Wakefield CCG

Evaluation of the Wakefield Vaccination Model to Health Inclusion Groups

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FOREWORD BY JO WEBSTER

I am pleased to have been invited to provide the foreword to this report, which presents the collective views of the people who have been at the forefront of ensuring that all of Wakefield's residents have the opportunity to benefit from vaccinations against Covid-19.

The local healthcare system was tasked with the unprecedented, unexpected and enormous task of vaccinating every adult in Wakefield over the period of a few short months. Immediately, we all recognised that we needed to come together to achieve this ambitious goal and I am pleased to see the involvement of so many people and organisations described in this report. From the smallest community group to the largest public sector organisation, the response has been amazing.

The report focuses on the work of the Wakefield Vaccinations Roving Team. As a key project within this wider response, it has relied upon and given support within our wider partnership. Its task has been focused but vital: to take vaccines to people who are not reached by the mass vaccination services and to ensure that no one misses out. It has sought out and vaccinated the most vulnerable people in our District; people who often do not receive their fair share of health services.

They have vaccinated the homeless, the economically peripheral, those with poor literacy and low mental health, people of Black, Asian and Minority Ethnic heritage and people without the means to travel far from home. In doing so, they have ensured that everyone is protected. The current cost of living crisis makes this more important than ever. This report concludes with options for learning from and building on their work as a model for ensuring that our local health services can deliver to everyone, regardless of their circumstances or characteristics.

Most importantly, I wish to acknowledge and appreciate the time given to this evaluation by the 101 people who agreed to be interviewed or take part in a focus group, including 64 of our colleagues across 25 organisations and services. This evaluation has relied on their testimonies and provision of data. It is through our shared efforts that Clearview have been able to produce a report which collates the perceptions of many of those who have contributed to the success of the Roving Team and to the delivery of Covid-19 vaccinations in Wakefield.

Jo Webster
June 2022

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CLEARVIEW

1 INTRODUCTION

This report presents the findings of an evaluation of the Roving Team delivery of Covid-19 vaccines to health inequalities groups, commissioned by the NHS Wakefield Care Commissioning Group (CCG) in partnership with Wakefield Council and conducted by Clearview CIR.

1.1 Background: the Roving Team

The Covid-19 vaccination programme has been the biggest vaccination programme to be implemented and delivered in the history of the NHS. The programme is one of the most effective Covid-19 control measures to protect people from serious illness and death. It has been critical to enabling other control measures to be eased and underpins a return to a form of normality.

NHS Wakefield CCG has had the responsibility for effective place-based delivery and oversight of the Covid-19 vaccination programme. To achieve this, they engaged with many other partners within and beyond the NHS to form a systemic response. This has been managed through the Covid-19 Vaccination Steering Group system partnership and associated task and finish groups.

Preparations for the Wakefield programme delivery began in October 2020, in advance of endorsed Covid-19 vaccination policy and guidance. On the 13 January 2021 the UK COVID-19 vaccine delivery plan was published. The delivery plan posed considerable challenges and strained operational logistics within the context of limited implementation flexibility.

To combat the associated programme complexities and locally identified barriers to vaccination participation amongst health inclusion groups, two stakeholder task and finish groups were established. These developed a multi-faceted outreach model to combat local inequalities and thus achieve maximum participation among the health inclusion groups.

The objectives of the multifaceted outreach model were:

- Achieve engagement from organisations and voluntary groups supporting health inclusion groups and subsequently their service users to build partnerships, trust and confidence in the Covid-19 vaccination programme.
- Equip supporting organisations and voluntary groups with the necessary skills and information to enable informed discussions with service users and community groups.
- To aid informed participation in the vaccine programme, listening to concerns, allying fears and combatting misinformation.
- To mobilise, deploy and coordinate a small multi-disciplinary vaccination team to temporary community-based locations across the Wakefield District (pop-up vaccination clinics.)

The model was designed to address known local barriers and practical considerations, some of these are outlined below:

- The timing, availability, and location of appointments.

- The public's costs associated with vaccination, such as transport and taking time off from work.
- Accessibility of information, including language barriers and the use of digital systems and media to which not everyone has access.
- The ease of physical access where vaccines are offered and accessibility of transport.
- Inaccurate or incomplete NHS records, which can result from patients frequently changing address common among some health inclusion groups including travelling communities, asylum seekers and people who are homeless.
- Vaccine beliefs or perceptions, reduced willingness to seek out or accept a vaccination.
- Complacency about disease prevention and perceived harms.
- Lack of trust in government agencies.

The model comprised a communications and engagement approach, resource distribution, vaccine hesitancy education and training, and pop-up vaccination clinics delivered in community settings by a Roving Team. Together, these outreach activities sought to engage people who would not otherwise come forward for vaccination because they experience significant barriers to accessing mainstream vaccination sites.

The agreed outcomes of the model are:

- Total number of vaccinations administered:
  - Number of first doses.
  - Number of second doses.
  - Number of booster doses.
- Number of pop-up vaccination clinics delivered.
- Number of vaccine hesitancy training sessions delivered.
- Increased confidence in addressing concerns about the programme.
- Increased knowledge to combat misinformation and address the local barriers to participation in the vaccination programme.
- Lessons learned for future way of delivering service for vulnerable groups.
- Positive service user experience.
- Improved perception of services for vulnerable groups.

These outcomes are intended to result from a small number of outputs:

- Enhanced community networks.
- Built stronger and new partnerships between private, voluntary and public sector organisations and groups.

- Engagement with decision makers, educators, trainers, Covid champions, service users, PCNs, existing and new stakeholders.
- Vaccine hesitancy package.

1.2 Evaluation purpose

The purpose of the evaluation is to:

- Inform the design of future outreach models of service delivery to support health inclusion groups known to experience health inequalities, to ensure positive and improved health outcomes for individuals; and,
- Aid decision-makers in shaping future commissioning arrangements for health inclusion groups that sustains partnership working in a way which works best for the population and infrastructure.

1.3 Aims and objectives

The aims of the evaluation are to obtain feedback on the multifaceted outreach model, how it was received by service users, professionals and volunteers incorporating a review of the existing evidence e.g. previous local survey findings and programme delivery data focusing on the following distinct areas:

- **Barriers** – understanding barriers to the group of individuals wanting to take the COVID-19 vaccine and factors of the outreach model which encouraged uptake
- **Demand:** reflections on activities/training to increase uptake of the vaccine and address vaccine confidence, staff training to ensure appropriate skills and competencies
- **Access**: reflections on actions/activities to make the vaccine more easily accessible to people that wanted to have it e.g. flexible booking approaches, appointments and walk-in sessions, transport provision and outreach models, pop-up clinics, surge vaccination events
- **Multiagency Working:** reflections on partnership working and a more co-ordinated approach
- **Legacy** – reflections on how we can take the lessons and apply them to the future work with inclusion health groups across Wakefield NHS, Local Authority, social care and VCS services e.g. inequalities, infrastructure, workforce, partnership and community engagement.

1.4 Methodology

The methodology for the evaluation is largely qualitative, being based around interviews and focus groups. Consultations took place with the following stakeholder cohorts:

- Members of the public from the health inequalities groups the programme targeted
- Frontline staff from a range of organisations involved in delivery of the Roving team's work. These included:
    - Staff from the Roving Team.

    - Third party champions – including voluntary, community and faith sector (VCFS) organisations, with existing links to the target groups/communities who acted as links advocates for the programme
- Key decision makers

Details of the approach for each of these groups is set out on the following pages.

1.4.1 Public

A total of 37 interviews have been undertaken with members of the public to gain information on perceptions of the vaccine, the barriers to its use and the factors which lead people to choose to be vaccinated. These interviews focused on individuals from the health inequalities groups in Wakefield. Most interviews were undertaken at the roving vaccination clinics, with nine taking place outside of the clinics. Each person had either attended a roving clinic or had been invited to do so.

The demographic make-up of this interviewee cohort is shown at Appendix 1. As may be seen, it is biased towards a male response (21:16) and heavily biased towards people under the age of 50 years. A slight majority of respondents are single and a slight majority have a disability. Around one third report a mental health issue and one third a long-term physical condition. Fewer than half describe themselves as White British and there is a good representation of people from the Gypsy Traveller community and those from the middle East and South America. The Christian, Muslim and 'no religion' categories form the majority of the response.

There is, however, a notable absence of people of Pakistani ethnicity and of sexual diversity.

1.4.2 Frontline workers

We interviewed a total of 17 people who may be considered to be frontline workers – people who have directly engaged with those to be vaccinated. Two of these interviewees also fall within the category of 'decision maker' because they attend the main partnership groups. Eight frontline workers are (or were) part of the Roving Team.

Nine interviewees represent organisations who became involved in the Roving Team programme because they have a long-standing track record of engaging people within the health inequalities groups. We refer to these as "third party champions" wherever it is useful to distinguish these organisations' responses from those of the Roving Team. They work within organisations who deliver services to the following groups:

- Asylum seekers and refugees.
- Homeless people.
- People with a very low income.
- Gypsy, Roma and Traveller.
- Geographically peripheral communities.
- Pakistani community.
- Eastern European migrants.
- People living with HIV.

1.4.3 Decision makers

The third group of consultees were key decision makers involved with co-ordination groups. 41 individuals contributed to five focus groups.

An additional six one-to-one interviews have been undertaken with individuals who were unable to attend a focus group or where their contribution to the Roving Team has been particularly significant.

1.5 Desk research

These qualitative methods have been supplemented by a limited amount of desk research. This has included three elements of work:

- An initial review of best practice in November 2021 covering literature which focused on overcoming barriers to vaccination based on studies from the UK.
- Basic analysis of quantitative data provided by the Roving Team and tabulated in the section on achievement.
- A brief literature search and review in April 2022 of reports on lessons learned from vaccinations across the UK.

In general, our approach has been to test the findings from our fieldwork against the literature in order to highlight anything which is anomalous within our research and to identify any potentially absent considerations.

1.6 Report structure

The evaluation aims to obtain feedback on the multifaceted outreach model, how it was received by service users, professionals and volunteers. The remainder of the reports is set out as follows:

- **Section Two:** Provides a narrative description of the Roving Team approach, the target groups and the timeline considered in this evaluation activity.
- **Section Three:** Details the views of respondents on the barriers to uptake of the Covid-19 vaccine.
- **Section Four:** Considers the factors which encourage people to come forward for vaccination and/or address the perceived or real barriers.
- **Section Five:** Details the lessons highlighted as such by consultees.
- **Section Six:** Provides a narrative description of the achievements and legacy of the programme.
- **Section Seven:** Sets out conclusions from the evaluation.

Appendix One: Details the demographic profile of respondents to the public interviews conducted as part of this evaluation.

Appendix Two: Details the third sector organisations engaged in the programme.

2 DESCRIPTION: THE ROVING TEAM

2.1 Introduction

This section sets out a narrative description of the Wakefield response to address the need for vaccinations amongst health inequalities groups. It explains the resourcing of the team, the main timeline and the roles of different partners. The history of the definitions of target groups is detailed, followed by a review of the role of the VCS sector and other exceptional partners.

