IFF Research

Department for Levelling Up, Housing & Communities

Community Vaccine Champions

Evaluation Report

July 2023

Contents

Glossary of terms

Term	Definition
Case study areas	Ten CVC-funded case study areas were selected for the purposes of this evaluation. These are comprised of 11 local authorities: Boston, Bristol, Cambridge, Hammersmith & Fulham, Kensington & Chelsea, Westminster (grouped with Kensington & Chelsea as one case study area), Lancaster, Newham, Oxford, Sandwell, Wolverhampton. All case study areas were included in qualitative and quantitative elements of the evaluation, to represent 'CVC-funded' areas.
Community Champions (CC1) scheme	The Community Champions programme (CC1), introduced in January 2022, awarded £23.75 million of funding to 60 local councils and voluntary groups, to support the communities most at risk of COVID-19. The CC1 programme used the Community Champions model.
Community Vaccine Champions (CVC) scheme	A further funding scheme, introduced in January 2022, as a response to the uneven effects of the pandemic in the country. The UK Government allocated £22.5m of funding to 60 local authorities (LAs) for the delivery of bespoke projects to promote vaccine uptake and address wider health inequalities, in the areas with the lowest vaccination rates in the country.
Comparison area	Wards / local authorities who did not received CVC funding, with similar population profiles / characteristics to the funded areas. Wards were initially selected on the basis of similar characteristics to the CVC-funded case study areas, then matched further using propensity score matching.
Champions	Also known as Community Champions, Community Vaccine Champions, Community Health Champions, and grassroots individuals. These are individuals were selected by local authorities and/or delivery partners to directly deliver CVC messaging and engagement with local residents.
CVC aware	Residents in CVC funded areas, who indicated in the survey that they have seen/heard/engaged with individuals in the community encouraging uptake /sharing information on the COVID-19 vaccine (outside of NHS settings) since the start of January 2022.
CVC-funded activities	Activities directly funded by the CVC scheme. Often these were delivered through the Champions or grassroots individuals, however delivery partner organisations were also involved. These activities included, but were not limited to, development and distribution of information materials on vaccine and local vaccination sites, vaccine busses, door-knocking, myth-busting and Q&A sessions, network building, and training and support opportunities for Champions, local authority staff and local voluntary sector organisations.

Term	Definition
CVC-funded area	Areas across England that received CVC funding. In this report there are three 'layers' of CVC-funded areas: 1. 60 LAs who received the funding. 2. 10 case study areas, focused on in the evaluation as a whole. 3. Wards within the case study areas, where CVC-funded activities were specifically focused / target audiences were most likely to reside. These were the focus of the survey element of the evaluation.
Delivery partners	Organisations, usually locally placed / led, involved in the delivery of or supporting CVC-funded activities. Delivery partners had a range of roles (both within and between LAs). For example, some of these partners received CVC funding via a micro-grant scheme and directly delivered the activities, others provided outreach support to target audiences, and some had individuals acting as Champions.
Department for Levelling Up, Housing & Communities (DLUHC)	DLUHC is a ministerial department, supporting communities across the UK to thrive, making them great places to live and work. DLUHC commissioned an evaluation of the CVC scheme to improve the evidence base around community-led engagement programmes' impact and outcomes on local communities.
Local authorities (LA)	An administrative body in local government. CVC funding was administered at the local authority level, and so this phrase is often used to define geographical areas in which CVC activities were taking place.
Local authority (LA) lead	Individuals placed within the local authorities, who had a primary role in the application, implementation and/or delivery of the scheme for their local area.
Micro grant schemes	In this context, schemes in which set sums of the local authority-level CVC funding are awarded to delivery partners and local organisations, to deliver CVC activities.
Propensity score matching	Propensity score matching is a statistical technique in which samples are selected from both comparison (without CVC funding) and treatment (CVC-funded) groups that are intended to be highly similar for analysis purposes. Specifically, propensity score matching helps select samples that are well balanced across confounding variables that affect both treatment assignment and the outcome variables.
Public health partners	Individuals either placed within the public health department, or involved in delivering health services in the local community (e.g., NHS professionals), and involved in the delivery of the CVC scheme.
Religious minority groups	Religious minority groups are defined as those giving their religion as Muslim, Buddhist, Hindu, Sikh, Jewish or 'other'. It excludes those who describe themselves as Christian or non-religious.

Term	Definition
Statistical significance	Within this report, findings identified as statistically significant are those that reach the 95% / p=0.05 threshold. This means that, statistically, 95 times out of 100 the finding is accurate. Those approaching significance can be defined as differences close to reaching the p=0.05 level.
Voluntary, community and social enterprises (VCSE) organisations	The VCSE sector is the current 'catch all' term that includes any organisation (incorporated or not) working with Social Purposes. This ranges from small community-based groups/schemes (Good Neighbour Schemes, 'Stitch & Knit' or Cubs & Brownies etc.), through to larger registered Charities that operate locally, regionally & nationally. The sector is sometimes called the Civil Society, the Third Sector, and the voluntary and community sector (VCS).

Executive summary

Introduction

In January 2022, as a response to the uneven effects of the pandemic in the country, the UK Government allocated £22.5m of Community Vaccine Champions (CVC) programme funding to 60 local authorities (LAs) for the delivery of bespoke projects to promote vaccine uptake and address wider health inequalities, in the areas with the lowest vaccination rates in the country.

At this time, the UK was experiencing a high COVID-19 infection rate due to the emergence of the Omicron variant in November 2021; in England, an estimated 3,735,000 people had COVID-19, equating to around 1 in 15 people in the week ending 6 January 2022[1]. Vaccinations had been available to residents in a care home for older adults and their carers; and all aged 80 and over for over a year, and all other adults aged 18 and over for at least 6 months. 79.2% of those aged 10 years and over in England were vaccinated[2].

It had also been almost a year since the launch of the Community Champions programme (CC1), which awarded £23.75 million of funding to 60 local councils and voluntary groups, to support the communities most at risk of COVID-19. The CVC programme built on the earlier CC1 programme: of the 60 LAs receiving the new CVC funding, 22 had previously received CC1 funding; the remainder had not.

Both the CC1 and CVC programmes use the 'Community Champions' model.[3] This is an established model in public health policy, both on a national and international level. Champions are volunteers who promote health and wellbeing within their established social networks by using their connections and lived experience to improve services and overcome barriers in their communities. It is intended as an alternative to top-down approaches in communities with low trust in government. It seeks to facilitate context-specific public health solutions, using true collaboration and co-production with target communities. This model has previously informed the design of other health-related initiatives, including HIV prevention and domestic violence reduction.[4]

The Department for Levelling Up, Housing and Communities (DLUHC) commissioned IFF research to conduct an evaluation of the CVC programme, to

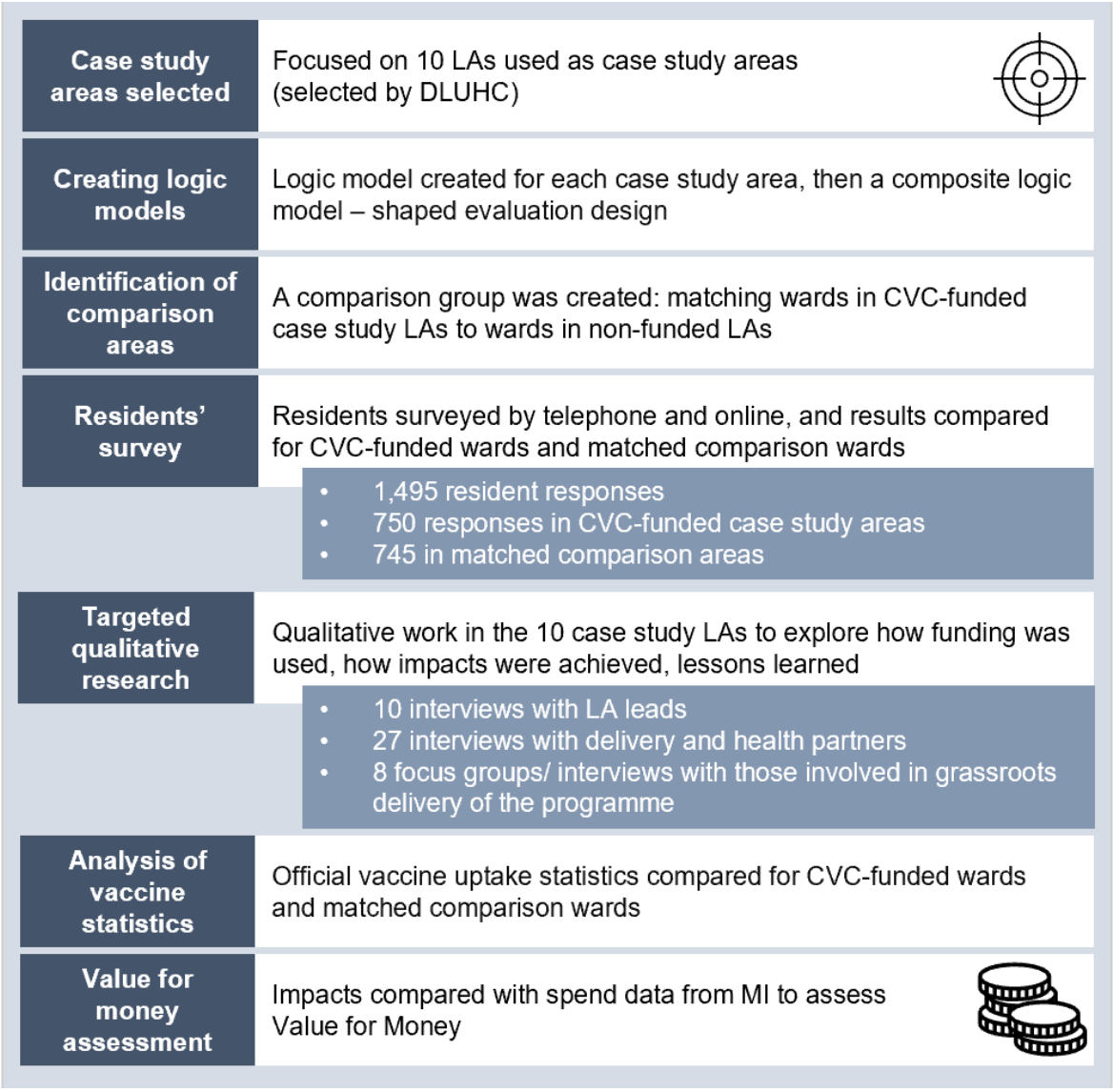
[1] Coronavirus (COVID-19) Infection Survey, UK - Office for National Statistics
[2] NHS vaccination data, analysed for this evaluation by Belmana.
[3] https://www.gov.uk/government/publications/community-champions-programme-guidance-and-resources/community-champions-programme-guidance-and-resources
[4]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1011854/A_rapid_scoping_review_of_community_champion_approaches_for_the_pandemic_response_and_recovery_V8.pdf

provide insights into the elements of funded activity that added the most value, and to identify transferable lessons learned for future similar initiatives.

Evaluation approach

As shown in Figure 0.1, the evaluation used a mix of quantitative and qualitative methods alongside analysis of management information and published vaccination data to obtain a thorough understanding of how the CVC-funded activities were implemented and the outcomes and impacts of the funded work:

Figure 0.1 Overview of evaluation approach



CVC-funded activities

The nature of CVC funding enabled local authorities to be flexible in the way that they worked with delivery partners and Champions. Most LAs followed a similar model when administering micro-grants to local organisations, who then recruited

and trained local people to become vaccine champions in their areas and deliver CVC-funded activities. Recruiting Champions from local organisations meant that in many cases champions had lived experience relevant to the target populations in their LA (e.g., similar socio-economic, ethnic or religious backgrounds, or experience of homelessness).

Once recruited and trained, the Champions implemented a range of activities to explore vaccine barriers (e.g., through informal conversations), challenge misinformation (e.g., with myth-busting sessions or tailored materials) and provide opportunities for vaccine take-up (e.g., by placing vaccine busses in targeted locations or at existing community events). Some LAs also implemented initiatives that aimed to promote health and wellbeing more generally. Activities varied between LAs, and were tailored to the needs of local communities.

Key findings

- **LAs varied in terms of the context in which CVC funding was introduced**. For example, where the previous CC1 funding had been used to make connections between LAs and health sector stakeholders, and to engage directly with communities, some of the groundwork for the CVC-funded work was already in place. Regardless of whether CC1 funding had been received, the extent to which existing networks and relationships with local and community organisations were already established varied. Some LAs needed to build these relationships from scratch when they began their CVC work.

- Overall, the CVC funding, and its focus on building local networks, enabled LAs to promote vaccine uptake and attempt to address wider health inequalities in a **less hierarchical way than previously**.

- A perceived strength of how LAs implemented CVC funding was that it avoided a ‘top-down’ approach. Key components of this included:

    - Identifying target audiences first and **using this to guide the choice of potential partners**.

    - **Avoiding LA branding**, which could have triggered community distrust.

    - **Avoiding prescriptive requirements** gave community-based partners ownership and thus supported the development of trusting relationships with the LAs.

    - **Leveraging the community organisations' expertise and relationships** (particularly with local people) that the LA and public health partners didn't possess, enabling a swifter response to communities' needs.

- **Empowering community organisations** to design and deliver the work in turn enabled public health messaging, particularly around vaccine uptake, to be tailored to the community by the community; and shared by already-trusted community voices. Using community-based partners to **recruit individual Champions with lived experience of their community** (e.g., similar socio-economic, ethnic or religious backgrounds), allowed Champions to use that lived experience to engage with their peers.

- As well as having Champions with lived experience, giving these individuals **time to be present and visible**, and **training on effective engagement**, were factors identified as key to successful community engagement and understanding vaccine barriers.

- Vaccine promotion (e.g., through informal conversations and the dissemination of information leaflets) and vaccine opportunities (e.g., vaccine buses and pop-up clinics) were **most effective where they took the work to spaces where community members already felt comfortable** (e.g., cafes and places of worship).

- A less hierarchical, lighter-touch approach meant there was a challenge in collecting monitoring data from across partners to assess impact. In many cases, **mechanisms for monitoring engagement were not built into the design of the CVC-funded activities**. Some LAs were also hesitant to collect vaccine uptake information because they felt it was counter to the informal, sensitive approaches to the work; and some LAs had deliberately chosen a focus on wider health issues. For this reason, LAs tended to have only anecdotal evidence of activities having combatted misinformation, or increased vaccine uptake.

- One LA successfully made use of a **model of incentivising community partners** for each additional vaccination achieved. This encouraged the work itself, and generated evidence of impacts (via the claims process).

- When taking into account survey analysis, which compares CVC-aware residents with a matched comparison group of residents in non-funded areas, there were **no significant impacts on vaccination uptake on the overall group**.

- When looking at sub-groups, analysis found that **religious minority groups**[5] **saw a significant positive impact on COVID-19 vaccine boosters**. Although not statistically significant, they were also more likely to report first vaccine doses, future vaccination appointments, trust in vaccine efficacy, and engagement with wider health information (to note, these positive impacts for trust in vaccine efficacy and engagement with wider health information are in the form of gentler declines than those seen in comparison areas)[6]. This suggests that the approaches taken within the CVC-funded vaccine promotion work[7] have been effective within faith communities.

- While affected by uncertainty in the data[8], it's estimated that, in the 10 case study CVC-funded areas, the funding was responsible for around 562 additional COVID-19 booster vaccine doses, delivering **a net social value of c.£5.7 million** in prevented COVID-19 cases alone, for costs of £4 million. Assuming these estimates are representative for all 60 CVC-funded LAs, the additional social value is estimated at around **£26.1 million**, for spend of £18.9 million[9] – meaning an estimated **£1.38 in value for every £1 spent**.

- Not all desired impacts of the programme have yet been realised. LAs and Champions suggest that **more time and funding is required to continue to create (and evaluate) longer-term impacts of the programme**. Anticipated further impacts relate to physical health, mental health, and community resilience.

- CVC-funded activities have left LAs with a **'proof of concept' for the approaches taken** to work with community-based organisations, and a legacy of improved local relationships and networks.

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[5] Religious minority groups – Includes Muslim, Buddhist, Hindu, Sikh, Jewish, and 'Other' religions; excludes Christian and those with no religion.
[6] Survey findings for residents in non-CVC funded comparison areas showed declines between January and Autumn 2022 in trust in vaccine efficacy and engagement with wider health information, but these were steeper declines than those observed amongst residents aware of CVC-funded activities.
[7] Namely, of encouraging community leaders (including religious leaders) to share their positive vaccine experiences; of vaccine promotion messages being tailored and delivered by Champions with relevant lived experience of the communities being targeted; and of vaccine promotion and vaccine opportunities being delivered in spaces (including faith settings) where the target communities already felt comfortable.
[8] See Chapter 8 for a discussion of the uncertainties surrounding these estimates.
[9] The 60 supported LAs were awarded a total of £22.5m, the total spend figure of £18.9m refers to the total committed spend as of July 2022, the difference relates to resource allocated but not yet spent or committed by LAs at the time the last MI data was reported. For the case study areas, the latest available MI was reported in October 2022 while for all supported LAs the latest data refers to July 2022.

- Transferable elements of the CVC approach, designed to create behaviour changes include: deploying funding **quickly and flexibly**; messaging being **tailored to the community by the community**, and **delivered by trusted voices**; and, using creative approaches to **enable community members to feel comfortable and safe** to share their views and ask questions. These approaches could be effectively utilised in initiatives focused on public health, the cost-of-living crisis, and environmental / neighbourhood issues.

Recommendations

For central government

The most compelling impacts of the CVC programme lie in the ways in which target communities, often characterised as 'underserved', have been effectively engaged. Learning suggests that there are key features of the model that are transferrable to other public health and community-focused interventions:

- **Working through the voluntary sector**, including religious organisations, is an effective way to engage with harder to reach communities.
- Utilise the already **well-established networks** that local authorities often have with the voluntary and community sector, or support / encourage these connections to be made where they do not exist. These networks are important for **increasing the reach, credibility of and trust in public health** (or other important) messages. They can also enable **new cross-sector initiatives** to be implemented quickly and effectively.
- The creativity of the voluntary and community sector and their **ability to draw on relevant lived experience to tailor approaches** to targeted communities is a critical component of effective engagement with these communities.
- Allow LAs to deliver funding to the voluntary and community sector **flexibly**.
- **Approaches adopted with CVC funding to reach faith communities** should be applied to other initiatives with this target audience in the future.
- Further initiatives from central government, delivered via local government and partner organisations, should deliberately **nurture now strengthened local networks**, to make them more likely to be sustainable.
- Consideration should be given to **incentivising community-based organisations** (e.g., per deliverable/output) in future similar initiatives. This delivers a potential solution to LAs' wariness of gathering their own data that might prove the efficacy of their public health promotion activities.

For local authorities

For local authorities there is strong qualitative evidence that suggests where and how both formal (e.g., vaccinations) and informal (e.g., information sharing as part of community gatherings) public health interventions take place is critical to engage targeted communities and effectively influence health behaviours. The most effective approaches, and those that should be considered for future public health interventions included:

- Activities within existing community groups, community centres and places of worship: **spaces where community members already felt comfortable**.
- Adding the intervention content to an existing event or a **wider topic that target communities were already interested in**.
- Community-based organisations drawing on **relevant lived experience to ensure messaging and approaches were effectively tailored** (this enhanced credibility of messages).
- Champions **investing time in being present and visible** among community members, to create opportunities for dialogue.

Other LA considerations for future initiatives include:

- **Training about how to have conversations** about the vaccine and wider health and wellbeing issues, to ensure that individuals delivering the funded work are **confident in engaging community members effectively**.
- The **use of data** (e.g., to identify target groups, or understand barriers and behaviours), and mechanisms to **systematically share insights**, will make future intervention approaches more effective.
- Invest time in establishing **strong lines of communication between the LA and partners** (such as community-based organisations, GPs and other NHS partners). The absence of this sometimes acted as a constraint on what the CVC-funded work was able to achieve.

For VCSE organisations

The evidence within this report suggests that the VCSE sector has a critical role to play within public health. Their connections, trust and rapport with minority groups and those experiencing higher levels of disadvantage means that they often have unique opportunities to influence health-supportive behaviours and should consider

the impact that they can have on wider public health measures such as vaccine uptake.

Future considerations for these organisations include:

- Building on the principles of the **Make Every Contact Count training** to consider how they can continue working in partnership with local authorities collaboratively to support broader public health initiatives going forward for mutual benefit.
- **Practical barriers can be tackled more readily** than attitudinal ones; however, dissemination of information tailored to specific communities via trusted sources can nevertheless make inroads into attitudinal barriers to desired behaviours.
- Having **translated materials and / or interpreters** will likely be highly important in building trust, with ethnic minority target communities.
- Consider **how to collect data from their target audiences in a way that maintains trust and feelings of safety**, while being better able to evidence their impact and become more systematic in recording data. The 'per vaccination' **incentive approach** (discussed above) offers a potential solution. It will also be important to consider how to **communicate the on-going purpose** of data collection in way that makes **minority communities feel safe**.

Conclusions

- The CVC-funded activities succeeded in delivering additional COVID-19 booster doses that likely would not have been administered without CVC funding. This means that, in prevented COVID-19 cases alone, the CVC programme represents value for money.
- The significant and near-significant impacts on religious minority groups suggest that the approaches taken within the CVC-funded vaccine promotion work (encouraging community leaders to share positive vaccine experiences; vaccine promotion messages being tailored and delivered by Champions with relevant lived experience; and vaccine promotion and vaccine opportunities being delivered in spaces where communities already felt comfortable) have been effective within faith communities.
- Training – particularly around the principles of Make Every Contact Count – was important in ensuring that the individuals delivering the funded work were

confident in engaging community members effectively. In future initiatives, funders and those receiving funding should invest in training for those delivering work on the ground, to ensure effective delivery and grassroots individuals feeling supported in their work.

- The voluntary and community sector proved effective in reaching target communities, suggesting it has a critical role to play within public health. Where LAs had existing networks with the sector, this provided an important foundation for the CVC-funded work. Ensuring these structures are in place and focusing time / efforts in strengthening them is a key first step to bottom-up approaches.

- The CVC-funded activities have left LAs with a proof of concept of ways of working collaboratively with the voluntary and community sector, and a legacy of improved relationships with community-based organisations that could be drawn on in future for similar programmes or other areas of work which would benefit from this approach (public health messaging, environmental issues, etc.).

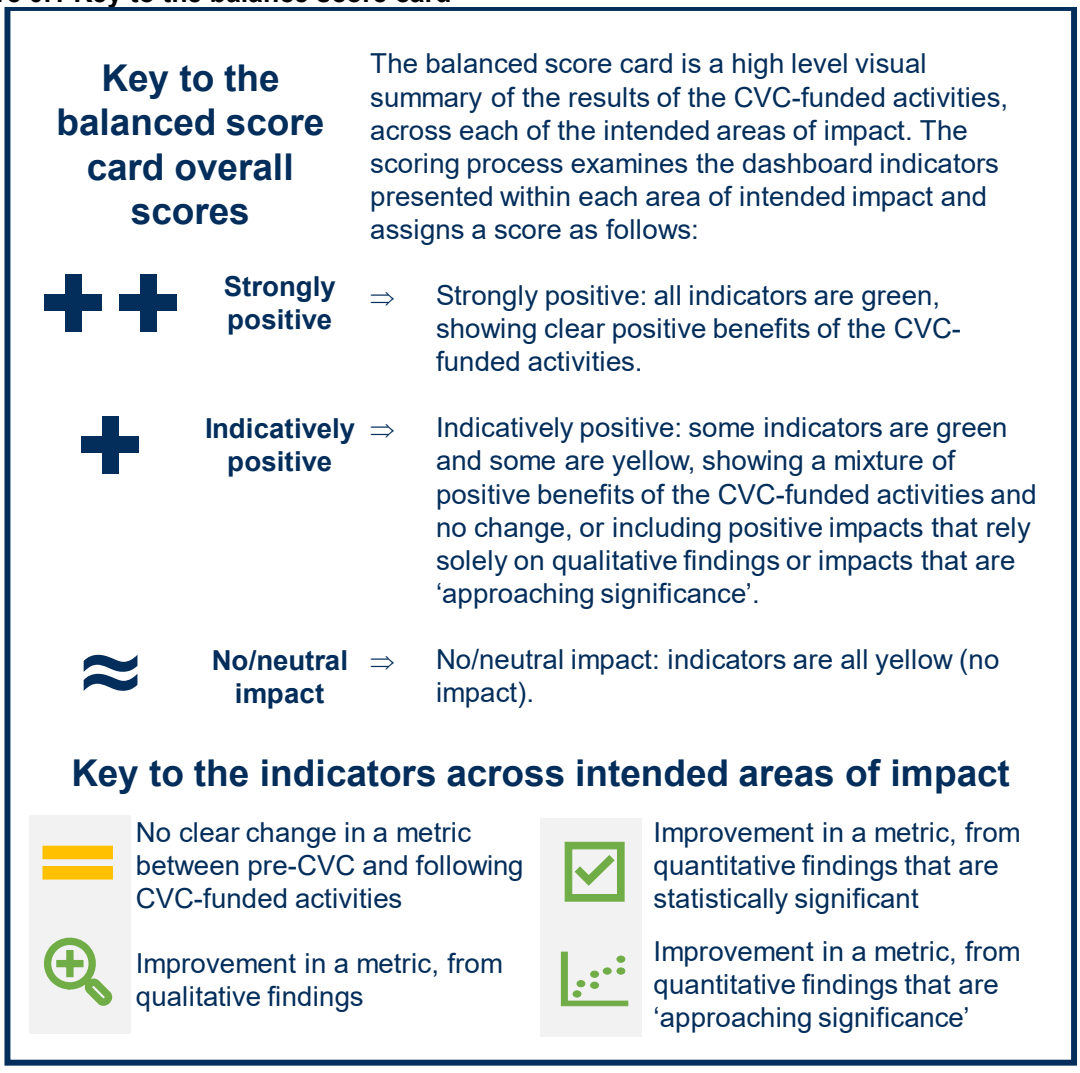
- Without the CVC funding, vaccine promotion activity would have been more 'top-down' and generic. The CVC funding and the way it was allowed to be administered enabled the work to be done creatively and collaboratively with community-based organisations. It is crucial that government funding structures allow flexibility and are delivered in a way that empowers grassroots organisations to deliver based on their understanding of the community. During the bidding process, local government should seek VCSEs partners who will deliver the work with them in this way.

- Taken together, this means that the CVC funding was important in enabling the ingredients that made community engagement successful. These are also the ingredients that emerged as being transferable to other contexts – particularly the ability of the CVC-funded work to draw on lived experience.

Evidence balanced score card

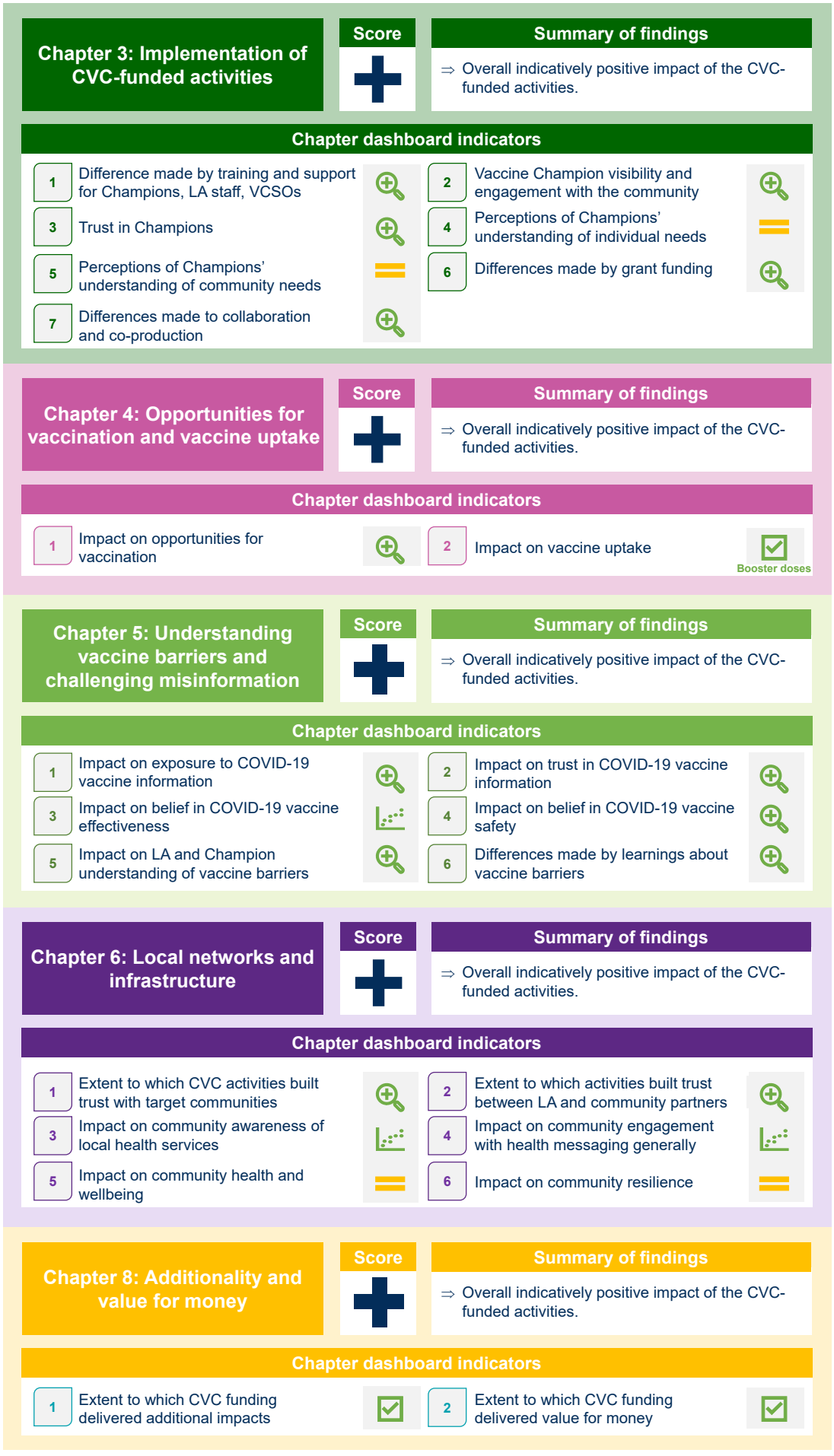
The evidence for all the intended areas of CVC funding impact, is summarised in a **balanced score card** below. This presents the findings visually, to reach a balanced view as to the overall impact of the CVC-funded activities. The score card brings together evidence from all of the evidence sources within each of the intended areas of impact to arrive at an overall score. This score was calculated by assessing whether each indicator in each domain of impact suggested a strongly positive benefit, indicatively positive benefit or no benefit to the CVC-funded activities. The mix of strongly positive benefits, indicatively positive benefits or no benefits found for each indicator then determined what the overall calculated score for each domain of impact was. Figure 0.2 shows the key to the balanced score card:

Figure 0.1 Key to the balance score card



As the balanced score card, overleaf, shows, **indicatively positive impacts of the CVC-funded activities were found for all of the intended areas of impact**. No strongly positive or neutral results were found (Figure 0.3).

