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England and NHS Improvement – South West

Integrated South West Public Health Team

Strategy to Increase Uptake and Equity of Access to the COVID19 Vaccine

Public Health England South West Centre

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Authors

Emma Kain - Screening and Immunisation Lead

Jon Roberts - Screening and Immunisation Lead

Contributors:

Rachael Marsh, Inclusion Health Lead
Jan Bond, Health and Wellbeing Programme Manager
Ann Tweedale, NHSEI
Richard Chidwick, Health and Wellbeing Programme Manager
Ian Keasey, Health and Wellbeing Programme Manager
Tina Garrett, Health and Wellbeing Programme Manager

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Glossary

BAME	Black and Minority Ethnic groups
BNSSG	Bristol, North Somerset, South Gloucestershire
BSL	British Sign Language
BSW	Bath, Swindon and Wiltshire
CCG	Clinical Commissioning Group
CHIS	Child Health Information System
COVID-19	Coronavirus Infectious Disease 2019
DCIOS	Devon, Cornwall and the Isles of Scilly
FAQ	Frequently Asked Question
ICS	Integrated Care System
JCVI	Joint Committee on Vaccination and Immunisation
MHRA	Medicines and Healthcare products Regulatory Agency
MMR	Measles, Mumps Rubella
NHSE&I	NHS England and Improvement
NICE	National Institute for Health and Care Excellence
PCN	Primary Care Network
PHE	Public Health England
POD	Point of Delivery
STP	Strategic Transformation Partnership

Background

The impacts of the coronavirus pandemic have been disproportionately felt by communities who already experience longstanding inequalities in the UK. Public Health England's Beyond the Data report showed how higher rates of infection and mortality from COVID-19 in people from Black and Minority Ethnic (BAME) communities is in large due to systematic exclusion.[1] The learning from this can equally be applied to other vulnerable groups (see Delivery models p.5).

Those at highest risk of mortality from COVID-19 include older adults and people with underlying medical conditions. Those working in certain occupations (e.g. key and manual workers, those on zero-hour contracts, and those in insecure work), and in crowded accommodation (e.g. multigenerational households, Houses of Multiple occupation, prisons, and migrant initial and temporary accommodation) have a higher risk of exposure to the virus.

Rollout of the UK COVID-19 immunisation programme began in December 2020. Three vaccines have now received emergency use authorisation by the Medicines and Healthcare products Regulatory Agency (MHRA) in the UK, with more vaccines in trials likely to be considered for approval during 2021.[2]

In order to maximise the population benefits of the available vaccines, the Joint Committee on Vaccination and Immunisation (JCVI) has provided interim advice on priority groups for vaccination.[3]

1 Public Health England: Beyond the data: Understanding the impacts of Covid-19 on BAME groups. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf
2 https://www.gov.uk/government/collections/mhra-guidance-on-coronavirus-covid-19
3 https://www.gov.uk/government/publications/priority-groups-for-coronavirus-covid-19-vaccination-advice-from-the-jcvi-30-december-2020/joint-committee-on-vaccination-and-immunisation-advice-on-priority-groups-for-covid-19-vaccination-30-december-2020#vaccine-priority-groups-advice-on-30-december-2020

Box 1: JCVI Priority Groups for COVID-19 vaccination

1. residents in a care home for older adults and their carers
2. all those 80 years of age and over and frontline health and social care workers
3. all those 75 years of age and over
4. all those 70 years of age and over and clinically extremely vulnerable individuals
5. all those 65 years of age and over
6. all individuals aged 16 years to 64 years with underlying health conditions which put them at higher risk of serious disease and mortality
7. all those 60 years of age and over
8. all those 55 years of age and over
9. all those 50 years of age and over

JCVI note that prioritisation means unequal access to vaccines and hence there are implications for health inequalities. This will require locally designed actions to address barriers to access during the implementation phase with monitoring and evaluation of uptake across inclusion groups.

JCVI advises that:

'implementation of the COVID-19 vaccine programme should aim to achieve high vaccine uptake. An age-based programme will likely result in faster delivery and better uptake in those at the highest risk. Implementation should also involve flexibility in vaccine deployment at a local level with due attention to mitigating health inequalities, such as might occur in relation to access to healthcare and ethnicity.'

Delivery models

A range of vaccine delivery models including vaccination sites at hospital hubs, large scale vaccination centres, GP practices and pharmacies are being deployed in order to support a rapid rollout of the programme to the priority eligible groups. This can be supplemented with roving vaccination teams and 'pop-up' vaccination sites as locally determined, for example, locally trusted sites such as buildings connected with faith organisations and community venues.

