London to increase uptake of the vaccine included targeted communication approaches and the use of data to identify who to target for discussion and support.

Interventions to make the vaccine more accessible included flexible booking approaches, appointments and walk-ins, and innovative transport and outreach models to reach vulnerable groups. Pop-up clinics, whose locations were informed by data on community uptake, were highlighted as being a key method for delivering the vaccine to those who could not access the vaccine in other settings. High-profile surge vaccination events proved popular with younger cohorts and raised the profile of the vaccine programme but have been much less effective at reaching specific populations with low uptake, requiring parallel dedicated activity for those groups to prevent exacerbating health inequalities.

Legacy considerations include reflections on how we can take the lessons and apply them to the future, across the NHS, social care and local authority activities. Several opportunities for new ways of working have been identified that could be sustained or built upon in five key areas: inequalities, infrastructure, workforce, partnership and community engagement.

Recommendations

This document contains recommendations for good practice to build on the learnings gathered throughout this programme of work. Some of these will build on what is already in place and include:

- ### For regional decision makers

  Widen the insights that are used to inform decision making, including community and staff voices to supplement more traditional scorecards and metric review. Sustain **partnership working** with a joined up, coordinated approach across multiple organisations and agencies; enabling flexibility for local systems to implement activities in the way that will work best for the local population and infrastructure. Consider **implications on inequalities** from the outset when designing and delivering programmes at scale and pace. Ensure **clear two-way communication channels** between organisations and teams working at national, local and regional levels and between decision makers and those implementing the decisions.

- ### For Integrated Care Systems

  Reflect on implications of **where to locate services** and benefits of using places communities frequent and of "hyper local" offerings. Distinguish activities between **creating demand for a service and improving access** to the service. Collaborate with local community groups and outreach teams.

- ### For Local Authorities

  Create capacity, e.g., through sustaining the community champions model, to maintain a **two-way dialogue with the community**, to both listen and respond, rather than just share messages.

- ### For healthcare providers

  Reflect on which broader health **activities across silos can be delivered together** to improve patient experience and efficiency. Empower staff to have autonomy and **build local solutions** to build trust and agility.

- ### For GPs

  Widen the workforce, providing opportunities for volunteers and community teams that supported delivery of the vaccine, and understand where activities can be delivered by non-traditional roles to create capacity for clinical staff.

Background

Rationale for the work

Successful rollout of the COVID-19 vaccination programme has been critical to the country's response to the pandemic, providing protection to those at greatest risk of poor outcomes from COVID-19 infection and enabling the easing of restrictions and increasingly a return to normality.

The COVID-19 vaccine programme has been the largest vaccine campaign in NHS history. Whilst led by the NHS, the programme has been delivered through partnerships at a London, ICS, borough, locality and hyperlocal level, with a multifaceted approach to delivery through mass vaccination centres, hospital hubs, and local and hyper-local vaccination services and sites – including primary care networks, GPs, pharmacies, pop ups and outreach models.

The aim of the evaluation programme was to learn from the approaches that were working and share this learning across different organisations in London, from boroughs to regional teams, helping those involved in the vaccine rollout to achieve the highest possible levels of uptake and for long term learning.

The evaluation was a multi-agency effort, with partner organisations and collaborators including:

- Association of Directors of Public Health
- Greater London Authority
- Integrated Care Systems (ICS) in London
- Local Authorities in London
- London School of Hygiene & Tropical Medicine
- NHS England and NHS Improvement (London)
- NIHR ARC North Thames at UCL
- Public Health England London
- UCLPartners

Timeline

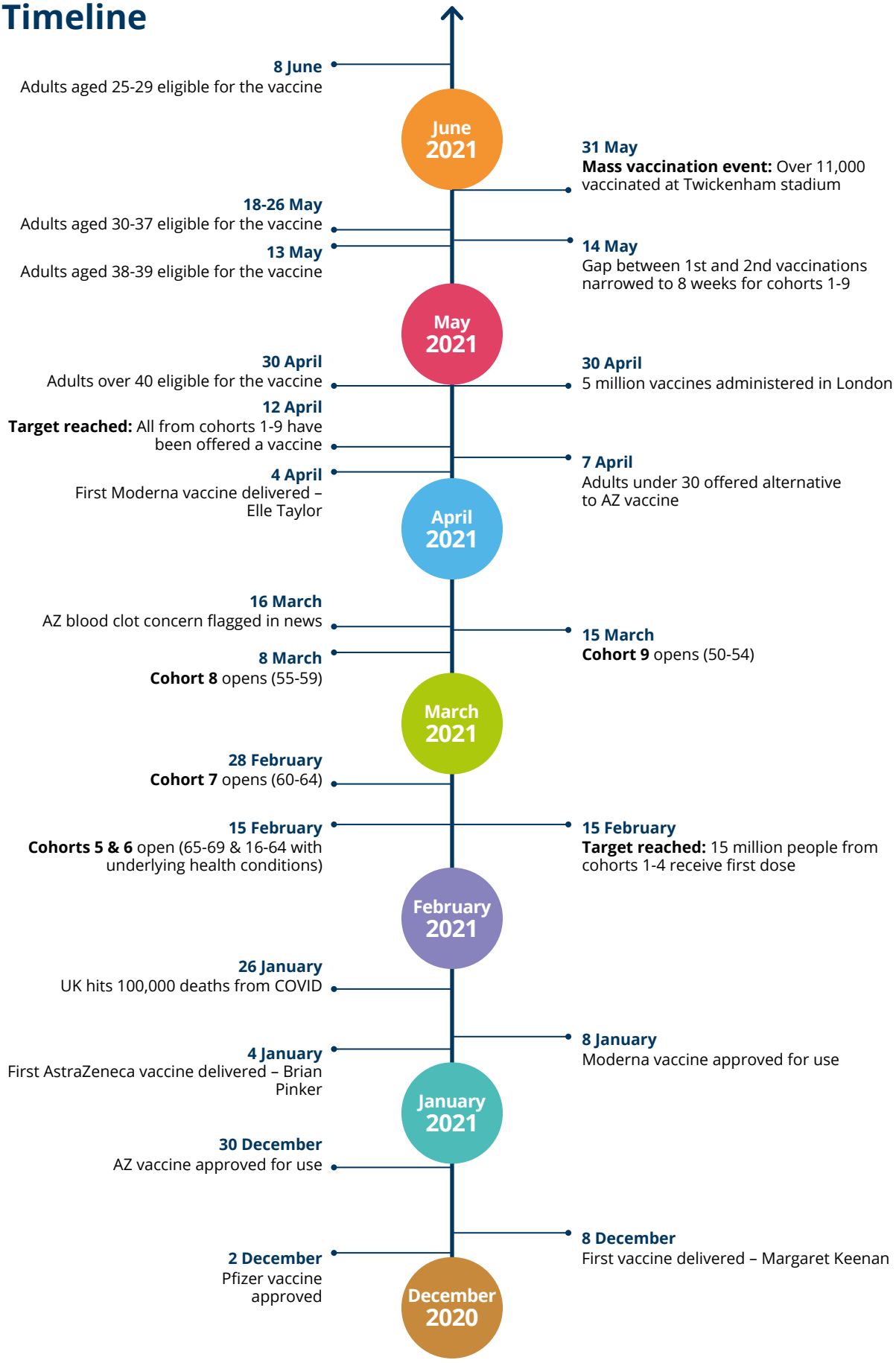


Figure 1: *National milestones for the COVID-19 vaccine programme – December 2020 - June 2021*

