



## CYFARFOD BWRDD PRIFYSGOL IECHYD UNIVERSITY HEALTH BOARD MEETING

<b>DYDDIAD Y CYFARFOD: DATE OF MEETING:</b>	30 May 2024
<b>TEITL YR ADRODDIAD: TITLE OF REPORT:</b>	Hywel Dda University Health Board (HDdUHB) Immunisation Equity Strategic Plan
<b>CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:</b>	Dr Ardiana Gjini, Executive Director of Public Health
<b>SWYDDOG ADRODD: REPORTING OFFICER:</b>	Hannah Thomas, Specialist Registrar in Public Health Glenna Jones, Head of Nursing Health Protection and Public Health Nursing

**Pwrpas yr Adroddiad** (dewiswch fel yn addas)

**Purpose of the Report** (select as appropriate)

Ar Gyfer Penderfyniad/For Decision

### ADRODDIAD SCAA SBAR REPORT

#### Sefyllfa / Situation

Despite the significant global achievements of vaccination programmes, we know that not everyone benefits from vaccination programmes in the same way. Inequity in access to both information about vaccinations, and the vaccination itself causes disparity in uptake across our communities. As a Health Board, we have a responsibility to reduce these inequities and improve the fair distribution of vaccination uptake across the population groups. To achieve this, we must better understand the barriers our populations may encounter in accessing these health protection services, provide service that is more accessible for the underserved populations, and create sustainable solutions to adapting and tailoring our delivery methods to ensure better accessibility and acceptability of vaccines and vaccination programmes.

Through this immunisation equity strategic plan, we present our current understanding of our region in Hywel Dda University Health Board in terms of vaccination uptake, we highlight areas where further tailored work is required and outline our plan for addressing these inequalities in vaccination access and uptake. We also highlight what we know from the latest available evidence on immunisation equity and draw upon some of the excellent work already undertaken by the vaccination teams in our region to ensure that we provide an equitable service.

The Board is asked for a decision to approve the HDdUHB Immunisation Equity Strategic Plan, thus ensuring everybody living in West Wales has a fair opportunity to receive the right information, services and support to access the vaccinations for which they are eligible throughout their life, protecting the health of individuals and our communities.

#### Cefndir / Background

Welsh Government has outlined that their vision for the future of immunisation programmes in Wales is high uptake of a sustainably delivered, effective vaccine, at the right time, to reduce mortality and morbidity. The National Immunisation Framework (NIF) published in October 2022 outlines the aspiration for vaccination services are clear, that citizens know what vaccinations

they are eligible for and how to receive them. They also seek to have high uptake and equity of access and opportunity at the core of service design and provision.

The NIF states that ‘Health Boards should develop a Vaccine Equity Strategy and programme of work with dedicated public health input.’ The following principles will be used as a check list to support the development of the HDdUHB Immunisation Strategic Plan.

### Vaccination Equity Strategy Principles checklist

Provision for identifying groups with low vaccination uptake	Provision for determining barriers to uptake	Partnership working and meaningful engagement with community champions, trusted voices and third sector organisations	Co-production of tailored interventions	Evaluation of actions and interventions
✓	✓	✓	✓	✓

Figure 1: Immunisation Equity Strategy Principles (Welsh Government, 2022)

The strategic plan is guided by regional and national policies which address equity of access and broader aims around the sustainability of our plans to address population health and wellbeing. Within the Public Health Wales Vaccine Preventable Disease programme (VPDP), the dedicated public engagement and immunisation equity team work to support organisations in improving vaccination access and opportunity, as well as using surveillance data to inform action.

Inequitable vaccination uptake does not exist in isolation. Action on immunisation equity must consider the healthcare landscape and the wider determinants of health which drive individual actions. Many of determinants of health are outside the control of the healthcare system. This is an opportunity for public bodies to have a broader mindset on the ability to influence the wider complexities of health, highlighting the need for cross-sector working and collaboration to tackle the issues.

Our main challenges with achieving optimal immunisation uptake rates for our population groups are: rurality, poverty and socio-economic deprivation, access to GP services, vaccine hesitancy (alternative medicine population groups), and our population groups that are marginalised and underserved (ethnic minorities, including Roma and traveller groups), etc. detailed information on our demographics in relation to immunisation programmes is contained in the Strategic Plan paper appended to the SBAR.

### Asesiad / Assessment

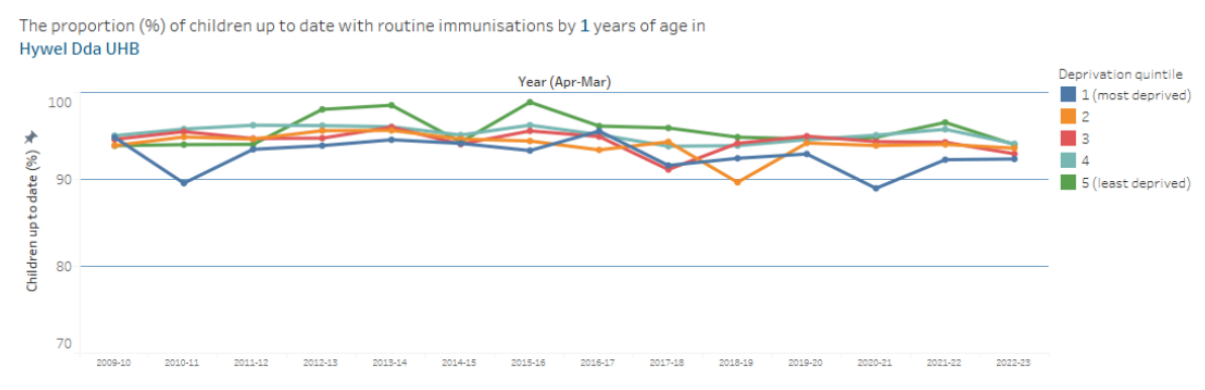
The reasons for inequity in immunisation uptake are multifactorial, but they can be addressed by first identifying and understanding the root causes. Several factors can influence immunisation equity. As the second most rural Health Board in Wales, for HDdUHB it is also important to highlight the challenge of accessing health services in rural settings. Additionally, our population has relatively limited access to public transport to enable them to travel to health settings.

Understanding our communities will enable us to tailor local interventions to their needs. Working with voluntary sector colleagues and other governmental organisations to engage with those representing underserved communities will better inform those planning services.

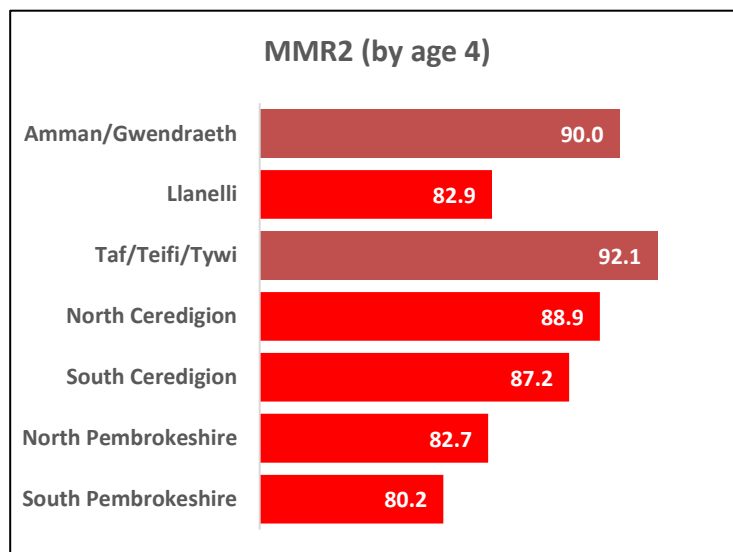
It is vital that we work in partnership with our colleagues and teams in primary care, local authorities, the voluntary sector and education to ensure that vaccination equity remains everybody's responsibility and that our approach is guided and driven by those working closely with communities. By practising vigilance in monitoring uptake rates, we can ensure early identification of inequalities and act to engage with communities to understand the barriers and enablers that meet their needs.

**WHERE ARE WE NOW**  
**HDdUHB Immunisation Data**

Having access to accurate, timely data on immunisation uptake for different population groups will ensure our approach can be monitored and evaluated. When examining the vaccination uptake for routine immunisations by 1 years of age, the data shows that the uptake gap between the most and least deprived has narrowed in the last few years; however, this has to a degree come at the cost of an overall drop in uptake. Further analysis will help understand this in more detail and enable us to identify areas of good practice which have had positive impacts.



The figure below illustrates that every GP cluster in HDdUHB fell short of the 95% target for MMR2; this is a very different pattern to the uptake of first dose of MMR; further work is needed to understand the barriers for this age group to increase pre-school uptake of the second dose of MMR.



More detailed examination of uptake rates is contained in the appended Strategic Plan.

### **What are we doing already?**

Our recent examples of innovation in practice include:

- The use of the Tenovus lorry to deliver vaccines to gypsy traveller communities in Pembrokeshire.
- Community nurse immunisers working alongside homeless outreach groups to deliver vaccines in temporary accommodation.
- Summer childhood immunisation catch up clinics targeting the electively home-educated community and looked after children.
- Training for Learning Disability nurses to administer covid and influenza vaccines to their clients at a time and place that worked best for them.
- Dedicated midwife vaccinators available at mass vaccination centres to discuss vaccines with pregnant women.

Our Immunisation Equity Strategic Plan builds on these examples, on the evidence of what works, maximising on the efforts of our vaccination and immunisation teams and taking the learning, outcomes and evaluations from these projects to develop sustainable plans for the future. Insights already gathered from the public and professionals will help us to shape an approach which considers our population and their preferences.

### **WHERE DO WE WANT TO BE?**

Our long-term aim is to achieve the recommended level of immunisation uptake (for most primary childhood immunisation this is 95% uptake of vaccination) amongst all relevant eligible population groups, to ensure all eligible individuals are able to benefit from these programmes and that we achieve (where appropriate) herd immunity levels, to better protect the community from vaccine-preventable disease.

