

Childhood Immunisation Strengths and Needs Assessment (CHISANA)

January 2024

In partnership with Southampton Place ICB



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Glossary of terms

| Term/Acronym | Definition |
|--|---|
| The Child Health Information Service (CHIS) | The primary objective of CHIS is to ensure standardised and accurate data and information to support the commissioning and delivery of child health services. |
| “COVER” Cover of Vaccination Evaluated Rapidly Data | <u>Cover of Vaccination Evaluated Rapidly : (COVER) programme</u> |
| Department for Health and Social Care (DHSC) | Government department responsible for government policy on health and social care matters in England. It oversees the National Health Service NHS and led by the Secretary of State for Health and Social Care. |
| Did Not Attend (DNA) | When a patient misses their appointment, it is referred to as a 'Did Not Attend' (DNA) |
| Herd or Population Immunity | Herd immunity occurs when the majority of a population develops immunity against a contagious disease either through vaccination or due to a previous infection. This significantly reduces the likeliness of disease transmission from one person to another |
| Joint Committee on Vaccination and Immunisation (JCVI) | Provides independent vaccination policy advice to DHSC. |
| HIOW | Hampshire and Isle of Wight. |
| Immunity | Immunity is the ability of the human body to protect itself from infectious disease |
| Improving Immunisation Uptake Team Initiative (IIUT) | A specialist team that works closely with and is part of, SCW's Child Health Information Services (CHIS). The IIUT are focused on reducing variation in immunisations and increasing uptake rates in children aged 0 – 5 years. |
| Integrated Care Board (ICB) | Statutory bodies that are responsible for planning and funding most NHS services in the area |
| National Health Service England (NHSE) | NHS England is an independent non-departmental public body, responsible for providing national leadership and direction for NHS organisations in England. |
| National Audit Office (NAO) | The National Audit Office is an independent Parliamentary body in the United Kingdom which is responsible for auditing central government departments, government agencies and non-departmental public bodies. |
| National Institute for Health and Care Excellence (NICE) | The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care. |

Glossary of terms

| Term/Acronym | Definition |
|--|--|
| Quality and Outcomes Framework (QOF) | Sets out how GP's are contracted & remunerated for providing good quality care to their patients. |
| Screening and Immunisation Team (SIT) | Embedded within regional NHS teams and provide specialist support and advice. |
| Strategic Immunisations Oversight Group (SIOG) | Provides oversight and governance for delivery of vaccination delivery. Chaired by NHSE. |
| The Green Book | The Green Book has the latest information on vaccines and vaccination procedures, for vaccine preventable infectious diseases in the UK. |
| Vaccine | Vaccines teach your immune system how to create antibodies that protect you from diseases. |
| Was Not Brought (WNB) | “Was Not Brought” (WNB) replaces the phrase “Did Not Attend” for children, in order to protect babies and young people who are not brought to appointments when an adult does not take them resulting in possible medical neglect |
| World Health Organisation (WHO) | The World Health Organization (WHO) is a specialized agency of the United Nations responsible for international public health. |
| United Kingdom Health Security Agency (UKHSA) | A government agency in the United Kingdom, responsible since April 2021 for England-wide public health protection and infectious disease capability and replacing Public Health England. It is an executive agency of the Department of Health and Social Care (DHSC). |
| Uptake | Vaccine uptake or vaccination rate: the number of people vaccinated with a certain dose of the vaccine in a certain time period. |

DPH foreword



Debbie Chase
Director of Public Health

Why are childhood immunisations important?

Around 4-5 million deaths are prevented globally each year through immunisation programmes making it one of the most **straightforward, successful** and **cost-effective** public health interventions.

Children that are immunised are protected from infectious diseases which can cause serious illness or disability and, in some cases, be fatal. **Maintaining high coverage rates is extremely important** to help avoid outbreaks of vaccine-preventable diseases, avoid increasing numbers of patients requiring health services and to reduce mortality and morbidity. Vaccines also protect our economy and our public services from the disruption and economic loss of an outbreak or pandemic, as well as the discomfort and distress borne by young people and families affected by an illness. Furthermore, vaccinations will also help reduce use of antibiotics and the growing issue of antimicrobial resistance. So, **it is in everyone's interest to ensure that vaccine preventable diseases are kept at bay.**

Globally childhood vaccination programmes have been a huge success. However, high immunisation uptake is required to protect as many of the eligible population as possible. **For highly infectious diseases such as measles, The World Health Organisation recommends an uptake of 95% or greater for herd or population level immunity** ensuring those that can't be vaccinated (for example children under 1) are protected by those around them. It is concerning that uptake in childhood immunisations in Southampton and England has been steadily decreasing for *some time*. This decline started prior to the COVID-19 pandemic. Whilst higher than the national average Southampton rates for 2022/23 were 90% for MMR at one year and 86% for two doses of MMR at 5 years.

This comprehensive Childhood Immunisation Strengths and Needs Assessment (CHISANA) seeks to understand **why pre-school immunisation uptake is declining and importantly, consider what practical and immediate action can be taken to address the issues that may be contributing to this.** It highlights the excellent work that is already being undertaken to commission and deliver immunisations in Southampton. It also highlights **that it is not possible to reliably link the decline in uptake to any one single issue or address it with any one intervention.** Many of the themes and recommendations put forward in this assessment have been previously identified in studies and reports locally and nationally over the last 10-15 years. **We know what we need to do.** Achieving them will only be possible by building further on the excellent work across the entire system, and a renewed commitment to take even greater steps to address inequalities.

There are multiple opportunities to help positively influence uptake of childhood immunisations from before a child is born right up to when they begin school. From midwives to early years settings, health colleagues and community leaders – we must all play our part to protect children and prevent outbreaks. Together we can make this happen and give our children the best chances for a healthy future.

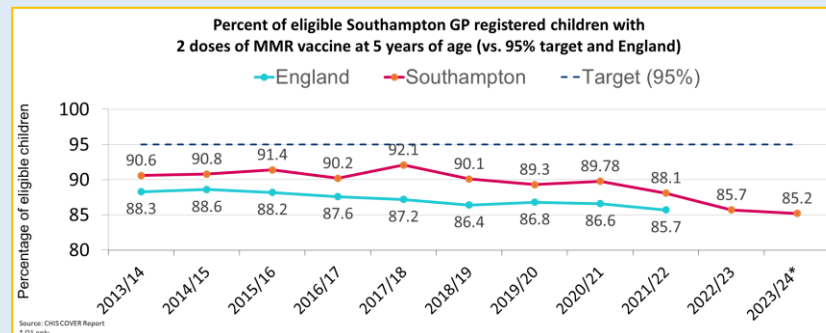
Context and Introduction



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Infection and Immunisation over time – measles and MMR as an example

1988
Introduction of measles, mumps and rubella (MMR) vaccine Oct 1988. Uptake levels in excess of 90%, measles transmission substantially reduced. Notifications of measles fell progressively to extremely low levels. Children in the UK no longer exposed to measles infection. If they had **not** been immunised, they **remained susceptible to an older age**.



2016/17
The UK achieved the WHO 95% target (first dose in 5-year-olds) for the first time and measles was considered eliminated in the UK, meaning transmission had stopped, but by 2018 it was spreading once more, and the UK lost its measles elimination status.

Vaccination Uptake Improves

1998 ⚠️
Wakefield Report

2020 ⚠️
COVID-19 Pandemic

2023 ⚠️
Outbreaks of measles in UK

1980's 1990's 2000's 2010's 2020's

Vaccination Uptake Declines

1993/94
Measles epidemic led to 138 teenagers being admitted to one hospital. A vaccination campaign was implemented in November 1994 and over 8 million children aged between 5 and 16 years were immunised with Measles & Rubella (MR) vaccine. A two-dose measles schedule was introduced in October 1996.

1998
A now discredited report linking MMR to autism resulted in national vaccine coverage dropping below 80% for one dose of MMR due to widespread concerns.

2012/13
The number of reported measles cases once again increased despite high levels being achieved in two-year-olds in England. This was thought to be due to the high numbers of under immunisation in the 10-16 years olds that missed out in the late 1990's early 2000's.

2018/19
Rates start to decline. UK loses measles elimination status.

2023
Post pandemic, vaccine uptake rates for routine childhood programmes have continued to fall globally. Coverage for the measles, mumps and rubella (MMR) vaccination programme in the UK has also fallen to the lowest level in a decade.

Measles is a highly contagious disease caused by a virus which usually results in a high fever and rash and can lead to serious disability, infections or death. Accelerated immunisation activities have had a major impact on reducing measles deaths, but **we have recently seen outbreaks in the UK** due to the falling level of population immunity. Uptake for the first dose of the MMR vaccine in children aged 2 years in England is **85.6%**, and uptake of 2 MMR doses at age 5 years is 85.5%. This is **below the 95% target set by the World Health Organization (WHO)** as necessary to achieve and maintain elimination. "Measles activity is picking up globally with outbreaks affecting many parts of Africa and some of South East Asia; WHO has warned that **a resurgence of measles is now an imminent threat, particularly** due to the fall in vaccination rates during the COVID-19 pandemic" (UKHSA February 2022).

Laboratory confirmed cases of measles, rubella and mumps in England: January to March 2023 - GOV.UK (www.gov.uk)

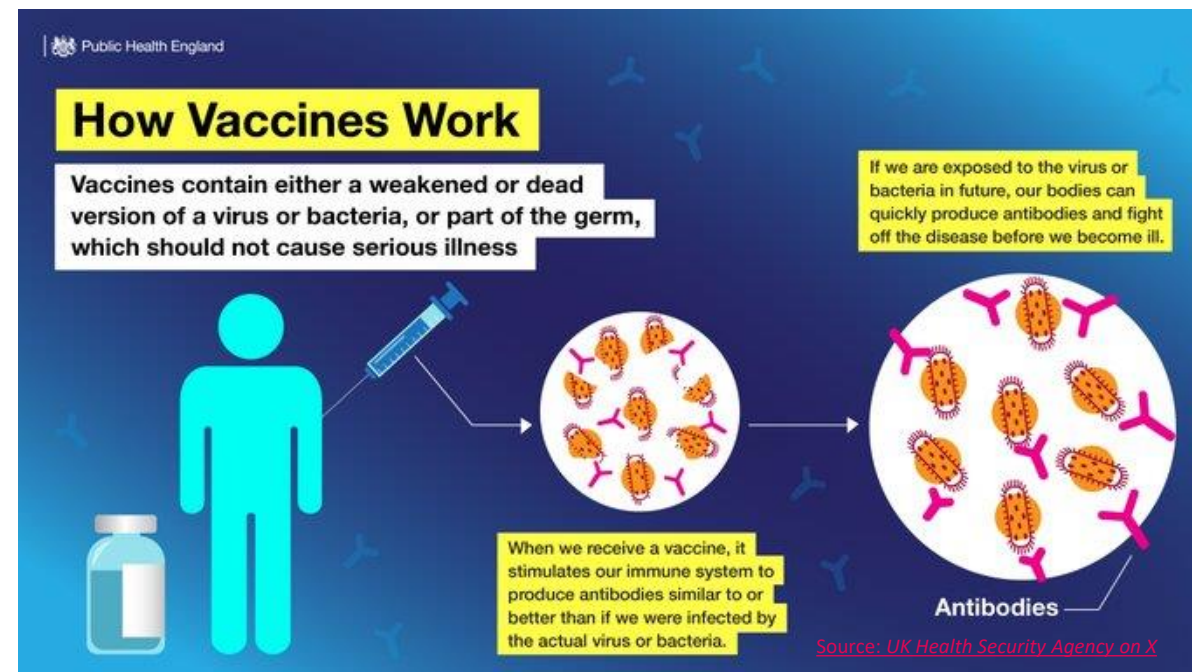
Immunity and how vaccines work

Immunity

- **Immunity** is the ability of the human body to protect itself against infectious disease which includes innate mechanisms and acquired systems.
- **Innate immunity** is **present from birth** and includes physical barriers, such as skin, as well as chemical barriers e.g. digestive enzymes.
- **Acquired immunity** is generally specific to a single organism, or to a group of closely related organisms. There are two basic mechanisms for acquiring immunity – active and passive. **Active immunity** is protection that is produced by an individual's own immune system and is long-lasting. **Passive immunity** is transfer of antibodies from immune individual, most commonly across the placenta and is temporary.

How vaccines work

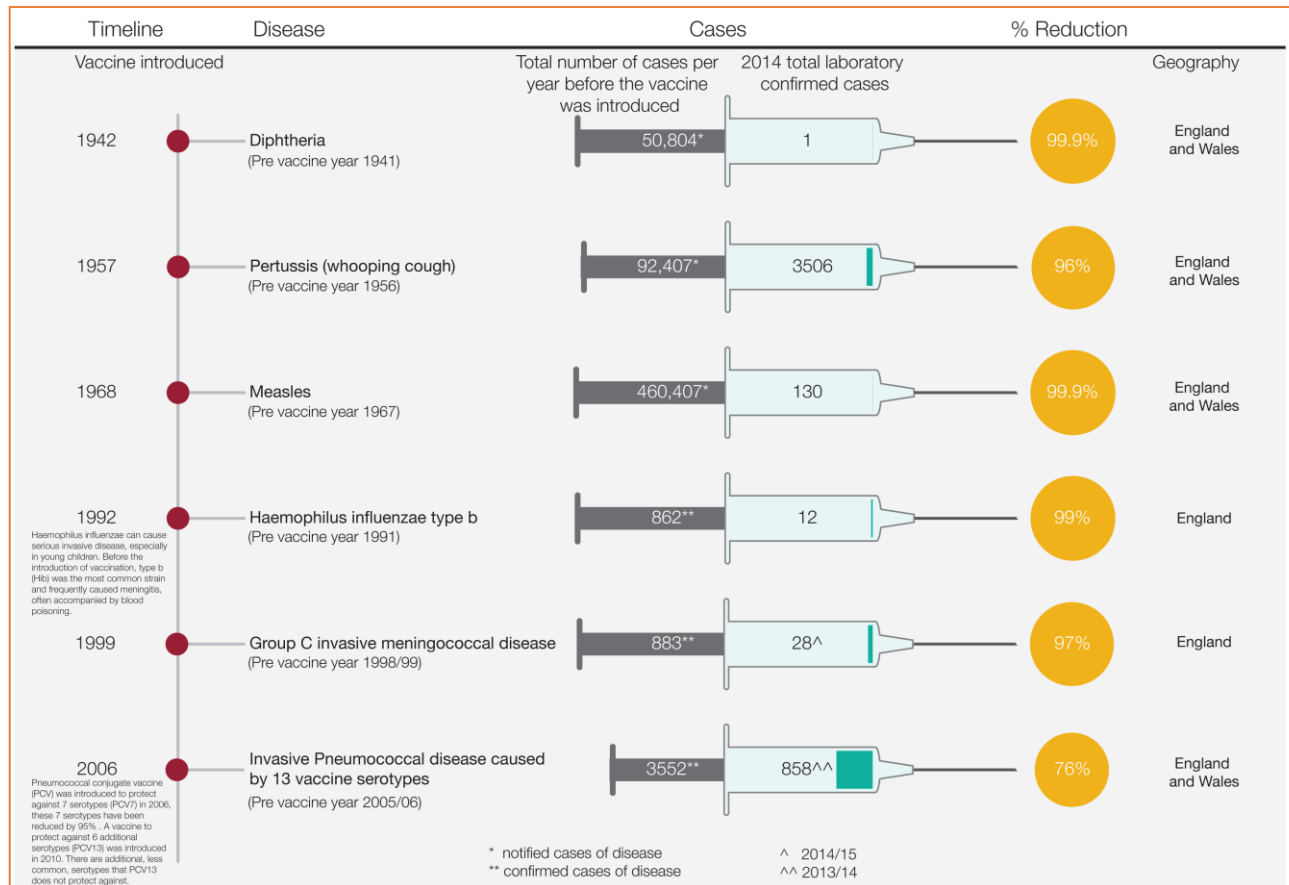
- Vaccines are a type of prescription-only medicine that are designed to **stimulate a person's immune system to produce antibodies** that will fight a specific disease. Vaccines contain a small part of the bacterium or virus that causes a disease, or tiny amounts of the chemicals the bacterium produces. If a vaccinated individual comes into contact with an infection, the antibodies will recognise it and be ready to protect them.
- Vaccines produce their protective effect by **inducing active immunity** and providing 'immunological memory'.
- Vaccinations are essential services **for ensuring that children are protected against vaccine preventable diseases**.
- The UK's **current routine immunisation schedule uses seven types of vaccines** which provides **protection against 14 infections**, including measles, meningococcal disease, and polio.
- **No vaccine offers 100% protection** and a proportion of individuals get infected despite vaccination. Primary failure occurs when an individual fails to make an initial immunological response to the vaccine. **This risk is reduced by offering a second dose of vaccine**. Secondary failure occurs when an individual responds initially but then protection wanes over time. A booster dose is given to improve protection.
- **Vaccines protect the individual** who receives the vaccine. **Vaccinated individuals are also less likely** to be a **source of infection** to others.
- **When vaccine coverage is high enough** to induce high levels of population immunity, **infections may even be eliminated from the country or region** e.g. smallpox.



Immunity and how vaccines work

Thanks to vaccination we have seen 99.9% reductions in infection like diphtheria (a highly contagious potentially fatal bacterial infection) and Haemophilus influenza type b (a serious infection especially for infants and young children).

Vaccines save lives. They prevent around 3-4 million deaths worldwide every year and the World Health Organization states that **after clean water, vaccination has the greatest impact on health globally**



Benefits of vaccination:

- Saves millions of lives.
- Prevents disease, disability and suffering.
- Safe and effective.
- Protects you, your child and other people in your community by stopping disease spreading.
- Can reduce inequalities and poverty.
- Reduces time away from childcare/school and work helping save time and money.
- Reduces the burden on the health system and helps reduce use of antibiotics.

Aim of our Childhood Immunisations Strengths and Needs Assessment

Aim

To understand and assess the strengths and needs in relation to routine childhood immunisation uptake (0-5 age group) in Southampton and what is being done to address them, identify priorities and gaps and make recommendations for further action.

Working with colleagues across the system, SCC HPT have undertaken a Childhood Immunisations Strengths and Needs Assessment (CHISANA) to better understand the issues surrounding uptake of routine childhood immunisation across the city. This has informed the development of the themes and recommendations set out in this report.

Statistics released by NHS digital in 2022 illustrated that vaccination coverage had **decreased in 13 out of the 14 routine childhood vaccination measures in 2021-22**, with **no vaccinations meeting the 95% target** set by the WHO.

[Statistics published for all routine childhood vaccinations in England in 2021-22: statistical press release - NDRS \(digital.nhs.uk\)](https://www.digital.nhs.uk/statistics/2022/04/22/childhood-vaccinations-2021-22)

Objectives of CHISANA

This needs assessment seeks to understand:



- **Who** are the children that aren't having vaccines?
- **Why** aren't they having vaccines?
- **How** can we support higher uptake?

The needs assessment will allow commissioners and providers of childhood immunisation services to use a systematic approach to understanding the needs of the population in relation to childhood immunisation, and allow for the planning and delivery of effective and equitable services.

Some of the key themes that we are looking to explore the 4 P's - Practice, Population, Personal, Pandemic. Including:

- Accessibility (appointments and advice)
- Insights (voice of workforce and parents)
- Impact of and learning from the pandemic (particularly regarding inequalities)
- Data - what's missing and could be improved?

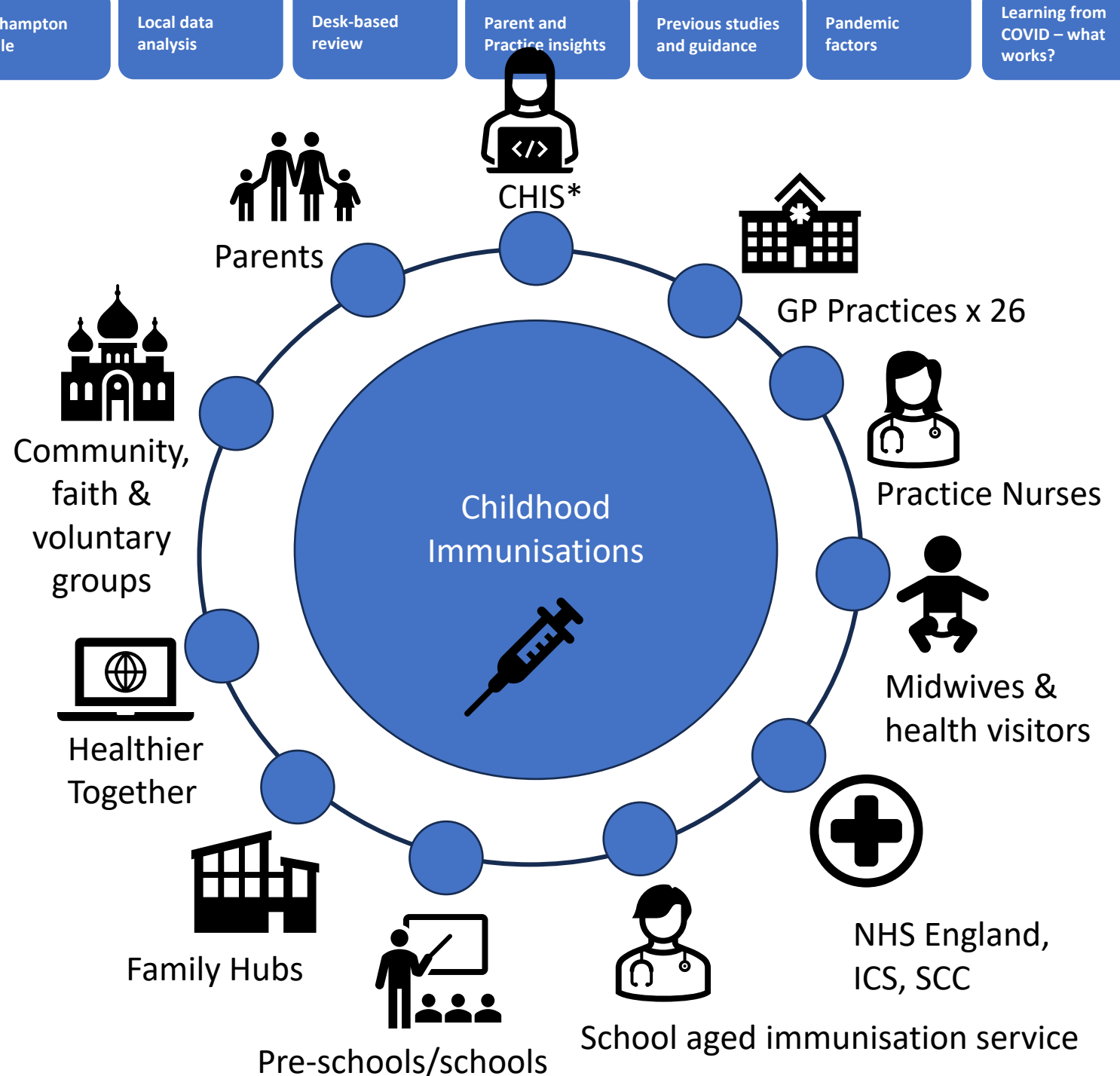
Objectives:

1. Provide an **analysis of existing data**: national/ local data and **summarise the status of current vaccine uptake locally, with key benchmarking against other comparator populations** (highlight any data limitations).
2. Describe the existing **childhood immunisation legislation, policy and guidance at the national and local levels**.
3. Describe the **existing childhood immunisation service provision** across the city and highlight where **any inequalities** exist within this service provision.
4. **Present stakeholder views as to what is working well and where improvements are needed**, as well as identify **any other factors (enablers and barriers)** that may be positively and negatively affecting vaccine uptake across the city.
5. **Identify the most important needs** in relation to routine childhood immunisations: in the short, medium and long term highlighting areas of higher need according to (but not limited to) geography, gender, ethnicity and socioeconomic status.
6. **Identify key recommendations based on this local intelligence and learning** from other areas (including COVID Vaccination programme) that can inform an ongoing programme of work.

Working together

- Many different stakeholders have a role to play in delivery of the childhood immunisation programme.
- **Our approach** to undertaking this needs assessment has reflected this.
- The project has been undertaken via a **multi-disciplinary working group** and we have reached out and sought input and views from a wide range of stakeholders.
- This includes **engaging with parents** and **workforce**.
- Improving and maintaining uptake **will require coordinated and sustained action from all parties taking every opportunity to promote and support immunisation at every stage of a child's journey from 0-5 years of age.**

***The Child Health Information Service (CHIS).** The primary objective of CHIS is to ensure standardised and accurate data and information to support the commissioning and delivery of child health services. This means providing a service that delivers a comprehensive local record of a child's public health (screening, immunisation and other health protection or health improvement interventions) and of their community-based healthcare.



Scope of CHISANA

The overall aim of the UK's current routine childhood immunisation schedule is to provide protection against the following **14 vaccine preventable infections via 7 different vaccines**:

- Haemophilus influenzae type b (Hib)
- Hepatitis B
- Human Papillomavirus
- Influenza
- Measles
- Meningococcal disease
- Mumps
- Pertussis (whooping cough)
- Pneumococcal disease
- Polio
- Rotavirus
- Rubella (German measles)
- Shingles
- Tetanus

This project has focused on **routine immunisations 0-5 years age group**.

The routine childhood immunisation schedule also aims to protect against cancers related to HPV. These vaccinations are offered to boys and girls aged twelve to thirteen years old.

The whole UK schedule would also include adult immunisations and selective childhood immunisations.

All vaccinations offered on the schedule are free of charge. None of them are compulsory.

Source: [schedule \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

Routine childhood immunisations

From September 2023

| Age due | Diseases protected against | Vaccine given and trade name | | Usual site ¹ |
|---|---|--|-----------------------------------|-------------------------|
| Eight weeks old | Diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib) and hepatitis B | DTaP/IPV/Hib/HepB | Infanrix hexa or Vaxelis | Thigh |
| | Meningococcal group B (MenB) | MenB | Bexsero | Left thigh |
| | Rotavirus gastroenteritis | Rotavirus | Rotarix ² | By mouth |
| Twelve weeks old | Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B | DTaP/IPV/Hib/HepB | Infanrix hexa or Vaxelis | Thigh |
| | Pneumococcal (13 serotypes) | PCV | Prevenar 13 | Thigh |
| | Rotavirus | Rotavirus | Rotarix ² | By mouth |
| Sixteen weeks old | Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B | DTaP/IPV/Hib/HepB | Infanrix hexa or Vaxelis | Thigh |
| | MenB | MenB | Bexsero | Left thigh |
| One year old (on or after the child's first birthday) | Hib and MenC | Hib/MenC | Menitorix | Upper arm/thigh |
| | Pneumococcal | PCV booster | Prevenar 13 | Upper arm/thigh |
| | Measles, mumps and rubella (German measles) | MMR | MMRvaxPro ³ or Priorix | Upper arm/thigh |
| | MenB | MenB booster | Bexsero | Left thigh |
| Eligible paediatric age group ⁴ | Influenza (each year from September) | Live attenuated influenza vaccine LAIV | Fluenz Tetra ^{3,5} | Both nostrils |
| Three years four months old or soon after | Diphtheria, tetanus, pertussis and polio | dTaP/IPV | Boostrix-IPV | Upper arm |
| | Measles, mumps and rubella | MMR (check first dose given) | MMRvaxPro ³ or Priorix | Upper arm |
| Boys and girls aged twelve to thirteen years | Cancers and genital warts caused by specific human papillomavirus (HPV) types | HPV ⁶ | Gardasil 9 | Upper arm |
| Fourteen years old (school Year 9) | Tetanus, diphtheria and polio | Td/IPV (check MMR status) | Revaxis | Upper arm |
| | Meningococcal groups A, C, W and Y | MenACWY | Nimenrix | Upper arm |

Source: [Routine childhood immunisations schedule from September 2023 \(publishing.service.gov.uk\)](https://publishing.service.gov.uk)

Executive Summary

Summary of approach. Key findings, headlines and priorities.

Background and Context

Aim, objectives scope

Introduction to vaccination & why important

City Profile (Demographics, deprivation, languages, other features)

Southampton Vaccination delivery (How & who)

Data Review

Vaccine uptake data review (summary of trends)

Uptake by GP practice (anonymised)

Comparator review (HIOW and National)

Narrative – what is the data telling us?

Data limitations What is missing that would be helpful?

