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# Evaluation of the Leeds Community Vaccine Champions Programme

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**Prepared by**: Kris Southby, Jenny Woodward & Jane South

**Contact:** Kris Southby, School of Health, Leeds Beckett University, Calverley 1013, City Campus, Leeds LS1 3HE; k.southby@leedsbeckett.ac.uk

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# Evaluation of the Leeds Community Vaccine Champions Programme – **key messages**

- Low vaccination uptake is driven by a complex interaction of structural, social and cultural factors that statutory health services are often ill-equipped to deal with, particularly for those most at risk of health inequalities.
- The Leeds Community Vaccine Champions programme trained volunteers and distributed small grants to local voluntary organisations to engage community in familiar settings.
- The evaluation demonstrates that community-centred approaches provide a critical and distinctive contribution to addressing low vaccine uptake. Through shared language, culture, and lived experience, Community Champions built trust and empowered community members via open, non-judgemental conversations about vaccination.
- A key strength of the programme was its relational and culturally appropriate nature. The "messenger" was as important as the message: trusted individuals embedded in communities are far more effective at countering misinformation, reducing fear, and creating safe spaces for people to explore concerns.
- The programme also generated wider impacts, strengthening relationships and connections, and creating mechanisms for community insights to inform local strategy. For the Voluntary, Community and Social Enterprise (VCSE) sector, it built capacity, relationships, and credibility, while for statutory services it provided both additional capacity and a direct route into underserved communities.

Recommendations:

- A more strategic and long-term approach to community-centred vaccination work is needed. Community Champions should be embedded within core vaccination and prevention strategies, rather than delivered as time-limited or stand-alone initiatives. Their complementary role alongside statutory services is essential for reaching those at greatest risk of inequality.
- Long-term and stable funding is required to build and sustain the relationships that underpin the model.
- Stronger integration with primary care and vaccination services is needed to translate increased awareness and confidence into uptake. This could include models of community-based delivery that reduce practical barriers to access.
- Finally, continued investment in the VCSE sector and community infrastructure is essential. These organisations are key partners in delivering equitable health outcomes and play a central role in connecting services with marginalised communities.

# Evaluation of the Leeds Community Vaccine Champions Programme – **executive summary**

## Introduction

Vaccination uptake in Leeds reflects a broader national decline, contributing to the re-emergence of vaccine-preventable diseases and the widening of health inequalities. Disadvantaged and underserved communities are disproportionately affected by low uptake, shaped by a complex interplay of social, cultural, and structural barriers.

The Leeds Community Vaccine Champions programme, delivered between May 2025 and May 2026, was developed in response to these challenges. Commissioned by NHS England through the West Yorkshire Integrated Care Board and delivered through a partnership between Leeds City Council Public Health, Voluntary Action Leeds, and Forum Central, the programme aimed to increase awareness, confidence, and uptake of vaccinations across low-uptake communities.

At the heart of the programme was a community-centred approach, drawing on the insight, relationships, and credibility of local people and organisations. Community Champions – volunteers and VCSE organisations embedded within their communities – were mobilised to engage communities. A cohort of volunteers were trained and supported, and small grants were distributed to local VCSE organisations. This enabled community members to be reached and engaged within familiar settings. The programme reflects a wider national policy direction, including the NHS Vaccine Strategy, which emphasises the importance of targeted outreach, community assets, and partnership working to address inequalities in vaccination uptake.

## Evaluation Methodology

The evaluation adopted a mixed-methods approach to develop a comprehensive understanding of how the programme operated, what it achieved, and what could be learned for the future. It combined qualitative insights with available monitoring data to capture both the lived experience of delivery and the scale of activity.

The evaluation was conducted alongside programme delivery, allowing learning to emerge iteratively and inform practice in real time. Qualitative data were analysed thematically, with findings integrated alongside descriptive analysis of monitoring data to provide a rounded and pragmatic assessment of the programme.

# Findings: What worked well about the Community Vaccine Champions programme and what impact did it have?

The evaluation highlights that low vaccine uptake is shaped by a range of complex, interconnected factors; individuals are navigating a complex landscape of confusion about entitlements and access, difficulty engaging with or accessing services, exposure to misinformation (both in the community and on-line), and the influence of cultural, social, and religious norms. Challenges are often compounded by poverty and longstanding experiences of inequality and structural racism that have eroded trust in statutory services.

Within this context, the Leeds Community Vaccine Champions programme made a distinctive contribution by engaging with these challenges in ways that statutory health (and other) services very often cannot. Community Champions and VCSE organisations were able to reach into communities that are often underserved or disconnected from statutory provision. By drawing on shared language, culture, and lived experience, Community Champions were trusted and approachable, enabling open and non-judgemental conversations about vaccination. This made it possible to discuss concerns, address misinformation, and build confidence in ways that felt safe and culturally appropriate.

A key strength of the programme was its ability to create meaningful, two-way engagement. Rather than just delivering health messages, Community Champions facilitated dialogue, allowing community members to shape conversations around their own priorities. This relational approach helped to reduce fear and hesitancy, while also generating valuable insight into community needs that could be fed back into public health planning.