Further to this, if lower vaccination rates are observed in particular groups, this increases the risk of outbreaks within these groups. It is, therefore, important that alongside high coverage across the whole populations, we must ensure the same high coverage for such communities.

An increasing trend, year on year to achieve the target 95% level for all primary childhood vaccines, with focus on our most under-served groups.

The approach to immunisation equity in HDdUHB must consider the need for change, and within that, the need for working co-productively with partners and stakeholders, including primary care. This will consider the elements of culture change, power dynamics and working relationships, and their underlying theories. It will build on existing relationships with the wider multi-disciplinary teams involved in delivering equitable immunisation services.

We need to consider that when working with the public, we must value their input as genuine partners, without the sense they are being patronised or controlled; we must respect their right to make their own decisions. We must review how we motivate and support our multi-disciplinary workforce, ensuring a shared vision of reducing immunisation inequities.

Research suggests that a local tailored delivery for vaccination interventions rather than a national approach meets the needs of the local population (demographically and geographically), and partnership working can increase immunisation performance, through elements such as information-sharing with local teams.

Delivery of the Immunisation Equity Strategic Plan will be measured against vaccination uptake figures and detailed actions to be taken assessed and monitored through the delivery of a detailed implementation action plan. An immunisation equity working group will enable close monitoring and delivery which will report into the Health Protection Oversight Group through the Immunisation Oversight Group.

The Hywel Dda Immunisation Strategic Plan 2024 – 2026 sets out our high-level strategic objectives with key milestones as to how we plan to tackle the deep rooted inequalities in immunisation uptake and achieve overall an increase in uptake in our population.

**Argymhelliad / Recommendation**

The Board is asked to **APPROVE** the Immunisation Strategic Plan 2024-2026, with its Strategic Objectives and milestones, for onwards submission to Welsh Government as per their request to all Wales’ Local Health Boards.

<b>Amcanion: (rhaid cwblhau) Objectives: (must be completed)</b>	
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Not Applicable
Parthau Ansawdd: Domains of Quality <a href="#">Quality and Engagement Act (sharepoint.com)</a>	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: <a href="#">Quality and Engagement Act (sharepoint.com)</a>	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	4. The best health and wellbeing for our individuals, families and communities
Amcanion Cynllunio Planning Objectives	10 Population health
Amcanion Llesiant BIP: UHB Well-being Objectives: <a href="#">Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022</a>	8. Transform our communities through collaboration with people, communities and partners 4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives

<b>Gwybodaeth Ychwanegol: Further Information:</b>	
Ar sail tystiolaeth: Evidence Base:	<p>Public Health Wales (2023) Fair access to vaccination in Wales. Available online at <a href="https://phw.nhs.wales/topics/immunisation-and-vaccines/fair-access-to-vaccination-in-wales/">https://phw.nhs.wales/topics/immunisation-and-vaccines/fair-access-to-vaccination-in-wales/</a></p> <p>Office for National Statistics (2021) <i>Census</i>. Available online at <a href="https://www.ons.gov.uk/census">https://www.ons.gov.uk/census</a></p> <p>Hywel Dda University Health Board (2018) A Healthier Mid and West Wales: Our Future Generations Living Well. <a href="https://hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/healthier-mid-and-west-wales-folder/documents/a-healthier-mid-and-west-wales-strategy/">https://hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/healthier-mid-and-west-wales-folder/documents/a-healthier-mid-and-west-wales-strategy/</a></p> <p>Hurth, V. Ebert, C. Prabhu, J. (2018). Organisational Purpose: The Construct and its antecedents and consequences. Cambridge Judge Business School. <a href="https://www.jbs.cam.ac.uk/wp-content/uploads/2020/08/wp1802.pdf">https://www.jbs.cam.ac.uk/wp-content/uploads/2020/08/wp1802.pdf</a></p> <p>Chantler, T. Bell, S. Saliba, V. Heffernan, C. Raj, T. Ramsay, M. Mournier-Jack, S. (2019). Is partnership the answer? Delivering the national immunisation programme in the new English health system: a mixed methods study. BMC Public Health. Volume 19. Pg.83. <a href="https://doi.org/10.1186/s12889-019-6400-6">https://doi.org/10.1186/s12889-019-6400-6</a>. <a href="https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-6400-6">https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-6400-6</a></p>
Rhestr Termiau: Glossary of Terms:	Noted within body of report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Cyfarfod Bwrdd Iechyd Prifysgol: Parties / Committees consulted prior to University Health Board:	<p>Immunisation Oversight Group</p> <p>Public Health Directorate Senior Leadership Team</p>

<b>Effaith: (rhaid cwblhau) Impact: (must be completed)</b>	
<b>Ariannol / Gwerth am Arian: Financial / Service:</b>	Service model delivery of all immunisation programmes will consider any financial constraints from existing budgetary allocations
<b>Ansawdd / Gofal Claf: Quality / Patient Care:</b>	It is important that there are effective plans in place for all Immunisation programmes, not only to improve overall health in the population of Hywel Dda but also to protect those at risk, prevent ill-health and minimise further impact on health and social care services.
<b>Gweithlu: Workforce:</b>	As for Quality / Patient Care impact.
<b>Risg: Risk:</b>	Risks are detailed in the report. Areas where uptake levels are lower than target will be reflected within directorate risk register.
<b>Cyfreithiol: Legal:</b>	Not Applicable
<b>Enw Da: Reputational:</b>	Approaches already undertaken in the area to encourage vaccination uptake and target interventions at groups and communities to address health inequities and inequalities.

	Communication team supporting the immunisation programmes.
<b>Gyfrinachedd: Privacy:</b>	Not Applicable
<b>Cydraddoldeb: Equality:</b>	Approaches already undertaken in the area to encourage vaccination uptake and target interventions at groups and communities to address health inequities and inequalities. Strategy designed to reduce inequities further.



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Bwrdd Iechyd Prifysgol  
Hywel Dda  
University Health Board

# **Immunisation Equity Strategic Plan 2024 - 2026**

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## Executive Summary

Despite the significant global achievements of vaccination programmes, we know that not everyone benefits from vaccination programmes in the same way. Inequity in access to both information about vaccinations, and the vaccination itself causes disparity in uptake across our communities. As a Health Board, we have a responsibility to reduce these inequities and improve the fair distribution of vaccine uptake across the life course. To achieve this, we must better understand the barriers our populations may encounter in accessing these health protection services and create sustainable solutions to adapting and tailoring our delivery methods to ensure better accessibility and acceptability of vaccines and vaccine programmes.

Through this immunisation strategic plan, we present our current understanding of vaccination uptake in our (HDUHB) region, we highlight areas where further tailored work is required, and outline our plan for addressing these inequalities in vaccination access and uptake. We also highlight what we know from the latest available evidence on immunisation equity and draw upon some of the excellent work already undertaken by the vaccination teams in our region to try and ensure that we provide an equitable service.

Our overall goal is to ensure that:

***Everybody living in Hywel Dda University Health Board has a fair opportunity to receive the right information, services, and support to access the vaccinations for which they are eligible throughout their life, protecting the health of individuals and our communities.***

This strategic plan provides the opportunity for us to reflect on our work to date, build on our existing networks with stakeholders and identify ways to continue to strive towards our goal. We welcome this chance for renewed engagement and enthusiasm from our teams and communities and encourage a two-way communication on improving immunisation equity so that we continue to learn and develop.

Our approach will take a whole systems approach, with a fundamental focus on the wider determinants of health.

## I. Introduction

Vaccination remains one of the most successful public health interventions as they prevent illness, disability and death and reduce healthcare costs. Vaccines are critical to the prevention and control of many communicable diseases. Optimising vaccine uptake is crucial in an age of growing antimicrobial resistance and global travel<sup>1</sup>

Welsh Government has outlined their vision for the future of immunisation programmes in Wales is high uptake of a sustainably delivered, effective vaccine, at the right time, to reduce mortality and morbidity. The National Immunisation Framework published in October 2022 outlines the aspiration for vaccination services are clear, that citizens know what vaccinations they are eligible for and how to receive them. They also seek to have high uptake and equity of access and opportunity at the core of service design and provision.

The National Immunisation Framework (NIF) sets out priorities for health boards to develop vaccination services that are fit for the future with a drive towards six focus areas<sup>2</sup>. These include:

- vaccination equity
- digitally enabled vaccination
- eligibility
- public vaccination literacy
- deployment
- governance

The NIF states that 'Health Boards should develop a Vaccine Equity Strategy and programme of work with dedicated public health input.' The following principles will be used as a check list to support the development of the Hywel Dda UHB strategic plan.

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<sup>1</sup> Andre, F. E., Booy, R., Bock, H. L., Clemens, J., Datta, S. K., John, T. J., Lee, B. W., Lolekha, S., Peltola, H., Ruff, T. A., Santosham, M., & Schmitt, H. J. (2008). Vaccination greatly reduces disease, disability, death and inequity worldwide. *Bulletin of the World Health Organization*, 86(2), 140–146.

<sup>2</sup> Welsh Government (2022) National Immunisation Framework for Wales. Available online at <https://www.gov.wales/sites/default/files/publications/2022-10/national-immunisation-framework-for-wales.pdf>

## Vaccination Equity Strategy Principles checklist

Provision for identifying groups with low vaccination uptake	Provision for determining barriers to uptake	Partnership working and meaningful engagement with community champions, trusted voices and third sector organisations	Co-production of tailored interventions	Evaluation of actions and interventions
✓	✓	✓	✓	✓

Figure 1: Vaccine Equity Strategy Principles (Welsh Government, 2022)

## II. Purpose

This strategic plan will guide Hywel Dda University Health Board (HDUHB) in implementing the recommendations of the NIF at a regional level. We will identify areas of inequity in vaccine provision and outline an action plan to increase equity and uptake of routine vaccinations in our communities. It will illustrate how we will work collaboratively with partners in other organisations and the voluntary sector to ensure a community-centric and tailored delivery model that meets the needs of everyone living within our Health Board area.