Insights (experiences & voices)

Information Available (desk-based review)

GP Practice Questionnaire and site visits

Parent Experiences and Attitudes (focus groups and/or surveys) – consider specific groups

Workforce Experiences (midwives, health visitors, early years, schools)

Learning

Learning from COVID vaccination (target groups & approaches that worked)

Case Studies (Positive/negative deviation)

ICB Immunisation self-assessment

National Studies and Recommendations

Impact of COVID

4 P's – Findings (strengths & needs)

Practice

Population

Person

Pandemic

Recommendations and Next Steps

Short

Medium

Long term

Childhood Immunisations Strength and Needs Assessment (CHISANA) Project Overview

The childhood immunisation strengths and needs assessment (CHISANA) has several strands to it. These aim to bring together Southampton specific data, insights and experiences from across all aspects of the childhood immunisation patient journey, to identify themes and recommendations.

Method

To understand and examine the issues relating to the delivery of pre-school immunisations in Southampton, we have drawn on a variety of evidence sources.

- We have **spoken to/interviewed a range of key stakeholders** involved in vaccination delivery including:
 - NHS England (NHSE) SIT Team
 - Child Health Information System (CHIS) Team
 - NHS Solent School Aged Immunisation Service (SAIS)
 - Health Visitor Lead
 - Healthier Together
 - GP Maternity Lead
 - Solent Looked After Children (LAC) Team
- We have **undertaken a parent survey (834 respondents)** and **workforce survey (23 out of 25 GP Practices from across Southampton responded)** to gain insights, experiences and attitudes.
- We have **reviewed** documents relating to **governance and accountability**.
- We have **analysed *COVER data** on vaccination uptake across the city to gain a more detailed picture as to what the numbers can tell us about what is happening locally, and we have considered how this can be linked to other issues such as deprivation and ethnicity.
- Key **policy and guidance has also been reviewed** and the **findings and recommendation drawn together** to build on and support the recommendations in this report.
- We have also **carried out a desk-based audit of all the key digital information sources**, including GP Practice websites, available to parents.
- Recent **learning from the COVID-19 vaccination programme** has also been draw together to consider where and how this can be applied to childhood immunisations.
- We have also **considered how the pandemic might have contributed to falling uptake** of childhood immunisations (pandemic factors).



5 key childhood vaccination uptake indicators have been analysed.

- 3 doses of **Hexavalent** at 1 year of age.
- 1 dose of **MMR** at **2 years** of age
- 1 dose of **MMR** at **5 years** of age
- DTaP** booster at **5 years** of age
- 2 doses of **MMR** at **5 years** of age

*[Cover of Vaccination Evaluated Rapidly : \(COVER\) programme](#) annual data on coverage achieved by the childhood immunisation programme

Building on strong foundations

Many of the recommendations in this report build on the findings and recommendations highlighted in previous reports, guidance and frameworks relating to the delivery of childhood vaccinations. These include: *(where publicly available links have been provided)*.

| | | |
|---|---|-----------|
| Association Directors of Public Health (ADPH), Sector Lead Improvement Vaccination Report | Not publicly available | 2023 |
| European Vaccine Action Plan | WHO-EURO-2014-2227-41982-57703-eng.pdf | 2015-2020 |
| European Vaccine Action Plan | WHO-EURO-2014-2227-41982-57703-eng.pdf | 2015-2020 |
| NHS South, Central West (SCW) Improving Immunisation Uptake Team (IIU) Initiative and Paper | Not publicly available | 2018 |
| Briefing Paper, Improving uptake of cervical screen and childhood immunisations in the Eastern European population in Southampton City. | Not publicly available | 2019 |
| Improving uptake of services by Eastern European population in Southampton City | Improving health and uptake of services by the Eastern European population in Southampton City | 2019 |
| Moving the Needle | https://www.rcn.org.uk/-/media/Royal-College-Of-Nursing/Documents/Publications/2022/February/010-074.pdf | 2019 |
| National Audit Office (NAO), Investigation into pre-school vaccination | National Audit Office (NAO) investigation into pre-school vaccination | 2019 |
| Southampton City Council (SCC), MMR Workshop (held March 2020) | MMR workshop DC_TH_030220.pptx | 2019 |
| Tailoring immunisation programmes | https://www.who.int/europe/publications/i/item/9789289054492 | 2019 |
| UK Measles and Rubella Elimination Strategy | UK Measles and Rubella elimination strategy 2019 (publishing.service.gov.uk) | 2019 |
| Public Health England (PHE) National Immunisation Programme: health equity audit | National Immunisation Programme: health equity audit (publishing.service.gov.uk) | 2021 |
| Local Government Association (LGA), Increasing uptake for vaccinations: maximising the role of councils | 'Increasing uptake for vaccinations: Maximising the role of councils' | 2020 |
| Equity and Best Practice immunisation, Factsheets, WHO | Equity and Best Practice immunisation - Factsheets - Immunisation Advisory Centre (immune.org.nz) | 2022 |
| Hampshire and Isle of Wite (HIOW) ICB DPH Imms self-assessment score sheet | Not publicly available | 2022 |
| Royal College of Nursing (RCN), Immunisation Knowledge and Skills Competence Assessment Tool, Third Edition | https://www.rcn.org.uk/-/media/Royal-College-Of-Nursing/Documents/Publications/2022/February/010-074.pdf | 2022 |
| Vaccine uptake in the general population, NICE guideline | Vaccine uptake in the general population (nice.org.uk) | 2022 |
| National Voices, 'Accessible and inclusive communication within primary care: What matters to people with diverse communication needs' | Accessible and inclusive communication within primary care.pdf (mcusercontent.com) | 2023 |
| NHS Vaccination Strategy (December 2023) | NHS England » NHS vaccination strategy | 2023 |

Findings and Recommendations



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Six things we learned!

1

The **Childhood immunisation programme** is a **huge success**. **Trust remains high** and **90% of parents** we spoke to were happy with the service they have received. Whilst rates are declining, we **did not find** evidence of any significant **anti-vaccine sentiment** and Southampton uptake is consistently higher than the national average. These are **strong foundations on which to build**.

2

It has **not been possible to get any meaningful ethnicity-based data** or establish trends as to who isn't getting vaccinated. This makes it **difficult to tailor services** to need and to address any health inequalities in uptake that might exist.

3

There are opportunities to **strengthen promotion of vaccination across the system** by training and empowering a wide range of professionals and people from within the community (community centred approaches) to have conversations about the importance of vaccination with parents, and confidently address concerns and myths.

4

Practical issues, such as **ease of booking and availability of appointments**, **remain a significant barrier** for parents. There **needs** to be a **greater range of appointment times** and a more **personalised approach** to following up missed appointments.

5

Ensuring **services are tailored** to meet needs **does not mean treating all people the same**. Providing more **bespoke support** for parents and families that need it, such as parents of children with disabilities, families with chaotic lives, or for whom English is not a first language, should be prioritised.

6

It **not possible to point to one single cause or solution** to improve immunisation uptake. It will require **action and sustained effort across a number of different elements**, and **multiple stakeholders have a role to play**.

CHISANA Key Findings - SWOT

Strengths



92% and **93%** of parents told us **vaccinations are important for children under 12 months and 18mths- 5 years** respectively. **Trust remains high** despite the COVID-19 pandemic with **1 in 5 parents** we spoke to indicating their feelings are **MORE positive**.



Whilst rates in Southampton are declining **the city has consistently achieved better than England average**. The **average gap to 95%** for 2021/22 was the equivalent to **7 additional children** at each GP practice having each vaccine.



90% of parents who responded to our survey and who have had their children vaccinated said that they were **satisfied with the vaccine visit**.



Parents we spoke **to understand the importance** of getting vaccinated and have generally had **good experiences**, but **making it easy and accessible**, including **offering a variety of appointments** to accommodate working parents **remains vital**.



Stakeholders across the system **are committed** to improving vaccination rates and there are **already many excellent working practices in place**.



There has been **significant learning** in relation to the delivery of vaccinations and inequalities during the COVID-19 pandemic **that can be applied to childhood immunisations**.



Limited evidence of any major impact on vaccination from **anti-vax messages**.



COVER data for Southampton indicates that for **7 out of 25 GP Practices are achieving 90% or over for all 5 indicators** that were included within this study.



52% of practices say the **wait for an appointment is less than a week**.

Weaknesses



Childhood vaccination (0-5 years age group) **uptake in Southampton has been excellent**, but **rates are decreasing** for all 5 indicators.



Only **61%** of **GP Practice** websites have **information on all recommended vaccines**. There is a gap in information about **specific diseases**.



COVER data for Southampton indicates that for **25 out of 25 GP Practices are NOT meeting the target (95%) in any of the 5 indicators** that were included within this study.



Data indicates that **MMR uptake rates at 5 years and DTaP at 5 years are most concerning**.



17% of **GP practices are not offering catch up clinics** despite the data indicating that immunisation tapers off as children get older.



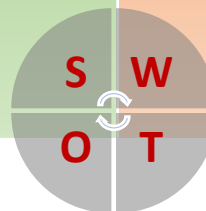
There is **no shared communications plan at system level**. Comms planning **tends to be opportunistic**/off the back of national campaigns. Need for consistent and targeted messages that avoids parents feeling bombarded.



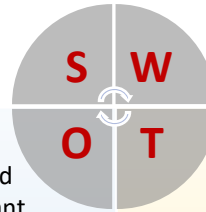
Only **35%** of **GP practices had translated information** on childhood immunisations available on their website. There are **disparities across the City in terms of the accessibility of practice websites** and the **information available** including translated materials and **signposting** to other sources of information.



It has **not been possible to get meaningful ethnicity related data** relating to childhood immunisation uptake from GP Practices across Southampton. **This is a significant barrier to establishing any trends** linked to ethnicity and in turn informing targeted approaches such as WHO TIP approach.



CHISANA Key Findings – Summary (SWOT)



Opportunities



Utilising community leaders, groups and other providers to help promote vaccinations is a cost-effective and proven approach that could be better harnessed.



Opportunities to **strengthen closer working between GP practices, health visitors and midwives.**



Educating workforce with the **provision of enhanced training**, as well as **refreshing knowledge** is vital and there are opportunities for this to be strengthened pre and postnatally.



The National Parent Attitude survey highlights that **having a conversation with a health professional** can be key to giving parents confidence. Scope for this to be offered more routinely.



Consider **utilising alternative venues** to deliver routine childhood immunisations e.g. Family Hubs.

Scope to more proactively provide support and advice for any specific needs.



Utilise **heightened awareness** resulting from spikes in cases such as measles.



78 LAC children (0-4) in SCC care (November 2023). Opportunities to work with **Social Workers** to help **secure parental consent** for childhood immunisations.



Existing initiatives e.g. pre-vaccine 'meet the nurse' visit and utilising **vaccine supporters at the front desk** to welcome and support patients **could be replicated** elsewhere.



Explore ways to **link parents to children** so that when a parent contacts the surgery opportunities to flag immunisations can be taken.



Ease of access, including, being sent **reminders, flexibility of appointments and support with booking** remains important, and there is scope for improvement on this.



There may be opportunities to **utilise secondary care teams** working in the communities.



Where **ethnicity/language is recorded** there may be an opportunity to **harness technology and send information/text in preferred language.**

Threats



Some parents may **not be aware of the serious harms infectious diseases can cause a child and the vital and incredibly effective role immunisations play in preventing this.** The earlier this conversation & education starts in pregnancy the better.



There is a **correlation between deprivation and low immunisation uptake**, but this complex issue is not fully understood.



Too much weight may be being given to the view that **parents aren't immunising** their child because they **'don't believe in vaccination'**. This is potentially a **barrier to understanding and addressing other factors**, such as getting time off work, needing more support or access to information in their own language.



Our survey would indicate that we **have not heard from parents who are not engaging with services** or taking up vaccination



The **number of trained immunisers in the city** could present problems for **workforce continuity** and **knowledge retention** in the future.



Some **parents remain concerned about the safety of MMR** and there is also evidence to suggest that **parents may benefit from being reminded about the benefits of vaccinations, risks of not being vaccinated and reassurance about side effects.**



In Southampton the **percentage of mothers born outside of the UK is increasing (41%)**. Any barriers linked to ethnicity are therefore likely to get worse.



It has **not been possible to identify any trends** as to **who is not taking up childhood immunisations.**



Where respondents indicated their **feelings** about childhood immunisations are **less positive** since the COVID-19 pandemic, **concerns about side effects was the reason most given.**

CHISANA Recommendations

4 Themes



Theme one:
Engagement



Theme two:
Inequalities
and inclusion



Theme three:
Service
improvement



Theme four:
Partnership
working





Recommendations: Theme one - Engagement

1.

Strengthen promotion at every stage of a child's journey.

Offer awareness (refresher) sessions for professionals across the system to ensure all (health visitors, midwives, practice nurses, admin leads, front line staff, pharmacies, schools/early years, family hub staff etc) understand their role in promoting immunisation (from antenatal to adulthood).

See RCN 8's: <https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2018/october/pdf-007201.pdf>

2.

Tailored comms. & engagement campaign.

Design & deliver a targeted & sustained grass roots comms & engagement campaign utilising multiple channels & simple messaging. Address myths, promote benefits & invite questions using different mechanisms & forums.

e.g. Q&A community awareness sessions at family hubs, translated videos.

3.

Collate and distribute Childhood Imms comms assets.

Collate and coordinate distribution of assets to a variety of stakeholders across the city (GP Practices, Family Hubs, Schools, Early Years providers, Healthier together, Community venues) via a central point to facilitate & support sharing of assets locally.

4.

Utilise faith & community leaders & groups.

Utilise community leaders & trusted people of influence e.g. faith leaders, groups, champions, social prescribers, baby banks, to promote importance of childhood immunisations, provide reassurance & tackle myths.

**see vaccine champion's model.*

5.

Targeted promotion of MMR.

Design a targeted public campaign to directly address prevailing concerns about perceived risks of MMR and continue to promote uptake across the city, particularly focusing on areas of highest deprivation.

**build on existing HIOW MMR uptake strategy and work e.g. webinars held for community children's nurse teams.*



Recommendations: Theme two - Inequalities and inclusion

6. Information availability

Appointment letters, reminders & information should be sent/available in a range of formats & languages (including easy read). Information to be proactively shared with parents prior to vaccination appointment & translation function available via Practice website.

7. Proactively provide reassurance

Time should be built into appointments to reassure parents about vaccine safety as well as potential 'normal' reactions e.g. raised temperature after Men B, to help reduce parental anxiety such as concerns about vaccine overload.

8. Trial alternative delivery model and venues.

Trial alternative venues for delivery of vaccinations in low uptake areas. Consider family hubs, fire stations* & other community venues, and ensure all practices are offering catch up clinics as well as a home immunisation service**.

**fire stations were used very successfully during the COVID-19 vaccination campaign.*

***Unsure if this is currently being offered by any Southampton GP Practices.*

9. Support for Additional needs.

Specialist support to be proactively offered by all practices to parents that need additional help and support immunising children with additional needs such as autism or disabilities or multiple children e.g. longer appointment slots.

10. Named frontline community immunisation champion.

Directly follow up with families that have repeatedly not taken up appointments and provide a supportive, culturally sensitive service, and the necessary awareness of and ability to address any concerns or issues that parents may have.

**This could be city wide, PCN or Practice based or sit within Health Visiting team if they are sent the list by CHIS*

***this approach was highlighted by SCW Thames Valley 'Improving Immunisation uptake Team Initiative (IIU) .*



Recommendations: Theme three - Service improvement

11. Enhanced Staff Training.

All key staff to undertake enhanced training (tailored to Southampton) to ensure consistency of service & message dissemination, and that they have confidence to address concerns about side effects. Inequalities & what's needed to address them to be included.

12. Greater appointment availability.

Greater range and availability of appointments required, including different /varied days and times of the week and weekends, to ensure working parents can fit in an appointment around other commitments.

13. Review data recording, cleansing, coding & extraction processes.

Ensure that frequent data cleansing is undertaken & that coding & data recording (*including immunisation history*) processes are tightened up to ensure that incomplete or out of date data is not negatively impacting uptake rates. Improve mechanisms to extract, utilise and share ethnicity-based data to enable accurate & timely understanding of the local situation.

14. Personalised (telephone) DNA/WNB Processes.

DNA* and WNB** processes to be reviewed to ensure it is working for their population. Consider personalising & captured at practice level. Ensure individuals that miss appointments are followed up in person by someone trained to discuss any concerns or issues and provide reassurance. (*Practice Nurse working with 'named' immunisation admin support*)

*DNA = Did Not Attend
** WNB= Was Not Brought

15. Ethnicity based data recording Policy.

Explore potential for a city-wide ethnicity-based data recording policy, to ensure a consistent and robust approach to capturing data. This will enable culturally sensitive services to be tailored & developed that meet the varying needs of different groups, as well as identification of any ethnicity related barriers that may be impacting uptake.



Recommendations: Theme four - Partnership Working

16. Establish local childhood imms Action Plan and group.

Establish a system led over-arching Immunisation Action Plan and group to coordinate effort, monitor progress/impact, and sustain focus across the entire system, to ensure delivery of recommendations and sharing of good practice, local initiatives and resources.

17. Increase uptake of Health Visitor 1 & 2 yearly reviews.

Healthy Child Programme 1 and 2 yearly reviews are not received by every family (53% and 60% respectively). This may impact on immunisation uptake with Health Visiting team missing opportunities to review and promote childhood immunisations.
(participation officer is already looking at understanding and addressing this)

**This is often delivered by practitioners so they should be included in any training.*

18. 'Share' resources within PCN's & across Southampton.

Consider and identify where services or capacity could be enhanced by 'sharing' resources across PCN's and/or Southampton e.g. clinic times, staff to cover sickness or expand offer and/or range of venues.

e.g. could trial extended hours.

19. Define responsibilities for local delivery.

Identify and agree leadership and accountability for different aspects of immunisation and vaccination programme. Named leads for key areas of delivery e.g. names lead for primary care and agreed lead for immunisation within each GP practice to who messages are communicated. Agree leadership for different elements.

**highlighted in Sector Lead Improvement (SLI) Imms report*

20. Integrated GP MDT meetings.

Immunisations to be routinely discussed at integrated team meetings at PCN level to review uptake & initiatives.

FIRST? - Prioritisation Matrix

FIRST – Prioritisation Matrix

What to do FIRST?

A matrix to assist with prioritising recommendations and action plans. It will help identify where to focus activity so that resources can be directing to the areas that will have the greatest impact in the short, medium and long term. It can help with undertaking phased approach by identifying which things need to be done immediately and which may need to wait until a later date.

| Criteria | Description | Rating | Score |
|----------------------------------|---|--------|-------|
| F: Feasible | How viable is implementing this going to be from an economic perspective and in terms of political will and acceptability?. | H/M/L | 3/2/1 |
| I: Impact or inequalities | What potential impact will this have on addressing inequalities? | | |
| R: Reach | What is the population reach? | | |
| S: Success | How confident are you this will succeed. Has this been piloted elsewhere? What is the evidence? | | |
| T: Time | How long is this likely to take to see results and how urgently is it needed? (Fast = High) Urgent (High) | | |

| Recommendation Number | Score | FIRST –Priority Ranking |
|--|-------|-------------------------|
| 4. Utilise faith & community leaders & groups. | 17 | 1 |
| 9. Support for additional needs. | 16 | 2 |
| 10. Named frontline community immunisation champion. | 16 | 2 |
| 12. Greater appointment availability. | 15 | 3 |
| 6. Information availability. | 15 | 3 |
| 2. Tailored comms and engagement campaign | 14 | 4 |
| 3. Collate & distribute Childhood Imms comms assets. | 14 | 4 |
| 13. Review data recording, cleansing, coding & extraction processes. | 14 | 4 |
| 14. Personalised DNA/WNB Processes | 14 | 4 |
| 15. Ethnicity based data recording policy. | 14 | 4 |
| 7. Proactively provide reassurance. | 13 | 5 |
| 11. Enhanced staff training | 13 | 5 |
| 16. Establish local childhood imms action plan and group | 13 | 5 |
| 1. Strengthen Promotion at every stage of a child's journey | 13 | 6 |
| 20. Integrated GP MDT meetings. | 12 | 7 |
| 8. Trial alternative delivery model and venues. | 11 | 8 |
| 18. Share resources within PCNs & across Southampton. | 11 | 8 |
| 19. Define responsibilities for local delivery. | 10 | 9 |
| 5. Targeted promotion of MMR. | 9 | 10 |
| 17. Increase uptake of Health Visitor 1 & 2 year reviews. | 9 | 10 |

Opportunities to strengthen and promote vaccination



Midwives

Start conversation early in pregnancy, including what comes next when the child is born, and what comes beyond (teenage years booster and HPV).

The routine childhood immunisation programme is also supported by health visitors who at mandated baby visits at the ages of 10 to 14 days, 6 to 8 weeks and 1 year promote and discuss immunisations with parents.

Antenatal groups could play a role in promoting vaccination & educating parents.



GP Practice

Support parents to get appointment booked in. Check imms are up to date. Send reminders e.g. birthday/celebration cards. Cleanse data & put in place robust administration ensuring the right codes are used.

Health Visitor

To discuss importance, encourage and remind.

Midwives

To check and remind.

Family Hubs

Educate & promote childhood immunisation.



9-12 month development check

Check imms status and ensure booking is made.



Nurseries and Pre-schools

To remind, encourage and support parents to check and get children vaccinated. Include within Policy.



2-year development check

Check imms status and have next stage vaccination discussion. Discuss any concerns.



Schools

School readiness – opportunity to promote via briefings & materials that go out to parents.



Secondary Care

Take any opportunities in secondary care units such as paediatric assessments, community nursing and Children's Outreach and Assessment Support Team (COAST) to promote childhood vaccinations.

Key recommendations:

💡 **Train and prepare all professionals to discuss and promote immunisation early in pregnancy and then at key touch points at every stage of a child's journey.**

💡 **Training should include likely conversations including; addressing concerns, dispelling myths and how to access support with any additional needs.**

Strengthening this will help to ensure every opportunity is taken to support parents to get children vaccinated.

[Moving the Needle RSPH](#)

Factors affecting uptake of childhood vaccination (potential enablers and barriers)



Practice Factors

What we considered:

- Data recording & cleansing processes.
- DNA/WNB processes.
- Accessibility and range of appointments.
- Facilities and support available.
- Initiatives in place.
- Website and information accessibility.

What we found:

- Practices across Southampton are already doing many of the things required to enable childhood vaccination.
- Building on existing approach and tailoring services even further to the needs of the population is required to further improve the service and maximise efforts to increase uptake. This requires good quality ethnicity-based data.



Person Factors

What we considered:

- **Confidence** levels amongst parents & whether past experiences have impacted this.
- **Complacency** as to the benefits of childhood immunisations & awareness of the risks of choosing not to.
- **Convenience** & accessibility & the role this might play for parents.
- **Compassion** & reassurance shown by health care providers for any specific needs & concerns e.g. needle phobia, safety & side effects.

What we found:

- Parents trust in childhood immunisations remains high, but they may benefit from being reminded as to the risks & benefits.
- Convenience, ease of access, support and practical issues is key.
- Being able to have a conversation with a health care provider or other trusted individuals can also play an important role.
- Some parents remain concerned about side-effects and expressed concerns about MMR.



Population Factors

What we considered:

- Culture and beliefs that may be influencing attitudes.
- Ethnicity and country of birth.
- Languages spoken.
- Age of child.
- Deprivation & other socio-economic factors that may be impacting on ability to take up immunisations such as cost of living crisis.

What we found:

- There is a correlation between high deprivation and uptake of childhood immunisations.
- Information availability in an accessible format e.g. translated assets, is important of parents who may have literacy issues or do not have English as a first language.
- Appointment availability outside of working hours is important for working parents.
- Extracting ethnicity data was not sufficient to identify trends.



Pandemic Factors

What we considered

- Poor access during the early stages of the pandemic.
- Additional strain on and reprioritisation of health services and lasting capacity issues.
- Whether the COVID vaccination programme has negatively impacted parental attitudes to routine childhood immunisations.
- How any changes in service provision have impacted on parents' experiences of accessing childhood immunisations.
- Learning from the pandemic.

What we found:

- Trust in childhood immunisation remains high, even where parents felt less positive about the COVID vaccine.
- There is scope to use trusted stakeholders across the system to engage with parents and promote childhood immunisations.

Practice Attributes/Enablers (checklist)

| | | | |
|---|---|---|---|
| <p>✓ Dedicated Immunisation Lead/Champion Dedicated and trained immunisation lead who can answer questions, provide reassurance and sign-post additional help and support. Will be aware of the specific needs of the local community and understand issues related to inequality.</p> | <p>✓ Personalised DNA &WNB Processes Did Not Attend (DNA) and Was Not Bought (WNB) processes are personalised. Practice attempts to make contact via telephone using staff members trained in immunisations, to understand any needs, answer questions and provide support. If appropriate, will link up with other professionals such as health visitors and social/family support workers.</p> | <p>✓ Accessible Website Practice website includes and/or signposts parents to key information about childhood immunisations in a readily accessible format appropriate to the needs of the local community. Translation facility is available and working and contact number for further advice and support advertised</p> | <p>✓ Multiple Trained Immunisers Sufficient numbers of trained immunisers to ensure workforce continuity, knowledge retention and offer the level of support and flexibility required. Staff will have undertaken enhanced training, so that they are able to answer questions and understand the potential barriers and facilitators.</p> |
| <p>✓ Vaccinate Opportunistically Take every opportunity to check immunisation status of children and where eligible offer to vaccinate/arrange appointment to vaccinate/discuss vaccination.</p> | <p>✓ Catch up Clinics Offered Catch up clinics/programe of work offered where there are more children needing to be vaccinated than there are appointments available. Practices have flexibility and know how many children require vaccinating and are proactive in this approach.</p> | <p>✓ Family Friendly Environment Family friendly facilities and environment that welcomes families and makes them feel safe and supported e.g. space for buggies, changing area, play space and support for multiple children e.g. 'Well Child Clinic' so parents can avoid general illness</p> | <p>✓ Data Cleansing Practice undertakes regular (monthly) data cleansing to ensure that records are up to date and ensure prompt action is taken.</p> |
| <p>✓ Ethnicity Data Recorded Robust recording of ethnicity-based data to help inform any targeted initiatives that may be needed.</p> | <p>✓ Will Vaccinate Without Red Book Will vaccinate even if parent has forgotten to bring child's personal health record (red book).</p> | <p>✓ Meet the Nurse Option to meet the nurse prior to immunisation appointment so that they can ask any questions and discuss any specific needs or concerns.</p> | <p>✓ Hours of Operation Offer a range of appointments including a mixture of mornings and afternoon, before 8am, at weekends and opportunistically.</p> |
| <p>✓ Promotion & Education Every opportunity it taken to promote and educate parents and staff as to the importance of childhood immunisation ensuring that information and knowledge remains up to date, and the health literacy of patients/caregivers is strengthened.</p> | <p>✓ Translated Materials Materials are proactively offered in a range of languages prior to immunisation appointments and additional information and resources signposted.</p> | <p>✓ Bespoke Support Positive and supportive environment. Flexible to unforeseen circumstances which occur. Actively listens to the needs of parents, with a particular focus on underrepresented groups. Longer appointment slots available to accommodate additional needs.</p> | <p>✓ Multi-Disciplinary Approach Stakeholders across the system are linked in and understand their role in promoting childhood immunisations thorough their interactions and relationship with parents.</p> |

Tailoring Immunisation Values and Principles

In Southampton, the findings from the parent survey carried out as part of this needs assessment support and align with previous studies relating to parent attitudes and childhood immunisations, including The Royal Society for Public Health, '**Moving the Needle, promoting vaccination uptake across the life course**' (2019), and **The UKHSA National Childhood vaccines: parental attitude's survey (2022)**.

These studies indicate that **parent attitudes to routine childhood immunisations remains positive**. **Common threads** relating to accessibility, concerns over side effects, awareness of the risks and benefits, language and cultural issues repeatedly come up. These underline that **to achieve equity, services need to be tailored to the specific needs of the local population with bespoke services and support** for parents and families that need it and recognition that the **social determinant of health, may create barriers**. **It does not mean treating all people the same.**

The World Health Organisation (WHO) Regional Office for Europe has developed the **Tailoring Immunisation Programme (TIP) approach**. It **provides stakeholders** working in the field of immunisation **with proven tools** to identify suboptimally vaccinated populations, determine barriers and drivers and design interventions. The approach is **underpinned by six values (see diagram)** opposite which can be applied when designing a targeted intervention.