Figure 0.2 Community Vaccine Champions programme: Balanced scorecard



1. Introduction

This chapter introduces the background to the evaluation, the evaluation objectives and methodology.

Introducing Community Vaccine Champions

Background

The COVID-19 pandemic highlighted and aggravated existing health inequalities among those of different ethnic backgrounds and socioeconomic status in the UK.

The Final report on progress to address COVID-19 health inequalities[1] revealed disparities in risks and outcomes for ethnic minority groups during the pandemic in the UK. The report highlights that the white British population generally experienced lower case rates of COVID-19 compared to other ethnic groups. Meanwhile those with Bangladeshi and Pakistani ethnic backgrounds tended to face a variety of risk factors that increased their likelihood of contracting COVID-19, such as their job, living conditions, and residing in densely populated and economically disadvantaged areas.

These disparities were also seen in vaccine uptake rates, which remain highest among the white British population and lowest among black ethnic groups, with the latter having much higher rates of vaccine hesitancy[2]. The latest ONS evidence also shows that people living in deprived areas and those who identified as being from an ethnic minority group (excluding white minorities) are less likely to have received a third dose of the vaccine[3]. These issues are not new: previous national vaccination programmes in the UK also reported lower vaccination rates for minority ethnic groups[4].

While the reasons behind low vaccine uptake are complex and multi-faceted, IFF Research (IFF)'s qualitative study into the attitudes of groups who are uncertain about receiving the coronavirus vaccine[5] isolated some of the main drivers of vaccine hesitancy. These were found to include concerns about the vaccine's safety and its immediate and long-term side-effects, and a low perception of the risk associated with the virus, especially among younger people. The research also found that a few vaccine-hesitant participants expressed a lack of trust in the government and pharmaceutical companies, and some mentioned getting their

[1] Source: https://www.gov.uk/government/publications/final-report-on-progress-to-address-COVID-19-health-inequalities
[2] Source: Final report on progress to address COVID-19 health inequalities - GOV.UK (www.gov.uk)
[3] Source: Coronavirus (COVID-19) latest insights - Office for National Statistics (ons.gov.uk)
[4] Source: Factors influencing COVID-19 vaccine uptake among minority ethnic groups (publishing.service.gov.uk)
[5] COVID-19 vaccine refusal, UK - Office for National Statistics (ons.gov.uk)

information on the pandemic and vaccines from social media or unverified sources. Another recent IFF qualitative study[6] reported that some ethnic minority participants found social media and alternative news sources to be more trustworthy in comparison to mainstream news sources.

The Community Champions programme (CC1)

The Community Champions programme (CC1) was launched at the height of the pandemic, in January 2021. It awarded £23.75 million of funding to 60 local councils and voluntary groups, to support the communities most at risk of COVID-19. The CC1 programme used the Community Champions model, and demonstrated that locally led responses, which ensure that interventions are appropriate to local contexts, are most effective at engaging communities and helping to reduce barriers to health seeking behaviours.

The Community Vaccine Champions programme

In January 2022, as a response to the uneven effects of the pandemic in the country, the UK Government allocated £22.5m of Community Vaccine Champions (CVC) programme funding to 60 local authorities (LAs) for the delivery of bespoke projects to promote vaccine uptake and address wider health inequalities, in the areas with the lowest vaccination rates in the country.

At this time, the UK was experiencing a high COVID-19 infection rate due to the emergence of the Omicron variant in November 2021; in England, an estimated 3,735,000 people had COVID-19, equating to around 1 in 15 people in the week ending 6 January 2022[7]. Vaccinations had been available to residents in a care home for older adults and their carers; and all aged 80 and over for over a year, and all other adults aged 18 and over for at least 6 months. 79.2% of those aged 10 years and over in England were vaccinated[8].

The CVC programme builds on the CC1 programme. Of the 60 LAs receiving the new CVC funding, 22 had previously received CC1 funding; the remainder had not. Those who received funding for the first Community Champions (CC1) scheme were eligible for a £185,000 top up grant, whilst the 38 LAs which didn't receive funding from the first Community Champions scheme were entitled to bid for up to £485,000. Like the CC1 programme, the CVC programme used the Community Champions model.

[6] Compliance with coronavirus (COVID-19) guidance: Ethnic minorities | IFF Research
[7] Coronavirus (COVID-19) Infection Survey, UK - Office for National Statistics
[8] NHS vaccination data, analysed for this evaluation by Belmana.

The establishment of both CC1 and CVC came following a recommendation by SPI-B[9] which supported these types of schemes as an alternative to top-down approaches in communities with low trust in government, and to facilitate context-specific public health solutions. It emphasised the importance of such schemes involving true collaboration and co-production with the target communities throughout and being properly resourced to avoid volunteer fatigue.

Table 1.1 below details the LAs receiving CVC funding and the amounts of funding awarded.

Table 1.1 Local authorities receiving CVC funding

Region or Local Authority	Amount received in CVC-funding (£)	Region or Local Authority	Amount received in CVC-funding (£)
London	**10,971,500**	**East of England**	**2,516,500**
Barking & Dagenham	485,000	Cambridge	391,500
Barnet	461,500	Ipswich	185,000
Brent	185,000	Luton	485,000
Camden	485,000	Peterborough	485,000
Croydon	485,000	Thurrock	485,000
Ealing	485,000	Welwyn Hatfield	485,000
Enfield	485,000	**North East**	**370,000**
Greenwich	185,000	Middlesbrough	185,000
Hackney	185,000	Newcastle upon Tyne	185,000
Hammersmith & Fulham	485,000	**North West**	**1,710,000**
Haringey	185,000	Knowsley	485,000
Harrow	185,000	Lancaster	485,000
Hillingdon	185,000	Liverpool	185,000
Hounslow	485,000	Manchester	185,000
Islington	484,689	Preston	185,000
Kensington & Chelsea	485,000	Salford	185,000
Kingston upon Thames	485,000	**South East**	**2,425,000**
Lambeth	485,000	Brighton and Hove	485,000
Lewisham	185,000	Oxford	485,000
Merton	485,000	Reading	485,000
Newham	485,000	Slough	485,000
Redbridge	485,000	Southampton	485,000
Richmond upon Thames	485,000	**South West**	485,000
Southwark	485,000	Bristol, City of	485,000
Tower Hamlets	485,000	**West Midlands**	740,000
Waltham Forest	485,000	Birmingham	185,000
Wandsworth	485,000	Coventry	185,000
Westminster	485,000	Sandwell	185,000
East Midlands	**1,640,000**	Wolverhampton	185,000

[9] https://www.gov.uk/government/publications/role-of-community-Champions-networks-to-increase-engagement-in-context-of-COVID-19-evidence-and-best-practice-22-october-2020

Boston	185,000	**Yorkshire & Humber**	1,040,000
Derby	485,000	Bradford	185,000
Leicester	485,000	Kingston upon Hull	485,000
Nottingham	485,000	Leeds	185,000
		Sheffield	185,000

The Community Champions model

Both the CC1 and CVC programmes use the 'Community Champions' model. The Community Champions model is an established one in public health policy[10], both on a national and international level. Champions are volunteers who promote health and wellbeing within their established social networks by using their connections and lived experience to improve services and overcome barriers in their communities. It is intended as an alternative to top-down approaches in communities with low trust in government. It seeks to facilitate context-specific public health solutions, using true collaboration and co-production with target communities. This model has previously informed the design of other health-related initiatives, including HIV prevention and domestic violence reduction.[11]

The Community Vaccine Champions evaluation

The Department for Levelling Up, Housing and Communities (DLUHC) commissioned an evaluation of the CVC scheme to improve the evidence base around community-led engagement programmes' impact and outcomes on local communities. The existing evidence reviewed by SPI-B and Public Health England shows that Community Champions do indeed successfully reach the target communities, but research on their impact on behaviour change has been limited[12].

The results of the CVC evaluation are intended to provide insights into the elements of funded activity that add the most value, and to identify transferable lessons learned for future similar initiatives.

More specifically, the evaluation aimed to explore:

[10] https://www.gov.uk/government/publications/community-champions-programme-guidance-and-resources/community-champions-programme-guidance-and-resources

[11] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1011854/A_rapid_scoping_review_of_community_champion_approaches_for_the_pandemic_response_and_recovery_V8.pdf

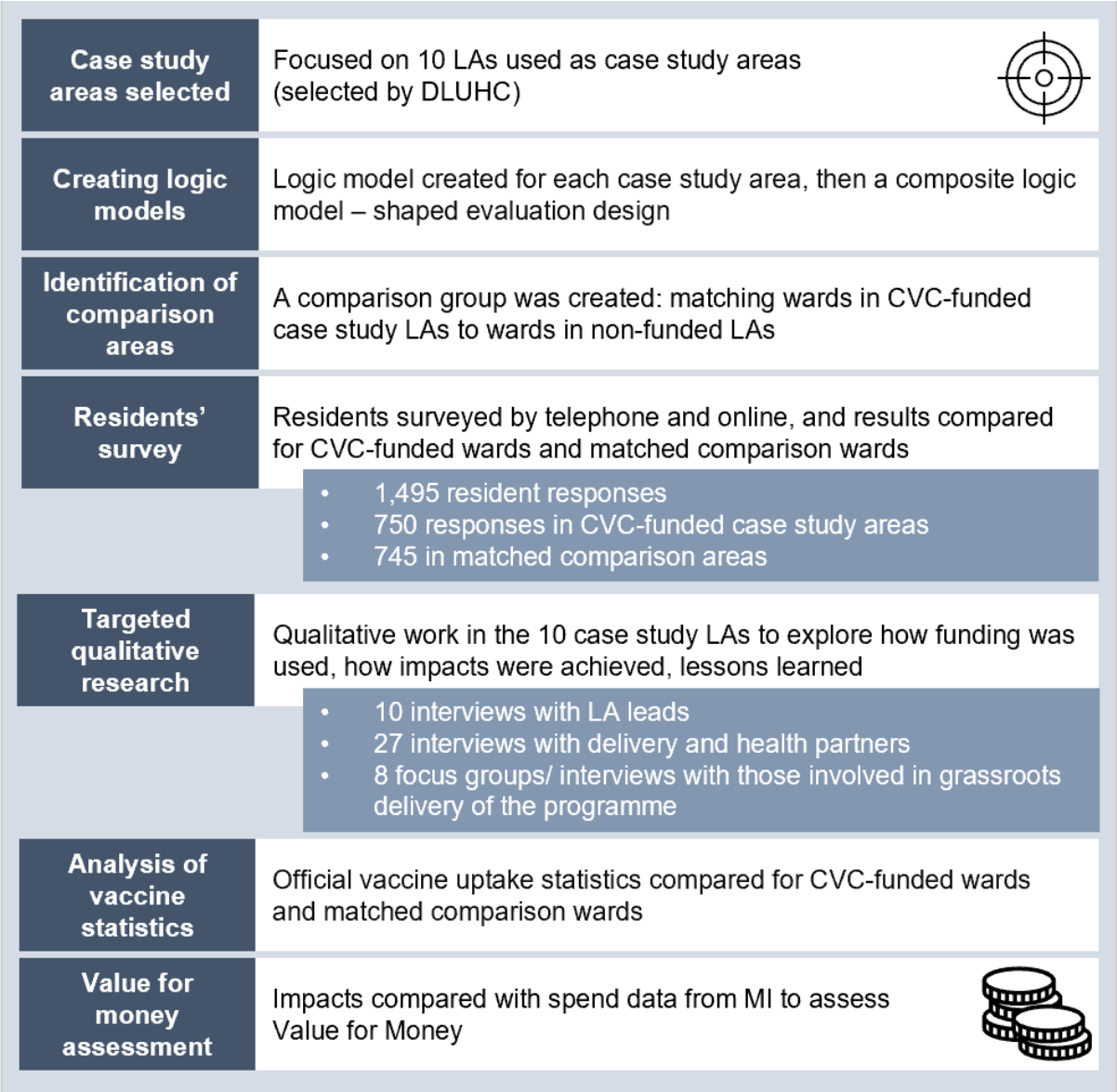
[12] Community Champions: A rapid scoping review of community Champion approaches for the pandemic response and recovery (publishing.service.gov.uk)

- The extent to which CVC-funded activities challenged misinformation around vaccines and whether it increased COVID-19 vaccine uptake in target communities.
- Whether the programme enabled LAs to build local networks and infrastructure for reaching target communities.
- Whether this in turn allowed them to increase the reach of, and trust in, official public health messaging; and raise awareness of local services.
- The extent to which the funding enabled the development of more tailored local messaging.
- How it affected community resilience and the communities' ability to respond to future crises.
- What models of CVC-funded activity had most impact, in what context and with whom.
- Lessons learned about the key ingredients for successful CVC-funded activities, and what worked less well.
- How individual Champions experienced the programme.
- The extent to which the CVC-funded activities delivered value for money.

Evaluation approach

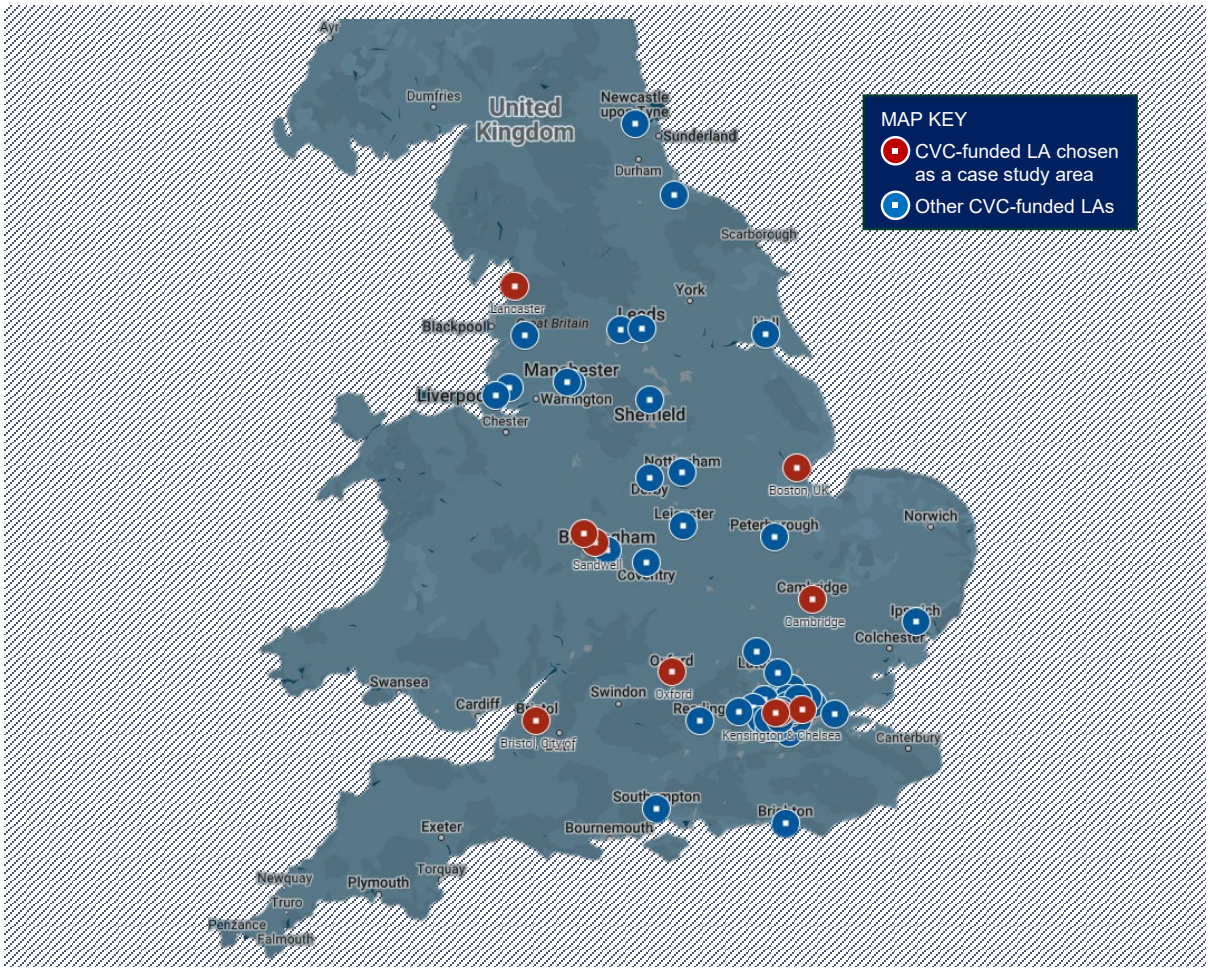
This evaluation was delivered by IFF Research, with analytical support from Bryson Purdon (regarding impact analysis of survey findings against a matched comparison group) and Belmana (regarding impact analysis of vaccine uptake data and the assessment of value for money). The study used a mix of quantitative and qualitative methods alongside analysis of management information and published vaccination data to obtain a thorough understanding of how the CVC-funded activities were implemented and the outcomes and impacts of the funded work. The mix of methods is summarised (Figure 1.1), then described in more detail, below:

Figure 1.1 Overview of evaluation approach



1. 10 of the LAs receiving CVC funding were selected by DLUHC as **case study areas**. They represented a mix of regions and demographic profiles, a mixture of approaches to delivering CVC-funded activities, and to ensure the inclusion of areas that were funded for CC1 and those that were not. The selection was also based on areas who had already made headway in delivering the programme (at the point of selection). The case study areas are shown as red dots on the map in Figure 1.2. Each area is profiled in the 'characteristics of the 10 case study CVC-funded areas' subsection below.

Figure 1.2 Map showing the location of the 10 case study CVC-funded areas



Note: CVC areas Hammersmith & Fulham, Kensington & Chelsea and Westminster are overlapping.

2. A **logic model** was created for each case study area, showing diagrammatically how the inputs, activities and outputs were intended to lead to the desired outcomes and impacts. These LA-specific logic models were used to create a composite logic model for the case study areas taken together. This informed the evaluation design, by guiding the development of surveys, qualitative interviews, and analytical approaches.

3. To establish the outcomes achieved in the 10 CVC-funded case study areas, the evaluation focused on specific wards where CVC-funded activities were likely to be concentrated. This was informed by CVC-funded LAs' delivery plans, which described specific wards and populations that they intended to target with their CVC activities. The evaluation therefore firstly identified *wards* that the CVC-funded LAs said they were targeting, and secondly identified further wards with high incidences of *populations* that the CVC-funded LAs said they were targeting. This selection of 'CVC-funded wards' was used to determine

where residents' surveys would be conducted and to inform the construction of a comparison group (discussed next).

4. To attribute any outcomes achieved to the CVC funding, a **comparison group**, which demonstrates what might have happened in the absence of the funding, was needed. This was constructed by identifying wards in non-funded LAs that had similar characteristics to the chosen CVC-funded wards (matched by characteristics such as vaccine uptake, age, ethnicity, deprivation, and disability).

5. **Residents were then surveyed** by telephone and online in both the chosen CVC-funded case study area wards and the matched comparison wards. The surveys used a combination of telephone interviewing via Random Digit Dialling (RDD) on landline and mobile, and lifestyle sample (which draws on records with demographic information attached to them, allowing better targeting of specific demographic groups), together with online completion, via a survey link disseminated to residents by each LA. A total of 1,495 interviews were achieved, 750 in CVC-funded case study areas and 745 in matched comparison areas. This allowed results to be compared for CVC-funded wards (focusing on the 10 case study LAs) and the matched comparison wards, using propensity score matching and impact analysis[13].

6. This was complemented by **qualitative research** in the 10 CVC-funded case study areas, via 37 in-depth interviews with LA leads, delivery partners, and public health partners, and 8 focus groups with individual Champions. The interviews and focus groups focussed on the activities delivered within each local area, the effect they had, and the lessons learned regarding how to achieve similar outcomes in the future.

7. **Analysis of official NHS vaccine uptake statistics** was used to examine levels of vaccination in the CVC-funded areas and the matched comparison areas, to explore whether rates of vaccination were higher in LAs receiving CVC funding[14]. As this element of the evaluation drew on

[13] Impact analysis used ordinal tests for scales (for which 'Don't know' and 'Prefer not to say' responses were excluded before running the tests) and chi-squared tests for categorical variables.
[14] This analysis used a Difference-in-Differences (DID) approach to consider the difference in the growth rate of the vaccination rate between the treated sample and the comparison group. Three comparison groups were considered for this analysis, one is the group of surveyed comparable wards which was selected based on their overall similarity to the surveyed CVC-funded wards, additionally two other comparison groups are constructed using Propensity Score Matching (PSM) based on two different matching methods (nearest neighbour matching and Mahalanobis distance matching). Statistical testing was done using a Wald statistic from a linear regression of the growth in the

national data, it was possible to examine this for both the 10 case study CVC-funded LAs *and* the wider group of all 60 LAs receiving CVC funding.

8. Management information supplied by the 10 case study CVC-funded LAs was used to analyse, for each LA, levels of spending, and the types and numbers of activities delivered. The impacts observed via analysis of the official NHS vaccine uptake statistics was compared with data on levels of spending, to make **an assessment of the value for money represented by the CVC programme.**

vaccination rate on a dummy variable for being treated as well as control variables which are the same as for the selection model (as suggested in Abadie and Spiess 2022).

Interviews achieved

Table 1.2 below profiles the samples achieved in the residents' surveys.

Table 1.2 Residents' surveys: profile of interviews achieved in CVC-funded case study wards and matched comparison wards

Profile	CVC-funded		Comparison	
	#	%	#	%
Age				
16-24	61	8%	45	6%
25-34	34	5%	45	6%
35-44	73	10%	86	12%
45-54	141	19%	119	16%
55-64	148	20%	163	22%
65-74	126	17%	142	19%
75 or older	104	14%	110	15%
Don't know	63	8%	35	5%
Ethnicity				
Asian ethnic groups	105	14%	65	9%
Black ethnic groups	73	10%	34	5%
Mixed or multiple ethnic groups	25	3%	8	1%
White ethnic groups	478	64%	599	80%
Other ethnic group	23	3%	3	0%
Prefer not to say	46	6%	36	5%
Socio-economic group				
A	64	9%	57	8%
B	223	30%	203	27%
C1	96	13%	115	15%
C2	125	17%	155	21%
D	53	7%	44	6%
E	94	13%	92	12%
Prefer not to say	95	13%	79	11%
Religion				
No religion	204	27%	221	30%
Christian	358	48%	388	52%
Buddhist	3	0%	4	1%
Hindu	21	3%	13	2%
Jewish	0	0%	6	1%
Muslim	83	11%	49	7%
Sikh	27	4%	5	1%
Any other religion	10	1%	22	3%
Prefer not to say	44	6%	37	5%

Base: CVC area (750); comparison group (745).

Table 1.3 below profiles the participants in the qualitative research in the 10 case study CVC-funded LAs.

Table 1.3 Qualitative research: profile of interviews achieved in CVC-funded case study LAs

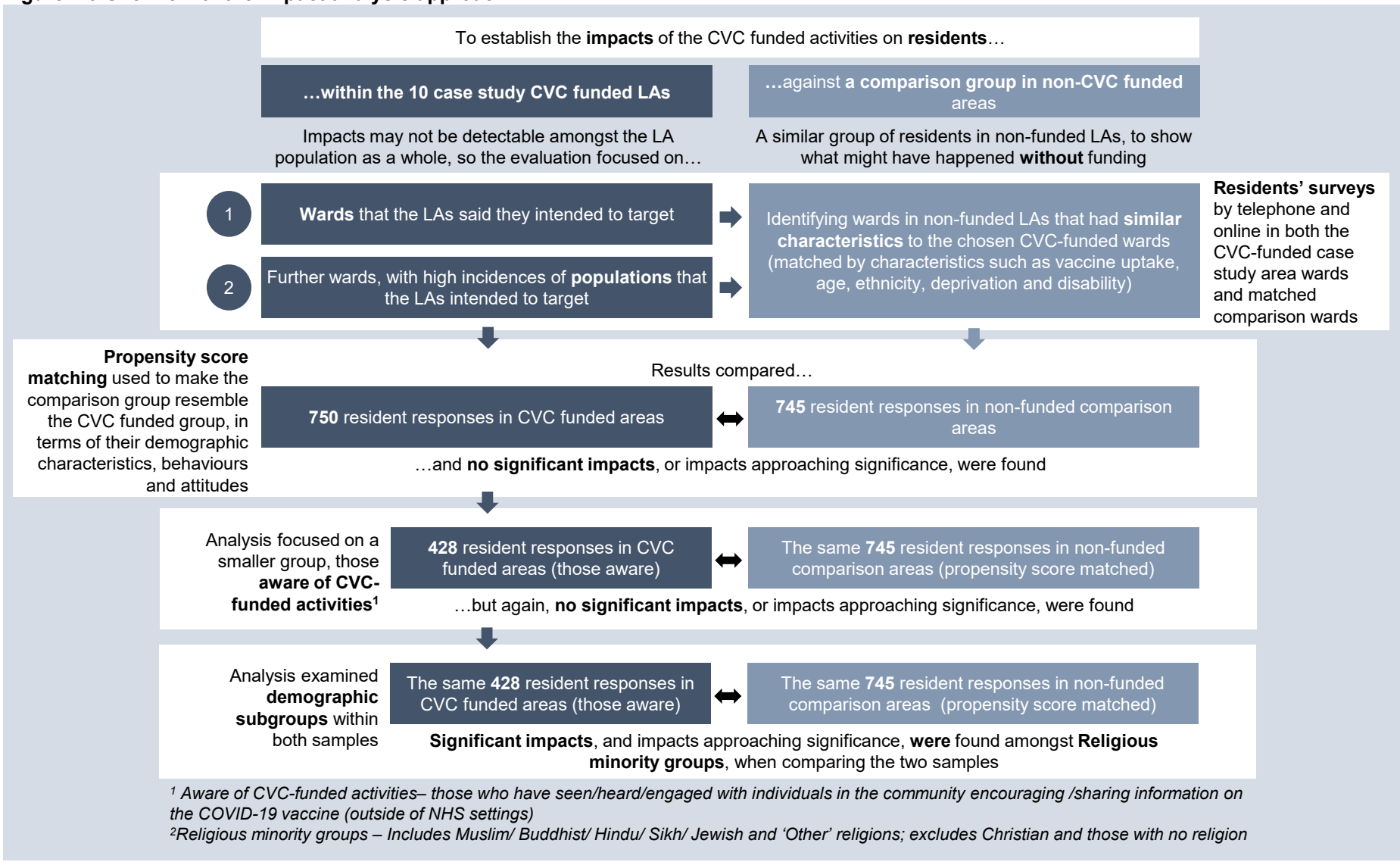
Audience	Method
Local authority leads	9 paired / triad / one-to-one interviews
Delivery partners	26 individuals, interviews and one group
Health partners	11 individuals, interviews
Champions / grassroots individuals	6 focus groups, 3 interviews

A note on the impact analysis approach

Using impact analysis to compare the two residents' survey samples initially identified no significant impacts of CVC funding on the behaviours or attitudes of residents in the CVC-funded case study area wards overall. As a result, the remaining impact analysis was focused on a smaller group of residents in the CVC-funded case study wards; those residents who were aware of the CVC-funded activities (428 of the 750 residents surveyed in CVC-funded case study LAs). The hypothesis was that significant impacts would be more likely to be observed among residents in the CVC-funded areas who were aware of CVC activities.[15] The diagram overleaf (Figure 1.3) summarises the analysis approach, from the initial selection of wards in both CVC-funded and non-funded areas, through to the focus on those aware of CVC activities in the funded wards.