2.2 The Roving Team

The Roving Team delivers Covid-19 vaccinations in a variety of community settings. These settings are selected in order to meet the needs of main groups experiencing health inequalities in Wakefield. More recently, their work has encompassed geographical communities which have low take up of vaccines. Initially, the Roving Team also delivered vaccines via home visits, although this element is excluded from the scope of this evaluation.

The Roving Team consists of a team of nurses working under a Wakefield CCG Senior Manager on temporary redeployment. The nurses are employed and funded through a variety of NHS sources including the CCG, Primary Care Networks (PCNs) and GP practices. A non-clinical administrator/receptionist is often available to the team. Around this medical delivery function, WDC Public Heath provides staff to welcome the public to the clinic and to encourage people to attend.

The Team is resourced from a number of partners, as shown in the diagram on page 7. Parts of this network of resources are funded from specific funding for the Covid response whilst other resources are drawn from mainstream budgets. In particular, the nurses undertaking the vaccinations were initially sourced via the CCG but were also provided by individual GP practices, PCNs and the NHS Mid Yorkshire Hospitals Trust.

The team and its operations developed in a context within which NHS England had issued a requirement to provide the vaccine to health inequalities groups but had not specified a methodology. The final form of operational delivery is therefore reflective of the specific health inequalities groups targeted at a given time together with the available opportunities in terms of the availability of nursing staff and VCS infrastructure.

Vaccines are supplied nationally and provided to the Roving Team via the PCNs.

2.3 Timeline

October 2020	Planning for vaccination begins in Wakefield
13/1/2021	UK Vaccine Delivery Plan published
Feb 2021	“Vaccine Inequalities Delivery Plan” published for Wakefield. Identified homeless people, Gypsy, Roma Traveller community and Refugees/Asylum Seekers as initial target groups.
Feb 2021	Third party champions recruited

March 2021	Third party champions commence activity
	Roving Team recruited from within Wakefield CCG
	Training programme delivered
	First vaccine delivered

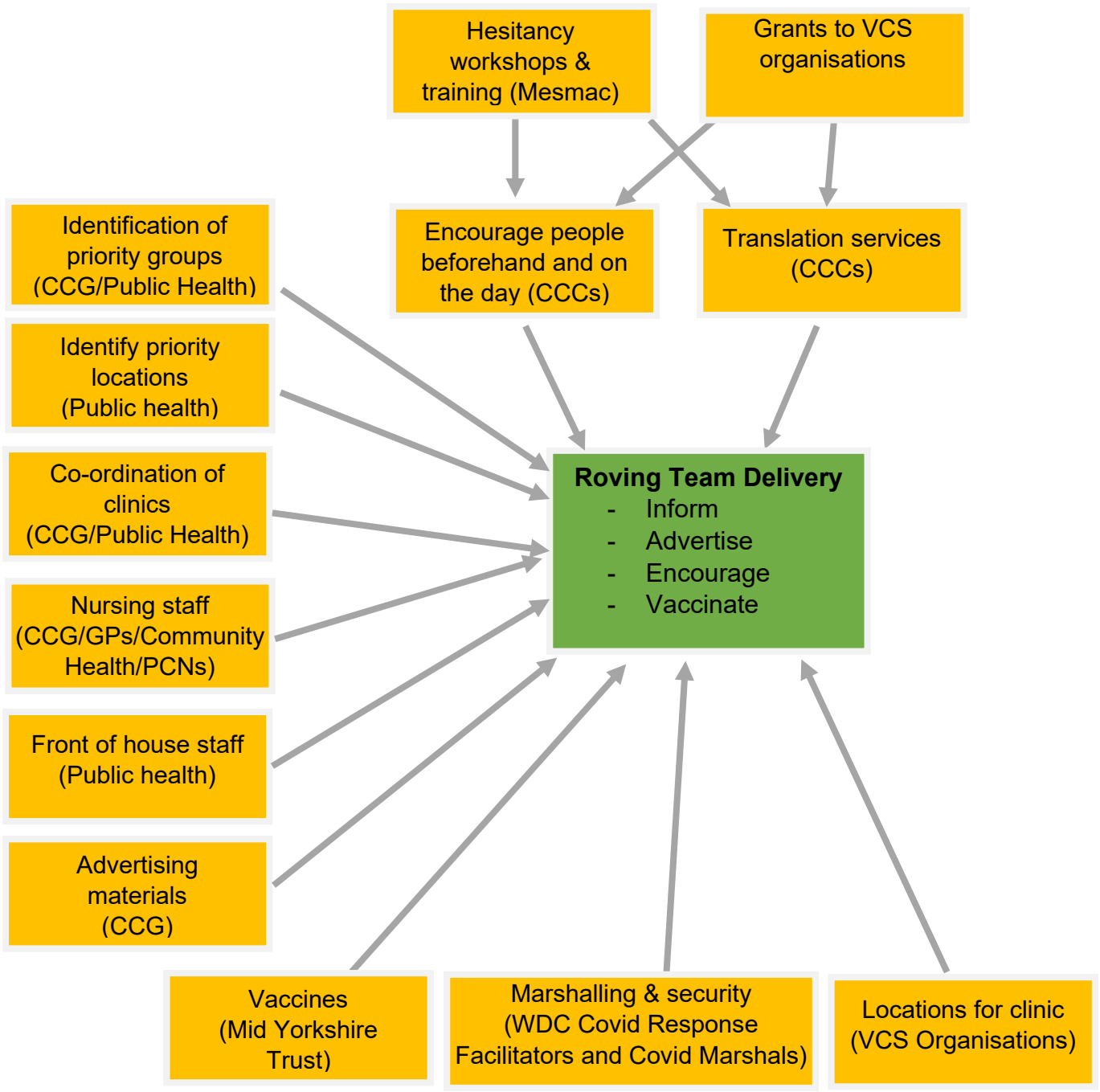

Figure 1: Roving Team Eco-system

2.4 Target groups

The work and remit of the Roving Team has developed over time. Initially, the team targeted five concentrations of clearly vulnerable groups in which previous outbreaks had occurred. These were:

- Initial and contingency accommodation centres for refugees and asylum seekers.
- Homeless hotels used by WDC's Homelessness Support Service
- The Community Awareness Project (CAP), which provide meals and support for people who are destitute. CAP's offer is not restricted to roofless or homeless people, but it is a main source of support for people in the initial target group of single homeless people.

As mainstream vaccination roll out was undertaken, intelligence developed nationally and locally to identify other groups who were falling behind in terms of vaccination rates. The Pakistani, Muslim, Black and Gypsy, Roma and Traveller communities along with carers had been identified as particularly vulnerable groups. Grants had been offered to VCS organisations to encourage vaccination among these and other 'at risk' groups.

There was also an early recognition that the main vaccine delivery sites would be unsuitable for people with a Learning Disability. Working with the SWYT's Learning Disability Team, the Roving Team appropriately furnished and decorated a community setting to welcome people with a range of learning disabilities.

By May 2021 it became apparent that take up among the Pakistani, Muslim, Black and Gypsy, Roma and Traveller communities would benefit from vaccinations being offered in locations which these communities trusted. Therefore, the Roving Team attended three mosques and the main traveller site at Heath. In addition, the vaccine hesitancy package was delivered to people from black majority churches.

Soon thereafter, low take up by Wakefield's 20,000 strong white European community and new arrivals in the UK was identified through scrutiny of shared data. Reaching the white European community presented a unique problem as there was no infrastructure of community groups leaders with which to partner. A social enterprise providing interpretation services was contracted to provide communication of key messages and co-ordination information in European languages.

Towards the end of 2021, it was recognised that vaccination rates were low in peripheral geographical communities. As a result, the Roving Team commenced delivery clinics initially in three of these communities, eventually delivering pop-up clinics in a total of ten community centres, pubs, employers' premises and festivals. (See section 6.2 for more detail.) More recently, the Roving Team has responded to requests to vaccinate at the premises of an employer and been present to vaccinate at a major event.

2.5 Hesitancy package

The 'hesitancy package' referred in Figure 1 includes a number of elements which were designed to increase the propensity of vulnerable people to come forward for vaccination. Critically, the information elements of this package and advanced motivational techniques

were also delivered to multi-agency staff working with the inequality target groups to allow for the training to be cascaded.

The main elements of the package were:

- Workshops for professionals and clinicians. staff working with people from vulnerable groups and those who experience vaccine hesitancy. These covered the use of motivational interviewing techniques and behaviour change methodologies tailored for vaccine hesitant people, with an accompanying suite of resources to aid better conversations about vaccine
- Workshops with hesitant groups in person and online, to generate group conversations and address concerns.
- Individual conversations with the public inside and near to locations where roving clinics occurred.
- Workshops for CQC registered care home staff.

Work to deliver the hesitancy package had the spin off benefit that the roving team gathered the latest myths and conspiracy theories circulating among vulnerable groups, allowing training materials to be promptly updated.

2.6 Role of the VCS sector and exceptional partners

The Voluntary and Community Sector (VCS) and other exceptional partners has been an essential element of the approach through the design, mobilisation and implementation phases. (In this context, “exceptional partners” includes public authorities with little or no previous engagement in the delivery of CCG programmes.) The Roving Team sought out intermediaries in the form of individuals and organisations which were trusted by their target groups. In some cases this is public sector staff supporting specific groups such as homeless families and people with a learning disability. However, it was more often people in the VCS sector and faith organisations. We have, for the purposes of this report, labelled all of these people as *third-party champions.*

These third-party champions have undertaken a range of tasks in support of the vaccination promotion programme. They have been the primary mechanism for stimulating interest and generating demand for the Roving Team’s clinics (with the beneficial side effect of increasing attendance at the mainstream venues for first and subsequent doses. The tasks which they have performed include:

- Distributing leaflets.
- Ensuring that carers are registered as such with their GP practice.
- Translating leaflets.
- Discussing the benefits of vaccination and individual concerns with their clients prior to the day of a clinic and addressing hesitancy.
- Establishing an environment where individuals could talk with each other about their fears and experiences of the vaccine.
- Challenging misinformation through ‘hesitancy training’ and one to one conversations a week prior to the roving clinics.
- Hosting speakers at their meetings.

- Dedicating a Facebook page to vaccination and creating ‘Facebook live’ postings in Eastern European languages to disseminate the latest news and statistics.
- Providing individuals with a written English response to the vaccination questions so that they feel more confident about attending.
- Door knocking on the day of the clinic to remind people to attend and to encourage additional walk-in activity.
- Hosting vaccination clinics in their trusted settings and providing free refreshments.
- Offering a welcoming environment where clients feel safe enough to access the vaccination clinic.
- Providing interpretation services at clinics.