Accountability and Governance

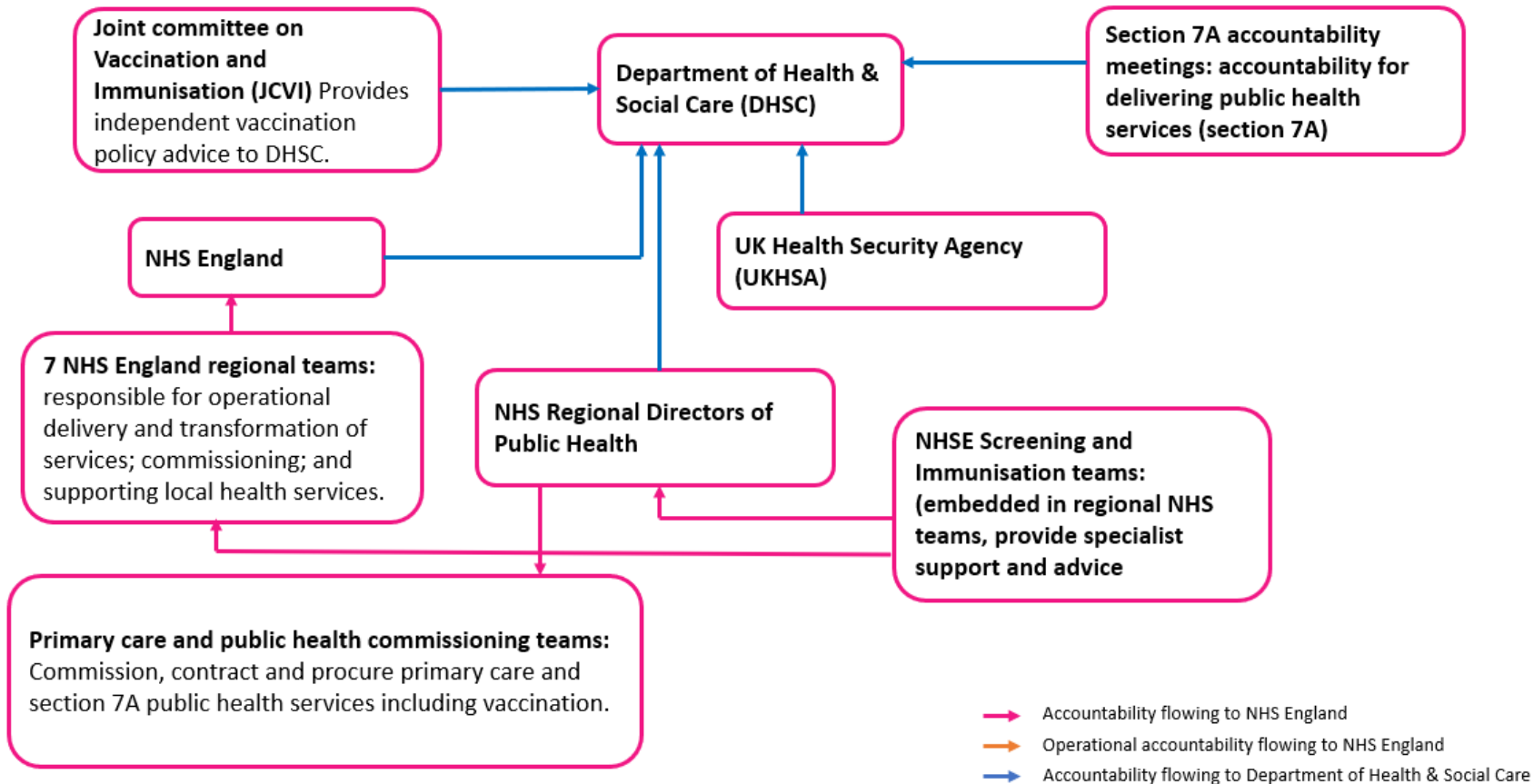


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Governance of pre-school vaccinations in England

Governance of pre-school vaccinations in England

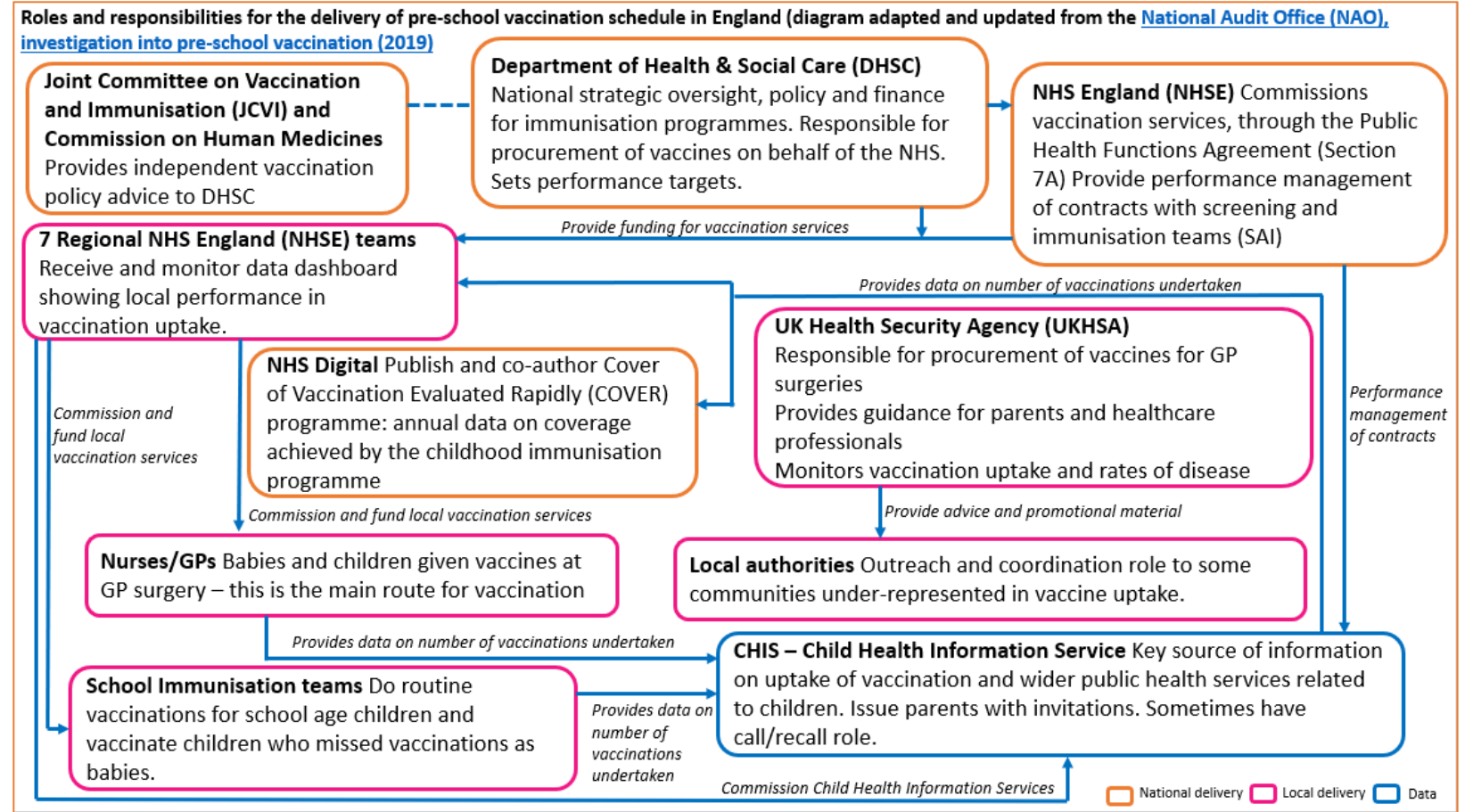
Governance involves the Department of Health & Social Care, NHS England and UKHSA



- **The Department for Health and Social Care (DHSC) chairs the Section 7A accountability meetings which is a public health oversight meeting** where the performance of vaccination programmes and other public health services are discussed every three months. These are attended by DHSC, NHS England (NHSE) and United Kingdom Health Security Agency (UKHSA) (formerly PHE).
- The DHSC is advised by the **Joint Committee on Vaccination and Immunisation (JCVI)**, an independent expert advisory committee.
- **UKHSA and NHSE attend the Public Health Oversight Group which provides informal insights** to the Section 7A accountability meetings as part of its wider role in monitoring performance of services delivered through Section 7A.
- **NHSE Regional teams** are responsible for quality and the financial and operational performance of all NHS organisations in their region. The regional teams **commission vaccination and Child Health Information Services (CHIS) within the regions.**

Roles and responsibilities for delivery of the pre-school vaccination schedule in England

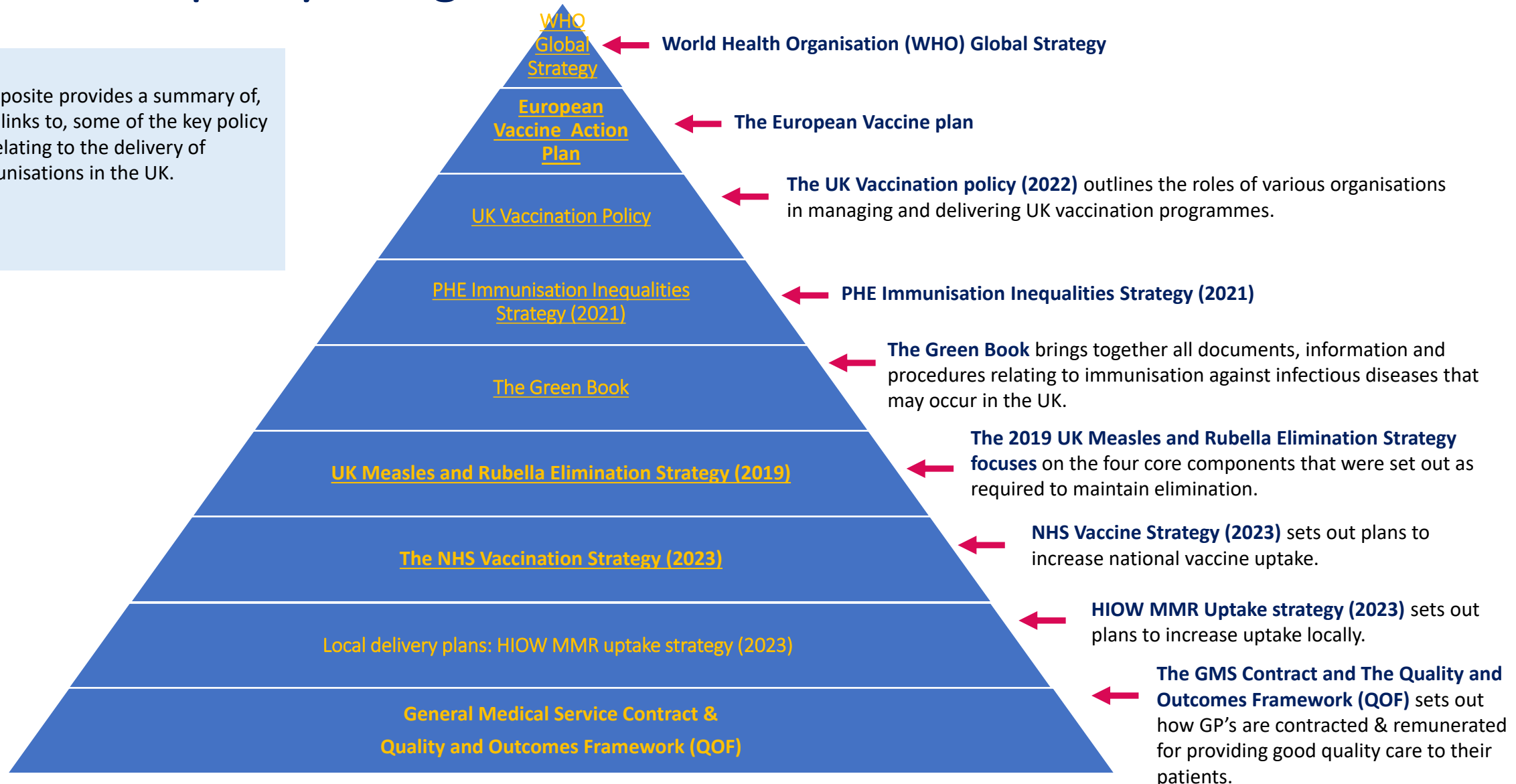
- The **DHSC sets performance targets**, and the UK Health Security Agency undertakes surveillance of vaccine-preventable diseases.
- NHS England** is **responsible** for the **commissioning** of immunisations and vaccinations through the [public health functions agreement \(S7A\)](#). This responsibility will move to the ICB in April 2024.
- Pre-school** and **adult vaccinations** are usually **delivered by GP surgeries**. School-age services are co-ordinated by seven regional NHS England teams and delivered through School Immunisation Teams.
- In Southampton, NHS Solent** manage the **school aged immunisation (SAI) programme** including offering school age catch up clinics.
- Health visitors** and **midwives** have a crucial role to play **advocating for childhood immunisations** and **supporting parents** to make the decision to get their children immunised. Delivery of this forms part of the **statutory responsibilities** of local authority **public health teams** and are commissioned through the annual Public Health Grant from DHSC.



- Local authority **Directors of Public Health** have a **scrutiny and assurance role** in relation to vaccinations, including providing appropriate challenge to the arrangements for screening and immunisation programmes. Also advocating for reducing health inequalities and improving access for under-served groups.
- Public health teams** are also **in a unique position to understand the health needs of their local population** and have a role to play in supporting vaccination services. This may be through helping immunisation teams' work with frontline services such as health visitors or children's centres or supporting pop-up vaccination clinics. They can also support health promotion through their communication channels and networks.

Key vaccination policy and guidance

The diagram opposite provides a summary of, where possible links to, some of the key policy and guidance relating to the delivery of childhood immunisations in the UK.



Local mechanisms, meetings and key points of contact for delivery

Hampshire and Isle of Wight (HIOW) Strategic Immunisations Oversight Group (SIOG)

- Provides oversight and governance for delivery of vaccination delivery.
- Chaired by: NHSE
- Frequency: Quarterly
- Membership: ICB, Local Authority, NHS E

Southampton Health Protection Board (HPB)

- Chaired by: SCC Consultant Lead, Health Protection
- Frequency: Quarterly
- Attended by: LA Health Protection Public Health, LA Communications lead, ICB Infection Prevention and Control (IP&C), Solent University, University of Southampton (UOS), University Hospital Southampton (UHS), Southampton Voluntary Services (SVS), UKHSA, Port Health, Public Health Screening and Immunisations Team (SIT) Lead Consultant.
- Reports to: Health and Wellbeing Board

Other key points of contact:

- Deputy Chief Medical Officer Children and Young People (CYP)
- ICB Southampton Place Director
- Deputy Director-Primary Care
- Primary Care Quality Lead, HIOW ICB

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Background

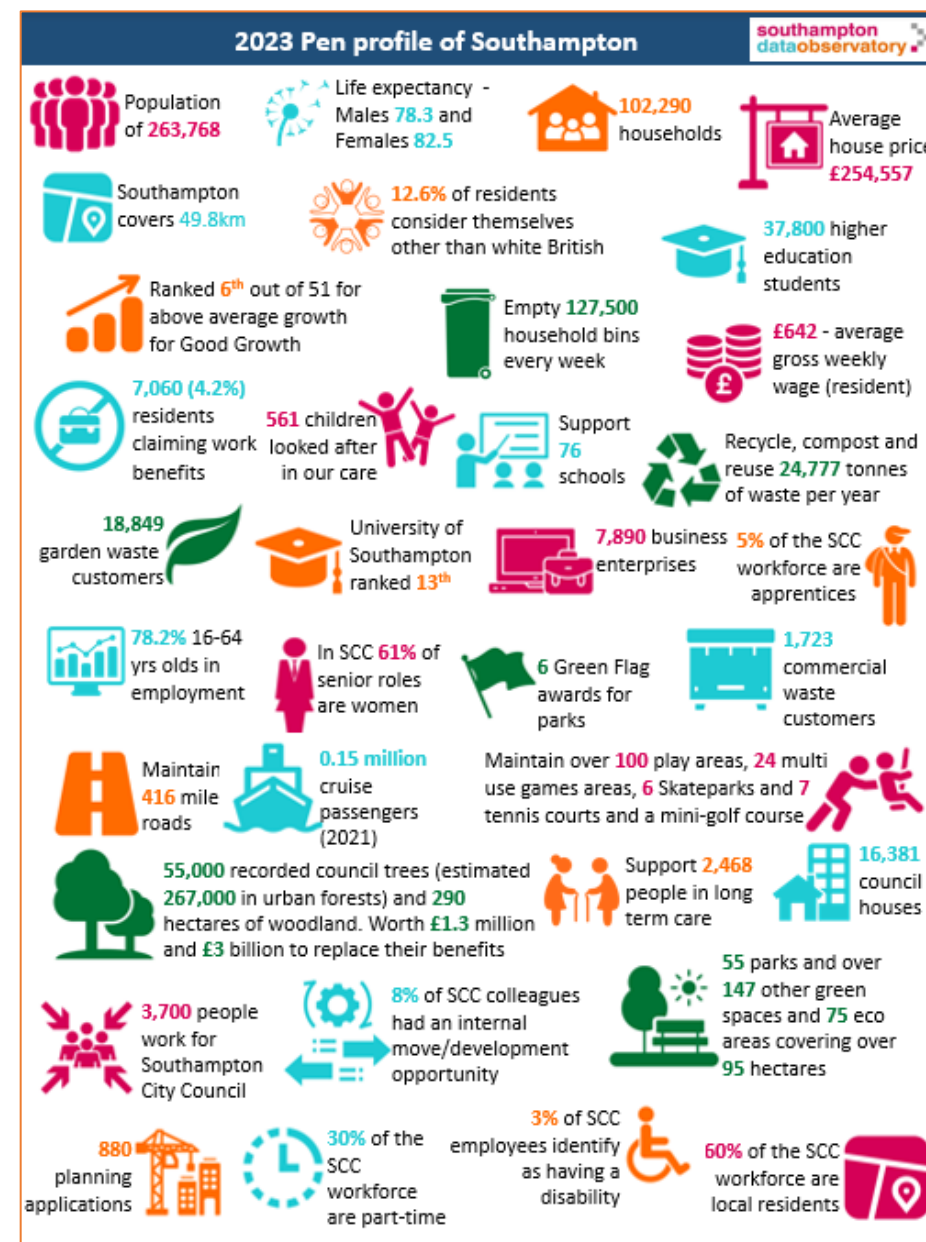
Many health outcomes in Southampton remain below regional and national average. We know that inequalities in the conditions in which we are born, grow, live, work and age lead to further unfair and avoidable different experiences of health and wellbeing. Therefore, reviewing data and information about the city's demographics is important to help us better understand and explain uptake of childhood immunisations in the city, consider what the strengths and needs might be, as well as inform service design and delivery.

Key findings:

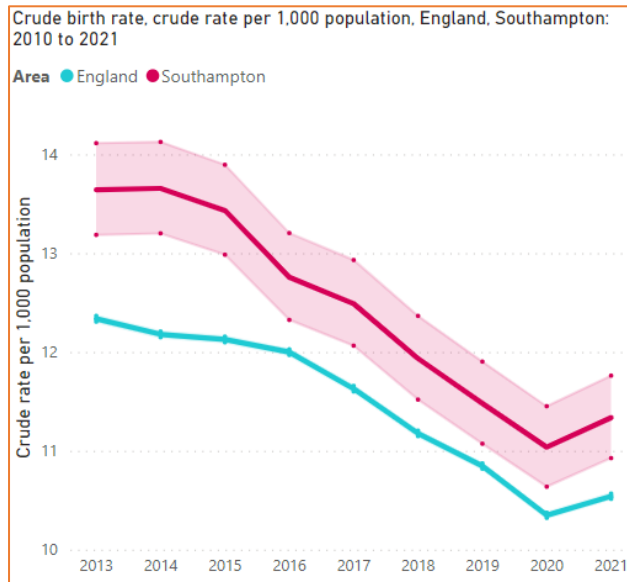
- Despite a **predicted increase** in Southampton's population, **Southampton has seen a decrease in both fertility rates and the number of births.**
- **41% of live births in Southampton were born to mothers who were born outside the UK (2022).**
- There is **some evidence** to suggest a **link between the overall GP registered population deprivation score and practice level vaccine uptake**, but this is not consistent across the city and without individualised uptake data is not possible to draw firm conclusions.

What does this mean for Southampton?

- Whilst the falling birth rate might indicate the numbers requiring vaccination will reduce, the diverse make up of the city, wide range of languages spoken and significant deprivation means **the need for a culturally tailored and supportive immunisation service is likely to increase.**
- Service design should aim to ensure that any **issues, such as language barriers and cultural and religious beliefs** that might be barriers to uptake, are given sufficient **priority.**



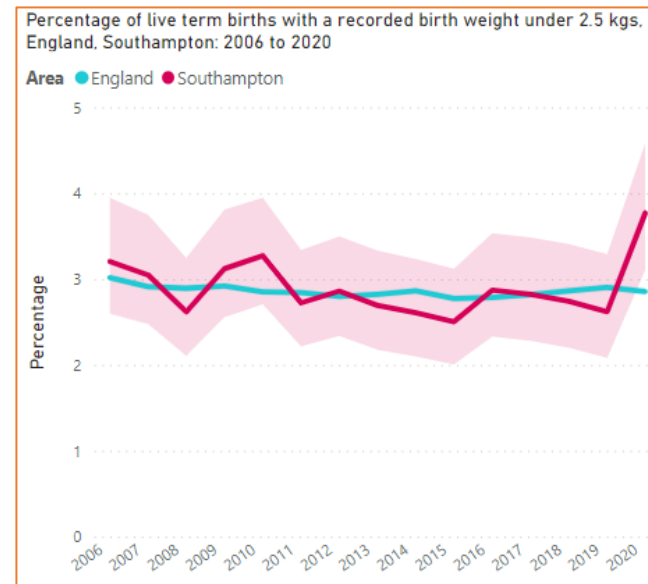
Births



The **birth rate** in Southampton remains **significantly higher** than England, although both are **falling** over time

Local rates are **falling faster** than nationally

In the **20% most deprived** areas, birth rates (12.4 per 1k) are **1.6x higher** than in the 20% least deprived (7.6 per 1k)



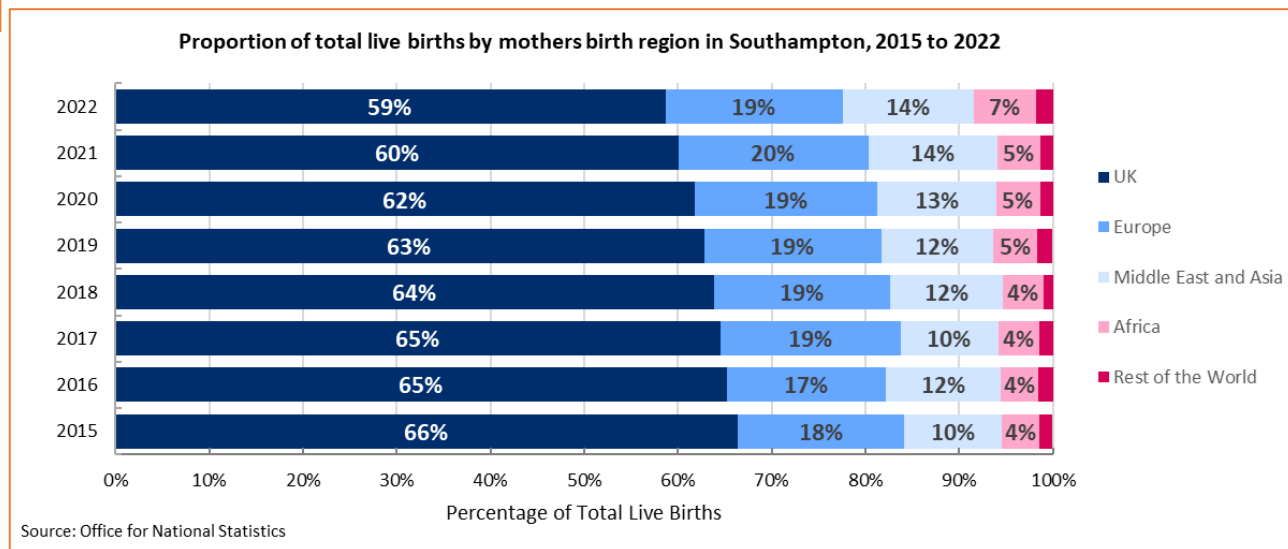
A **public health concern** is babies being born of **low birth weight** (under 2.5kg).

In **2020**, **3.8%** of births were of **low birth weight**; **significantly higher** than England.

Bevois Ward was found to have the **highest percentage** of **low birthweight** babies. Local analysis shows **Bevois** has a **higher concentration** of **Asian mothers** who are **more likely** to have **lower birth weight** babies compared to the **UK average**. This reflects published literature where analysis confirms **lower birth weight** in second generation **South Asian babies**.

Births data details the **mothers birth region**, understanding this, along with births rates and changes in migration helps with **maternity service** and **school pupil place planning**.

In Southampton, the percentage of **mothers born outside the UK** is **increasing**.



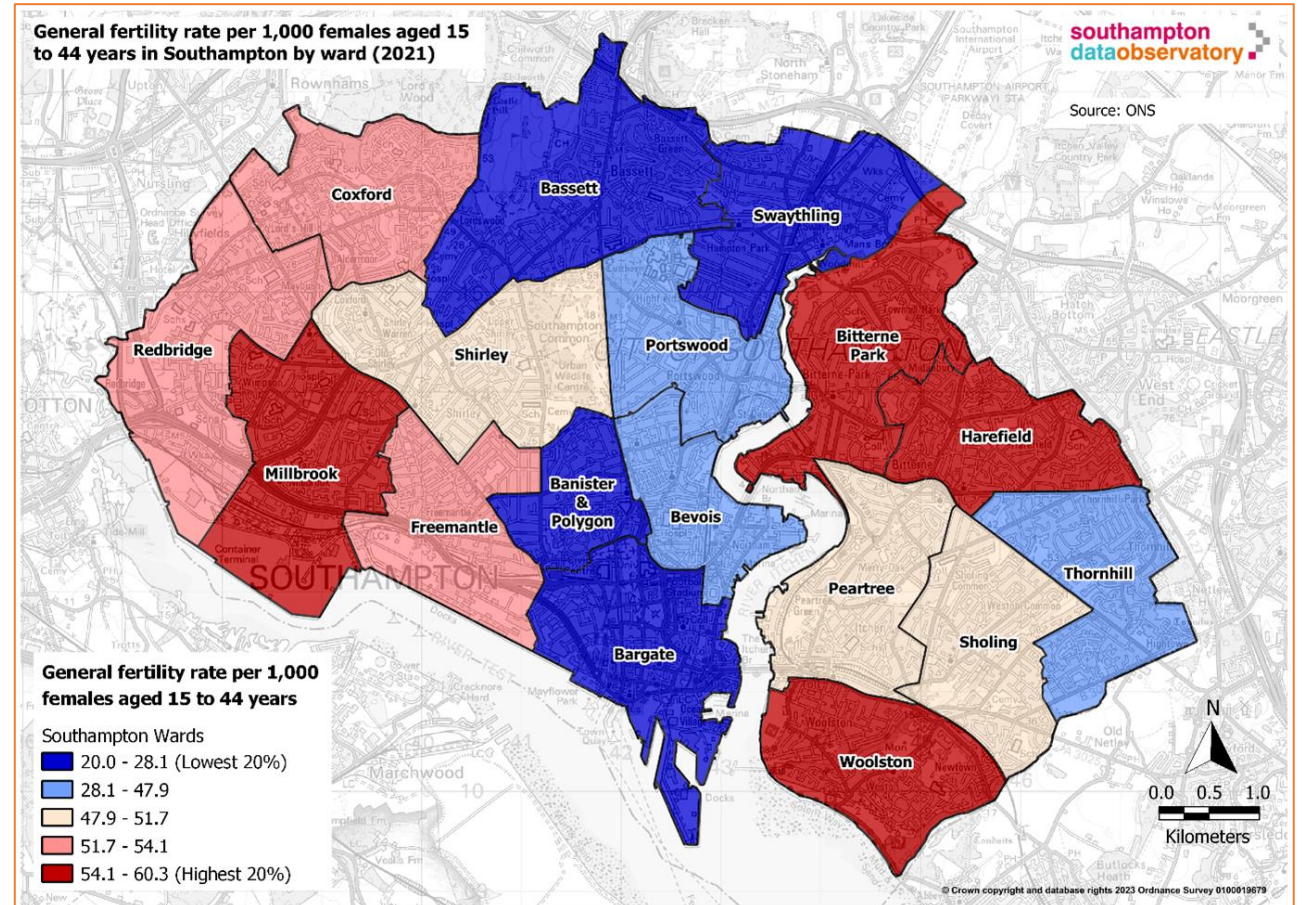
In **2018-20**, the percentage of low weight births in the **20% most deprived** areas (3.5%) was **3.2x higher** than in the **20% least deprived** (1.1%)

Source: [Microsoft Power BI](#)

Population and demographics

- In 2022, the resident population of **Southampton was estimated to be 263,769**, of which **129,191 (49.0%)** were female and **134,578 (51.0%)** were male.
- Children between the ages 0 to 5 make up 6.5% (17,032)** of the population, which is similar to the England average of 6.9% (MYE 2020)
- 18.5% (48,818) of Southampton's resident population is aged between 16 and 24 years compared to just 10.5% in England.** This is largely due to Southampton being a university city and home to approximately 37,800 students
- Despite a **predicted increase** in Southampton's population **to approximately 270,000 by 2040** from the current population of approximately 260,000, **Southampton has seen a decrease in both fertility rates and the number of births.**
- Whilst the **number of births remains higher than the national average** (11.0 per 1,000 population in Southampton compared to 10.3 nationally), both the **general fertility rate at 48.3 per 1,000 females aged 15 to 44 years**, and **total fertility rate, at 1.4 children per woman**, remain **below the national average of 55.3 and 1.6** respectively.