The evaluation could not provide conclusive evidence of increased vaccination uptake, reflecting both the complexity of behaviour change and the limitations of available data. However, there is strong evidence that it supported people to move closer to vaccination. Community members reported increased awareness and understanding of vaccines, greater confidence in engaging with health services an enhanced ability to make informed decisions, and many stated their intention to get vaccinated.

Importantly, the impact of the programme extended beyond those directly engaged. Conversations initiated by Community Champions spread through families and wider social networks, creating a ‘ripple effect’ that amplified awareness and shifted narratives around vaccination within communities. In this way, the programme contributed to tackling misinformation and normalising discussions about vaccination.

The evaluation also highlights the value of the programme at a system level. For statutory services, the Community Champion programme provided a vital mechanism for reaching the most marginalised communities at risk of the greatest health inequalities and understand the barriers they face. This helped to challenge assumptions and support more responsive and evidence-informed approaches to service delivery.

For the VCSE sector, the programme strengthened capacity, relationships, and credibility. Organisations were able to build partnerships with health services, play a more active role in shaping local strategy and in some cases deepen their engagement with communities. The Small Grants model enabled a diverse range of organisations—from established providers to smaller grassroots groups—to contribute to public health priorities, although it was not clear how different organisational characteristics may have effected programme delivery and outcomes.

The effectiveness of the programme was underpinned by several key features, including strong partnership working between public health, the VCSE sector, and local government; a high degree of flexibility in delivery; and a focus on trust and relationships at all levels. However, the evaluation also identified challenges, particularly the limited integration with primary care, the short-term nature of funding, and constraints in evidencing impact using quantitative measures.

## Conclusion and recommendations

The Leeds Community Vaccine Champions programme demonstrates that community-centred approaches are critical to addressing inequalities in vaccination uptake. It provides clear evidence that Community Champions can reach into communities that statutory services alone struggle to engage, particularly those experiencing the greatest disadvantage.

The programme's primary value lies not in delivering vaccinations directly, but in addressing the upstream, complex, and deeply rooted barriers that underpin low uptake. By building trust, improving understanding, and supporting informed decision-making, Community Champions create the conditions in which individuals are more likely to engage with vaccination services.

The evaluation findings have important implications:

- Efforts to improve vaccination uptake, particularly among underserved populations, cannot rely solely on service availability or information campaigns. Instead, they must be complemented by sustained investment in community infrastructure, trusted relationships, and partnerships with the VCSE sector.
- The programme also highlights the importance of moving beyond short-term, project-based approaches. Building trust and changing behaviour requires time, continuity, and long-term commitment. Embedding Community Champions as a core component of local vaccination and prevention strategies would enable more consistent engagement and greater impact over time.
- Strengthening integration with primary care will be essential in translating increased awareness and confidence into actual uptake. There is also a need to continue developing the evidence base, particularly in demonstrating how community-centred approaches contribute to outcomes across the full pathway to vaccination.

# Evaluation of the Leeds Community Vaccine Champions Programme

## 1. Introduction

Vaccination rates in Leeds mirror the national decline in uptake across the NHS vaccination programme. This has contributed to a rise in vaccine preventable diseases across the UK, most recently measles, which has led to the UK losing their measles elimination status in January 2026. Also mirroring the national picture [1, 2], disadvantaged and underserved communities in Leeds are disproportionately affected by low vaccine uptake, exacerbating health inequalities and leaving many individuals at risk.

The *Leeds Community Vaccine Champions* programme (May 2025 – May 2026) has been developed to **support awareness of vaccinations and increase uptake across the life-course in low-uptake communities**. The programme was developed and delivered by Voluntary Action Leeds, Forum Central, and Leeds City Council, and commissioned by NHS England through NHS West Yorkshire Integrated Care Board.

Specific objectives of the programme were to:

1. Engage with local communities to increase awareness and confidence in the NHS vaccine programme across the life course in the most deprived communities of Leeds
2. Work closely with practices and Primary Care Networks (PCNs) to promote access to vaccinations.
3. Deliver a grants programme to support small community organisations / groups to deliver targeted vaccination messages in targeted areas.
4. Develop an evidence-based *Community Vaccine Champion* model which supports the delivery of the NHS vaccination programme
5. Provide a community voice in the planning and development of innovative approaches to influence the implementation of the future NHS England vaccination strategy in Leeds.

### Who are Community Champions?

Community Champions (also known as health champions) are community members who volunteer to promote health and wellbeing or improve conditions in their local community. They use their social networks and life experience to address barriers to engagement and improve connections between services and disadvantaged communities [3]. Community Champions are part of a broad range of community-centred approaches, which are about utilising and enabling the resources already within communities – skills, knowledge, networks, commitment – to promote health and wellbeing and reduce health inequalities.

