Health Services Learning Hub

COVID-19: ACTION BRIEF

Title

Using community assets in primary care to increase COVID-19 vaccination uptake and maintain essential health services

Country

United Kingdom

Author

Jack Lewis, MFPH

Key Learning Themes

- Delivering COVID-19 vaccinations effectively in primary care
- The value of integration between primary care and community organizations
- Using community assets to rapidly optimize health workforce capacity

Background

As of May 2021, the UK COVID-19 vaccination programme has provided at least one dose to more than two thirds of the adult population. In the North East and Yorkshire region, uptake is over 90% in those who are aged over 50. Vaccinations are delivered by the National Health Service via a combination of large vaccination sites run by hospitals, and various sized vaccination centres run by primary care and pharmacies.

Photo: Working with the local church community – targeting homeless, asylum seekers, refugees, and our Eastern European community

What was the intervention or activity?

Invitations to receive the vaccine are sent to people either by text, letter or a phone call according to their priority group and vaccine availability. A national booking service allows users to book an appointment at a convenient time and place. While this system provides easy access for most, it is an excellent example of the inverse care law. Vulnerable people who would benefit the most from vaccination are the least likely to book using the self-service system. Digital literacy, vaccine confidence, access to transportation, language barriers, caring responsibilities - the list of friction points between eligibility and receiving the vaccine can be long. Primary care organisations making vaccine appointment phone calls found the process labour intensive, with variation in the level of effort required to secure a “yes” ranging from a quick phone call to multiple missed calls, long conversations, “not now’s” and “no’s.”

More advanced primary care organisations have established call-centre triage pathways. The initial phone call is made by an administrator and those that decline or do not answer are passed on to “health coaches” - local voluntary community sector staff and community leaders trained to address individual barriers to vaccination. As COVID-19 rates have fallen, some local governments have also had extra contact tracing staff available to act as health coaches, people who can draw on their intimate knowledge of the impact of COVID-19. Doctors and nurses are available to have more detailed conversations where any clinical input is required.

What was the outcome of this intervention?

This pathway: from administrator, to health coach, to clinician, appears effective. We have qualitative and limited quantitative evidence that the health coaches' approach decreases vaccine uptake inequalities and can successfully convert initially declined offers into vaccine appointments. The pathway saves clinician time when doctors and nurses are only speaking to the most in need of support and frees administrative capacity to focus on high volume. Clinicians and administrators in primary care are also heavily overstretched and generally benefit from the increased capacity. A secondary impact is a closer working relationship between community organizations and primary care. Health coaches have links back into the community and have been promoting the vaccine more broadly, engaging with vocal vaccine skeptics and helping primary care organizations set up vaccination clinics in community settings.

What were the key challenges involved?

Issues around information governance have delayed widespread adoption of this approach. Patient identifiable details including phone numbers and vaccination status are held by primary care and are not necessarily available to other local organizations in the health and care system wishing to establish a call-centre function.

How were these challenges overcome?

Several primary care organizations have directly employed health coaches on secondment from the voluntary care sector. We are currently working to facilitate standard data sharing agreements that would allow a wider workforce to contact those who have yet to take up the vaccination offer.
We have also begun training community organizations to have vaccine hesitancy conversations using motivational interviewing techniques as part of a "Making Every Contact Count" initiative. This ensures staff have the skills, knowledge and confidence to deliver the right messages to members of the public.

What important lessons do you wish you had known before starting?

Addressing health inequities within the vaccination programme is a combination of vaccinating as many people as quickly as possible, identifying those who have been left behind, and adjusting future vaccine delivery structures to prevent leaving anyone behind. We have learned that we can quickly go from perfect equality prior to anyone receiving the vaccine, to large differences in uptake based on ethnicity, deprivation and age. We have also learned that it is possible to simultaneously move at pace and equitably address needs. It is important for the UK’s vaccination programme to exist at scale, but have the local flexibility to work in partnership, demonstrated by the health coaches triage pathway.

What are the unmet learning needs?

We wish to understand the cost effectiveness of this intervention.