Source: Southampton Data Observatory



What does this mean for Southampton?

- In Southampton the **percentage of mothers born outside of the UK is increasing.**
- In **2022, 41% of live births were born to mothers who were born outside the UK.** Of the live births in Southampton, **19% were to mothers born in Europe, 14% to those born in the Middle East and Asia, 7% to mothers born in Africa and 2% were born in the rest of the world.**
- Understanding a mothers' background can allow for **tailoring of service provision to ensure a healthier antenatal, delivery and postnatal period** for both mother and child.

Inequality and deprivation

- Health inequalities are avoidable differences in health outcomes between groups of people due to social, geographical, biological or other factors.
- A health equity audit carried out by PHE in 2021 highlighted that **avoidable inequalities in vaccination still exist within some population groups**.
- NHS England has a legal duty to offer immunisation to ‘under represented groups’. These groups may require special arrangements. Consequently, a reduction in health inequalities is a key objective for the delivery of the immunisation programme.
- At the regional level, **London** and the **South East tend to have the lowest coverage for most childhood vaccines**, and the North East the highest. **Performance varies with vaccine type** and **worsens for booster doses**. These figures highlight geographical inequalities in terms of vaccine timeliness as well as uptake.
- The graph opposite taken from PHE’s Health Equity Audit shows a **correlation between deprivation lower immunisation uptake**. Whilst **falls in immunisation uptake** have been seen nationally across most programmes, they have been **larger in the most deprived deciles** compared to the nation average.

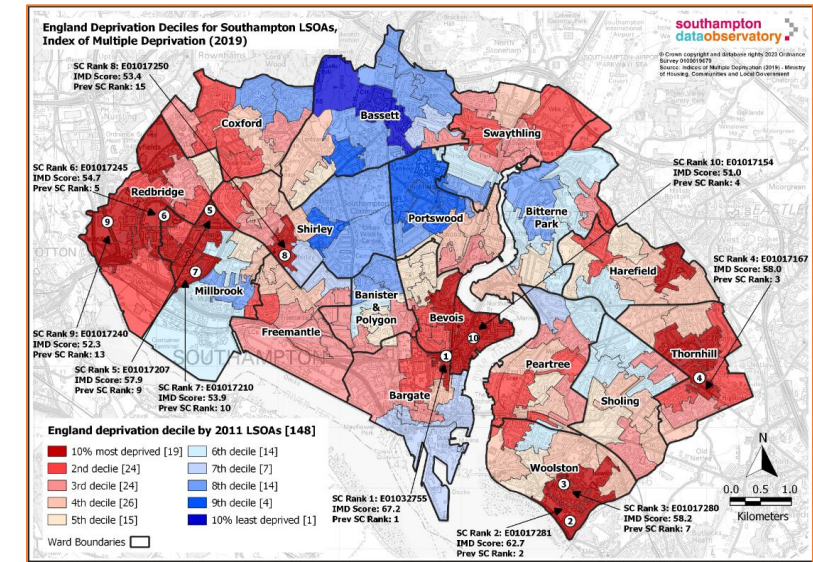
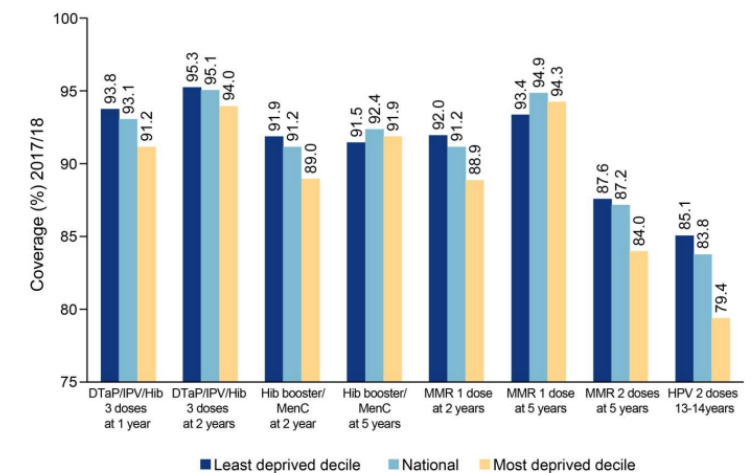


Chart 1. Immunisation coverage nationally, and in the least- and most-deprived population decile for routine childhood and HPV immunisation programmes with data available, England 2017 to 2018

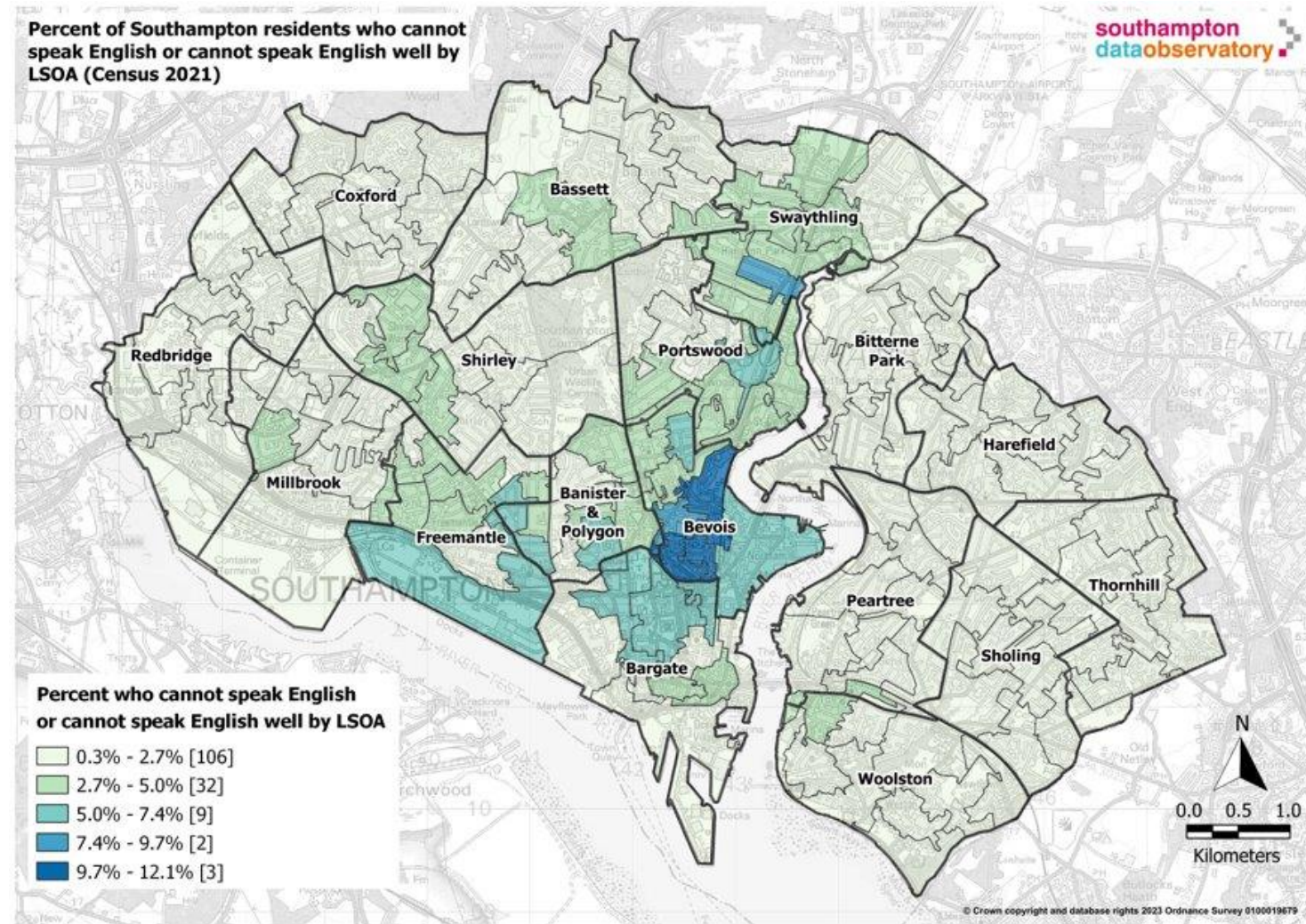
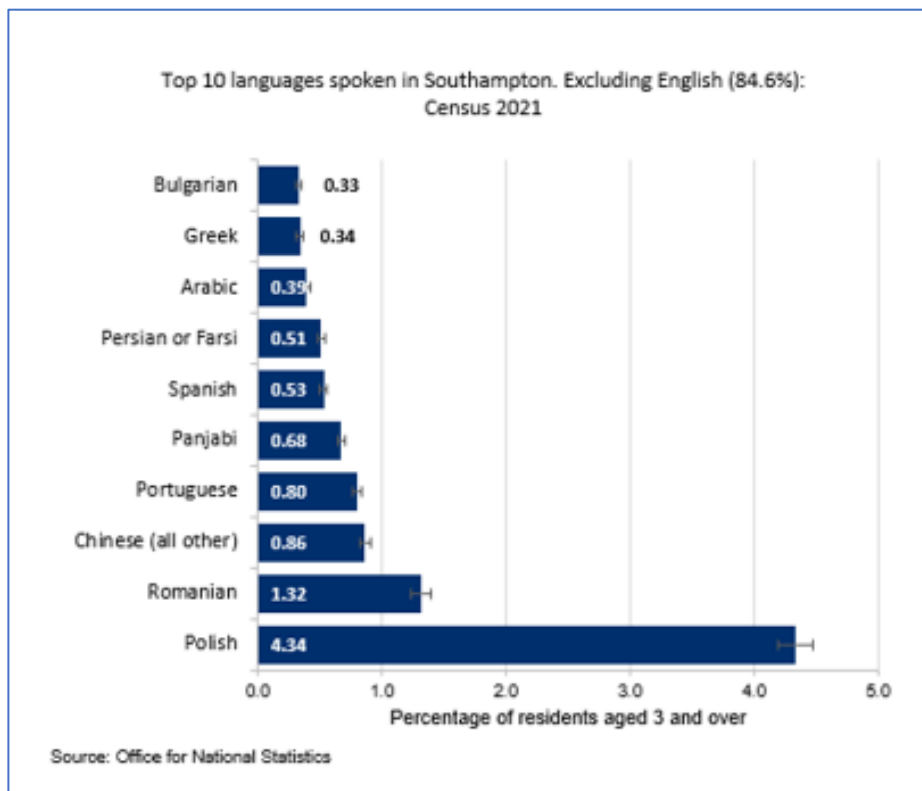


What does this mean for Southampton?

- The Index of Multiple Deprivation (IMD 2019) illustrates how **Southampton continues to be a relatively deprived city**. Based on average deprivation rank of its neighbourhoods (LSOAs), **Southampton is now ranked 55th** (where 1 is the most deprived) **out of 317 local authorities**: more deprived than the comparator cities of Bristol (82nd), Leeds (92nd) and Sheffield (93rd).
- When we look at the Index of multiple deprivation map (2019) we can see there are **pockets of high-levels of deprivation** across the city including the wards of **Redbridge, Beovis, Bargate, Woolston, Shirley, Thornhill** and **Harefield**.

Ethnicity, language and religion

- Diversity is increasing in Southampton with residents from over **55 different countries, speaking 165 different languages**.
- Understanding the ethnic and cultural make-up of the city is important for ensuring services are tailored for differing cultures and their current and future sexual and reproductive health needs taken into consideration.
- In Bevois there is a very high percentage of different languages spoken and this may be even higher for literacy. Both language and literacy may be barriers to vaccination.



Ethnicity, language and religion

- [The NAO Health Equity report](#) states that for the routine childhood vaccinations there was **no simple relationship between ethnicity and coverage**. However, coverage did appear to be **more consistently lower than White-British children in certain ethnic groups**, for example **Black Caribbean, Somali, White Irish and White Polish populations**.
- It is notable that some ethnic groups **including South Asian ethnicities, tended to enjoy similar or higher** vaccination coverage than White children.
- This relationship is less clear **for MMR**, with **coverage of children of White ethnicity being similar to or lower than other non-White groups**. This may be linked to the false but prevailing concerns about MMR.
- The report also found that where both deprivation and ethnic origin were adjusted for, **deprivation was typically less of a determinant of vaccination uptake than ethnic group**.
- There is **less evidence relating to the link between inequalities in vaccination coverage and religious affiliation** and this is mainly in **Orthodox Jewish communities**.
- The NAO report also found that **children with learning disabilities were much less likely to be vaccinated** than their peers.

Other under vaccinated groups

- There have also been well documented outbreaks in Europe and the UK in both **traveller communities** and **Steiner communities**.
- Outbreaks in **migrant communities** also suggest that this is another group that may be under vaccinated for whom the vaccination status may be unknown
- There is limited evidence around vaccine coverage amongst **looked after children (LAC)** but what is available suggests they are **less likely to be vaccinated (estimated this could be equivalent to 31 children in Southampton)**.
- **Having a large family** reduces likelihood of vaccination against MMR of primary course.
- Parental age, specifically **mothers aged 20 or under** at birth, is significantly associated with being under immunised.

Source: National Health Equity Audit (2021).

Percent of Southampton residents who cannot speak English or cannot speak English well by ward (Census 2021)

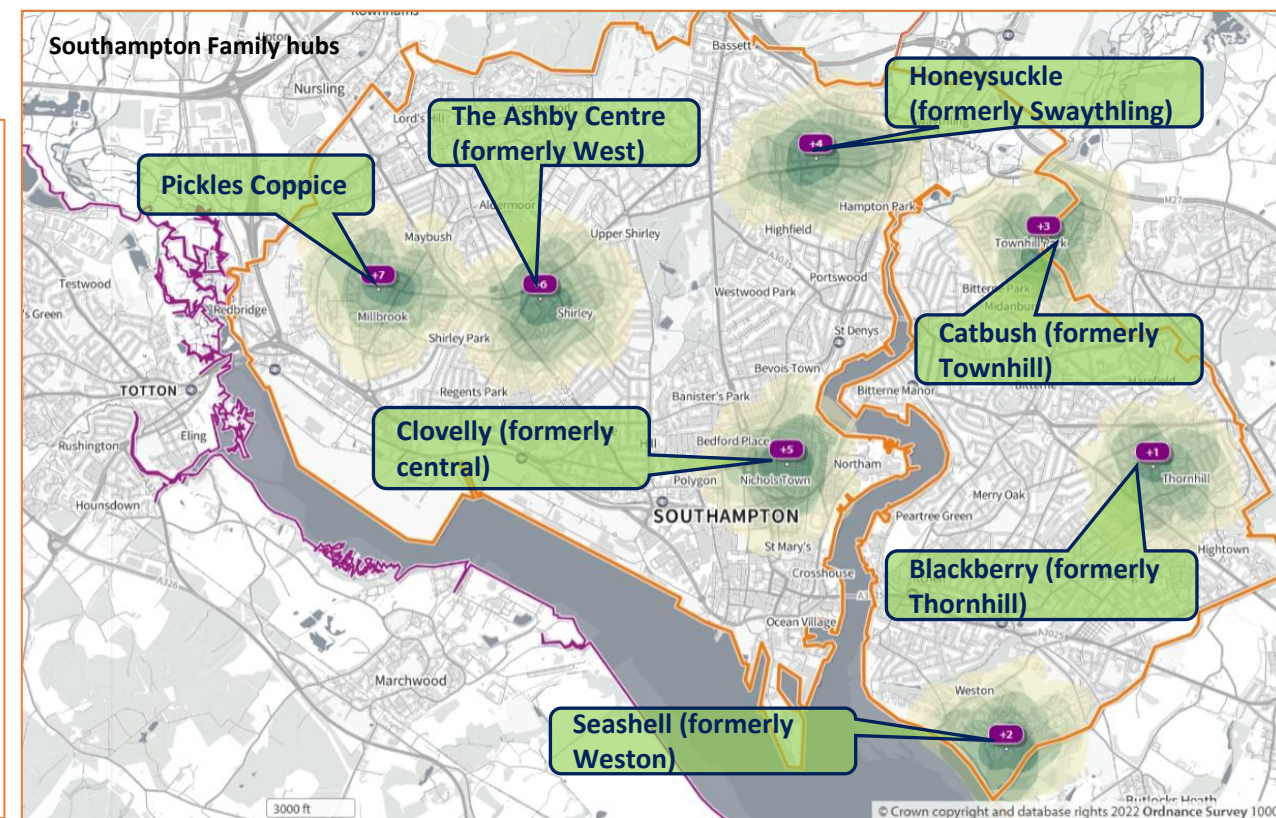
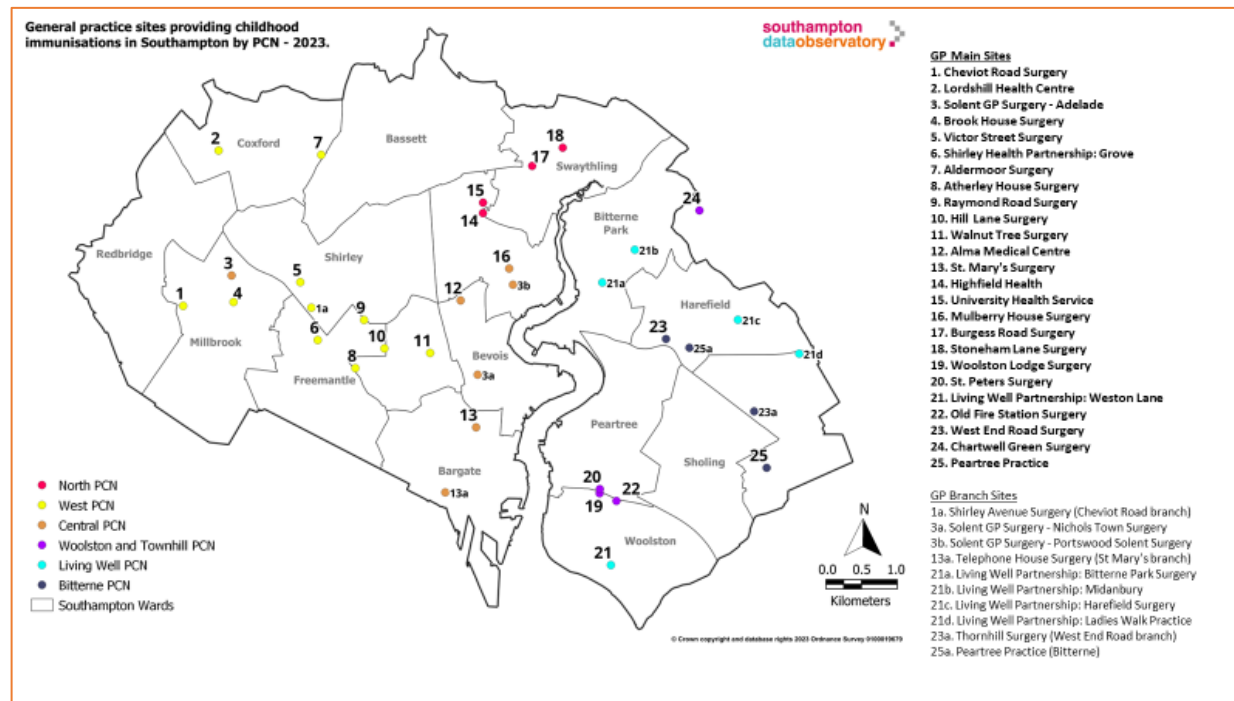
| | Total number of residents | Cannot speak English | | Cannot speak English well | | Cannot speak English or cannot speak English well | |
|--------------------|---------------------------|----------------------|------|---------------------------|------|---|------|
| Bevois | 15,817 | 162 | 1.0% | 1,053 | 6.7% | 1,215 | 7.7% |
| Bargate | 15,112 | 73 | 0.5% | 567 | 3.8% | 640 | 4.2% |
| Banister & Polygon | 16,396 | 56 | 0.3% | 504 | 3.1% | 560 | 3.4% |
| Swaythling | 15,084 | 72 | 0.5% | 444 | 2.9% | 516 | 3.4% |
| Portsmouth | 12,623 | 43 | 0.3% | 389 | 3.1% | 432 | 3.4% |
| Freemantle | 11,433 | 35 | 0.3% | 348 | 3.0% | 383 | 3.3% |
| Shirley | 14,550 | 56 | 0.4% | 296 | 2.0% | 352 | 2.4% |
| Millbrook | 13,930 | 36 | 0.3% | 263 | 1.9% | 299 | 2.1% |
| Bassett | 14,208 | 32 | 0.2% | 246 | 1.7% | 278 | 2.0% |
| Woolston | 15,118 | 34 | 0.2% | 225 | 1.5% | 259 | 1.7% |
| Bitterne Park | 14,794 | 26 | 0.2% | 186 | 1.3% | 212 | 1.4% |
| Redbridge | 13,985 | 28 | 0.2% | 184 | 1.3% | 212 | 1.5% |
| Coxford | 13,579 | 23 | 0.2% | 166 | 1.2% | 189 | 1.4% |
| Peartree | 13,816 | 24 | 0.2% | 158 | 1.1% | 182 | 1.3% |
| Harefield | 12,754 | 17 | 0.1% | 149 | 1.2% | 166 | 1.3% |
| Thornhill | 13,856 | 25 | 0.2% | 113 | 0.8% | 138 | 1.0% |
| Sholing | 13,572 | 14 | 0.1% | 99 | 0.7% | 113 | 0.8% |
| | 240,627 | 756 | 0.3% | 5,390 | 2.2% | 6,146 | 2.6% |

Source: Census 2021

What does this mean for Southampton?

- Establishing a clear link, or trends, concerning ethnicity and vaccination uptake in Southampton is difficult due to a **lack of sufficient ethnicity-based data**.
- When considering the demographic and ethnic profile of Southampton it is likely that **issues such as language and culture may be affecting immunisation uptake negatively**.
- This **underlines the importance of tailoring services to the needs of the local community**, particularly in wards where there are high numbers of non-English speakers and/or multiple languages spoken. Also **ensuring that translated information is provided proactively and support available** to those that need it as well as working with community/faith leaders.

GP Practices and family hubs



- Southampton has 6 Primary Care Networks (PCN's) which are comprised of 26 GP practices. 25 of these offer childhood immunisations (see map above).
- There are also 7 Family Hubs.

What does this mean for Southampton?

- Southampton Family Hubs were launched in 2023. **These venues have the potential to support promotion and delivery of routine childhood immunisations** in the city. Staff working at these facilities have contact with parents across the city and engage with them on a range of topics. Some of the venues also have the space and facilities to accommodate clinics.
- Utilising alternative venues to deliver vaccinations was highly successful during COVID and is also identified as a recommendation within Nice Guidance, 'Vaccine uptake in the general population' (2022).

Local Data Analysis



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Data analysis

SCC data and intelligence team have analysed available COVER data (Cover Of Vaccination Evaluated Rapidly) to get a more detailed understanding of where the opportunities and challenges may be to improve uptake of childhood immunisations and reverse the declining trend.

Approach

- **5 key childhood vaccination** uptake indicators have been analysed.
 - 3 doses of **Hexavalent** at 1 year of age.
 - 1 dose of **MMR** at **2 years** of age
 - 1 dose of **MMR** at **5 years** of age
 - **DTaP** booster at **5 years** of age
 - 2 doses of **MMR** at **5 years** of age
- The **COVER report (Q1-4 22/23 and Q1 2023/34)** data is provided by **CHIS** (Child Health Information Services), based on the information they receive from GP practices.
- **25/26 Southampton GPs included in the analysis (Homeless Healthcare is not included in the COVER report data).**
- Southampton **GP practice names** have been **anonymised**.
- The WHO target level of uptake for these vaccines is 95%.
Where a RAG rating has been used in this document:
 - **Red** uptake is less than 90%
 - **Amber** uptake is between 90% and 94.9%
 - **Green** uptake is at or above the target of 95%
- The 'gap to 95%' has been calculated to show **how many additional vaccinations** would be needed for each GP practice to **reach 95%**.

Key findings:

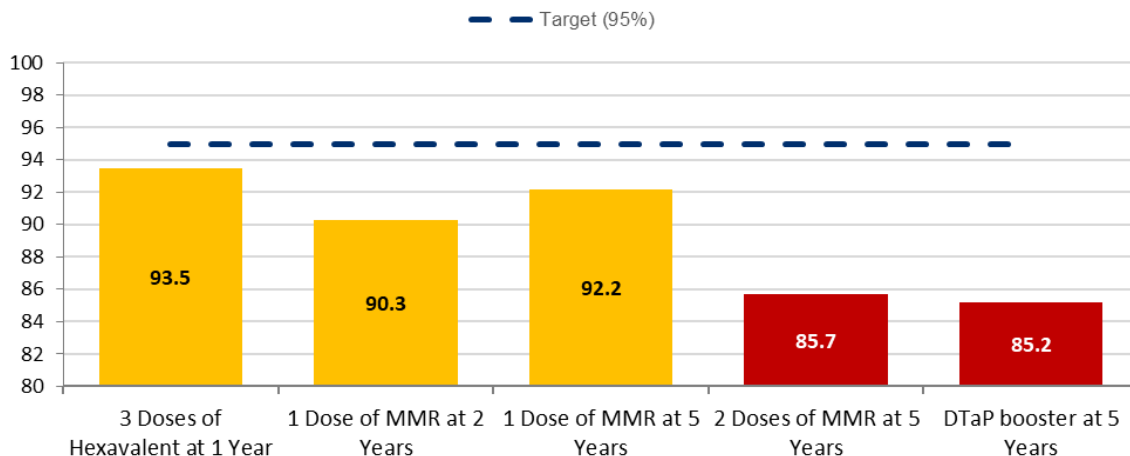
- **In 2021/22 and 2022/23** Southampton **missed** the target (95%) **for all 5 indicators**.
- Uptake in Southampton and England has been **decreasing** for **all 5 indicators**.
- **9/25** Southampton GP practices were **amber** or **red** for all 5 indicators in 2022/23.
- **0/25** Southampton GP practices were **green** for all 5 indicators in 2022/23.
- There was **no clear trend between** the **size of the cohort**/number of children eligible and **vaccination uptake**
- The **average gap to 95%** for 2022/23 was the equivalent to **7 additional children** at each GP practice having each vaccine.
- **Data is lacking on local uptake amongst people from different ethnicities**, including Eastern Europeans.
- **Absolute numbers** required to meet 95% target by individual GP practice is **relatively small**.

Vaccine uptake

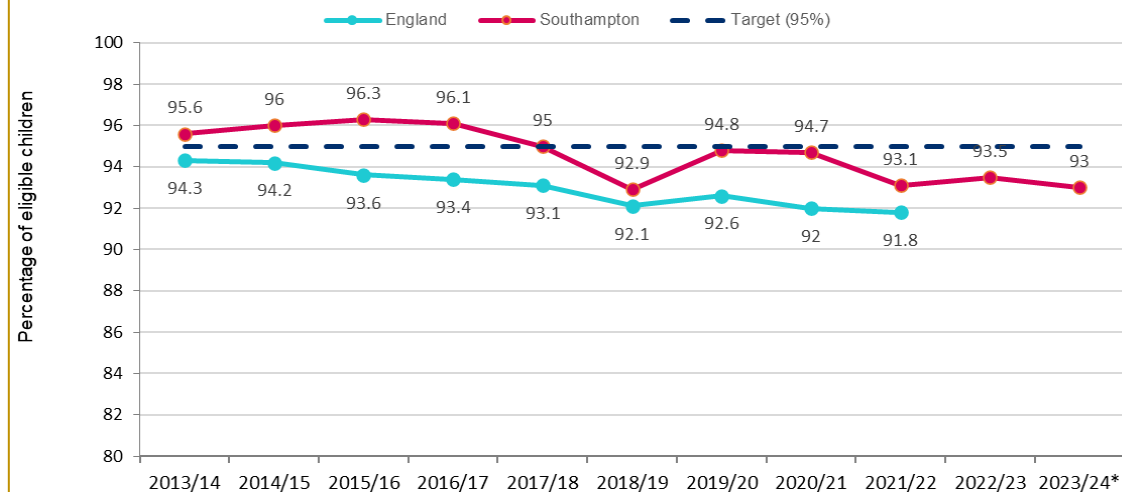
All 5 indicators

- In 2021/22 and 2022/23 Southampton **missed** the 95% target for **all 5 indicators**.
- Uptake for **2 indicators** was below 90% and rated **red (2 doses MMR at 5 years and DTaP booster at 5 years)**.
- This data indicates that **uptake gets worse as children get older and that the declining trend is continuing**.