The support to the third-party champions has focused on the Covid Community Champions a weekly online zoom call hosted by the Director of Public health, with guest speakers such as the Clinical Lead for vaccinations. The interactive sessions focused on listening as much as sharing / updating new information. Membership was open to all and many trusted community voices, grant funded and commissioned services used this as the regular place to receive information, ask questions of all partners and provide feedback from their communities. This ran from Sept 2020 until the present, although frequency has reduced over time and it is now monthly.

Appendix 2 summarises the VCS organisations who were involved as Covid Community Champions. A majority of these received one-off grant funding to raise awareness of coronavirus, its effects and the means of controlling infection rates. However, some of the key VCS partners did not receive additional funding for their involvement.

3 BARRIERS

3.1 Introduction

All consultees were asked about barriers to vaccination among the public in general and the health inequalities groups in particular. In the case of the public, this was the barriers which affected themselves and their family. For frontline workers or decision makers, the questions focused on the barriers of which they were aware.

Overall the barriers may be seen as covering a number of dimensions:

- Perceptual barriers.
- Practical barriers.
- Cultural, behavioural and emotional barriers.
- Institutional barriers

3.2 Public perceptions

The main sources of perceptual barriers were reported to be information provided via mainstream and social media. In some cases the information was received directly but in others it was stories from family and friends. For settled people whose families live abroad, this included a significant component of information from their country of origin. The information which did not support vaccination included a mixture of disinformation, conspiracy theories and confusion about the official messages.

People with routine access to foreign media and/or with limited English skills report being confused about what they should believe and that this confusion itself becomes a significant barrier. The most widespread messages to have had an impact on people's willingness to come forward for vaccinations are:

- Mainstream news about blood clots with the Astra Zeneca vaccine.
- Suspicion of the fast turnaround time for creation of the vaccine.
- Suspicion that the vaccine is a means of social control, with many vaccinated and unvaccinated individuals concerned that micro-chips were being injected.
- Claims that the virus does not exist.
- Belief that age and lack of vulnerability mean that vaccination is irrelevant.
- Belief that the virus is a slow poison injected as part of an international conspiracy to reduce population.
- Belief that an interviewee will not qualify for the vaccine.
- The vaccine induces paralysis.
- The vaccine does not work in preventing Covid.
- Belief that the consultee would have to pay for injections.

One third of the public interviewed were concerned about at least one of these messages. Often this concern continued after their first and subsequent vaccinations. Several also noted that they had waited to see how other people reacted to their vaccinations before being willing to come forward themselves.

The conspiracy and misinformation theories have recently received a boost with the abolition of Covid restrictions by government and the absence of Covid stories on the mainstream media. This has led several interviewees to question whether Covid was ever a serious issue or whether it was, instead, the cover story for another policy objective.

3.3 Public experiences

Members of the public also reported a number of other, practical and experiential barriers.

The booking system and availability of appointments outside of the Roving Team was an issue for one in three interviews. Unpacking these barriers identified the following issues:

- Unaware of the booking system and unable to find information.
- Unable to book online because not registered with a GP.
- Poor literacy.
- Poor technical capability.
- No mobile data or Wi-Fi.
- Working shifts and their rote known no more than a week in advance.
- Depression.

Difficulty traveling to the main vaccination centres was an issue for around one in four of those interviewed. The specific responses are listed here but most interviewees with a travel issue experience several of the specific problems listed below and it is the combination of these problems rather than a single problem which provides particular difficulty:

- Lack of a car restricts travel window.
- Multiple buses required.
- Need a taxi to travel.
- Cannot afford the time to travel.
- Poor mobility increases travelling time and is painful.

Fear of needles was another significant barrier, referred to by one in five interviewees.

For four people who have not been vaccinated or will refuse their booster, the loss from coronavirus of a trusted individual who acted as their Covid champion was a major barrier. This respected individual was fully vaccinated but nonetheless died through a coronavirus infection. This specific experience has undermined the positive messages.

Poor literacy in English, whether as a first or other language, was reported as a significant barrier throughout the process. Poor literacy means that word of mouth and oral testimonies on social media are not addressed effectively through mainstream media. In addition, booking becomes difficult and there is a fear of not being understood by NHS staff. Understandably, this is much more intense for those with difficulty in oral English.

Other practical and experiential barriers include:

- Awaiting a call from the GP surgery before attending.
- Religious belief.
- Unhelpful NHS staff when tried to book via GP.

- Reports of friends' actual experiences.
- Childcare responsibilities.
- Memory loss.
- Feeling unwelcome in NHS settings.

Ten individuals reported that they had experienced side effects from an earlier vaccine. Of these, two said that it had been a barrier to subsequent vaccination.

3.4 Frontline workers' on perceptions

Frontline workers reported that many clients were slow in coming forward because they wished to wait and see how others within their peer group fared before electing for vaccination. In one or two cases, the poor experiences of early adopters had increased vaccine hesitancy.

The role of social media and foreign mainstream media was reported as an issue for many migrants. Concerns which the interviewees had been required to address included:

- The vaccine is non-Halal.
- The vaccine is tested on embryos.
- Death from the Covid-19 virus, or survival, is God's will.
- Covid-19 is a myth.
- The vaccine adds to illness.
- The vaccine is a poison or the carrier of a micro-chip.
- Individuals who have died because of the vaccination.
- The potential impact on a foetus or embryo.
- One vaccine is enough.

The speed at which a vaccine was developed and approved fed into these concerns.

Interviewees also referred to the regularly changing government guidance as an issue for their clients. This played into the conspiracy theories and confused people as to what was required of them. The recent lifting of restrictions was widely interpreted as meaning that the pandemic is over and there is no need for people to be vaccinated.

Interviewees reported that, for some of their clients, this misinformation and changing advice builds synergy with an underlying distrust of the establishment. In particular, the changing advice re the Astra Zeneca vaccine and mainstream media emphasis on the prevalence of blood clots had a negative impact among this group. One interviewee commented that this underlying distrust and the changing messages had created an apathetic response to the virus and hence vaccination within their client group.

The need for an environment and space in which people could have their questions answered was commonly viewed as an appropriate response to these issues.

Members of the Roving Team and third-party champions also make reference to people who have believed that they are not entitled to the vaccine due to pregnancy, their nationality, immigration status, age or lack of registration with a GP.

3.5 Frontline workers' experiences

Frontline workers noted that many of the people encountered through the project had no access to a phone and/or mobile data. Others, although having good data, were confused by the booking system. This was reported as being especially the case for those who use English is a second language, those with low IT skills/ technical vocabulary and those whose literacy is limited.

A combination of poverty wages, long and chaotic hours of work, expensive / unavailable public transport and other commitments was reported by several interviewees as making it difficult for many people on low pay to seek vaccination. This group of factors were reported to integrate to form reasons not to travel for vaccination and also made it difficult to book in advance. Related to this, it was reported that people may have difficulty in walking from a car park to a vaccination centre or standing at a bus stop. Geographical peripherality and the limited opening hours of mainstream sessions are related as an additional factor to these travel barriers.

Interviewees working with displaced people noted that chaotic or complex lifestyles made the significantly reduced the viability of any appointment system. Whilst people may agree in good faith to attend, diary management can be poor and more urgent requirements arise at short notice.

Three third-party champions noted that signposting 'hard to reach' people to services outside of their day-to-day experiences does not work. They consider the Roving Team methodology essential if their clients are to seek access to vaccinations and other health enhancing services.

A range of interviewees reported the need to be GP registered before booking as a barrier to vaccination. People did not know who their GP was; they did not receive correspondence from their GP or were not registered with a GP. All three variants led to a reluctance to book into a vaccination centre or to actively seek a roving clinic.

For many of the health inequalities groups, language was a critical barrier. It meant that they were unaware of the NHS' message and that the inaccurate information from overseas was not countered by the messages from within the UK. It was also reported as forming a barrier to requesting a vaccine among those who wished to be vaccinated. These individuals were concerned about giving the wrong answer to a question and thus being refused the vaccine. Others wished to have their questions answered prior to vaccination but did not come forward to the NHS because they would not understand the clinician's responses. This is reported as a reflection of a general exclusion from a positive relationship with primary care providers.

More practically, a number of nurses reported that fear of needles and injections had been a regular concern among those considering vaccination.

A number of barriers relating specifically to one group or another were reported:

- Some religious leaders, often from outside Wakefield, advising against vaccination.
- A general distrust of all health staff among a nationality.
- Individuals with severe disabilities unable to enter clinics.

- For Gypsy Travellers and Russian people, a distrust of all state sponsored provision.
- Transience within the hostel dwelling community leading to difficulties in building relationships and preventing the booking of appointments.
- Suspicion and resistance increased in three locations where clients experienced blood clots soon after vaccination.
- There is an expectation that vaccination will be refused, or not be free, to people with no recourse to public funds.
- For eastern European people, an expectation that the vaccine is not free here because they must pay a charge in their country of origin and/or that access to the vaccine is limited as per their country of origin.
- A preference for the type of vaccine which was most common in an individual's country of origin.
- Many Muslims require separate sessions for men and for women in order to feel comfortable.

Two interviewees raised the issue of people being laid off work as a barrier. Such individuals become invisible during lockdowns and have no need to go out into the world. Thus, they do not keep up to date with the latest Covid news and are not encouraged by friends and families.

The role of mental health as a barrier was noted by three interviewees. This had several dimensions, one of which is to lead to people to a fear of leaving their home which extends to vaccination. Agoraphobia and fear of catching Covid whilst in transit both apply here. Waiting in a room with other people for even 15 minutes also becomes difficult. A second reported dimension is that vaccination myths have a greater impact on those who are anxious or paranoid. A third dimension is that depression and/or substance dependency prevents people making an investment to attend for vaccination. It was also reported that a number of people seen by the Roving Team were confused about their vaccine history and the arrangements for being vaccinated.

It is important to recognise that the balance of these barriers has changed over time. Conspiracy theories come and go. Reports of complications with the Astra Zeneca vaccines reports were a specific instance in time. In comparison, practical difficulties in attending a site continue to present vaccination candidates with issues.

Members of the Roving Team also noted a number of institutional barriers which they had experienced in delivering the clinics. Middle managers had found difficulty gaining access to workplaces and institutional inertia had meant that little progress was made on this goal.

Frontline staff (and decision makers) reported difficulties arising from vaccine supply. Initially, there were issues with managing the vaccine outside of the main delivery centres. There have also been difficulties with the certainty of vaccine supply which have affected the number of clinics and vaccinations that can be delivered. On occasions, proposed and planned roving clinics have had to be delayed during periods of vaccination surges. In both instances, the impact of standing down the roving team has been reported as a cause of inefficiency and reduced equality of access to the vaccine.

3.6 Decision makers' perceptions and experiences

Decision makers identified multiple barriers which reflect the experiences of frontline staff. The consensus was that this correspondence indicated the close working relationships between those responsible for strategic and tactical decision making and those with operational responsibility during the unprecedent challenges (in living memory) of the pandemic. There was however a recognition that the programme played a key role in ensuring the targeted delivery of vaccines to the targeted group by working to overcome those barriers.

