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RSPH
ROYAL SOCIETY FOR PUBLIC HEALTH
VISION, VOICE AND PRACTICE

Taking Forward the Best Practice from the Covid-19 Vaccination Programme

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Royal Society for Public Health was sponsored by MSD to coordinate and disseminate learning from a roundtable on the Covid-19 vaccination programme. MSD did not have input into the arrangements of the event, its agenda, or the contents of this paper.

About this briefing

The Covid-19 vaccine roll-out has been distinctive in many respects from the UK's routine immunisation programmes, not only in its scale, but also in the infrastructure and resources behind its delivery.

Covid-19 vaccines have been researched, produced and delivered at unprecedented speed, inspiring a new-found agility and collaborative ways of work across public health systems. The success in the development and roll-out of the vaccines here in the UK and abroad has played a key part in demonstrating and promoting the value of vaccinations among policy-makers and the public, and facilitating public engagement – as trial participants, volunteers in clinics, or champions of the vaccination.

However, there is still uncertainty about how much of this innovation will be maintained and applied across the routine vaccination programmes. In the absence of sharing learning, there is a risk for the system to default to old ways of working – there are concerns across the system that partnerships could break down, community engagement efforts come to an end, and resources dry up.

Taking Forward the Best Practice from the Covid-19 Vaccination Programme

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RSPH, with the support of MSD, held a roundtable in July 2021 to identify key learnings which should be mainstreamed across routine immunisation programmes in the UK. The roundtable brought together academic experts and professionals leading on the commissioning and delivery of vaccinations. This included:

- **Christina Marriott**, Chief Executive, RSPH (Chair)
- **Professor Linda Bauld**, University of Edinburgh
- **Dr Joanne Yarwood,** National Immunisation Programme Manager, Public Health England
- **Dr Doug Brown**, Chief Executive of the British Society for Immunology
- **Ranjit Senghera**, National Lead for Equality & Health Inequalities, NHS England & NHS Improvement
- **Professor Helen Bedford**, Professor of Children's Health, University College London
- **Dr Matthew Snape**, Associate Professor in General Paediatrics and Vaccinology, University of Oxford
- **Mike Barker**, Strategic Director of Commissioning and Chief Operating Officer, Oldham Council and Oldham Clinical Commissioning Group
- **Jake Beech**, Researcher, King's Fund
- **Jonathan Lloyd Jones**, Policy and Engagement Lead, Royal Pharmaceutical Society
- **Harry Brady**, Director of Policy and Communications, MSD (UK)

This paper summarises the learnings from the roundtable with an aim to highlight emerging good practice from the Covid-19 vaccination programme to be taken forward into routine immunisations.

Recommendations

Implement a data strategy to identify and address inequalities in coverage across the immunisation schedule.

A national Immunisation Inequalities Strategy should be developed to understand barriers to access and levels of confidence among different demographic groups, with action plans channelled down to local levels.	NHS England & NHS Improvement (NHSE&I), Public Health England (followed by the UK Health Security Agency), and Regional Directors of Public Health jointly
Ethnic coding should be consistently recorded for all vaccinations.	All providers of vaccinations
GP and Pharmacy IT systems must transfer data about vaccinations between each other smoothly so that patient records are consistently updated and their demographic data can be used to analyse disparities in uptake and coverage.	GP and Pharmacy IT system providers with the support of NHSE&I
Data-sharing arrangements which have been put in place for Covid-19, giving Directors of Public Health access to real-time data about the vaccination roll-out in their area should be applied to routine immunisations. Local public health teams must have access to data on immunisations before publication, to the most granular level possible, so they can target interventions in areas of lower uptake.	NHSE&I and NHS Digital

Encourage local collaboration.

Contractual arrangements should be reviewed to better facilitate long-term partnership-working. This may include developing a single register for patients which can be shared across healthcare providers and commissioning GP practices and community pharmacies to deliver immunisations under the same contract.	The Department for Health and Social Care (DHSC) and NHSE&I
Community health and wellbeing hubs should be used as bases for multi-disciplinary teams, bringing together medical and allied health professionals alongside representatives from the welfare, housing and voluntary sectors to provide more comprehensive and holistic support. The pilot of Cavell Centres should be used as an opportunity to exemplify this, and the extent to which they enable place-based approaches and inter-professional working should be incorporated in their evaluations.	Integrated Care Systems (ICSs)

Involve local communities in the design and delivery of public health programmes.