It builds on work we are already undertaking to reduce inequities in vaccine access across Hywel Dda, including initiatives developed during delivery of the Covid-19 vaccine. It will identify specific areas to focus on over the next three years to enable us to strive for equitable vaccination uptake across our population. Using Welsh Government targets and key performance indicators, we will measure our successes against these primarily through immunisation uptake data. In developing and delivering on an action plan, we aim to reduce the burden of vaccine preventable disease on our communities and health system in an equitable way through collaborative working.

## III. Strategic Context

The strategic plan is guided by regional and national policies which address equity of access and broader aims around the sustainability of our plans to address population health and wellbeing.

Within the Public Health Wales Vaccine Preventable Disease programme (VPDP), the dedicated public engagement and immunisation equity team work to support organisations

in improving vaccine access and opportunity, as well as using surveillance data to inform action<sup>3</sup>.

In *A Healthier Mid and West Wales: Our Future Generations Living Well*, Hywel Dda University Health Board set out plans to provide a safe, sustainable, accessible, and kind healthcare service<sup>4</sup>.

The NIF advocates for a core immunisation workforce within each health board to improve uptake and reduce inequity by providing in reach, outreach, targeted intervention, outbreak management and expert advice and support.

We will ensure our immunisation services provide equity in vaccine provision, with tailored delivery models that serve our population in all phases of their life.

The Wellbeing of Future Generations Act (2015) aims to empower organisations to look at the long-term wellbeing and health of the population of Wales. It highlights a more equal Wales as one of its seven goals and highlights the importance of working in partnership with communities to reduce health inequalities.

This work will consider the sustainable development principle and the potential impact on the future of people living in Wales, as outlined by the Well-being of Future Generations Act (2015).

## IV. What does the evidence tell us?

### Wider Determinants of Health

Inequitable vaccination uptake does not exist in isolation. Action on immunisation equity must consider the healthcare landscape and the wider determinants of health which drive individual actions. Many of determinants of health are outside the control of the healthcare system. This is an opportunity for public bodies to have a broader mindset on the ability to influence the wider complexities of health, highlighting the need for cross-sector working and collaboration to tackle the issues.

Health inequalities are the systematic differences in the status of people's health and can include differences in access and quality of care, health status and opportunities to lead healthy lives. They can also arise because of the conditions in which we are born, grow, live, work and age, the "wider determinants of health". These conditions affect our

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<sup>3</sup> Public Health Wales (2023) Fair access to vaccination in Wales. Available online at <https://phw.nhs.wales/topics/immunisation-and-vaccines/fair-access-to-vaccination-in-wales/>

<sup>4</sup> Hywel Dda University Health Board (2018) *A Healthier Mid and West Wales: Our Future Generations Living Well*. <https://hduhb.nhs.wales/about-us/healthier-mid-and-west-wales/healthier-mid-and-west-wales-folder/documents/a-healthier-mid-and-west-wales-strategy/>

opportunities for health, how we think, feel and act and this shapes our mental health, physical health and wellbeing.

Delivering immunisation equity requires a holistic approach, taking into consideration the wider determinants of health. Poor educational attainment, housing and employment impact people's health and the decisions that they make regarding their health and wellbeing, including preventative measures such as vaccination. It is important to recognise that inequalities are not inevitable, and evidence shows that there is the ability to make a difference to the health of communities when combining a comprehensive, multifaceted approach to tackle the inequalities.

Provision of equitable vaccine services means ensuring that barriers associated with the socio-economic determinants of health are minimised to enable all communities to have access to services that can protect their health, such as immunisations. 'Access' needs to consider physical location, timings, communications, cultural acceptability, and several other factors which are important to communities.

### **How can we address vaccine inequity- what works?**

Understanding our communities will enable us to tailor local interventions to their needs. Working with voluntary sector colleagues and other governmental organisations to engage with those representing underserved communities will better inform those planning services. By practising vigilance in monitoring uptake rates, we can ensure early identification of inequalities and act to engage with communities to understand the barriers and enablers that meet their needs. In HDUHB our Community Development Outreach Team (CDOT) identify under-represented and under-served communities, aiming to 'make every contact count' by having vaccination conversations, while developing effective professional relationships within the communities. It is vital that we work in partnership with our colleagues and teams in primary care, local authorities, the voluntary sector, and education to ensure that vaccination equity remains everybody's responsibility and that our approach is guided and driven by those working closely with communities.

Education is essential to overcome vaccine hesitancy. As an organisation, we must play our part to build trust in vaccine programmes from an early age through our pre-school and school-based programmes, which include, the Healthy and Sustainable Pre-schools Scheme, Health Promoting Schools, and the School Nursing Service. We need to normalise immunisation and be honest about potential side effects, reassure our communities about vaccine safety and challenge misinformation in a meaningful way, ensuring that information is available in accessible formats that are tailored for different audiences. Ensuring our health workforce can make every contact count and have confident vaccine conversations with service users is one way that we can instil trust in vaccination programmes in our communities.

## Factors influencing equitable access to vaccination.

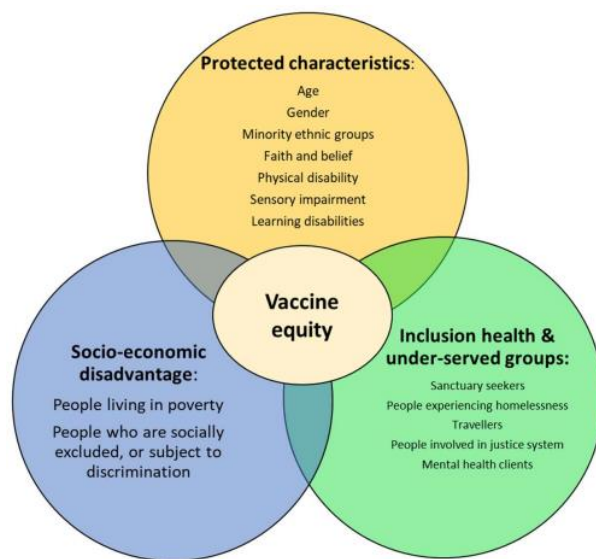


Figure 2: Factors which influence vaccine equity (Welsh Government, 2021)

The reasons for inequity in immunisation uptake are multifactorial, but they can be addressed by first identifying and understanding the root causes. Several factors can influence immunisation equity. As the second most rural Health Board in Wales, for Hywel Dda it is also important to highlight the challenge of accessing health services in rural settings. Additionally, our population has relatively limited access to public transport to enable them to travel to health settings.

For vaccination uptake, research highlights that people from different sociodemographic groups and culture are motivated by varied reasons. Solutions to support the whole community must take into consideration approaches which are culturally sensitive, evidence-based and co-created with communities<sup>5</sup>.

### Vaccination uptake: Barriers and facilitators

To promote immunisation equity, we need to understand barriers to vaccination, and develop solutions so all people can be vaccinated regardless of their income, education, age, geography, ethnicity, religion or beliefs.

#### Barriers

Several models have been used to understand the determinants of vaccination uptake. For example, the 3c model maps the main barriers for vaccination uptake: confidence,

<sup>5</sup> Robertson E, Reeve KS, Niedzwiedz CL, Moore J, Blake M, Green M, Katikireddi SV & Benzeval MJ. (2021) Predictors of COVID-19 vaccine hesitancy in the UK household longitudinal study. *Brain Behav Immun.* 94:41-50

complacency, and convenience<sup>6</sup>. Whereas the 'Increasing Vaccination Model'<sup>7</sup> considers elements including social networks and hesitancy.

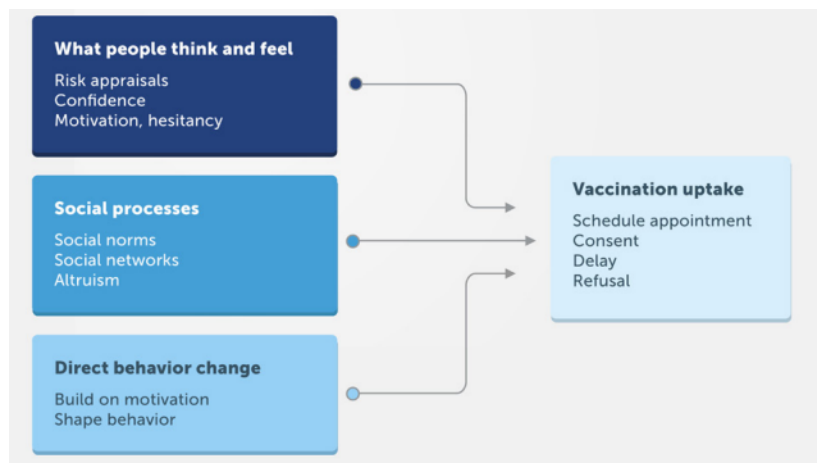


Figure 3: Increasing Vaccination Model

There are several reasons for areas of low vaccination uptake. These can range from language barriers, a particular area of focus for our communities with Welsh as a first language, difficulties in the appointment booking process as well as challenges in reaching vaccination locations. The Covid-19 pandemic provided examples of how barriers and facilitators were considered for the Covid-19 vaccination programme, there were groups within the UK population with higher levels of vaccination hesitancy. These included those with lower education levels, as well as black, Pakistani and Bangladeshi ethnic groups.

Other examples of vaccination hesitancy can be seen for particular vaccines, including MMR. Giving rise to periodic outbreaks of measles. Understanding the reasons for low vaccination uptake at a local level is crucial to developing a tailored action plan.

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<sup>6</sup> World Health Organisation. 2014. Report of the SAGE working group on vaccine hesitancy. [https://www.who.int/immunization/sage/meetings/2014/october/1\\_Report\\_WORKING\\_GROUP](https://www.who.int/immunization/sage/meetings/2014/october/1_Report_WORKING_GROUP)

<sup>7</sup> Brewer, N. T., Chapman, G. B., Rothman, A. J., Leask, J., & Kempe, A. (2017). Increasing Vaccination: Putting Psychological Science Into Action. *Psychological Science in the Public Interest*, 18(3), 149-207. <https://doi.org/10.1177/1529100618760521>

## Vaccination hesitancy

*Vaccination hesitancy refers to delay in acceptance or refusal of vaccines despite availability of vaccination services. Vaccination hesitancy is complex and context specific, varying across time, place and vaccines<sup>8</sup>.*

The World Health Organisation describe vaccination hesitancy as resulting from one or combination of three factors:

- Confidence – the level of trust in the safety and effectiveness of the vaccine itself and the provider of the vaccination.
- Complacency – indicates a perception that the vaccination is not needed or that the illness it prevents is not serious.
- Convenience – delivery of the vaccination in a convenient setting that is easy for parents and children to access.