[15] These were residents who, since January 2022, had heard or seen something about people or organisations in their local community who were either encouraging people to receive the COVID-19 vaccination or sharing information in support of the COVID-19 vaccination; or who had heard or seen something about Community Vaccine Champions / Community Health Champions; or had personally had any dealings with people or organisations in their local community who were encouraging people to receive the COVID-19 vaccination or sharing information in support of the COVID-19 vaccination; or were aware of local meetings or events that talked about COVID-19 vaccines; or who'd seen or heard something else about COVID-19 vaccines since January 2022, from talking to people in your local community who were encouraging people to receive the COVID-19 vaccination or sharing information in support of the COVID-19 vaccination.

Figure 1.3 Overview of the impact analysis approach



[1] Aware of CVC-funded activities– those who have seen/heard/engaged with individuals in the community encouraging /sharing information on the COVID-19 vaccine (outside of NHS settings)
[2]Religious minority groups – Includes Muslim/ Buddhist/ Hindu/ Sikh/ Jewish and 'Other' religions; excludes Christian and those with no religion

Evaluation limitations

Our ability to draw conclusions from the evaluation evidence is constrained by a number of factors.

Firstly, the timings of CVC funding delivery and evaluation commencing meant that it was not possible to collect data on awareness, attitudes, and behaviours of residents in the CVC-funded LAs prior to CVC-funded activities beginning, to act as a baseline. The baseline data therefore relies on residents recalling their awareness, attitudes, and behaviours in January 2022 at a later date (when the surveys were conducted, in autumn 2022). Answers may have been affected by imperfect recall.

Secondly, the surveys of residents in CVC-funded LAs were unable to perfectly establish which residents had been exposed to the CVC-funded activities. The nature of these activities (e.g., informal conversations in the community and community-based events at which anyone was welcome) meant there was no data on which individuals were engaged by the CVC-funded work; and the activities were not consistently named or branded in a way that would help residents to recognise that they'd encountered the CVC-funded work. LAs were also not comfortable recording the identities of individuals engaged by the CVC-funded activities, given the sensitivity of the subject matter. The evaluation is therefore reliant on resident recall of conversations, activities, events and individual Champions that were necessarily described in more generic terms, in the residents' surveys.

Thirdly, assessments of value for money involved working with Management Information (MI) supplied by the CVC-funded case study LAs, for which data was provided monthly, except for two months immediately after the main stage of CVC programme delivery; and with NHS vaccine statistics, which in some instances contained conflicting information. The economists, Belmana, cleaned the data and provided estimates for missing values as far as possible, but this remains imperfect.

A note on the context for the CVC-funded activities and the evaluation

It is important to acknowledge the context in which both the CVC-funded activities and the evaluation took place:

- **Local authorities had varying starting points for their CVC-funded work:** As outlined above (and explored in further in Chapter 3), some LAs had previously received CC1 funding and were well underway in delivering a Community Champions model when CVC funding was awarded. Non-CC1 areas receiving higher amounts of CVC funding went some way in addressing this difference, but the evidence of this evaluation suggests that the Community Champions model requires strong foundations in local networks

before outreach can begin. This meant that at the time of the evaluation (Autumn 2022) many non-CC1 areas were still in the development phases, or had only just begun outreach activities with residents. Many had planned activities into 2023. In some LA areas, it is more likely that impacts will be seen in future.

- **A decline in national messaging on COVID-19 and vaccinations:** Over the course of 2022, media coverage of the pandemic and national campaigns to encourage vaccine uptake declined. This was combined with an attitudinal shift among residents in England over the same period, with an increasing tendency to believe that the COVID-19 emergency had passed.

- **External pressures facing local authorities:** Throughout 2022, local authorities faced various external factors which put pressure on their staff and residents. For example, the cost-of-living crisis, LA spending freezes and higher levels of staff turnover, and, for some LAs, further localised crises (e.g., a tower block fire in Bristol). It is important to acknowledge the impact that these factors had on the workloads of those delivering the scheme. It also impacted on the engagement LAs had with their residents; vaccine messaging did not always feel appropriate or pertinent in discussions with residents due to the wider context.

The characteristics of the 10 case study CVC-funded areas

The following pages describe the context of each CVC-funded area at the point of receiving CVC funding (Figure 1.4).

Figure 1.4 Context of each CVC-funded area at the point of receiving CVC funding

Case study area: Boston CC1

Area profile:

Boston has an estimated population of 70,800 (ONS 2020), and has seen significant growth in Eastern European populations (Polish, Lithuanian, Latvian, Romanian & Bulgarian) in the last 10-15 years. Take up of the first COVID-19 vaccine - as of December 2021 – was low at 66%. Uptake was significantly lower in the four central Boston LSOAs. Boston Borough was the recipient of funding from the first Community Champions programme.

- Boston within UK

Summary of activity

Focussing in areas where first vaccine dose uptake was low, Boston recruited and trained Champions. Activities included myth-busting sessions, work with a Youth Ambassador program, and the development of a Health Communities grant. Materials were co-produced with key employers, schools, and Primary Care Networks, and distributed via multiple mediums.

Target groups

⇒ Focus on population as a whole
⇒ Particular focus on Eastern European population.

Pre-funding:

Vaccine hesitancy in Polish, Bulgarian, and Romanian communities, due to negative press around Pfizer in these countries. Distrust of a free vaccine.
- Community vaccine champion

GP reception staff viewed as obstructive to non-English people, who consequently struggle to get medical appointments and feel unwelcome.
- Community vaccine champion

Mistrust and misinformation within Boston's homeless community.
- Community vaccine champion

Case study area: Bristol

Area profile:

Working as part of the Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group, Bristol started identifying the vaccine hesitant in 2020, including engaging with communities more at risk of harm. Some wards (Easton, Ashley, and Lawrence Hill) had the lowest vaccination rates, combined with high levels of inequality, and a high proportion of minority ethnic residents. Only 57.6% of eligible residents aged 18+ in Lawrence Hill received at least one dose of the vaccine.

- Bristol within UK

Summary of activity

Bristol formed new partnerships with small community organisations, set up a Community Champions grant fund, and set up a communications group. They targeted those unable/unwilling to travel to vaccination centres, and those generally not affiliated with community groups (e.g. white, working-class men). They established a trust-based system to hear from and collaborate with priority communities.

Target groups

⇒ Black and minority communities
⇒ Disabled people
⇒ Neighbourhoods with the highest inequality
⇒ Wards with the lowest vaccine take-up
⇒ Young people
⇒ Working-class white males aged 40-60

Pre-funding:

Stagnating vaccine efforts, with one Health Partner describing how they realised that "no matter how many times they turned up with the vaccine, people wouldn't come." They had to change their approach and initiate the conversation about what was putting these residents off.
- Health Partner Interview

Low uptake among hard to reach and under-privileged individuals.
- Health Partner

Case study area: Cambridge

Area profile:

The transient nature of Cambridge's population meant the LA's vaccine data was difficult to interpret. There was a desire to understand what they were missing, and dig deeper, with a focus on quality training and trust.

There were many organised working groups, and collaborations already doing research and outreach work, much of it funded by Containment and Outbreak Management Funding.

- Cambridge within UK

Summary of activity

Grants and projects were executed in an "Ecosystem approach", using co-production between the LA and community groups, and also between different community groups.
Projects were not designed or delivered in silos, so as to maximise value.
Training, co-learning and upskilling were emphasised throughout.

Target groups

⇒ Ethnic minorities
⇒ Young people
⇒ People over 50
⇒ People with disabilities
⇒ People with a pre-existing health condition

Pre-funding:

Health inequalities was not a core focus of "evergreen" one-size-fits-all approach to health.
- LA Lead interview

Issues with Ghost Data, as 1 in every 6 resident is a non-permanent resident.
- LA Lead interview

Many existing working groups:
- **Vaccine Access Partnership**
- **County Council Vaccine Hesitancy Steering Group**
- **Our Cambridge Council Transformation group**

- Logic model work

Case study area: Hammersmith and Fulham

Area profile:

H&F had the third lowest vaccine uptake in West London. Wards with low vaccine uptake, Wormholt and White City, North End and College Park and Old Oak (rates of 53% to 56%), were those with low income households in general. First dose uptake was low amongst those from black backgrounds, especially younger people.

The programme was delivered borough wide as the very diverse population has closely intermingled pockets of wealth and poverty.

- Hammersmith and Fulham within London

Summary of activity

Champion co-ordinators were recruited from five specific groups. They identified and contacted unvaccinated / unboosted individuals, and continue to promote vaccines, vaccination sites, and health events. Culturally appropriate/adaptable materials were co-produced and translated, then disseminated in harder to reach communities. On estates with low vaccine uptake, a grant scheme was run, as were active programmes.

Target groups

⇒ First focus was on black individuals.
⇒ Focus on Asian communities followed.

Pre-funding:

Concerns about and experiences of institutional racism resulting in lack of trust in the NHS and government messaging.
- Logic model work

Local Authority deliberately taking time to listen to concerns.
- Logic model work

Local Authority access to vaccine take up data and feedback (including from pre-ran "Building Trust" residents workshops).
- Logic model work

Case study area: Kensington and Chelsea & Westminster

Area profile:

Boroughs of mixed prosperity and poverty, Westminster and Kensington and Chelsea have been developing their Public Health commissioned Community Champions network for over 12 years. Seeking to address the challenges of COVID-19, the LAs have built a network of community and health champions.

- Kensington and Chelsea and Westminster within London

Summary of activity

Community led vaccine promotion events and activities with priority groups: this included 300 activities and 80 events (including outdoor/street engagement, online events, and face-to-face community activities), and a vaccine bus. They ran a grant scheme, and recipients had access to 32 training courses.

Target groups

⇒ Ethnic minorities
⇒ Young people

Pre-funding:

Hesitancy towards vaccines: one champion herself was apprehensive about taking it until she attended the training sessions with the NHS, and needed months to be convinced.
- Community vaccine champion

Misinformation about the vaccine was common, from different sources including social media.
- Community vaccine champion

"There was a trust issue with the NHS system, we all have been let down by this, that or the other"
- Community vaccine champion

Case study area: Lancaster

Area profile:

Lancaster is a lower-tier authority, so public health is not usually in their remit. They did not have very low vaccine uptake overall at the time of funding, other than in specific wards (which was put down to ghost GP data, or populations who were vaccinated abroad but registered as unvaccinated in the UK). A combination of these factors meant Lancaster wanted to use the CVC funding to address wider disease prevention and health inequality, and create a lasting health legacy.

- Lancaster within UK

Summary of activity

They ran a grant scheme with £500 to £10,000 available for trained individuals from community groups to run their own projects. They offered bespoke vaccination provision for the hardest to reach individuals, including arranging travel and work with needle-phobic people. They ran a School Arts Project for KS2 and KS3 students, plus more.

Target groups

⇒ Wards with the lowest vaccine uptake
⇒ Young people
⇒ Refugees and asylum seekers
⇒ Homeless community
⇒ Ethnic minorities including Roma and Traveller communities

Pre-funding:

Refusal among Health Professionals to treat asylum seekers.
- Community vaccine champion

An established, active and collaborative if over-worked third sector, and well-respected CVS.
- Community vaccine champion

Stark health inequalities, localised to certain wards.
- Community vaccine champion

Case study area: Newham

Area profile:

London's most ethnically diverse Borough, Newham had been working with partners to support vaccine uptake for all residents. As part of the original CC1 bid, activity was grouped into four categories: vaccine delivery, vaccine engagement, low number high risk groups, learning and evaluation.

- Newham within London

Summary of activity

Newham built on existing work with high risk groups (homeless, sex workers, undocumented residents, those with addictions).They led evidence-informed outreach, and ethnicity-focussed engagement. Activities included: casual conversations, scaling-up of a vaccine bus, one-stop wellbeing shops, training of non-clinical vaccinators from target communities, and co-producing & co-delivering materials. Newham also ran a grant scheme.

Target groups

⇒ Focus on groups where uptake is under 60%

Pre-funding:

Sense of disconnect between communities and statutory organisations.

- LA Lead interview

Pre-existing Vaccine Peer Support Programme and work done for a CC1 bid. Experience running other Champion schemes.

- Logic model work

Strong desire for feedback from the community to feed into policy making via Champions.

- LA Lead interview

Case study area: Oxford

Area profile:

Oxford is one of the most unequal cities in the UK, it also has a high proportion of ethnic minority residents at 22%, compared to 13% in England overall, making it the third highest ethnic minority population in the southeast.
Across all ethnicities, there are concerns around vaccine side effects, pregnancy and fertility, vaccine safety and generally being exposed to misinformation and conspiracy theories. Lack of trust in the LA is also an issue.

- Oxford within UK

Summary of activity

100 community champions recruited from low uptake cohorts & existing networks, plus 8 anchor organisations. Health work was embedded into existing organisations, events and partnerships in community spaces.
Individual community champions, and grant recipients at organisations, were trained and spread positive vaccination messaging and materials.

Target groups

⇒ Geographical areas with low vaccine uptake
⇒ Ethnic minorities
⇒ Homeless community

Pre-funding:

"In some communities there was so much fake [vaccine] news, coming from Asia, from this country, that country, in their own native language which is really easy to digest, it came from their mother tongue."

- Community vaccine champion

Lack of access to healthcare among ethnic minorities due to:
- **Language barriers**
- **Cultures of politeness**

- Community vaccine champion

Younger people in all groups perceived to be more vaccine-hesitant.

- Community vaccine champion

Case study area: Sandwell CC1

Area profile:

Sandwell is a religiously and ethnically diverse metropolitan borough. They ran a highly successful CC1 programme which was award winning.

Keen to build on the successes of this, their CVC work reflected the shift to COVID-19 becoming endemic, with intensive work planned in Soho and Victoria and St Pauls wards.

- Sandwell within UK

Summary of activity

Sandwell built on their CC1-funded activities, continuing to recruit and train CVCs from a range of backgrounds (including younger people). They created vaccine sites with improved accessibility, collaborated with local employers, and ran a grant scheme to set up COVID 19 safe community settings.

Target groups

⇒ Black, African, and Caribbean populations
⇒ Working age populations

Pre-funding:

"Lots of different issues going on in terms of views of the vaccine, generational differences and scaremongering. Young people would see it on social media and see the misinformation and would then pass it onto their elders."

- Community vaccine champion

"There was a lot of loneliness. Some people put the shutters up and wouldn't get close to anyone, some understood it a bit more and did go outside."

- Community vaccine champion

Case study area: Wolverhampton CC1

Area profile:

Wolverhampton is the 4th most deprived city in the country and has a relatively large, and increasing ethnic minority population.

Wolverhampton has a diverse voluntary sector, and a head of Public Health who actively engages with the LA.

- Wolverhampton within UK

Summary of activity

Wolverhampton built on the blanket approach of CC1 work, to create bespoke vaccine materials and opportunities.
An incentive model was used, whereby existing community groups received a monetary reward per-vaccinated person. These groups largely wove vaccine messaging into pre-existing activities and initiatives.

Target groups

⇒ Religious minorities
⇒ Ethnic minorities
⇒ Lower socioeconomic status
⇒ Young people

Pre-funding:

"Fear and myths". Some people, especially young people, were very anti-vaccine.

- Community vaccine champion

Some champions involved in generalised CC1 work had experienced aggression from anti-vaxxers.

- Community vaccine champion

Distrust in healthcare professionals, especially among those who were either unable to see loved ones who were in care/hospital.

- Community vaccine champion

2. Programme Theory

The Community Vaccine Champions (CVC) logic model, shown overleaf in Figure 2.1, sets out the inputs, activities and outputs of the programme, the short- to medium-term outcomes that should be achieved through these processes, and the longer-term impacts that should eventually be realised. This is a composite model, representing what the funding is seeking to achieve across the evaluation's 10 case study areas overall. Local level targets and delivery models are, by nature, variable; the logic models for each of the 10 case study areas can be found in Appendix A.

The primary outcomes intended to be achieved or worked towards in the CVC funding period include:

- Increased vaccine uptake in target areas and groups
- Champions being better able to support community needs (as a result of training)
- Increased trust between the local authority (LA) and community stakeholders
- More official public health messaging being shared with target areas and groups through local trusted voices
- Improved reach of / engagement with official public health messaging on vaccine safety among target areas and groups
- Increased trust in the vaccine and reduced vaccine hesitancy among target areas and groups

The secondary outcomes related to wider health factors. These involved increased engagement with local health and wellbeing services by target groups, leading to:

- Target groups having improved understanding of health and wellbeing issues
- Increased access to guidance and awareness of local health services in target groups

The evaluation findings suggest that delivery worked as intended, i.e., in line with the approach described in the composite logic model.

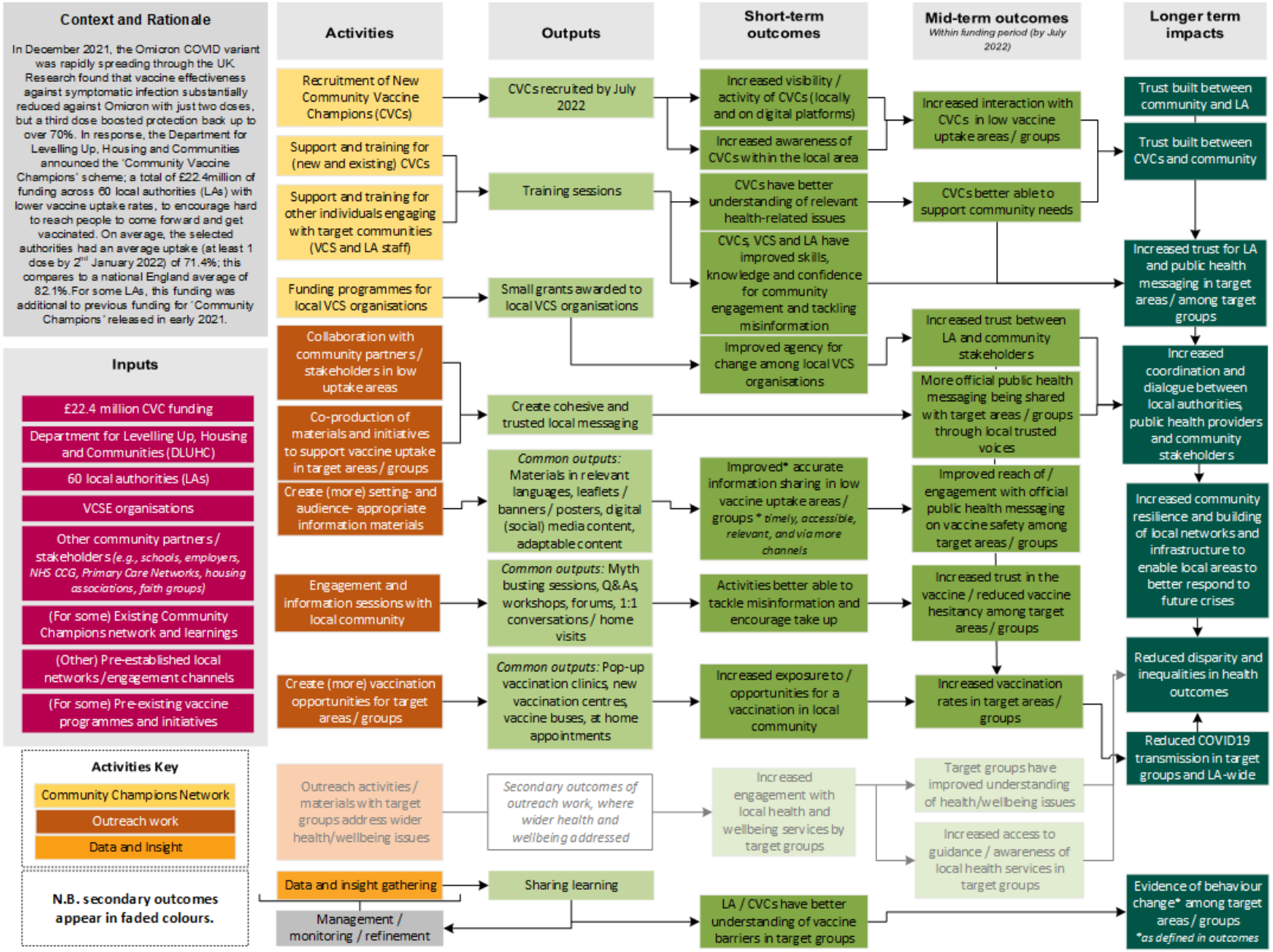
Table 2.1 overleaf provides the definitions of logic model elements, for comprehension of this model.

Table 2.1 Overview of logic model elements and their definitions

Element	Definition
Context and Rationale	Justification for CVC funding, the challenge it would address, and the situation at the time it was introduced.
Inputs	Resources committed to allow the CVC activities to take place.
Activities	The programme logic model focused on the required activities for delivery, and others identified as common across multiple areas. Activities have been divided into those most relevant to the Community Vaccine Champions network, those involving outreach work with the community, and the data and insight element.
Outputs	The direct products of the programme's activities, such as types of activities, materials and deliverables.
Outcomes	Short-term outcomes are likely to occur during CVC delivery and can include, for example, changes in confidence, knowledge and opportunities. Medium-term outcomes are likely to occur for most local authorities by the end of the funding period, if positive changes from short-term outcomes are achieved and followed through.
Impacts	Long-term impacts are the ultimate, high-level effects that the CVC programme is working towards. It is important to note that with impacts, the programme is 'contributing to' their achievement rather than 'causing' it; impacts cannot be directly associated with / referenced as a sole direct result of the programme, as it is likely that there are several other influencing factors contributing to any impact.
Arrows	Show the connections between specific elements of the programme (activities, outputs) and resulting outcomes and

	impacts, i.e., which activities are expected to lead to each outcome.

Figure 2.1 Community Vaccine Champions - composite logic model



3. The implementation of CVC-funded activities

Chapter summary

Prior to CVC funding, **some LAs had tackled mistrust in public health information through generic messaging** (e.g., posters and leaflets), **others utilised a more targeted approach** (e.g., myth-busting sessions with interpreters).

In some cases, the previous CC1 funding had been used to establish **health inequality groups**, which helped to make connections with other health sector stakeholders, and engage directly with communities e.g., through conversations or vaccine busses. In these cases, **some of the groundwork for the CVC related work was already in place**.

In the LAs that did not receive the CC1 funding, **some reported having strong relationships with local and voluntary sector organisations already**, related to other cross-sector vaccine uptake/ misinformation combatting initiatives. However, **others described almost needing to build these relationships from scratch** when they began their CVC programme of work.

A recurring theme – and perceived strength – of LAs' implementation, was that it **avoided 'top-down' approaches**. This manifested in various ways:

- **Avoiding LA branding** that could trigger community distrust.
- **Avoiding prescriptive requirements** so that community-based partners could take ownership and tailor approaches to target communities.
- **Using community-based partners** who could leverage trust to recruit individual Champions with lived experience of their community (e.g., similar socio-economic, ethnic or religious backgrounds), who could in turn use that lived experience to engage with their peers.

Overall, avoiding top-down working has a 'snowball effect' of one advantage leading to another (e.g., flexibility in terms of how to recruit champions, leading to community partner empowerment, leading to better tailoring).

What was the context for the CVC-funded activity?

Local contexts

By nature of their selection, there was a low level of vaccine uptake in each of the local authorities that received CVC funding. As a result of the criteria used, London LAs were overrepresented in the LAs selected to receive the CVC funding. However, the groups and communities among which vaccine uptake was reported to be the lowest, and those for whom the impacts of COVID-19 have been the greatest, varied between the participating LAs. For example, in some areas these groups included disabled people and pregnant women, whereas in other areas they included young people and asylum seekers (see Chapter 1 for more information). Despite this variation, a common factor across the target populations was a perceived lack of trust in public health information.

CC1 funding

Three of the 10 case study areas received Community Champions scheme (CC1) funding – Boston, Sandwell, and Wolverhampton.[1] All of these local authorities had used the CC1 funding to tackle mistrust in public health information and disseminate vaccine-promotion messaging.

Generic vs targeted engagement

Some of the CC1-funded activities implemented in Boston, Sandwell and Wolverhampton involved generic outreach and messaging about the COVID-19 vaccine. For example, developing and distributing posters and leaflets including information about the vaccine and local vaccination sites, through vaccine busses and door-knocking. These materials and accompanying conversations were not tailored to address the concerns of specific target groups but rather, they were intended to be applicable to multiple audiences. Some aggressive confrontations by residents during door-knocking exercises were reported and this contributed to a desire for a more tailored approach to the CVC-funded activities, involving vaccine promotion in the context of building trusting relationships with target communities.

Other CC1-funded activities used more targeted approaches to tackling vaccine misinformation and mistrust in public health information. For example, in Wolverhampton, the funding was used to organise online meetings with black African communities to explore specific concerns about the vaccine and provide

[1] The Community Champions scheme (CC1) was launched at the height of the pandemic, in January 2021. It also targeted 60 local councils and voluntary groups, to support the communities most at risk of COVID-19.

information. In Boston, the CC1 funding was used to create a Youth Forum for young people to discuss their beliefs, concerns and questions about the vaccine with peers. In Sandwell, a group with faith leaders was set up to facilitate a safe space in which local people could discuss their views, concerns and questions about COVID-19 and the vaccine.

Engaging with wider networks

In some areas, the CC1 funding had also been used to establish cross-sector working groups e.g., Health Inequality Groups. By providing regular opportunities to meet and discuss the delivery of vaccine promotion work, these groups facilitated communication between local authorities and other health sector stakeholders, such as public health colleagues and local organisations. These were felt to be particularly effective when representatives from local communities also attended and could share their communities' concerns about public health messaging directly with policy makers. This enabled CVC-related materials to be co-produced by LAs, public health colleagues and local people.

"We had partnership meetings… to bring us all together as one unit. The range was very broad; we had access to public health officers [and] we were their sounding board for getting the messages across [to the target populations]."

Champion

Impact of CC1 funding on the design and delivery of CVC-funded work

Leads from the LAs that received CC1 funding reported that engaging with their local communities, public health colleagues and delivery partners in the ways described above helped to make decisions about the design and delivery of their CVC programmes of work.

Specifically, they reported the positive impact of having recently established or strengthened partnerships with health-sector colleagues and delivery partners, as well as having recently engaged with local communities. In addition, these local authorities were able to replicate aspects of previously planned activities that were deemed to have been effective (e.g., the provision of vaccine busses in Wolverhampton) or make adjustments based on the lessons learnt (e.g., in Boston, hosting events online instead of face-to-face due to issues around social distancing and IT).

Engagement with other vaccine uptake/ misinformation combatting initiatives

Seven of the participating local authorities did not receive the CC1 funding – Bristol, Cambridge, Hammersmith and Fulham, Lancaster, Newham, Oxford, and Westminster alongside Kensington and Chelsea.

Despite not receiving the CC1 funding, many of these local authorities reported having previously used other sources of funding to deliver initiatives that aimed to address mistrust in public health messaging and low vaccine uptake. For example:

- In Cambridge, funding from their Primary Care Network facilitated a programme of work around increasing access to information about the COVID-19 vaccine and mistrust in public health messaging among communities disproportionately affected by COVID-19. The funding enabled them to create informative social media videos about the vaccine and hold Q&A sessions with these various communities (e.g., Sudanese and Cantonese).

- In Kensington and Chelsea and Westminster, funding from the Imperial Health Charity supported a programme of work across several North-West London boroughs to explore local community needs in relation to COVID-19. This involved hosting workshops with local authority and public health colleagues, as well as local community organisations who then bid for grants to deliver projects to address the identified needs of their communities.

- In Lancaster, funding from the Containment and Outbreak Management fund enabled them to deploy a vaccine bus, create informative digital content about the vaccine and deliver talks in schools.

In these LA areas, some of the leads and delivery partners suggested that their involvement in these other vaccine uptake initiatives supported their ability to implement the CVC-funded activities quickly and effectively. The key lessons learnt and transferable elements were similar to those reported by the local authorities that *did* receive the CC1 funding, such as having recently established or strengthened relationships with delivery partners and local communities, and being able to continue, replicate or adjust activities.

"[Pre CVC funding] we held [health-related] talks and healthy living workshops in the library … we used our existing model of having events to hold [vaccine-related] events with a stall attached to them manned by a member of staff who could engage with the community. The CVC funding allowed us to run these."

Delivery partner

Other local authorities reported having had no previous experience of delivering initiatives to support vaccine uptake and tackle misinformation. However, in these areas, often other programmes aimed at addressing the wider social determinants of health and health inequalities had been delivered, which also required local authorities to work with voluntary organisations and engage with communities and minority groups. As such, these initiatives also helped to prepare local authorities for the delivery of CVC-funded activities.

In a minority of areas, leads and delivery partners reported not having strong relationships in place with community or voluntary organisations. In these cases, local authorities had to prioritise building these relationships when the CVC funding was awarded.

Delivering in the context of COVID-19

The unprecedented and urgent nature of the COVID-19 pandemic required DLUHC, local authorities, delivery partners and voluntary organisations to work quickly and flexibly in the delivery of CC1 and CVC-funded activities.

The CVC-funding process specifically enabled local authorities to design and implement activities quickly by minimising the bureaucracy normally involved in local authority grant giving. For example, a re-application system allowed local authorities and delivery partners to easily apply for additional 'top-up' funds if needed, to supplement the initial grant.

Many LA leads also spoke positively about the flexibility of the CVC funding, which allowed them to implement activities that not only focused on COVID-19 and vaccinations, but also sought to address wider health issues and inequalities.