Context in London

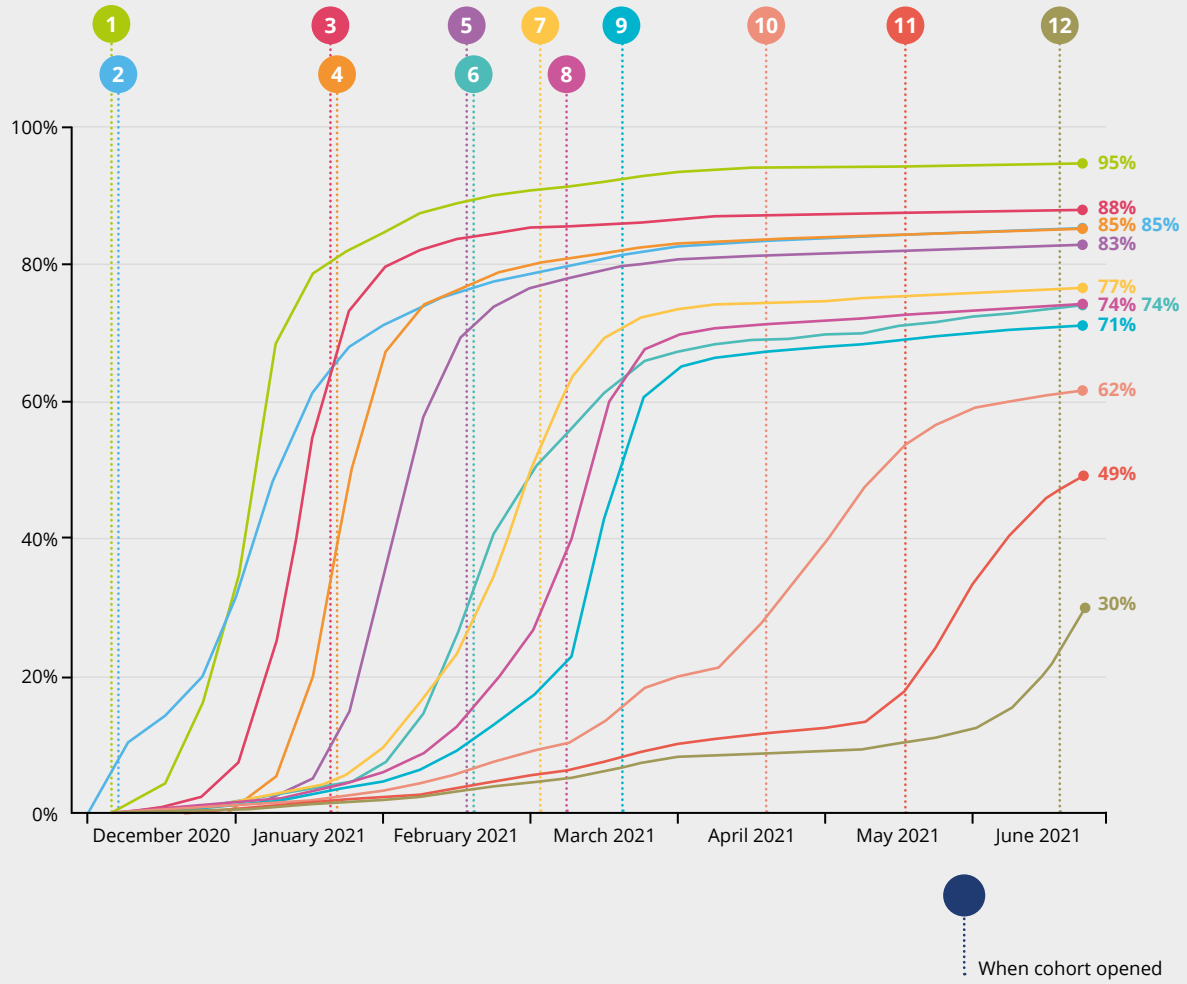
Preceding this evaluation there was some understanding of the causes of vaccine hesitancy and barriers to access from an understanding of general vaccination programmes and early lessons from the COVID-19 vaccine roll out in the UK and abroad. For example, uptake in previous adult vaccination campaigns has varied significantly across different ethnic groups and across different levels of deprivation. Black Caribbean, Black African, Pakistani and Chinese ethnic groups in particular have lower uptake of the flu vaccination than the white population, and the proportion of the population who are vaccinated declines with increasing levels of deprivation.[1]

Significant progress had been made with understanding of practice at both borough and ICS level. However, there was no comprehensive mapping of the work across London incorporating surveys, qualitative interviews and the data for immediate and longer-term learning on vaccine uptake and mitigating inequalities more generally.

[1] Factors influencing COVID-19 vaccine uptake among minority ethnic groups, 17 December 2020. Paper prepared by the ethnicity sub-group of the Scientific Advisory Group for Emergencies (SAGE). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/952716/s0979-factors-influencing-vaccine-uptake-minority-ethnic-groups.pdf

[2] Reference: London COVID-19 Scientific and Technical Advisory Cell. COVID-19 vaccine equity. Briefing note. Date issued: 8 March 2021.

Cumulative COVID-19 vaccine uptake by JCVI cohorts in London



JCVI Cohort	Detailed Cohort	JCVI Cohort	Detailed Cohort
1	Care Home Residents Residential Care Workers	7	Age 60-64
2	Age 80+ Health Care Workers – NHS Social Care Workers	8	Age 55-59
3	Age 75-79	9	Age 50-54
4	Age 70-74 Clinically Extremely Vulnerable	10	Age 40-49
5	Age 65-69	11	Age 30-39
6	At Risk	12	Age 18-29

Source: NHS Foundry. NIMS and MPI

Figure 2: ***Cumulative vaccine uptake by JCVI cohorts – proportion 1st dose vaccine uptake by JCVI cohorts 1-12 in London***

Gathering insights

The main aim of the evaluation was to map the work that has been undertaken across London to increase COVID-19 vaccine uptake, to share good practice and lessons in an agile way and to record the work done for longer term learning. Within this, the objectives were to: identify the activities of partners in increasing vaccine uptake; evidence initiatives aimed at tackling vaccine hesitancy; identify gaps in the system, learn from mistakes and share good practice across the health system and local government.

The evaluation consisted of a three-phase approach, adopting qualitative and quantitative components that allowed both a broad scope of the work going on as well as a deep dive into specific areas. The aim was also to triangulate the qualitative survey findings with quantitative data to set findings in context and understand activities that appeared to have a positive impact on vaccine uptake.

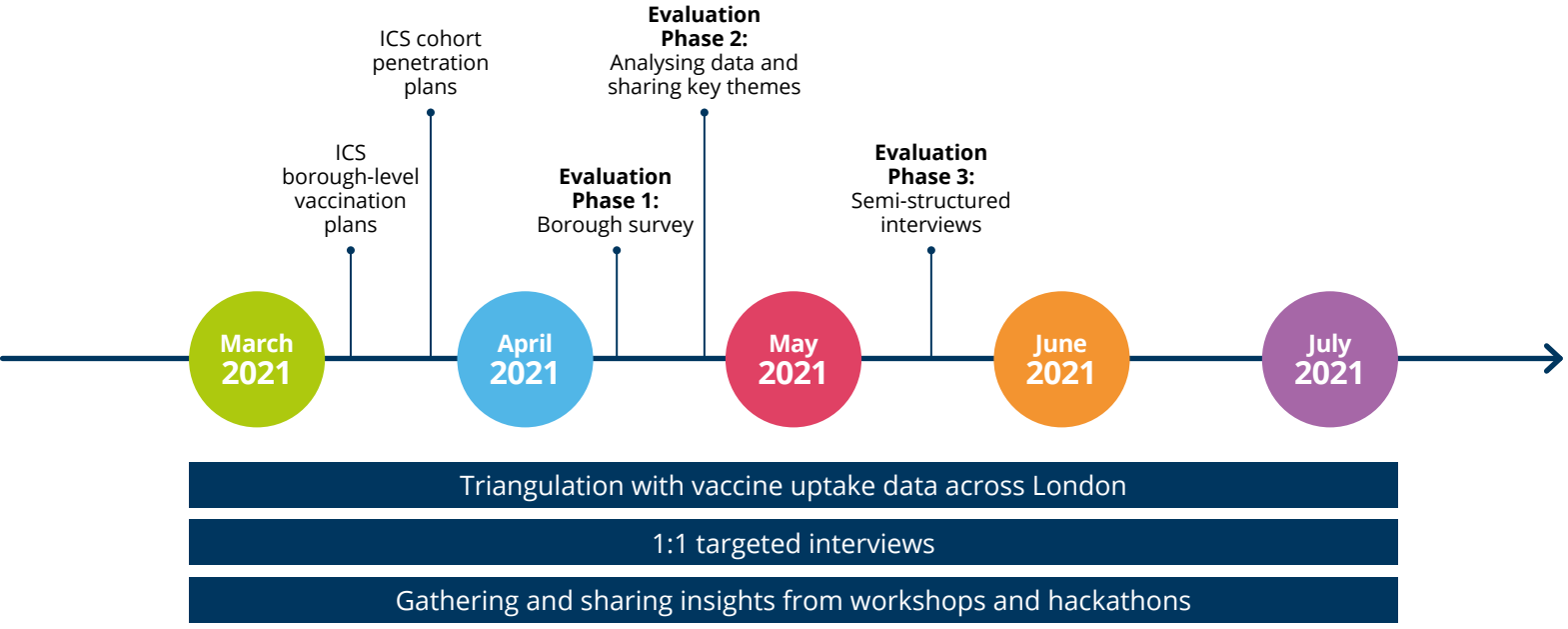


Figure 3: ***Evaluation and programme activities from March to July 2021***

Phase 1: Borough surveys

A structured survey was co-developed by the collaborating partners and sent to all Directors of Public Health to understand from them or their teams what had been done at a borough level to combat vaccine hesitancy and increase uptake and to highlight key lessons learnt (see appendix).

The questions involved elements of Theory of Change modelling as well as considering the three C's of the WHO framework – complacency, convenience and confidence – and core aspects along the whole vaccination pathway. The survey asked respondents to reflect on the populations they have been focussing on, the type of interventions put in place for engagement and to increase vaccine confidence, interventions put in place to improve access to the vaccine, and the barriers encountered to vaccine uptake. The survey also requested information on the resourcing, governance and partnership working that had been developed to deliver the programme.

Twenty seven of thirty two boroughs in London completed the survey between 24 March and 14 April 2021.

Phase 2: Analysing data and sharing key themes

Findings from the surveys were analysed alongside the Integrated Care System (ICS), borough level vaccine delivery plans and cohort penetration plans submitted to NHS England London region on 15 March and 23 March respectively. The ICS and borough plans provided an overview of activities that were being put in place to both increase demand for the vaccine and support access, if there were any population groups that were being specifically targeted, and, where applicable, how additional resources were being used. The cohort penetration plans provided a summary of activity by vaccine cohort, highlighting where activities were across all populations and where activities were specific to a particular cohort. The analysis looked to identify common themes around interventions to increase demand for the COVID-19 vaccine, and ensure access to the vaccine. The findings were shared with local authority, ICS and regional teams, and triangulated with the quantitative data being used to monitor uptake.

Phase 3: Semi-structured interviews

A team of ten individuals conducted interviews, using a semi-structured interview guide across each of three domains: demand, supply and legacy (see appendix). Interviewers were trained and provided with guidance for how to complete the interview (with standard scripts for introduction and question guides) and provided with a template for collating interview outputs. Interviews took on average 30 minutes, were conducted on Microsoft Teams, recorded and transcribed.