There was a shared recognition in discussions that although Wakefield has delivered a very strong booster programme with a corresponding high uptake of a first dose, everybody that needed to be vaccinated needed warming up. That warming up took many forms from a hesitancy conversation to, maybe, translation service, but they presented barriers making it highly unlikely that the target (health inequalities) group are likely to agree to vaccination even if *'…you roved into their community and you were in a room with an 'A Board' outside, they're not going to walk in.*' Therefore, a key barrier was identified as the need for another conversation and/or enabling action before the target (health inequalities) group are ready to agree to vaccination.

In summary, aside from the above, the identified barriers can be broken down into the following broad themes

- Data to target programme activity.
- Cultural and behavioural issues within the target group.
- Workforce issues.
- National priorities versus local need.
- Established organisational/operational priorities.
- Access.
- Funding to deliver the programme.

These additional barriers identified by conversations with decision makers are discussed in more depth below.

3.6.1 Data and intelligence to target programme activity.

A fundamental barrier identified in decision makers' discussions was the role that shared data and intelligence had in the successful delivery of the programme. However, this was not the case from the start of the programme and the issues can be broadly summarised as:

- Wakefield CCG had overview of the numbers and characteristics of the target groups but did not have knowledge or information on the specific location of these groups.
- Wakefield Council had the local intelligence related to the specific locations, behaviours and access to key champions within those communities. This through the grassroots involvement activity of the council's public health and community engagement teams.

- The existing data sharing regulations in place within and between these two partners did not allow this valuable intelligence to be shared, at least initially, which made identification and targeting of the health inequalities groups very difficult.

3.6.2 Cultural and behavioural issues within the target group.

The decision maker cohort identified a series of barriers encountered when establishing and delivering the Roving Team's vaccination programme to the target groups in Wakefield, including:

- The often reported language and cultural issues within communities from ethnic minority background including, amongst other things, a reliance on social media and TV messages from 'home', where there were other issues at play in national policies which are not replicated in the UK.
- Reports of a perceived lack of value in vaccines that were viewed as being given away 'free.'
- The tendency to conform to cultural behavioural norms within close communities.

There was a clear recognition that people with complex issues who do not present to healthcare anyway are very hard to find to deliver vaccines to. Specific issues highlighted included:

- Gaining informed consent to administer a vaccine from individuals facing specific challenges (drunk/drugged)
- A tendency to see a correlation between vaccine reluctance and attitudes to other issues such as mental health in the target groups.

Overall this was identified as a challenge of the novel and the new among communities that traditionally are not engaged with healthcare services or are attitudinally conservative in their approach to new situations. The Covid-19 pandemic and the rapid development of vaccines in response were felt to be front and centre in this classification of 'new and novel.' This led to the additional task of having to do the groundwork with the target communities/groups in order to ensure effective delivery of the vaccine to establish relations and trust.

3.6.3 Workforce issues.

A primary barrier, at least at the commencement of the pandemic, and to some extent during the peaks of evolved around workforce issues. These were broadly identified as

- ***Availability of workforce:***
  The availability of workforce to deliver vaccinations was seen as a key barrier, particularly in the early days of the programme, which put consequential pressure on the system in finding suitably qualified staff. This represents a disconnect from the national messaging which implied that the number of available trained staff was adequate for local demand.

  Decision makers also noted that clinical qualifications were not the only quality required for successful work within a Roving Team. The aptitude to work and make prompt clinical decisions in a complex environment was equally as important.

- ***Workforce availability versus demand:***
  It was reported that Wakefield was not a large enough district to justify having a team roving every day. Therefore there was a constant pressure to 'stand up and then stand down' the team. This was an operational barrier in terms of resourcing the team when shift patterns were not always published in advance.

- ***Surge***
  Barriers were experienced in workforce due to the direction to the programme to 'surge' from early December 2021. The result of this was that for four weeks, the Wakefield vaccination programme went from one delivering a mixture of high volume and quality work around inequalities to just being a numbers game. Wakefield has a finite workforce and due to the required volume of vaccinations concentration was, therefore, on a static site model which is most efficient method under those circumstances, resulting in significant barriers to the Roving Team approach to people requiring additional support.

3.6.4 National priorities versus local need.

There was an identified tension between the appropriate concentration of activity from the national level, which focussed on maximising the number of people vaccinated, against recognised local priorities, summed up by one respondent as follows:

> *"I think from an inequality point of view, we would never potentially deliver the program in the way it was mandated nationally, but obviously we're in COVID response and we had a national mandate to respond."*

Discussions in these areas with decision makers can be summed up as follows:

- ***Focus of the programme and the speed at which it was delivered***
  The vaccine programme's aim was to get as many jabs in as many arms as fast as possible, to put a break on Covid-19 infections. Adopting this approach presented a significant local challenge in recognition of the potential to miss 'big chunks' of the community out.

  The challenge was summed up as

  > *"…how can you change the mindset to move away from doing the low hanging fruit first and then go to the difficult and hard communities to reach?"*

- ***Communications***
  Communications was felt to be a barrier in that Wakefield, along with all other local areas, were very restricted in what could be communicated the general public around vaccinations. All comms was directed from the national level which was both a challenge to overcome and different to how Wakefield would normally work.

- ***The speed of change***
  Due to the speed at which the vaccine response was developed and the emerging nature of the pandemic there was a perception of ever-changing guidance from NHS England via the government. Therefore trying to get on the right path and set guidance when people wanted lots of information was a significant challenge.

3.6.5 Established organisational/operational priorities.

Conversations with decision makers identified barriers around established organisational / operational priorities within partner organisations around two broadly grouped themes:

- The attitudes of healthcare professionals to carers.
- The implications for commissioners of meeting programme targets and the implications that this has for the target group.

These are expanded further below.

- ***The attitude to carers***
  Initially it was identified that, despite being a vulnerable group in their own right, carers were not being 'picked up' by the national vaccination programme when they attended with the person they cared for. The programme identified a barrier in shifting the professional mindset to co-administer the vaccine to the vulnerable patient and their carer that turned up at the same time, not allowing that carer to be turned away.
- ***Target for commissioners at 90/95%***
  in terms of delivering vaccines to target groups, one of the key barriers identified was the targets for achievement required of commissioners. Essentially, targets which do not include all of the population, however unreasonable this may be to set, always tend to exclude those who require additional work to reach.

3.6.6 Access.

Access in a number of forms to the vaccination programme was felt to be a key barrier.

- ***Access: articulate and mobile versus those who aren't***
  It was felt that the initial model worked very well if people requiring vaccination were *'savvy and articulate and able to navigate the online booking system,*

  and you could get in a car and you could take yourself down to the Navigation Walk vaccination centre.' The barrier in this instance was felt to be for people that lacked access to a car, could not easily get from one place to another, or who were not digitally literate.
- ***Access: complex needs***
  coupled with issues of transport and digital access the target groups were identified as facing a more complex set of factors than others; factors which prevented access to the vaccination programme.
- ***Access: White European residents***
  Access to people with poor health outcomes or experienced difficulties in accessing healthcare was generally achieved through pre-existent community infrastructure but that this was not the case for white European residents. This facilitating infrastructure was created through a chance encounter with a single start-up social enterprise which required grant funding to build capacity to diversify its operations and perform the function of a community leader.

3.6.7 Funding to deliver the programme

Money to deliver the programme was identified as a key barrier for future delivery. Funding for the roving team and partnership activity was provided as part of the overall response to the pandemic from central government. Decision makers were clear that, without this funding, achieving the aims of the Roving Team would have been significantly more difficult. In particular, one focus group considered that priority would not have been given to the partnership co-ordination or resources which underpinned the Roving Team and the consequent focus on health inequality groups.

"Our usual target is 90% or 95%, so we never have to focus on the health inequality groups."

3.7 Literature review

A limited number of barriers identified in the literature review did not reveal themselves within our consultations. Nonetheless, it might be expected that the following barriers will have been in play within Wakefield:

- Doubt in the vaccine's effectiveness given that masks and other control measures remained in place for a considerable period of time.
- Belief that having had Covid-19 provides adequate natural immunity.
- Fear that personal data may be shared with enforcement agencies.

3.8 Summary

Barriers identified by consultees covered four dimensions which often interact to create a seemingly complex web to be disentangled:

- Perceptual barriers.
- Practical barriers.
- Cultural, behavioural and emotional barriers.
- Institutional barriers

Perceptual barriers affect the decision making of at least one half of the public who were interviewed including many of those vaccinated. It seems that misinformation and conspiracy theories form a barrier more for the confusion and hesitancy which they cause than because they are believed outright. They are a particular barrier for those with poor literacy in English. In addition, there are groups of socially excluded people who believe that they have no entitlement to a free vaccine or that they will not be welcome in NHS settings. Those born overseas may expect that vaccine availability and access arrangements are standardised with those in their country of origin. They may also be disadvantaged by difficulty in understanding the NHS entry point for vaccination and similar services.

Practical barriers are often closely linked to poverty of time and money but are associated in some cases with depression. They particularly relate to using the online booking system and travel. It is striking that focus groups decision makers rarely emphasised these practical barriers which is in contrast to responses from the public and frontline staff.

Cultural, behavioural and emotional barriers encompass religious beliefs which reject vaccination, the side effects of previous injections, fear of needles and reactions to friends' experiences. Attitudinally conservative communities and those who do not traditionally engage with healthcare providers face additional barriers to attendance unless the settings are designed to address their cultural expectations.

A further cultural barrier to be overcome is that individuals are expected to communicate changes in address etc to their primary care providers. Hard to reach groups, especially those with limited written English skills, often become lost to the provider and so have not received their invitation to be vaccinated.

Complex institutional or bureaucratic barriers included difficulties with the availability of vaccine and absence of a dedicated workforce. The roving programme was postponed at times due to the diversion of resources to the main vaccination sites. Unhelpful data sharing regulations in a context of fragmented data assets was a difficulty in the initial stage. Whilst institutional inertia seems to be minimal, the impact of national directives and ever-changing guidance have been felt by the partnerships. The lack of dedicated continuation funding for the Roving Team is viewed as a significant threat to making the most of its' legacy.

4 ENABLERS

4.1 Introduction

In this section we define 'enablers' as those factors which encourage people to come forward for vaccination and/or address the barriers to vaccination.

4.2 Public perspectives

We were able to enter discussions about the process of making choices with several of the interviewees. From this, it is apparent that most arrive at a roving clinic with, or having overcome barriers to, attendance. However, they balance the perceived risk of the vaccine with the perceived benefits. Only three reported perceiving no barriers to vaccination.

Factors which are commonly reported as important social enablers ***prior to choosing to attend a vaccination clinic*** include:

- A desire to make life safer for other people, usually family or friends.
- Pressure from family and friends.
- They wish to travel and need a 'Covid passport'.