> *"It is not just a vaccination issue, it is a much wider issue… [related to] health inequalities… we're definitely becoming more joined up and I think we can only benefit from working with our partners more closely in this way."*
>
> **Delivery partner**

As discussed in chapter 4, this flexibility to engage individuals and communities on wider health and wellbeing topics was felt to be an effective way to begin conversations about vaccinations.

How were the CVC-funded activities prepared for and implemented?

Grant schemes

Micro grant schemes

Most local authorities followed a similar model when administering grants. This involved utilising pre-existing relationships with networks of voluntary organisations, making the application process as easy and transparent as possible (e.g., through simple, accessible application forms) and administering funding by bank transfer prior to any activity. Most groups were then supported by a key local authority contact through email, WhatsApp or over the phone. Beyond the monthly monitoring information data collection arrangement with DLUHC (which is drawn upon on for the VFM analysis), local authorities took a light touch approach to monitoring to avoid burdening local community groups.

Overall, local authority leads and delivery partners reported that this process worked well. However, several challenges were mentioned, some of which local authorities were able to overcome, and some that they were not able to. These were:

- Delivery partner **concerns that the application would impact other funding opportunities**. This was overcome by local authorities explicitly stating that it would not impact other funding opportunities in the initial communications.
- Some of the partners involved in award decisions reported **not feeling supported to make these decisions**. There was no feedback in the qualitative interviews about how this was overcome.
- Some of the smaller delivery partner organisations **did not have bank accounts via which funding could be delivered**. In these cases, these organisations collaborated with larger organisations in the area (facilitated by the flexibility of the funding) or were supported by the local authority to open a bank account. However, this was itself a challenge due to the tight time frames.
- In some areas, **delivery partners wanted more IT support, or more peer-to-peer support with other organisations**. Local authorities provided additional IT support where necessary and some Champions independently organised meet-ups to share knowledge and ideas.
- The **light touch approach to monitoring delivery partner activity made it difficult to access impact**. Most local authorities accepted this as a less than ideal outcome of operating in the fast paced context of COVID-19, and of working with smaller voluntary organisations. In addition, some local authority leads and delivery partners expressed ethical concerns, questioning the appropriateness of collecting data on minority groups in this context because it was felt to be counter to the informal, sensitive approaches required to engage these groups.

Monetary incentives

Wolverhampton opted for a unique grant giving model. They provided an initial £1,000 grant (utilising a similar process to the micro grant schemes described above) and a £35 incentive per vaccinated person, tracked with a project-specific code given at vaccination sites. These funds could be used at the group's discretion, not solely for health/vaccination initiatives. This approach enabled the local authority to collect quantitative data on the number of vaccinations resulting from funding (although no demographic data); helped to re-circulate funds back into communities; and supported the longevity of involved groups by providing regular funding (via the incentives instead of a one-off grant). This model is revisited as a case study in Chapter 4.

Recruitment of Champions

The nature of CVC funding enabled local authorities to be flexible in the way that they recruited Champions to facilitate the CVC-funded activities. Overall, local

authorities utilised the approaches set out in their delivery plans, with minimal changes. In most areas, the recruitment of Champions was facilitated by local authority leads and delivery partners.

Recruiting Champions with lived experience through local organisations

Several local authorities made use of micro-grant schemes to work with local community-based organisations to recruit Champions. This involved local authorities giving grants to local organisations, to identify individuals they work with to sign up to the CVC programme in their area.

This process was felt to be conducive to a grassroots approach to engagement, as opposed to more top-down approaches, which some local authority leads mentioned had been utilised in the past with limited success. Overall, this approach was felt to be a success because:

- It empowered local organisations to be involved in the programme from the start, and gave them the flexibility to make decisions about how to recruit Champions. In this way, it was felt to rebalance the power relations between local authorities, local organisations and local people and in turn, foster more genuinely collaborative relationships;

  "The funding has given us the opportunity to work in a different way. What we wanted to achieve wouldn't have been possible if [the Champions] were volunteering directly for the council. [Because they are working for the voluntary organisations] it stops the power imbalance of the council holding all the cards… [this] has helped to build more genuine partnerships."

  Local authority lead

- It helped to ensure that people with lived experience relevant to the populations targeted by the CVC activities were involved in delivering the activities (e.g., similar socio-economic, ethnic, or religious backgrounds). This was considered to be important for enabling Champions to foster genuine, trusting connections with local people and communities;

  "Champions are from groups that we want to target and are in one way or another related to them – this is an advantage; they are on the same level and can overcome some of the barriers [to engagement with vaccination messaging]."

  Delivery partner

- It meant that many of the recruited Champions had personal and professional connections with the target communities, and in many cases, previous experience of similar work e.g., volunteering for local organisations or involvement in community engagement projects.

"I'm from here, I have gone through it all, you can't beat personal experience, it gives a better understanding of what's going on, people will also believe you and… they will have more empathy. I could get… a real-life understanding."

Champion

Having existing relationships with local organisations was felt to be advantageous as it enabled this process for recruiting Champions to be implemented quickly and effectively.

Figures 3.1 and 3.2 (overleaf) provide examples of how individuals were recruited as Champions, and their context/role within local communities.

Figure 3.1 Individual case study: Afro-Caribbean community worker

Individual's background and experience

The Champion was an active member in their city's Caribbean community. They were involved in multiple community groups, including a women's group, and a mutual-aid support group that works with families in the community helping them integrate, and directing those from ethnic minorities who are struggling to foodbanks and other sources of support.

Champion journey

Champion heard about event from someone at the LA. Was initially **uninterested and suspicious**, and was **concerned it was a "box tick activity"**, with **no actual benefits to the community.**

"Why are you giving us this money, what's in it for you? They must've wanted an outcome for themselves"

Champion was also insulted that at the intervention seemed **to target people of colour**. Noting their community were the ones who were initially dying in front line jobs, that many had taken the vaccine (so found the intervention stereotyping).

"The first person from the council made out like they wanted to do research into us, the black community, no thank you, but then [trusted contact] explained that it was looking into health disparities and health inequality and I thought OK... maybe""

Champion refused to work on the project if it was **vaccine focussed,** noting they would be worried about discussing it in their community due to **negative perceptions** from rumours that the jab was to be tested in Africa. Champion also noted that the most pressing issues to their community were not the vaccine, but wider inequalities.

"Why are we being targeted, our people in the front line were the first ones dying, and lots of them did take up the vaccine"

Champion was convinced to partake due to **wider health focus**, and realisation a **trusted LA contact** was involved in the scheme.

Champion took part in the **Make Every Contact Count** training and found this very useful.

"I felt that they tried to limit the scope to vaccines, they didn't realise the whole system is broken, even education"

Champion organised a **wider-health** event for the Caribbean community, including sexual health, other screening, vaccine information (COVID and other), dietary information. Food and entertainment was provided at this event.

"Deliver money to local communities. Only grassroots initiatives and social enterprises have the community at heart"

Champion has built a relationship with another champion, who works with an entirely different group, and has **plans to collaborate in the future.**

Figure 3.2 Individual case study: recruitment journey of arts worker

Materials

Individual's background and experience

The Champion was a paid employee at a Cancer charity, which did much work with bereaved children. They also worked as a freelance arts worker, often also with children. They had worked in the Third Sector of the local area for over twenty five years. They had strong connections, both personal and working, with others in the local voluntary community.

Summary of activity

Encouraging reflection and processing among children through art. The champion ran multiple art sessions with children, using many mediums from dye, to paint, to poetry. Children were encouraged to reflect on the pandemic: including the positives of family life in lockdown, and health more widely.

The art was compiled into a book, which formed a keepsake for the participants and has also been distributed locally. Further work is ongoing to create a tapestry of fabric-based creations.

Recruitment journey

Champion attended information event at local Rugby Club with other organisations. The event was focussed on health outcome initiatives, with speakers from the county council and other organisations.

Champion had negative experience. They perceived the logic behind the initiative to be rooted in **classism**, and fixation on vaccine data to be **authoritarian.**

""It was a bit odd, it felt a bit Big Brother, George Orwell, I didn't feel entirely comfortable. The figures were given to us …of who'd taken up the vaccine in different wards. And then some really awful assumptions were made about why that was, that they were poor people who were disadvantaged and didn't understand... I nearly left at that point, I thought I didn't agree with how it was being sold to us"

Were motivated by desire to break down systemic, generational health access and outcomes inequalities. As part of their job at a cancer charity, they had also **worked with bereaved children** who had lost family to COVID. They also believed **they had the skills** to deliver the work well, as had done similar work in the past.

"Supporting long term health and wellbeing of children, but also knowing that COVID hasn't gone away. They lived in fear at the time, it was a fearful time for children, there was a big mental health toll. We wanted to run a hopeful project"

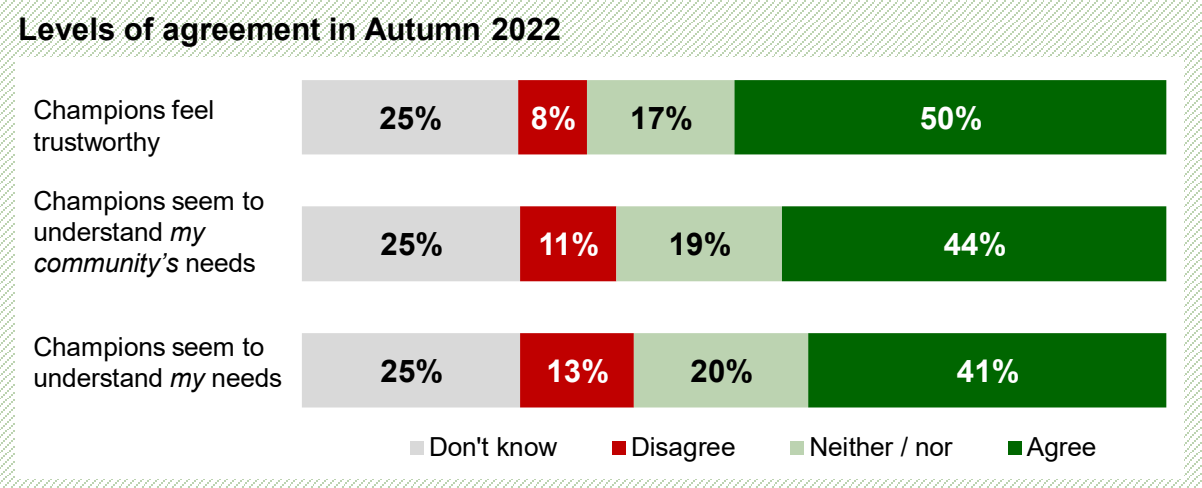
They were **motivated by the positive outcomes** for the children involved in this project they previously worked on. They felt the project had provided escapism for the bereaved children and an opportunity to reflect on their experiences, which helped to improve their emotional wellbeing.

"We've got 6 months of funding…I've been working in this area 25 years, I am working with the children of children I worked with, and… levelling up takes generations. That is really what it takes"

They were **disappointed** at the fixed-term nature of the funding.

Residents in CVC-funded areas who were aware of the Champions, were asked questions about their perceptions of these Champions. Survey data points to a slight disconnect between the views from LAs and delivery partners, and the sentiments of CVC aware residents. As shown in Figure 3.3 below, levels of trust in Champions and perceptions that they understood community and individual needs were fairly middling, with no more than half of CVC aware residents agreeing that Champions were trustworthy (50%), understood community needs (44%) and understood individual needs (41%). Very few, however, disagreed with these statements (11%, 10% and 8%, respectively), with CVC aware residents more likely to state that they did not know or neither agreed nor disagreed, than to say they disagreed. This may suggest that either the selection of individual Champions or the quality of their engagement with residents could have been better; however it is impossible to determine conclusively the reasons for residents' middling responses.

Figure 3.3 CVC aware residents' views on Champions (Autumn 2022)



Survey question G1. Thinking about the 'Community Vaccine / Health Champions' you are aware of in your local area, to what extent do you agree or disagree that...? Base: All residents in CVC-funded areas exposed to Champions (365)

Other approaches to recruiting Champions

Some local authorities continued to work with Champions recruited as part of their CC1 funding. In these cases, Champions had previous experience of working with the LA and delivering vaccine-promotion activities, which was felt to be positive by LA leads. However, the use of Champions recruited within the CC1 funding was not always possible due to some relationships having been lost over time. In these cases, local authority leads recognised the need to invest in more ongoing and genuinely collaborative relationships with volunteers.

"[We didn't have a] way to keep [the volunteers] updated, and we don't know what they have gone off and done… we didn't say to them 'how do we keep you up to

date'. We didn't have a mailing list for them as such… So, the second phase [the CVC funding] is about providing a bit of structure and a two-way communication."

Local authority lead

Other local authorities recruited Champions through existing pools of volunteers or part-time staff, or worked with known and trusted individuals e.g., local councillors and GPs, to recruit Champions. Some recruited specific professionals relevant to the target populations in their area e.g., teachers and midwives to help disseminate vaccine information to young people, parents, and pregnant women respectively. Again, this approach to recruitment meant that Champions had previous experience of working with the LA and delivering vaccine-promotion activities, particularly within target groups with which they normally work. Here, in the absence of relevant lived experience, professional experience and familiarity with target populations helped to build trust and engagement with local people.

Sharing learning about recruitment approaches

Within some areas, learnings and examples of best practice were shared between the LA and stakeholders e.g., local organisations and local councillors. In some cases, learnings were also shared between local authorities, for example at a cross-sector conference on vaccine access. However, it was suggested that more opportunities for sharing learning and examples of best practice within and across LAs participating would have been beneficial, as would an opportunity for Champions to feedback on their experiences to local authorities.

Training and support

Across local authorities, as part of the preparation for and implementation of the CVC-funded activities, a range of training and support opportunities were offered to Champions, local authority staff, and local voluntary sector organisations.

There were some similarities between the opportunities offered in different areas, however some of the sessions and activities were tailored to specific types of volunteers and in recognition of the varying target populations with whom they would be engaging.

Champions

Once recruited, there were a range of opportunities available for Champions, including training on:

- having conversations e.g., the 'Make Every Contact Count' training
- creating effective messaging materials
- cultural awareness training

- general health and wellbeing topics e.g., mental health
- health topics related to vaccinations
- health inequalities

Overall, Champions reported being satisfied with the training they received, with some feeling very positive about it. Many reported that the training enabled them to feel confident engaging with target populations (especially when Champions' first language was not English) and to provide the necessary information, which in some cases was quite complicated official or medical advice. Some Champions also reported feeling more confident in themselves outside of the CVC work.

> *"[It is] good to be part of something… [it has] given me more confidence."*
>
> **Champion**

However, there were mentions of consistency issues, with Champions from the same local authority receiving different training. This suggests that some Champions were missing out on beneficial training.

In addition, some of the training material was felt to be quite complex and, when considered all together, a lot of information to digest. This could be particularly difficult for disabled Champions, and those for whom English is not their first language. It was suggested that more support for these Champions is required (e.g., the provision of easy read documents), in addition to more opportunities to feedback on training sessions[1].

Some suggestions for additional training opportunities included learning about general health and wellbeing or social issues that individuals within the target populations might be facing. For example, Diabetes or domestic abuse. This was felt to be particularly important given the insight that conversations about the vaccine are often most effective when tied into wider conversations about health and social issues.

Ongoing support for the Champions commonly involved informal meetings with local authority leads (either in-person or online) and the use of digital communication channels (e.g., WhatsApp or MS Teams). In one area, the Council for Voluntary

[1] While the base size is small for residents whose first language is not English (n=56), there is an indication that the CVC-funded vaccine promotion work was less effective in reaching community members whose first language is not English: they were less likely to report receiving a COVID-19 booster vaccine since January 2022 (35%, compared with 66% of residents speaking English as a first language) and more likely to report that they'd not taken up any of: a first COVID-19 vaccination, a booster, or an appointment to receive either of these (46%, compared with 20% of residents speaking English as a first language).

Services played a big role in delivering the training and providing a shared platform for peer-to-peer support.

Delivery and health partners

In some areas, representatives of the local voluntary organisations involved in the recruitment of Champions and/or grassroots delivery of the CVC-funded activities received the same training as the Champions; for example, the Make Every Contact Count training.

Other delivery and health partners reported that they received little or no CVC-specific training, however:

- One delivery partner mentioned just being given a fact-book about the vaccine by the local authority which was useful to refer to throughout an arts project to help children access information about the vaccine.
- Another delivery partner who had been involved in the CC1 activities reported that they had not received any training for the CVC-funded activities but were told to continue with their CC1 work.
- One health partner reported receiving training on how to administer the vaccine, but not any kind of training or logistical information about how to access the target populations.

Visibility of Champions

Champions were made visible to the community mainly through being physically present in local areas. Other factors that contributed to the visibility of Champions included:

- Being able to have conversations about wider health issues (e.g., stress and weight management), which increased the Champions' reach and helped to engage individuals by not immediately talking about vaccinations (in the context of perceived fatigue with COVID-19 as a topic). In many cases, the training provided (e.g., Make Every Contact Count) supported Champions to have these conversations.

- Having tailored materials in accessible and translated formats to share with individuals from target populations (e.g., leaflets with information about the vaccine in local languages). The most effective materials were co-produced with local organisations, the local authority and public health colleagues.

"The language you choose is really important. Translations are needed. We need to use terms that people relate to."

Delivery partner

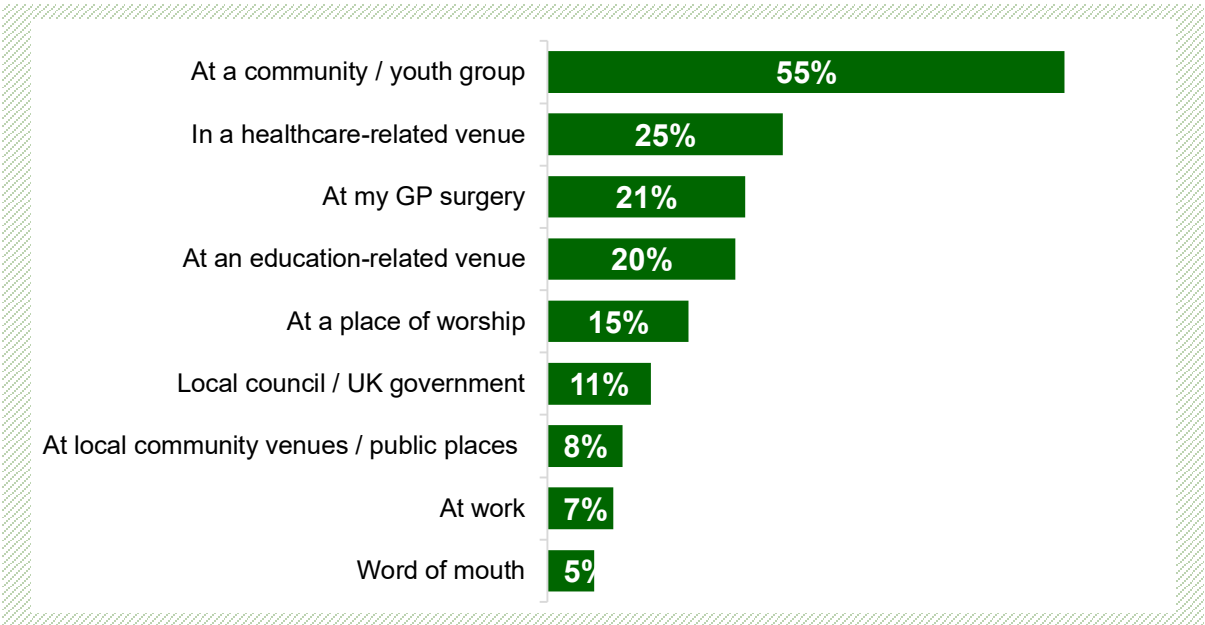
In some areas, Champions used local authority logos to increase their visibility in the community. However, the areas which did not do this felt that avoiding local authority branding was an advantage, as it increased approachability, reinforced that Champions are part of the local communities and therefore it helped to build trust between target populations and Champions. Overall, this helped to overcome some of the negative connotations held by local people towards local authorities and government, some of which stemmed from a general mistrust of authority or of public health messaging, in addition to more specific issues related to, for example, perceived institutional racism or a perceived lack of local service provision or local investment.

Measures of awareness of Champions

Among those in the survey who indicated that they had been exposed to CVC activity (i.e., those described as 'CVC aware' in this report), only 19% had heard or seen something specifically about 'Community Vaccine Champions / Community Health Champions'. [2] The likelihood of having heard or seen something about the Champions was higher among those from ethnic minority groups (25% compared to those from white ethnic groups).

Those residents who had seen or heard something about the Community Vaccine Champions / Community Health Champions were asked where they had heard or seen this. Most commonly, residents had explicitly heard or seen about Community Vaccine / Health Champions at a community or youth group (55%, see Figure 3.4).

Figure 3.4 Where residents saw / heard about 'Community Vaccine Champions' specifically



Survey question F4. You mentioned that you had heard or seen something about 'Community

[2] The title of this role differed in some local authorities.

Vaccine / Health Champions'...Where did you hear or see this?: All residents specifically aware of 'Community Vaccine / Health Champions' (81). Showing responses >5%.

Activities implemented by Champions

Once recruited and trained, the champions implemented a range of activities to explore vaccine barriers, challenge misinformation and provide opportunities for vaccine take-up. Some LAs also implemented initiatives that aimed to promote health and wellbeing more generally. Activities varied between LAs, and were tailored to the needs of local communities. They included:

- Touring vaccine busses, often arranged to attend existing community events.
- Myth busting sessions, often with medical professionals, and sometimes in schools with the hope that young people would then share these messages with their families at home.
- Encouraging individuals and community leaders to share their positive vaccination experiences, which was felt to be especially effective with religious leaders.
- Co-producing materials, such as leaflets and posters with local people, voluntary organisations and local people to ensure that they are in appropriate formats and languages, and tailored to address specific concerns from specific groups.
- Informal conversations with local people, utilising the 'Make Every Contact Count' (MEC) training, often as part of wider health and wellbeing conversations, and in local settings e.g., in parks, cafes, places of worship.
- Champions attending existing events e.g., Eid celebrations, community kitchens, neighbourhood markets, walking groups, which was felt to be an efficient and effect way to engage with people (e.g., on their terms and in settings they were familiar with).
- Creating safe spaces for certain groups to explore vaccine concerns together. These settings encouraged relaxed and open conversations where individuals felt understood and listened to, without judgement. They were opportunities to challenge each other's ideas.

Changes to delivery over time

In general, the CVC-funded activities implemented by local authorities were similar to those outlined in their original delivery plans. However, in some instances, local authorities adapted their programme:

- Reducing mandatory training for local voluntary organisations and Champions from a full day to a half day, acknowledging time restraints relating to capacity of small organisations, and other employment or caring responsibilities of volunteers;
- Introducing mechanisms for Champions to regularly feed back to the local authority and record information on vaccination activities;
- Specific changes to the delivery of activities, or to the intended recipients e.g., increasing reach from target populations to wider communities, or targeting engagement within specific sub-groups of target populations.

Others described moving away from purely COVID-19 focused activities, as a perceived fatigue around the topic set in and national media coverage waned. These LAs pivoted to activities focused on broader health and wellbeing topics, perceiving these to have greater appeal.

Lessons learnt – what works

Participants highlighted the following lessons learnt about what works:

Investing in building networks of organisations and establishing genuine relationships with partners is valuable, as it can support new cross-sector initiatives to be implemented quickly and effectively.

Tailoring engagement approaches to specific target groups and prioritising building trusting relationships with communities over time can be a more effective way to tackle mistrust in public health messaging than more generic and ad hoc activities, such as door-knocking.

Training on how to have conversations (about health, wellbeing, social issues and the vaccine) is crucial to enable Champions to feel confident engaging individuals sensitively and effectively. Additional training on cultural awareness and creating effective messaging materials also supports this.

Recruiting Champions with relevant lived experience (e.g., shared socio-economic, ethnic or religious backgrounds) helps to build trusting relationships and genuine engagement with target populations.

Flexible funding, enabling delivery partners to recruit Champions directly, in turn **facilitates a more grassroots approach** to community engagement and helps to rebalance power relations between local authorities and local people.

4. Opportunities for vaccination and vaccine uptake

Chapter summary

Additional vaccination opportunities delivered through the CVC funding were most effective where they took place within existing community groups and venues, e.g. community centres and places of worship: spaces where community members already felt comfortable.

Effectiveness of additional vaccine opportunities delivered through the CVC funding were **constrained by last-minute scheduling changes**, **variable vaccine availability** and related variable **GP surgery engagement**, and **inadequate on-the-ground communication** with NHS services on the day.

Anecdotally, these opportunities were thought to have led to increased vaccination rates, but LAs struggled to prove causal relationships. For example, they were often unsure to what extent additional vaccine opportunities were just increasing convenience for those who would have received vaccines anyway.

LAs' evidencing of impact was hindered by a perception that collecting data from those engaged with was **counter to the informal, sensitive approaches deemed to be necessary for engaging target groups**; and by some LAs having deliberately chosen a focus on wider health issues (to overcome communities' sensitivities and fatigue with COVID-19 vaccination as a topic, and to make the work more engaging). This widening of the focus made it more challenging for them to prove impacts on vaccination, however.

One possible solution to this was a model of incentivising community partners for each additional vaccination achieved, which both encouraged the work itself and generated evidence of impacts through the process for claiming the incentive.

When taking into account survey analysis, which compares CVC-aware residents with a matched comparison group of residents in non-funded areas, there were **no significant impacts on vaccination uptake on the overall group**.

However, when looking at sub-groups, analysis found that **religious minority groups did see a significant positive impact on COVID-19**

vaccine boosters (and appointments for boosters were also more likely, albeit not statistically significantly).

To what extent did the Community Vaccine Champions (CVC) programme increase opportunities for vaccination?

Activities to increase vaccine opportunities

The Community Vaccine Champions (CVC) programme funded additional vaccination opportunities in most local authorities (LAs). Many LAs used the funding for activities such as pop-up vaccine clinics, mobile vaccine busses or to improve access to vaccine opportunities by providing transport to vaccination centres, such as taxis.

When running these activities, many local authorities found it useful to build on already-operating infrastructure, groups, and venues, within the community. One LA lead described these as "pre-existing locality hubs", frequently used by or exposed to the target populations. These included community centres and faith settings, places people routinely attended in their day-to-day lives, for reasons other than vaccination, which therefore felt familiar and comfortable and were proven to be accessible to the target populations. This was also felt to reduce the perceived formality of the vaccination process.

"Bring the doctors to the people, not the people to the doctors."

Delivery partner

Vaccination events and opportunities took place at these venues, thus taking the awareness raising activities and vaccination opportunities into places where the community already gathered. To further increase awareness of these opportunities, LAs spread the word through residents already visible in the community, building on the local leaders, trusted community voices and Champions' existing relationships with community members. LAs perceived these to be the most effective approaches.

Within CC1-funding, it had been common for LAs to use colder approaches such as door knocking and leafletting in the street to promote new vaccination opportunities and encourage vaccination appointments through more formal routes (established vaccine centres of GPs, for example). Some LAs also opted to do this with their CVC funding, but – in a refinement of the CC1 approach – this time they used data to identify where these activities would be best-targeted (namely, where there were areas with lower vaccination rates or higher populations of target audiences).

The individual Champions felt safer when operating in familiar areas and targeting community groups already known to them. One Champion was involved in both CC1 door knocking, and CVC community engagement. They described often being harassed and involved in angry interactions within the CC1-funded work, and noted that this never happened during the CVC activity where they were more focussed on familiar areas and groups. This led to them having a more enjoyable and safe experience at the CVC stage. This suggests that Champions working in areas or among communities unfamiliar to them were more vulnerable to experiencing discomfort or abuse in their work.

Although not as effective as using local leaders and Champions' existing relationships to spread the word, colder methods such as door-knocking and in-street leafleting were nevertheless thought to be useful in understanding vaccination barriers. LAs and delivery partners felt that, through this work, they gained an understanding of the bespoke needs of some of the most hard-to-reach individuals. This led to some solutions, particularly for practical barriers, including: home vaccination, arranged transport, chaperones, and needle-phobia support.

How CVC funding impacted engagement with communities

Training Champions and micro-funded organisations to engage with community members effectively when promoting vaccine opportunities was viewed as key to their success.

The most common training that Champions received was Make Every Contact Count training, which sought to encourage the delivery of health and wellbeing information within routine interactions between Champions and target community members. This was frequently mentioned by LA leads, delivery partners and Champions themselves.

Also common was training in health information by health professionals, both COVID-19 vaccination specific and on wider health issues. This training aimed to equip Champions with accurate information and relevant signposting to draw on when addressing queries from their communities.

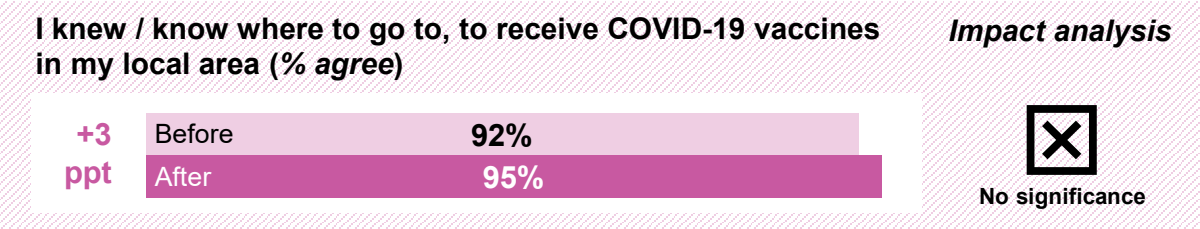
Other training included upskilling Champions to interact with a wider pool of people: two local authorities each mentioned offering mental health awareness and cultural awareness training. Others mentioned attending training that focussed on engaging communities in the online space, with effective online meeting training and social media communications training being offered by one LA.