Purposive sampling was used to identify potential interviewees. Those who had completed the phase 1 borough survey were invited to interview along with leads from each of the five London Integrated Care Systems (ICSs) and regional decision makers from NHS England and NHS Improvement and Public Health England, Greater London Authority, London Councils and community champion leads, to provide a breadth of perspectives.

To support long-term learning, the findings from the evaluation also form the basis of an academic paper produced by the NIHR Applied Research Collaborative North Thames for publication.

Forty-nine individuals were invited to interview, and 36 interviews with 38 participants (representing 21 local authorities, 5 ICSs and 7 individuals from London Region) were completed between 24 May and 4 June 2021.

Gathering wider insights

The programme adopted a learning health system approach, to ensure insights were accessible and shared as they emerged throughout the programme, so that decisions could be made and actions implemented as appropriate.

Taking an agile approach to gathering and sharing the learning from the programme with a broad set of stakeholders – in parallel to the formal evaluation – enabled the region, ICSs and frontline teams to learn and react in real time to insights that were being gathered, which was critical to the success of the vaccine programme in reaching as many people, particularly those in vulnerable groups, as quickly as possible.

In addition to the formal evaluation activities outlined above, the programme gathered insights from a range of sources and activities:

- **Data gathering, analysis and dissemination**, through ongoing collaboration with NHS England and NHS Improvement London and Public Health England London.

- **Holding virtual learning events**, bringing people together to share experiences on challenges and what was working well. In the early stages of the programme, workshops focused on targeting large groups, such as NHS workforce, care homes, and adult social care staff. As the programme progressed, the workshops developed into focussed sessions on specific topics such as wider inclusion health groups and reducing inequalities. The approach of each workshop was to enable facilitated conversations around the activities and approaches that helped to increase uptake, feeding into the wider narrative that was developing. A thematic write-up of each event was produced and shared with attendees. Visual summaries and infographics were also produced as a way of distilling data and sharing information in an accessible format.
- Providing opportunities for people and teams to share learning, challenges, ideas, and resources through a **virtual learning platform**. Hexitime is a free to access platform that was set up to support people working in healthcare to collaborate over ideas and challenges. It offered a private project space in which members could share documents and resources and communicate through chatrooms, plus public campaign space where members could ask for or offer expertise on specific challenges. The site is still active and can be accessed via: **London Vaccine Impact Programme**.
- In the course of the programme "knotty issues" or topics of particular importance were highlighted that required further investigation. **Targeted interviews** were held with teams or individuals to provide further context, understanding and insights to help find solutions to challenges. For example:
    - Staffing management at the vaccine centres
    - Using data in real time to make decisions on where to hold pop-up events
    - The development of community champions for addressing hesitancy
    - Pharmacy delivery over time
    - Innovative approaches to make every contact count for health inclusion groups

Learning from these interviews was fed into the virtual learning events and feedback provided to the London region teams.

Limitations and scope

This report aims to share insights gathered from the different evaluation and programme activities, to support short, medium and longer term learning across health, local authority and community partners. Whilst a breadth of individuals were interviewed, from different roles, organisations and geographic locations, it was not intended as an exhaustive process. There will be individuals that have played substantial roles in the programme whose views may not be reflected in the document.

Findings

The programme insights have been divided into four sections:

- **Barriers** – understanding barriers to individuals wanting to take the COVID-19 vaccine
- **Demand** – reflections on activities to increase uptake of the vaccine and address hesitancy
- **Access** – reflections on activities to make the vaccine more easily accessible to people that wanted to have it
- **Legacy** – reflections on how we can take the lessons and apply them to the future, across the NHS, social care and local authority activities

Each of these is described in more detail below.

Barriers to COVID-19 vaccination

Extensive work has been done to date to understand drivers of vaccine uptake and potential barriers. The London COVID-19 Scientific and Technical Advisory Cell produced a briefing for the London Strategic Co-ordination Group in March 2021[2] that provided a summary of drivers of vaccine uptake, using evidence from previous adult vaccination programmes, and emerging intelligence specific to London and the COVID-19 vaccination programme, using the World Health Organisation's framework[3]:

- **Convenience** – how easy it is to access vaccination
- **Complacency** – awareness of the vaccine, the need for the vaccine or its benefits, or whether the vaccine is relevant to them
- **Confidence** – relates to trust in the vaccine, healthcare services and policy makers

For consistency with the rest of the report, complacency and confidence are described as barriers to demand for the vaccine, and convenience as barriers to access the vaccine.

[2] London COVID-19 Scientific and Technical Advisory Cell. COVID-19 vaccine equity. Briefing note. Date issued: 8 March 2021.

[3] MacDonald, N (2015) Vaccine Hesitancy: Definition, scope and determinants. Vaccine 33(34) pp4161-4164 Accessed from https://www.sciencedirect.com/science/article/pii/S0264410X15005009?via%3Dihub

A summary of barriers to the COVID-19 vaccine referenced in the survey, borough and ICS plans, and in the semi-structured interviews included:

Demand
Concerns of the severity of **side effects**
Potential impact on **fertility**
Concerns about the **safety** of the vaccine, particularly given the **speed of development**
Misinformation via social media on the ingredients of the vaccine, its intent and impact
Loss of income to take time off work to get the vaccine and recover from side effects
Preference to **"watch and wait"** for more to have received the vaccine and more understanding of its impact before opting to take it

Access
Navigating the booking system, particularly before multiple ways to book were introduced
Location of the clinic, particularly for early cohorts who were vaccinated in mass centres
Safety of vaccination site – particularly for early cohorts who have been shielding and therefore advised not to travel or be in areas with lots of people
Unfamiliarity of the vaccination site – particularly for those with neurodiversity and anxiety
Language of materials for both information about the vaccine and how to book
Requirement to have an **NHS number** in order to access the booking system

The depth of community engagement provided additional insights behind the barriers. For example, the impact on fertility was flagged as a concern, which led to extensive engagement from health professionals, and targeting communication materials, to provide reassurance that there is no evidence that the COVID-19 vaccine affects fertility and chances of becoming pregnant. Messages were particularly targeted at younger men and women. However, community work in a borough in East London found that for some, it was parents who were driving the concern, highlighting the more generalisable learning of understanding motivations and drivers for beliefs to target messaging appropriately:

> **When we talked about the fertility concerns, we just assumed the hesitancy was from the woman. It wasn't. When we talked to them, they said, 'Look, our fathers are frightened that no one will marry us if we take the vaccine'.**
>
> **Local authority interviewee**

Spotlight on: Domiciliary care workers and financial barriers

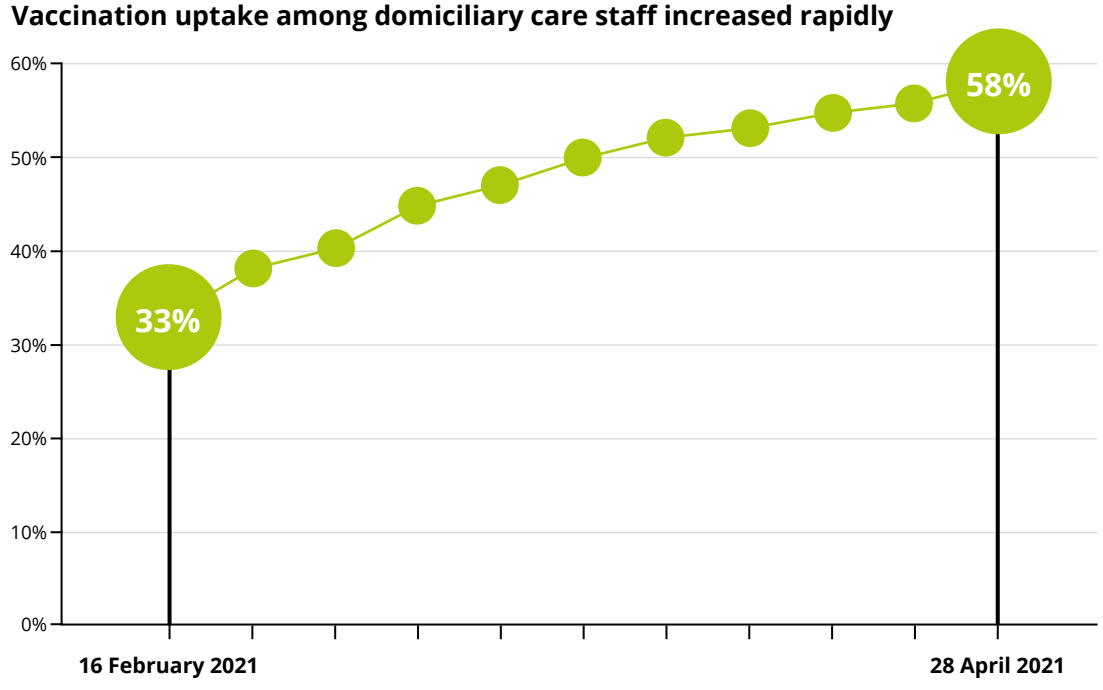
Despite being within the second cohort of people prioritised to get the vaccine (cohort 2 – All those 80 years of age and over and frontline health and social care workers), domiciliary care staff had a slower uptake than other groups. On 22 February 2021, 38% of domiciliary care workers in London had received their first dose of a COVID-19 vaccine compared with 54% for care home staff, 70% for health care staff and 89% for community pharmacists also in cohort 2. Specific work was done to understand in more detail what was behind the lower uptake levels.