A range of factors were also identified by only one or two individuals:

- Being a risk taker.
- Being medically vulnerable myself.
- A friend received the vaccine with no side effects.
- Received the flu vaccine with no harmful effects.
- Losing a family member to Covid.
- Mainstream media and social reports.
- The helpfulness of a member of NHS staff.
- Positive conversations about the vaccine at their place of work.

In addition, we interviewed several people who had not made a choice to attend a vaccination clinic until they were ***invited to the roving clinic*** by a member of the Roving Team or a trusted organisation. For these people, common factors included:

- Conversations with trusted individuals at the clinic locations, some of whom are accredited Covid Community Champions.
- The approachability and helpfulness of the team.
- They were already at the location for another purpose.
- Being able to see the people, needles etc before they make their decision.
- Being asked by members of the Roving Team.
- Able to take a friend or family member

The role of the "trusted individual" was key for many people in and was the only aspect of the partnership working commented on by the public. Other than for those at the geographically chosen drop-ins, almost all made a positive statement that they arrived at an NHS delivery clinic because of a recommendation by an individual whose opinion they trust. This may take the form of a long conversation over several meetings, attendance at a short event hosted by a 'third party' organisation or a simple suggestion that they would benefit by attending.

The partnership between community organisations and the NHS is visible through this transfer of trust from a community contact partner to the Roving Team.

There are also a number of factors which commonly led to the choice of the roving clinic. These commonly include:

- There is no need to book beforehand.
- Speed of service: no waiting required.
- A convenient location
- Social media chat groups and adverts – notably Whatsapp and Facebook.
- Walk-in allows a person to build up their courage in the morning and go when they are ready.

The requirement for Covid vaccination as a pre-requisite for foreign travel was also mentioned as a motivation to receive the vaccine by younger people who wished to see family.

4.3 Frontline workers' perspectives

The Frontline workers viewed the provision of good quality information (to themselves and the public) as being generally, but not universally, effective in addressing misinformation and myths. However, there was a diversity in their source of this information and the delivery media.

- GPs attending group work sessions.
- Specific hesitancy training sessions.
- Social media updates using Facebook Live to allow for presentations and discussions.
- One to one canvassing.
- PowerPoint presentations.

This diversity was seen as a strength, responding to the different types of people that different communities hold in trust.

There was also diversity in interviewees' views on the best time to provide information sessions. This diversity reflected the characteristics of their communities:

- Asylum seeks and refugees – one week in advance of clinics to allow time for attendees to discuss among themselves and return with follow up questions.
- Eastern European communities – regular updates as new information circulates.
- Homeless people – two days before the clinic.
- Pakistani community – as the vaccine information becomes available.

The partnership between health services and the third-party champions was universally viewed as an important factor in the success of the Roving Team. Third party champions felt valued and gave examples of support they had received. There was a sense of a common aim and they understood the part which they could play in the process. They felt appreciated as a result of their interactions with the Roving Team.

However, third party champions placed greater importance on the longer-term relationships they had made with staff from the CCG and public health and/or the manner of support they

had received in dealing with the Covid pandemic prior to the first vaccinations. The recordings give a clear indication that all the partners had shared aims and built significant trust before being invited to share delivery of the vaccination programme.

Frontline workers ascribe the success of the Roving Team to the role of partnership in providing extensive reach into the most disconnected and hard to reach communities as well as practical support from partners, such as organising rooms. The third-party champions have universally provided a welcoming 'front of house', a transfer of the trust which clients have in them and they have actively recruited their clients. In locations where the clients speak English as a second language, the third-party champions have provided translation services. Some interviewees report that the offer of free food and drinks made by these third parties has attracted additional people for vaccination.

Interviews with third party champions also indicate that they have been able to extend the network of people promoting vaccination among the target community. For example, the manager of a hotel was publicly vaccinated as a demonstration to the vulnerable residents of that hotel. More common is the assistance of peers who have been vaccinated to tell their story of vaccination.

The flexibility of the Roving Team and the individuals therein is also reported as an enabler of success. Interviewees recount examples of vaccinations in car parks where someone is very disabled, visits to hotel rooms to vaccinate someone who is anxious about leaving their room and being prepared to listen to and engage with adamantly anti-vaccination clients. Roving Team staff have been observed to undertake street intercepts and have worked with local shops to increase the breadth of active marketing. Of particular note is that they act on community intelligence to set times, to bespoke the 'sales pitch' and to market sessions.

In terms of practical delivery, interviewees reported that the delivery model for the sessions met people's needs:

- The walk-in model addressed organisational and time commitment barriers.
- The venues were well chosen to effectively reach the target audience.
- Sessions happened where people were already attending or near their homes.
- Social media pre-announcements were clear.
- Support with publicity from GP practices and PCNs.
- Sessions timed appropriately.
- Provision of interpreters for the more common languages and, where an interpreter could not be found, the use of web-based translation apps by the Roving Team.
- Staff cheerful, approachable, initiating conversations.
- Time is available to explain the benefits of vaccination and answer questions.
- Visible willingness to answer queries on other health issues.
- People able to attend in family groups.

Three interviewees noted that returning to the same venues was a helpful strategy as, in some cases, the first sessions attracted a minimal number of early adopters but many more people attended subsequent visits.

Frontline workers also noted family pressure and the introduction of Covid passports as factors which have increased demand. However, this was given minimal significance within this group of interviews.

The third-party champions were asked about their experiences of the training, awareness raising programme and support sessions (as distinct from their ongoing relationships with the health services). Very few specific responses were received and these reflected the parts which an interviewee had found specifically useful. Overall, the third-party champions had felt well-informed via the training, weekly briefings and update emails. They all reported a high degree of confidence that any queries would be answered with a telephone call. One third party champion described this support as assisting their role of engaging, educating and persuading people.

4.4 Decision makers' perspectives

Conversations with decision-makers identified the following enablers to delivery of the vaccine program to the health inequalities groups:

- The national response to the pandemic set the priorities for action which supported the delivery of activity to meet local need.
- The ability of local partners to network and act together.
- A collective will to act rather than identifying reasons not to act.
- Working in partnership to deliver local intelligence to allow targeting of the programme to those most in need.
- Being tasked with a single priority to deliver a programme to break the infection rate cycle in a time of national and international emergency.

Each of these is discussed in turn below.

4.4.1 National priorities naturally supporting local need

Decision makers were clear that a key enabler was the status of Covid vaccination as a national priority and the enactment of emergency legislation by the Secretary of State for Health to allow data sharing between organisations. This allowed analysis at a more granular level than normally occurred, facilitating the identification of appropriate target groups across Wakefield and allowing corresponding deployment of resources.

There was, however, a note of caution sounded in that, with the move from pandemic circumstances and emergency powers to 'business as usual', this data sharing freedom may well disappear.

4.4.2 Local partnership working

The impact of local partnership working was identified as a key enabler in the programme, notably:

- ***Working as a district***
  The Roving Team approach was reported to have been enabled by the adoption of a district wide approach, summed up in the comment:

"…some of our PCN boundaries are more affluent and didn't have the level of variation that others did. So when we did it, we did it on a Wakefield level."

- ***Working with the voluntary and community sector/gaining confidence***
  The consensus was that the programme was significantly enabled by the effective involvement of the voluntary and community sector and recognising the strength they brought in understanding local communities.

  "… I found out loads around what strong community groups we've got…the voluntary and third sector organization, social enterprises to involve those and how valuable that was as well in getting people out there and knowing where to go. So, yeah, massive bonus that was."

- ***Use of non-clinical community members***
  The initial focus of the roving programme was conversation, not going out and starting vaccinating, but instead you would have hesitancy conversations. Decision makers consider that built up with the links with the voluntary and community sector allowed the programme to arm non-clinical people who were respected members of their communities to have honest conversations and therefore improve vaccination uptake. Therefore, this element became purely about health inequalities and allowed people to 'get their heads around' what they were being asked to do. The view was that, prior to Covid, the position of many partners would have been:

  'we don't know how to engage with that population',

  coupled with a very clinical view on the requirements to deliver the programme:

  'we'd have had hours of conversations about how you get medical equipment out there and oh, that's a risk and someone might steal it and all that stuff.'

- ***Interagency working***
  The success of the programme was also reported to rely on the extent to which inter agency working was embedded within delivery, one case cited was between Roving Team delivery and local policing.

  "So one of the things that I think has been quite important recently has been…the involvement of the Police…at the right level. We've had really good senior buy-in to support us…if there's an anti-vax incident

  The Police are very responsive and they always do the nice things like they'll ring up afterwards and say, how is everybody? you don't tend to imagine that as partnership working, do you? But it's actually been really important."

  It was reported that inter-agency working had been embedded because it was essential to pool understanding and staff in order to reach the most disadvantaged and reluctant residents. However, decision makers also identified that the vaccination programme at large and the Roving Team was unusual because it had

been clearly mandated to be 100% inclusive, had received investment to incorporate an infrastructure and was an intentionally developed network.

- ***Breaking down local bureaucracy***
  The success of the programme was cited for its ability to remove, within reason, local bureaucracy. The partnership working was felt to enable and provide permission to do so, although there were constraints from NHS England. The Wakefield partners felt they had the permission to *'…just go ahead and do it…'* as long as it was within legal mechanisms, regulatory frameworks in relation to the vaccines and safe practice. This in turn fostered creativity in responses to the call to *'get vaccines in arms to manage this pandemic.'*

4.4.3 Adopting a "how can we" instead of "we can't" attitude

The programme's partnership response to foster a problem-solving approach was identified as a further enabler. This delivered local innovation in terms of delivering vaccines to the target group. A key element was the recognition of the importance of taking vaccines into community settings rather than asking the target group to come to healthcare setting, which many in this cohort either saw as a barrier or had no pre-existing relationship with. In addition this was also:

- ***Going beyond health professionals' approach***
  The programme adopted a more holistic cultural understanding of health, moving beyond a traditional 'health professional' approach; not just meeting targets. When people just come forward, it is cheaper, easier and more transactional for the target group. The programme changed the balance to recognise that those generally deemed to be 'hard to reach' by health professionals were best served by a model designed with their access needs in mind. The provision of this support means there is now a greater reach into communities previously deemed to be 'hard to reach'.
- ***Public health approach to grass roots involvement***
  The traditional view of delivery is that public health professionals engage with communities and really understand grassroots and what they are telling us. This experience and approach have been key to the success of the programme. It was enhanced by linking to the wider community engagement team within Wakefield Council who had corresponding expertise and significant links with the target communities.

4.4.4 Local intelligence

While data sharing between partners has been identified as a key enabler, the role of local intelligence was also seen to have significant importance as an enabler of the programme's success. Specifically, but not exclusively, this focuses on:

- Identification of patterns: working with data available to the partners the programme was able to identify communities which were seeing a significant increase in infections and target similar communities elsewhere in Wakefield to minimise the likelihood of similar events.