LA Leads and partners noted that the CVC funding's flexibility allowed for multiple streams of bespoke work, where a blanket approach to vaccine opportunity provision would otherwise have been adopted.

Measures of impact on increasing vaccine opportunities

As shown in Figure 4.1, survey data found that knowledge of where to receive a COVID-19 vaccine was very high even before CVC-funded activities started. At the start of January 2022, 92% of residents who later became aware of CVC-funded activities felt they knew where to go for a vaccine. This awareness increased by three percentage points (to 95%) after CVC-funded activities were rolled out. However, impact analysis indicated that the CVC-funding had no significant impact (overall and by subgroups) on knowledge for where to go for a vaccine.

Figure 4.1 CVC aware residents' knowledge of where to receive a COVID-19 vaccine (before/after CVC-funded activities)



Survey question E1_9. How much do you agree or disagree that the following describe how you felt at the start of this year: I knew where to go to, to receive COVID-19 vaccines in my local area? Base: All residents in CVC-funded areas aware of CVC activity (428)

To what extent did the CVC programme increase vaccination rates?

Stakeholder perceptions of impact

While LAs believed that CVC-funded vaccine opportunities had a positive impact on increasing vaccination rates, they also acknowledged that it was challenging to definitively link the increase in vaccination rates to their efforts. They recognised that vaccination rates may have increased even without their CVC-funded opportunities.

> *"We don't know whether that person was going to get a vaccine anyway. Yeah, it was because the bus was there, and it was accessible. That's what they did. But that doesn't mean that if they've been somewhere else and there had been the opportunity to have a vaccine, that they wouldn't have done that anyway."*
>
> **Local authority lead**

Others felt more confident that they were, even on a small scale, delivering vaccines through CVC-funded activity to those who would not have otherwise had one.

"The vaccine bus is still getting people turning up and they're having the first jab. My colleague who works in my team shall say, 'Oh, I spoke to so and so, and they did get a vaccine.' It's not huge numbers."

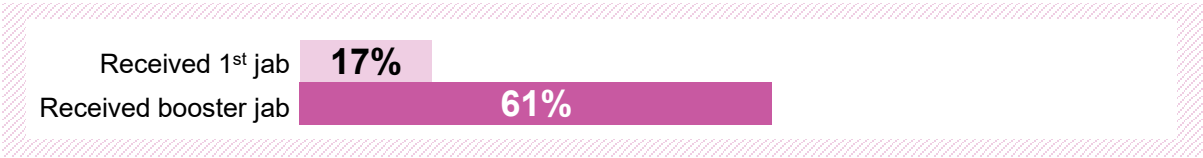
Local authority lead

Measures of impact on increasing vaccination rates

NHS vaccinations data and the MI data supplied by the 10 case study CVC-funded LAs, however, provided evidence that CVC-funded activities had a positive impact on booster vaccine behaviours. MI data showed a total of 4,975 vaccines being administered during CVC-funded events. Some of these vaccines would likely have been administered even without CVC funding, so the NHS vaccinations data was used to compare vaccination rates for surveyed CVC-funded wards and for comparison areas. While no statistically significant additional impact is found for first and second dose vaccination rate, the NHS data shows a 14.7% of growth in booster vaccinations across all residents in case study areas which is not observed in the comparison areas (p-value=0.18). While there is some uncertainty in the data, this implies 562 additional booster vaccinations attributable to the programme in these case study areas. Further details on the analysis of NHS vaccinations data can be found in Technical Appendix C.

Survey data also showed that between January and Autumn 2022, 17% of all CVC aware residents received their 1st COVID-19 vaccination, and 61% received a booster (See Figure 4.2). The proportion receiving a 1st dose was higher in Wolverhampton (30%), and the proportion receiving a booster was higher in Cambridge (81%).

Figure 4.2 Vaccine update for CVC aware residents (January – Autumn 2022)



Survey question I5. So, just to check, since January 2022 , have you personally ...? Received a COVID-19 first vaccination; Received a COVID-19 booster vaccination. Base: All residents in CVC-funded areas aware of CVC activity (428)

The impact analysis of this survey data (comparing CVC aware residents with a matched comparison group of similar residents in non-funded areas) showed no significant impacts on vaccination uptake on the overall group. However, when looking at sub-groups, analysis found that religious minority groups did see a significant positive impact on COVID-19 vaccine boosters. Religious minority groups are defined as those giving their religion as Muslim, Buddhist, Hindu, Sikh, Jewish or 'other'. As shown in Table 4.1, there is statistically significant evidence that receipt of a booster vaccination during 2022 was higher among the CVC aware group than for

the matched comparison group, when looking at those from religious minority groups only (46% compared to 27%). The p-value for the difference is 0.028. Furthermore, appointments for boosters were also more likely in this CVC aware subgroup, albeit not statistically significantly.

This positive impact on booster vaccinations among religious minority groups suggests that the approaches taken within the CVC-funded vaccine promotion work have been effective within faith communities – namely, of encouraging community leaders (including religious leaders) to share their positive vaccine experiences; of vaccine promotion messages being tailored and delivered by Champions with relevant lived experience (e.g., shared socio-economic, ethnic or religious backgrounds) of the communities being targeted; and of vaccine promotion and vaccine opportunities being delivered in spaces (including faith settings) where the target communities already felt comfortable.

The sample sizes for these religious minority groups are small, just 92 from CVC areas in our CVC aware group, and 99 in comparison areas, reducing the chances of reaching statistical significance. It can therefore be beneficial to also highlight differences *approaching* significance. Those approaching significance can be defined as differences close to reaching the p=0.05 level, in the context of a general positive trend for related measures. As Table 4.1 shows, the impact on making an appointment for a booster dose is, by this definition, **not** statistically significant.

Table 4.1 Impact of CVC activities on vaccination behaviour among religious minority groups

Impact on:	% received in CVC period	ppt diff.	P-value	Impact?
1st dose	CVC-aware 17% Non-CVC 16%	+1	0.809	☒ No significant impact
1st dose appointment	CVC-aware 13% Non-CVC 11%	+2	0.807	☒ No significant impact
Booster	CVC-aware 46% Non-CVC 27%	+20	0.028	☑ Significant impact
Booster appointment	CVC-aware 26% Non-CVC 17%	+9	0.198	☒ No significant impact

Survey question I5. So, just to check, since January 2022, have you personally ...? Received a COVID-19 first vaccination; Received a COVID-19 booster vaccination; Made an appointment to receive a COVID-19 booster vaccination. Base: Religious minority groups – CVC aware group (92); comparison group (99). Note: percentage point differences may not appear aligned with percentages shown in the charts due to rounding.

Challenges for local authorities in evidencing impact

Ideally, LAs would record data in a more structured way to better capture outcomes, but some local authorities were against collecting any data on whether activities led to additional vaccinations, as they believed it undermined the values of a programme that that was based on community trust.

"The program is based on trust and transparency. So, I think if we said to people, 'we want to know if you had a vaccination as a result of coming in to chat to us', that would alter the nature of our relationship with them. So we haven't."

Local authority lead

"[We need] other ways that we can thoughtfully measure the impact of the programme without necessarily going into people's personal details or information on issues that are very sensitive in communities that are very wary, rightly so, of programmes like this and of, you know, partners and professionals working in that area."

Local authority lead

Others noted that the casual nature of some of the activities meant, logistically, it was impossible to know how many of the people that they spoke to went on to get a

vaccine, as there was no way to track who had been engaged with or involved in activities such as community conversations.

"But now the problem is that a lot of this is, 'how many vaccines did that lead to?' Well, who knows? But what it did do, is start a conversation."

Local authority lead

Some LAs were focused more on general health and wellbeing in their CVC work, and therefore they did not anticipate seeing a big increase in vaccine uptake. Many felt the money was best used sowing seeds for a generally healthier future.

One LA who did gather concrete evidence on the vaccination impact of the funding was Wolverhampton. They used a model of incentivising community partners for each additional vaccination achieved, which both encouraged the work itself and generated evidence of impacts through the process for claiming the incentive (Figure 4.3):

Figure 4.3 Case study: Incentives used to encourage delivery partners in Wolverhampton

Case study: Monetary incentives in Wolverhampton

"£35 went right back into the communities. It was almost like we were recycling money."

Activity

Wolverhampton used a unique grant model, providing a £1,000 initial grant and a £35 incentive per vaccinated person, tracked with a project-specific code given at vaccination sites. These funds could be used at the group's discretion, not solely for health/vaccination initiatives. Most groups worked vaccine encouragement into their usual style of activities or events, using the money to increase their frequency or capacities.

What went well

Clear quantitative data on the number of vaccinations resulting from funding: 2000 associated vaccinations.

Money goes into community (instead of paying a provider) which builds trust and supports groups.

The grants funded **activities that promoted togetherness:** social gatherings; bingo; film night; live music; clay, hair, flower arranging & wreath making workshops.

Incentives paid for repairs and equipment, ensuring the longevity of involved Groups.

60 community groups received grants and delivered projects reaching more people than the local authority could if working alone.

"I was able to work and speak to those community groups where I probably wouldn't have before."
- Health Partner

Challenges

Data only on numbers of vaccinated (no demographics, which would have been useful). It was assumed many groups don't have skills or set-up to gather sensitive data.

Some vaccine centres **unaware** of code system.

Some Champions noted the potential to play the system. This method was trust based. This hypothetical 'gaming' would involve distributing the code to family/friends who weren't involved in the project, who were going to be vaccinated anyway, and receiving £35 for their vaccination.

Some Champions struggled with the **monthly monitoring form**, which had to match vaccine site data to receive incentive. This required "advanced IT skills". LA support was given upon request.

One champion raised that this form would have been "impossible for someone with a disability to do".

Lessons learnt – what works

Participants highlighted the following lessons learnt about what works:

- **Training for individuals delivering the work ensured effective engagement with the community.** Training for Champions and micro-funded organisations – most commonly Make Every Contact Count training, and training in COVID-19 vaccination information and wider health information by health professionals – was critical to successful community engagement, as it increased confidence and supported the delivery of consistent and concise information.

- **Utilising existing community sites and organisations when creating vaccination opportunities was effective**. These were places residents already routinely visited, or groups that they already had a relationship with, and this helped build trust and make individuals feel comfortable.

- Similarly, **adding vaccine-related conversations or vaccination opportunities to an existing event was effective**; as was **weaving vaccination into something that looked after individuals' health more holistically**. Some LA Leads noted that by the time of the funding, which came late in relation to nationwide vaccine drive, vaccine fatigue and solidified anti-vaccine sentiment were prevalent, and having other health topics and opportunities available alongside vaccination helped to make the events more appealing. Additionally, some Champions noted reluctancy to be involved unless there was a wider health focus. This was mentioned by a Champion with an ethnic minority background, who noted that such a targeted intervention on vaccines stereotyped and othered their community.

- Many LA leads noted **that flexibility is required when generating vaccine opportunities**. The funding enabled the exploration of more creative approaches which considered the bespoke needs of different groups, and indeed individuals within them.

> *"It's not one size fits all."*
>
> **Local authority lead**

- **Vaccine data was a useful tool when deciding where to target activities** which otherwise would have been applied more indiscriminately. LAs also used this vaccine data to identify or confirm less-vaccinated target groups, and then utilised demographic data, to target activities in areas with a high proportion of these target group populations.

- **Practical barriers for residents receiving a vaccination were thought to be easier to address than attitudinal ones**, when creating additional vaccination opportunities.

Lessons learnt – challenges

Participants highlighted the following lessons learnt about challenges they faced:

- **Antivaxxers crashing the events was a challenge for multiple LAs**. This was most difficult during the start of the funding when there was much more media coverage of the COVID-19 vaccines. The frequency of this reduced over time, as news around the vaccines and messaging urging people to not receive them became less prevalent in the media.

- **Varying enthusiasm of GPs was challenging for LAs who collaborated with them.** LAs noted how useful it was to have GPs, with their professional medical knowledge, expertise, and teams, on board. They shared their knowledge with the community when myth-busting at events, and with LAs, Champions and delivery partners through forums and GP-run training sessions. They also provided settings for clinics, and had their trained staff on hand to administer vaccines. LA leads gave the current high workloads of GPs as a reason that some were more engaged than others. Some LAs were able to better reach GPs by utilising a middle-person, for example, a Clinical Director Lead.

"I've done work with community groups in [location] who are 200 yards from a GP's clinic, but they've never had contact with those GPs."

Delivery partner

- **Good communication between the NHS and LAs was important when trying to deliver additional vaccination opportunities, and its absence created challenges.** LA leads were aware that the NHS was important in providing access to the necessary resources, specialist knowledge and skills (e.g., individuals who are trained to administer vaccines), so any events could not go ahead without them. Communication with NHS could have been better on the ground. One Health Partner noted that communication with the NHS in advance was good but was poorer on-the-day during events. Many LAs described communicating with the NHS formally via weekly or biweekly meetings, which may have left a gap in terms of more agile on-the-day communication.

- **Collaboration with third sector organisations and statutory services was also very important** when organising community events. One

employee at a grant-funded organisation spoke of how their service (a health hub for refugees, which provided COVID vaccination among other vaccines) could have done so much more had there been better channels of communication, collaboration and signposting both ways. One example given was appointment texts received by the refugees, which were in English. These could have been co-produced to be bespoke, and in a language that the refugees were fluent in, to ensure they were understood.

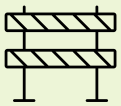
Lastly, as noted above, **practical barriers for residents receiving a vaccination were thought to be easier to address than attitudinal ones.** However, there were some persistent logistical challenges in addressing practical barriers. For example, there was a tendency for last minute scheduling of vaccination sites in terms of location, time, and vaccine availability. In some instances, vaccination events were left short of vaccines overall or of the specific vaccine type that had been promised; or events were cancelled altogether. As well as impacting the effectiveness of these events by reducing the number of vaccinations, it also impacted trust among those community members hoping to receive a vaccine. Limitations in staff capacity also restricted the scale of vaccination opportunities.

5. Understanding vaccine barriers and challenging misinformation

Chapter summary

The important ingredients of challenging misinformation involved tailoring messages to specific audiences (including via co-production with the audiences themselves) **and adopting gentle, informal approaches**, such as ad hoc conversations about general health issues and quizzes – in essence giving people time and engaging them in a relaxed way rather than being too pushy.

For LAs, the effectiveness of this work was anecdotal, with reports of positive impacts of community outreach particularly in faith settings.



Some LAs felt that practical vaccine barriers to vaccine uptake were more readily understood than attitudinal ones, and attitudinal barriers were sometimes felt by the LAs to be too entrenched to overcome.

Using Champions with lived experience (e.g., shared socio-economic, ethnic or religious backgrounds) better equipped them to explore barriers amongst their own community.

Other important ingredients for understanding vaccine barriers were: **Champions giving time to be present and visible**, so as to create opportunities for dialogue; and **Champions being trained to confidently have conversations**.

To what extent did the CVC programme lead to increased understanding of vaccine barriers, accurate information sharing amongst target groups and improved engagement?

Understanding vaccine barriers and tackling misinformation

Local authorities implemented a range of approaches to understanding vaccine barriers and tackling misinformation in their areas. These activities focused on listening to individuals and communities; to explore their beliefs, behaviours, concerns and questions about the COVID-19 vaccines and public health issues more broadly.

The implementation of these activities required Champions to be physically present and visible among the target populations and equipped with the tools and confidence

to build trust with individuals, hold sensitive conversations and disseminate correct information about the vaccines. Using Champions with lived experience (e.g., shared socio-economic, ethnic or religious backgrounds) better equipped them to explore barriers amongst their own community.

As such, the CVC funding enabled these activities not only in the provision of the resources needed to logistically organise these activities, but also in the provision of resources to recruit and effectively train Champions.

Figures 5.1 and 5.2 below outline the key CVC-funded activities implemented by local authorities, delivery partners and Champions to understand vaccine barriers and tackle misinformation amongst target populations. The figures include specific examples and the related lessons learnt.

Figure 5.1 Key CVC-funded activities implemented by local authorities (1)

Piggy-backing on existing events

What it involved	**Impact / outcome**
Champions attending, having conversations and sharing information with target populations at events.	Champions felt this encouraged individuals to explore their concerns about the vaccine, have conversations with family/friends, do their own research and in many cases, get vaccinated.
Example	**Lessons learnt**
Eid celebrations and walking groups in Westminster, Kensington and Chelsea; community kitchens in Oxford.	Piggy-backing on existing events increased efficiency (easier to organise) and helped encourage people to engage, particularly by integrating conversations about the vaccine into more general chats related to the events.

Creating safe-spaces

What it involved	**Impact / outcome**
Opportunities for specific groups of people to explore vaccine concerns together (sometimes utilising existing groups/ activities).	Individuals were able to meet with similar people, who may share beliefs and concerns about the vaccine. This encouraged relaxed, open conversations, where individuals felt understood and listened to.
Example	**Lessons learnt**
A group for older women in Wolverhampton; focus groups with young people in Cambridge.	These meetings required champions to hold non-judgemental conversations and provide factual information. They worked best when champions were part of the groups as this helped them to relate and build trust.

Figure 5.2 Key CVC-funded activities implemented by local authorities (2)

Myth-busting sessions

What it involved	Impact / outcome
Often with medical professionals, both in the community and in schools, with the aim that young people will share information with their families at home.	Individuals were able to learn about the vaccine and ask questions directly to healthcare professionals.
Example Webinar myth-busting sessions with the public in Oxford; in-person sessions with young people in Sandwell.	**Lessons learnt** Hosting alongside vaccine busses was effective so that individuals who decided to get vaccinated could do so straight away.

Sharing positive vaccination experiences

What it involved	Impact / outcome
Community and religious leaders sharing their positive vaccination experiences within their areas and congregations.	Many in the congregation felt much more comfortable with the vaccine and decided to get vaccinated.
Example A church leader in Cambridge shared his positive vaccination experience with his congregation.	**Lessons learnt** Community and religious leaders can be very influential. However, this approach may not encourage others to engage critically with the topic.

Co-producing materials

What it involved	Impact / outcome
Materials co-created by champions, local organisations, and public health colleagues, to ensure materials address specific concerns of communities and in accessible formats.	These materials explained official guidance about the vaccine in digestible and visual ways. They helped to direct individuals to vaccination sites and encourage conversations.
Example Information leaflets in translated languages in Boston; vaccine information leaflets in 'goodie bags' at pop-up stores in Westminster, Kensington and Chelsea; posters to display in community centres and in Cambridge.	**Lessons learnt** Effectively translated materials were felt to be crucial to reaching target populations. Joint partnership meetings provided valuable opportunities for champions to feed back insights to policy makers to create tailored materials together.

Informal conversations

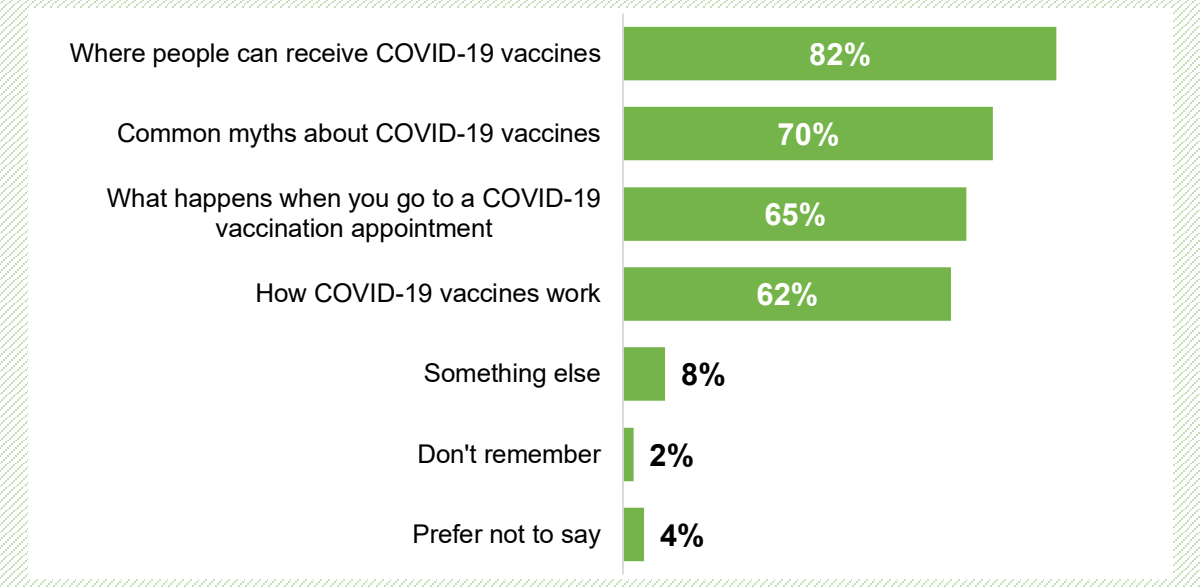
What it involved	Impact / outcome
Champions having conversations with local people, utilising the MEC training often as part of conversations about wider health and wellbeing.	Champions felt this encouraged individuals to: explore their concerns about vaccines, have conversations with family/friends, do their own research and in many cases, get vaccinated.
Example Conversations about stopping smoking to help build trust before discussing the vaccine in Cambridge; conversations with parents at the school gates in Oxford.	**Lessons learnt** Integrating vaccine uptake in conversations about broader health topics was effective. Approaching topics sensitively, without judgement and focusing on factual information about the vaccines were also crucial to effective engagement.

Measures of awareness of local COVID-19 vaccine information

Survey data indicated that around one-fifth (22%) of CVC aware residents were aware of local meetings or events about COVID-19 vaccines specifically, that took place since January 2022. Of these individuals, just over half (52%) attended a meeting / event (equating to 11% of all CVC aware residents).

Half (50%) of these meetings were said to cover other topics / information alongside COVID-19; a similar proportion (47%) were described as 'mostly about COVID-19 / the COVID-19 vaccine'. The chart below (Figure 5.3) shows what, specifically, was covered in these meetings regarding COVID-19 / vaccines. Most common was information about where to receive a COVID-19 vaccination (82%), followed by common COVID-19 vaccine myths (70%).

Figure 5.3 Topic covered in meetings / events about COVID-19



Survey question F9. Did these local meetings or events that you went to, tell you about ...? Base: CVC aware residents that attended a meeting / event about COVID-19 (53). Caution should be taken with these results due to low base size.

From the survey, just over half (52%) of CVC aware residents recalled seeing or hearing anything else about COVID-19 vaccination from other sources. Approaching half (44%) could not recall any other information sources and the remaining 3% didn't know or preferred not to say.

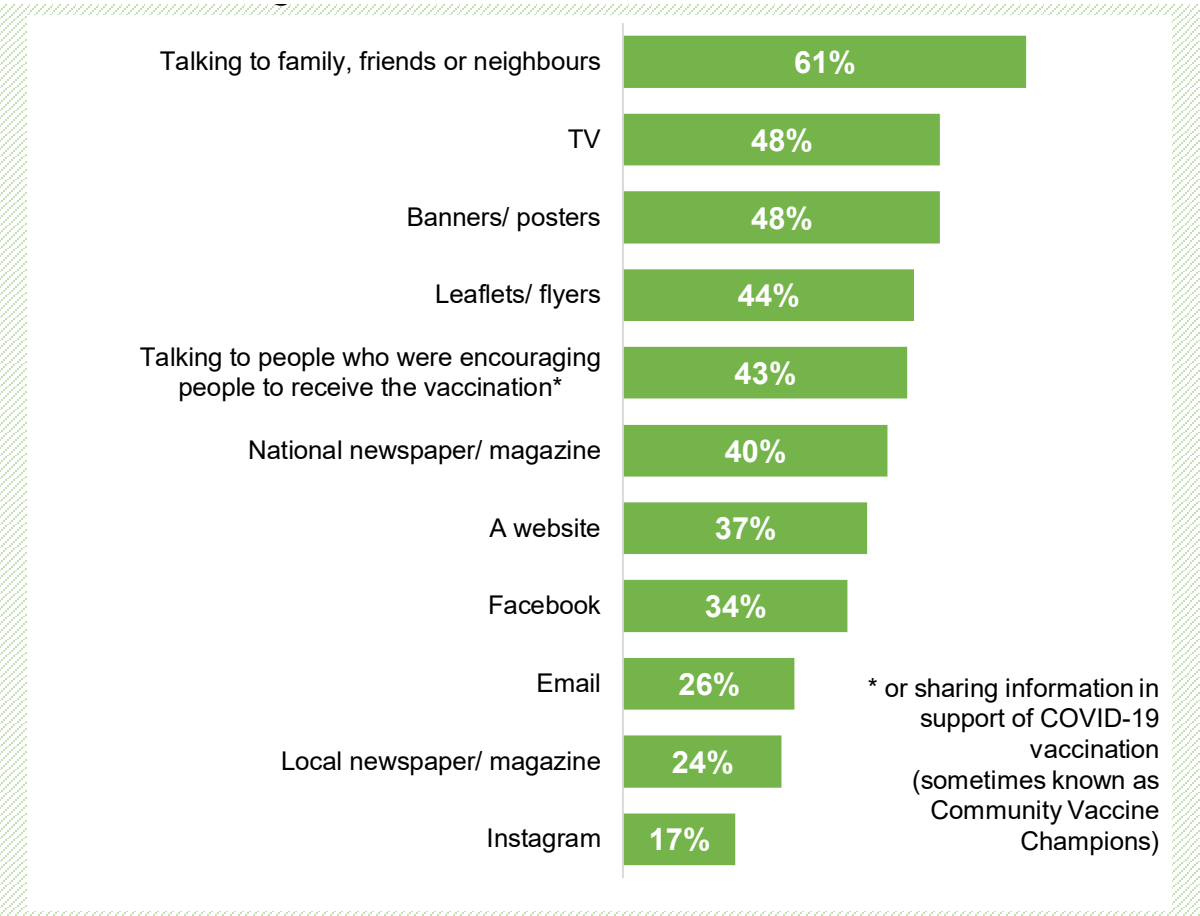
The CVC aware who *did* recall other sources were shown a prompted list of potential other sources and asked which they had heard or seen; Figure 5.4 below shows those used by at least one in ten people.

Over two in five (43%) mentioned talking to people in their community who were directly encouraging others to get vaccinated i.e., Community Vaccine Champions.

However, the most common source was talking to family, friends or neighbours (61%), which highlights the importance of 'word-of-mouth'. The tactic of Champions approaching people who are embedded in community, and who might spread the message to their network, may have indirectly contributed to this.

Offline marketing was more often mentioned than online sources as shown in Figure 5.4 below; with television, posters/banners, leaflets/flyers and national press each being mentioned by more than four in ten. The most common online sources were websites and Facebook, each cited by over a third.

Figure 5.4 Sources of hearing about COVID-19 vaccines

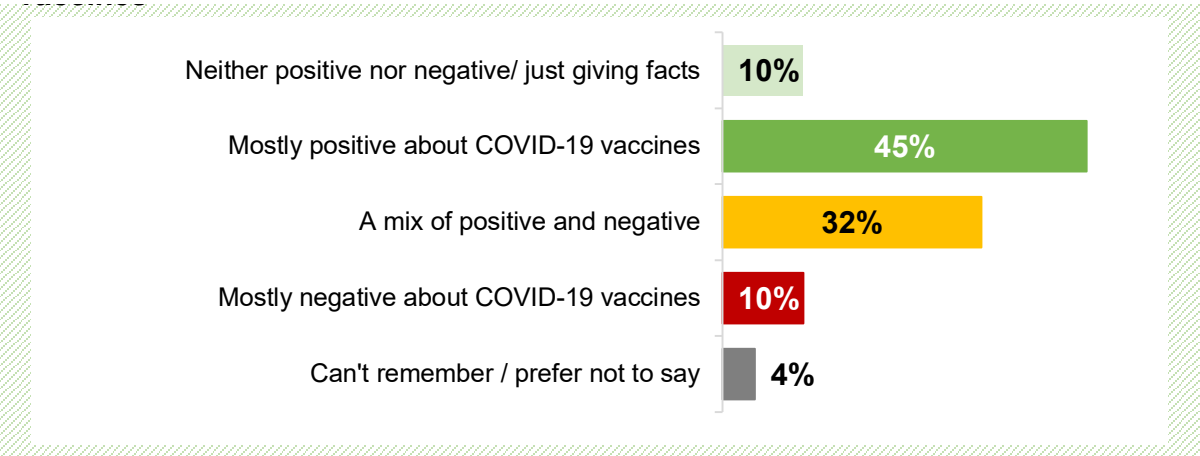


Survey question H2. You say you remember seeing or hearing something else about COVID-19 vaccines, since January 2022. Was this from…? Base: CVC aware residents who recall seeing/hearing about other information about COVID-19 vaccine (229). Showing responses with >10%.

CVC aware residents who said they remembered seeing or hearing something else about COVID-19 vaccines were also asked whether those information sources were positive or negative in their coverage. Reassuringly, residents were more likely to have been exposed to mostly positive messaging (45%), than mostly negative (10%), as Figure 5.5 shows. However, a third (32%) said they had been exposed to a mixture of positive and negative information; which may dilute the power of the

positive messages. One in ten (10%) said their exposure had been to neutral fact-based sources. Combining the mostly positive and neutral sources of information, more than half (55%) had been exposed to one or the other of these.