Mistrust of governing bodies and drug companies contributes to vaccination hesitancy, and marginalised communities may avoid vaccination because of historically negative experiences with healthcare or a lack of effective health messaging<sup>9</sup> and greater access, availability, and improvements to vaccines alone are insufficient. Decision makers must also take steps to increase vaccination uptake. While some of the world is at risk of low access to vaccines, all the world is at risk of low uptake<sup>10</sup>.

## Facilitators

Elements of an immunisation equity strategy will need to be tailored to each target group. Vaccination services need to be accessible and convenient, which will mean something

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<sup>8</sup> World Health Organisation (2014) Strategies for addressing vaccine hesitancy - a systematic review (Microsoft Word - 3\_ SAGE WG \226 Strategies for addressing vaccine hesitancy \226 Final copy\_17Oct 2014.docx) (who.int)

<sup>9</sup> Cole J, Dodds K, Mkrтчhyan H, Ayikoru M. (2021). Unpacking vaccine “hesitancy:” the spectrum of vaccine acceptance. *BMJ Open*. Cited in Lazarus J V, Karim S S A, Batista C, Rabin K, El-Mohandes A. Vaccine inequity and hesitancy persist—we must tackle both *BMJ* 2023; 380 :p8 doi:10.1136/bmj.p8. <https://www.bmj.com/content/380/bmj.p8>

<sup>10</sup> Razai MS, Osama T, McKechnie DGJ, Majeed A. (2021). Covid-19 vaccine hesitancy among ethnic minority groups. *BMJ Open*. doi:10.1136/bmj.n513 pmid:33637577. Cited in Lazarus J V, Karim S S A, Batista C, Rabin K, El-Mohandes A. Vaccine inequity and hesitancy persist—we must tackle both *BMJ* 2023; 380 :p8 doi:10.1136/bmj.p8. <https://www.bmj.com/content/380/bmj.p8>

different for everyone<sup>11</sup>. For care home staff, successful interventions include addressing negative beliefs and concerns as well as challenging misconceptions<sup>12</sup>.

Faith-based organisations can play a role in facilitating vaccination uptake particularly for those from racial or ethnic minority populations<sup>13</sup>. Successful approaches include elements of education and enablement.

### **The COM-B behaviour change model**

The COM-B framework for behaviour change can be used to develop equitable systems that enable interventions to be successful. It considers the elements which determine behaviour and recognises that it is a result of several factors, namely Capability, Opportunity and Motivation. We will use this framework to help us to understand the drivers and barriers to vaccination uptake, identify barriers and direct action and solutions.

#### **Capability**

We must ensure our communities have the knowledge and skills to access vaccines when they need them. Those with protected characteristics must have their needs met to enable and empower them to access vaccines easily by removal of avoidable barriers, whether they be physical or psychological.

‘Capability’ can be further segmented into physical capability (e.g., can individuals get to a vaccination clinic?) and psychological capability (e.g. is there good understanding about the safety of the vaccine?)

#### **Opportunity**

We must ensure clients have the time and resources to access vaccines. Clinics should be available when and where people can attend. Across Hywel Dda, over 15% of households have no car or van accessible to them according to 2021 Census data. When considered against the backdrop of our rurality, especially in Ceredigion, access to GP services and vaccination clinics may be a barrier to uptake. With poor or no public transport links in our most rural areas, rural communities may be disproportionately affected by decisions made regarding vaccination delivery. These are examples where ‘pop-up’ clinics can help to meet need, as well as opportunities for further data analysis when considering distance travelled to GP surgery.

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<sup>11</sup> NHS England (2023) Shaping the future delivery of NHS vaccination services. Available online at <https://www.england.nhs.uk/wp-content/uploads/2023/12/PRN00339-nhs-vaccination-strategy.pdf>

<sup>12</sup> Alsaif F, Twigg M, Scott S, Blyth A, Wright D & Patel A. (2023) A systematic review of barriers and enablers associated with uptake of influenza vaccine among care home staff. *Vaccine*. 6;41(42):6156-6173.

<sup>13</sup> Syed U, Kapera O, Chandrasekhar A, Baylor BT, Hassan A, Magalhães M, Meidany F, Schenker I, Messiah SE & Bhatti A. The Role of Faith-Based Organizations in Improving Vaccination Confidence & Addressing Vaccination Disparities to Help Improve Vaccine Uptake: A Systematic Review. *Vaccines (Basel)*. 15;11(2):449.

Vaccination resources should be available in a format that enables all communities to develop knowledge and make informed decisions. Written leaflets should be available in Welsh, as well as in other languages where required, in an easy read format, and videos should be used to meet the needs of those whose level of literacy means written information is not easily accessible.

'Opportunity' can include the social opportunity e.g. *what are the social or community norms around vaccination or vaccination hesitancy?*

## **Motivation**

'Automatic' motivation may consider that individuals or groups may experience fear when contemplating vaccination. These feelings need to be treated with compassion, as well as recognising that such feelings may be unfairly spread across communities. This provides a chance to consider how our approach may be tailored.

## V. Where are we now?

### Our population

HDUHB comprises the three counties of Carmarthenshire, Ceredigion, and Pembrokeshire, with a Census 2021 total population estimate of 382,700<sup>14</sup>.

County	Population estimate, Census 2021	Population density (residents per square kilometre)
Carmarthenshire	187,900	79
Pembrokeshire	123,400	70
Ceredigion	71,500	40
<b>Total</b>	<b>382,700</b>	<b>66</b>

The population-density of HDUHB differs by local authority area, with significant rurality in Ceredigion, with 40 residents per square kilometre; rurality is a key element to consider when looking at understanding and addressing immunisation equity, taking into consideration the potential for challenges in accessing vaccination appointments. Other factors to consider are the trends in internal and international migration and how these might impact vaccination coverage in the region. International migration to West Wales is similar to the Welsh Average. Net migration to HDUHB for the period 2021-22 was 609 equating to 1.4% of population increase for the period (Wales net increase 1.05%). European migration into the region comes predominantly from Poland, and more recently from Ukraine. An understanding of the current and projected population levels in HDHB, along with the projected changes, will help to ensure that vaccination planning can take these factors into account; this is particularly relevant when considering the different routine vaccination schedules in different countries. Sources such as the Census 2021 can help inform our understanding, alongside real-time data on vaccination uptake.

Usual resident population in Wales by country of birth and area

Source: ONS, census 2021

	United Kingdom		Europe (non-UK)		Africa		Middle East and Asia		The Americas and the Caribbean		Antarctica and Oceania		TOTAL POPULATION
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	
Wales	2,892,065	93.1	100,142	3.2	28,760	0.9	69,328	2.2	12,631	0.4	4,573	0.1	3,107,499
Ceredigion	66,431	92.9	2,797	3.9	533	0.7	1,128	1.6	429	0.6	165	0.2	71,483
Pembrokeshire	117,408	95.2	3,332	2.7	656	0.5	1,288	1.0	491	0.4	193	0.2	123,368
Carmarthenshire	178,385	94.9	5,615	3.0	934	0.5	2,141	1.1	554	0.3	259	0.1	187,888

### Deprivation

Deprivation is the lack of access to opportunities and resources, which we might expect in our society. This can be in terms of material goods or the ability of an individual to participate in the normal social life of the community. The Welsh Index of Multiple Deprivation (WIMD) is the official measure of relative deprivation, calculated for small areas (with average populations of 1600), known as Lower Super Output Areas (LSOAs). It identifies the LSOAs with the highest concentrations of several different types of deprivation including income,

<sup>14</sup> Office for National Statistics (2021) *Census*. Available online at <https://www.ons.gov.uk/census>

employment, health, access to services, physical environment, housing, and community safety. All the LSOAs in Wales are ranked from 1 (most deprived) to 1909 (least deprived).

Ten LSOAs in HDUHB are in the most deprived 10%, predominantly in Carmarthenshire and Pembrokeshire.

LSOA Name	Local Authority	WIMD Rank (out of 1909 across Wales)
<i>Tyisha 2</i>	Carmarthenshire	17
<i>Pembroke Dock: Llanion 1</i>	Pembrokeshire	62
<i>Glanymor 4</i>	Carmarthenshire	68
<i>Haverfordwest: Garth 2</i>	Pembrokeshire	71
<i>Bigyn 4</i>	Carmarthenshire	84
<i>Pembroke: Monkton</i>	Pembrokeshire	85
<i>Aberteifi/Cardigan - Teifi</i>	Ceredigion	125
<i>Tyisha 3</i>	Carmarthenshire	144
<i>Pembroke Dock: Central</i>	Pembrokeshire	148
<i>Llwynhendy 3</i>	Carmarthenshire	172

Further to this, Appendix 1 includes examples of the demographics of those living in the most deprived 20% of WIMD, providing insight into these communities and some of the elements which need to be considered in terms of immunisation equity. Our more deprived communities in HDUHB tend to have younger populations, for example families with children, and are more likely to reside in urban settings.

### Groups to consider:

Our understanding of our population in HDUHB needs to consider its diversity. Pembrokeshire has both the highest percentage of people identifying as Gypsy/Roma travellers and the second highest proportion of armed forces veterans in Wales. Over 15% of our population have no car or van in their household and our population is ageing; with our over 65-year-old population increasing faster than the under 15-year-old population. Additionally, the table below provides figures on the breakdown of Ethnic Minority Groups across Hywel Dda UHB from the 2021 Census.