Local systems should continue working with community champions to improve uptake rates for other immunisation programmes, so that community engagement remains integral to how immunisations are commissioned and delivered across the country.	ICSs and Primary Care Networks (PCNs)
Healthcare providers should actively encourage patients to become champions of the services they have received. For example, when a patient is supported for an issue which relates to population health, a feedback survey sent afterwards could include the suggestion for the patient to advocate for the service to a friend or relative, with shareable resources or tips on how best to do so.	GPs, and healthcare professionals involved in mental health, screening, smoking cessation and weight management services amongst others

Maintain independent academic advice on vaccinations.

To ensure trustworthy and accurate reporting about vaccinations, academic and research institutions should maintain science press officer roles who can effectively engage with journalists.	Academic and research institutions
There must be a clear demarcation between the communication of scientific research by academics and Government departments, with those involved in the research itself being able to lead on releasing the findings, and the timing of the publication.	Government communication departments

Increase access to vaccinations.

To enable the vaccinator workforce to be expanded at times of high pressure, Health Education England should develop training modules to equip health professionals who do not routinely administer vaccinations to take on that role.	Health Education England
Local systems should assess where, in the immunisation schedule and across the population, their coverage is lowest, and map potential touchpoints with health services which could become opportunities for vaccination. Health professionals involved in those contact points should then be supported to offer opportunistic vaccinations for underserved and at-risk patients.	ICSs together with Directors of Public Health and with the support of NHS England Local Teams
DHSC should explore whether the NHS app could be used to host a user's digital health record as this could increase access to vaccinations and expand the vaccinator workforce simply by utilising opportunities for on-the-spot vaccinations as and where needed.	DHSC, NHSE&I and NHS Digital

Maximise the learning opportunity of the Covid-19 vaccine roll-out.

Funding should be provided by DHSC for organisations who have contributed to the vaccination programme – including local authorities, charities, professional bodies, and community organisations – to evaluate the impact of their efforts and identify lessons learned.	The Department for Health and Social Care, and organisations directly involved in the immunisation programme, including local authorities, St John's Ambulance, social care providers, charities, professional bodies and community organisations
The insights drawn from these evaluations should be collated and shared through PHE's Connect and Exchange Hub.	Public Health England (followed by the UK Health Security Agency)

Innovative features of the Covid-19 vaccination programme

The roundtable explored three key innovations from the Covid-19 vaccination programme: data and IT systems; efforts to reduce inequalities; and new settings and workforce.

Data and IT systems

In 2020, NHS England & NHS Improvement (NHSE&I) established a centralised service for the management of both the Covid-19 and seasonal flu immunisation programmes. Unlike the previous system, the National Immunisation Management System (NIMS) runs an automated call/ recall service, and collects information about vaccinations from GP practices, pharmacies and other vaccination centres, so that patient records can be updated and the progress of the vaccination programme can be monitored on a daily basis.

Data about the Covid-19 vaccination programme has been available to those leading the programme, whether in the NHS, Public Health England (PHE), or Directors of Public Health through several dashboards, including the Covid-19 Situational Awareness Portal, Coronavirus Shielded Patient List Dashboard, Covid-19 Vaccine Equalities Tool, Adult Social Care Covid-19 Dashboard, and the National Immunisation Management System Dashboard. These break down data about the vaccination programme to a level of granularity not previously available for immunisations, including by detailed ethnic group, age, priority cohort, Index of Multiple Deprivation, vaccination setting, first and second dose, and with a specific dashboard for care home residents and workers.