Figure 5.5 Where CVC aware residents recall seeing or hearing something else about COVID-19 vaccines



Survey question H3. You say you remember seeing or hearing something else about COVID-19 vaccines, since January 2022. Was this…? Base: CVC aware residents who recall seeing/hearing about other information about COVID-19 vaccine (229).

Practical and attitudinal vaccine barriers

Through the activities described above, local authority leads and Champions reported being able to gather a lot of meaningful insight into the various target populations' barriers to vaccination.

Unsurprisingly, these barriers varied a lot between the different target populations depending on particular groups' experiences, beliefs and environments. In each local authority, both attitudinal and practical barriers were reported.

Attitudinal barriers included misconceptions about the vaccine and a lack of trust in official guidance. These were best addressed through the dissemination of tailored (e.g., translated) information from trusted sources (e.g., Champions with relevant lived experience) who focused on listening to individuals and taking seriously their concerns.

Some specific examples of attitudinal barriers include:

- Chinese communities had misconceptions about needing certain brands of the vaccine to be able to travel to China;
- History of institutional racism and 'guinea pig trials' contributed to some individuals' decisions not to get vaccinated in black African and Caribbean communities;

- Scepticism among some Eastern European communities relating to the vaccine being free;
- Misinformation about certain brands of the vaccine, came from individuals' home countries and/ or social media;
- Lack of trust in official guidance, stemming from the frequency of developing advice around the pandemic from the UK government.

Practical barriers faced by target populations across the participating authorities included issues relating to access to vaccination centres (particularly among older and disabled people), and a lack of access to translated information about the vaccine and vaccination sites among groups for whom English is not a first language. These barriers were most effectively addressed by the provision of practical support (e.g., transport and translated materials) to increase vaccine access.

Some local authority leads reported that they felt they had a better understanding of the practical barriers their target groups face than the behavioural/ attitudinal barriers. Attitudinal barriers can be more difficult to gather insight on because they can be difficult for individuals to articulate (especially when English is not a first language), and given their personal nature, individuals can be hesitant to share their reasons for being vaccine hesitant with Champions.

In addition, previous vaccine uptake projects carried out by some local authorities, and the language used within these projects, had focused on vaccine *access* as opposed to vaccine hesitancy. This to some extent influenced the focus on understanding and addressing *practical* vaccine barriers within the CVC-funded work.

"[The group has] always been [called] a vaccine access partnership… not a vaccine hesitancy partnership."

Local authority lead

Local authority leads and Champions suggested that addressing both attitudinal and practical vaccine barriers among target populations primarily requires the dissemination of tailored and accessible information delivered by trusted sources (e.g., Champions or medical professionals with whom relationships have been built).

Two local authority leads suggested that better understanding how health messaging is delivered in some of their target communities' countries of origin, would ensure Champions are better placed to address concerns target populations may have and to explain how the UK health system works in comparison to individuals' country of origin.

Mechanisms for sharing insights into vaccine barriers between delivery partners, LAs and wider stakeholders

Some LAs shared the insights about vaccine barriers and misinformation gathered through the CVC-funded activities at joint partnership meetings, which brought together stakeholders including public health colleagues. These meetings were felt to be really effective ways to co-produce materials for CVC-funded activities, but also for sharing learnings that could be applied to other initiatives. Some LAs consciously built these mechanisms into their CVC delivery plans.

Some LA leads, delivery partners and Champions felt that there were not always sufficient mechanisms in place for feedback to be shared between them. In these cases, it was suggested that some of the insight gathered through the CVC funded activities was being lost and not acted on. Ensuring these systems are in place, beyond informal catch ups, would enable on the ground insight from Champions to be fed back to policy makers to inform the continual development of the CVC programme but also enable learnings to be applied in other settings/ initiatives.

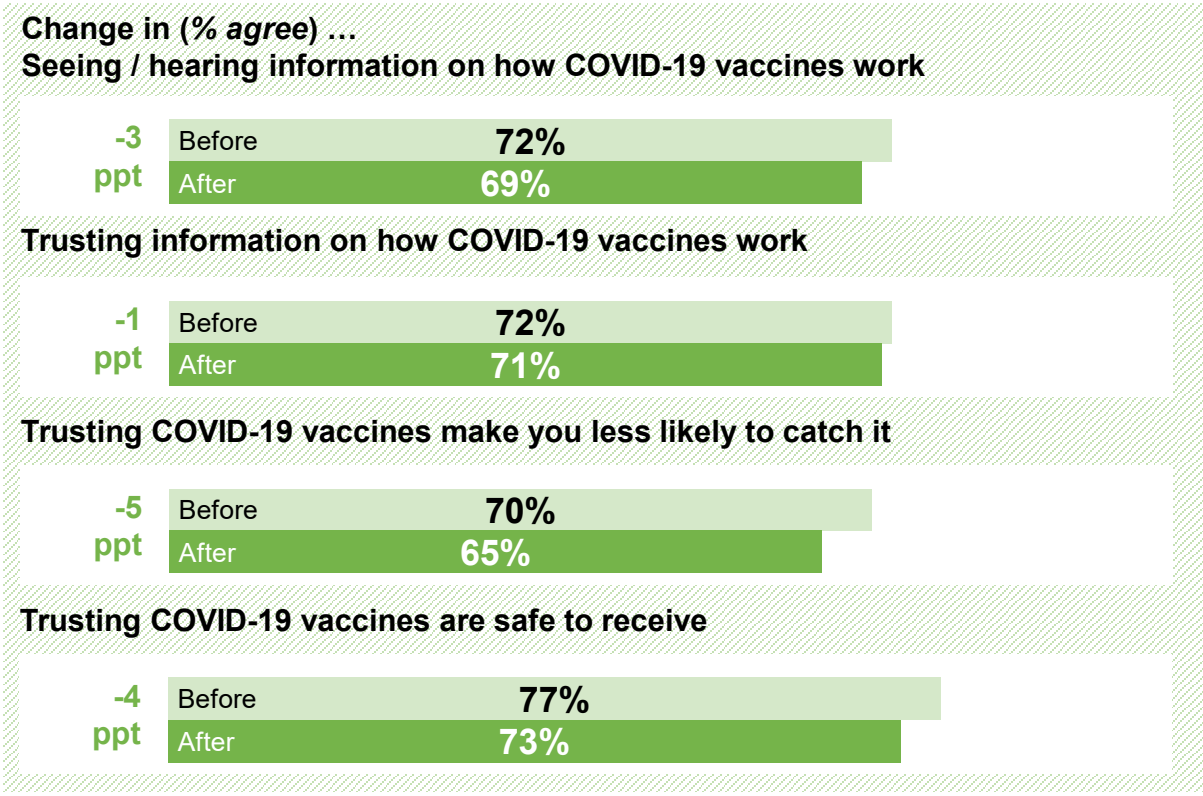
"I think we as a project have probably learned a lot about what the barriers to getting a vaccine are. However, there doesn't seem to be a straightforward way to feed that back to government. There's no way you feel like you can log it. It just seems like the same issue is going to happen [again]; they'll target the majority and everyone else will get left behind and there will be a series of these sort of individual little projects again."

Local authority lead

Measures of impact of work tackling vaccine misinformation and distrust

Figure 5.6 below shows that between January and Autumn 2022, there was a slight general decline in exposure to and trust in information on COVID-19 vaccines among the CVC aware group. This decline could reflect the decline in national media coverage of COVID-19 and a reduction in messaging encouraging vaccination during this period. The same slight decline is found amongst residents of non-funded comparison areas, across the same period.

Figure 5.6 CVC aware residents' exposure to and trust in COVID-19 vaccines (before/after CVC-funded activities)



Survey question E1/D1. How much do you agree or disagree that the following describe how you felt at the start of this year / how you feel now. Base: All residents in CVC-funded areas aware of CVC activity (428).

The impact analysis of this survey data (comparing CVC aware residents with a matched comparison group of similar residents in non-funded areas) showed that there was no statistically significant impact (i.e., close to reaching the p=0.05 level) on religious minority groups' trust that COVID-19 vaccines make you less likely to catch COVID-19. As Table 5.1 shows, the impact on levels of agreement in Autumn 2022 had a p-value of 0.167, meaning an impact failing to approach significance. However, anecdotal qualitative evidence detailed CVC-funded work tackling vaccine misinformation and distrust that may have had isolated positive impact on trust in vaccine efficacy among religious minority groups. For example, community and religious leaders sharing their positive vaccination experiences and Champions attending existing religious events (such as Eid celebrations) to speak informally with communities about health, wellbeing and COVID-19 vaccinations.

Table 5.1 Impact on trusting having a COVID-19 vaccine making you less likely to catch it among religious minority groups

% agreeing they trust having a COVID-19 vaccine making you less likely to catch it in Autumn 2022	ppt diff.	P-value	Impact?
CVC-aware 66% Non-CVC 55%	+11	0.167	☒ No significant impact

Survey question D1. How much do you agree or disagree that the following describe how you feel now: I trust COVID-19 vaccines will make me less likely to catch COVID-19? Base: Religious minority groups – CVC aware group (92); comparison group (99). Note: percentage point differences may not appear aligned with percentages shown in the charts due to rounding.

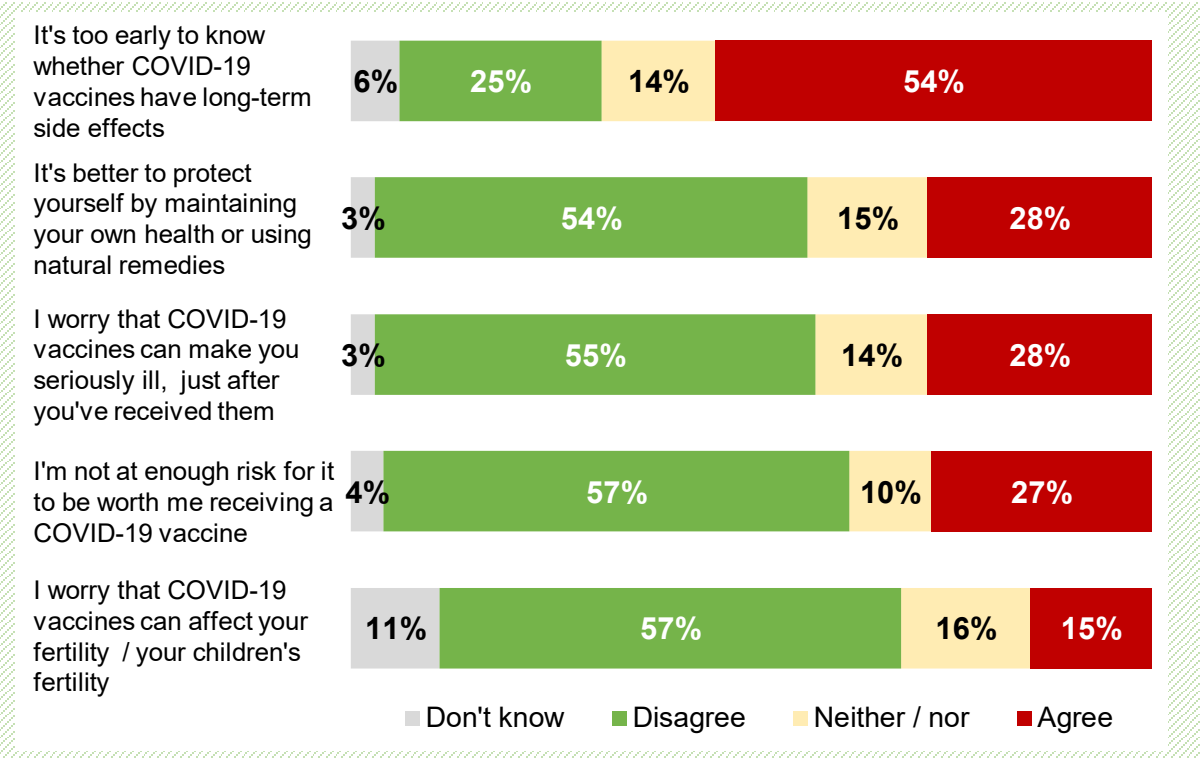
There were no differences approaching or reaching significance across the remaining three statements (seeing / hearing information on how COVID-19 vaccines work; trusting information on how COVID-19 vaccines work; trusting COVID-19 vaccines are safe to receive), either for CVC aware religious minority groups or CVC aware residents in general.

Residual attitudinal and practical barriers among CVC aware residents, following the CVC-funded work

Attitudes towards vaccination at Autumn 2022, amongst the CVC aware residents surveyed, show the extent to which negative vaccine beliefs persist (see Figure 5.7 below). Note that the 'agree' bars are coloured red as, in this context, agreement with each statement is a negative finding. The main area of residual vaccine scepticism was a perceived lack of evidence on whether there are any long-term side effects of vaccination: 54% agreed with this, whilst only 25% disagreed. This would be a key area to focus upon in future messaging.

Just over a quarter felt that other approaches to protecting themselves were better than vaccination, were worried that the vaccine could make them ill, or thought that risk to them from COVID-19 was not high enough to warrant vaccination. However more disagreed with these sentiments than agreed. Only one in seven worried about fertility issues from the COVID-19 vaccine.

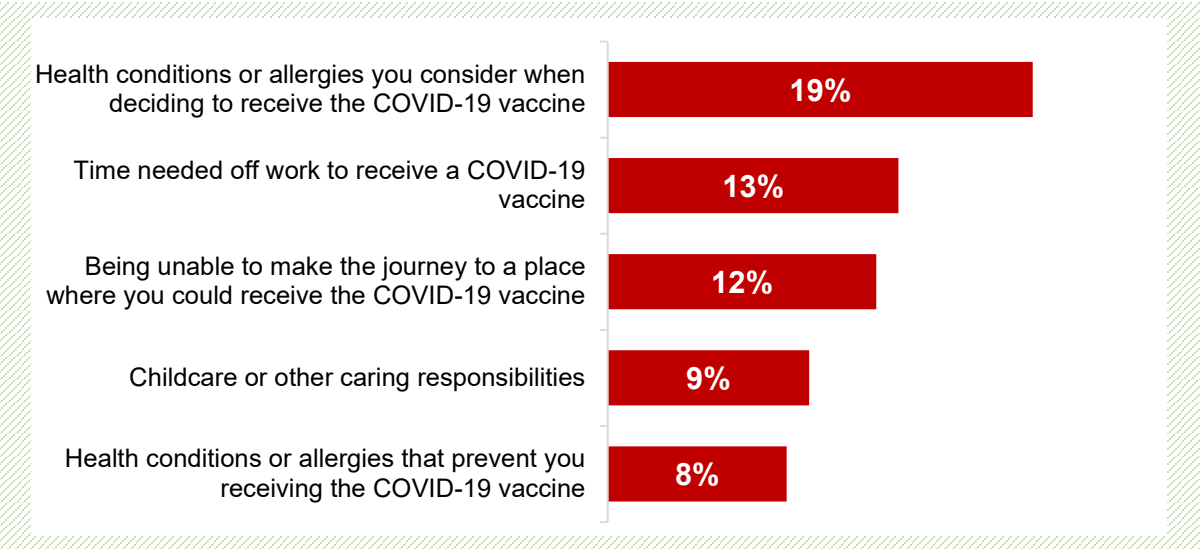
Figure 5.7 CVC aware residents' agreement with common vaccine hesitancy views (Autumn 2022)



Survey question J1. To what extent do you agree or disagree that… Base: All residents in CVC-funded areas aware of CVC activity (428).

The remaining practical barriers among the CVC aware group as at Autumn 2022, were each cited by a minority, as shown in Figure 5.8. Just under one in five (19%) said they *considered* health conditions or allergies when deciding whether to receive a COVID-19 vaccine; whilst 8% said these *prevented* them from taking the vaccines. Around one in eight felt that needing time off work was a barrier to being vaccinated; and a similar proportion cited travel difficulties. One in eleven were hindered by childcare or caring responsibilities.

Figure 5.8 CVC aware residents' residual barriers to vaccination after CVC-funded activities (Autumn 2022)



Survey question J2. Are any of the following things that make it harder for you to go to receive your COVID-19 vaccination? Base: All residents in CVC-funded areas aware of CVC activity (428).

Lessons learnt – what works

Participants highlighted the following lessons learnt about what works:

- **Approaching individuals sensitively**, avoiding judgement, not being too pushy, and **exploring general health and wellbeing topics first**, were all felt to be crucial to effectively engaging individuals in conversations about the vaccine. For many, the **training** provided (particularly the MEC training) enabled Champions to feel confident doing this.

- Champions **giving time to be present and visible** within the target communities, created opportunities for dialogue with community members. Using **Champions with lived experience** (e.g., shared socio-economic, ethnic or religious backgrounds) meant they were better equipped to explore barriers amongst their own community, as this helped the Champions relate to community members and build trust.

- **Adding vaccine-related conversations to existing community events** was both efficient (since the events had already been organised) and encouraged target communities to engage, where the existing community event was on a subject that appealed to the community.

- **Attitudinal barriers** (such as misconceptions about COVID-19 vaccines and lack of trust in official guidance) were best addressed through **dissemination of tailored information** (e.g., translated information) **via trusted sources** (e.g., Champions with lived experience)**. Community and**

religious leaders sharing their positive vaccination experiences could be highly influential within their communities.

Practical barriers could be effectively addressed by the provision of appropriate practical support; for example, providing transport to address older and disabled people's difficulty accessing vaccination centres; and providing translated information to groups for whom English is not a first language.

Hosting vaccine promotion or myth-busting sessions alongside vaccine uptake opportunities was effective, as it meant that individuals who decided to get vaccinated could do so straight away, if they wished.

Mechanisms to share insights into vaccine barriers between Champions, local authorities and other health sector partners are necessary to ensure insights can be acted on and materials can be effectively co-produced.

Materials and activities need to be **tailored to the specific contexts and needs of target populations** in order to achieve genuine engagement. Co-producing materials and events between Champions and public health colleagues helped to ensure vaccine information was both factually correct and accessible.

Lessons learnt – challenges

A perceived lack of evidence on long-term vaccine side-effects was the main residual area of vaccine scepticism, meaning this would be a key area to focus on in future messaging.

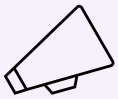
6. Local networks and infrastructure

Chapter summary

Within grant-giving, the CVC programme's grassroots-up approach manifested itself in identifying target audiences first and using this to guide the choice of potential partners.

The LA giving local communities ownership and equal input into the CVC-funded work, built trust between the LA and community-based partners (e.g., via co-design, collaboration, shared training, and recruiting community members to roles). It also allowed the CVC-funded activity to leverage expertise and relationships (particularly with local people) that the LA and public health partners didn't possess, in turn enabling a swifter response to communities' needs.

The funding (and its flexible nature) encouraged community organisations to implement more creative vaccine-promotion activities and/ or on a bigger scale compared to what they had done previously.



Communities trusted public health and vaccine related messaging when it was delivered by a trusted source. Delivering messages via community-based organisations and individuals who already had relationships with the community (e.g., religious leaders or people with relevant lived experience), enhanced the credibility of health messaging.

Being non-hierarchical also empowered these community-based partners to tailor messaging approaches to communities (and individuals within them), which was felt to have further enhanced the messaging effectiveness within target populations.

However, a challenge of adopting a 'light touch' approach to empower community-based partners and build trust, was that LAs lacked monitoring data from community-based partners, to assess impact.

A comparison of survey findings for residents aware of CVC-funded activities against a matched comparison group of residents of non-funded areas, shows a positive impact approaching significance for religious minority groups: in the CVC-funded areas, religious minority groups seeing / hearing information

about local health services had declined more gently over time than in comparison areas.

How did collaboration, co-production and funding work between the LA, VCSOs, local delivery partners, and public health partners?

Administering the funding

As discussed in Chapter 4, there was **flexibility** in how the CVC funding was administered – for example, in the amount to apply for, in funding agreements reached with different organisations, and the incentive-based approach in Wolverhampton. Crucially, for the effective delivery of tailored responses, the **flexibility of CVC funding enabled LAs to empower community partners to work creatively and independently** in terms of recruiting Champions with lived experience, in designing tailored approaches to specific local communities, and in delivering engagement activities.

There were several localities where the CVC funding added value. Examples were cited of enabling a greater scale, broader scope, greater diversity, or pace of response. A couple of LA leads also said that the small grants approach allowed greater appetite for risk in those whom they funded.

Collaboration

Utilising an **existing network** of community organisations was felt to be a key ingredient of success, enabling the CVC-funded work to utilise the organisations' existing relationships, and experience of working with, other organisations and local communities. Sometimes this involved a Council for Voluntary Services and Volunteer Centres (CVS) umbrella body as the conduit administering the grants on the LA's behalf.

"It's a much better system. They [local CVS organisations] are trusted, they've been delivering for years, and you can almost say 'here's the money, you manage this, we trust you, just let us know how you're going to do it', rather than if Public Health, it's no disrespect to Public Health, but there's no way they would have been able to achieve so much if they tried to do it. So, trusting the CVS and the infrastructure organisations to do the work with their organisations is a really good model I think."

Champion

In terms of models for disseminating the funding to delivery partners, allowing anchor organisations to recruit Champions helped to rebalance the power relations to build more genuine partnerships – the CVC funding enabled this different way of working, meaning that Champions were not volunteering directly for the local authority but instead for organisations in their local communities.

The approach of funding grassroots organisations led some LAs to adopt the strategy of first identifying target audiences and then looking to identify suitable VCS or business partners who were already engaging with those specific target groups. For awarding the funding, if the decision-making panel involved various parties e.g., from the LA, NHS/Public Health, voluntary and community organisations, the collaboration to decide which organisations to fund was thought to be effective.

Other key ingredients for effective collaboration were regular meetings between stakeholders (especially including Public Health), and information sharing between parties.

Some reported that trust between the local authority and voluntary organisations improved as a result of collaborating on the delivery of CVC-funded activities. This is discussed further in the next section.

A legacy of collaborating on the CVC-funded work was establishing or cementing longer-term relationships between stakeholders (the LA, Public Health and community organisations), which stakeholders hoped could be used in future initiatives.

Co-production

Co-production was used in a variety of ways, namely: deciding upon areas of need for the CVC-funded work to focus on; developing a Memorandum of Understanding (MoU) for specific activities and outcomes; agreeing a communications strategy; designing innovative messaging approaches; production of materials (including translations into other languages); hosting events (vaccine clinics, weekly drop-in sessions, health festivals); and agreeing evidence to gather for monitoring purposes.

LAs supported community partners but didn't dictate to them, which allowed more genuine partnerships to develop (instead of more transactional relationships). Partners were able to use their expertise to creatively design and deliver tailored activities to communities.

"The impact of co-production was: community groups would do leaflets, we'd take a look and just tweak the wording – they really liked that. The impact was definitely strengthened more. It gave organisations skill to go off and pass the messages over. We give them the resources, they run with it. It was honestly really, really good."

Local authority lead

To what extent did the CVC programme build trust and develop relationships and networks?

Building trust between the LA and community partners/stakeholders

To build relationships and trust among partners, some local authorities utilised and built on relationships with partners established during CC1 funding. In the local authorities that did not receive the CC1 funding, whilst some reported having strong relationships already in place, others described almost needing to build these relationships from scratch as previous engagement had been ad hoc or facilitated by individuals no longer employed by the LAs.

Overall, many localities reported an increase in trust and improved partnership working during the implementation of CVC-funded activities, not least because of the collaboration and co-production described above. This in turn helped to foster non-hierarchical relationships between the LAs and delivery partners.

Some described this as a positive feeling and understanding between different agencies, cultivated by a shared project and ambition. Others mentioned this in relation to having established new ways of working together (e.g., putting in place robust contractual arrangements), or having co-produced elements of the programme together (e.g., the delivery plan).

Shared training opportunities and regular contact were also enablers of improved relations between parties. For example, myth-busting training supported local organisations to co-produce accessible information, about the science behind the COVID-19 vaccines, with experts. Various localities reported that regular communication improved relationships between stakeholders; whilst in Bristol specifically the Inclusion Health Group facilitated cross-sector communication.

"We've been on quite a journey with [the] voluntary sector over past years. Perception of us as a council has been quite negative. [Within the CVC-funded work] it was moving away from that very transactional relationship to being very collaborative, and I think that has helped."

Local authority lead

Working together on shared goals, and regular communication, also helped develop greater familiarity with and appreciation of different parties' roles.

Figures 6.1 and 6.2 present case studies for two areas – Sandwell and Wolverhampton – and how they built trust between their LA, other stakeholders and the community.

Figure 6.1 Case study: Building trust between the local authority, other stakeholders and the community, in Sandwell

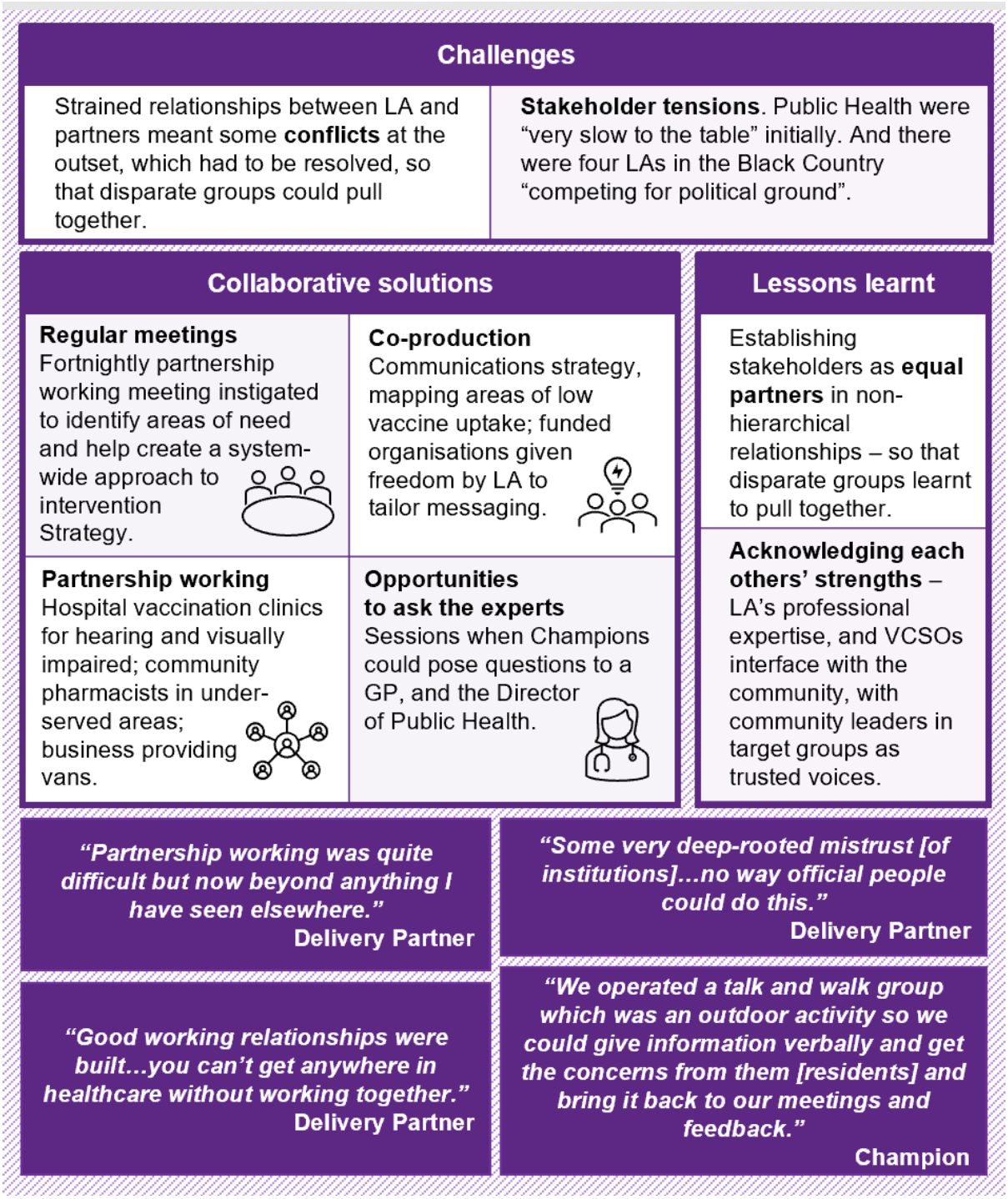
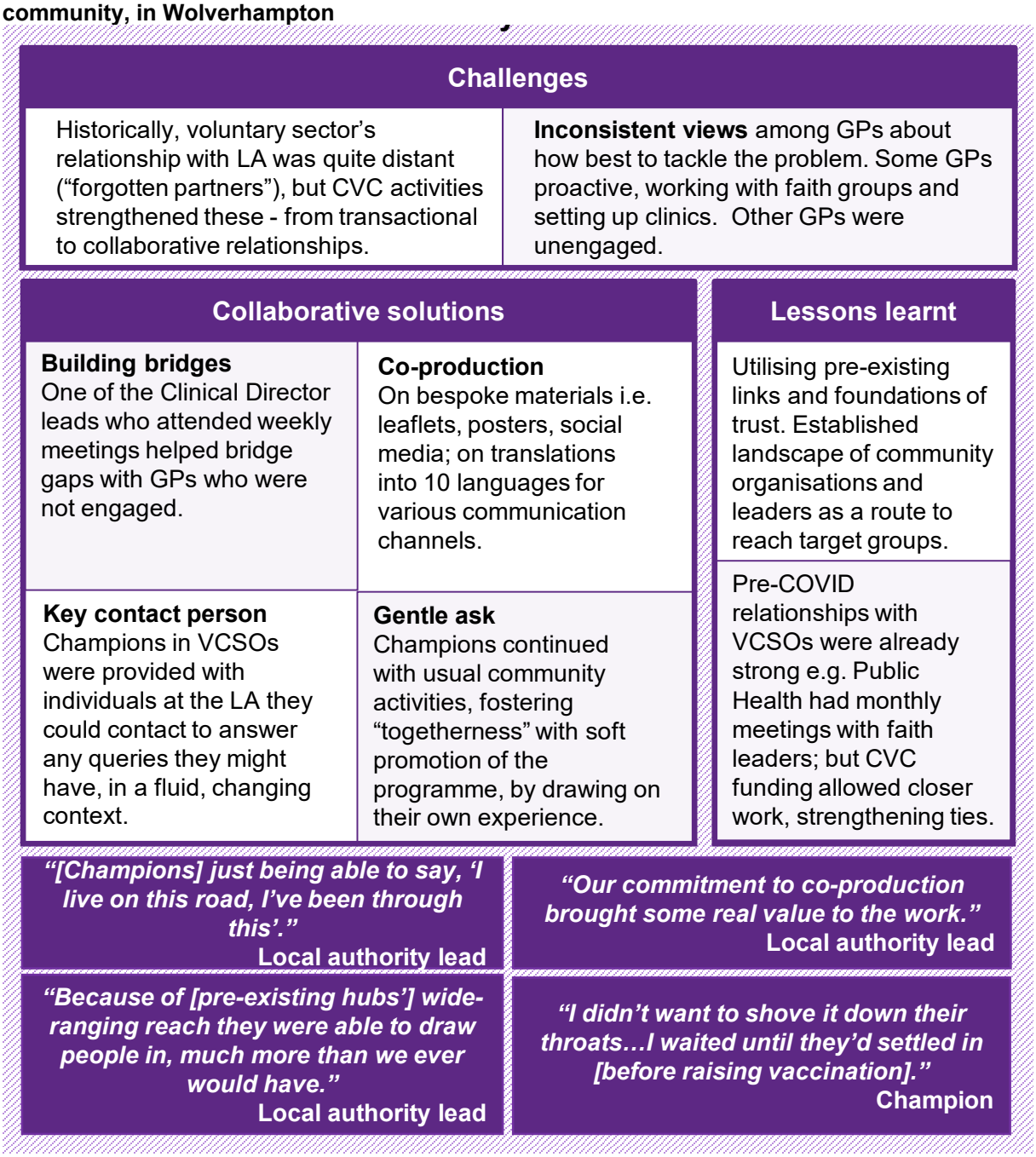


Figure 6.2 Case study: Building trust between the local authority, other stakeholders and the community, in Wolverhampton



Some LAs mentioned going to **regional meetings** to share what they were doing but there was some scepticism about how useful this had been when each community needed unique solutions. A national conference involving 16 areas had been useful however, in sharing approaches to monitoring and evaluation.