Area	Asian, Asian British or Asian Welsh	Black, Black British, Black Welsh, Caribbean or African	Mixed or Multiple Ethnic groups	White	Other ethnic groups
Wales	2.9%	0.9%	1.6%	93.8%	0.9%
HDdUHB	1.2%	0.3%	1.0%	97.0%	0.4%
Carmarthenshire	1.2%	0.2%	0.9%	97.2%	0.4%
Ceredigion	1.5%	0.5%	1.2%	96.2%	0.5%
Pembrokeshire	0.9%	0.2%	0.9%	97.6%	0.3%

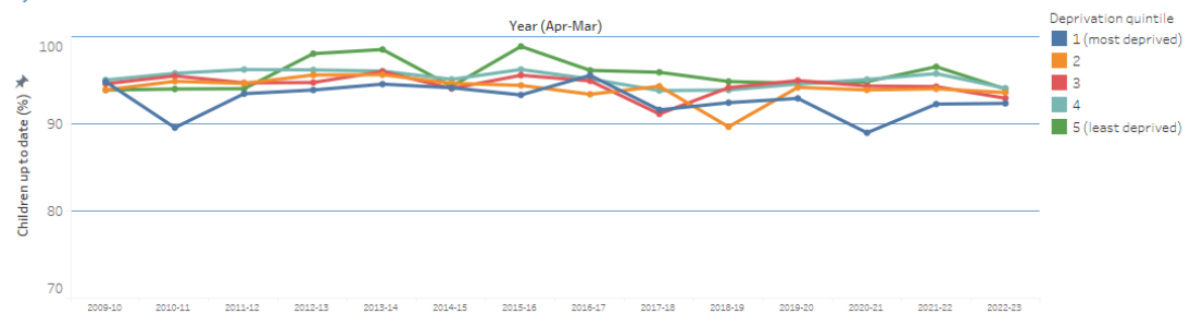
## Individuals who are immunocompromised

Other key groups to consider include those who are immunocompromised, a particular target group for vaccines including Covid-19 and shingles. Our most recent data highlighted that the Covid-19 immunisation uptake in the immunosuppressed group was 52.9%, the lowest rate for this group in Wales. Given the risks posed to this group by vaccine-preventable diseases, our work must seek to better understand any barriers to vaccination uptake.

## HDUHB Immunisation Data

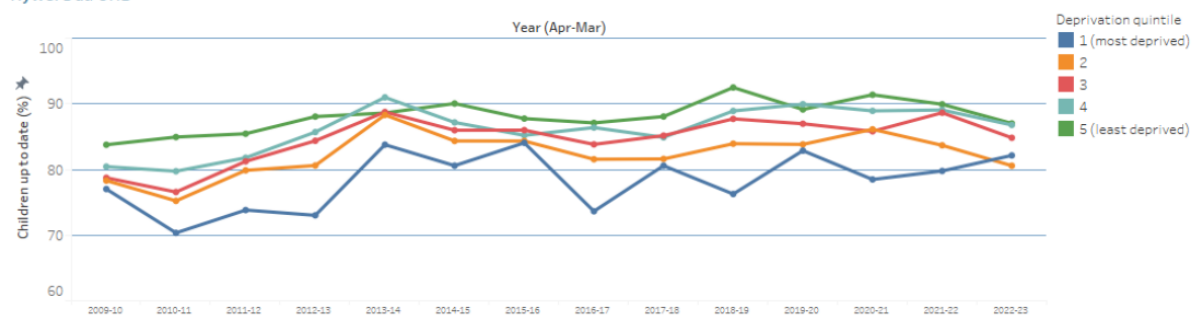
Having access to accurate, timely data on vaccination uptake for different population groups will ensure our approach can be monitored and evaluated.

The proportion (%) of children up to date with routine immunisations by 1 years of age in Hywel Dda UHB



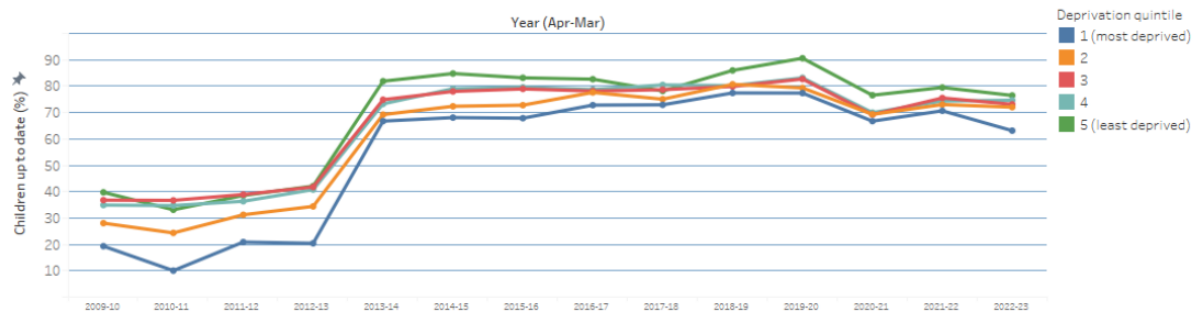
When examining the vaccination uptake for routine immunisations by 1 years of age, the data suggests that the uptake gap between the most and least deprived has narrowed. Further analysis will help understand this in more detail and enable us to identify areas of good practice which have had positive impacts.

The proportion (%) of children up to date with routine immunisations by 4 years of age in Hywel Dda UHB



The underlying drivers of differences in uptake need to be better understood. Further analysis needs to consider the factors which may cause a drop in uptake from those aged 1 to those aged 4; these could be factors such as attendance at nursery and parental employment status.

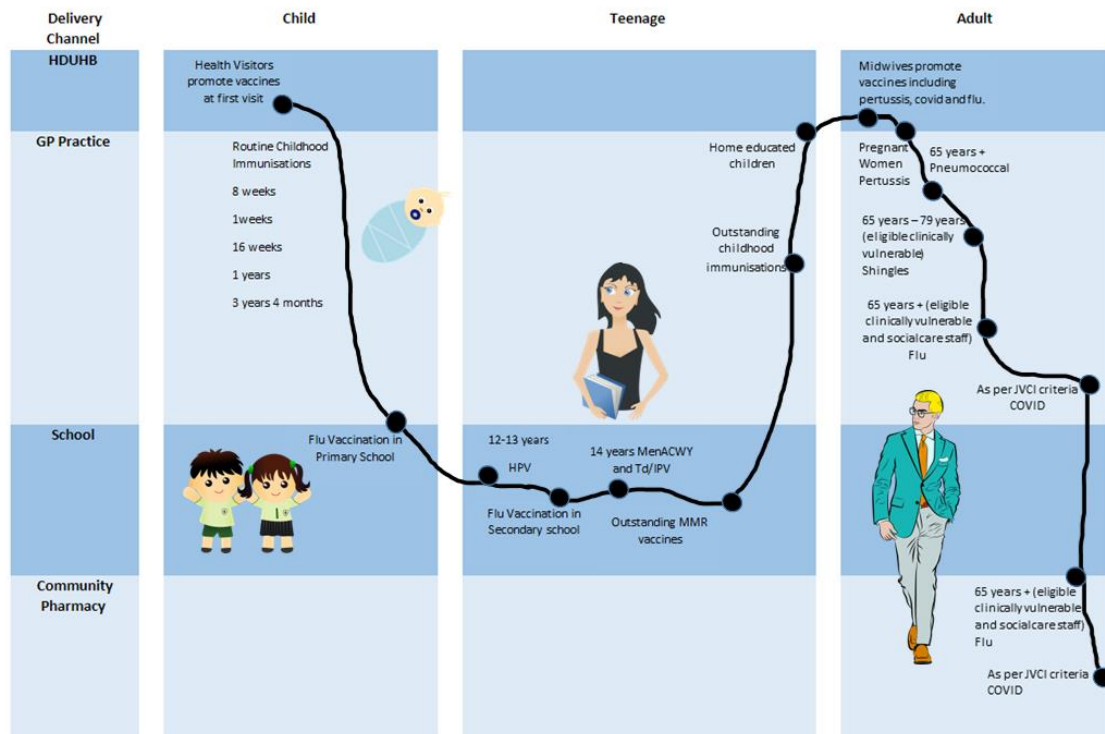
The proportion (%) of children up to date with routine immunisations by 15 years of age in Hywel Dda UHB



In HDUHB, teenage vaccines are delivered by the school nursing team to children in school. This delivery method is a way in which HDUHB is encouraging improved uptake, which can also demonstrate reductions in the gap between most and least deprived. Again, better understanding this data will enable more targeted interventions in the future.

### Current Delivery Model

Vaccination is delivered by multi-disciplinary teams in various settings. The Health Board is charged with delivering the UK Schedule of Immunisations on behalf of the Welsh Government as either population-based call-recall programmes (e.g., childhood, teenage adult immunisations), or targeted (selected) programmes (e.g. groups at risk, e.g. Hep B, BCG, etc), or chronic conditions targeted vaccinations. The schedule includes immunisation throughout the life course, encompassing routinely scheduled vaccines, selective immunisation programmes, and additional immunisation programmes for those with underlying health conditions.



## What are our current vaccination rates?

### Childhood Immunisations

Surveillance of uptake and equity of routine childhood vaccinations in Wales is led by Public Health Wales Vaccine Preventable Disease Programme through the national COVER scheme (Cover of Vaccinations Evaluated Rapidly). COVER reports are published on a quarterly basis and summarise vaccination uptake for children and young people reaching key birthdays in each quarter. An annual COVER report is produced summarising coverage of vaccinations for children and young people reaching key birthdays during the 12-month period April to March.

National Institute for Health and Clinical Excellence (NICE) and Joint Committee on Vaccination and Immunisations (JCVI) recommend 95% vaccination coverage target for UK routine childhood vaccination programmes, with at least 90% coverage in each defined area (if otherwise not considered at risk).

### Recent data on childhood immunisations

Our most recent report highlighted that for the July to September 2023 quarter, uptake of immunisations in infants by the first birthday slightly decreased across all immunisations. Uptake of the complete three-dose course of “6 in 1” has remained below 95% for this quarter in Hywel Dda, as it has across all other Health Boards in Wales.

Coverage of one dose of Measles, Mumps and Rubella (MMR) at two years in Hywel Dda was 92.7% (all-Wales 93.3%).