Data has also been made available to the public, with PHE's Covid-19 dashboard publishing daily updates across 200 metrics, receiving 19 million views per week (more than any page on the gov.uk portal since it was created).[i]

Efforts to reduce inequalities

Inequity in vaccine uptake among various demographic groups has been a longstanding issue facing immunisation programmes in the UK. But the data has not been consistently collected to establish how great those disparities are, along what sociodemographic lines they typically occur, or to evaluate how they can be reduced. From mid-January 2021, however, ethnicity began to be recorded as part of the Covid-19 vaccination collection data to monitor and address the difference in uptake by ethnic groups.[ii]

A new Vaccination Equalities Committee, led by NHSE&I, was established to bring together government departments with national representatives from the Association of Directors of Public Health, local authorities, Fire and Police services and third sector organisations to advise and guide the vaccine deployment programme on addressing inequalities. NHSE&I also developed a framework for maximising vaccine uptake in underserved communities – with case studies of best practice, a national resource bank, and recommendations for interventions based around partnerships, access and communications.[iv]

The Department for Health and Social Care (DHSC), PHE and NHSE&I worked together, with third sector organisations, to produce targeted communications for different demographic groups ensuring there were resources available in a variety of languages and formats, braille and accessible for those with a hearing impairment. NHSE&I and PHE worked with Rethink Mental Illness to develop communications to address the concerns of people living with severe mental illness.[v] They developed top tips for vaccinators

to support people living with learning disabilities and autism to access vaccinations. To support effective communication with NHS staff from ethnic minority backgrounds, a dedicated team, headed by the Medical Director of Primary Care and the Chief People Officer was also set up to ensure staff communications were culturally sensitive and reflected perspectives of staff from ethnic minority communities.[vi]

In October 2020, the Ministry for Housing, Communities and Local Government made £23 million available for community champion schemes run by 60 councils and voluntary groups across England to encourage take-up of the vaccine[vii]. In February and March 2021, the Covid-19 vaccine deployment programme made available a further £7.2 million to enable locally-led community engagement in all areas with health inequalities, with each STP receiving a notional allocation of £100k, to be used across its constituent CCGs[vii]. To draw on this resource, CCGs were asked to develop a plan in collaboration with the local community and local Directors of Public Health, detailing how the initial funding would be used, ensuring the community was an active partner in the process.

New settings and workforce

In order to improve access to vaccinations, clinics have been run in various new settings, using an expanded workforce, often working extended hours. Vaccinations have been administered within general practice, as well as in mass centres, hospital hubs, community pharmacies, mobile clinics, drive-through clinics, community settings such as places of worship, and through outreach teams visiting care homes, hostels and private residences.

To scale vaccination across multiple settings, the NHS also needed to bring new professions into the vaccinator workforce. A Statutory Instrument was agreed to amend the Human Medicines Regulations, enabling unregistered staff with appropriate training to administer the vaccine.[ix] As a result, the workforce involved in the Covid-19 vaccine delivery expanded from nurses, community pharmacists, and midwives, to allied health professionals, medical students, dental hygienists, primary care and hospital pharmacists, phlebotomists, returning GPs, airline staff and St John's Ambulance volunteers.

The vast expansion of the vaccinator workforce was supported by a national recruitment campaign. NHSE&I offered Primary Care Network (PCN) groupings and other providers access to additional staff from a central pool of over 10,000 unregistered vaccinators. PCNs were also able to claim extra funding to bring in additional workforce in January 2021 to ensure that all records for vaccination of priority cohorts were up to date and recorded properly in the IT system, Pinnacle. Each Integrated Care System (ICS) designated a Workforce Lead Employer to serve as the operational workforce hub for all vaccination providers in the local area, providing healthcare professionals and volunteers to providers, and supporting providers with workforce communications and rostering systems for volunteers.[x]

Key Lessons from the Covid-19 Vaccination Programme

Good data is the cornerstone of a successful vaccination programme

Good data has undergirded all aspects of the Covid-19 vaccination programme, from clinical trials, to communications, delivery, and reporting. For example, one of the success stories of the programme has been the amount of funding which the UK Vaccines Taskforce has allocated to clinical trials. These trials have produced the data needed for the Joint Committee on Vaccination and Immunisation (JCVI) and the Medicines and Healthcare Products Regulatory Agency (MHRA) to make evidence-based decisions about not only the initial product, but also different modes of delivery, such as mixed schedules, co-administration with a flu vaccine, and booster jabs.

"I want to really emphasise how important actually generating information has been so that you can look people in the eye and say, 'yes, we have this data to make that decision'….The rest of the world is looking at us and saying, 'how are you doing these studies? How are you getting information ahead of time? How are you convincing trial volunteers to get a flu vaccine in Spring, how are you convincing people to get the mix and match schedules, the booster schedules?' So that's been a great success story."