Building trust with local communities

Building trust with **local communities** was a crucial intended outcome of the CVC-funded activities, as this underpinned the success of various other outcomes. Local authorities described the various approaches they felt helped achieve this. Key mechanisms that helped build trust with the local community generally were:

- Working with local individuals, businesses, or community hubs, who were already known to, integrated within, and trusted by the community.
- LAs learning more about community preferences and expectations of their LA and having accessible contact points to whom community members could reach out for advice; as well as LA experts being visible by going out into community settings to meet people and deliver messages.

Key mechanisms that helped build trust with **specific target groups** were:

- **Trusted voices** - Working with community leaders, or other key influencers in specific target populations, to gain their buy-in, tap into their greater knowledge of the target group, or act as role models. LA staff could fulfil this role as a 'trusted voice', only if they were already well known and respected. Champions being drawn from within the target populations was ideal.

> *"Champions are from groups that we want to target and are in one way or another related to them – this is an advantage; they are on the same level and can overcome some of those barriers."*
>
> **Delivery partner**

- **Trusted organisations** – As well as trying to connect with key individuals most LAs chose to work with local community organisations that were known to already be trusted by the community.
- **Safe spaces** – Using safe, familiar environments in which to raise and explore concerns about vaccination. This worked well with religious minority groups, young men, and asylum seekers, as well as with target audiences displaying a high degree of resistance to formal NHS messaging. Informal approaches here could relax people enough to overcome fatigue with formal messages about COVID-19 and vaccination. Sometimes starting with another unrelated health topic and then gradually introducing the topic of vaccination, proved effective. Hosting activities based in familiar, local settings e.g., community centres, was successful.
- **Snowballing effect** – If you build trust and convey arguments successfully with one individual they will often share what they've learned with their friends. This

'snowballing effect' was deliberately encouraged by providing ways for people to hear from others within their community about their vaccine experiences, within group sessions.

- **Communication skills** - Champions needed to have good listening skills and cultural awareness; and sometimes training was used to develop or enhance these skills. If engaging with ethnic minorities, having translated materials and/or interpreters "absolutely improved trust". It was felt to be important to show sensitivity in one-to-one conversations, gauging carefully how receptive each individual was to the message, and not being 'pushy'.

"Volunteers need to be open-minded, impartial and a good listener – these are qualities that build trust."

Champion

Various **barriers** to increasing trust with target audiences were mentioned. Firstly, target populations' experiences of **racism and cultural tension**. In one locality, Boston, votes to leave the EU were among some of the highest in the country resulting in apparent community cultural tensions. This had created distrust among local Eastern European groups towards the wider community, including local government, who they did not feel supported or welcomed by during these times of tension. A history of institutional racism and 'guinea pig trials' negatively impacted trust of COVID-19 messaging and CVC activity among some black African and Caribbean communities: communications were adapted with this in mind, and space was given to listen to these communities' concerns.

The **developing national COVID-19 guidance** and **fatigue with official information about COVID-19** were also identified as barriers. When the national COVID-19 guidance was perceived to have been regularly evolving it reduced people's confidence in official messaging on vaccination. In some areas there was a need to overcome resistance to vaccine information where people expressed fatigue and mistrust of official information sources. There was also a perception that, as official vaccine messaging became less prominent over time, it made it harder to raise the topic.

"Everybody is backing off from official information. We've seen too much of it."

Champion

To what extent did the CVC programme increase awareness of and trust in LA services and public health messaging generally?

When asked whether the CVC programme had increased trust in LA and public health messaging more generally (i.e. beyond the issue of COVID-19 vaccination), the most common stakeholder view was that it had done so, at least to some extent.

One felt it had done so “significantly” due to messaging via community members and co-production. Only one LA lead felt it had not done so at all, because people were “put off by NHS messaging”.

Those who felt the CVC funding had increased receptiveness to health messaging more broadly, cited ingredients that were similar to those used to build trust with local communities around COVID-19 vaccination specifically:

- **Working through trusted community organisations** – that have established connections with the target populations, building on existing networks and previous activities; and fostering greater collaboration between organisations.

- **Empowering community organisations to be the experts** – delivery organisations flexing how they engaged with different groups, and enabling them to make decisions about the best approach to use, tailoring information and support to their needs.

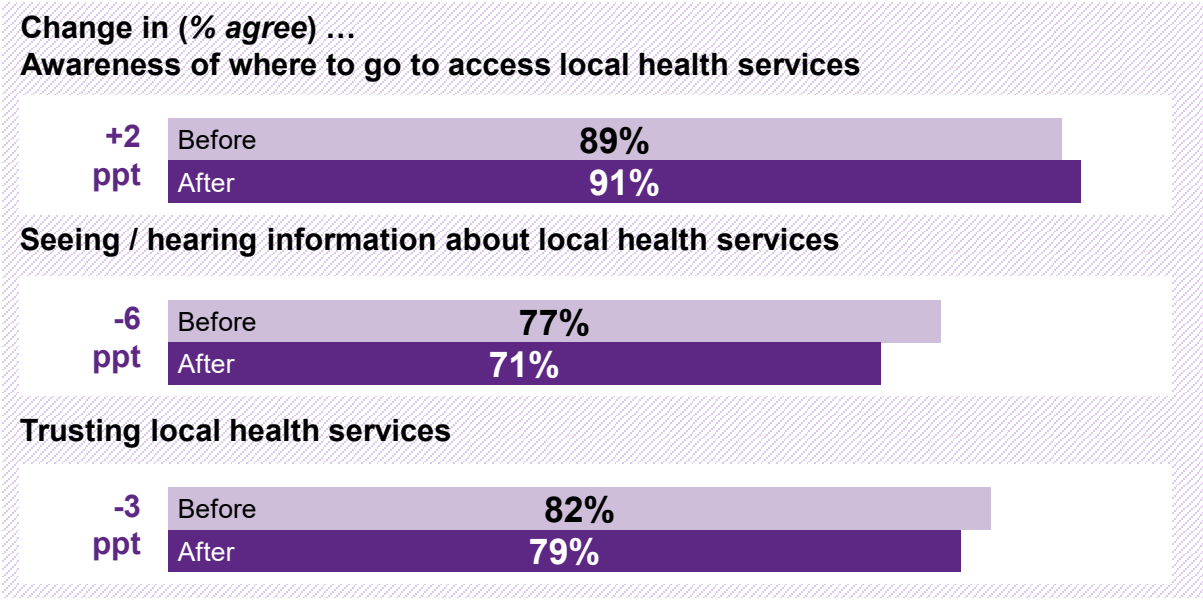
“It gave groups some time and space to really think about what is best for their communities, and how can they deliver that in effective ways for the people that they’re working with; without us saying, ‘this is how you’ve got to do it’.”

Local authority lead

Measures of increased awareness and trust in local health services

Survey data showed that, between January and Autumn 2022, CVC aware residents showed a slight increase in their (already fairly high) awareness of where to go to access local health services. As shown in Figure 6.3, awareness rose two percentage points, from 89% to 91%. There was a decrease in exposure to seeing / hearing information about these local services (from 77% to 71%) and, to a lesser extent, trust in local health services (from 82% to 79%). The same pattern over time was found amongst residents of non-funded comparison areas, across the same period.

Figure 6.3 CVC aware residents' awareness of and exposure to local health services (before/after CVC-funded activities)



Survey questions E1/D1. How much do you agree or disagree that the following describe how you felt at the start of this year / how you feel now. Base: All residents in CVC-funded areas aware of CVC activity (428).

There were some differences in Autumn 2022 ('after' the CVC-funded activities) by socio-economic group. Those from the lowest socio-economic group (E) were more likely to be hearing / seeing information about local health services (83% compared to 71% average), and those in higher socio-economic groups (AB) were more likely to have trust in these services (85% compared to 79% average).

The impact analysis of this survey data (comparing CVC aware residents with a matched comparison group of similar residents in non-funded areas) showed that there was an impact *approaching* significance (i.e., close to reaching the p=0.05 level) on religious minority groups' exposure to information on local health services; those in the CVC aware group demonstrated a gentler decline from January 2022 levels than the comparison group. As Table 6.1 shows, the impact on levels of agreement in Autumn 2022 had a p-value of 0.057, meaning an impact approaching significance for this gentler decline. This suggests that CVC-funded work seeking to increase awareness of and trust in local health services, may have had a positive impact on seeing or hearing information about local health services, among religious minority groups.

Table 6.1 Impact on seeing / hearing about local health services among religious minority groups

% agreeing they see or hear information about what health services are available in their local area, in Autumn 2022	ppt diff.	P-value	Impact?
CVC-aware 73% Non-CVC 61%	+12	0.057	Approaching significance

Survey question E1. How much do you agree or disagree that the following describe how you feel now: I see or hear information about what health services are available in my local area? Base: Religious minority groups – CVC aware group (92); comparison group (99). Note: percentage point differences may not appear aligned with percentages shown in the charts due to rounding.

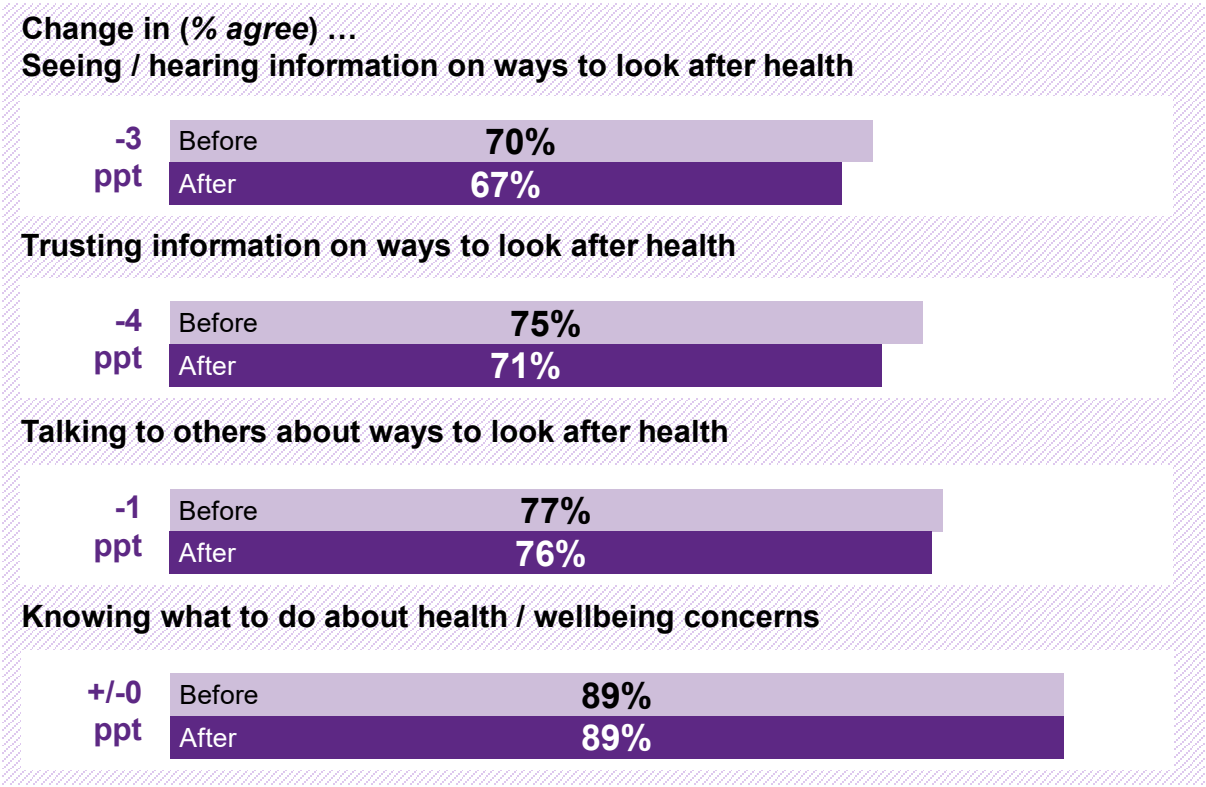
There were no differences approaching or reaching significance across the other two statements (awareness of where to go to access local health services; trusting local health services), for either the CVC aware religious minority groups or CVC aware residents in general.

Measures of increased health information engagement

Many local authorities sought to improve residents' awareness, trust and behaviour with regards to their general health. Intended outcomes included getting residents to talk about their health more and increasing exposure to and trust in information on looking after their health.

As shown in Figure 6.4, survey data showed that CVC aware residents tended to show a very slight decline in measures relating to looking after their health between January and Autumn 2022. The exception to this was knowing what to do about health and wellbeing concerns; levels of agreement for this statement remained unchanged. The same pattern over time was found amongst residents of non-funded comparison areas, across the same period.

Figure 6.4 CVC aware residents' exposure to and trust in health / wellbeing messaging



Survey questions E1/D1. How much do you agree or disagree that the following describe how you felt at the start of this year / how you feel now. Base: All residents in CVC-funded areas aware of CVC activity (428).

The impact analysis of this survey data (comparing CVC aware residents with a matched comparison group of similar residents in non-funded areas) showed the declines were gentler among CVC aware religious minority groups for two of these measures: seeing / hearing information on ways to look after health and trusting this information. However, this impact **was not** statistically significant (i.e., close to reaching the p=0.05 level) for both measures, as shown in Table 6.2 below.

Table 6.2 Impact on exposure and trust in information on how to look after health: religious minority groups

% agreeing they see or hear information about ways to look after their health, in Autumn 2022	ppt diff.	P-value	Impact?
CVC-aware 68% Non-CVC 62%	+6	0.297	☒ No significant impact
% agreeing they trust information on ways to look after their health, in Autumn 2022	**ppt diff.**	**P-value**	**Impact?**
CVC-aware 75% Non-CVC 69%	+6	0.201	☒ No significant impact

Survey question E1. How much do you agree or disagree that the following describe how you feel now: I see or hear information in my local area, about other ways I can look after my health; I trust the information I see or hear, about other ways I can look after my health? Base: Religious minority groups – CVC aware group (92); comparison group (99). Note: percentage point differences may not appear aligned with percentages shown in the charts due to rounding.

There were no differences approaching or reaching significance across the other two statements (talking to others about ways to look after their health; knowing what to do about health / wellbeing concerns), for either the CVC aware religious minority groups or CVC aware residents in general.

Measures of community resilience

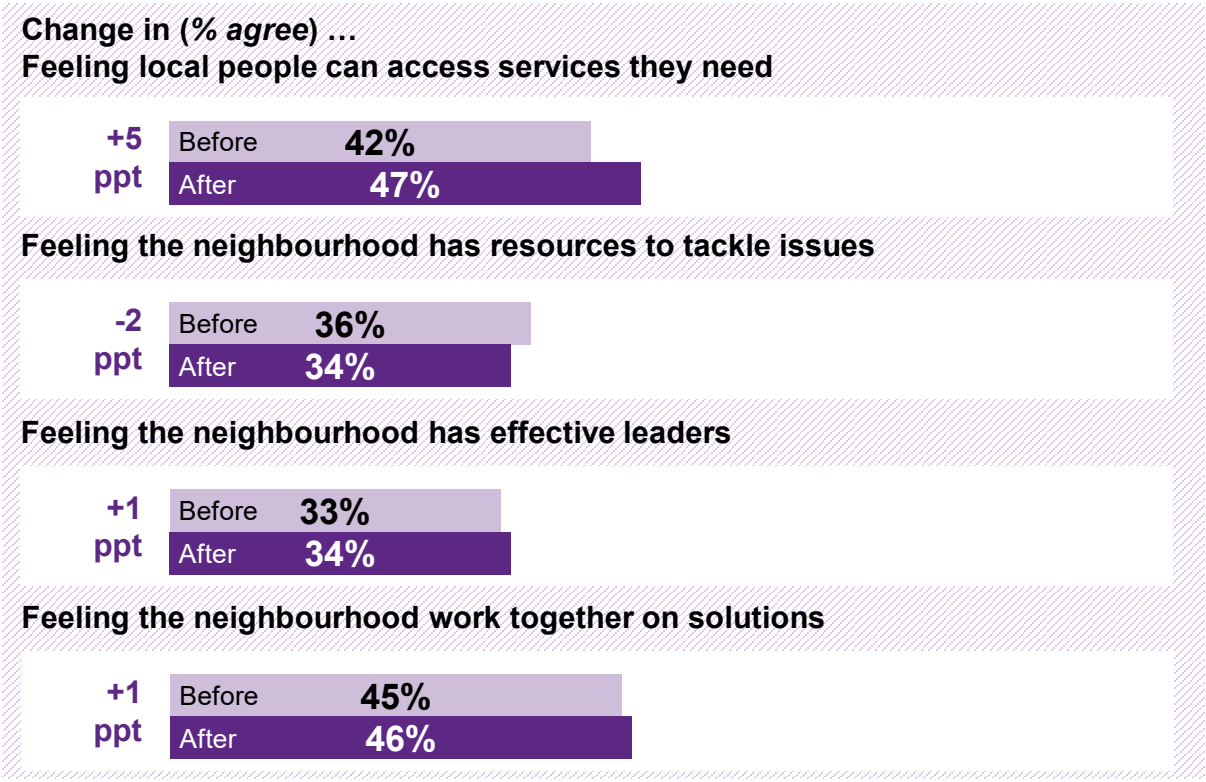
Community resilience is the ability of a community to use available resources to respond to adverse conditions. This resilience requires a community to have the access to services, resources, and leaders needed to support effective response and adaptation following disaster or unprecedented situations[3]. Many of the intended outcomes of CVC funding (strengthening local infrastructure, collaboration, trust in local leaders) align with the qualities of community resilience, with the intention that community resilience would be strengthened for any challenging situations in the future.

The survey explored residents' views on community resilience, using four measures which could potentially be influenced by the CVC programme. Figure 6.5 shows that CVC aware residents had very slightly improved levels in three of the measures, between January and Autumn 2022: feeling that local people can access the

[3] Community Resilience Development Framework, Cabinet Office, 2019: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/828813/20190902-Community_Resilience_Development_Framework_Final.pdf

services they need, that the neighbourhood has effective leaders, and that it works together on solutions. Likelihood of agreeing that the neighbourhood has the resources to tackle issues showed a very slight decline.

Figure 6.5 CVC aware residents' views on factors of community resilience



Survey questions B1/C1. How much do you agree or disagree that the following describe how you felt about your neighbourhood at the start of January 2022 / feel about your neighbourhood now. Base: All residents in CVC-funded areas aware of CVC activity (428).

However, impact analysis of this survey data (comparing CVC aware residents with a matched comparison group of similar residents in non-funded areas) showed no significant impacts on these measures, when comparing the CVC aware group to a matched comparison group. This was true amongst CVC aware residents overall and amongst subgroups including religious minority groups.

Lessons learnt – what works

Participants highlighted the following lessons learnt about what works:

Using an existing network of community organisations, enabled the CVC funded work to leverage the organisations' existing relationships, and expertise in working with, other organisations and local communities. This provided the CVC-funded activities with a pre-existing route to reach target communities. This was applicable both to vaccine-promotion work, and efforts to increase receptiveness to health messaging more broadly.

- **The flexibility of CVC funding enabled LAs to empower community partners to work creatively and independently**, for instance, in recruiting Champions with lived experiences and designing approaches tailored to specific local communities. LAs supported community partners but didn't dictate to them, which allowed more genuine, non-hierarchical partnerships to develop (rather than more transactional relationships). Again, this was applicable both to vaccine-promotion work, and efforts to increase receptiveness to health messaging more broadly.

- **Regular meetings and information-sharing between stakeholders supported effective collaboration.** Collaborating on shared objectives in turn improved trust between LAs and voluntary organisations, building or further strengthening ties.

- **Trust was built with specific target groups by building relationships with existing leaders or trusted voices within communities.** By working with religious or community leaders or other key influencers within target populations, the CVC-funded work was able to draw on these individuals' knowledge of community members and ensure that vaccine-promotion or wider health messages were delivered via a trusted voice.

- **Allowing time for informal conversations gave community members space to become less defensive.** Informal approaches could relax community members enough to overcome fatigue with formal messages about COVID-19 and vaccination.

- The CVC-funded work **created opportunities for people to hear from others within their community, about their positive vaccine experiences.** This deliberately built on an observed snowballing effect whereby, if you build trust and convey arguments successfully with one individual, they will often share what they've learned with friends.

- When engaging with ethnic minority groups, **having translated materials and / or interpreters** was highly important in building trust.

7. Future impacts and transferability

Chapter summary

With more funding to enable the continued delivery of CVC-related activities, LAs, partners and Champions anticipated that a range of further impacts might be realised. These included impacts on:

physical health (e.g., reduced COVID-19 transmission, more active lives, more openness to discussing health issues).

mental health (e.g., more social contact, increased take-up of counselling).

community resilience (improved relationships and having a 'proof of concept' of a new way of working with community-based organisations).

However, reducing **young people's vaccine hesitancy**, and tackling **wider health inequalities** were often perceived to be outside the scope of the programme, with the CVC-funded activity being seen as merely "starting the conversation" about addressing these issues.

LAs and delivery partners thought that the CVC-funded activities had **left LAs with a 'proof of concept'** for working with community-based partners; and **a legacy of improved relationships** between LAs and community groups, local businesses, or educational institutions.

Various elements of the approach were thought to be **transferable to new contexts** (e.g., to public health initiatives to encourage take up of other vaccines or cancer screening, or smoking cessation; to the cost of living crisis; or to environmental and neighbourhood issues). These include:

Deploying funding quickly, with **flexibility** for delivery partners in how to use it, to enable a swift and effective response.

Messaging being **tailored to the community by the community**, and **shared via trusted community-based voices.**

Using **creative approaches to enable community members to feel comfortable** to share their views and ask questions about the COVID-19 vaccine.

An **existing landscape of community-based organisations** was seen as a necessary pre-condition for transferability to new geographic areas - better still with **constructive relationships between LAs and community organisations** already in place.

What further impacts of CVC-funded activities are expected in future, in this space?

To date, not all the intended impacts of CVC-funded activities have yet been realised. Local authorities (LAs) and Champions suggested that, alongside drawing on lessons learned already, more time and funding is required to continue to create (and evaluate) longer-term impact.

When asked about further potential impacts of CVC-funded activity, some thought there might be future impacts around physical and mental health and wellbeing, and increased community resilience through improving the quality of the VCS support offer and embedding good practice. Some postulated that there might be longer term outcomes that only surface a considerable way into the future.

Health and wellbeing

Some of the outcomes expected in the near future for residents included:

- Improved physical health (e.g., vaccine preventing ill health and reducing COVID-19 transmission; links into other projects that encourage active healthy lifestyles; systems in place for communicating with local stakeholders on other health topics; more openness amongst residents to discussing health issues).
- Improved mental health and wellbeing (e.g., residents are more connected with each other, thus addressing social isolation; more people accessing counselling via the funded organisations).

There was also an aspiration to tackle young people's vaccine hesitancy - for themselves, or further into the future for their children. In this respect there could be inter-generational impacts that have not yet materialised.

With respect to reducing health inequalities, several localities considered this to be "a huge issue" that can only be resolved gradually over time, but at least the CVC initiative had started to tackle it.

> *"Levelling up takes years. We've got 6 months' of funding…. [but] it takes generations. That is really what it takes."*
>
> **Champion**

Overall, reducing young people's vaccine hesitancy, and tackling wider health inequalities were often perceived to be outside the scope of the programme, with the CVC-funded activity being seen as a first step towards exploring and attempting to address these issues within target groups.

Community resilience

Expected future outcomes for organisations involved in the programme were more collaboration between the statutory and third sectors, with the potential for increased longevity, size, and quality of support delivered.

LAs and delivery partners talked of ways in which community resilience and preparedness to respond to future challenges (e.g., the cost of living crisis) had been enhanced through the CVC funding. The key ingredient here was LAs and delivery partners working together, which in turn:

- ⇒ Empowered communities to take issues into their own hands and find creative solutions that work for them.
- ⇒ Increased civic engagement, with more people being drawn into volunteering.
- ⇒ Cemented relationships (e.g., between LAs and community groups, local businesses, or educational institutions) in readiness to launch further joint health initiatives.
- ⇒ Afforded opportunities to pilot schemes for health messaging.
- ⇒ Provided a platform to demonstrate to other partners their capabilities.
- ⇒ Enabled ongoing relationships for collaboration on future funding bids.

It also provided a 'proof of concept' for the way in which LAs had used the CVC-funding to work with community-based partners.

"[The funded organisations] have appreciated the contact they've had with funders before and during this programme. This links to the longer term model about health works and how organisations feel they've got a say and a voice."

Delivery partner

In various areas there had been progress with forging new connections with ethnic minority groups which it was hoped could be sustained.

In a couple of localities, LA leads expressed aspirations of broader future impacts of the CVC funding, around tackling digital exclusion or inputting into young peoples' careers advice.

Some argued that without the continuation of funding, the momentum generated would be lost and outcomes could diminish; the suggestion being that continuing the programme for longer (with more funding and incorporating learnings to date) will help to realise these additional longer-term outcomes.

"Hopefully it will be the catalyst for improved health and wellbeing across the district in the next 5 years. That does need resourcing, so they won't be able to continue it without continuation funding in some way, but at least they've tried a way of doing it."

Delivery partner

How much could the CVC-funded activity approach be applied to other contexts?

Transferable elements

Some elements of the CVC programme were felt to be transferable to other contexts – either to other localities, or to other types of community or health initiatives. These included the way funding was disseminated and how local authorities worked with community organisations:

- **Agility:** deploying the funding quickly with flexibility for delivery partners in how to use it, to enable a swift and effective response.
- **Embeddedness:** working with individuals and organisations from within target communities (including people who will be the voice of seldom-heard groups, i.e., those who are typically under-represented in or excluded from policymaking). This helped to rebalance the power relations between LAs and local people, and it was an effective way to engage with target communities, who were more receptive to people with similar experiences.
- **Creativity:** using creative, tailored approaches (including use of the arts and various communication / facilitation tools) that relax people into a state of mind where they are open to talking about vaccination; and give permission to / empower people to talk.

Key ingredients

The key ingredient most often cited as necessary to have in place when transferring the approach to other **geographic locations** was the LA having an **existing landscape of community and voluntary organisations**. The ideal is well-established relationships between these organisations and the LA, but even if relationships with the LA and voluntary sector are just in their infancy this was thought to be sufficient. However, if community-based organisations are completely disconnected from the LA, then this will hinder success – since bridges would need to be built first and that takes time. The presence of a CVS umbrella body was particularly beneficial.