The opportunities presented through these novel vaccine delivery mechanisms must be assessed against the potential to create unintended consequences and inequality in access to the vaccination.

The core service specification for the National Immunisation Programme has reduction in health inequalities as a key objective in delivery of the programme.[4]

Immunisation delivery models should provide services that have no barriers to access for groups defined by the Equality Act 2010 and must optimise access for underserved populations.

These include:

- people in lower socio-economic groups
- those with the nine protected characteristics as described in the 2010 Equality Act, particularly BAME communities[5,6 3]
- those who are not registered with a GP
- homeless people and rough sleepers
- asylum seekers and vulnerable migrants
- gypsy and traveller groups
- sex workers
- those in prison
- those experiencing severe and enduring mental illness
- those with drug or alcohol addictions
- those with learning or communication difficulties
- others who may be excluded or marginalised within the community

Uptake

The COVID-19 vaccination programme has an ambition of a 100% offer to all in the eligible cohorts. Initial completion of cohorts 1-4 is aimed for the middle of February 2021 with subsequent expansion through the next cohorts leading to the whole adult population expected to be offered a vaccination by the autumn.

High vaccine uptake will play an essential part in the ability to reduce non-pharmaceutical interventions such as lockdown measures and social distancing, however, the proportion of the population that must be vaccinated to begin inducing herd immunity is not known.*

4 NHS public health functions agreement 2017/18. Core service specification National immunisation programme.
5 The public sector equality duty (Equality Act 2010) http://www.legislation.gov.uk/ukpga/2010/15/section/6
6 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

*Herd immunity is a form of indirect protection from infectious disease that occurs when a large percentage of a population has become immune to an infection, thereby providing a measure of protection for individuals who are not immune.

Two doses of the currently recommended vaccines are required, so it is important that robust tracking and follow-up of individuals is in place to ensure that both doses are delivered, and maximum protection gained. This will present challenges where individuals are not registered with practices or have poor access to healthcare. [7]

Vaccine hesitancy

Vaccine hesitancy is defined as 'a behaviour, influenced by a number of factors including issues of confidence (level of trust in vaccine or provider), complacency (do not perceive a need for a vaccine, do not value the vaccine), and convenience (access).[8]

Recent research has estimated that 37% would 'definitely have' and 31% would 'probably have' the COVID-19 vaccines but that 9% would 'definitely not' and 13% 'probably not' take up the offer.[9]

When asked for reasons not to have the vaccine, the most common replies are that there hasn't been enough time to see what the side-effects might be (61%) or to test whether it really works (58%).

Clearly the decisions that the combined 44% who are 'probable' in either direction will be crucial, meaning careful communications and promotion of the programme will be needed.

[7] COVID-19: the green book, chapter 14a - GOV.UK (www.gov.uk)
[8] World Health Organization Strategic Advisory Group of Experts (SAGE) on Immunization. Report of the SAGE Working Group on Vaccine Hesitancy. Geneva: WHO, 2014.
[9] https://www.ipsos.com/ipsos-mori/en-uk/covid-19-vaccine-trials-announcements-have-lifted-nations-spirits-some-concerns-remain

Factors that have been shown to be linked to vaccine uptake and reducing hesitancy include: [10]

- Tackling negative misconceptions about vaccines including mis-information online and via social media.
- Utilising the trusted healthcare professionals and community champions to address concerns about vaccine safety, side effects and effectiveness.
- Improving access to vaccination clinics by making use of different settings and locations.
- Consideration of commonly cited reasons not to attend vaccination sessions such as language barriers, difficult appointment times, travel costs and childcare needs.

Aims and Objectives

The aim of this document is to provide a framework for the regional approach to supporting local systems to ensure good uptake and equitable access to the COVID-19 vaccination programme across all population groups.

Approach

This strategy has been developed by the South West Public Health England Centre, drawing on the work of the national multiagency Inequalities and COVID-19 vaccination working group and the NHSE&I national COVID-19 Health Inequalities work.

What works in increasing vaccination uptake?

Evidence and guidance

This summary outlines key guidance on approaches to increasing the uptake of vaccinations, including among underserved populations.