Public confidence in vaccines are linked to the trust in the whole system, including research, production and delivery. The public facing role of the JCVI has played an important part in building public confidence, as has the media who have, for the most part, reliably conveyed the evidence and reasoning behind the decisions of the MHRA and the JCVI to the public. As one participant put it, *"people have felt reassured that there have been experts, whatever that means to individuals, advising and carefully considering every aspect of this programme"*.

Data has also been intensively collected around the delivery of the Covid-19 vaccines. This real-time reporting and publication have allowed for targeted interventions. Data granularity has helped to identify individuals who have received the vaccine and crucially, parts of the population that have not come forward. The Foundry Covid-19 Vaccine Equalities Tool, for instance provides daily updates on vaccine uptake with breakdowns for age, priority cohort, ethnicity and IMD, with the ability to set an uptake target for a Sustainability Transformation Partnership (STP) population and calculate the gap between actual uptake and the target.[xi]

Likewise, PHE, the Office for National Statistics, the Vaccine Confidence Project and various other research institutions have undertaken and published regular surveys in public attitudes towards Covid-19 since Spring/Summer 2020. Although biannual surveys on attitudes towards vaccinations have been conducted for 30 years by PHE and its predecessors, this was the first time surveys have been carried out on a continual basis. Combined with the level of data consistently collected at the point of vaccination, this has made it possible to map evidence on attitudes to actual uptake, and identify populations whose confidence has increased or not. Given the nature of some of the inequalities in vaccine confidence, this sort of monitoring, and the remedial action it prompts, would not be possible if ethnic coding had not been included in the reporting requirements – a first for any UK vaccination programme.

"The Covid equalities dashboard that was developed has actually been able to help regions and systems to really drill down and look at where the vaccination take up is getting better and where there's still some gaps. For example, with the Black African and the Black Caribbean groups in particular, the numbers haven't started to go up. In fact, they're stagnating. So, we know there [are] areas where we need to do more targeted intervention."

The Covid-19 Vaccine Equalities Tool, has allowed, for the first time, a significant amount of data around health inequalities to be collected and published, confirming what people working in this field had known from experience but could not always substantively prove.[xii] We heard in the roundtable discussion that having this data collected and easily accessible has inspired wider interest in the health inequalities agenda where previously it had been difficult to co-ordinate action across the health system.

We were pleased to hear that work was underway by NHSE&I to develop a health inequalities dashboard, and that the Covid-19 Vaccine Equalities tool would be aligned with the dashboard for flu vaccination. Going forward, we strongly recommend that the same socio-demographic data which has been collected at the point of vaccination in the Covid-19 programme is also consistently reported by all providers and for all vaccinations, so that inequalities in coverage can be identified, and acted upon, across the immunisation schedule.

> **"We've been able to share the Covid vaccination dashboard information with each of the seven regions and with the 42 systems to look at where some of the gaps are, where they need to drill down further for particular groups. Where the data is an issue, they've been able to work on data quality and develop local dashboards at the ICS level or regional level."**

Crucially, newly collected data around health inequalities must lead to concerted, and well-resourced action by all actors across healthcare, public health and social care. Covid-19 has served as a unifying focus across these sectors, inspiring strong collaborative working and community engagement. It is vital that addressing inequalities is put at the front and centre of the new National Immunisation Strategy, but how the new strategy is implemented across the national, regional, local levels is going to be a real test for the new public health system.

The data-sharing between NHSE&I, PHE and Local Authority Directors of Public Health must be sustained into the future. With routine immunisation programmes, Directors of Public Health can be given access to ImmForm, which allows them to see immunisation data broken down to GP-area level. However, confusion about these permissions persist in some local areas. Local public health teams in these areas, can only access to the data around local immunisations once it has been published by PHE – a lag of several months. In contrast, for the Covd-19 immunisation programme, Directors of Public Health have had access to full range of PHE's, NHSE&I's and DHSC's dashboards.

Access to this sort of data is vital for local public health teams to carry out their scrutiny and assurance activities, and to reduce inequalities in coverage. Therefore, data sharing agreements which have been put in place through the pandemic must be sustained.