Percent of eligible Southampton GP registered children covered by each vaccine in 2022/23 (vs. 95% target)



Percent of eligible Southampton GP registered children with 3 doses of hexavalent vaccine at 1 year of age (vs. 95% target and England)



Source: CHIS COVER Report
* Q1 average only

Hexavalent (3 doses at 1 year of age)

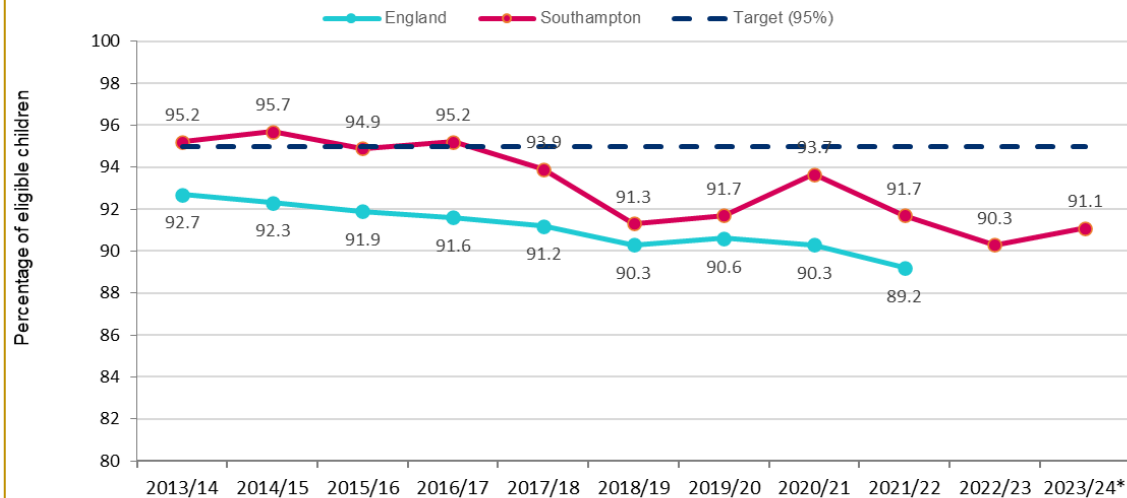
- **3 doses of hexavalent at 1 year of age** has been below the target of 95% in Southampton for the **last 5 years**.
- The **highest uptake** in **Southampton** over the last 5 years was during the peak of the COVID-19 pandemic (2019/20 and 2020/21), uptake was **within 0.3%** of target during these years. Uptake has decreased since.
- **Uptake in Southampton and England** has been **decreasing**.

Vaccine uptake

MMR (1 dose at 2 years of age)

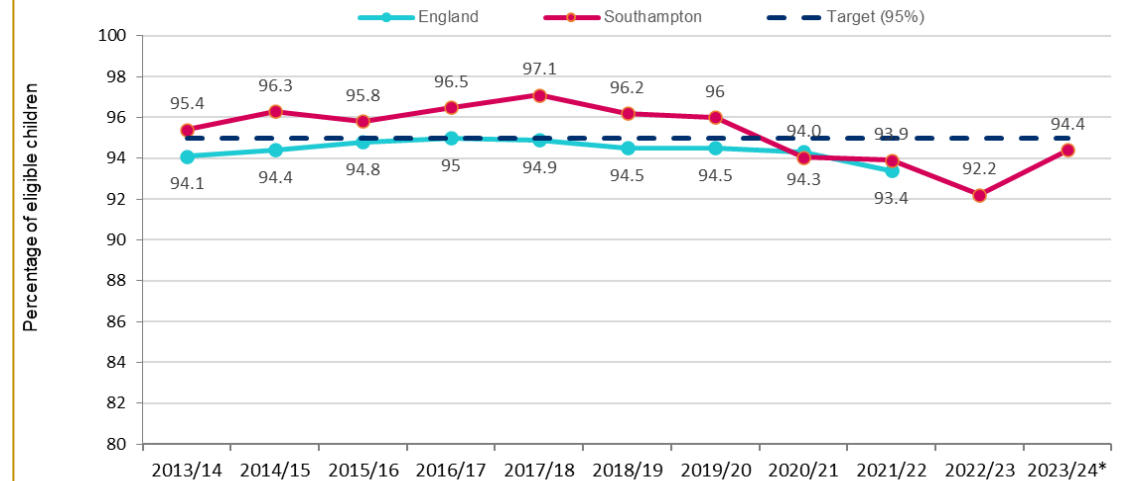
- **1 dose of MMR at 2 years of age** has been **below the target** of 95% in Southampton for the **last 6 years** but has **increased slightly in Q1 of 2023/24**.
- The **highest uptake in Southampton** over the last 4 years **was in 2020/21 during the peak of the COVID-19 pandemic**. Uptake has decreased since.
- Overall the trend in uptake for Southampton and England has been **decreasing and getting worse** and **remains below 95%**.

Percent of eligible Southampton GP registered children with 1 dose of MMR vaccine at 2 years of age (vs. 95% target and England)



Source: CHIS COVER Report
* Q1 average only

Percent of eligible Southampton GP registered children with 1 dose of MMR vaccine at 5 years of age (vs. 95% target and England)



Source: CHIS COVER Report
* Q1 average only

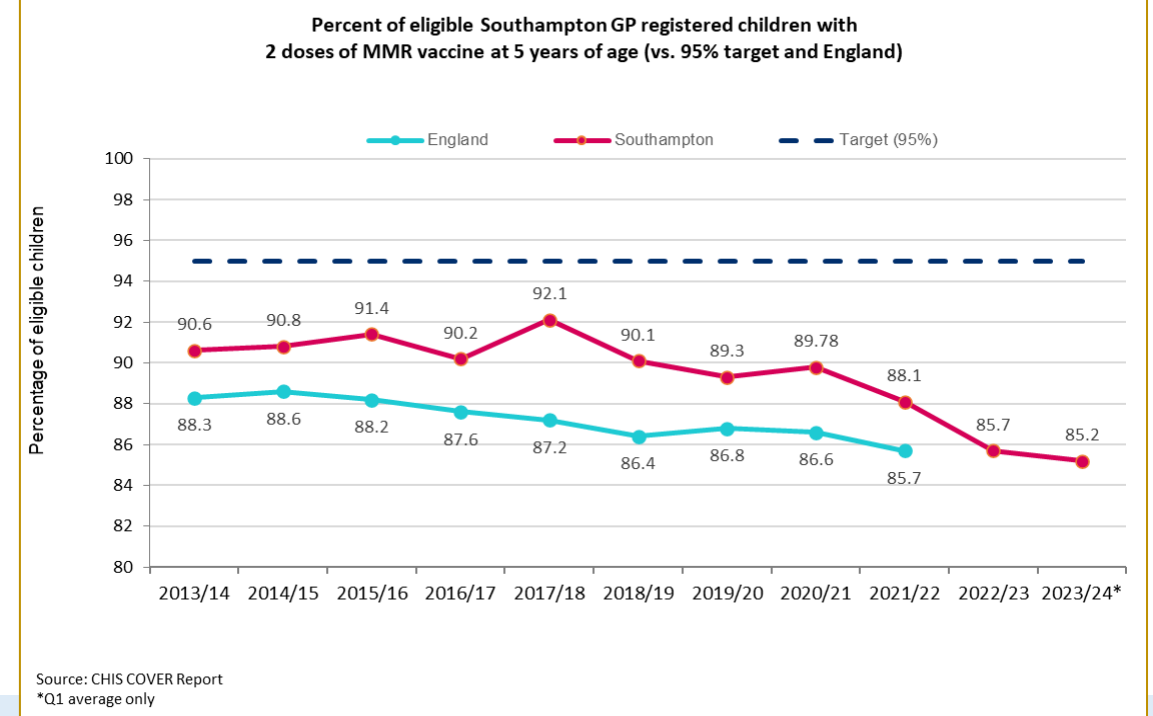
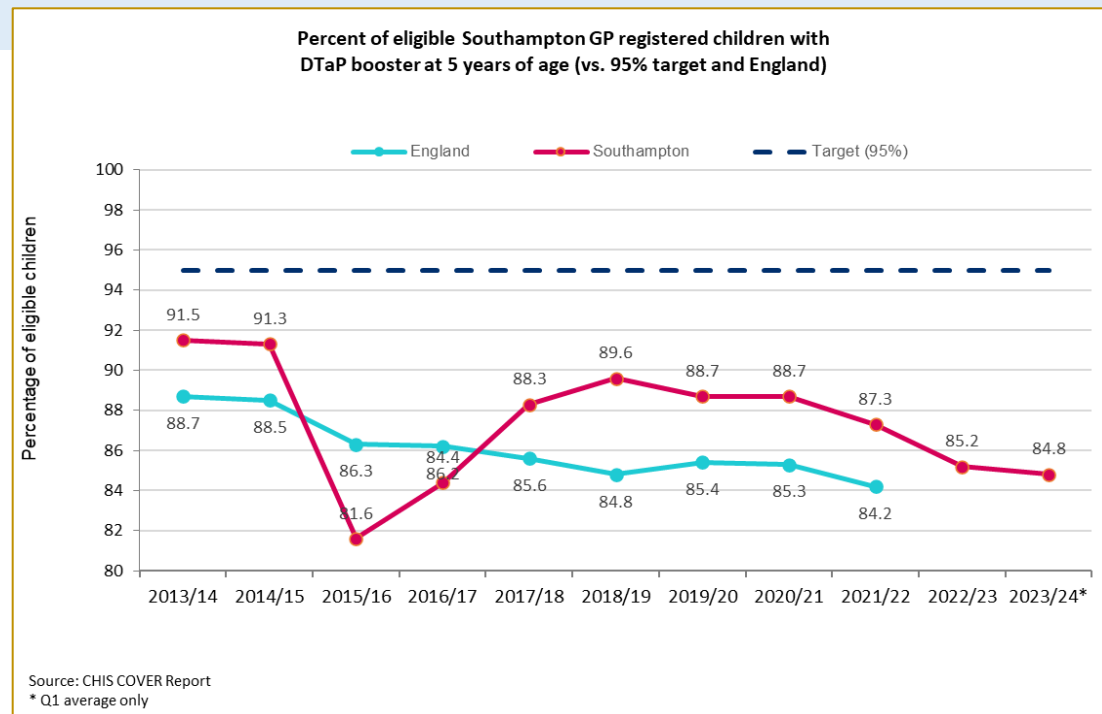
MMR (1 dose at 5 years of age)

- **1 dose of MMR at 5 years of age** has been **below the target** of 95% in Southampton for the **last 2 years** and is **on track to miss again in 2022/23**.
- **Uptake was increasing** in Southampton **until 2017/18**. Uptake has reduced every year since.
- Uptake has **increased to 94.4% in Q1 of 2023/24**
- **Prior to this, uptake in Southampton and England** had been **decreasing and getting worse** year on year since 2017/18.

Key vaccine uptake

DtAP booster at 5 years of age

- **DTaP booster at 5 years of age** has been **below the target** of 95% in Southampton since records began in 2013/14 and is **on track to miss again in 2023/24**.
- **Uptake in Southampton and England** has been **decreasing and getting worse**.



MMR (2 dose at 5 years of age)

- **2 doses of MMR at 5 years of age** has been **below the target** of 95% in Southampton since records began in 2013/14 and is **on track to miss again in 2023/24**.
- **Uptake in Southampton and England** has been **decreasing**.

Vaccine uptake

Uptake by anonymised Southampton GP practice

- **9/25 Southampton GP practices** were **amber** or **red** for all 5 indicators in 2022/23.
- **0 Southampton GP practices** were **green** for all 5 indicators.
- **1 Southampton GP practice** was **red** for all 5 indicators.

| Anonymised GP Practice | % Uptake (2022/23) | | | | |
|------------------------|---------------------------------|--------------------------|--------------------------|-------------------------|---------------------------|
| | 3 Doses of Hexavalent at 1 Year | 1 Dose of MMR at 2 Years | 1 Dose of MMR at 5 Years | DTaP booster at 5 Years | 2 Doses of MMR at 5 Years |
| GP-1 | 88.8 | 88.1 | 89 | 79 | 79.7 |
| GP-2 | 93.8 | 94.5 | 86.8 | 76.7 | 79.9 |
| GP-3 | 90.6 | 91.9 | 93.5 | 83.5 | 82.5 |
| GP-4 | 93.6 | 96.3 | 93.6 | 91.3 | 91.3 |
| GP-5 | 88.4 | 88 | 90.3 | 74.8 | 77.7 |
| GP-6 | 93.9 | 94.4 | 95.9 | 88.9 | 88.5 |
| GP-7 | 91.9 | 90.7 | 86.4 | 79.5 | 81.8 |
| GP-8 | 93.1 | 93.8 | 92.4 | 83.5 | 83.5 |
| GP-9 | 87.1 | 90.1 | 86.1 | 83.5 | 83.5 |
| GP-10 | 96.6 | 95.8 | 87.5 | 73.6 | 75 |
| GP-11 | 95.5 | 96.1 | 93.5 | 84.9 | 85.5 |
| GP-12 | 88.5 | 91.2 | 89.7 | 82.1 | 82.8 |
| GP-13 | 81.3 | 86.7 | 91.2 | 85.3 | 85.3 |
| GP-14 | 97.6 | 96.5 | 96.6 | 90.7 | 92.2 |
| GP-15 | 96.2 | 92.6 | 98.1 | 92.5 | 90.6 |
| GP-16 | 95.7 | 97.6 | 91.5 | 89.4 | 89.4 |
| GP-17 | 93.1 | 100 | 86.5 | 76.9 | 78.8 |
| GP-18 | 98.6 | 98.6 | 92.4 | 81.8 | 80.3 |
| GP-19 | 100 | 91.1 | 88.9 | 77.8 | 84.4 |
| GP-20 | 97.2 | 98.4 | 93.1 | 86.1 | 84.7 |
| GP-21 | 97.4 | 100 | 100 | 97.3 | 94.6 |
| GP-22 | 99.2 | 95.6 | 97.4 | 91 | 89.7 |
| GP-23 | 97.3 | 97.4 | 94.4 | 93.3 | 93.3 |
| GP-24 | 97.5 | 98.1 | 96.1 | 91.4 | 91.4 |
| GP-25 | 96.8 | 94.7 | 94.7 | 94.7 | 94.7 |

NB:

- The size of the eligible cohort at each GP Practice varies year on year.
- The average eligible cohort for 2022/23 was 360 children per practice (ranging between 88 and 1,312).
- There was no clear trend between the size of the cohort/number of children eligible for vaccination and uptake.

Hexavalent (3 doses at 1 year of age)

- **5 Southampton GP practices** had **less than 90% uptake** for **3 doses of hexavalent vaccine at 1 year of age** in 2022/23.
- **13 Southampton GP practices** had **more than 95% uptake** in 2022/23.

MMR (1 dose at 2 years of age)

- **3 Southampton GP practices** had **less than 90% uptake** for 1 dose of MMR vaccine at 2 years of age in 2022/23.
- **12 Southampton GP practices** had **more than 95% uptake** in 2022/23.

MMR (1 dose at 5 years of age)

- **8 Southampton GP practices** had **less than 90% uptake** for **1 dose of MMR vaccine at 5 years of age** in 2022/23.
- **6 Southampton GP practices** had **more than 95% uptake** in 2022/23.

MMR (2 doses at 5 years of age)

- **18 Southampton GP practices** had **less than 90% uptake** for **2 Doses of MMR at 5 Years of age** in 2022/23.
- **0 Southampton GP practices** had **more than 95% uptake** in 2022/23.

DTaP booster (at 5 years of age)

- **17 Southampton GP practices** had **less than 90% uptake** for the **DTaP booster at 5 Years of age** in 2022/23.
- **1 Southampton GP practices** had **more than 95% uptake** in 2022/23.

Gap to 95%

Hexavalent (3 doses at 1 year of age)

- **74 more children** would have needed vaccinating for all GP practices in Southampton **to reach 95%.**

MMR (1 dose at 2 years of age)

- **65 more children** would have needed vaccinating for all GP practices in Southampton **to reach 95%.**

MMR (1 dose at 5 years of age)

- **109 more children** would have needed vaccinating for all GP practices in Southampton **to reach 95%**

MMR (2 doses at 5 years of age)

- **306 more children** would have needed vaccinating for all GP practices in Southampton **to reach 95%.**

DTaP booster (at 5 years of age)

- **300 more children** would have needed vaccinating **for all GP practices** in Southampton **to reach 95%**

Gap to 95%* (2022/23)

| Anonymised GP Practice | Gap to 95%* (2022/23) | | | | |
|------------------------|---------------------------------|--------------------------|--------------------------|-------------------------|---------------------------|
| | 3 Doses of Hexavalent at 1 Year | 1 Dose of MMR at 2 Years | 1 Dose of MMR at 5 Years | DTaP booster at 5 Years | 2 Doses of MMR at 5 Years |
| GP-1 | 17 | 22 | 17 | 45 | 43 |
| GP-2 | 3 | 1 | 16 | 35 | 29 |
| GP-3 | 10 | 7 | 3 | 23 | 25 |
| GP-4 | 6 | 0 | 7 | 18 | 18 |
| GP-5 | 7 | 7 | 5 | 21 | 18 |
| GP-6 | 2 | 2 | 0 | 14 | 15 |
| GP-7 | 4 | 5 | 12 | 21 | 18 |
| GP-8 | 2 | 2 | 3 | 10 | 10 |
| GP-9 | 8 | 5 | 11 | 14 | 14 |
| GP-10 | 0 | 0 | 6 | 16 | 15 |
| GP-11 | 0 | 0 | 3 | 19 | 18 |
| GP-12 | 8 | 6 | 8 | 19 | 18 |
| GP-13 | 5 | 3 | 2 | 4 | 4 |
| GP-14 | 0 | 0 | 0 | 9 | 6 |
| GP-15 | 0 | 2 | 0 | 3 | 5 |
| GP-16 | 0 | 0 | 2 | 3 | 3 |
| GP-17 | 2 | 0 | 5 | 10 | 9 |
| GP-18 | 0 | 0 | 2 | 9 | 10 |
| GP-19 | 0 | 2 | 3 | 8 | 5 |
| GP-20 | 0 | 0 | 2 | 7 | 8 |
| GP-21 | 0 | 0 | 0 | 0 | 1 |
| GP-22 | 0 | 0 | 0 | 4 | 5 |
| GP-23 | 0 | 0 | 1 | 2 | 2 |
| GP-24 | 0 | 0 | 0 | 6 | 6 |
| GP-25 | 0 | 1 | 1 | 1 | 1 |

* Number of extra children taking up the vaccine for the practice to reach 95% coverage (rounded up to the nearest whole number)

Desk-Based Review



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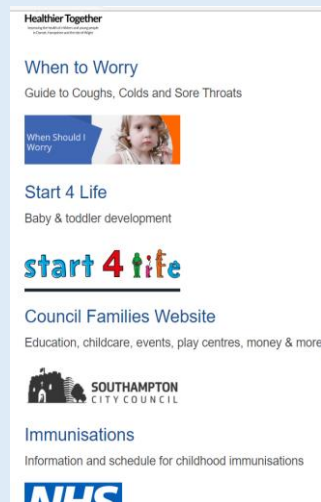
Desk-based information review

Method:

- **35 websites (26 of which were GPs, including homeless health) were included in a desk-based review method.**

All were reviewed by 1 person who looked at;

- availability of information on childhood immunisations
 - language and accessibility
 - use of signposting
 - pathway to book a childhood immunisation appointment
- 1 website was inaccessible (at time of review)
- Findings were put into quantitative data
- Other information sources included within the review:
 - Healthier together website
 - NHS vaccinations page
 - Family Assist
 - National Childbirth Trust
 - UHS Maternity Services
 - Southampton City Council
 - Hampshire Healthy Families
 - Gov.uk



Key findings:

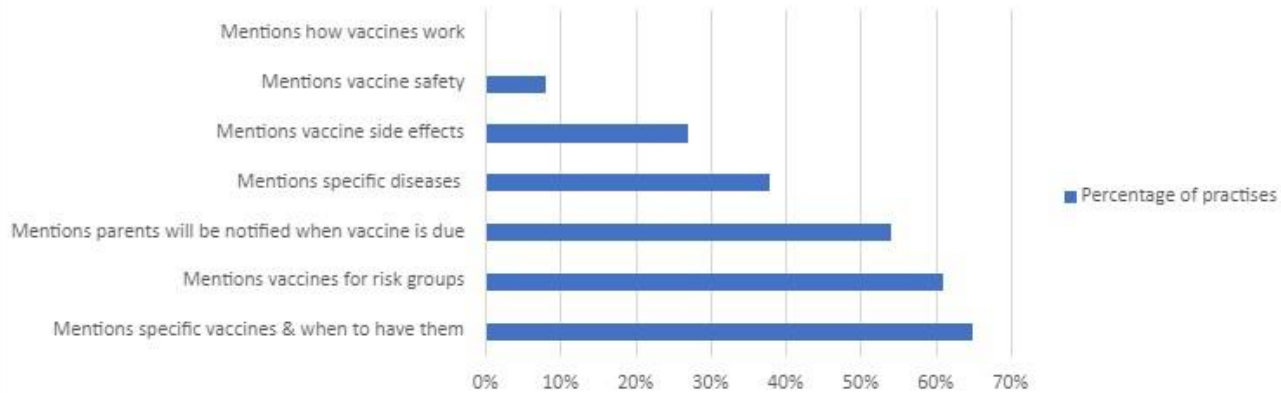
- There is **significant variation** in the **quality, scope and accessibility of information** available via practice websites relating to childhood immunisations.
- Whilst our review **did NOT find a correlation** between the **quality of practice websites and uptake**, the **inconsistency between practices across the city may be adding to inequities** in accessibility.
- Some GP practices located within **wards with high numbers of residents for who English is not a first language did not** have a **translation function available**.
- There is **scope for all Practice websites to improve** the **quality and accessibility of information available** in relation to childhood immunisations.

Key recommendations:

- ⚙ All GP websites to have the **translation option available** on the **whole page**.
- ⚙ All to have **childhood immunisations section, that is easily accessible** from the home menu.
- ⚙ **Direct route to book/rearrange an appointment** from the childhood immunisations page.
- ⚙ **Support for booking** an appointment or **accessing additional help and information** advertised.
- ⚙ More **information on diseases** the vaccines protect against.
- ⚙ **Signposting to key websites** including NHS and Healthier Together.
- ⚙ More **information on vaccine safety and importance and successes of vaccinations**.
- ⚙ Support for parents in **confirming child immunisation status**
- ⚙ **Consider statements from faith leaders** as to importance of childhood vaccination.

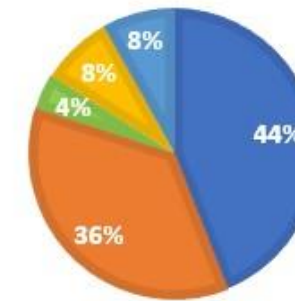
Findings

What information is currently mentioned on GP websites?



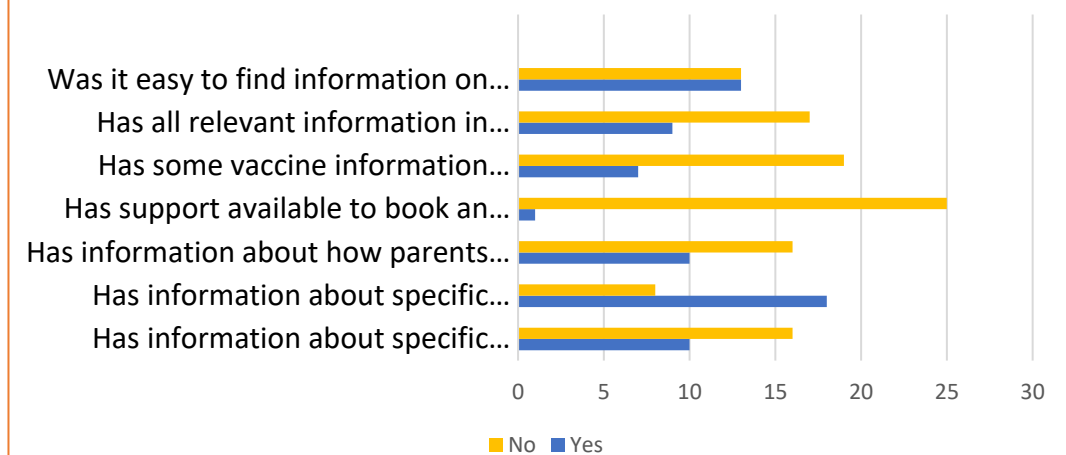
SIGNPOSTED RESOURCES ON GP WEBSITES

■ NHS vaccinations page ■ Healthier Together ■ SCC website ■ Start 4 Life ■ GOV.UK



| What Information is available | Mentions specific vaccines & when to have them | Mentions vaccines for risk groups | Mentions parents will be notified when it's due | Mentions specific diseases | Mentions Vaccine side effects | Mentions vaccine safety | Mentions how vaccines work |
|-------------------------------|--|-----------------------------------|---|----------------------------|-------------------------------|-------------------------|----------------------------|
| No. of practises | 17 | 16 | 14 | 10 | 7 | 2 | 0 |
| Percentage of practises | 65% | 61% | 54% | 38% | 27% | 8% | 0% |

Information Available on GP Websites



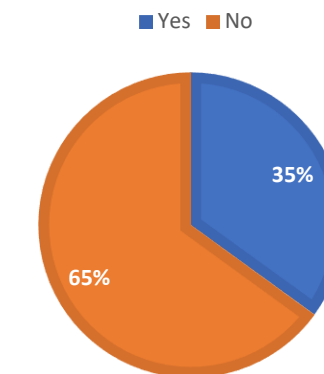
Key Findings

- We know that **language and literacy may be a barrier**, particularly in parts of the city where there are high numbers of individuals for whom English is not a first language
- Only 35% of GP practices had translatable information** on childhood immunisations available on their website.
- 5 practices indicated that there was the option but the function is not working** (those powered by 'Mysurgery' system)
- The majority of GPs (**61%**) **have information on all recommended routine vaccines** but there's a gap in information about specific infectious diseases.
- Childhood immunisation **information** was **hard to find on 50% GP websites** (subjective to 1 researcher's experience).
- NHS vaccination page is included on most** GP pages (Positive).
- Most practices do not offer support with booking** an appointment, **only 1 GP mentioned support.**
- Other parent-guardian resources** for immunisations are **under signposted**.

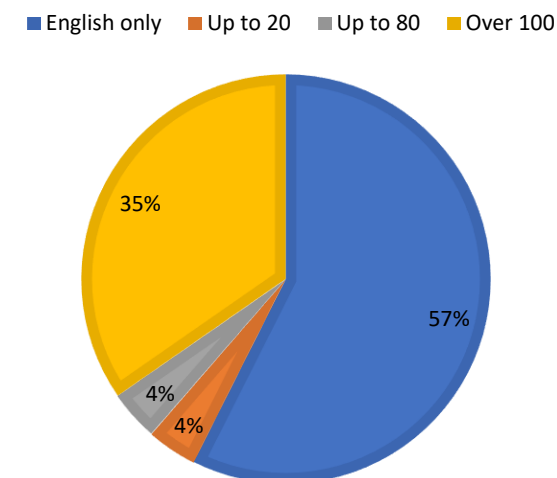
Examples of good practise

- ✓ **Information available** as to recommended routine vaccinations and when to have them
- ✓ **Signposting other resources**: NHS vaccinations page, healthier together website, start for life
- ✓ Option **to translate the page**, with options of over 100 languages.
- ✓ **Speaker translation option** for the whole page (Healthier together website)
- ✓ An **accessibility menu** to change the page (e.g. dyslexia friendly)
- ✓ 1 practice included the **statement from the Muslim Council of Britain** on the importance of vaccinations
- ✓ **Myths about immunisation** section (National Childbirth Trust)
- ✓ **Information on the importance** of vaccinations and that it's **safe**
- ✓ Availability of an **electronic consent** form (Hampshire healthy families)

HAS ALL RELEVANT INFORMATION IN TRANSLATED LANGUAGES



NO. OF LANGUAGES AVAILABLE



Parent Insights



Are you a parent, carer or guardian living in Southampton?

Or are you planning to have children?

Southampton City Council would like to hear your views and experiences of vaccinations offered to children under the age of five to help inform and improve the delivery of services in the future.