Domiciliary care staff had a slower uptake than other staff groups...

There were a number of barriers highlighted that included fertility concerns, misinformation and the speed of the vaccine development. Staff were particularly concerned about financial loss as a result of needing to take time off work to get the vaccine (at the time, staff were being advised to access one of the mass vaccination sites that were not necessarily local to where they worked) and the potential financial loss as a result of experiencing side effects that could require a period of time off work to recover.

In response, domiciliary care providers agreed to pay staff travel expenses to get to a vaccination centre, to pay for the time taken to get the vaccine, and to provide sick pay for up to two weeks afterwards if required. Staff were required to produce a vaccination card to prove they had received the vaccine, and to confirm which date it was received on, in order to access financial reimbursement.

Vaccination uptake among domiciliary care staff increased rapidly



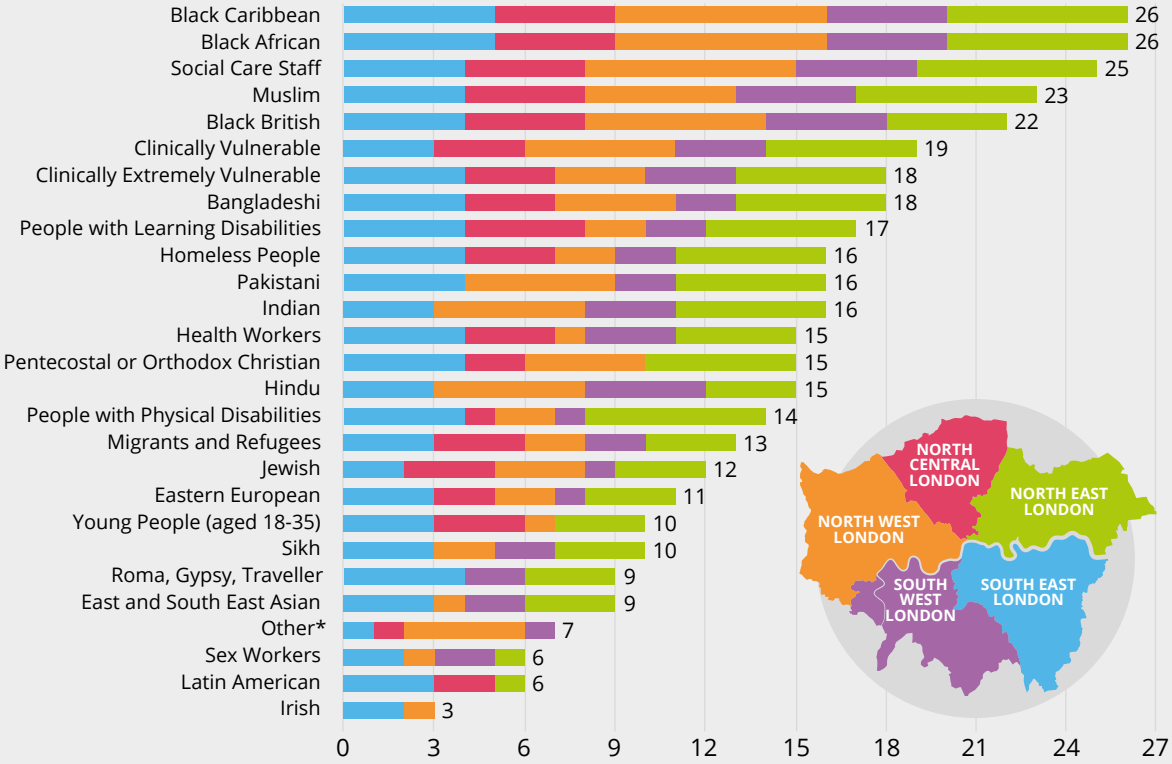
Source: ADASS, provided 28.04.21

Figure 4: ***Percentage uptake of COVID-19 vaccine in domiciliary care workers in London between 16 February and 28 April 2021***

Demand – reflections on activity to increase uptake of the vaccine and address hesitancy

Local authorities and ICSs took targeted approaches to increasing uptake of the vaccine and addressing hesitancy in their populations. The graph below shows which communities local authorities had created specific engagement activities for. Twenty six out of twenty seven responding local authorities highlighted Black Caribbean and Black African communities as priority communities, closely followed by social care staff and Muslim communities. At the time of the survey, increasing uptake in these groups was highlighted as a priority for London.

Local authorities undertook engagement activities for specific communities



**Other included: Somali, Tamil, Polish, Korean, People Living in Temporary Accommodation and HMOs*

Number of local authorities that referenced the population group (n=27)

Source: Evaluation Survey 03/21

Figure 5: ***Number of local authorities that referenced target population groups in evaluation survey by ICS for uptake interventions***

The analysis of ICS plans and the survey also included questions or themes around interventions that were in place to increase uptake and address demand related barriers. Common interventions across London included:

- **Community champions and faith leaders** – identifying and working in partnership with thousands of trusted individuals living and working in their communities, to share information and hear concerns about the COVID-19 vaccine in order to increase vaccine confidence.
- **Media and social media campaigns** – local authorities used traditional media channels such as local newspapers, radio website, community newsletters, posters and flyers, as well as videos, infographics and Q&As on social media and Whatsapp.

> **The national invitation letters that come through look like bills, and a lot of our deprived populations won't open those.**
>
> **ICS interviewee**

- **Translating materials** – across London, local authorities had translated materials into over 30 different languages to ensure residents fully understood the information being provided.
- **Call and recall services** – a combination of volunteers and paid workforce in NHS, local authority and voluntary sector organisations was used to resource call and recall services to provide information on the COVID-19 vaccine and to book appointments over the phone.
- **Targeted events, Q&As and drop-in information sessions** – events ranging in size and formality were held for specific community groups on to address concerns, such as fertility. Events were held in multiple languages with speakers from relevant communities to ensure fully informed dialogue could take place.

Spotlight on: Community champions

Over the course of the vaccine programme, the region has seen the growth of community champions as key to sharing information about the vaccine with their communities, as well as providing feedback to the health service on what their community needs and wants.

> **The region has seen the growth of community champions as key to sharing information.**

The London Borough of Newham has strongly advocated the engagement of community champions since June 2020 and highlighted elements as key to success:

- **A two-way dialogue is essential.** In addition to sharing information provided by the health service – which is the traditional approach to community engagement – as trusted individuals living within their communities, champions are able to provide knowledge and insights into the perspectives of their family, friends and colleagues, and feedback to the health service what is and isn't working for them. This enables the health service to ensure it is addressing any concerns about the vaccine and meeting their needs in terms of access.
- **Trust is key to a successful relationship.** Champions are self-identified and do not go through a formal selection process. They must be trusted to use and communicate the information given to them in the best way they see fit.
- **Less formal communication channels can be highly effective.** The main method of communication has been via Whatsapp, which has enabled rapid information sharing as well as a forum for asking and responding to questions within a peer group. In a fast-moving environment, it is essential to be able to share updates fast.

Local authorities across London have introduced community champions for the vaccine programme and, now that relationships, trust and a different way of working have been established, there is a clear sense of duty that this resource should be sustained beyond the COVID-19 vaccine programme.

Spotlight on: 1:1 conversations and motivational interviews

> 1:1 conversations were perceived by many to be negative...

In the early stages of the programme, guidance to NHS organisations was for managers to hold 1:1 conversations with staff members who had not yet taken up the offer of the vaccine. Rather than build confidence in staff, this intervention was perceived by many to be negative (as it was reliant on the nature of the relationship with your manager, who may not be from a similar social or cultural context) and may not address concerns or change minds. A more successful approach was to use a peer champion or buddy approach, which allowed space for people to discuss some of the deep-rooted concerns with colleagues in a way that felt safe and supportive.

Creating time and space for these conversations has been an effective tool in supporting people's decisions to take the vaccine, and there are examples of successful models across London in workforce and community settings. The activity was particularly impactful when underpinned by training in motivational interviewing and a guidance framework for holding 1:1 conversations. In the London Borough of Haringey, a clinical psychologist developed a training module on how to have brief conversations on the vaccination based on knowledge of myths and common questions, and on motivational interviewing focused on talking to people in a way in which you recognise their autonomy.

One site which used this model to great success with its workforce was Barts Hospital NHS Trust. They recognised early in the programme that the decision to take the vaccine was going to be difficult for many of their staff members and that it was a journey to be supported through a range of activities.

By acknowledging and confronting issues around mistrust in societal structures and embedded inequalities from the outset, and providing a safe space with trusted peers, staff felt more able to raise their concerns and have open conversations with colleagues about their decision.

Demand – what worked well

Communications approach

Using multiple communications channels – developing tailored messages and using a range of media to target specific groups.

> *We used Snapchat, Instagram, created films and animations in multiple languages and kept changing the approach by cohort. We can map interaction online to booking vaccination.* Local authority interviewee

Creating resource packs for managers to support consistent information on key topics, such as how the vaccine was made, potential side effects, benefits of uptake and how to access.

Outreach activities going to different communities and making time for conversations, recognising it can take time to make a decision.

> *Engagement events have been effective in getting the message out generally and provided a forum for communities, using trusted leaders who looked like them.* Local authority interviewee

Community champions

Engaging with community champions early in the programme helped to support two-way dialogue with the population, including wide range of people e.g. faith leaders, local authority leaders etc.