Similarly, as we explored in *Mind the Gap: London's Low Flu Vaccination Rates and How to Fix Them*, since community pharmacies were introduced as a nationally commissioned provider of flu vaccinations, accurate uptake data has been impeded by the inability of a significant number of general practices to receive digital data transfers from community pharmacies.[xiii] In 2019, the figure was put at 60%[xiv]. Other settings, such as schools and hospitals, also face issues with being able to feed vaccination data back into GP records.

However, these issues have been resolved for the Covid-19 vaccination programme by moving GPs onto the Pharmacy IT system Pinnacle as the Point of Care System to record vaccination data, and through the National Immunisation Management System which collects information about vaccinations from all settings. Vaccination event data captured within Pinnacle by PCN-designated sites and other providers flows back to the relevant GP patient record within 24 hours.[xv]

GPs are unlikely to be able to continue to use Pinnacle, so a longer-term solution to data-sharing and data flow is required. Echoing our recent paper *Improving Flu Vaccination Coverage Through the Public Health System Reforms and Immunisation Strategy*, we recommend NHSE&I work with GP and Pharmacy IT system providers to improve their ability to flow data effectively to the central database and their direct interoperability.[xvi]

Local collaboration must be encouraged.

The ease with which data has been shared between providers and across the tripartite framework of PHE, NHSE&I and local authorities has been one expression of another strength of the Covd-19 vaccination programme: strong collaborative working. As one participant put it:

> **"Our regions and systems are saying that, for the first time, a lot of the bureaucracy that prevented joint working disappeared because it made people at system and place level come together to look at their local population and look at what they needed to do together."**

Another commented that, while what works for one area will not necessarily work for another, the most significant commonalty across the country was the benefit of *"getting the local system to work together"*.

> **"That's not the health service sat in the corner, doing its own thing, and local government sat in another, and then the voluntary sector as the poor relations […] We need to get rid of all of that and bring everybody together without the organisational boundaries as a barrier."**

This participant described how, in their area, representatives from the voluntary and community sector, hospital directors, commissioners, and community health service leaders met on a weekly basis to discuss their actions and priorities for the week ahead. While perhaps not possible on such a regular basis beyond the pandemic, cross-system meetings should certainly be a fundamental feature of how 'integrated care' is achieved through ICSs.

Several other ways of embedding that sort of partnership working emerged during the discussion. These included:

- Developing single registers for patients, which can be accessed by healthcare professionals across the system and combined with data held within local government
- Hub-style models of delivery, with a wide range of practitioners working in the heart of communities alongside GPs. The Additional Roles Reimbursement Scheme was mentioned by one participant as a step towards achieving this
- Bringing GPs and pharmacies together onto the same contract for delivering vaccinations so they can more easily work in partnership and share data and stock.

We encourage DHSC and NHSE&I to review how contractual arrangements and patient registers can be amended to enable long-term partnership-working. As an increasing number of health and wellbeing hubs being set up, with a pilot of Cavell Centres underway,[xvii] ICSs should develop plans for how these hubs can be centres of place-based, interprofessional working. The extent to which they drive this should be one of the criteria by which the pilots are evaluated.

Involving people in the design and delivery of public health campaigns can promote vaccination uptake.

Another key success of the Covid-19 vaccination programme was the level of community engagement. Leaders from local government, the NHS and PHE worked in close partnership with community leaders and members of the public to design and deliver public health campaigns to improve vaccination uptake.

Our roundtable participants described how the success of the programme had depended on having "boots on the ground", listening to the questions and concerns prevalent in different communities, and developing tailored approaches accordingly. We heard several examples of healthcare professionals going out into communities, ensuring they have access not only to the vaccine itself but also to information about the vaccination from a trusted source.

The importance of trusted local messengers to building confidence in the vaccine could not be overstated by roundtable participants. That is not to say that communications at the national level are insignificant or ineffective. Rather, they are an underpinning for more targeted interventions at a local level, and ensuring there is consistency in content, while allowing for flexibility in delivery, is crucial.

As a range of organisations in the VCSE sector have sought to contribute to the response to Covid-19, there has been a wealth of resources produced, translating public health guidance and information to a wide range of groups and into different contexts. This includes people with particular health conditions or needs, religious groups, and ethnic communities. At the same time, PHE has produced its resources in 23 different languages, braille and easy to read translations.