By taking part in the survey you can enter a prize draw* to be in with a chance of winning a family swimming pass for an Active Nation leisure centre near you!

The survey will run from Tuesday 13 June until Sunday 2 July 2023. The survey should take less than ten minutes to complete.

To find out more and have your say, visit: southampton.gov.uk/childvaccinesurvey

WIN a family swimming pass

Hampshire and Isle of Wight

ACTIVE

SOUTHAMPTON CITY COUNCIL

*% Not all of the Terms and Conditions for the prize draw can be read on the screen web page.



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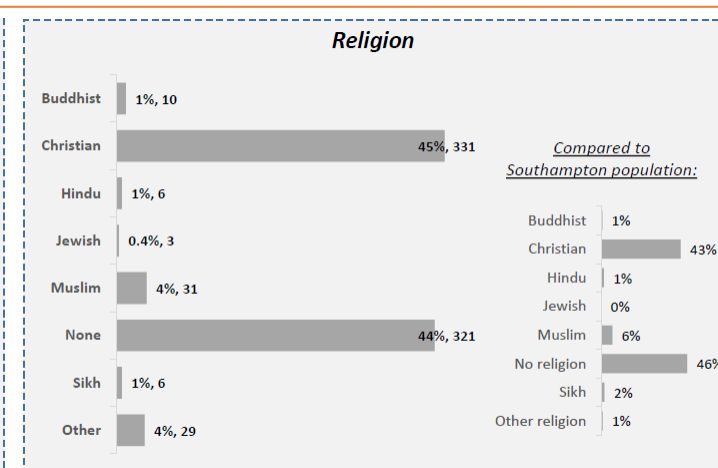
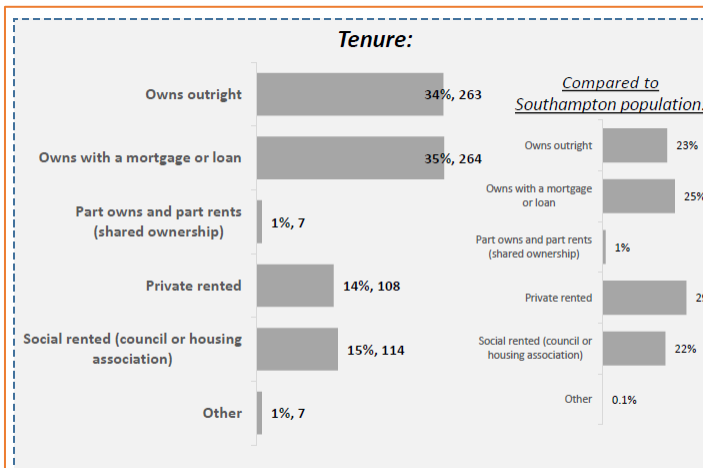
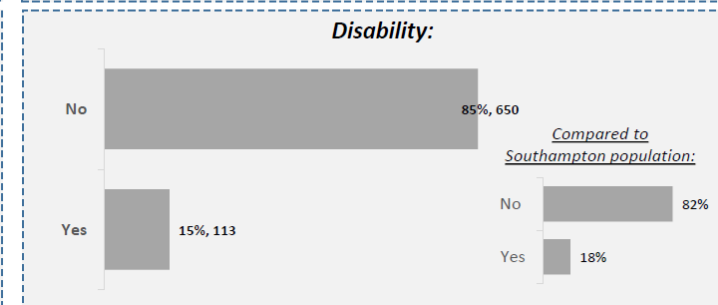
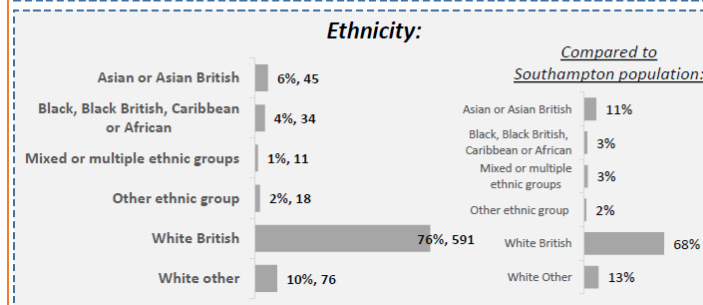
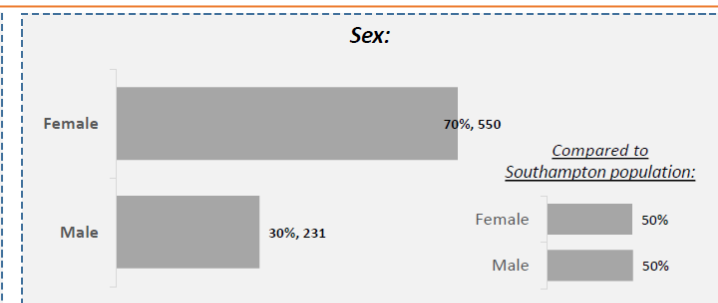
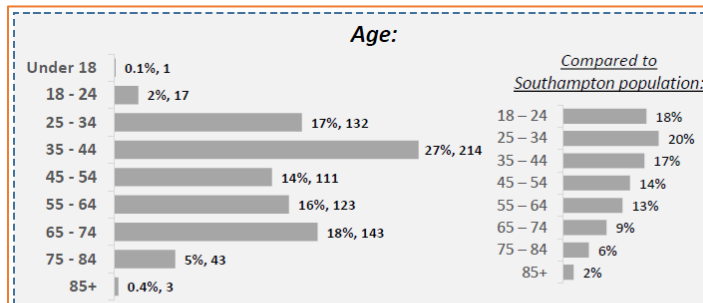
CHISANA Parent Survey

SCC designed and carried out a survey to explore the views and experiences residents have regarding routine childhood vaccinations offered to children under five years of age. Fieldwork took place between 13th June – 2nd July 2023.

- Total of **823 responses** through promotion across;
 - E-alerts, People's Panel, SCC website, Social media
 - Libraries, Family hubs, Tenant participation, Gateway
 - In-person events e.g. toddler groups
 - Shared with businesses and organisations
 - At local community groups and venues including food banks, community centres and parks

About the respondents

- 401 of the 823** respondents were a parent, guardian or carer of a child/children under the aged of 10, expecting a child/children or planning to have a child/children.
- 70%** of people who took part in the survey **were Female**.
- 76%** of respondents were **White British**. Responses collected from across other ethnic groups was **close to being representative of the general Southampton Population**.
- 15%** of responses were also collected from **parents with a disability**.
- 15% (114)** of respondents indicated they **reside in social rented housing** (council or housing association), **14% (108) in private rented** and **1% (7) Part own and part rents (shared ownership)**.
- 34% (263) own their housing outright** and **35% (264) own with a mortgage or loan**.



N.B: The survey was only available in English which may have been a barrier to some ethnic groups participating. Support was available in person with many of the surveys undertaken verbally and in some cases with the help of a translator.

Parent Survey - Key findings

Importance of vaccination

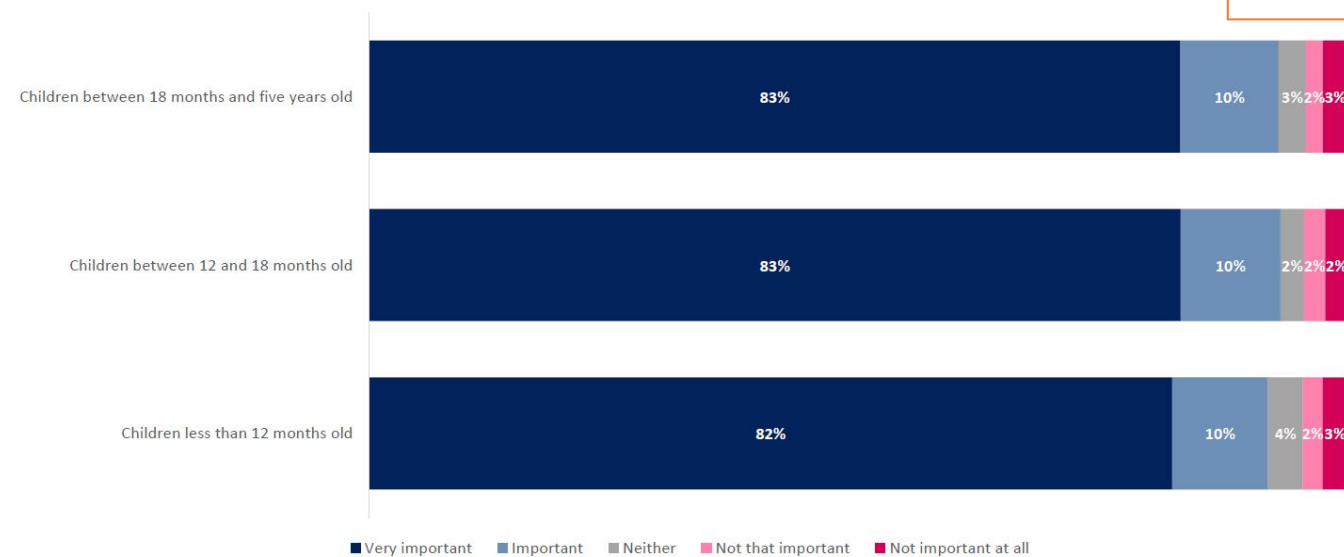
- The **importance of vaccination was high regardless of the age of the child.**
- Feelings** around childhood immunisation are **generally high.**
- 92% said vaccinations are important** for children **under 12 months**
- 93% said vaccinations are important** for children aged **between 12-18 months and 18**

Important of child vaccines by age

south data

Question: How important do you think routine childhood immunisations are for the following age groups?

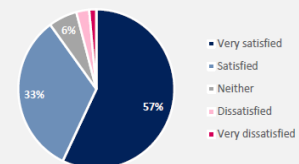
Overall:



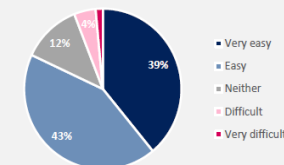
3. Respondents have had good experiences when receiving vaccinations.

southampton dataobservatory

90% of respondents who had their children vaccinated said that they were **satisfied with their vaccine visits.**



82% of respondents found it **easy to book vaccinations** for their children.



Nationally, 84% of parents found it easy to get a convenient appointment.

Source: Childhood Vaccines Parental Attitudes Survey

Uptake

- 90% of our survey respondents** who have children under 10 said their children were **fully vaccinated.**
- 88%** of those who are planning or expecting a child said that they **plan to get them vaccinated.** This is similar to the average vaccination uptake across Southampton, which was 91% in 2021/22 (*source: CHIS COVER report*)

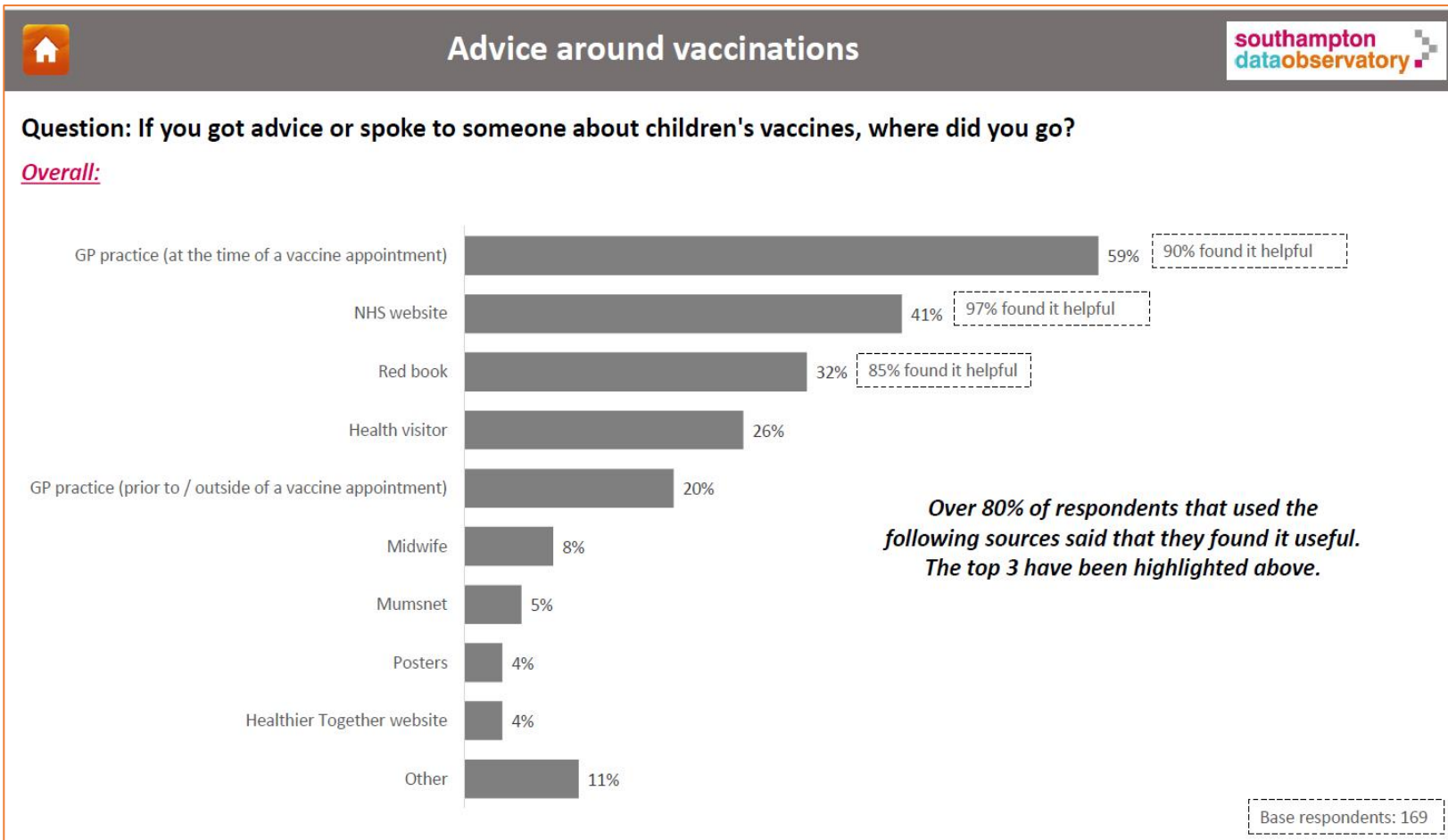
Parent Survey - Key findings

Advice

- Around half of respondents, **49%**, got advice about their children's vaccines.
- The most common place respondents went for advice was at a **GP practice and the NHS website**. The majority of people **found these sources helpful**. The most common reason for those who didn't get any advice was because they didn't feel they needed more information.

Experience of receiving vaccination

- **90% of respondents** who had their children vaccinated said that they were **satisfied with the vaccine visit**.



Parent Survey - Key findings

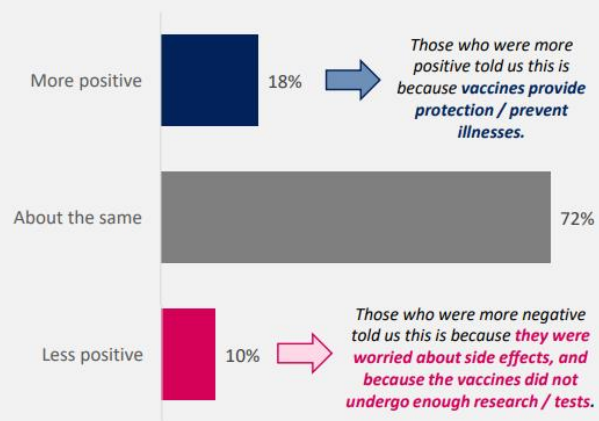
Enablers and barriers

- The **single most important or helpful thing** people would look for when booking a vaccine in an **easy booking system, greater availability of appointments** and **being sent reminders**.
- The most common barrier that respondents had was **a bad experience in a GP surgery or vaccination centre (16%)**.

Feelings since the COVID pandemic

- Whilst the majority feel the same about childhood vaccinations following the COVID-19 pandemic, around **1 in 5 respondents** told us that their feelings are now **more positive**.
- Where respondents indicated their feelings about childhood immunisations are less positive since the COVID-19 pandemic, **concerns about side effects was the reason most given**.

Whilst the majority feel the same about childhood vaccinations following the COVID-19 pandemic, around **1 in 5** respondents told us that their feelings are now **more positive**.

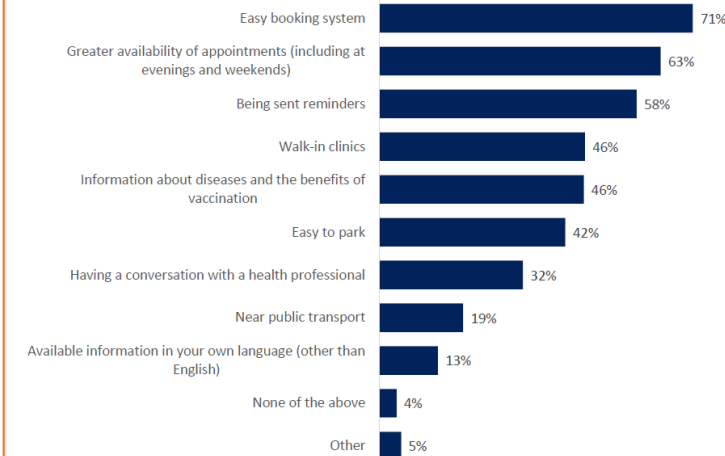


Important or helpful when considering child vaccinations

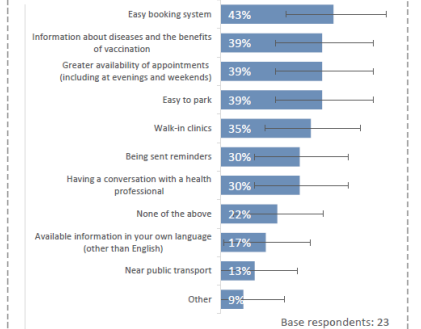


Question: What things would be important or helpful to you when considering or booking child vaccines?

Overall:



Broken down by those whose children are not fully vaccinated:



Confidence intervals are a measure of how reliable the results from the sample are in relation to the wider population. The Confidence Interval is a margin of error, a measure of the reliability of the results from the sample in relation to the wider population.

Key recommendations:

- Greater availability of appointments required (evenings/weekends).
- All GP practices to consider **automatically sending an appointment with a date and time** and have dedicated email or telephone option for any queries or needs (including rescheduling).
- Ensure that parents are sent **information in their chosen language**.
- Offer **support for parents with children with additional needs** e.g. assistance keeping children calm at the time of appointment and/or longer appointment slots.
- Proactively provide greater **education and reassurance** regarding **side effects**.
- Directly **address myths and concerns**.
- Promote the benefits**.

Parent Survey - Anecdotes

When carrying out surveys face to face, parents would sometimes continue the conversation and share further views in relation to childhood immunisations. It wasn't always possible to capture these comments within the survey template. Some of the comments that came up most frequently have been captured and summarised in quotes below. These provide further insights about parent's feelings and experiences of getting children immunised in Southampton.



Some parents told us about...

Vaccine hesitancy

Parents I know are anti-immunisation because of conspiracy theories or because they favour alternative medicine and 'organic' food.

Additional needs

It is stressful attending an appointment with an autistic child and having to restrain them. I need to know there will be support with this.

Ease of booking

It is so much easier when the GP just sends the appointment, but it can be very difficult to rearrange

Walk in clinics

I don't like walk in clinics because I am unsure how long I'll have to wait and whether my child will have a tantrum.

Walk in clinics are great.

Side effects

My child felt unwell after their vaccine, so they haven't had their boosters.

Language

My wife is unable to read letters and information that arrive in English

Appointment availability

Limited appointment options. I need weekends and/or evenings or walk in. Appointment time clashed with work, so I had to move to a different surgery.

Benefits

I was reluctant to vaccinate my children because I was worried about the side effects. A relative explained the benefits in my own language and I am now less anxious.

Specialist advice

I had a premature baby and the nurses seemed unsure as to what was best for a low weight (for age) baby, including dosing with Calpol.

COVID Vaccine

The COVID vaccine was developed far too rapidly, but this has not impacted how I feel about childhood immunisations. If anything, I feel it is more important.

MMR

I believe that this may have been a 'cover up'.

My child reacted after the first one, so I won't have the second.

Support

I worry about seeing my child distressed so I have asked Grandma to take them to the appointment.



Practice Insights



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CHISANA Workforce Survey

- SCC designed and carried out a GP practice survey to explore the views, experiences and approaches regarding the delivery of routine childhood vaccinations to under five years of age in Southampton. The survey took place between 13th June – 2nd July 2023. It was live for 3 weeks and was sent to all 25 GP Practices in Southampton offering childhood immunisations.

About the respondents

- Total of 23 responses from **25 GP Practices**.
- **56%** of respondents were **practice nurse or immunisation lead nurse**. **26%** **practice managers**. **9%** **GP** and **9%** **other**.

Key Findings - Strengths

- **95%** of practices have a **dedicated immunisation lead**.
- **83%** are **using translation resources**.
- **91%** of GP Practices said their process is to **book appointments themselves**.
- **52%** say the **wait** for an appointment is **less than a week**.
- **83%** say they hold ***catch up clinics**
- **100%** say they **will vaccinate without red book**.
- **100%** say they have **completed accredited training**.

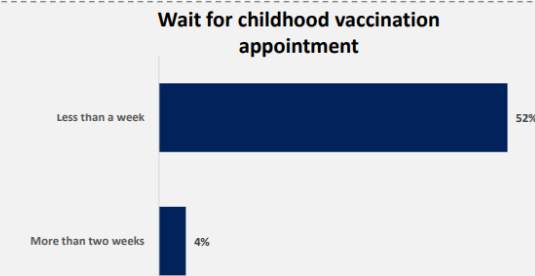
92% of GP practices said their process for parents / carers / guardians to book a child vaccine appointment was to contact them themselves. However, waiting for parents / carers / guardians to contact the practice scored just under at 83%.

Contacting parents through **text messaging reminders** is the most popular DNA process (**96%**). This was also shown across the breakdowns.



Just over **half (52%)** state the wait for an appointment is **less than a week**.

Lower uptake (aged 1) (**80%**) and Medium uptake (aged 5) (**78%**) were the highest scoring for having to wait less than a week. However, they also scored the lowest for GP practice's contacting parents regarding appointments (**78%**) & (**89%**).

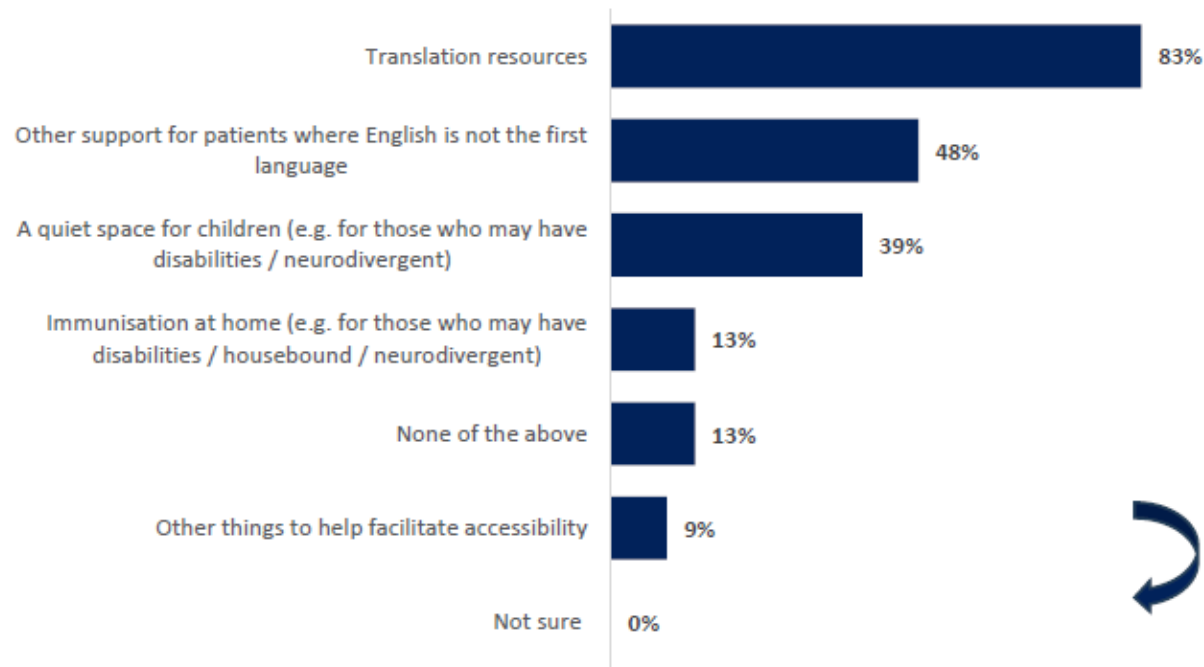


**the term 'catch up clinics' may be referred to differently in different practices/settings but usually refers to either a) a 'catch up' programme of work designed to 'catch-up' anyone who has missed doses of vaccinations, or b) where there are more children needing to be vaccinated than there are appointments available. Practices should offer flexibility, know how many children require vaccinating and be proactive in this approach.*

CHISANA Workforce Survey

Question: Does your practice provide any of the following facilities/support to improve accessibility for childhood immunisations?(please tick all that apply) *Multiple choice*

Overall:



- *“Language line if necessary”*
- *“One set clinic a week- Monday afternoons. Otherwise, children can be booked in anytime Mon-Fri between 8-6. I have had contact with parents of neurodivergent children and booked them in at the end of clinics and welcomed them straight into the clinic rooms, so they don’t have to wait in loud waiting areas”*
- *“We can offer a pre-vaccination visit to 'meet the nurse' for anyone who might benefit from that. And a longer appointment slot for any children with disabilities.”*

Key findings

- **83%** of responses said that have **translation resources** that provide support to improve accessibility.

Base respondents: 23

CHISANA Workforce Survey

Key Findings – Opportunities for Improvement

It is difficult to draw out any significant theme or pattern from the survey that explains the data but the surveys do highlight opportunities for improvement

Trained Immunisers

- **5 GP Practices (22%) who responded to our survey** have indicated they have **only 1 x trained immuniser**. Workforce continuity is a risk (business continuity, knowledge, capacity). 4 of these practices also indicated that their clinics are 'always full'.

Discussing vaccinations

- Only **43% have multi-disciplinary team (MDT) meeting** where vaccinations are discussed. Opportunity to strength this and working more closely with health visitors and midwives.

Working with health visitors/midwives

- Only **36% say** that they work with them on an **ad hoc basis**. **27% say** they work with them **monthly**.
- **5% said** they **do not work with them** at all.

Data Cleansing

- Accurate data and records and routine data cleansing could have significant improvements on practice data. **35% of practices** indicated they were **not sure how often they cleanse practice population register**.

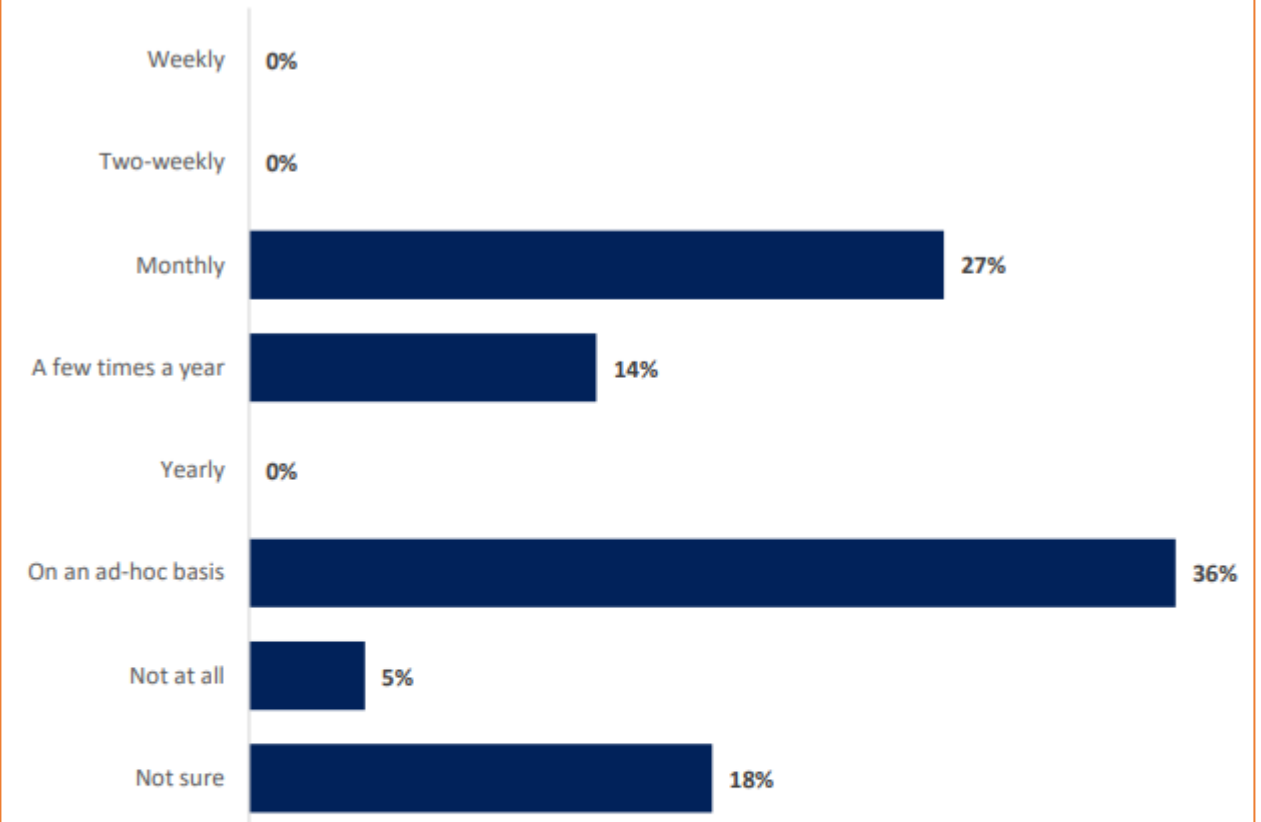
Initiatives

- **50%** of practices who responded say they **were not sure if they undertake any initiatives** for child immunisations.