[10] RSPH | Moving the Needle: Promoting vaccination uptake across the life course

Tackling barriers to access

- Limiting barriers to accessing vaccinations including providing a range of appointment times[11] and locations, making venues easy and affordable to access (including by public transport recognising that in some areas public transport links are poor- such as very rural, and isolated coastal communities).[12],[13]
- Providing vaccinations in safe and familiar environments[13] including trusted (non-clinical) community settings, with the support of community leaders.[14]

Invites and reminders

- Ensuring people receive timely invites, and appropriate reminders including text messaging where appropriate.[11]
- Ensuring IT systems flag when patients have been missed and these individuals are followed up.[11]

Trusted advice

- Strong recommendations from healthcare professionals are effective in increasing uptake. Some have adopted call-back systems where a healthcare professional can call people back who are unsure about the vaccination to discuss their concerns.[11]
- Showing that healthcare professionals are being vaccinated helps to build trust in the vaccine.[13]
- Signposting people to reliable online resources where they can learn more eg. the Oxford Vaccine Knowledge Project.[11]
- Utilising community champions and respected community leaders to promote the vaccine.[15]

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[11] Public Health England, 2019. Public Health Matters. Guidance on increasing vaccine uptake https://publichealthmatters.blog.gov.uk/2019/05/16/increasing-vaccine-uptake-strategies-for-addressing-barriers-in-primary-care/

[12] ADsPH briefing note https://www.adph.org.uk/wp-content/uploads/2021/01/ADPH-Vaccine-Explainer-January-2021.pdf

[13] WHO technical advisory group on behavioural insights and sciences for health, 2020. Behavioural considerations for acceptance and uptake of COVID-19 vaccines https://apps.who.int/iris/handle/10665/337335

[14] NHS Health Scotland, 2019. Interventions to improve engagement with immunisation programmes in selected underserved populations http://www.healthscotland.scot/media/2826/interventions-to-improve-engagement-with-immunisation-programmes-in-selected-underserved-populations-september-2019.pdf

[15] A guide to community-centred approaches for health and wellbeing (publishing.service.gov.uk)

Communications

- Communications need to be clear and credible,[13] increasing knowledge and correcting misinformation.[12]
- There should be open and transparent discussion about the safety, risks and benefits of vaccinations, including use of fact-checking resources and responding to misinformation.[13]
- Dialogue about the vaccination programme needs to manage expectations, including making clear that people will still need to adhere to protective measures put in place.[13]
- Translated materials and/or translator support may help to positively influence intention to vaccinate among people with limited English[14] so targeted resources including resources in multiple languages with culturally appropriate messaging.[12] Including innovative communication methods for those with limited literacy, eg. video, radio formats.

Local leadership and engagement

- Local engagement is key. Local systems should work with communities including faith groups, businesses, schools and the third sector.[12]
- Using social influences, including trusted community figures.[13]
- Using the community 'C2' approach – social networks, asset-based approaches and volunteer health roles. [15]

Experience

- Ensuring that people have a good quality patient experience when they attend for vaccination.[13]

Learning from previous work to increase vaccine uptake

The South West has a good record of innovative approaches to increasing uptake amongst hard to reach groups. These include a range of strategies including increasing access to clinics, bespoke projects with community groups and using a range of communication strategies to support uptake (see *Appendix 1* for examples).

Systems have already begun to carry out local work to engage communities and gather insights to inform their approach (*Box 1*).

Box 1 Case studies: planned approaches to working with underserved communities

Pop-up clinics for communities less likely to engage with static sites e.g. Romany and Gypsy Travelers, Boaters

Bespoke clinics at settings of convenience e.g. faith settings, community venues, walk in centres and drive through models

Targeted clinics for inclusion groups e.g. at homeless shelters or via drug and alcohol treatment services, sexual health clinics

Tailored communications and support to access to the vaccinations for people with Learning Disabilities

Translated materials and resources to support engagement and uptake in ethnic minorities where English is not the first language.

The South West approach to tackling health inequalities and increasing uptake of the COVID 19 vaccination

This section details how we will work as a regional team to support local action to ensure equity of access across the South West population through these key workstreams:

- Systems leadership
- Supporting local action
- Communications and resources
- Data monitoring and analysis.

Systems Leadership

Systems leadership will be provided by the South West PHE Screening and Immunisation Team working closely with the PHE Health and Wellbeing team, to support collaboration between Local Authorities, NHS and other key partners to ensure equitable delivery of programmes.

The South West Screening and Immunisation team will build on existing links to support locality health inequality steering groups as they develop local plans to ensure access for all. This builds on previous examples of systems working to tackle inequalities in access to vaccinations.

Supporting local action

The Screening and Immunisation team will set up a regional network with monthly meetings to bring together colleagues from across the region to review uptake data and encourage cross-fertilisation of ideas.

The PHE Health and Wellbeing team and NHSE/I South West will use their existing networks, including learning disability, health and justice, migrant health and homelessness networks to develop plans for these groups, share ideas and resources.