Training community champions in how to have 1:1 conversations and support decisions using motivational interviewing. This helped to ensure it was used as a mechanism to listen as well as share messages. Location of the clinic, particularly for early cohorts who were vaccinated in mass centres.

"People like me" – Where possible ensuring that people were able to access people like them from a similar background. This was equally important to field health professionals from similar backgrounds as well as community leaders.

> *The system is in service of the resident, so trust the residents to do with the information as they see fit.* Local authority interviewee

Co-ordination and partnership

There was a joined up, coordinated approach across multiple organisations and agencies, which enabled everyone to see who was doing what across the landscape.

This was reflected at multiple levels, working across different groups in the voluntary and community sector to access existing networks.

Sharing resources and supporting documents to help maximise reach, impact and increase efficiency. For example, The Keep London Safe campaign – developed by communication and engagement teams in the 32 London boroughs working with London Councils – shared translations, insight toolkits and event guides to rapidly share effective practice and support hyper local communication.

Where possible local authorities and grass roots community organisations are best placed to lead the dialogue.

> *From early on we had an understanding that no single organisation can deliver something like this – it relies on collaboration, in this case across four agencies and at multiple other levels.* Regional interviewee

Data

Active monitoring of uptake across different groups to identify who to target for discussion and support.

> *The ability to share data, look at trends and have an informed language about what we wanted to achieve has worked well.* Regional interviewee

New delivery models

The rise in pop-ups, vaccination in local community sites and vaccination buses all made the vaccine more visible and accessible to local communities.

Outreach models for delivery of the vaccine have supported access to hard-to-reach groups.

> *We took the vaccine bus to Chinatown in Soho. The bus caters for about 100, but we saw over 1,000 people turn out. These were undocumented migrants, who had a fear of the system, but there was a demand for the vaccine. People came from as far as Northampton.*
> Local authority interviewee

Demand – what did not work well

Communications approach

Engagement events are not enough. A more embedded outreach approach is needed rather than "just turning up" at community groups.

Communications approach needed to be more tailored for different groups, rather than generic, although consistent messaging remained important too. Information overload for both staff and team leaders, as well as the community, in the first months of the programme.

Providing materials in multiple languages took time to implement.

> *Communications need to be right from the start to mitigate language barriers.* Local authority interviewee

AZ media coverage

Extensive media coverage of potential link between AZ and risks of blood clots, alongside lack of ability to provide a choice of vaccine, reduced uptake until choice was available.

> *Mixed messages around blood clots harmed engagement. Age restrictions changing and being different to other countries where people might be getting their information [because their friends and family are overseas].* Local authority interviewee

Language used

There were sensitivities around the use of "hesitancy" with negative associations and groups feeling labelled or blamed for not taking the vaccine, regardless of their reasoning.

National vs local messaging

National messaging from the NHS was thought to be rigid and difficult to adapt locally. Interviewees reported that a more explicit balance of consistent national messaging and scope for local adaption or tailoring for specific communities would be beneficial.

> *This is very much a nationally driven programme and it doesn't work locally. You need local figures, local influence, understanding of the local situation, and then you need to flex your programme locally.* Local authority interviewee

Local NHS and local authorities

The local NHS were felt to be key decision makers on supply of and access to the vaccine and at times were felt to make decisions that were not appropriate for the local communities. Local authority and borough leads perceived themselves to have a stronger connection with the community and would have preferred that role to be more quickly recognised. Responsiveness of NHS colleagues to local community insights was also thought to be slow, but improved over time.

> *We need more autonomy for local authorities and genuine partnership with the acute trusts. The ICS structure has been a real barrier.* Local authority interviewee

Data

Data availability in the early stages of the programme was poor and unreliable, making it difficult to identify with confidence target community groups. This has changed over time.

Demand – recommendations

Communication and community dialogue

Communications materials need to be translated into different languages from the beginning to ensure they are easily accessible to a wide audience.

Messages and communications channels should be targeted to specific population groups to ensure equitable access to information as not all communication channels are accessible to all.

> *You need to have ongoing engagement with communities, identifying their concerns and addressing them on an iterative basis.* Local authority interviewee

Access

Ensure the delivery model (location, opening hours, booking and invitation system, materials and digital literacy) is fit for purpose and flexible to be appropriate for different populations.

Outreach and walk-in models are particularly important for those not registered with a GP.

> *The way we offer the vaccine is critical. System partners need to identify what is required to get the right response when interventions are implemented in the community.* Regional interviewee

Locally led

Whilst it has been a national programme, it has been thought to be more successful where there has been local presence for the programme (to show local communities that it is tailored and relevant to their needs) and local leadership that has had autonomy and flexibility to respond quickly to insights, harness opportunities as they arise and utilise pre-existing relationships.

> *We need to reduce the complexity, make it very local and make sure the material that you're using and promoting is using local people. It's the local connection that often makes the biggest difference.* Regional interviewee

Surge vaccinations

(Taking a maximalist approach to ensuring easy access and uptake to the vaccine for open cohorts)

A more considered communications plan and activities are required to maximise these events. It is recommended by interviewees that these cover multiple communications channels (digital and print media, flyers, door to door presence) alongside a balance of surge events and utilising mobile units.

Interviewees also shared perspectives regarding integrating the workforce for surge testing with surge vaccination so the two services can go hand in hand going forwards.

> *For surge vaccination, there must be a connection of the opportunity for community-based clinics with the resource to deliver it quickly, linking it to the surge testing model with mobile vaccination units.* Local authority interviewee

Incentives

Several interviewees shared ideas for incentivising uptake of the vaccine, from more light touch initiatives such as being entered in lottery draws, to more formal incentives, such as vaccine passports for travel. It was felt that incentives may be of particular importance for younger cohorts given the perceived personal risk of COVID-19 is likely to be low.

> *In the USA they've been doing some interesting and significant incentives, which is something we've not done that much of and could spur the younger cohorts into prioritising getting the vaccine.* ICS interviewee

Data

Sustain the use of large linked datasets to enable active monitoring of uptake across different groups and to identify who to target for discussion and support.

Other

Interviewees also commented on the need for ongoing learning and adopting an agile approach, as well as more formal evaluation of the work done to date.

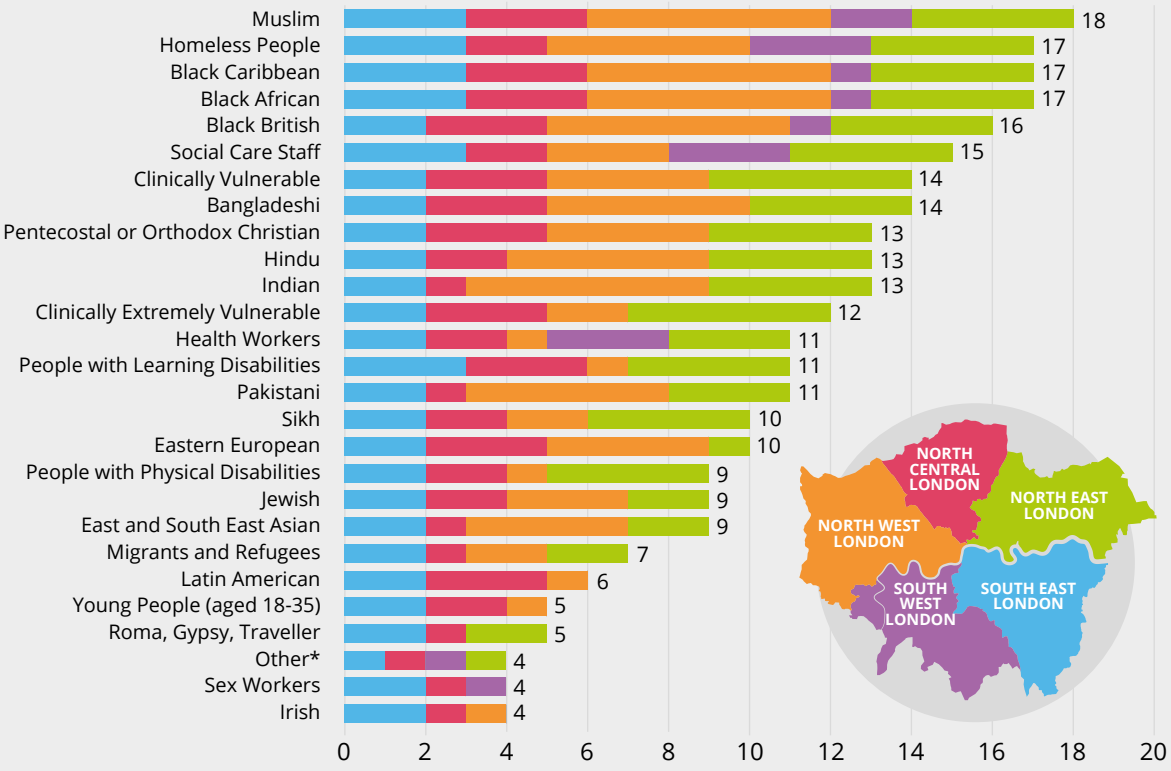
> *We need to reflect on the learning from initial roll out of vaccines before we get to the stage of boosters.* ICS interviewee

Access – reflections on activity to make the vaccine more easily accessible to people

Local authorities and ICSs took targeted approaches to ensuring access to the COVID-19 vaccine. The chart below shows which communities ICSs at borough level developed specific access interventions for. Most commonly cited were the Muslim population, and people experiencing homelessness, and the Black Caribbean and Black African communities. At the time of the information gathering, increasing uptake in these groups was highlighted as a priority for London. For example, Ramadan was due to begin within three weeks.