CHISANA Workforce Survey

Question: How often do you/your practice do the following? Work with health visitors/midwives *Single choice*

Overall:



Key findings

- **36%** said that on an **ad-hoc basis** the practice works with a health visitor/midwife.
- **5%** of the practices said they **do not work at all** with health visitors/ midwives.

Base respondents: 23

CHISANA Workforce Survey

Key Findings – Opportunities for Improvement (continued)

Barriers and Enablers

Translation resources

- **83%** are **using translation resources**. This is encouraging but it is not clear from the survey how these are used. Further work required to understand at what stage these are provided and how actively they are promoted.

Barriers

- **‘Don’t believe in vaccination’, ‘Forgotten/not got around to it, ‘Obtained/obtaining a vaccine outside of UK and ‘English not first language’** were the barriers most frequently selected by Practices in response to ‘select any elements you or your colleagues have experienced as barriers to getting their children vaccinated’. This contrast with the parent survey which highlighted appointment availability, having a conversation with a health care provider and being sent reminders.

Initiatives

- **52% were not sure** if their practices are offering any initiatives.
- **30% said no** they aren’t running any initiatives and **17% indicated ‘yes’** they are running initiatives. This would indicate scope for more initiatives at practice level.

Bad experience

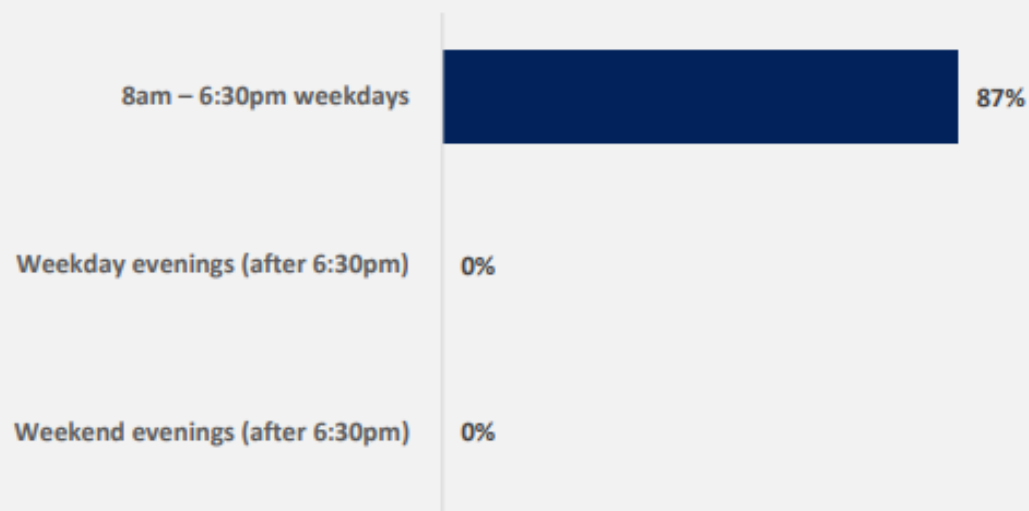
- There were very few examples provided in relation to ‘bad experience’.

CHISANA Workforce Survey

Question: What hours are child immunisation clinics held or offered at your practice? (please tick all that apply) *Multiple choice*

Clinics are being held/offered mainly during **weekdays between 8am – 6:30pm (87%)**. While no clinics are being held during **evenings (after 6:30pm)** on both weekdays and weekends.

Clinic's held/offered



While **11%** of Lower uptake (aged 1) and **11%** Medium uptake (aged 5) had clinics **rarely full**.

CHISANA Workforce Survey

Booking process

DNA Process

- **96% send text messages.** Evidence suggests that having a conversation with a health care provider can be vital where parents are hesitant or have concerns. **Exploring a more personalised approach** e.g. phone call, may help address this.

Operational hours

Appointment availability/operational hours

- GP practices are split on the time spent holding child immunisation clinics per week, with **both 2-4 hours** and **more than 8 hours** receiving **35%**.
- **8 x GP practices** indicated that they are **not offering more than 4 hours** of childhood immunisation clinics a week.
- **13 x GP Practices** are **not offering** childhood immunisations **opportunistically**.

Appointment time

- The survey indicates that on average **10 minutes is available per immunisations** carried out. Longer appointment slots should be available to allow time to discuss benefits and answer any questions, particularly where there may be language barriers.
- Longer slots should also be made available for larger families so multiple vaccinations can be given at one appointment.

Catch up Clinics

- 17% are not offering catch up clinics despite the data indicating that immunisation takes off at children get older and may benefit from opportunities to get up to date.

Key recommendations:

- ⚙ Longer appointments for parents with children with additional needs.
- ⚙ Was not Brought (WNB) and Did Not Attend (DNA) DNA Processes and ensure this is personalised.
- ⚙ Ensure translation resources are being use prior to appointment
- ⚙ Catch up clinics to be offered as standard by all GP Practices.
- ⚙ Longer appointment slots should be available to allow time to discuss benefits and answer any questions.
- ⚙ Strengthen work with health visitors/midwives to ensure routine collaboration.
- ⚙ PCN wide collaboration – only 13% are looking to share staff within the PCN. Explore scope for greater collaboration within PCNs.
- New initiatives above and beyond standard practice should be routinely offered.

Previous Studies and Guidance



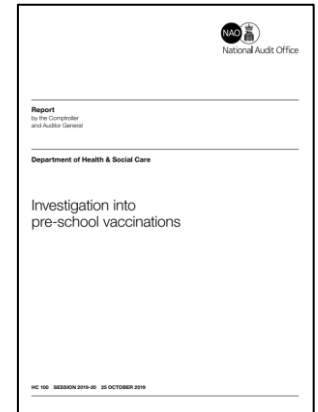
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Investigation into pre-school vaccines NAO (2019)

Key findings/themes:

- **No single issue** but a range of **factors that operate together** are causing a decline.
- **Inconsistencies** in how healthcare **professional remind (call/recall) parents** to vaccinate their children.
- Parents can find it difficult to access vaccination services citing **timing and childcare as barriers**. Some under-served communities do not access healthcare in expected ways e.g. traveller communities or religious groups.
- **Limited evidence of any major impact** on vaccination uptake **from anti-vaccination messages**. This is backed up by our own survey and the National UKHSA parent attitudes survey.
- A **small minority of parents** are reluctant because of **concerns about vaccination** (complacency, inconvenience or lack of confidence).
- NHS England and PHE (UKHSA) do not know the relative impact of the possible causes on the declining uptake of vaccination. **Unable to indicate the extent to which each factor impacts on uptake nationally.**
- NHS England and PHE monitor regional variations at a high level.
- NHSE and PHE **do not use a consistent approach to engage with under-served groups.**
- PHE, NHSE and the Department of Health and Social Care are **developing a joint communications strategy to promote positive messages** and **overcome vaccine hesitancy.**

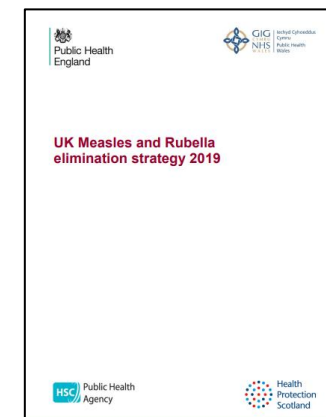
Source: [Investigation into pre-school vaccinations \(nao.org.uk\)](https://www.nao.org.uk)



“ NHSE considers that there is a **link between deprivation and uptake of MMR**. Whilst higher deprivation can be associated with lower vaccination uptake, **there is also in its view, some evidence of wider dissemination of anti-vaccination messages and vaccine hesitancy amongst higher income groups**. However, the data, when analysed by areas of deprivation indicate the **uptake of MMR is lower in the most deprived local authorities**. ”
(p28)

“ In 2018, a small-scale review of GP practices in England by PHE and the London School of Hygiene and Tropical Medicine showed **no GP practices (out of nine) had services to increase uptake in groups who had low vaccination uptake or to identify vulnerable or ‘under-served’ populations**. In its action plan, NHS England requested that regional teams share examples of local responses to measles outbreaks in under-served communities. ”
(p35).

UK measles and rubella elimination strategy (2019)



Key findings/themes:

- UK achieved elimination status in 2016 but lost status in 2018.
- **Young people born between 1998/99 and 2003/04** (aged 15 to 20 years in 2018) are **most susceptible**. ('Wakefield Cohort' now aged 19-25).
- **London remains the most vulnerable region** with immunity targets not achieved for many birth cohorts - including younger children of primary and secondary school age.
- There are **inequalities in vaccine uptake** by ethnicity, deprivation and geography and the burden of measles and rubella falls disproportionately on certain communities.
- **Measles and rubella remain endemic in many other countries** and, with current large measles outbreaks across Europe, **imported infections pose a very real threat** to the UK's recent achievements.
- **Prior to Measles vaccine there were 100 deaths** from acute measles in the **UK each year**.
- **Rubella infection in pregnancy** caused a **significant burden** in terms of **terminations and babies born with Congenital Rubella Syndrome**

Source: [UK Measles and Rubella elimination strategy 2019 \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414242/uk-measles-and-rubella-elimination-strategy-2019.pdf)

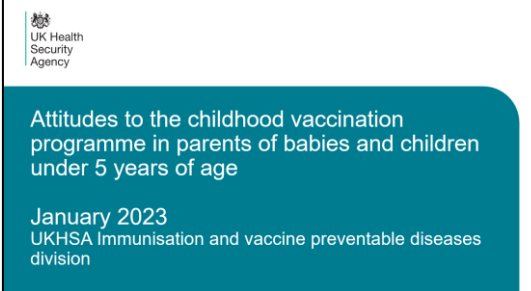
Four key components to strategy:

1. Achieve and sustain **≥ 95% coverage with two doses of MMR vaccine** in the routine childhood programme (**<5 years old**).
2. Achieve **≥ 95% coverage with two doses of MMR vaccine in older age cohorts** through **opportunistic and targeted catch-up** (>5 years old).
3. **Strengthen measles and rubella surveillance** through rigorous case investigation and testing **≥80% of all suspected cases with an Oral Fluid Test (OFT)**
4. Ensure **easy access to high-quality, evidence-based information** for health professionals and the public.

National vaccine attitude parents (under 5s), 2022

An email was sent on 2nd September 2022 to parents registered with Bounty (a commercial parental marketing organisation) of behalf of UKHSA.

- 328,542 email addresses.
- A total of 1485 surveys were completed.
- People living in London were under-represented and the Southeast were over-represented.
- Older mothers were over-represented and younger mothers were under-represented
- White British parents were over-represented and non-white parents were under-represented (based on ethnicity of live births, 2007 to 2019)



Key Findings:

- **95%** of parents **think vaccines work**, **91%** of parents **think vaccines are safe** and **90%** **trust vaccines**.
- **71%** of parents remember **recently coming across information** about vaccines for babies or young children.
- **74%** of parents came across information that **made them feel vaccination was important** for their baby or child.
- Only **15%** of parents read, heard or saw **something that made them concerned or worried** about their baby or child having their vaccines. **This most often came from friends or family, social media, the internet (Netmums or Mumsnet), TV or magazines or radio.** This was most often about 1) Coronavirus vaccine 2) MMR vaccine 3) DTaP-IPV-Hib-HepB vaccine.
- **Meningitis and septicaemia** were considered very serious by **95%** of parents.
- Parents reported that the **most common sources** of vaccine information came from the **red book/Personal Child Health Record (52%), health visitor or midwife (49%), other healthcare professional (40%) the NHS website (31%), NHS leaflet (25%).**
- **90%** of parents **thought that measles, rubella, mumps, polio, pneumonia and hepatitis could be serious** or very serious.
- COVID-19, flu and rotavirus were least likely to be considered serious.
- **92%** of parents were **happy with vaccine safety**.
- **95%** of parents felt that their baby **would have all vaccines offered before any discussion** with a health professional.
- **36%** of parents **felt more confident** about vaccinating their baby **after receiving information from a health professional**.
- **42%** of parents who **were undecided** about whether to get their baby vaccinated **felt more confident after speaking to a health professional**.
- **90%** of parents agreed they **like to have their child vaccinated at their GP practice**.
- **98%** of parents agreed that they **like to be reminded about upcoming appointments**.

Moving The Needle: Promoting vaccination uptake across the life course (2019)

Royal Society for Public Health (RSPH)

In 2018, RSPH carried out an investigation into attitudes to and awareness of vaccinations with regards to childhood, adolescent, working age adulthood and older age. This included a literature review of relevant articles, and three public surveys (adults, parents and workforce).

Key findings/themes:

Access:

- **Timing, availability** and **location identified as barriers** although the vast majority who chose not to vaccinate did not cite inconvenience as a key factor.
- **Improving access** to vaccination remains **crucial** especially when tackling inequalities.

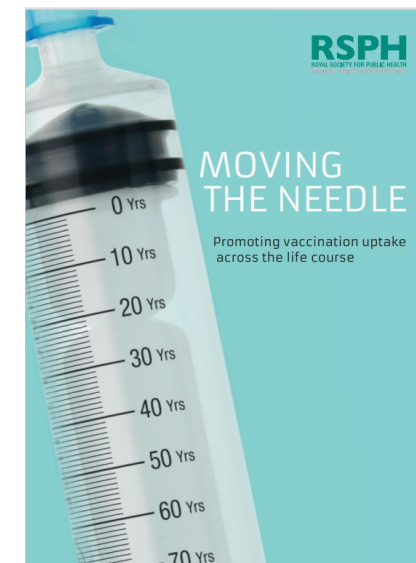
Attitudes:

- Attitudes are largely positive. **91% agreed vaccines are important for their children's health.**
- **Fear of side effects** of vaccines was consistently found to be the primary reason for choosing not to vaccinate (except for the childhood flu vaccine, for which it was the second most common reason).
- **Lack of confidence in the effectiveness** was the number one reason for choosing not to vaccinate against flu.
- **Fairly low understanding of herd protection** and the **myth of vaccine overload remains persistent** with just over a quarter (28%) of people believing you can have too many vaccinations'

Influences:

- **Trust** in healthcare professionals **remains very high.**
- **Social media** was identified as **propagating negative messages** around vaccination.
- **Traditional media** continues to be **influential** particularly seen in the ongoing ramifications of the Wakefield scandal.

Source: [RSPH | Moving the Needle: Promoting vaccination uptake across the life course](#)



Calls to action

• Tackling negative misconceptions of vaccines

- Efforts to limit health misinformation online and via social media should be increased, especially by social media platforms themselves.
- Responsibility of the press to share factual information about vaccines should be enforced by considering health impact when the IPSO Editor's Code is broken.
- Education on vaccines in schools should be increased and improved, especially in the PSHE curriculum.

• Improving access to vaccinations

- Vaccinations should be offered in a more diverse range of locations, including high street pop-ups, utilising the wider public health workforce.
- Health professionals to use the Making Every Contact Count (MECC) approach to ensure vaccine advice is delivered across the health system.
- Reminder services to be improved by using innovative methods such as social media pop-ups.

'Tailoring Immunisation Programmes' (TIP) approach, 2019

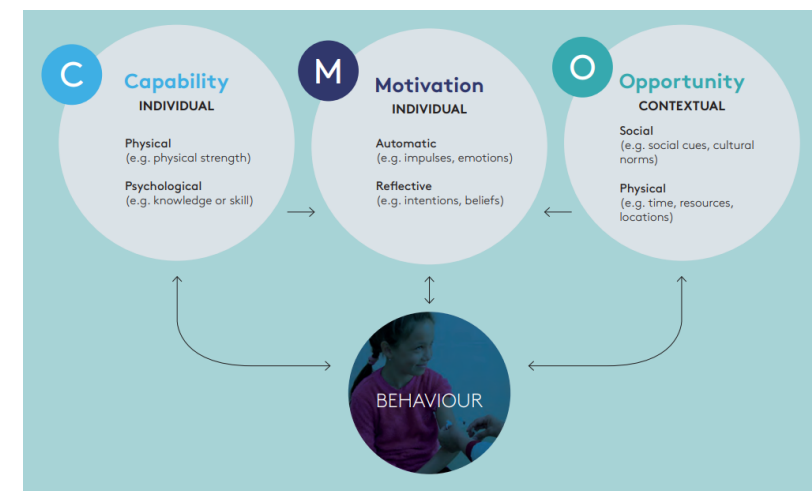
The WHO Regional Office for Europe developed the Guide to tailoring immunisation programmes (TIP), offering countries a process through which to diagnose barriers and motivators to vaccination in susceptible low vaccination coverage and design tailored interventions. The approach aims to integrate people centred research and behavioural insights.

Key findings/themes:

- A TIP approach aims for **high quality** and **equitable vaccination uptake**. This means achieving the same level of vaccination uptake across population groups, regardless of factors such as income, education, geography, ethnicity or integration in society.
- Equitable vaccination uptake can be achieved through **considering** and **addressing differences** and inequalities by ensuring **vaccination services are tailored to meet the needs of patients. It does not mean treating all people the same.**
- Assuming that knowledge alone will lead to behaviour change to make the 'right' decision ignores other **important influences on behaviour.**
- Psychological science has shown that **facilitating the vaccination behaviours directly** e.g. changing the encounter with the health worker, can have a great impact than trying to change how people think and feel about vaccination.
- **System factors** such as policies, health service provision, cost and logistics are important for vaccination behaviour.
- **Other context factors** such as **cultural, community, social support, norms** and **identity, including religious, education** or **philosophical one's** shape vaccination attitudes and behaviours.
- TIP processes also contribute to strengthening **health literacy. People need to be supported to access services** as well as with **clear, appropriate, accessible information.**
- **The TIP approach suggests a phased approach** and **provides a framework** and **exercises to design an intervention** to address research findings using a logical approach. *Source: [9789289054492-eng.pdf \(who.int\)](#)*

🗨️ Social and behavioral insights studies and engagement of stakeholders can help in first understanding the problems and then designing immunization programme solutions tailored to the local barriers to vaccination. 🗨️

P6



The COM-B model was originally developed for any behaviour in any setting and TIP adapt it for vaccination behaviours. Barriers and enablers are linked to associated COM-B factors and mapped to appropriate intervention types for target groups.

HIOW MMR data and knowledge, (2020)

Workshop and study carried out in HIOW in 2020 but interrupted by COVID pandemic. Particular focus on Eastern European community.

Key findings/themes:

- **Importance of data quality** and **accuracy** including:
 - *Accurate coding and recording*
 - *Patient movement and deregistration/cleansing*
 - *Practice mergers affecting process alignment and activity.*
 - *Issues with MMR1 being given too early due to recall system.*
- Practice processes for **call/recall** of those under-immunised
- **Language/knowledge/understanding of parents, Health Care Providers and community.**
- **Health Care Providers** are the **most trusted source** therefore contact with services is important.
- Main languages spoken in schools: **Polish, Panjabi, Urdu, Pashto/Pashto, Bengali, Romania**

What Works?

- **Actively engaging** and working alongside the target audience.
- Access to services and **practical help** to book and attend appointments.
- **Information tailored** at different communities
- **Personal reminders** and GP endorsement.
- **Use of pharmacies, retail outlets** and **local community venues.**

Southampton

| Language | Number of pupils | Percent |
|---------------------------|------------------|---------|
| English* | 23,392 | 72.2 |
| Polish | 2,677 | 8.3 |
| Panjabi | 645 | 2.0 |
| Urdu | 494 | 1.5 |
| Pashto/Pakhto | 383 | 1.2 |
| Bengali | 351 | 1.1 |
| Romanian | 321 | 1.0 |
| Dari Persian | 270 | 0.8 |
| Farsi/Persian (Any Other) | 258 | 0.8 |
| Arabic | 254 | 0.8 |
| Portuguese | 223 | 0.7 |
| Malayalam | 213 | 0.7 |
| Russian | 195 | 0.6 |
| Somali | 149 | 0.5 |
| Spanish | 139 | 0.4 |
| Chinese | 107 | 0.3 |
| Persian/Farsi | 107 | 0.3 |
| Italian | 101 | 0.3 |
| Kurdish | 99 | 0.3 |
| Lithuanian | 95 | 0.3 |
| Bulgarian | 88 | 0.3 |
| French | 87 | 0.3 |
| Hindi | 87 | 0.3 |
| Latvian | 80 | 0.2 |
| Hungarian | 79 | 0.2 |
| Illipino | 71 | 0.2 |

Languages spoken in schools 2020



Specific barriers for EE women

- Low healthcare self-efficacy and lack of trust
 - Understanding of entitlements to healthcare
 - Language barriers / health literacy

"The GP I have here is good but... I don't really trust, I don't know... There's something in me, I just know that in Poland they will do all the tests.. Maybe because its in Polish, but I speak English fluently"

- Low perception of risk of disease
- Practical barriers: childcare, time off work
- Roma travellers: mobility, literacy, trust

What does the EE population look like in Southampton?

- Polish:
 - 6% (15,000 people)
 - Second most common nationality (6%) after British (82%)
- Romanian: 1%; 3,000 people
- Slovakian: 0.4%; 1000 people

HIOW MMR data and knowledge, (2020)

Lessons from good practice in England

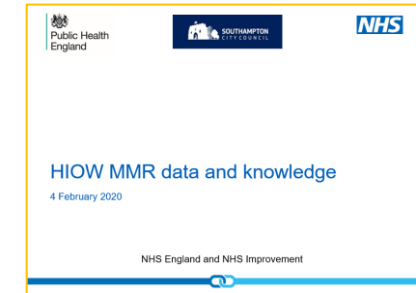
- **Combination of interventions** work best.
- **Tailor services to specific needs** of target group.
- **Provide outreach** support to engage, support and inform.
- **Support primary care** to engage under-represented populations.
- Use **community specific communication channels**.

Summary:

- No HIOW area achieving 95% uptake
- Some variation between GP practices – absolute numbers by practice small
- Potential for different health beliefs, cultural difference and language barriers.
- Broad ethnicity high % white other, high %not recorded.
- Lower uptake in most deprived areas of city.
- Families supported by both universal and intensive health visiting provision.
- Need for local system approach to improve MMR uptake.

Tailoring Immunisation Programmes Charedi community, north London

Implementation of the WHO's Tailoring Immunisation Programmes (TIP)



Who isn't attending for MMR1 and MMR2 - snapshot

- Birth cohort born in a 6 month consecutive period in 2015/16 registered at GP practices in Southampton, due to start school Sept 20

- 331 children in cohort, 52% male. 23 – parents refused vaccination

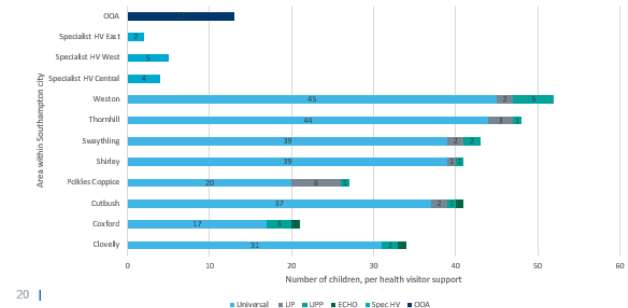
Ethnicity

- White British 36% (120/331), White other 29%
- Asian 8%
- Black 4%
- Other 3%

19 - Not recorded 21%

Who isn't attending for MMR by locality and health visiting provision

Number of children who have not completed MMR vaccination course as per area within Southampton City, and per health visitor support



Sector Lead Improvement (SLI) (ADPH) 2022



In August 2022 as part of the Southeast Sector Lead Improvement (SLI) programme, a sector led immunisations and vaccination project was funded by the NHSE Covid Vaccination Programme (Demand Team) for the Association of Directors of Public Health Southeast (ADPH SE). ADPH SE commissioned Population Health Ltd to work with the SE DPH and their teams, **bringing all the Covid vaccine inequalities work together in a learning event and good practice report to support the Covid vaccine uptake rate as part of Sector Led Improvement.**

This piece of work was time limited and undertook a baseline assessment of immunisations & vaccination systems & services across the ADPH SE area in November 2022. The scope of this project was initially focused on COVID but was widened to encompass routine immunisations (child and adult) and season immunisations (influenza and Covid). A summary of the findings from the learning event held November 2022 are provided below.

Key findings/themes:

- The key messages taken away from the event were the **need to collaborate with colleagues** and work in partnership at ICB level and to have **Regional collaboration for proactive communications.**
- Three priority areas were identified during the challenge session. These related to
 - Communication**
 - Inclusion and inequalities**
 - System**

Conclusions: The project highlighted excellent partnership work being undertaken to commission and delivery immunisation

- Delivery of immunisations is complex** requiring an **understanding** of **roles and responsibilities** of all partners and an **ongoing commitment.**
- Insights must be utilised to **understand and address vaccine hesitancy** for routine vaccinations.
- Timely** and appropriate **data is urgent.**
- Learning from Covid – 19 should be harnessed, in particular the **'can-do' attitude** to vaccinate at speed through accessible services with the **support of community leaders.**
- Findings** from report to be used as baseline and **as a resource for DPH** and their teams to **inform strategic approach.**

CYP self-assessment tool themes:

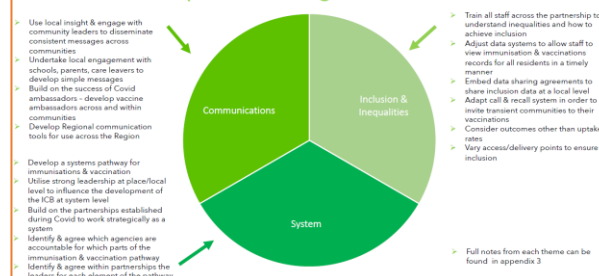
System

- Partnership
- Accountability
- Leadership
- Communication & engagement
- Data & insight informed
- Outcome led
- Focus on inequalities

Service

- Accessibility
- Invitation & recall
- Safe & effective practice
- Everyone's business
- Information systems

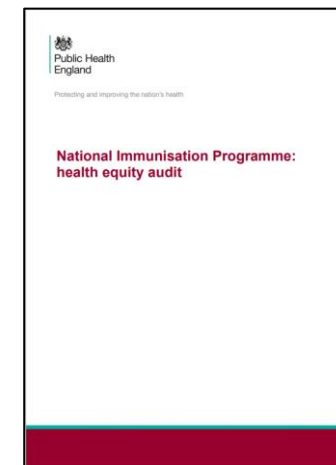
Priorities from peer challenge session



Recommendations

- ADPH SE to work with system partners to agree a shared understanding of roles and responsibilities across immunisations and vaccinations services and systems, including a focus on who can add value where and how
- ADPH SE and ICS to develop a whole systems approach to immunisations and vaccinations, building on existing, and developing, relationships and utilising the shared understanding of roles and responsibilities of system partners
- ADPH SE and partners to consider broadening outcome measures in addition to uptake rates e.g. process outcomes such as accessibility of clinics at different places/times
- ADPH SE to recommend that NHSE and UKHSA adapt current immunisations data collection to mirror that used for the Covid-19 vaccination, enabling timely data analysis, access for all system partners, including the Local Authority, to improve vaccination uptake rates
- ADPH SE to recommend that NHSE and UKHSA adapt current immunisations data collection to mirror that used for the Covid-19 vaccination enabling insights for improving inclusion through adapting the call & recall system
- ADPH SE to recommend to NHSE and UKHSA that DPH and their teams receive data in a timely manner, replicating Covid-19 data access, to target populations with low uptake rate, including groups experiencing health inequalities and underserved groups

National immunisation programme: health equity audit (2021)



The audit aimed to describe how the national immunisation programme identifies and addresses inequalities; describe the areas and extent of inequalities in vaccine coverage; identify evidence gaps for areas where inequalities have not yet been adequately estimated; identify how inequalities in vaccination uptake may arise, to inform a framework for action.