- The strength of the combined local intelligence in Wakefield Council (Public Health and community engagement) coupled with the data held at CCG level provided invaluable insight into the target communities.
- Organisational memory: the importance of the experience and skill of the nurses involved in the programme, their capacity to use clinical discretion and the associated organisational memory around issues such as the limitations of eligibility for the flu program (e.g. vulnerable homeless people and asylum seekers often do not fit the cohort criteria for the vaccine.)

4.4.5 One priority supported by resources and money

An overarching enabler, mentioned in some form or other by all decision makers, was the fact that vaccination was the single most important priority for any health programme during the pandemic, in short:

- It was a single task, getting vaccines into arms, which was given national priority.
- The pause of many other activities meant that resources were freed up that would have otherwise been involved in other endeavours. This included many people from a nursing background who were able to assist in the administering vaccinations.
- Money: put simply the funding was available to make this happen, found at the national level and provided to Wakefield to enable the introduction of the Roving Team approach (among other things.)

4.5 Summary

Responses indicate that the factors which enable more vaccinations to occur in the target groups fall into two main theatres.

On the frontline, social pressures and aspirations can be clearly identified. However, these social factors have previously provided insufficient motivation for people to overcome their perceptual, practical and cultural barriers and thus come forward for vaccination. In most locations, the mobilisation of individuals trusted by the target community has been the critical factor. The whole hearted commitment of these “trusted individuals” commonly relies on the trust that they have in prior relationships with health professionals. The pre-session activities of all parties on the frontline form a persuasive sales eco-system.

Many practical and perceptual objections have been overcome in this way. However, practical solutions have also been important. These have included the flexibility of the service, convenient / trusted locations and speed of service. In addition, a wide range bespoke responses to difficulties faced by specific health inequality groups have deployed.

At the level of planning and co-ordination, the Roving team has been given a clear mission to vaccinate health inequality groups. Guidance based on strong intelligence is available and the partnership structures provide a strong network of communication in both directions. The environment for this is an appropriate delivery geography and support with resources from multiple partners. This inter-agency commitment brings a range of perspectives and skills as required. The prevailing culture is reported as “can do” with an appetite to support innovation.

5 LESSONS LEARNED

5.1 Introduction

The preceding section reports a range of learning which has arisen through the development and then delivery of the Roving Team. This section identifies activities and issues which consultees have highlighted as significant 'learning points' for them or, more often, as important points of re-discovery. The majority were reported by decision makers and, in some cases, echoed by frontline staff.

5.2 Working model

The powerful impact of sharing priorities, plans, best practice and ideas was a common theme. Many consultees were already aware of the assets which each partner could bring to the table, but the Roving Team and the partnership structures which enabled it were a powerful demonstration of the value of bringing these together. Consultees report key ingredients as encompassing the CCG's capability and capacity for clinical co-ordination, the local authority's intelligence and networks together with the commitment and excellence of the individuals.

There was consensus among consultees that this shared planning had led to shared action and to shared responsibility for the success of the Roving Team. Shared planning, activity and ownership is also reported to have permitted other activities which assisted implementation of the Roving Team:

- Effective prioritisation of the communities to be targeted on a weekly basis.
- A single message to the community via many meaningful trusted persons.
- Maintaining the commitment of many partners to facilitating the team with resources and operational venues.
- Transmitting relevant and specific advice from the clinical experts to individual members of the public in a timely manner.

Consultees reported that the Roving Team's effectiveness was due to a 'mission management' delegation or 'practice led' style which is atypical of clinical settings. Focus on the mission of "as many vaccinations as possible" was balanced by appropriate assessment of delivery risk at each session. *"The process was made to work within the Rules."*

It is recognised that this freedom to innovate required specific backing from key individuals within NHS England to set the context in which the whole system would accept this method of working. In comparison, some NHS England guidance arrived late and reduced momentum without clear benefits.

Conversely, one consultee noted that breaking the barriers of service boundaries may not be so simple if the mission is broader and less focused on an individual clinical transaction. This may be a constraint on future development.

Several consultees reported that the governance model behind the Roving Team was clear to them and effective. However, not all consultees considered it to be a clear model and thought that decoding the partnership would be helpful for new people joining the process.

5.3 Reach

A key learning point for some decision makers is that, culturally, much of the NHS receives a target of, e.g. 90% coverage, and that this then mediates planners' view of what is achievable. The Roving Team had demonstrated that it is possible to include the 'hard to reach'. This is a fundamental driver of many consultees' desires to see the Roving Team continue in some form.

Several consultees reported that their appreciation of mechanisms for increasing reach had been augmented, specifically in relation to:

- The significant benefit of intelligence provided by the enhanced data released to local authorities by NHS England.
- The power of the third sector in providing access to communities experiencing health inequalities and in providing advice on how to engage effectively with these communities or individuals.
- The value of training non-clinicians in multiple organisations as conversation leaders within a marketing strategy as opposed to viewing them simply as gatekeepers.
- The impact on timescales of being able to mobilise pre-existent relationships with community facing actors across a range of organisations and settings.
- The expectation among several members of the public that they were not worthy of vaccination and the impact of a friendly face in achieving their access to health care.
- The importance of treating socially excluded people in a setting where they already feel at ease, at a time that suits them and with reduced bureaucratic requirements.

5.4 Practical considerations

A number of practical lessons were also reported as significant learning:

- That there is significant diversity within the "health inequalities" category and each group needs to be addressed with specialist understanding and appreciation.
- The partnership continues to identify new niche markets – specific groups of rough sleepers, specific employers and specific church sites.
- Not all clinical staff will feel comfortable within the fast-developing context of the Roving Team's delivery model.
- More use could have been made of pharmacy sites for vaccinations in the geographical areas of low take up.
- The impact on migrant and socially peripheral communities of assumptions derived from, and messages circulating in, from their country of origin or other international networks. Examples include an assumption that they would be charged for a vaccination and misinformation which is current in their networks.

5.5 Voluntary, community and faith sector organisations

The involvement of non-clinical organisations, particularly those from the voluntary, community and faith sectors (VCFS), provided a major ingredient of success. Their role of reaching communities with low take up in the early vaccination programme was critical. They provided briefings, countered mis-information, acted as role models, encouraged

people to attend and provided ‘safe’ spaces for vaccinations. Interviewees emphasised a number of key lessons for working with the VCFS:

- The key VCFS organisations from the perspective of the Roving Team are those who are most engaged in the lives of the hardest to reach. The quality of past relationships with these organisations has determined the effectiveness of the partnership. Maintaining a readiness to effectively respond to new waves of infection and/or vaccination cycles requires long term investment in these relationships.
- Supporting and working with only one organisation from each target community – in effect one channel of communication – is insufficient to give good coverage of that community. For example, the deaf community was reached by three channels and the homeless community by two. The issue is that people will often align their trust to a specific organisation and not engage another even of the same community. Therefore, messages to only one group working with a client group will not reach people from that client group who relate to a different organisation.
- Many of the most effective VCFS channels – the points at which people are persuaded to be vaccinated - have involved working with organisations who have no paid staff and a wide variety of working cultures. This means that a state sector provider that wants to reach those most in need will need to accept that engagement will require flexibility and, possibly, an acceptance that bureaucratic expectations (e.g. meeting times) may need to be set aside.

5.6 From the literature

The literature also reports a number of relevant lessons from the vaccination programme. In particular, the Timmins and Baird report for the Kings Fund of January 2022 emphasises many of the lessons above concerning the power of data sharing, the value of outreach in plugging gaps in vaccination demographics and the power of joint working. It reports that it is not enough for the NHS just to offer a universal service going forward. It has to offer equal access by continuing to take services to places where the NHS would not normally go.
The report also identifies:

- An appetite to retain the benefits of meaningful and effective joint working.
- The relative contributions of each partner. Leadership, community understanding and community interface from the local authority alongside scale of response from the NHS.
- The potential legacy of volunteers as a resource and the definite legacy of community partners who have seen that their involvement in outreach work can have a wider application to improving health within their community.

The authors distil this learning as follows:

> *“In other words, the combination of these factors is perhaps the key lesson from the roll-out. Far better use of data and mapping data. Improved integration between local government, the voluntary sector and the NHS – including local government’s ability to take NHS services to places they do*

not normally go. With all of that helping build trust and thus uptake. And with important parts of the community wanting to facilitate that."

Timmins N and Baird B. January 2022. The Covid-19 vaccination programme: Trials, tribulations and successes. London. The King's Fund.

6 ACHIEVEMENTS AND THE FUTURE

6.1 Introduction

The consultations and deskwork identified a range of achievements by the Roving Team. Consultees also developed these achievements into observations on organisational factors and priorities for the future operation of the Roving Team. These are detailed in this section.

6.2 Achievements

The achievements of the Roving Team may be divided into four main categories:

- Activity.
- Reach.
- Added value.
- Organisational

Overall, 4,246 vaccines have been given at a total of 135 clinics in 33 venues, an average of 31 vaccines per clinic between 16/3/2021 and 17/3/2022. The following table details the delivery activity of the Roving Team during this period:

Location	No. of sessions	Vaccinations
Hotels for homes people (x2)	9	38
Community Awareness Programme	30	289
Turning Point Needle Exchange	3	10
City of Sanctuary	8	125
Art House	1	4
Mosques (x3)	8	746
Initial accommodation centres (x2)	32	1,107
Homeless persons' accommodation (x2)	4	35
Gypsy traveller Site, Heath	4	59
Bridge IT	1	12
Riverside Housing	2	23
Dominion Housing	2	15
MESMAC	1	8
St Saviours Trust	3	87
Community Kitchen Pontefract	2	34
Learning Disability Clinics	6	113
Wakefield College	2	60

Pontefract New College	3	263
Pop up: South Elmsall	4	427
Pop up: Trinity Medical Centre	1	110
Pop up: Lupset	2	189
Pop up: Upton Arms	1	115
Pop up: Airedale	1	55
Pop up: Warwick	1	6
Pop up: Ossett	1	225
Pop up: Agbrigg Community Centre	1	19
Pop up: Rhubarb Festival	1	36
TK Maxx (Workplace)	1	36
Total	**135**	**4,246**

Decision makers identify that the team have exerted considerable reach into the homeless community, carers, people with learning disabilities and the Muslim communities who would not generally come forward for mainstream programmes. The reach was described as district wide and, "..capturing economies of scale."

Third party champions who intensively support specific groups (e.g. homeless, refugees) considered that reach within these communities had been excellent and better than might have been predicted. Three third party interviewees offered opinions of the difference the Roving Team had made. One estimated that 80% of those attending would not have been vaccinated through the standard routes and two others considered that none of their clients would have been vaccinated without the Roving Team. Those who supported larger cohorts with a walk-in service were content with the number of people they had been able to help via the roving clinics but more likely to stress the numbers of people who had not been reached.

Added value is seen by decision makers as encompassing:

- The delivery of flu vaccines to people who have never previously come forward.
- Treating some urgent conditions.
- Capturing, registering and/or treating many individuals who are not registered with a GP or have no contact with their GP.
- Providing a mechanism for delivering Covid safety messages and information updates to people who do not follow mainstream media, providing a single message through multiple media.
- Providing additional real time intelligence on developments in myths and barriers to mainstream take up.