When comparing demand and access activities, it is interesting to note that access interventions were targeted towards different groups than demand interventions highlighted on page 19, for which most interventions were aimed at Black Caribbean and Black African communities where increased engagement and trust in the vaccine was the priority.

Partners focused on ensuring access for specific communities



**Other included: Nepalese, Somali, Romanian, Chinese, Polish, Mental Health Residents*

Number of local authorities that referenced the population group (n=27)

Source: Evaluation Survey 03/21

Figure 6: ***Number of local authorities that referenced target population groups in evaluation survey by ICS for service delivery interventions***

Summary of common interventions to increase uptake across London included:

- **Multiple ways to book** – several boroughs adopted composite invitation and booking approaches e.g. Camden included "a letter, text message, email and phone call to ensure that all residents stand the best possible chance of being contacted."
- **Pop-up clinics** – boroughs across London set up local pop-up clinics in places such as general practices, pharmacies, community accessible venues allowing vaccinations to take place in "moment[s] of engagement" (Tower Hamlets) including in town halls, places of worship, asylum seeker facilities and even supermarkets.
- **Transport to and from appointments** – often boroughs offered free taxis to those who could not arrange travel to their appointment. Others arranged a network of volunteer drivers and free transport for wheelchair users.
- **Outreach models** – roving/outreach models, including vaccination buses, have been used to reach the housebound, homeless populations in hotel/hostel accommodations or for sex workers, to accommodate people in care homes, traveller communities at their sites, as well as reaching those experiencing mental illness or with learning disabilities.
- **Learning disability specific clinics** – specific vaccination sites were set up to cater for learning disability patients, with virtual tours of the clinics often offered beforehand. Staff training was put in place to further support the delivery to patients in other settings and appointments were also used as an opportunity to offer health checks and vaccinations to carers.
- **Flexible clinics and appointment times** – evening and weekend slots were offered, as well as time changes in specific response to cultural and religious requirements such as Ramadan. Other initiatives have included drop-in/walk-in sessions and re-scheduling for those unable to make an appointment.

Spotlight on: Pop-up clinics

Pop-up vaccination clinics were utilised by most boroughs across London. Organisers highlighted the pop-up approach as a key method for delivering the COVID-19 vaccination to those who could not, or were not willing to, attend an appointment at a mass vaccination centre, and used data on community uptake to make decisions on where to hold pop-up sessions.

There is no common definition of pop-up clinics...

Through analysis of the survey responses, targeted interviews and semi-structured interviews, it is clear that there is no common definition of pop-up clinics in the COVID-19 vaccination programme.

Variation in approach was seen in the following elements:

- **Type of location** – organisers used a variety of locations to host pop-up clinics to attempt to make attendees feel most comfortable e.g. community church pop-up sites were reported to have delivered vaccination to more than 60% Black attendees in Lewisham; highlighting how these venues had the prospect of reaching people that otherwise might not have been vaccinated.
- **Booking vs walk-ins** – some pop-up sessions were only open to those who had booked an appointment, often by registering interest with the organiser of the session/ community leader. Some clinics were specifically designed as walk-in sessions which was seen to work best for those who prefer to minimise contact with the health system, such as people experiencing homelessness, asylum seekers and the traveller community.
- **Repetition of pop-up session** – where some pop-up clinics were held once in any given location because they reached the number of people they aimed for; others were held repeatedly at the same location to raise awareness of the vaccine availability; and others still have second sessions planned for 12 weeks after the first event to provide attendees with their second dose.

It was difficult to assess the impact of pop-up clinics across London because data for the clinics was integrated into broader Primary Care Network data. However, anecdotal feedback from PCNs is that while the sessions might not vaccinate the same number of patients in a session as a mass vaccination centre, the approach was highly effective for reaching those who might not have otherwise accepted the COVID-19 vaccine.

Spotlight on: Surge vaccination events

Large scale, surge vaccination events have been increasingly used as the programme opened to younger cohorts, and in response to rapid increase in the rates of the Delta variant of COVID-19. These high-profile events, often held in destination venues, such as football grounds, offered an opportunity to vaccinate high numbers of people in a single day and were well promoted across the media, raising awareness of the vaccine programme.

The surge vaccination events have proved popular with younger cohorts, with anecdotal reports that this may have helped some to convince older members of their family to take the vaccine. However, while these events are good at raising the profile of the vaccine programme, there is a risk that these type of events could inadvertently exacerbate existing disparities in uptake between communities.

The event held at Twickenham Stadium, which was planned and delivered at pace at the end of May and was the first event of this scale, vaccinated over 10,000 people in one day. Most of the people vaccinated tended to be young (cohort 12 – 18-29 year olds) and almost half were White British. Few however were from the communities with the lowest level of uptake in North West London. In addition, the location of the Twickenham event may have contributed to the demographic of people being vaccinated at the event. As one local authority interviewee said, "the location appealed much more to white middle class populations than it did to those communities we were trying to reach in Hounslow".

Through real-time monitoring of inequalities data and agile learning, the vaccine impact programme was able to identify increased disparity that coincided with early surge vaccination events. These insights were discussed with system planners in a variety of fora to enable them to factor this intelligence into their hyper local plans in order to contribute to reducing disparities in uptake. Subsequent events, such as those seen at Tottenham, Arsenal and West Ham football grounds appear to have vaccinated an older population (e.g. people who had been eligible for vaccination for a longer time but had not yet decided to take up the vaccine) and a more ethnically diverse population as well.

Considerations for surge events:

- Reflections on the impact of surge events have tended to emphasise that scale does not necessarily provide equity of access, and a hyper-local approach in planning which people will use these events is needed in addition.
- Working with local groups to identify venues that communities can easily access, which feel familiar to them, and they can be booked into, can be far more successful in terms of reaching particular communities and groups with low uptake.
- Similarly, targeted call and recall is cited as generating more success in reaching specific communities than offering vaccination at a large scale. A range of activities and delivery channels, recognising and responding to the different needs of different communities, needs to be offered.
- Large scale vaccination needs to be linked with community education and engagement. Communities need to know that the event is for them to attend and may not access news in the same way, so messages need to be communicated through a range of methods and in multiple languages.
- Integrating surge testing and surge vaccination has potential to work well, but needs clear messaging. There was confusion as to whether people would be able to have the vaccine if they tested positive for COVID-19, which meant there was reluctance to participate. There needs to be clarity on the process, communicated to both vaccine centre staff and the public.

Access – what worked well

Local vaccination centres

Community based provision to minimise distance travelled and provide access in familiar community settings was consistently referenced as a success of the programme to date. These settings were where people go, not just where they live. The use of pharmacies was referenced in many of the interviews as providing a trusted and accessible option, particularly for deprived communities. "Pop-ups" were also widely referenced, however the definition of these varied widely, from providing vaccination in a site that usually has other purposes, to short term presence in a particular setting. Vaccine buses have further provided flexibility in taking the vaccination to places that are easily accessible. Overall, interviewees spoke widely of the benefits of a diverse range of local vaccination centres that have provided options, flexibility and accessibility for local people.

> *People want to get the vaccine from a centre they know and a centre which addresses their practical concerns.* Local authority interviewee

Outreach

Planned outreach sessions for specific communities were flagged as a distinct activity from pop-ups, and enabled partners to reach communities that may not have been vaccinated otherwise. Specific examples included going to hostels and areas that homeless people congregate to reach asylum seekers and homeless populations, and taking the vaccination to housebound people and care home residents and staff. This required detailed work with supply chain management to secure appropriate numbers of vaccine and plan delivery that adhered to the protocols for storage, transport and administration of the different vaccines.

> *Community clinics, pop ups and vaccine bus. These reached people who otherwise would not have been vaccinated.* Local authority interviewee

Booking and travel

Providing support for people to book the vaccination, with local booking lines in addition to the national team, and ensuring multiple ways to book (online, text, phone call, someone completing on your behalf) all aided access to appointments. Introducing walk-ins was thought to further help access, particularly for those without a known NHS number as this is a pre-requisite for most booking channels. Providing free transport, which in some boroughs was provided by local volunteers and community champions, further supported people to get to appointments and to access centres they may not have felt able to get to alone.

Access – what did not work well

Supply complexity

Not being able to provide transparency on which vaccination you would receive and not being able to offer a choice of vaccination have been widely accepted as limitations of the programme to date. The uneven and unpredictable nature of the supply of the vaccination, with sites running out early in the programme, and an interruption to supply, caused challenges for vaccination centres. Supply channels were further complicated by changes in guidance over time, for example with regards to transporting Pfizer, and more latterly the recommendations for different age groups to receive different vaccines. Some interviewees highlighted that local authority teams working to drive up demand felt disconnected from decisions about supply and the availability of the vaccine. This could have a negative impact if communities that were encouraged to get the vaccine then found it hard to access.

> *The council has been operating with one hand behind their back and has felt very unconnected to supply. It was a real struggle to get the bus and the worry is that if it's successful and they don't have the supply, they will lose the trust of people they have just convinced to take it.*
> Local authority interviewee

Booking

The booking process was difficult to navigate and had teething issues with the technology. It took time for alternative methods to be put in place (e.g. telephone calls). Communication on walk-ins was inconsistent as was cohort discipline.

Site selection

The mass vaccination centres and hospital sites required individuals to travel to get the vaccine, at a time when the public were being asked to limit travel. In addition some of the centres were less accessible, such as the ExCeL centre, and therefore had lower utilisation.