The proportion of children who were up to date with their routine immunisations by four years of age slightly increased this quarter from 84.5% to 84.7% at an all-Wales level. Here in Hywel Dda our uptake has increased from 82.0% in Quarter 2 of 2023 to 83.4% in Quarter 3 but remains below the all-Wales average.

Figure 5 illustrates that every GP cluster in Hywel Dda fell short of the 95% target for MMR2; this is a very different pattern to the first dose delivery; further work is needed to understand the barriers for this age group to increase pre-school uptake of the second dose of MMR.

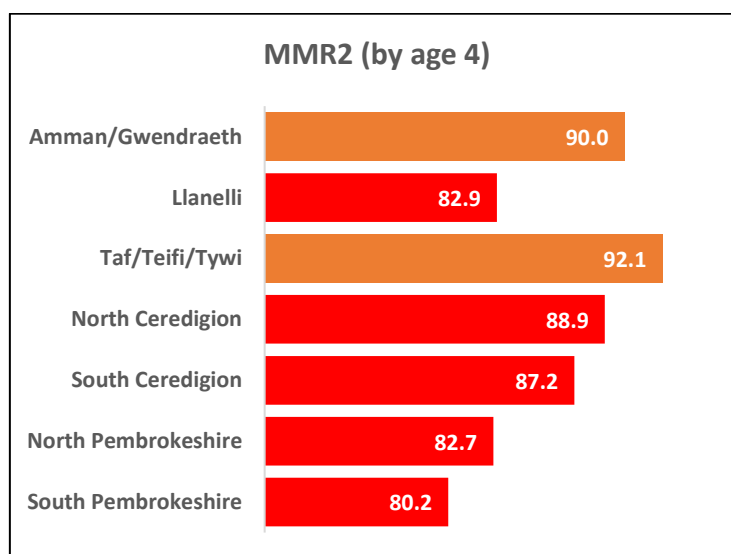


Figure 5: Percentage uptake of second dose of MMR by GP Cluster in Hywel Dda UHB in Quarter 2, 2023

Figure 6: Percentage uptake of second dose of MMR in Hywel Dda UHB by deprivation quintile, 2018-2023

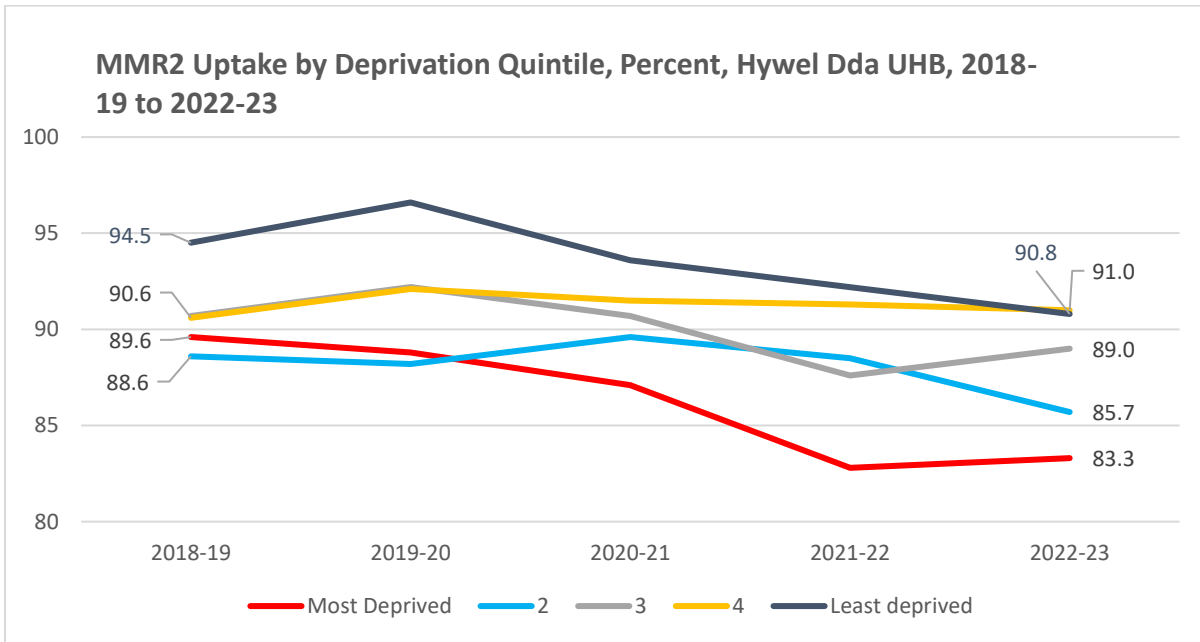


Figure 6 illustrates the difference between our most and least deprived areas against uptake of MMR 2 vaccine which indicates that it is our most deprived communities with the least uptake for their second dose.

**What are we doing already?**

Our recent examples of innovation in practice include:

- The use of the Tenovus lorry to deliver vaccines to gypsy traveller communities in Pembrokeshire.
- Community nurse immunisers working alongside homeless outreach groups to deliver vaccines in temporary accommodation.
- Summer childhood immunisation catch up clinics targeting the electively home - educated community and looked after children.
- Training for Learning Disability nurses to administer covid and influenza vaccines to their clients at a time and place that worked best for them.
- Dedicated midwife vaccinators available at mass vaccination centres to discuss vaccines with pregnant women.

Our approach to equitable immunisation programmes strives to achieve:

- A similar uptake of routine vaccines across those with protected characteristics as those without.

- Vaccination clinic delivery in our most rural communities using alternative means, such as pop-up clinics in village halls, nurseries or farmers markets.
- Working alongside third sector partners to attend soup kitchens and other outreach opportunities to offer vaccination to those experiencing homelessness.
- Working with our CDOT team to identify which languages we may need to offer vaccination information in to reach our ethnic minority population.

### **Putting strategy into action: Local examples of striving towards equitable vaccination provision in HDUHB**

Across the Hywel Dda University Health Board region, we have seen excellent examples of teams adapting their approach to reach communities and individuals who have historically faced challenges in access to vaccination and to generally maximise vaccination uptake. Some of these examples are highlighted below.

- Advocacy and engagement: I&V public health attendance at local forums in 2023 to relay vaccination messages and provide basic vaccination information to those working with 'hard-to-reach' groups such as the homeless and migrants.
- We delivered teaching with the Community Development Outreach Team (CDOT) to provide a foundational knowledge of vaccination provision and eligibility. This has improved their confidence in vaccination conversations with clients and the communities they serve.
- The Community Immunisation Team coordinate bespoke vaccination sessions as needs are identified by Local Authorities, Third sector and the CDOT team.
- The Community Immunisation Team continue to support primary care with childhood immunisations, monitoring queue lists, data cleansing of child health records and offering support to reach marginalised individuals.
- A vaccination champion programme was introduced to care homes in collaboration with the Regional Health Protection Team, to raise the profile and knowledge of immunisation in care staff.
- Training Learning Disability nurses to administer covid and influenza vaccines to their clients at a time and place that works best for them during the Covid 19 pandemic period.
- Provision of a domiciliary immunisation service for hard-to-reach families.
- The use of the Tenovus lorry to deliver Covid-19 and flu vaccines to gypsy traveller communities in Pembrokeshire during 2022.
- A pilot scheme to reach 3-year-olds in local authority nursery settings in our lowest uptake areas. There was a good response and uptake was excellent. An extension to the pilot is planned for 2024/5.
- Delivering consistent communications and messaging on childhood vaccines and digitally accessible resources.

Our Immunisation equity Strategy will build on these examples, maximising on the efforts of our vaccination and immunisation teams and taking the learning, outcomes and evaluations from these projects to develop sustainable plans for the future. Insights already gathered from the public and professionals will help us to shape an approach which considers our population and their preferences.

## VI. Where do we want to be?

Our long-term aim is to achieve a 95% uptake of vaccines in all areas to ensure herd immunity levels are reached and to better protect the community from vaccine-preventable disease.

Further to this, if lower vaccination rates are observed in particular groups, this increases the chance of outbreaks within these groups. It is therefore important that alongside high coverage across the whole populations, we must ensure the same high coverage for such communities.

An increasing trend, year on year to achieve the target 95% level for all primary childhood vaccines, with focus on our most underserved groups.

### **Tailoring our approach**

Delivering equitable services ensures that all groups in our community can access vaccines in a way that meets their needs. To enable equity, we must engage with our population to understand barriers to vaccination uptake and work together on solutions to overcome these and develop tailored approaches.

Throughout the Covid-19 pandemic, HDUHB used opportunities to think innovatively and collaborate more effectively with our communities and the organisations which serve them. The Immunisation equity Group provided a forum for third sector organisations, local authorities and health services to meet and plan delivery of the Covid-19 vaccination programme to ensure all groups in our population had equality of opportunity to receive their vaccines. It provided a reporting structure to enable issues to be escalated and acted upon. This group has now evolved into a broader group considering equity across all services.

Research into Covid-19 vaccination uptake in Wales suggested that although uptake of the primary dose in Wales was around 92.1%, significant inequalities were observed across several groups including those born outside of the UK and those with a history of substance misuse<sup>15</sup>. This serves as an example for the need to tailor approaches to vaccination.

### **A partnership approach.**

The approach to immunisation equity in Hywel Dda must consider the need for change, and within that, the need for working co-productively with partners and stakeholders, including primary care. This will consider the elements of culture change, power dynamics and working relationships, and their underlying theories. It will build on existing relationships with the wider multi-disciplinary teams involved in delivering equitable vaccination programmes.

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<sup>15</sup> Jones G, Perry M, Bailey R, Arumugam S, Edwards A, Lench A, Cooper A, Akbari A, Collins B, Harris C, Richardson G, Barry M, Harris P, Fry R, Lyons RA, Cottrell S. (2023) Dimensions of equality in uptake of COVID-19 vaccination in Wales, UK: A multivariable linked data population analysis. *Vaccine*. 2023 Nov 30;41(49):7333-7341.