It was clear from our discussion that tokenistic attempts at community engagement did not drive uptake. In fact, even engagement efforts that were owned by the local authority, NHS or a third sector body had been shown, in participants' experience, to be less effective than empowering communities to share resources themselves.

> **"The minute we tried the community engagement ourselves, it was destined to fail. It took about two days to figure that out. So, we simply just got a pot of cash to give to the community. We told them what we need as an outcome and to fix it in a way that they saw fit. What we ended up with was a load of information going through closed WhatsApp groups, closed Facebook groups that we'd never reach into, adverts on things like Bangla TV. Then we saw people turn up in quite massive numbers."**

It stands to reason that if this is what is required of Covid-19 vaccination programme, it would also benefit other immunisations programmes. As much of the Government funding for community champions is available until March 2022, local authorities should continue to utilise the scheme in relation to the other vaccination programmes where coverage in their area could be improved, in order to drive uptake and to evaluate the impact it can have on confidence and coverage beyond Covid-19. One participant explained that some PCNs have decided to continue employing community champions on a long-term basis, having seen their success in this year's roll-out. We encourage all PCNs to do the same to ensure community engagement remains integral to how immunisations are commissioned and delivered across the country.

It can also be helpful for healthcare professionals to have as broad a view of who a community champion is as possible. We heard, for example, that some GPs were using the 15-minute wait that patients had after receiving the vaccination to encourage them to advocate for it with their friends and family.

"One important thing that I've seen GPs do with that time is basically saying 'you're here, you've had the vaccine, how might you make other people in your communities want to come and have the vaccine? What are you hearing and how might we put you at ease?'"

Seeking opportunities to empower patients not only to take care of their own health but also to signpost others to relevant healthcare services would surely bring benefits to a wide range of other health promotion, prevention and protection programmes, including immunisations. Healthcare providers should thus explore ways of encouraging patients to become champions of services they have received. For example, when a patient is supported for an issue which relates to population health, a feedback survey sent afterwards could include the suggestion for the patient to advocate for the service to a friend or relative, with shareable resources or tips on how best to do so.

Independent academic advice should remain accessible to the public.

The role of the Science Media Centre was praised as one of the "real assets" to the vaccination programme. By hosting daily briefings throughout the pandemic which brought together scientific experts and journalists, the Centre has supported responsible reporting in the UK about the Covid-19 vaccination. This, one participant suggested, may account for why UK journalists covered the risk: benefit ratio of the AstraZeneca vaccine more accurately than parts of the press in other countries, where confidence in that vaccine had collapsed. Indeed, this example demonstrates why communications about vaccines – whether coming from Government, scientists or public health professionals – should be honest and transparent about any risks or side-effects as well as vocal about the benefits.

To support accurate, trustworthy news coverage of vaccinations, academic and research institutions should maintain science press officer roles – we heard from the Science Media Centre that those organisations which have transferred their research communications capacity into public affairs or internal communications have proved less able to get their scientific experts into the media and engage with the public. Similarly, even when commissioned by a Government department, research findings should be communicated by the scientists responsible, when they feel it is the right time to do so. Heavy political involvement in the timing or delivery of the release risks public trust in scientific research.[xviii]

Expanding the vaccinator workforce may enhance the speed of vaccine administrations.

In order to deliver Covid-19 vaccinations at scale across the country, the vaccinator workforce was expanded, with the law amended to allow registered healthcare professionals who do not normally vaccinate to do so as part of the Covid-19 and flu vaccination programmes. If Covid-19 becomes endemic and annual vaccination programmes must be run, with a potentially larger eligibility list than that for flu, then it may be necessary to permanently enable health professionals other than GP practice nurses and community pharmacists to administer adult vaccines.

An expanded vaccinator workforce, roundtable participants suggested, would increase access to other immunisations, but that this hypothesis should be properly investigated. One participant added that any additions to the workforce should be led by patient preference so that trust in the delivery remains high. Another suggested that rather than create a distinct workforce of vaccinators, any proposed solution should have flexibility and adaptability at its core:

> **"The big thing has been not being precious about 'it's got to be a Band 5 nurse competent to this level'. We're really starting to reshape some of the skills and competencies that are there. I think that's probably the way forward - how do we create a kind of resource that is there for an emergency but actually can help in normal situations?"**

To effectively expand the vaccinator programmes at times of high pressure and support catch-up programmes, or deliver on-the-spot vaccinations to those who struggle to access immunisations, Health Education England should develop training modules to upskill health professionals who do not routinely administer vaccinations. In turn, local systems should assess where, in the immunisation schedule and across the population, their coverage is lowest, and map potential touchpoints with health services which could become opportunities for vaccination. Health professionals involved in those contact points should then be supported to take up this training offer.