> *It is still monumentally difficult to navigate the booking system. People want a local offer and in urban areas this means hyper local.* Local authority interviewee

Volume vs equity

The national aim to vaccinate as many people as quickly as possible created an undertone of imbalance between the need for volume and equity. Under-served populations and those in areas of high deprivation, while being fewer in number, require more targeted approaches. Some interviewees referenced diminishing returns from some of the pop-ups and models geared towards inclusion health, and had difficulty justifying dedicated resources for those groups amidst a need for high numbers overall.

> *Twickenham worked better at attracting people from affluent white communities, not the population that was being targeted with the surge event.* Local authority interviewee

Access – recommendations

Local centres and locations

Delivering the vaccine through local centres was felt to be a more sustainable model going forwards, particularly utilising pharmacies. "Hyper-local" was a phrase used in several interviews and some spoke of the artificial nature of borough boundaries when reviewing specific communities and potential vaccine delivery sites. In addition, co-location of vaccination services with other services people in the borough accessed, such as schools, foodbanks and places of worship, can increase access.

> *We need to start thinking about the artificial nature of borough boundaries, which contain shared communities who don't always have access to the same treatment – we need to work hyper-local, even if it crosses boundaries.* Local authority interviewee

Widen the workforce

Resourcing vaccine models with a wider workforce for vaccinating beyond GPs, including pharmacists but also inclusion health workers and volunteers that have been trained as vaccinators, will ensure a more sustainable model. The workforce needs to be planned in advance and able to be stepped up quickly when decisions on boosters, and future seasonal vaccinations are taken.

> *We need to think of more creative ways of providing the vaccine. Look broader in primary care – it's not just GPs and pharmacists. There is a wider primary care workforce who are willing to get involved.* Local authority interviewee

Access for unregistered population

Walk-ins and outreach models were felt to be particularly important for those not registered with a GP who were unlikely to be able to book an appointment, and who are likely to have wider social context to make it less likely they would access the vaccine.

Communications approach

Targeted communications relevant to the local population, available in multiple languages from the beginning, and with consistent and clear messaging. For pop-ups and surge vaccination activity, a clear communications plan to ensure time to make people aware of the service and have time to plan attendance.

Community collaboration

Working with local authorities and their communities from the beginning to co-design vaccine delivery. They know their population and the best locations for vaccination centres for different groups.

> *Community groups are essential to communicate messages – they understand and are trusted by their community.* Local authority interviewee

Legacy – reflections on how we can take the lessons and apply them to the future, across the NHS, social care and local authority activities

The programme of work has required extensive collaboration across partners in London, has necessitated new ways of working with communities and created opportunity for future legacy. There are important implications for other programmes through which these new ways of working could be sustained or build upon.

Inequalities

Data – There has been a significant push to obtain granular levels of data to inform interventions. Interrogation of data on multiple dimensions ensures population groups are not over simplified, and that it is recognised that people fit in to several different groups.

> *Equal access is not as easy as saying the clinic door is open to everyone. Being data driven and not going in with any preconceptions is really important. You have to monitor uptake and then change your programmes to make sure it addresses barriers. Otherwise, equal access doesn't work.*
> Local authority interviewee

Community dialogue – Having a more prolonged discussion of health in general, making time to listen to and understand different perspectives, and working with communities to co-design interventions, and solutions that respond to their needs and harness their assets, can help build trust, more sustainable relationships and provide wider opportunities for improving health, wellbeing and tackling inequalities.

Inclusion health – Dedicated approaches have been put in place for inclusion health groups, which, despite being resource intensive, need to be sustained for the future to make progress for inequalities. These have included outreach models for discussing and then delivery of the vaccine.

Infrastructure

Local approach with local centres – Understanding local communities and building services around their needs and preferences.

> *The main learning is that whatever you do, the offer needs to be hyper-local!*
> Local authority interviewee

Reuse assets – Reusing vaccine buses for wider health promotion, screening and immunisation campaigns, as well as reusing the concept of co-locating vaccine provision in other community settings.

> *Women receiving vaccinations at the temple during the Eid celebrations asked, why can't their children receive childhood vaccines there?* Local authority interviewee

Workforce

Widen the workforce – staff are performing tasks that they would not have previously (for example, unqualified people giving vaccines). This has created new roles that we should maintain and further build on, and will hopefully have provided gateway career pathways into health and care roles. This can also support improved availability of staff and rebalance the workload for existing staff where tasks can be performed by others to make workloads more sustainable and improve retention.

> *Maintain the army of volunteers. Think wider than GPs for the administration of vaccine e.g. health care assistants.* ICS interviewee

Staff as the door to the community – many staff are from the local community and have unique insights that can be shared and acted on as appropriate. Staff can also provide greater access to the community particularly when they are from similar social or cultural contexts.

Building trust with staff – empowering staff to have autonomy and build local solutions can help to build trust. The ongoing consultation and debates about mandating the vaccine could reduce trust, but equally trust could be diminished if there is an inconsistent approach across health care and social care (with the vaccine now mandated for care home staff).

Partnership

System wide – building partnership working across health services and the local authorities, but further with grass roots community organisations has created a deeper connection with the community and recognised local assets, expertise and ways of working required to succeed.

> *Using partners to reach people, for example the. food bank delivering leaflets and answering questions about vaccination when giving food to people.* Local authority interviewee

> *Partnership/collaboration between the NHS, Local government, and communities is key to having successful population health/prevention/public health programmes. Success cannot be achieved where system partners work in silo.* Local authority interviewee

Common purpose – the shared common goal of the vaccine programme has created a common purpose for community groups, local authorities and NHS organisations to come together. Consistent communication of the goals of future programmes can help to build alignment and bring organisations together.

> *By having the shared common goal, it has brought people together and there is good partnership working.* ICS interviewee

Community engagement

Community dialogue – new ways of connecting to the local communities, to listening to them and sharing information have been established. Maintaining this going forwards will require ongoing listening, dialogue and ensuring that feedback is acted on.

> *Community engagement as an approach has been crucial to successful engagement with certain communities and co-creating solutions/approaches to vaccinating certain populations.* Regional interviewee

Community champions – these individuals have played specific roles in connecting to communities and creating two-way dialogues. Training community champions, for example in 1:1 interview techniques, and working in collaboration has demonstrated their crucial role as a member of the team and extended workforce.

Spotlight on: Inequalities

Health inequalities have been widening over the past decades in the UK[4,5], and the COVID-19 pandemic has further exacerbated these inequalities. Actively monitoring impact and implications of different interventions and service changes across multiple cross-sections of the population can support understanding of whether inequalities are widening, remaining constant, or progress is being made.

In the vaccine programme, the availability of data changed over time providing opportunities for increasingly sophisticated data analysis. This demonstrated the complexity of population groupings. Age, gender, ethnicity and level of deprivation were the main groupings used for analysing uptake in each of the priority vaccination cohorts.

Detailed review within groups was particularly important for understanding where there were. Reviewing variation within ethnic groups gave a deeper understanding of where to target efforts than looking at Black, Asian and Minority Ethnic groups together.

Example 1: Uptake of the COVID-19 vaccine among staff working in NHS provider Trusts in London

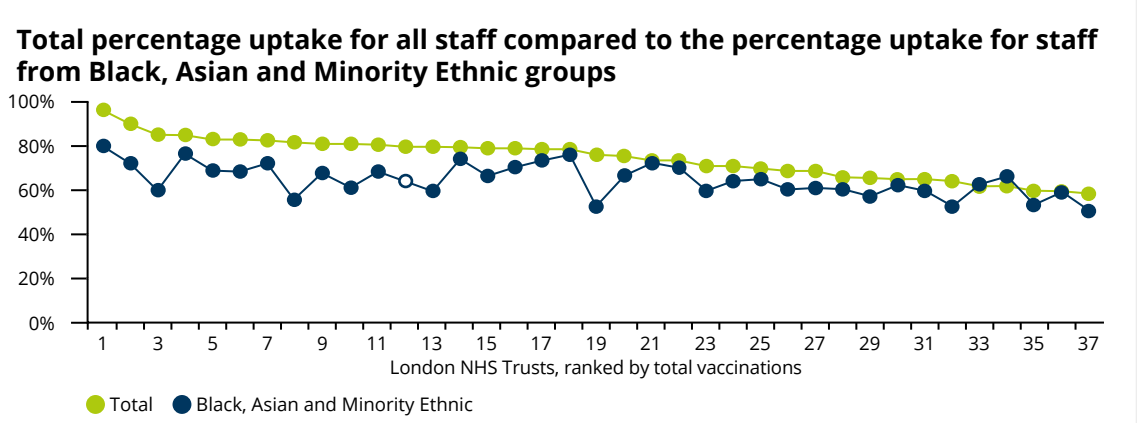


Figure 7: ***Percentage of staff working in NHS provider Trusts in London to have received at least a first dose of the COVID-19 vaccine by 31st March 2021***

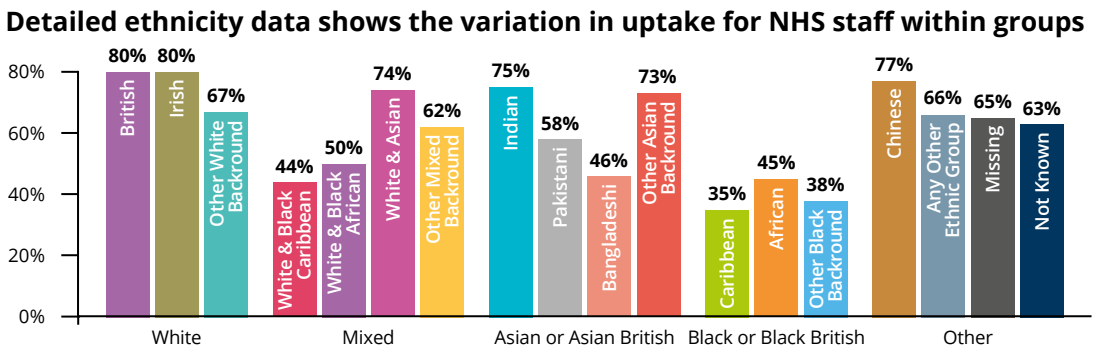


Figure 8: ***Variation in COVID-19 vaccine uptake for staff in NHS provider trusts in London by NHS ethnicity category on 22nd February 2021***

[4] Bennett H, Kingston A, Spiers G et al (2021) 'Healthy ageing for all? Comparisons of socioeconomic inequalities in health expectancies over two decades in the Cognitive Function and Ageing Studies I and II', International Journal of Epidemiology. Online ahead of print.