We need to consider that when working with the public, we must value their input as genuine partners, without the sense they are being patronised or controlled; we must respect their right to make their own decisions.

We must review how we motivate and support our multi-disciplinary workforce, ensuring a shared vision of reducing immunisation inequities<sup>16</sup>.

Research suggests that a local tailored delivery for vaccination interventions rather than a national approach meets the needs of the local population (demographically and geographically), and partnership working can increase immunisation performance, through elements such as information-sharing with local teams<sup>17</sup>.

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<sup>16</sup> Hurth, V. Ebert, C. Prabhu, J. (2018). Organisational Purpose: The Construct and its antecedents and consequences. Cambridge Judge Business School. <https://www.jbs.cam.ac.uk/wp-content/uploads/2020/08/wp1802.pdf>

<sup>17</sup> Chantler, T. Bell, S. Saliba, V. Heffernan, C. Raj, T. Ramsay, M. Mournier-Jack, S. (2019). Is partnership the answer? Delivering the national immunisation programme in the new English health system: a mixed methods study. BMC Public Health. Volume 19. Pg.83. <https://doi.org/10.1186/s12889-019-6400-6>. <https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-6400-6>

## VII. Strategic Objectives (2024/25 to 2027/28)

The table provided below identify the key objectives and goals aligned to the three-year strategic plan. A detailed implementation plan will be developed and monitored through that period. It is anticipated actions will evolve as key deliverables are achieved and will be dynamic throughout the duration of the strategic plan.

Objective	Goal	Key Deliverables / Actions	Responsible	Target for Review
<b>Leadership</b>	Provide leadership to vaccine equity.	Establish monitoring of equity through Immunisation Oversight Group	Head of Nursing	Q4 24/25
		Develop equity as a core element within each immunisation delivery group agenda	Head of Nursing	Q4 24/25
<b>Discovery</b> <i>Making sense of the available data and intelligence to identify areas for targeted action.</i>	Establish accountability and oversight to data management, ensuring that this runs throughout the action plan timeline, underpinning the work.	Develop continual cleansing of data, ensuring it is accurate and teams take a consistent approach to data collection.	Head of Nursing	Q1 25/26
		To reflect uptake and provide detail at a level to analyse equity and identify areas of inequitable vaccination coverage.	Senior Public Health Practitioner	Q4 24/25
	Develop and agree a model to support ongoing data management, cleansing and analysis.	Explore the potential for developing a single database for immunisation.	Head of Nursing	Q1 25/26
		Develop sustainable and transparent dashboard for childhood immunisations as priority	Senior Information Manager	Q3 24/25
	Take 'deep dive' sessions with primary care to consider mapping and understand the vaccine uptake pathway; from invitations and reminders, through to accessibility and appointments.	Explore ways in which immunisation and vaccination teams support primary care.	Primary Care Lead & Head of Nursing	Q2 25/26
		Establish the areas of inequity between MMR1 and MMR2 and complete a deep dive through immunisation process.	Senior Public Health Practitioner / Senior Nurse Immunisation	Q3 24/25
Establish areas of inequity across all immunisation programmes, completing a delivery plan for deep dive exercises.		Senior Public Health Practitioner	Q2 25/26	

Objective	Goal	Key Deliverables / Actions	Responsible	Target for Review
			/ Senior Nurse Immunisation	
	Explore the potential for community initiatives which achieve improved vaccine uptake, developing ways to capitalise on these approaches.	Explore evidence-based approaches to community initiatives in Immunisation uptake.	Senior Public Health Practitioner	Q3 24/25
		Collate evaluations of initiatives used in Hywel Dda in previous campaigns,	Senior Nurse Immunisation	Q3 24/25
<b>Engagement</b> <i>Establishing and maintaining co-productive relationships with communities, using behavioural science to support the approach.</i>	Establish and implement a communication and engagement workplan for addressing vaccine equity. The workplan will design and deliver on a range of ways of engaging with communities who have poorer vaccine uptake, using behavioural frameworks to better understand the barriers faced.	Evaluate current communication and engagement approach to vaccine uptake.	Communication Lead	Q2 24/25
		Develop use of behaviour frameworks to better understand the barriers faced within immunisation programmes.	Senior Public Health Practitioner / Communication Lead	Q4 24/25
		Develop and deliver communication workplan to address areas of inequity.	Communication Lead	Q2 25/26
	Review existing vaccination information and resources to ensure they are fit for purpose and tailored to meet the needs of our different communities.	Consider how the resources use behavioural science and models.	Senior Public Health Practitioner / Communication Lead	Q1 25/26
	Undertake a stakeholder mapping exercise to understand our partners and establish networks and communications channels.	Develop and deliver a stakeholder mapping exercise for those involved in childhood immunisations, prioritising MMR.	Senior Public Health Practitioner / Communication Lead	Q3 24/25
Develop and deliver a stakeholder mapping programme across all immunisation programmes		Senior Public Health Practitioner	Q4 25/26	

<b>Objective</b>	<b>Goal</b>	<b>Key Deliverables / Actions</b>	<b>Responsible</b>	<b>Target for Review</b>
			/ Communication Lead	
	Develop a vaccine engagement and communications plan, considering tailored communication channels and use of local knowledge, including voluntary sector input.	Engage with trusted voices within communities to facilitate communication and peer-support within vaccination programmes.	Community Development Outreach Lead	Q1 25/26
	Develop a vaccine engagement communications toolkit to support a range of engagement activities with our communities.	Explore the range of channels for community engagement including social media, local channels, local newspapers.  Develop key messages produced by experts to enhance a communication toolkit.	Communication Lead  Communication Lead	Q4 24/25  Q1 25/26
	Develop a schedule of proactive, tailored approaches to vaccination in the community, informed by our engagement with communities.	Link with local authorities and their events calendars, for example considering how we can attend community events to maximise on these opportunities. Consider the need to involve prominent clinicians, someone to trust, for example GP's, lead midwives, health visitors.  Explore and develop opportunistic promotion of vaccinations, for example with vaccination birthday cards and school admission letters and other significant milestones in the early years.	Senior Public Health Practitioner / Senior Nurse Immunisation  Senior Public Health Practitioner / Senior Nurse Immunisation	Q3 24/25  Q2 24/25
<b>Delivery</b>	Establish mechanism to ensure that every immunisation	Review delivery plans for all immunisation programmes ensuring equity built in,	Senior Nurse Immunisation	Q3 24/25

<b>Objective</b>	<b>Goal</b>	<b>Key Deliverables / Actions</b>	<b>Responsible</b>	<b>Target for Review</b>
<i>Tailoring and adapting our approach to meet the needs of communities.</i>	programme builds equity into their delivery plans.	prioritising those for MMR and childhood vaccines.		
	Establish feedback mechanisms to ensure we understand how the intervention has been received by communities, individuals and those delivering the interventions.	Develop and promote a PDSA (plan, do, study, act) approach to ensure continuous improvement.	Head of Nursing	Q4 24/25
	Deliver tailored approaches to interacting with patients/ parents of children to understand barriers to taking up vaccination offers	Involve positive framing e.g., “ <i>what would help you to attend the appointment?</i> ” into all interactions / correspondence.	Head of Nursing	Q4 24/25
	Monitor patient experience using follow up texts	Explore tools for capturing feedback during and following immunisation campaigns and opportunistic vaccination offers.	Senior Public Health Practitioner / Senior Nurse Immunisation	Q3 24/25
	Develop a training plan which considers the training and needs of different departments in relation to a MECC approach to promoting vaccine uptake.	Review current methods for capturing vaccination status routinely on children’s wards, use of patient information boards  Develop training for different professional groups to optimise opportunities to discuss vaccination.  Staff training in behaviour change conversations, as well as how to initiate vaccine conversations and offer guidance/ signposting where needed.	Head of Nursing  Senior Nurse Immunisations  Senior Public Health Practitioner / Senior Nurse Immunisation	Q2 24/25  Q4 24/25  Q2 25/26
	Continue to strengthen partnership to mobilise action, extend reach and share resources.	Identify key stakeholders that can extend the reach of the vaccination and immunisation team- this could include health, local	Head of Nursing	Q2 25/26

Objective	Goal	Key Deliverables / Actions	Responsible	Target for Review
		<p>government, community organisations and the voluntary sector.</p> <p>Build knowledge and capacity around vaccine equity.</p> <p>Maintain continuous engagement and collaboration with partners to share best practice, resources and adapt the partnership strategy to address changing needs and challenges in improving vaccine uptake.</p>	<p>Senior Public Health Practitioner</p> <p>Head of Nursing</p>	<p>Q3 25/26</p> <p>Q3 25/26</p>
<p><b>Evaluation and dissemination</b>  <i>Understanding the impact of our interventions and communicating this to the right people</i></p>	<p>Establish short to medium KPI's to measure progress, and regularly monitor these to understand the effectiveness of our approach.</p>	<p>Establish key metrics to enable accurate measure of success within a delivered programme.</p>	<p>Head of Nursing</p>	<p>Q4 24/25</p>
	<p>Establish a standardised approach to project monitoring and evaluation for continuous improvement establishing these at the start.</p>	<p>Develop planning and debrief periods into immunisations programmes through project management approach</p>	<p>Senior Public Health Practitioner</p>	<p>Q3 25/26</p>
	<p>Build in the resilience into action planning to address and adjust our plans to ensure we continue to meet the needs of our changing population.</p>	<p>Develop robust and timely review periods with continuous monitoring built into immunisation delivery groups.</p>	<p>Head of Nursing</p>	<p>Q1 25/26</p>
	<p>We will ensure that our evaluations are captured and communicated to stakeholders, including the immunisation equity</p>	<p>Develop and deliver regular stakeholder debrief and feedback programmes.</p>	<p>Head of Nursing</p>	<p>Q2 25/26</p>

Objective	Goal	Key Deliverables / Actions	Responsible	Target for Review
	network to continue to share best practice.	Ensure evaluations are shared wider across All Wales key lead groups to enable wider learning opportunities.	Head of Nursing	Q3 24/25
<b>Value</b>	Consider how we communicate the value of the vaccine and immunisation programme, including social value and benefits to population health.	Develop measures of value which could include: <ul style="list-style-type: none"> <li>• Value to the individual (measure of wellbeing and satisfaction)</li> <li>• Value to society/population – increased vaccine coverage, reduction in health disparities and better health outcomes</li> <li>• Service value – provider collaboration, care coordination, sharing best practice.</li> <li>• Economic value – resource management, cost effectiveness etc</li> </ul>	Principal in Public Health	Q4 24/25

## VIII. Next steps

The development of a strategic group to monitor this strategic plan has been developed through the formation of the Immunisation Oversight Group. A detailed implementation action plan will be further developed to provide detailed actions required to operationalise the strategic objectives within this plan. This will be supported through a newly formed, dedicated immunisation equity group.