Organisational achievements reported by decision makers as being associated with the Roving Team include:

- Being the first team in West Yorkshire to become active.
- Flexibility to use a range of resources from many partners.
- Flexibility to increase or decrease activity to reflect other emerging priorities and intelligence.
- Deploying intelligence from databases with clinical expertise and community knowledge in order to effectively target their interventions.
- Increasing GPs' understanding and appreciation of voluntary sector organisations.

6.3 Legacy

Consultees ascribed a range of legacies to the Roving Team and the partnerships which support it.

Most commonly, the partnership process has built new relationships and strengthened existing relationships at an individual level. People have a wider network through which they can access up to date information quickly and more easily. For example, three third party champions noted that they feel comfortable to call members of Public Health and/or the Roving Team for guidance on other health issues that affect their work. Thus they offer a better service to their clients: e.g. guidance on risk assessment for a client who has an infectious disease.

For decision makers and those within the Roving Team, access to timely, high-quality data and the resultant early intelligence and networking had been an important benefit of the partnership working. There is an expressed hope that this will continue, ideally with the continued disposal of some restrictions by NHS England.

Some decision makers foresaw the opportunity to maintain an emphasis on improving health inequalities at a strategic level via the various working groups. The template of partnership structures and relationships was also identified by some as a good basis for prompt mobilisation in the event of future emergencies.

There is some, albeit limited, evidence that networks between the third-party champions have been augmented, enabling people with multiple dimensions of exclusion to receive a more comprehensive package of support.

Third-party champions reported that engagement with individuals from the Roving Team individuals and the client recruitment process had built trust and understanding between their clients and health care services. One reported seeing an increase in the take up of flu vaccinations and children's vaccinations as a result of this connection.

6.4 A basis for future delivery

There is a clear and widespread appetite for the partnership working to continue, recognising the benefits that have flowed from the significant new partnerships created to address the pandemic.

Third sector champions and decision makers identified issues to address if the roving model is to continue for some time. The most significant is the need to build resilience by addressing over-reliance on a few key individuals and to remove uncertainty over the team's future. The initial difficulties in engagement with white European residents and the

limited scope of established community activity among this group illustrate the potential dangers of not maintaining community investment. Conversely, the early and effective engagement of other groups highlights the benefits of continued investment in community infrastructure by Wakefield Council and Wakefield CCG..

More positively, decision makers noted that existing postholders within GP practices, PCNs and the Mid Yorkshire Trust do not have the time to focus on outreach activity and that buying into a bespoke team which can provide a leadership role for a defined set of priorities may thus be an attractive long term funding proposition. This team would need to provide a district wide overview.

Three interviewees noted that relationship with the VCS organisations had commenced in an ad hoc manner but that any more permanent future activity needed to give attention to ongoing funding of key organisations.

The potential of learning from recent research in the field of psychology was also identified in a focus group.

6.5 Potential services and clients

Decision makers and frontline workers identified a number of services which are suitable for delivery of health services for ‘hard to reach’ groups through a methodology which replicates or is derived from that of the Roving Team. In general, the assumption of consultees is that the services would be available on a drop-in basis.

The most frequent suggestion was mental health services for people who do not speak English as a first language and for people whose lifestyle is traumatic. This was variously proposed to include work to enable access to mainstream services, specialist counselling and suicide prevention awareness.

A second suggestion was to deploy the team to routinely deliver influenza vaccinations and/or the full range of vaccinations.

A third common suggestion was for a range of screening and testing sessions available on a ‘drop-in’ basis at the main centres used by the Roving Team. This includes screening for sexually transmitted illnesses, CVD, diabetes, respiratory illnesses and hypertension. One interviewee suggested that this might include assistance with GP registration, an activity which it is understood has been undertaken by staff working with the Roving Team.

Some proposals are very specific; e.g. a wound dressing clinic at the Community Awareness Programme (CAP) or awareness raising sessions explaining healthcare charging to people without access to public funds. Others have a wider applicability across the different communities of need.

A regular series of health education workshops and exercise classes was recommended for two of the locations along a model of wellbeing coffee mornings.

One interviewee suggested that the next stage should be comprehensive support for an exercise and nutrition programme led by the NHS.

Three interviewees identified interventions outside of the NHS' remit which would improve people's health and could usefully be available alongside the Roving Team during workshops. These were IT sessions, domestic violence advice and benefits advice.

The frontline workers also perceived a continuing need to vaccinate for Covid-19 in community settings. There was also a degree of support among the staff team for delivering clinics in large workplaces and peripheral communities such as Knottingley.

Interviews with the public also asked for examples of specific demand for NHS services to be delivered at the location where they received their vaccine. For the most part, we interviewed people with little knowledge about the healthcare system or who were content to access services through their GP. Their most common suggestions were dentistry services, GP surgeries and diabetes clinics. Other suggestions included those identified above and optician services, post-natal services, dementia clinics, ICT classes, STI clinics, exercise classes and advice on the use of self-test equipment.

One of our visits to the CAP coincided with attendance by staff from Spectrum CIC who performed a community triage function. We observed a steady flow of people using this service for recent and long-standing injuries and conditions.

6.6 Summary

Overall, 4,246 vaccines have been given at a total of 135 clinics in 33 venues, an average of 31 vaccines per clinic between 16/3/2021 and 17/3/2022. Consultees universally reported the reach of the team into the target communities as being very good. Third party champions estimate that 80% of those vaccinated by the team would never have been vaccinated without the Roving Team's attendance. Flexibility and responsiveness were seen as key characteristics in the Roving Team's success.

The partnerships surrounding the Roving Team are seen as a key legacy. This provides a model for future responses to emergencies and increases the effectiveness of the agencies engaged in the work. The Roving Team itself provides a model for future work with groups and communities which are the least likely to benefit from healthcare. A legacy of improved trust of the healthcare services by marginalised people and the related anchor organisations is also reported.

The continuation of a Roving Team is favoured by the consultees, although this may be easier wished than attained. One suggested future is to retain the Roving Team methodology and partnerships as a shadow organisation to be re-activated for emergencies. A second is to maintain the Roving Team intact to cover vaccinations for flu and future Covid outbreaks. A third suggestion is to retain and wider the remit of the team and partnerships to cover a range of health protection and prevention services which are to be delivered to severely disadvantaged people and communities.

7 CONCLUSIONS

7.1 Introduction

This section outlines conclusions in respect of the key lines of enquiry outlined in the Introduction. It then goes on to bring together the findings covering a number of issues which will influence the future of the Roving Team and its associated partnership groups. Finally, the competing paradigms for the future of a Roving Team are discussed.

7.2 Delivering outputs

The qualitative findings strongly indicate that there has been a strengthening of networks between health providers, health strategists and community organisations. These ***enhanced community networks*** have resulted in increased vaccination rates and ensured that the most disadvantaged communities in Wakefield have had a fair and realistic chance of receiving the Covid vaccine.

A clear consensus exists that the process of addressing health inequalities groups has built ***new and stronger partnerships*** between NHS agencies and organisations in the public and voluntary sector. These partnerships have provided enhanced intelligence and reach into disadvantaged communities. Strong ***engagement with decision makers, Covid champions, service users, PCNs and other stakeholders*** is suggested by the consultations at the level of delivery of vaccination sessions and in preparing members of the target group for vaccination.

The ***vaccine hesitancy package*** has been well received. The range of potential communication and learning methods appear to have met the needs of all third-sector champions. It is difficult to judge the importance of the training as a preparation for the Roving Team in early 2021: the timing of the evaluation means that any importance it had was left behind by more recent events.

7.3 Delivering outcomes

4,246 vaccines have been given at a total of ***135 clinics*** in 33 venues, an average of 31 vaccines per clinic between 16/3/2021 and 17/3/2022.

Those interviews expressed significantly ***increased confidence in addressing concerns about the vaccines*** with people from a wide range of target groups. This confidence arises in part from the hesitancy package and in part from experience in holding conversations with the public. This is founded in ***increased knowledge to combat misinformation***.

Decision makers have benefitted from the network's ability to provide information on how to engage and find the developing range of target groups. Combined with the permissive sharing of data between public institutions, this has provided a powerful tool for planning clinics, engaging potential recipients and ***addressing specific local and community barriers***.

The range of ***lessons learned*** for future delivery of services to vulnerable groups are discussed in detail in sections 4 and 5. The implications of this learning are considered below.

Interviews with the public revealed a uniform ***satisfaction*** with the Roving Team as a concept and as a workforce. The enthusiasm and welcoming attitude of staff within the clinics was notable during *ad hoc* observations. Third party champions provided occasional testaments of ***improved perceptions of NHS services*** by their client community.

7.4 Reflections on the evaluation objectives

Sections 2 and 3 detail the understanding of consultees concerning barriers, demand enablers and actions to increase access. Very few individuals related a single barrier and it may be assumed that a ***multi-layered cocktail of barriers*** is experienced by many people. It may be postulated that people experiencing very few barriers will readily overcome those barriers and attend at a mainstream vaccination centre. In comparison, someone experiencing a range of perceptual, practical and cultural barriers or particularly severe practical difficulties will require a roving response.

There appear to be three key ***enablers of demand***. The first is the social value which people place on 'doing their bit' for their friends, family and/or society. The second is interventions from trusted individuals (whether this be friends, family or a supportive worker) to encourage vaccination.

The third is the removal of practical and emotional/cultural barriers around place, timing and system design – what may be described as ***access***. The roving clinics are, by their nature, of particular benefit to people who do not attend mainstream centres because they lack the money, time and control over working patterns. The choice of partner organisations for delivery of the clinic *and the preparatory work* with the specific target group are the critical factor in reaching socially excluded groups.

The ***multi-agency working*** has clearly offered a co-ordinated approach and partners feel that they are appropriately involved. The approach has provided effective targeting, resources the Roving Team and provided a high degree of reach to the most marginalised residents of Wakefield. The structured groups have kept people feeling involved in the work of the vaccination system at large and provided a means for accelerated problem solving.

The partnerships surrounding the Roving Team are seen as a key ***legacy***. The structure of partnership groups provides a viable and effective template for addressing future health emergencies and/or health campaigns and ensuring that marginalised people and communities are included in these initiatives. Whilst modifications will be required to accommodate the new Integrated Care Systems (ICS) the scale of change need not undermine the template. The Roving Team itself provides a model for effective future work with groups and communities which are the least likely to benefit from healthcare. A legacy of improved trust of the healthcare services by marginalised people and the related anchors is also reported. Addressing barriers

7.5 Strengths and challenges

The Roving model demonstrates a number of strengths which and future work by the Roving Team should seek to maintain and replicate. We present these in an order which reflects a flow of implementation from strategic decision to prioritise vaccination to work on the ground.