[5] Scobie S and Morris J (2020) 'Quality and inequality: digging deeper', The King's Fund.

Example 2: Uptake of the COVID-19 vaccine among the general population in London

Figure 9 shows the cumulative COVID-19 vaccine uptake of the general population in London from December 2020 to June 2021, when cohorts 1-12 were open to vaccination. Over the course of the vaccine programme, uptake in some ethnic groups saw surges at different stages. While some change in uptake will reflect the different age profiles within different communities, part of the change in uptake will be linked to targeted activities aimed at increasing confidence in and access to the vaccine. As with the data detailing staff uptake, granular review of ethnicity data was important to target interventions appropriately and to monitor in group variation, and was undertaken throughout the programme.

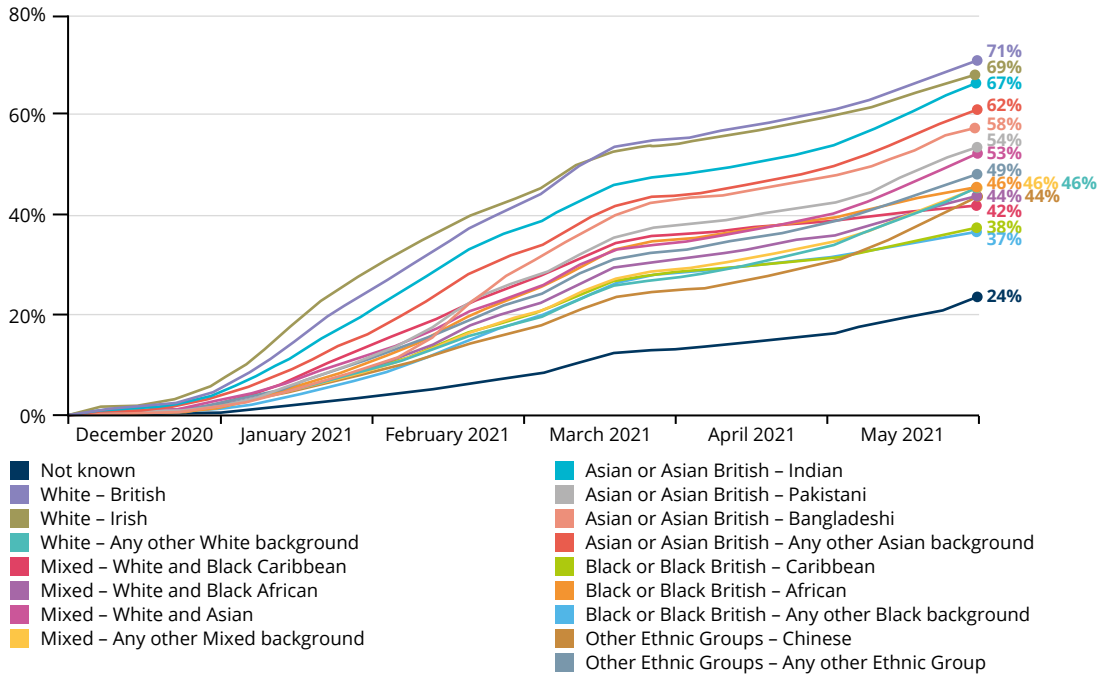
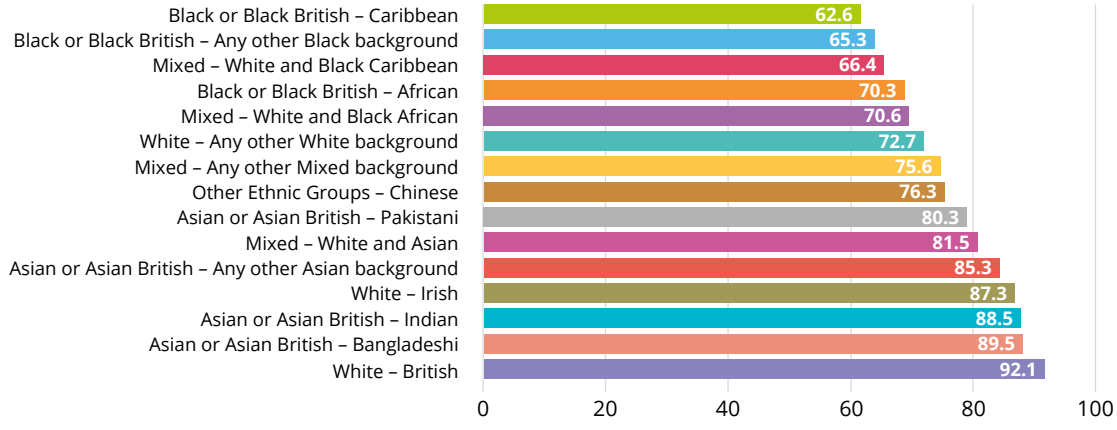


Figure 9: ***Cumulative uptake of the COVID-19 vaccine across the London population by NHS ethnicity category up until 31st May 2021***

Source: NHS Foundry. NIMS AND MPI



Source: Public Health England NIMS; Regional Vaccination Report for London produced by LKISL, 24/06/21

Figure 10: ***Percentage of the population aged 50+ to have received a 1st dose of the COVID-19 vaccine by NHS ethnicity category before 24th June 2021***

Recommendations

Throughout the document there are recommendations of actions to take to build on the learnings gathered throughout this programme of work which can build on good practice already in place.

Examples of recommendations for different audiences include:

For regional decision makers

- Create wider opportunities to **gather insights** as a core part of a programme can bring community and staff voices to the fore and supplement traditional scorecards and metric review. Linking these insights into decision making, as part of a learning health system, can ensure insights are acted on in a more agile way.
- Sustain **partnership working** with a joined up, coordinated approach across multiple organisations and agencies, understanding different assets across organisations and utilising existing networks to access communities and create two-way dialogues to feed insights. Enable flexibility for local systems to implement national or regional guidance in the way that will work best for the local population and infrastructure.
- When setting metrics, whilst single targets can create common goals and align attention, they can also lead to unintended consequences, particularly with regards to widening inequalities. Balancing consideration of overall volume with more detailed review of **equity** can help mitigate this, and using big datasets to provide different lens on progress for different population groups.
- Clear **communication** between national and regional NHS leaders and the wider delivery system is critical for ensuring consistency. Creating reliable communication channels between organisations can support health services and local authorities to deliver messages consistently and in a manner in which it will be heard by different community groups.

For Integrated Care Systems

- Expanding perspectives on where different services can be delivered can offer wider opportunities for **co-locating services** with other health promotional activities and access communities in places that are familiar, or access communities that may otherwise not have engaged. Ongoing consideration of the role of outreach and of the “hyper-local” service offering can increase access to disperse communities.
- Distinguishing between activities that **create demand for a service and those that improve access** to the service can help to further target interventions.
- Collaborating with local community groups and outreach teams can help **widen participation in health services** more generally.

For Local Authorities

- Creating capacity to maintain a **two-way dialogue with the community**, to both listen and respond, rather than just share messages, enables a deeper level of understanding. Sustaining the community champions model, to ensure the local population have access to people who they trust, who have a similar cultural and/or social background, will be a valuable asset to sustain for wider local authority and NHS services, as well as using multiple communications channels to relay messages.

For healthcare providers

- Reflecting on what broader health **activities can be delivered together** can help to improve patient experience and efficiency. Co-locating services is one mechanism to achieve that, as has been done in one-stop diagnostic services before, but also reflecting on widening the value of that contact, as was shown by an inclusion health team, for example, bringing podiatry, dentistry and health promotion teams to a vaccine clinic.
- Empowering staff to have autonomy and **create local solutions** can help to build trust and can also ensure solutions are reflective of the needs of the local community, with staff often part of that community. Listening to staff and enabling them to put in place solutions in an agile way can accelerate progress.

For GPs

- Recognising the breadth of people recruited and trained to deliver the vaccine highlights opportunities to **widen the workforce** and understand where activities can be delivered by non-traditional roles to create capacity for clinical staff. Training inclusion health workers, volunteers and utilising pharmacies, are examples that could be relevant to future vaccination and immunisation programmes, including the seasonal flu vaccine.

Appendix

Appendices content (Click the links below):

- **Learning health system approach**
- **Survey questions**
- **Interview questions**
- **COVID-19 vaccine uptake across domiciliary care staff in London infographic**
- **COVID-19 vaccine uptake across care home staff in London infographic**