Communications and resources

A suite of resources has been developed nationally to support the vaccination rollout, incorporating learning and evidence from flu programmes, behavioural science and attitudinal surveys. These include targeted resources for BAME risk groups, older adults, health care workers and women who are pregnant or breastfeeding. Leaflets have now been developed in 20 languages, Braille, British Sign Language (BSL), Large print, Easy Read and for different settings including secure settings (see accompanying Resources

List for further details). Local systems can build on their existing relationships with their communities and local insights work to develop locally appropriate and culturally sensitive communications (Box 3).

The South West regional NHSE&I communications team are working with communications leads from systems across the South West to support localisation of the national communications strategy and support with media interest in the vaccine rollout.

Consistency of messaging across the South West between health professionals and individuals eligible for the vaccine is important. Feedback loops between people inviting members of the community for vaccination and at delivery points will enable the messaging to be refined according to local insights gathered.

Box 3 Case study: local insights work

All systems have undertaken insights work involving engagement with residents from marginalised communities, including local ethnic minority populations. Comms and engagement approaches are being developed driven by the community. Examples include:

BNSSG: Homeless communities, community citizens panel
BSW: Boating community
Devon: Learning disabilities, autism and ethnic minorities
Dorset: Gypsy, Roma and Traveller communities

Data monitoring and analysis

The Joint Committee on Vaccination and Immunisation have highlighted the need to monitor inequalities in uptake, acceptability and outcomes in key underserved groups and across protected characteristics as part of the post-implementation vaccine surveillance strategy.[16]

PHE plan to deliver detailed vaccine uptake analysis, including by key inequality characteristics (e.g. ethnicity, deprivation) and inclusion health groups. The Screening and Immunisations team will share uptake data with analysis of uptake across different population groups for local systems to review. As a team, we can support areas with low uptake which may need bespoke models of delivery.

Conclusion

The rollout of this global mass vaccination of unprecedented scale brings a multitude of challenges. In the South West we have made significant progress in vaccinating some of our most vulnerable groups.

Despite the operational challenges in delivering the programme at pace, we must build on our significant experience of tackling health inequalities in the South West and adopt a systems approach to ensure equitable access to the vaccine, maintaining a focus on our underserved communities at this critical time.

[16] Public Health England COVID-19: vaccine surveillance strategy

Appendix 1 Previous South West approaches to tackling inequality in immunisation uptake

Category	Strategies	Examples from the South West
Strategic	Development of a strategy	Development of South West Measles and Rubella Elimination Strategy project plan (14 projects) aimed at achieving the 95% target and reducing inequalities, pulling together a series of evidence-based projects based on recent national strategies and NICE guidance
	Education and training	Training for children centre staff and health visitor teams (MMR)
	Toolkits	MMR GP good practice guide Festivals measles tool kit Flu resource pack developed for all practitioners working with people with LD, including letters, slide set, videos, leaflets
	Funding	Primary care MMR innovation fund (BNSSSG and DCIOS)

Communications	Translated materials	Development of a Somali leaflet and catch up letter to support parents of children in the Somali community in Bristol who prefer to wait until their children have started speaking before having an MMR vaccination
	Reminders	Year 10 failsafe letter from CHIS to parents of children that had not completed their child imms schedule by the end of year 9
	Use of a trusted health care worker or peer support worker	Health link workers previously worked with Somali community to increase uptake
	Targeted communications	Social media animations and content around flu for people with Learning Disabilities Targeted postcard drops to areas of higher deprivation/lower uptake

Accessibility	Venues and accessibility of clinics	MMR targeted GP visits (BNSSSG and DCIOS) Commissioning of a GP clinic in Inner City/Eastern Bristol to vaccinate babies moving into the area to ensure not lost to follow up (accessible to area of deprivation) Rolled out the offer of flu vaccines to maternity units in addition to GP/pharmacies to increase accessibility as women will almost all attend an acute setting for scans, reducing the need for additional appointments to be made A pilot of a flu clinic pod based at a mosque in Bristol.
	Roving models	Roving teams to support hard-to-reach groups with flu vaccines eg homeless cohorts
	Catch up clinics	Catch-up MMR project for young people
	Opportunistic approaches	Encouraging providers to deliver shingles vaccinations alongside flu vaccinations to maximise on any interventions to increase uptake of flu vaccinations amongst hard to reach groups.

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Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000

www.gov.uk/phe
Twitter: @PHE_uk
www.facebook.com/PublicHealthEngland

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Prepared by: Dr Emma Kain and Dr Jon Roberts
For queries relating to this document, please contact: emma.kain@nhs.net

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