Key strengths include:

- The team's mission has the visible support of NHS England.
- The formal partnership structures provide for the sharing of intelligence and learning from a wide range of competent partners. They demonstrate the commitment of senior decision makers to those involved in frontline delivery and foster a learning culture.
- Shared responsibility for the success of the Roving Team promotes prioritisation of work to address health inequalities in the take up of the vaccine.
- The informal partnerships and trust with a network of frontline partners is an essential ingredient to providing intelligence and reach into peripheral communities and groups of marginalised people. Previous relationships with frontline partners were essential to obtaining their early commitment to action.
- The key synergy between the data held by the CCG and the local intelligence into the target communities held by Wakefield Council (Public Health and Community Engagement) which showed best advantage when the data picked up infection spikes in a geographical target community in one neighbourhood and the magic synergy allowed the partners to target similar communities elsewhere in Wakefield to prevent similar infection spikes.
- The Roving Team have been delegated the task of ensuring that vaccinations are accessible for everyone through a 'practice led' approach utilising a form of mission delegation. The core requirements for this level of delegation have been met: clear mission definition; clear parameters of delegation; clear quality requirements; experienced and competent leadership on the ground staff able and expedited communication to both the project executive and support organisations.
- Roving clinics are in appropriate locations and the range of attached support services are appropriate to the regular attendees at each location.
- The staff employed by the Roving Team are experienced in both the tasks of their post and in working with marginalised people. Researchers observed them going 'above and beyond' to make people feel welcome, to answer questions and their enthusiasm increased the numbers of vaccinations.
- The Roving Team operate to a simple, effective sales message which is shared by the partners on the frontline.

Challenges:

- Whilst funding for vaccinations continues, NHS England is promoting a 'business as usual' priority, potentially reducing the focus on both health inequalities and vaccinations and thus depleting the partnership of attention and resources. Whilst most programmes returning to a pre-Covid configuration for the majority, resources aimed at focusing on the excluded are at risk of being lost unlikely to be maintained. The reality of this challenge may be seen in the postponement of roving clinics in favour of operations at the main vaccination centres during a period of vaccination 'surge'.

- Lack of continuation funding now “Covid’s over” – the success of the Wakefield Roving model has drawn on funding dedicated to Covid mitigation (e.g. grants to third sector organisations). It relies for operation on a bank of resources across a wide range of partners and the goodwill of individual frontline staff. The loss of any one of these resources will significantly impact delivery.
- Lack of ‘war footing’ going forward – the data sharing was enabled by the Secretary of State’s enactment of emergency powers. With this removed the partners are likely to fall back on traditional ‘play it safe’ approaches to data sharing and thus this essential mechanism for underpinning shared prioritisation may be lost.
- The initial commitment of partners to the thinking, design and development process reflected this ‘war footing’. Will interest in the Roving Team’s work wane now that Covid officially under control and the team is moving into a consolidation phase? There is a particular risk that momentum in engaging health inequalities groups will be lost or even, in the case of white Europeans, reverse with consequences for future health initiatives include vaccinations.
- The development from CCG to ICS means that the Wakefield roving model will be one of five competing paradigms. This represents a significant medium-term threat.
- Staff commitment to the Roving Team is mediated by a range of agencies and it is a relatively small team. There is thus a potentially significant loss of knowledge, know-how and connectivity if any one member of the team departs.

7.6 The future business environment

It is apparent from the foregoing that the success of the Roving Team arises from the environment in which it operates as much as the excellence of the operation on the ground. Maintaining a Roving team beyond March 2023 first requires action to foster and achieve the necessary environment.

A ***clear rationale*** needs to be promoted. Consultations suggest that traction can be achieved locally through the expression of the following:

- Health inequalities are health priorities; and,
- People with unequal access to health knowledge and services tend, in the long run, to have a greater call on NHS resources.
- The Roving Team has demonstrated an effective method for ensuring that people with unequal access to health knowledge and services are able to access those assets.
- The additional short-term costs of the Roving Team will, most likely, lead to long-term savings.

It must be acknowledged that there are significant challenges in turning a shared rationale into resources for a Roving Team. Many are discussed above but there is an additional systemic issue in that the resources which appear most appropriate for a Roving Team are often held by services which will not experience the long-term benefits.

There is a requirement for a ***clear and simple mission*** for the Roving Team. This mission needs to be capable of being applied to an evolving suite of services. Consultees made the

point that health emergencies and campaigns are likely to be endemic over the forthcoming years. Therefore, a suitable mission may be:

> *Take the necessary action to bring health campaigns to marginalised people who are shown by current intelligence to be unlikely to benefit from standard provision.*

The Roving Team would thus be the spearhead of health delivery to these communities, directly providing services and, in doing so, opening up access to mainstream services through increased trust of healthcare professionals, increased knowledge and socialising marginalised people into seeking health outcomes.

The ***partnership structures*** are a necessary resource for a Roving Team. The frequency of meetings will depend on the amount and complexity of the work required of these bodies. However, it is essential that new individuals and organisations are effectively inducted into these teams so that the Wakefield health eco-system is equipped with the networks, trust and intelligence to respond to future challenges. It will also be beneficial to document the network of third-party champions and to confirm a funding infrastructure to ensure they have the capacity for continued involvement in health initiatives.

Decisions are required to provide ***responsibility for the long-term*** co-ordination of the Roving Team and partnerships together with the level commitment to resourcing it. Five areas of responsibility may be divided:

1. For the whole roving model.
2. Curating learning.
3. Co-ordination of individual networks and partnerships.
4. Co-ordination / management of, and first point of contact for, the Roving Team.
5. Relationships with third-party champions.

The specific form that these responsibilities will take will depend on the preferred level of delivery activity.

7.7 Options for future delivery

The partnership has a number of options for delivery going forward. Leaving aside the ‘do nothing’ option, four discreet paradigms for the future of roving delivery have been discussed by consultees.

Continuing with the current practice will likely lead to the slow withering of the Roving Team and associated partnerships as resources are withdrawn and bank staff move on. Any new health emergency will need to rebuild the partnership structure and re-assemble a delivery team.

The least resource intensive option is to develop a ***team in waiting.*** This would entail the long-term commitment to employing individuals who action the responsibilities identified in section 7.6. Each responsibility may be included within a wider role remit and the partnership structures meet on a long cycle or *ad hoc* basis. These staff will then prioritise roving work whenever a new health emergency is identified.

A ***roving vaccination service*** provides a third option. This model could work as a permanent team who rove to provide different vaccinations across the seasons or be activated only for Covid and flu vaccinations in the winter. It would require permanent central staffing and partnership structures and could operate with dedicated staff or bank staff.

A more ambitious ***roving health service*** would involve a dedicated team of staff working with marginalised groups on a rolling programme of specific health awareness campaigns, delivering specific health interventions and undertaking action research with the most marginalised communities. The possible services for delivery are identified in section 6.5.

Appendix 1: Interviews with the Public – Equal Opportunities Profile

Table 1: Age

Age group (years)	Nos
18-29	10
30-39	11
40-44	5
45-49	5
50-54	1
55-59	1
60-64	1
65-59	1
70-74	0
75-79	0
80+	1
Prefer not to say	1
Total	**37**

Table 2: Gender

Gender at birth	Nos
Male	21
Female	16
Other	0
Prefer not to say	0
	37

Table 3: Does gender identity match gender at birth

	Nos
Yes	36
No	0
Prefer not to say	1
	37

Table 4: Marital status

Status	Nos
Single	18
Cohabiting	8
Married	7
In a civil partnership	0
Separated	2
Divorced or civil partnership dissolved	1
Widowed or surviving partner	1
Total	37

Table 5: Pregnant / recently pregnant

Gender at birth	Nos
Yes	1
No	34
Prefer not to say	0
Not applicable	2
	37

Table 6: Disability, long term illness or health condition or illness

	Nos
Yes	19
No	17
Prefer not to say	1
	37

CLEARVIEW

Table 7: Type of disability, long term illness or condition

Age group (years)	Nos
A long-standing illness or health condition (e.g., cancer, HIV, diabetes, chronic heart disease, or epilepsy)	11
A mental health difficulty (e.g., depression, schizophrenia, or anxiety disorder)	12
A physical impairment or mobility issues (e.g., difficulty using your arms or using a wheelchair or crutches)	3
A social / communication impairment (e.g., a speech and language impairment or Asperger's syndrome/other autistic spectrum disorder)	2
A specific learning difficulty (e.g., dyslexia, dyspraxia, or AD(H)D)	0
Blind or have a visual impairment uncorrected by glasses	0
Deaf or have a hearing impairment	0
An impairment, health condition or learning difference that is not listed above	1
Prefer not to say	0
Total	**37**

Table 8: Care responsibilities

Age group (years)	Nos
None	15
Primary carer of a child or children (under 2 years)	4
Primary carer of a child or children (between 2 and 18 years)	8
Primary carer of a disabled child or children	1
Primary carer or assistant for a disabled adult (18 years and over)	2
Primary carer or assistant for an older person or people (65 years and over)	1
Secondary carer (another person carries out main caring role)	0
Prefer not to say	7
Total	**37**

Table 9: Service in the armed forces

Age group (years)	Yes.	No
Are you currently serving in the UK Armed Forces (this includes reservists or part-time service)?	0	37
Have you ever served in the UK Armed Forces?	0	37
Are you a member of a current or former serviceman or woman's immediate family / household?	0	37
Total		

Table 10: Ethnicity

Age group (years)	Nos
Bangladeshi	1
Chinese	0
Indian	1
Pakistani	0
African	0
Caribbean	0
Gypsy or traveller	6
Mixed Race: Black & White	0
Mixed race: Asian & White	0
British	13
Irish	1
European	2
Rather not say	0
Middle Eastern	8
South American	5
Total	**37**

Table 11: Religion

Gender at birth	Nos
No religion	11
Christianity	11
Buddhist	0
Hindu	1
Jewish	0
Muslim	9
Sikh	0
Prefer not to say	5
Other religion	0
Total	**37**

Table 12: Sexual orientation

Age group (years)	Nos
Heterosexual or straight	27
Gay man	0
Gay woman or lesbian	0
Bisexual	0
Asexual	0
Prefer not to say	10
Other	0
Total	**37**

Table 13: Postcode

Postcode	Nos
S72	2
WF1	18
WF2	9
WF3	1
WF4	4
WF9	3
Total	**37**

Appendix 2: Third Sector bodies

Recipients of Ministry of Housing, Communities and Local Government (MHCLG) grants

Bilal Community Association

Deaf and Hard of Hearing Support Services

Deaf ex-Mainstreamers

Eastmoor Community Project

Featherstone Rovers Foundation

Hawaa Appeal

Kidz Aware

MJ Languages

Next Generation

Nigerian Community Wakefield

Oasis Christian Church Centre

Spectrum People

Wakefield Trinity Foundation

Yorkshire Mesmac

Young People's Empowerment Project

Other third sector bodies engaged in the Roving Clinics

Carers Wakefield and District

Community Awareness Programme

Leeds Gate

Swafia Mosque

Wakefield City of Sanctuary