Key findings/themes:

- Equality in immunisation is an important way to address health inequalities. Ensuring coverage is not only high overall, but also within underserved communities is also **essential for disease control and elimination strategies**.
- “The Immunisation Programme has achieved high coverage overall in the population. However, we have demonstrated that **avoidable inequalities in vaccination still exist** within some population groups.
- Inequalities** in immunisation for a given population group can be **complex** to describe and **may vary** between areas.
- Community, institutional**, and **policy factors**, as well as the **health beliefs** and **knowledge** of individuals and within families **may lead to inequalities** in vaccination.
- There are **limitations in terms of available data** and **evidence to describe and monitor the situation**, and to **explain why inequalities** may have occurred.

Recommendations (in brief):

- Develop **a national vaccinations inequality strategy**, and **provide a template local action plan to enable best practice**;
- Share new practice** and **evaluation findings between stakeholders** to develop the evidence base;
- Develop **locally relevant data** and **intelligence** resources to support needs assessment;
- Use existing data sources to develop a routine report to **monitor inequalities** in routine vaccination coverage for key indicators, at national and regional level;
- Continue **national level leadership** and support **to address inequalities.**”

Source: [National Immunisation Programme: health equity audit \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/97822/nip-health-equity-audit-2021.pdf)

“In the least deprived decile coverage decreased for 3/9 indicators and increased in 5/9, whereas in the most deprived decile coverage decreased for 8/9 indicators and falls were greater than the national average. Thus, **though falls in coverage were seen nationally across most programmes, they were larger in the most deprived compared to the average**, whilst coverage was more likely to have increased in the least deprived (except for HPV), widening inequalities compared to 2016 to 2017. Further analysis is required to place these findings in the context of longer-term trends in coverage for more and less deprived populations. (p20) ”

Improving immunisation uptake (IIU)

The IIU initiative was developed as a result of a health inequalities pilot project that took place in 2017. The initial project clearly demonstrated that **health inequalities could be reduced** with the **nurse leading the project worked closely with the Child Health Information Service (CHIS)**. A further one-year pilot was commissioned by NHSEI and the Improving Immunisation Uptake (IIU) Team was established with the objectives of reducing variation in immunisation uptake across the Thames Valley, through the utilisation of CHIS data and direct collaboration with colleagues in primary care, predominantly General Practice. The model chosen provided the opportunity for **dedicated clinical input, cleansed CHIS data** and **“hands on” direct practical support** to be deployed by the team to **GP’s**. This approach ensure **targeted support was provided**, which not only improved immunisation uptake rates in the short term but also empowered GP’s to develop their own whole practice approach to achieve long term and sustainable high vaccination uptake rates.



Key findings/themes:

- Ongoing **facilitation of change crucial**.
- Immunisation **processes weren’t reviewed regularly** or in place.
- Many practices has **no clinic or admin lead**. Where immunisation leads were in place **roles/responsibilities** were often **undefined** and/or agreed.
- A **whole practice approach** often **wasn’t in place** with **little collaborative** working **between clinical and admin** staff (often first point of contact for queries) and **no clear escalation plan** for common issues.
- Availability** and **flexibility of immunisation appointments** was a common challenge identified by both staff and parents. This affected timeliness of immunisation and also contributed to Did Not Attends (DNA’s).
- Many practice Nurses (and some Practice Managers) were **unaware of their immunisation uptake rates** and how robust processes (such as new registrations), could help improve these.
- Many **practices did not understand the role of CHIS** and their processes/data requests.
- Data quality was a major ongoing issue** for practices with “ghost patients” common place on missing immunisation reports with **no process to identify these** and **deregister where appropriate**.
- Sharing good practice** across GP’s helped individual surgeries recognise where they could make improvements and the benefits that could be realised as a result.

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Appendix A: Feedback from GPs

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- Facilitation of practice meetings by IIU team was really beneficial
- Changes to registration process were developed as a result of IIU support
- Responsibility for administration/co-ordination of immunisations given to a named individual, using tools provided by the IIU team
- Data provided supports the practice to monitor/follow up children with missing immunisations
- Use of telephone/text follow up, rather than letter is proving more effective
- The IIU team support has helped identify and deregister “ghost patients” and “cleanse” data
- Invaluable support and advice for new staff was provided. “Immunisation folders” (electronic/paper) now in place to support staff and ensure good practice.
- Improved and updated information/resources from practice, for parents and staff are now in place

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Appendix B: Support provided to practices

14 // Appendix B

Review Data

- Utilise primary care immunisation data to target surgeries with the highest percentage of incomplete immunisations within a CCG.
- Provide each practice with up to date monthly trackers and reports for children with outstanding and/or incomplete immis.
- Share data with practices and commissioners to ensure all are kept in the loop re progress and outcomes achieved and where necessary escalate concerns.
- Data cleansing – identification of “ghost patients”, incorrect coding etc which impacts uptake rates.

Provide direct support

- Facilitate a whole practice multi-professional approach.
- Review/develop processes.
- Action planning and monitoring.
- Provide resources – GP toolkit/top tips/templates. Signpost to national tools and guidance.
- Training.
- IIU Team support includes clinicians and data manager.

Empower practices

- Motivation, engagement and confidence.
- To follow relevant policy/guidance set out by NHSEI, commissioners and public health bodies, to achieve the best outcomes for practices and recipients of immunisation services.
- Establish and clarify roles and responsibilities for immunisations within practices – lead for immunisations etc.
- Encourage practices to lead/take responsibility for data, including cleansing, in order to identify and address issues affecting uptake rates.
- Practice led sustainable solutions.
- PDSA cycle.
- Leave legacies of learning.

Reducing difference in the uptake of immunisations (NICE Guidance)

The NICE guidelines set out recommendations for local commissioners and providers of healthcare that should be taken into account alongside individual needs, preferences and values of their patients or the people using their services.

Key findings/themes:

Recommendations are set out in relation to the following areas;

- Named vaccination leads.
- Designing and raising awareness of payment schemes.
- Making vaccination services accessible and tailoring to local needs.
- Audit and feedback.
- Training and education for health and social care practitioners.
- Appointments and consultations.
- Using compatible systems and processes.
- Keeping records up to date.
- Identifying people eligible for vaccination and opportunistic vaccination.
- Recording vaccination offers and administration.
- System organisation and accessibility issues.
- Initial invitations.
- Reminders and escalation of contact.
- People who are not registered with a GP practice.
- Vaccinations for school-aged children and young people.

Box 1 Some key barriers to routine vaccine uptake

- Inflexible and inconvenient clinic times and locations
- Perceived lack of balanced information (including misinformation)
- Language and literacy problems
- Insufficient time in consultations to discuss concerns about vaccinations
- Lack of staff training in how to discuss vaccinations effectively
- Uncertainty about vaccine safety and effectiveness
- Uncertainty about whether vaccines are needed (including how severe the diseases are or how likely it is that someone will be exposed to the disease)
- Previous negative experiences of vaccination
- Lack of trust in the government, drug companies and the healthcare system
- Religious or cultural views that are against vaccination (this may relate to specific vaccinations, for example HPV [human papillomavirus])
- Individual barriers such as needle phobia or sensory impairment.

Box 2 Some population groups that are known to have low vaccine uptake or be at risk of low uptake

- People from some minority ethnic family backgrounds
- People from Gypsy, Roma and Traveller communities
- People with physical or learning disabilities
- People from some religious communities (for example, Orthodox Jewish)
- New migrants and asylum seekers
- Looked-after children and young people
- Children of young or lone parents
- Children from large families
- People who live in an area of high deprivation
- Babies or children who are hospitalised or have a chronic illness, and their siblings
- People not registered with a GP*
- People from non-English-speaking families*
- People who are homeless*

Communities with low uptake other than those listed above may also be identified specifically in your local area.

Sources: [UK Health Security Agency \(previously Public Health England\) Health Equity Audit of the National Immunisation Programme](#), apart from those marked with an asterisk, which were raised by the committee.

Pandemic Factors



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Literature review

A literature review was carried out to understand the impact of the pandemic on routine childhood vaccination uptake.

Context

- Globally, the COVID-19 pandemic has had a significant impact on childhood immunisation uptake worldwide. With **increased strain on healthcare systems, lockdowns**, and the **suspension of routine vaccination services**, many children missed out on timely vaccinations.
- According to the World Health Organization (WHO), **around 80 million children under the age of one** are **at risk of diseases** like diphtheria, measles, and polio because routine immunisation services have been disrupted due to COVID-19.
- The pandemic has also affected vaccine supply chains and caused delays in vaccine shipments, leading to shortages in some cases. Additionally, **caregivers may have been hesitant to take their children to healthcare facilities due to fear of exposure to COVID-19**, leading to a decrease in immunisation uptake.
- Global decline in childhood immunisation uptake during the COVID pandemic. This combined with increased migration increases the risk of outbreaks in the UK.

Approach

- 26 studies were included within the review.
- 21 of 26 eligible studies sighted decreased vaccination rates in children during the COVID-19 pandemic.
- 3 x studies sighted increased uptake or no significant changes, only in influenza vaccination.
- 2 x remaining studies (Brazil and Sweden) showed no significant change in vaccination rates during the pandemic.

Key findings: Summary of ‘Pandemic Factors’

1) Parental hesitation

- Reduction in ‘well child’ visits reported in almost all studies reporting decreased immunisations.
- Fears of COVID infection outweighing importance of routine immunisations in the UK.
- Fear of overburdening the NHS during and post pandemic.

2) Social distancing policies and lockdown

- Disruption to usual services
- Disruption to transportation and accessibility
- Health services closed or reduced.

3) Severe shortages of healthcare providers

- Disruptions in supply chain due to border closures and travel restrictions contributed to disruption to immunisation program in many countries
- Redistribution of health work and budget diverted to COVID-19
- Staff shortages due to COVID isolation policies

4) Absence of clear guidelines and recommendations for non-COVID-19 issues

- Ineffective communication between healthcare staff and policy makers (reported in Pakistan, Bangladesh and Nigeria)
- Shortages of PPE for health workers made staff reluctant to engage with patients in primary care.

5) Reprioritisation and changes to how services are delivered

- Move from in person visits and consultation to virtual visits.

Vaccination **did however increase in demand** in some countries

- Switzerland post pandemic survey parents expressed enthusiasm for influenza vaccination for children (more than double previous year).
- Similar behaviour observed in China (80% declared willingness for influenza vaccine)
- The global issue of COVID-19 seems to change public behaviour towards influenza vaccination overwhelmed by COVID-19 the most.

Literature Review - Key recommendations:

Delivery of a strong childhood immunisation programme requires a multi-faceted approach that involves several steps, including:

1. Education and awareness:

Education should be provided to parents, caregivers, and healthcare professionals on the importance of childhood immunisations. This could be in the form of educational campaigns, brochures, social media campaigns, and community outreach programs.

2. Vaccine availability and accessibility:

Vaccines should be readily available and accessible to all children, regardless of their socioeconomic status or geographic location. This can be achieved through school-based vaccination programmes, community clinics, and mobile vaccination clinics.

3. Monitoring of immunisation rates:

Routine monitoring of immunisation rates will ensure that all children receive scheduled vaccines. Medical professionals and government organisations should implement programmes that track vaccination rates and identify areas that require improvement.

4. Promotion of vaccine safety and efficacy:

The safety and efficacy of vaccines should be well-documented and communicated to parents and caregivers. Providing this information can help address vaccine hesitancy and concerns.

5. Partnership and collaboration:

The successful delivery of childhood immunisation programmes requires a collaborative and multi-disciplinary approach involving local and national governments, medical professionals, and advocacy groups.

6. Reminder systems:

A system should be in place to remind parents and caregivers about upcoming immunisations. Reminder systems can help ensure that children receive all vaccines according to their schedule.

7. Continuous improvement:

Evaluation and monitoring of the programme to identify areas for improvement is essential. The programme should be continuously evaluated, with a focus on identifying areas that require improvement and addressing those areas through targeted interventions.

Learning from COVID What Works?



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Learning from COVID

A review of the approach taken to successfully deliver COVID-19 vaccinations across the city was undertaken. The review aimed to identify key strengths and considered any learning that could be applied to routine childhood immunisation uptake.

Approach

Key learning and success factors to the approach taken were considered in relation to;

- Communications and engagement - the approach to developing a communications and engagement strategy.
- Partnership working - The approach taken to partnership working and how this supported delivery.
- Accessibility - the arrangements that were put in place to make vaccination easy and accessible for residents.
- Digital tools – the use of digital tools in support of the vaccination programme.

What does this mean for Southampton?

- Approaches used during the pandemic, in particular engaging with stakeholders and communities to have conversations about vaccination, could be replicated for routine childhood immunisations. There is considerable scope to build on this success and utilise existing resources, workforce and relationships across the system and community.
- Communications in relation to Childhood Immunisation are predominantly led Nationally with local level cascading assets opportunistically across the system. There is scope for development of a targeted and localized shared communications plan at a system level to help ensure consistent, effective and targeted messaging when needed.
- Learning from COVID underlines the importance of convenience and providing **practical help to book appointments**.
- There is scope to consider utilising pharmacies, retail outlets and local community venues in support of the childhood immunisation programme.

Key findings: What Worked?

- ✓ **Utilising trusted people of influence** within communities (faith and community workers, schools, parents, businesses and champions) to promote and have conversations about vaccination, was key to securing engagement and build trust.
- ✓ Messages were at times **better received** when they **aren't seen to be coming from the Council or the Government**.
- ✓ Taking a **'hyper-local' approach**, including using a range of local communication channels (local radio stations, social media groups, faith leaders etc) to disseminate key messages tailored to local needs, including **translated assets**. This was **enabled by good quality ethnicity-based data** made available during the pandemic.
- ✓ Providing **practical help** to book appointments to make getting vaccinated as convenient as easy as possible.
- ✓ Using **pharmacies, retail outlets** and **local community venues** (as we learned in COVID).
- ✓ **Need for local system approach** to improve MMR uptake.

Communication

- Communication is key when it comes to vaccine uptake. The UK COVID vaccine delivery programme developed extensive communication strategies to promote vaccine uptake, including social media campaigns, public figures getting vaccinated, and mass vaccination sites.
- Similar communication efforts could be developed to promote childhood immunisations, including targeted social media campaigns, school-based vaccine programs, and messaging that addresses common concerns and misconceptions.



Local Efforts:

- One Southampton campaign— **targeted comms** using uptake data by LSOA.
- **Translated comms** for low uptake communities and ethnicities.
- **Traditional flyers** and posters delivered in low uptake postcodes.
- **Social media campaigns** through community groups on apps like NextDoor – a neighbourhood based social media platform.
- **OOH digital billboards** – In high traffic areas and areas of low uptake.
- **Local Radio and TV/social media adverts** using Unity 101 and Awaz FM.

Engagement and Trust

- Engaging local communities, community leaders, and influencers helped in **building trust at the grass roots level**.
- Engaging with communities through **transparent and consistent communication** helped **address concerns, dispel myths**, and provide **accurate information** about vaccines. This educational approach helped build trust by empowering individuals with knowledge to make **informed decisions** about vaccination.



This involvement facilitated **open discussions, allowed concerns to be addressed**, and ensured that **communities felt heard** and understood.

- Recognising and **respecting cultural and religious factors** helped to build trust amongst different communities.
- By **actively engaging**, informing and building trust with families, confidence in childhood immunisations could increase.

Local Efforts:

- Focus groups in areas of low uptake
- Vaccine Champions – trusted community groups or organisations
- Covid-19 champions – shared information
- Resident surveys

Partnership working

- Successful delivery of the COVID-19 vaccination programmes required **community collaboration, partnerships, and targeted outreach efforts.**
- If contractual and practical issues can be overcome, this same approach could be applied to achieve a **more holistic approach to childhood immunisations** that engages multiple community stakeholders and healthcare providers to increase vaccine uptake.

Local Partners:

- Southampton and Solent University
- Solent NHS
- HIOW ICS
- University Hospital Southampton
- Southampton City Council
- Southampton Voluntary Services
- Faith Groups
- Local Businesses
- Refugee Charities
- Community groups
- Domestic Violence Charities



Accessibility

- Access to vaccines plays a significant role in vaccine uptake.
- The UK COVID vaccine delivery programme used large-scale vaccination sites and mobile vaccination teams to increase access to vaccines.
- Likewise, childhood immunisation programmes could **consider alternative delivery models to increase accessibility and uptake.**

Local Efforts:

- Places of worship
- Leisure centres
- Community centres
- Family spaces (swimming pools, health centres, Hubs)
- Local fire stations (Health Hubs)



Digital tools

- The UK COVID vaccine delivery programme developed a digital tool, the NHS COVID Pass, which allows people to prove their vaccination status.
- Such **digital tools could be developed to support delivery and monitoring of childhood immunisations**, which could help to identify and address areas with low uptake.
- It could also serve as a **convenient way for parents** to keep track of their child's vaccine schedule.



Foreword

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Appendices



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Appendix One - What do to FIRST? Prioritisation Matrix

| Recommendation | F: Feasible | | I: Impact on inequalities | | R: Reach | | S Success | | T: Time | | Score |
|---|-------------|---|---------------------------|---|----------|---|-----------|---|---------------|--------|-------|
| 1. Strengthen Promotion at every stage of a child's journey | Medium | 2 | Medium | 2 | Medium | 2 | Medium | 2 | Low High | 2 3 | 13 |
| 2. Tailored comms and engagement campaign | Medium | 2 | Medium | 2 | Medium | 2 | High | 3 | Medium High | 2 3 | 14 |
| 3. Collate & distribute Childhood Imms comms assets. | High | 3 | High | 3 | Medium | 2 | Medium | 2 | Medium Medium | 2 2 | 14 |
| 4. Utilise faith & community leaders & groups | High | 3 | High | 3 | Medium | 2 | High | 3 | High High | 3 3 | 17 |
| 5. Targeted promotion of MMR. | Low | 1 | Low | 1 | Low | 1 | Medium | 2 | Low High | 1 3 | 9 |
| 6. Information availability. | High | 3 | High | 3 | Medium | 2 | Medium | 2 | Medium High | 2 3 | 15 |
| 7. Proactively provide reassurance. | Medium | 2 | Medium | 2 | Medium | 2 | High | 3 | Medium Medium | 2 2 | 13 |
| 8. Trial alternative delivery model and venues. | Low | 1 | Medium | 2 | Low | 1 | High | 3 | Medium Medium | 2 2 | 11 |
| 9. Support for additional needs | High | 3 | High | 3 | Medium | 2 | High | 3 | Medium High | 2 3 | 16 |
| 10. Named frontline community immunisation champion. | High | 3 | High | 3 | Medium | 2 | High | 3 | Medium High | 2 3 | 16 |

Appendix One - What do to FIRST? Prioritisation Matrix

| Recommendation | F: Feasible | | I: Impact on inequalities | | R: Reach | | S Success | | T: Time | | Score |
|--|-------------|---|---------------------------|---|----------|---|-----------|---|------------------|--------|-------|
| 11. Enhanced staff training | Medium | 2 | Medium | 2 | Medium | 2 | High | 3 | Medium Medium | 2 2 | 13 |
| 12. Greater appointment availability. | Medium | 2 | Medium | 2 | Medium | 2 | High | 3 | High High | 3 3 | 15 |
| 13. Review data recording, cleansing, coding & extraction processes. | Low | 1 | High | 3 | High | 3 | High | 3 | Low High | 1 3 | 14 |
| 14. Personalised DNA/WNB Processes | Medium | 2 | Medium | 2 | Medium | 2 | High | 3 | Medium High | 2 3 | 14 |
| 15. Ethnicity based data recording policy. | Low | 1 | High | 3 | Medium | 2 | High | 3 | Medium High | 2 3 | 14 |
| 16. Establish local childhood imms action plan and group | High | 3 | Medium | 2 | Medium | 2 | Medium | 2 | Medium Medium | 2 2 | 13 |
| 17. Increase uptake of Health Visitor 1 & 2 year reviews. | Medium | 2 | Low | 1 | Low | 1 | Medium | 2 | Low Medium | 1 2 | 9 |
| 18. Share resources within PCNs & across Southampton. | Medium | 2 | Medium | 2 | Low | 1 | Medium | 2 | Medium Medium | 2 2 | 11 |
| 19. Define responsibilities for local delivery. | High | 3 | Low | 1 | Low | 1 | Medium | 2 | Low Medium | 1 2 | 10 |
| 20. Integrated GP MDT meetings. | High | 3 | Medium | 2 | Medium | 2 | Medium | 2 | Low Medium | 1 2 | 12 |

Appendix 2 - Findings from each strand and how they link to recommendations

| Ref | Key Issues Identified | Recommendations | |
|------------------------|--|--|--|
| 1. Local Data Analysis | <ul style="list-style-type: none"> In 2021/22 Southampton did not reach the target (95%) for all 5 indicators Uptake has been decreasing and getting worse for all 5 indicators. Absolute numbers required to meet 95% by individual GP practice is relatively small. Data indicates that there is a link between deprivation and low uptake. | <ul style="list-style-type: none"> It was not possible to obtain meaningful ethnicity-based data for GP Practices. Rates for MMR (1 dose and 1 year and 5 years) have increased in 2023 Q1. This could be attributed to recent comms & engagement in response to increase in measles cases Nationally. | <ul style="list-style-type: none"> 11) Enhanced staff training including reinforcing MECC approach at all levels. 13) Review data recording, cleansing, coding & extraction processes. Include process to check imms stats of new patient registrations and share with CHIS. Also regularly inform CHIS of children moving out of area. 15) Develop a city-wide ethnicity-based data recording policy. |
| 2. Pandemic Factors | <ul style="list-style-type: none"> Parental hesitation - fears of COVID infection outweighed importance of routine immunisations in the UK which may have impacted uptake. Social distancing policies and lockdown - Health services being reduced or closed during the pandemic and disruption to usual services including transportation acting as a barrier to getting children vaccinated. Severe shortage of healthcare providers – staff shortages and diversion of resources to COVID-19. Reprioritisation and changes to how services are delivered – move from in person visits to virtual consultations may have had an impact | <ul style="list-style-type: none"> The COVID-19 pandemic has had a significant impact on childhood immunisation uptake worldwide. With increased strain on healthcare systems, lockdowns, and the suspension of routine vaccination services, many children have missed out on timely vaccinations. Some countries have reported increased enthusiasm post-pandemic for influenza vaccination (more than double the previous year) | <ul style="list-style-type: none"> 1) Strengthen promotion at every stage of a child's journey 2) Local comms & engagement plan. 8) Trial alternative delivery model and venues. 13) Review data recording, cleansing, coding & extraction processes. 16) Establish local childhood imms uptake group and action plan. 17) Increase uptake of health visitor 1 & 2 year reviews. 18) Share resources within PCNs and across Southampton. 19) Integrated GP MDT meetings. |
| 3. Desk Based Review | <ul style="list-style-type: none"> Only 35% of GP practices had translated information on childhood immunisations available on their website. 5 practices indicated that there was the option to translate but the function wasn't working 61% have information on all recommended vaccines but there is a gap in information about specific diseases. | <ul style="list-style-type: none"> Most practices do not offer support with booking an appointment. Parent/guardian resources are under signposted. | <ul style="list-style-type: none"> 3) Collate and distribute childhood immunisation comms assets. 5) Target promotion of MMR. 6) Information availability and accessibility (including translated information in different formats). 9) Support for additional needs. 10) Named front line community immunisation champion |

Appendix 2 - Findings from each strand and how they link to recommendations

| Ref | Key Findings/Issues Identified | Recommendations | |
|---------------------------------|---|--|---|
| 4. Parent and Practice Insights | <p>Parent insights</p> <ul style="list-style-type: none"> 92% said vaccinations are important for children under 12 mths. 93% said vaccinations are important for children aged between 12-18 months and 18 months – 5 years Whilst the majority feel the same about childhood vaccinations following the COVID-19 pandemic, around 1 in 5 respondents told us that their feelings are now more positive. | <ul style="list-style-type: none"> 90% of our survey respondents who has children under 10 said their children were fully vaccinated. 88% of those who are planning or expecting a child said that they plan to get them vaccinated. The single most important or helpful thing people would look for when booking a vaccine in an easy booking system, greater availability of appointments and being sent reminders. The most common barrier that respondents had was a bad experience in a GP surgery or vaccination centre (16%). | <ul style="list-style-type: none"> 6) Information availability. 7) Proactively provide reassurance. 8) Trial alternative delivery model and venues. 9) Support for additional needs. 10) Named frontline community immunisation champion. 11) Enhanced staff training. 12) Greater appointment availability. 14) Personalised (telephone) DNA processes. |
| | <p>Practice insights</p> <ul style="list-style-type: none"> Discussing vaccinations – only 43% have multi-disciplinary team (MDT) meeting where vaccinations are discussed. Only 36% say that they work with Health Visitors on an ad hoc basis. 27% say they work with them monthly. 5% said they do not work with them at all. Data Cleansing – accurate data and records and routine data cleansing could impact on figures. DNA Process – 96% send text messages. Evidence suggests that having a conversation with a health care provider can be vital where parents are hesitant or have concerns. | <ul style="list-style-type: none"> Appointment availability/operational hours – GP practices are split on the time spent holding child immunisation clinics per week, with both 2-4 hours and more than 8 hours receiving 35%. Appointment time - Survey indicates that on average 10 minutes is available per immunisations carried out. Longer appointment slots should be available where additional support is required, to allow time to discuss benefits and answer any questions. Catch up Clinics – 17% are not offering catch up clinics despite the data indicating that immunisation takes off at children get older. | <ul style="list-style-type: none"> 13) Review data recording, cleansing, coding, extraction processes. 12) Greater appointment availability. 14) Personalised DNA processes. 16) Establish local childhood imms uptake group and action plan. 18) Share resources within PCN's & across Southampton. 20) Integrated GP MDT meetings. |
| 5. Previous Studies & Guidance | <ul style="list-style-type: none"> Inconsistencies in how healthcare professionals remind/recall parents to vaccinate. Limited evidence of any major impact on vaccination from anti-vax messages. Improving access to vaccination remains crucial. Fear of side effectives, lack of confidence in effectiveness, low understanding of herd immunity and myths remain persistent. Combination of interventions works best. Need to collaborate with colleagues and work in partnership. Small minority of parents concerns over vaccination. | <ul style="list-style-type: none"> Link between deprivation and uptake of MMR. There are inequalities in vaccine uptake by ethnicity, deprivation and geography. 42% of parents who were undecided about whether to get their baby vaccinated felt more confident after speaking to health professional. Ensuring services are tailored to meet needs does not mean treating all people the same. Health literacy – people need to be supported to access services. Learning from COVID-19 should be harnessed. Delivery of immunisations is complex and requires understanding of roles and responsibilities of all partners and ongoing commitment. | <ul style="list-style-type: none"> 2) Local comms & engagement campaign. 4) Utilise faith & community leaders & groups. 5) Targeted promotion of MMR. 7) Proactively provide reassurance. 10) Named frontline community immunisation champion. 11) Enhanced staff training. 12) Greater appointment availability. 14) Personalised DNA and WNB processes. 15) Ethnicity based data recording policy. 16) Establish local childhood imms uptake group and action plan. 19) Define responsibilities at a local level. 20) Integrated GP MDT meetings. |

Appendix 2 - Findings from each strand and how they link to recommendations

| Ref | Key Findings/Issues Identified | Recommendations |
|------------------------|---|--|
| 6. Learning from COVID | <ul style="list-style-type: none"> Utilising people of influence within communities was used effectively during the pandemic response and roll out of the Covid-19 vaccination programme.. This could be replicated for other initiatives. Taking a hyper-local approach, including using local radio, social media, faith leaders etc to disseminate key messages. | <ul style="list-style-type: none"> Providing practical help to book appointments. Using pharmacies, retail outlets and local community venues to promote vaccination. Need for local system approach to improve MMR and across all vaccinations e.g. Strategic Vaccination Uptake Group (SVUG) |
| | | <ul style="list-style-type: none"> 2) Local comms& engagement plan. 3) Collate and distribute childhood imms comms assets. 4) Utilise faith & community leaders & groups 5) Targeted promotion of MMR 8) Trial alternative delivery model and venues. 9) Named frontline community immunisation champion. 16) Establish local childhood imms uptake group and action plan. 18) Share resources within PCN@s and across Southampton. 20) Integrated GP MDT meetings. |

Appendix 3- Literature Review

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