NHS app should be scaled up to allow patients and medical professionals to access a wide range of vaccination records.

The NHS app could also enable opportunistic vaccinations. The NHS app has been downloaded millions of times since the announcement that it would be used to display one's Covid-19 vaccination status.

Building on the app to function as a personal, digital medical record which included what vaccinations one had had across the life course.

One participant in the roundtable described how, for instance, when a child came into A&E, a doctor could check whether they had received all their vaccinations, as could anyone with multiple health professionals involved in their care, such as pregnant women, people with long-term health conditions, and children in hospital. If patients were able to give access to their medical record held in an app then, another participant remarked, it would solve a lot of the problems with data sharing that community pharmacies often face.

Expanding the NHS app is not a universal solution given that a reasonable proportion of the population are digitally excluded. Nevertheless, DHSC should explore whether the NHS app could be used to host a user's digital health record as this could increase access to vaccinations and expand the vaccinator workforce simply by utilising opportunities for on-the-spot vaccinations which already exist.

We must continue to invest in building a robust evidence base to inform future decision-making about vaccinations.

Given the importance of data highlighted throughout the discussion, participants all agreed that a thorough evaluation of each of the components of the Covid-19 vaccination programme should be undertaken. This would help make the case for the most impactful innovations to be taken forward into routine vaccination programmes, where relevant. It was added that, although rapid disseminations of case studies would be helpful in the immediate future, a more robust evidence base would be more effective in making the case to policymakers when the high level of funding which has been made available for the Covid-19 vaccination programme is no longer available for other immunisations.

> **"I think we should be collecting that data because otherwise it could be quite difficult for us as a community of advocates in this space to really put the case forward to the Government for the funding that's needed. We probably need to revisit our health economics models around the value of vaccination and all of the different elements that we need to deliver effective vaccination programmes."**

We understand that PHE (followed by the UK Health Security Agency) will continue to evaluate the programme in terms of coverage levels, inequalities in uptake, and to estimate the effectiveness of the vaccine at preventing a spectrum of disease outcomes and onwards transmission. But we would urge all organisations – including local authorities, charities, professional bodies, and community organisations, who have contributed to the vaccination programme, to evaluate the impact of their efforts and identify lessons learned.

These evaluations could begin to answer questions around what good community engagement looks like, and in which areas; and whether pop-up clinics and outreach services increase coverage levels or just choice for those who would be equally willing to go to a GP practice. RSPH is aware that work is underway to build on PHE's Vaccine Update newsletter and the Connect and Exchange Hub. As part of this, we suggest that PHE (followed by the UK Health Security Agency) collate the insights to be drawn from these evaluations and case studies and share them through the Hub.

Conclusion

It was noted at the beginning of our roundtable that many of the innovations seen during the Covid-19 vaccination programme were ones for which third-sector organisations in the immunisation space have long advocated. As one participant remarked, while no one would wish for a mass vaccination programme to be necessary, it had at least testified to the soundness of the policy recommendations which had been made with regards to routine immunisations.

But the fact that these suggestions had been implemented for the Covid-19 vaccine roll-out does not mean that the need for advocacy has disappeared. Indeed, it was clear that the possibility of defaulting back to 'business as usual' feels very real to partners across the system. Our roundtable participants could imagine how local investment in community engagement initiatives could dry up once the roll-out is complete; that efforts to reach the underserved could fade; and organisational boundaries could become impermeable again.

Given that childhood vaccination rates have been dropping in recent years, and the significant inequalities in immunisation uptake across sociodemographic characteristics, we must not miss the opportunity to embed the hard-won lessons from the Covid-19 vaccination programme more widely. Not only would this strengthen the country's protection against the infectious diseases for which we already have vaccines, but it would also ensure we have the infrastructure we need should another pandemic hit the UK.

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