"[Having] the partnerships in place. So if we hadn't had a partnership with the CVS. [But] we could just plug in and straight away go with some of these things and run with them."

Local authority lead

"I think having those sort of community relationships, even tenuously, at the start helped it to be a success."

Local authority lead

Other supplementary learnings were the benefits of being clear on purpose and target outcomes; transparency from the LA, to ensure stakeholders are working towards shared goals; involving community members at an early stage to get their buy-in and their input into co-design of the tailored approaches; building delivery approaches for target audiences from the 'bottom-up' based with a person-centred approach focused on equity; and making sure the programme materials are culturally appropriate for diverse communities.

There was also a hypothesis raised that the approach might be more effective where the target populations were more densely clustered, rather than geographically dispersed – since community members may be better connected to each other, which supports the 'snowballing' effect of community members' trust in messages then influencing other community members.

Applicability to other behaviour change initiatives

The CVC-funded approaches were thought to have transferability to other initiatives designed to create behaviour change. These included:

- public health initiatives – to encourage take-up of other vaccines (e.g., flu, pneumonia, MMR); to increase uptake of cancer screening (e.g., for cervical cancer); to encourage registration for oral healthcare; to encourage cessation of smoking; to reduce obesity; and for general health monitoring programmes.
- cost of living crisis – considering how to apply behavioural change models to this current issue.
- environmental and neighbourhood issues – reducing negative behaviours such as fly tipping, anti-social behaviour, or burning rubbish in gardens; and also promoting waste reduction, recycling and energy saving behaviours, to address the climate emergency.

Lessons learnt – what works

Participants highlighted the following lessons learnt about what works:

- Community resilience and preparedness to respond to future challenges was enhanced by **LAs working together with local delivery partners through collaborative and communicative relationships.** These relationships empowered communities to find their own creative solutions to the vaccine promotion and other health and wellbeing-related work; and this provided a **proof of concept** of a different way of working, that could be applied to future challenges. The improved relationships between LAs, community groups and other local partners were in themselves a legacy that could be drawn on in future work.

- Elements of the CVC programme that were deemed **transferable to other contexts** were its **agility** in **deploying funding quickly** with **flexibility** in how it was used; its **embeddedness** in working with and **drawing on the lived experience** of **individuals and organisations from within the target communities**; and its **creativity**, in using **tailored approaches** to relax people into a state of mind where they are open to talking about vaccination; and to give empower people to talk.

- For these elements of the CVC programme to be effective in a new context, it's important that **the LA has an existing landscape of constructive relationships with community and voluntary organisations**.

- Stakeholders felt that the effectiveness of transferable CVC programmes elements would also be enhanced by being **clear about the purpose and target outcomes** of the work, **involving community members early** to get their buy-in and their in-put into co-designing tailored approaches; and ensuring that approaches for target audiences are **designed in a bottom-up way**, appropriate to the communities being targeted.

8. Additionality and value for money

Chapter summary

Without the CVC funding, it is likely that LAs would have continued previous vaccine promotion activity, or implemented initiatives that would have been more **top-down and generic**. The CVC funding, and ability to administer micro-grants, provided the flexibility for LAs to work collaboratively with local organisations, who in turn were able to involve local people in the design and delivery of vaccine promotion activities, so that the CVC-funded activities were able to draw on **lived experience** to increase their relevance.

The CVC funding helped enable the work to be done more **collaboratively with community-based organisations**, which in turn enabled tailoring and message delivery via existing trusted sources, drawing on lived experience – the very ingredients that have emerged as making community engagement successful.

It also created space for LAs to **pause, reflect and use insight** to refine their approaches.

From Management Information (MI) data, it is estimated that the **total vaccines administered at CVC-funded events across the 10 case study areas was 4,975**, of which 427 were first doses, 726 were second doses and 3,822 were boosters. Taking into account vaccine effectiveness and the transmission rate of COVID-19, **an estimated 8,008 COVID-19 cases were prevented by these vaccines**.

A comparison group was used to estimate to what extent these vaccinations would likely have happened anyway, in the absence of CVC funding. This suggests that **CVC funding was responsible for around 14.7% of booster vaccines** (around 562 doses), **preventing around 979 COVID-19 cases**.

While affected by uncertainty in the data, it's estimated that, in **the 10 case study CVC-funded areas**, the funding delivered a **net social value of £5.7 million** in prevented COVID-19 cases alone (from vaccine boosters that likely wouldn't have happened without CVC funding), for costs of £4 million – **meaning an estimated £1.44 in value for every £1 spent.**

Assuming these estimates are representative for **all 60 CVC-funded LAs**, the **additional social value is estimated around £26.1 million**, for spend of £18.9m – **meaning an estimated £1.38 in value for every £1 spent.**

What would have happened without CVC funding?

LA leads and delivery partners felt it was likely that that vaccine promotion would have continued without CVC funding, but that the scale and speed would have been reduced, and the approach to the programme of work have been more generic, less tailored and much less collaborative. It would not have had the ability to draw on the lived experience of the communities being targeted. This would have led to difficulty in reaching and influencing the target groups as effectively.

"Without the CVC funding, it felt like the message was less likely to have reached the target audiences."

Local authority lead

"I don't think it would have happened to the extent that we were able to make it happen. I think what this gave us was the opportunity to scale up, and at pace."

Local authority lead

LA leads and delivery partners also felt the approach would have been more 'top-down', and connections with the community and volunteering sector would not have been created or strengthened. The funding and its structure allowed these partnerships to work in a more grassroots manner, with investment going directly to community organisations to work with as they saw fit; or being used in a collaborative way.

Ultimately, the absence of the CVC funding would have very likely negatively impacted LAs' ability to collaborate with local organisations and people. The flexibility of the CVC funding was also highly important in enabling LAs to have space to consider, be creative and use insights to inform their approach. The CVC funding was therefore perceived to have helped enable the ingredients felt to be central in the success of the CVC-funded work.

"Without the funding… and the [Champions] turning up to activities, it wouldn't have worked… it allowed us to keep them on board. They also influenced us [around] what [communications] worked for each group."

Delivery partner

Another element LAs felt would have been unlikely without the funding was scope to train Champions / individuals delivering the work on the ground. This was felt to be

important in ensuring effective engagement with residents. It was also a factor that built trust with the community (as training the Champions was a way of investing in the skills of the community).

However, even with the CVC funding, LAs reported facing significant challenges to delivering an effective programme of vaccine uptake activities in the context of a global pandemic, a national cost of living crisis and reduced local funding. These broader contextual factors impacted LAs capacity and thus restricted what the funding might have enabled them to achieve without these constraints.

To what extent did the CVC-funded activities deliver value for money?

Quantifying social value

To quantify value-for-money, management information (MI) data from the 10 case study areas was analysed to assess the cost and the outputs of CVC-funded activities. MI data included CVC activities up to and including July 2022, as data beyond this was not reported by all areas.

The **number of vaccines administered at CVC-funded events** is considered as the main, direct gross output of the programme. The additional social value of this output is estimated by determining **how many of these vaccines would not have been administered without CVC funding**, and then estimating the resulting quantifiable impact in terms of the **number of COVID-19 cases prevented** and **associated costs avoided**.

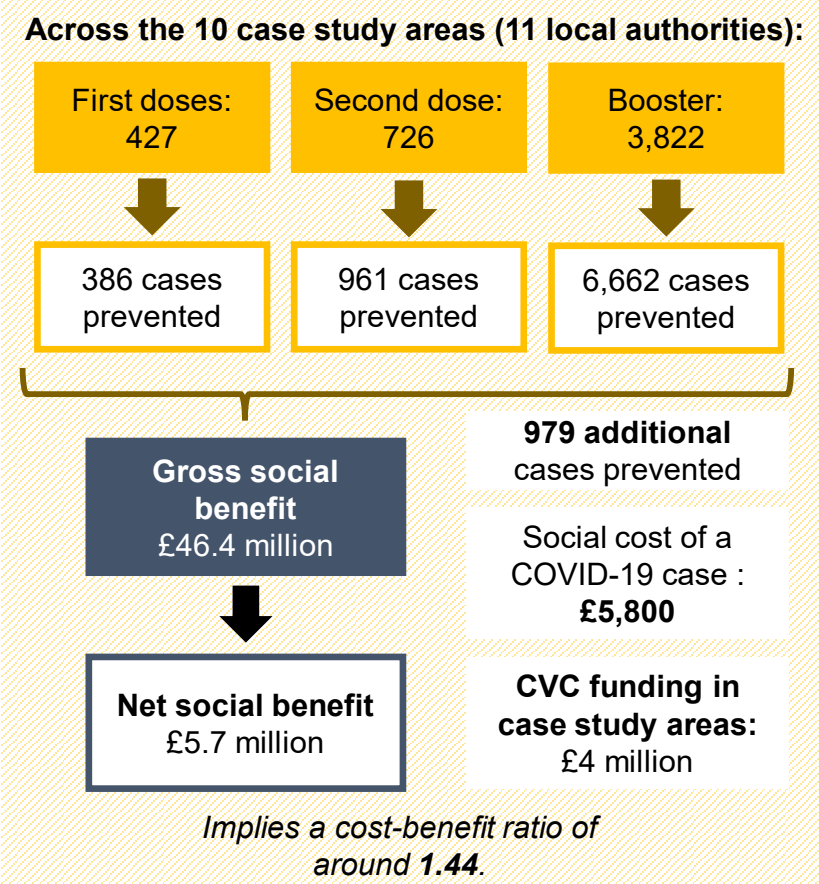
The social value of preventing a COVID-19 case is determined by various factors and it is likely to evolve over time. The estimate used in this note is taken from the report by Technical Advisory Group to the Welsh Government published in May 2022,[4] which updates the figure of the social cost of a COVID-19 case using parameters relevant in January 2022. This study was the most up-to-date estimate of the social cost of a COVID-19 case as of October 2022 and it used parameters which were relevant for the timing and location of the CVC programme. The cost estimates are based on the ratio of cases to other outcomes – hospital admissions, ICU admissions, deaths and estimated long COVID cases. The social cost of a COVID-19 case is estimated at around £5,800 per case.[5]

[4] https://www.gov.wales/sites/default/files/publications/2022-06/the-social-value-of-a-covid-case-january-2022.pdf accessed on the 2nd February 2023.
[5] The estimate of the social value of preventing a COVID-19 case varies substantially across time as immunity from vaccines of previous exposure lowered the likelihood of severe symptoms. At the start of the pandemic, April 2020, the social cost of a COVID-19 case is estimated to be $286k by Bethune and Korinek (2020), Kirson et al (2022) estimate the number of QALYs lost from a COVID-19 case

As a note, this means the social value outlined does not take into consideration other value added from the CVC-funded work (for example, changes in trust, awareness or attitudes to COVID-19 vaccines or wider health issues; or changes in the strength of local networks and relationships).[6]

MI data recorded that, within the 10 case study areas, **4,975 vaccines were administered** at CVC-funded events between January and October 2022[7].

Figure 8.1 Overview of CVC-funding social value



varying between 0.007 to 0.0161 (£490 - £11.3k valuing a QALY lost at £70,000) depending on the severity of the case, while TAG (2022) estimate the social cost at £21k for December 2020. The value used in the analysis refers to the January 2022 estimate from the latter study. The study is chosen as it provides an estimate for the relevant time-frame of the intervention, and it includes a comprehensive overview of the health and economic costs of a COVID-19 case.

[6] The comparison of survey findings for residents aware of CVC-funded activities against a matched comparison group of residents of non-funded areas showed an absence of identifiable significant impacts of the CVC funded work on factors such as trust, awareness or attitudes to COVID-19 vaccines or wider health issues; or on the strength of local networks and relationships. This meant that value for money analysis had to focus on vaccinations delivered and, relatedly, the social value of COVID-19 cases likely to have been prevented by these vaccinations (which was also monetizable).

[7] The VfM analysis focuses on 10 case study areas, comprising 11 local authorities, as more recent MI data was available for these areas. Across all 60 LAs the number of vaccines administered at CVC-funded events as of July 2022 was 27,850.

Taking into account vaccine effectiveness and the transmission rate of COVID-19, extracted from the literature,[8] an estimated **8,008 COVID-19 cases were prevented** by the vaccines delivered at CVC-funded events.

The additional social value considers the social value only from the additional vaccines, those which wouldn't have been observed without CVC funding, this figure was estimated by comparing the difference in growth in the vaccination take-up rates before and after the programme between the funded and comparable areas identified through propensity score matching (see Technical Appendix C). A comparison group was used to estimate to what extent these vaccinations would likely have happened anyway, in the absence of CVC funding.[9] Analysis suggests that CVC funding was responsible for around 14.7% of booster vaccines (around 562 doses), while the first and second doses would probably have been administered anyway. This means that approximately **979 of these prevented COVID-19 cases were thought to be additional** (prevented by vaccines which would not have been administered without CVC funding).

Using the estimated £5,800 cost per case, the **gross social value** of the prevented cases in the 10 case study areas is estimated to be around £46.4 million, while the **additional social value** created (by vaccine boosters that likely wouldn't have happened without CVC funding) is estimated at around £5.7 million.

Taking into consideration that the cost of the CVC programme in the 10 case study areas was £4 million, this indicates that the CVC programme[10] has a **cost-benefit ratio of 1.44** – meaning an estimated **£1.44 in value for every £1 spent.**[11]

Assuming the proportion of additional vaccines is representative for all 60 CVC-funded LAs[12], the **total gross social value (benefit)** of the CVC programme can be

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[8] Vaccine effectiveness was extracted from BMJ (2022) accessed from https://www.bmj.com/content/379/bmj-2022-072141 while the transmission rate was taken from the UK Health Security Agency (UKHSA) https://www.gov.uk/guidance/the-r-value-and-growth-rate both accessed on the 2nd of February 2023.

[9] Further detail about the comparison group approach is in Technical Appendix C.

[10] The assessment of social value of CVC funding is based on vaccinations delivered and the cost of likely COVID-19 cases prevented. This means that, while the costs are those of CVC funding overall, the benefits are likely to be principally derived from vaccines delivered at CVC-funded events and wider programme elements concerning active vaccine promotion (e.g., influencing vaccine attitudes so that individuals were more open to receiving COVID-19 vaccines).

[11] For booster vaccines, 391 additional vaccines would have meant a cost-benefit of 1, this would imply a gross number of 2,662 booster vaccines would have to be administered at CVC funded events to reach the threshold for vaccinations then being 'additional' (switching value). This figure would change slightly for first or second doses due to impact of these different vaccinations on prevention rates.

[12] The estimates for all 60 LAs only reflect the impact up to July 2022 as MI data is not available for all the LAs for later months. The number of vaccines recorded for all 60 CVC-funded LAs is 27,850, of which 4,283 first doses, 5,945 second doses and 17,622 booster doses. Assuming 14.7% of booster

estimated around **£246.2 million**, while **additional** social value (benefit) is estimated around **£26.1 million**.[13] Since the total allocated spend of the CVC programme amounted to £18.9m[14], this implies a **cost-benefit ratio of around 1.38** – meaning an estimated **£1.38 in value for every £1 spent.**

Given that the estimate of the proportion of additional vaccines comes with uncertainties and may not be statistically significant, the resulting estimate of cases prevented is also subject to uncertainty. The estimated social value created is sensitive to changes in the social cost of a COVID-19 case and the proportion of vaccines which are attributable to the CVC programme, i.e., additionality. Alternative assumptions yield a more conservative valuation of the social value of a COVID-19 case at **£2,400**, resulting in the estimated net social value created decreasing to **£2.4m**. Relying on alternative estimates of additionality yields a net social value within the range **£0 - £10.5m**, the lower figure resulting from a model which finds **no additional impact of the CVC programme[15]**.

Differences in delivery

An observation from the MI data is that some of the local authorities focused on vaccine administration as their main output with a focus on pop-up clinics and vaccine buses. This resulted in a high number of vaccinations recorded. However, it is to be noted that these LAs had the highest level of funding[16], so that for LAs with lower funding there may have been considerations of whether community engagement activities were more feasible.

The lack of vaccine administration by some of the LAs does not represent a lack of impact of the CVC programme. In fact, focusing on community engagement rather than vaccine delivery may have been necessary to inform individuals of the benefit of vaccines, as a precursor to seeking to improve vaccine uptake at a later date. Additionally, these types of events have other community-wide benefits in terms of outreach and social value, for example the Live Well events organised by Hammersmith and Fulham Borough and the Bangladeshi Health Fair organised by

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doses are additional (from the analysis of the case study LAs) implies that an additional 2,590 vaccines were administered at CVC-funded events across all 60 LAs up to July 2022.

[13] The social value is reported in present value terms, not future savings.

[14] The 60 supported LAs were awarded a total of £22.5m, the total spend figure of £18.9m refers to the total committed spend as of July 2022, the difference relates to resource allocated but not yet spent or committed by LAs at the time the last MI data was reported. For the case study areas the latest available MI was reported in October 2022 while for all supported LAs the latest data refers to July 2022.

[15] For further detail on sensitivity analysis considered for the value for money estimates, please see Technical Appendix C.

[16] These LAs had not received the previous CC1 funding and so were able to bid for this higher level of CVC funding.

Cambridge informed participants on a wide range of health topics, not solely related to COVID-19.

Thus, two types of activities are identified (as summarised in Figure 8.2 below): one aimed at **informing hard-to-reach communities** while the other at **delivering vaccines**. Both create social value, and they complement each other; one by directly increasing vaccination rates, the other by increasing the pool of people who are willing to receive vaccines. In fact, most LAs chose a balance between these two approaches to maximise impact.

Figure 8.2 Two types of delivery activities

Main delivery focus:	
Community engagement	**Vaccine delivery**
Type of events: Community outreach, COVID-19 / Healthcare awareness	**Type of events:** Pop-up clinics, Vaccine bus/Roving clinic
Median cost: £341,274	**Median cost**: £485,000
Median vaccines recorded: 6	**Median vaccines recorded:** 553
Case study LAs employing this approach: Boston, Cambridge, Hammersmith and Fulham, Oxford, Wolverhampton	**Case study LAs employing this approach:** Bristol, Kensington and Chelsea, Lancaster, Newham, Sandwell, Westminster

Note: The median is the total spend of the LA which spent the 'middle' amount in each group. It's shown here because it's more stable against outliers compared to the average, so is better in this context, as the sample is small.

Further details on the value-for-money analysis can be found in Technical Appendix C.

9. Conclusions

In January 2022, as a response to the uneven effects of the pandemic in the country, the UK Government allocated £22.5m of Community Vaccine Champions (CVC) programme funding to 60 local authorities (LAs) for the delivery of bespoke projects to promote vaccine uptake and address wider health inequalities, in the areas with the lowest vaccination rates in the country. At this time, the UK was experiencing a high COVID-19 infection rate due to the emergence of the Omicron variant in November 2021.

The CVC programme built on the earlier Community Champions programme (CC1), which awarded £23.75 million of funding to 60 local councils and voluntary groups, to support the communities most at risk of COVID-19. Of the 60 LAs receiving the new CVC funding, 22 had previously received CC1 funding; the remainder had not.

Both the CC1 and CVC programmes use the 'Community Champions' model[17], an established model in public health policy. Champions are volunteers who promote health and wellbeing within their established social networks by using their connections and lived experience to improve services and overcome barriers in their communities.

The following **conclusions** can be drawn from an evaluation of the CVC programme:

- A comparison of survey findings for residents aware of CVC-funded activities against a matched comparison group of residents of non-funded areas, shows that, in CVC-funded areas, **religious minority groups who were aware of CVC-funded activities were significantly more likely to have received booster vaccinations than similar residents in the comparison areas**. There was also an impact approaching statistical significance for these CVC aware religious minority groups around engagement with wider health information (although these positive impacts for engagement with wider health information are in the form of gentler declines than those seen in comparison areas).

- While affected by uncertainty in the data, it's estimated that, **in the case study CVC-funded areas, the funding delivered an estimated 562 additional COVID-19 booster doses which would not have been administered without CVC funding**. Using the estimated social cost of a

[17] https://www.gov.uk/government/publications/community-champions-programme-guidance-and-resources/community-champions-programme-guidance-and-resources

COVID-19 case[18], these additional booster doses represent a net social value of c.£5.7 million in prevented COVID-19 cases alone, for costs of £4 million. This indicates that the programme has a **cost-benefit ratio of 1.44** – meaning an estimated **£1.44 in value for every £1 spent.**[19]

- Assuming the proportion of additional vaccines are representative for all 60 CVC-funded LAs, the **additional** social value is estimated around **£26.1 million** for all 60 funded LAs. Since the total allocated spend of the CVC programme amounted to £18.9m, this implies a **cost-benefit ratio of around 1.38** – meaning an estimated **£1.38 in value for every £1 spent.**

- Without the CVC funding, vaccine promotion activity would have been more 'top-down' and generic. **The flexibility of the CVC funding enabled the work to be done creatively and collaboratively with community-based organisations, drawing on lived experience (e.g., similar socio-economic, ethnic or religious backgrounds) to increase its relevance**.

- This in turn enabled **message tailoring** and **message delivery via trusted sources**, and an **informal, creative approach that relaxed individuals to be more receptive to conversations about COVID-19 vaccines.**

- **This means that the CVC funding was important in enabling the ingredients that emerged as making community engagement successful, and that are identified as transferable** – particularly the ability of the CVC-funded work to draw on lived experience.

- However, a tailored and less hierarchical, more sensitive approach has been accompanied by a **wariness of** gathering impact evidence, as LAs felt collecting data from residents was counter to the informal, sensitive approaches taken in their CVC work. This left LAs unsure of whether what they were doing was working.

- Wolverhampton adopted **a model that circumvented this issue, and which might provide a possible solution** to this wariness of gathering impact evidence in future. This involved **incentivising community partners for each additional vaccination achieved**, which both encouraged the work itself and generated evidence of impacts through the process for claiming the incentive.

[18] https://www.gov.wales/sites/default/files/publications/2022-06/the-social-value-of-a-covid-case-january-2022.pdf accessed on the 2nd February 2023.
[19] Note that Value for Money analysis did not account for any non-monetizable impacts, e.g., in terms of trust, awareness, strength of networks.

- Mechanisms to **share on-the-ground feedback between Champions, local authorities and other health sector partners** are necessary to ensure insights into vaccine barriers can be acted on and communication materials can be effectively co-produced.

- Some LAs felt that **practical vaccine barriers were more readily understood** than attitudinal ones, and **attitudinal barriers were sometimes felt to be too entrenched** to overcome within the scope of the programme.

- The key elements of the CVC programme that emerged as being **transferable** to other contexts were:
    - **Agility:** deploying the funding quickly with flexibility for delivery partners in how to use it, to enable a swift and effective response.
    - **Embeddedness:** working with individuals and organisations from within target communities (including people who will be the voice of seldom-heard groups i.e., those who are typically under-represented in or excluded from policymaking). This helped to rebalance the power relations between LAs and local people, and it was an effective way to engage with target communities, who were more receptive to people with similar experiences.
    - **Creativity:** using creative, tailored approaches (including use of the arts and various communication / facilitation tools) that relax people into a state of mind where they are open to talking about vaccination; and give permission to / empower people to talk.

Recommendations

For central government:

The most compelling impacts of the CVC programme lie in the ways in which target communities, often characterised as 'underserved' have been effectively engaged. Learning suggests that there are key features of the model that are **transferrable** to other public health and community-focused interventions:

- **Working through the voluntary sector**, including religious organisations, is an effective way to reach targeted communities who are less likely to engage with mainstream public health messaging, due to the trust these organisations engender and strength of networks they have access to.

- **Local authorities often have well-established networks with the voluntary and community sector** that can support the recruitment and training of community champions and similar initiatives within identified target communities. Where these networks need to be built more from scratch,

central government should encourage local authorities to develop these networks as an important foundation for increasing the reach and credibility of public health (or other important) messages; and ensure there are trusted routes for communications to land on a range of issues. These networks can also enable new cross-sector initiatives to be implemented quickly and effectively.

- **The creativity of the voluntary and community sector and their ability to draw on relevant lived experience** to tailor approaches to targeted communities have been highlighted as critical components of effective engagement with these communities. Their contribution should be valued appropriately in any future interventions, as essential to success. Allowing LAs to deliver funding to the voluntary and community sector flexibly, will be important to ensure the voluntary and community sector can be empowered to fully bring its expertise to bear on future initiatives.

The positive impact on booster vaccinations among religious minority groups suggests that the approaches taken within the CVC-funded vaccine promotion work have been effective within faith communities specifically – namely, of encouraging community leaders (including religious leaders) to share their positive vaccine experiences; of vaccine promotion messages being tailored and delivered by Champions with relevant lived experience of the communities being targeted; and of vaccine promotion and vaccine opportunities being delivered in spaces (including faith settings) where the target communities already felt comfortable. These approaches should be applied to other initiatives targeting faith communities in future.

The CVC-funded activities have left LAs with a proof of concept of ways of working collaboratively with the voluntary and community sector around public health promotion activities; and a legacy of improved relationships with community-based organisations. These have the potential to make communities better equipped to respond to future challenges. **However, feedback suggests the communities have a history of distrusting engagement that isn't sustained**. Further initiatives from central government, delivered via local government and partner organisations, should deliberately nurture these now strengthened local networks, to make them more likely to be sustainable.

An approach of incentivising community-based organisations 'per vaccination' delivered offers a potential solution to LAs' wariness of gathering their own data that might prove the efficacy of their public health promotion activities. Consideration should be given to building this into future similar initiatives as a core component.

Opportunities for sharing feedback on community insights were limited within the CVC-funded work. There is a need for more systematic methods of gathering and sharing community insights to be designed into similar programmes in future.

For local authorities:

For local authorities there is strong qualitative evidence that suggests where and how both formal (e.g., vaccinations) and informal (e.g., information sharing as part of community gatherings) public health interventions take place is critical to engage targeted communities and effectively influence health behaviours.

The CVC approach has been most effective when activities take place within existing community groups, community centres and places of worship - spaces where community members already felt comfortable. Sometimes adding the intervention content (in this case, vaccine promotion and vaccine opportunities) to an existing event or a wider topic was effective, by adding the intervention topic to something that target communities were already interested in.

The ability of community-based organisations to draw on relevant lived experience enabled vaccine promotion and wider health messages to be tailored to target communities by members of those communities, thus enhancing the credibility of messages. Champions invested time in being present and visible among community members, to create opportunities for dialogue. It is therefore hugely important that this learning is taken forward into future public health interventions, when seeking to work with specific target communities. Similar principles could also be adopted in seeking out the places, spaces and means of communication that young people will best respond to, since qualitatively there was less clear impact observed for this group and additional work may be required to target this group effectively.

Training about how to have conversations about the vaccine and wider health and wellbeing issues will be vital to ensure that individuals delivering the funded work are confident in engaging community members effectively. **Training should be built into the delivery of similar initiatives in future.**

The use of data will make intervention approaches more effective. This can be statistical evidence to identify target communities or geographic areas where an intervention is most needed; or qualitative insight to understand the relevant behaviours and attitudes, in order to identify how to change them. Stakeholder feedback suggests that mechanisms to more systematically share insight into behaviours and attitudes will need to be built into future interventions. For future work on COVID-19 vaccine promotion specifically, there's a need to address a perceived lack of evidence on the long-term vaccine side effects.

It will be important to invest time in establishing strong lines of communication between the LA and partners (such as community-based organisations, GPs, and other NHS partners). The absence of this sometimes acted as a constraint on what the CVC-funded work was able to achieve. Strong lines of communication need to encompass both formal contact (such as regular meetings, which can help build trust through a shared purpose and shared objectives) but also informal, agile contact to solve problems on-the-ground / on-the-day.

For VCSE organisations:

The evidence within this report suggests that the VCSE sector has a critical role to play within public health. Their connections, trust and rapport with minority groups and those experiencing higher levels of disadvantage means that they often have unique opportunities to influence health-supportive behaviours and should consider the impact that they can have on wider public health measures such as vaccine uptake.

VCSE organisations should build on the principles of the Make Every Contact Count training to consider how they can continue working in partnership with local authorities collaboratively to support broader public health initiatives going forward for mutual benefit.

Evidence suggests that practical barriers can be tackled more readily than attitudinal ones; however, the VCSE organisations' dissemination of information tailored to specific communities via trusted sources, such as Champions with lived experience and community leaders, can nevertheless make inroads into attitudinal barriers to desired behaviours.

Having translated materials and / or interpreters will likely be highly important in building trust, with ethnic minority target communities.

However, while there is strong qualitative evidence of the role of VCSE organisations, **the lack of monitoring data and commitment to building a solid evidence base** around vaccine uptake from the activities they supported, means they can be less definitive about their impact.

VCSE organisations should consider how they can collect data from their target audiences in a way that maintains trust and feelings of safety, while being better able to evidence their impact and become more systematic in recording data. There are likely to be opportunities for public health teams within local authorities to support this initiative and build on the partnerships created or enhanced through Community Vaccine Champions.

The ‘per vaccination’ incentive approach (discussed above) offers a potential solution to VCSE and LA wariness of gathering data from potentially more vulnerable or less trusting groups, but whose outcomes are essential to capture in order to better prove the efficacy of the model. Building the ‘per vaccination’ concept into similar initiatives as a core component is likely to be an effective way of incentivising data collection more broadly, but it will also be important to consider how to communicate the on-going purpose of data collection in way that makes minority communities feel safe.

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