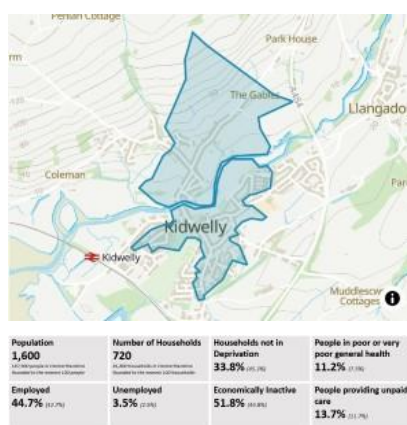
Our next steps will involve 'socialising' this strategic plan with our partners and stakeholders to jointly develop working groups, establishing reporting mechanisms and governance for the action plan as well as timescales for delivery.

Our actions are informed by national guidance and will be further developed by working with our communities using an asset-based approach. We will work 'with and by' our communities, not 'to and for' them. We will be guided by the data and evidence to ensure our work is targeting the areas which need it the most. Adapting a behaviour change focus will enable us to use evidence-based approaches which consider the wider influences on behaviour relating to vaccination.

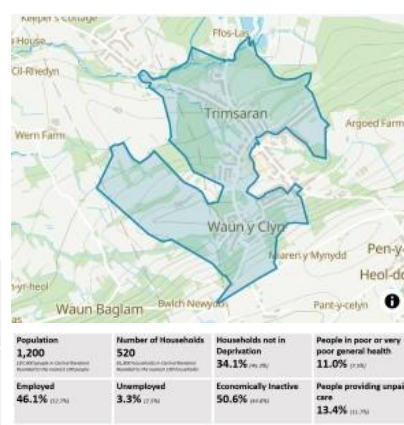
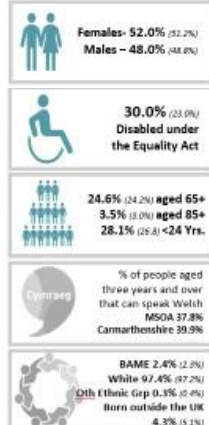
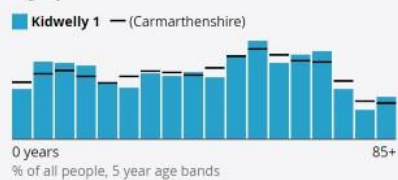
Our approach will include elements such as encouraging the use of "e-consent" for parents to provide consent for vaccinations digitally. We will also work with primary care to ensure that clinic times and commissioning of vaccine programmes take equity into consideration.

# Appendix 1

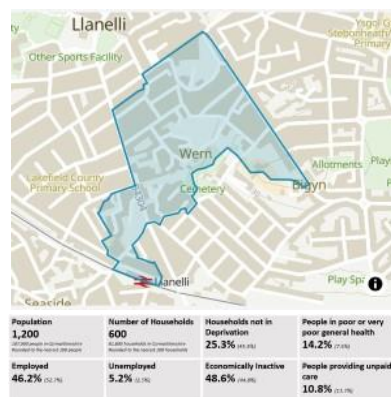
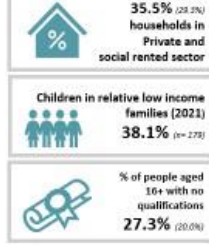
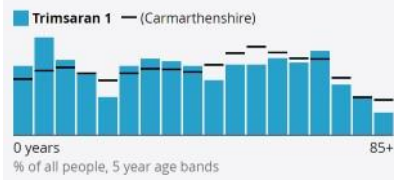
## Examples of Hywel Dda Communities in the Most Deprived 20% of WIMD



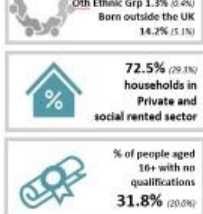
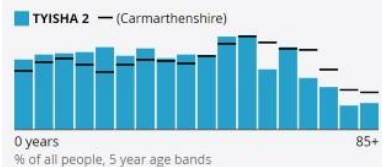
### Age profile



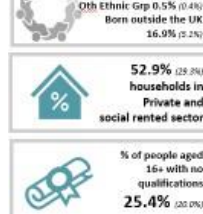
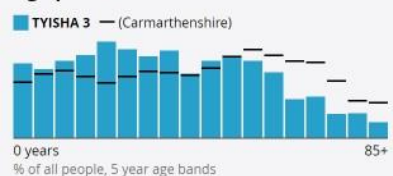
### Age profile

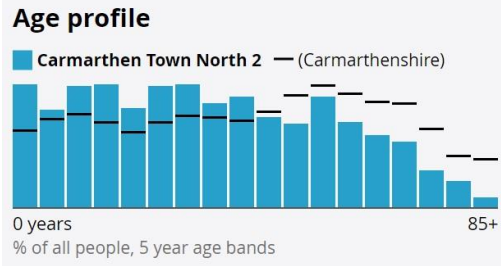
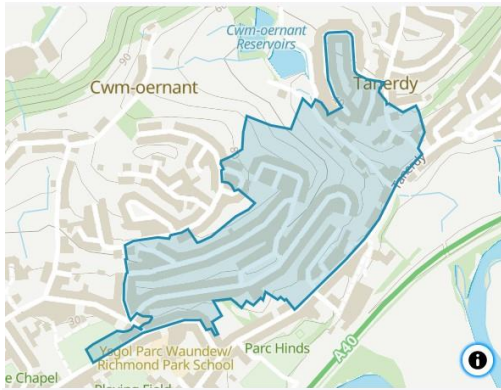


### Age profile



### Age profile





**Population**  
**1,200**  
187,900 people in Carmarthenshire  
Rounded to the nearest 100 people

**19.8%** (23.0%)  
**Disabled under the Equality Act**

**Children in relative low income families (2021)**  
**30.0%** (n= 318)

**Number of Households**  
**520**  
81,800 households in Carmarthenshire  
Rounded to the nearest 100 households

**% of people aged three years and over that can speak Welsh**  
**25.5%**  
Carmarthenshire **39.9%**

**% of people aged 16+ with no qualifications**  
**24.5%** (20.0%)

**Males**  
**48.9%** (48.8%)  
**Females**  
**51.1%** (51.2%)

**People in poor or very poor general health**  
**6.9%** (6.8%)

**Employed**  
**55.6%** (52.7%)

**13.1%** (24.2%) **aged 65+**  
**0.6%** (3.0%) **aged 85+**  
**35.3%** (26.8%) **<24 Yrs.**

**People providing unpaid care**  
**9.1%** (10.9%)

**Unemployed**  
**4.4%** (2.5%)

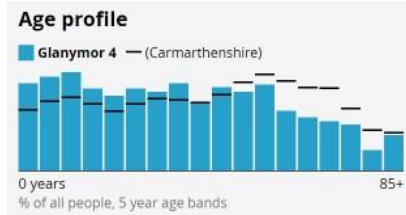
**BAME 5.5%** (2.4%)  
**White 94.5%** (97.2%)  
**Other Ethnic Group 0.0%** (0.4%)  
**Born outside the UK 8.5%** (5.1%)

**54.8%** (29.3%)  
**households in private and social rented sector**

**Economically inactive**  
**40.0%** (44.8%)



**Population** 1,400  
**Number of Households** 600  
**Households not in Deprivation** 27.2% (45.1%)  
**People in poor or very poor general health** 12.6% (7.1%)



**Females - 50.7%** (51.2%)  
**Males - 49.3%** (48.8%)

**16.1%** (24.2%) **aged 65+**  
**2.8%** (3.0%) **aged 85+**  
**34.5%** (26.8%) **<24 Yrs.**

**30.0%** (23.0%)  
**Disabled under the Equality Act**

**% of people aged three years and over that can speak Welsh**  
**16.0%**  
Carmarthenshire **39.9%**

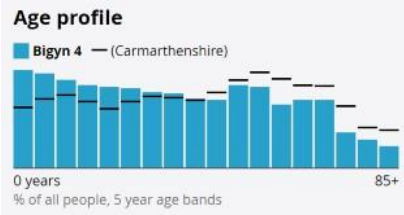
**BAME 2.6%** (2.3%)  
**White 97.1%** (97.2%)  
**Oth Ethnic Grp 0.4%** (0.4%)  
**Born outside the UK 9.0%** (5.2%)

**61.5%** (28.3%)  
**households in Private and social rented sector**

**% of people aged 16+ with no qualifications**  
**33.4%** (20.0%)



**Population** 1,800  
**Number of Households** 760  
**Households not in Deprivation** 29.7% (41.4%)  
**People in poor or very poor general health** 12.0% (7.1%)



**Females - 51.9%** (52.2%)  
**Males - 48.1%** (48.8%)

**17.5%** (24.2%) **aged 65+**  
**1.7%** (3.0%) **aged 85+**  
**35.3%** (26.8%) **<24 Yrs.**

**29.0%** (23.0%)  
**Disabled under the Equality Act**

**% of people aged three years and over that can speak Welsh**  
**15.0%**  
Carmarthenshire **39.9%**

**BAME 3.9%** (2.3%)  
**White 95.9%** (97.2%)  
**Oth Ethnic Grp 0.2%** (0.4%)  
**Born outside the UK 7.7%** (5.2%)

**56.4%** (28.3%)  
**households in Private and social rented sector**

**% of people aged 16+ with no qualifications**  
**32.0%** (20.0%)