Community Champions approaches are endorsed by NICE guidance on Community Engagement [4] and recognised within Public Health England's family of community-centred approaches [5]. The model was widely used in the pandemic by local authorities and voluntary, community, and social enterprise (VCSE) organisations as an evidence-based approach to improve connections with diverse communities and support vaccine uptake [6, 7]. Later the NHS Core20PLUS5 Community Connectors built on the value of 'connectors', who had insight into their communities, to address healthcare inequalities with target populations groups [8].

Theme 2 of the current NHS England Vaccine Strategy [9] is to target underserved populations through data-driven, focused outreach. To achieve the goal of increasing vaccination uptake and coverage, every local system will need vaccination services that: 1) are high quality, convenient and tailored, 2) include targeted outreach, and 3) delivered in a joined-up way [9]. The intention is for local systems to use their resources to develop local approaches. While not mentioning Community Champions specifically, the strategy advocates greater use of community assets, insights and facilities to reduce inequalities, and collaboration between NHS Integrated Care Boards, local government, and the voluntary sector in support of local solutions.

## What we already know about the value of Community Champions?

A growing body of evidence shows the value and efficacy of Community Champions as a way of engaging diverse communities in support of addressing health inequalities, including vaccine uptake and preventing communicable diseases. Community Champions are a flexible intervention that have been adapted to local contexts [10]. In the UK, Community Champions have commonly focused on reducing health inequalities through community empowerment, building social action, and training volunteers to be 'change agents' in their communities [2, 10]. International evidence shows that similar models have successfully contributed to community-based prevention of communicable disease, such as HIV [11] and the Ebola [12]. Community Champions, as part of a strong community infrastructure, can be a key asset in emergencies [13] and more generally, volunteering is a feature of resilient communities [14].

Community Champions were used extensively as part of the Covid-19 response in the UK, and development in England was supported by national COVID champions scheme [6, 15]. This was found to be an effective and flexible approach for community engagement and mobilisation [7].

The (mostly qualitative) evidence showed the complementary role of Community Champions alongside statutory health services, engaging marginalised groups, building trust, and tackling misinformation[16-18]. Evidence showed that where Champion schemes worked best they improved relationships and supported two-way flow of information between communities impacted by inequalities and public services [7, 18] and, in some cases, leading to additional vaccinations [19].

## Previous Community Champions in Leeds

Between January 2021 and July 2022, a successful *Leeds Community Champions* programme ran in Leeds. *Leeds Community Champions* were initially part of the local Covid-19 response to engage better with diverse communities and reduce health inequalities. Latterly, the programme evolved to have a broader health and wellbeing focus but still working with communities that had the highest health needs. Funding was provided by Leeds City Council Safer Stronger Communities programme and then the Department for Levelling Up, Housing and Communities (DLuHC) as part of the national COVID champions scheme [15]. Management and administration of the programme was shared between Leeds City, Voluntary Action Leeds, and Forum Central.

An independent evaluation of the *Leeds Community Champions* programme [20] showed how Community Champions were effective at engaging diverse communities at risk of significant health inequalities and providing flexible additional capacity in support of statutory health services and other community-based activities. A strong partnership approach between statutory services and VCSE organisations at all levels was a major factor in the success of the programme. Learning from the programme and evaluation were well received across the city and insights were taken forward as part of a commitment to implementing community-centred approaches, such as in the Leeds Volunteering Strategy [21]

## Evaluation aim

The agreed aim of this evaluation was to assess the success of, and capture learning from, the *Leeds Community Vaccine Champions* programme to provide evidence to inform both future local Community Champions (or similar community-centred) strategies and local implementation of the NHS Vaccine Strategy.

Specific evaluation questions are listed in Appendix 1.

This report will describe how the evaluation was carried out, summarise the findings, and then discuss the results in relation to existing knowledge about Community Champions and present recommendations.

# 2. How was the evaluation conducted?

The evaluation utilised a mixed-methods approach, which combined data from different sources to give an overall picture of the programme. The approach was pragmatic, making use of existing evidence, data, and engagement strategies/structures where possible.

Collecting views and opinions from a wide range of stakeholders was emphasised, including those who had been involved in setting up the programme, the people who managed it, and the volunteers and organisations that delivered the programme[1].

The evaluation occurred alongside programme implementation, meaning that emergent learnings were fed back into programme delivery. This included presenting an interim report mid-programme (October 2025), and evaluation team members attending regular programme steering-group meetings to feed-back findings.

## Data collection methods

In total, 34 people took part in individual interviews (n=21), focus groups (n=5) or listening sessions (n=9). The aim was to capture a wide set of perspectives on the programme, and the sample was agreed in discussion with the steering group. (See Appendix 2 for a full list of participants and topics discussed).

Monitoring forms returned by community organisations that received small grants were analysed, as well as demographic data about Community Champions.

### Interviews, focus groups, and listening sessions

Semi-structured interviews were held with programme organisers (n=5), wider stakeholders (n=4) and the VCSE organisations that received small grants (n=8). Potential interview participants were contacted (up to three times) and invited to take part in an online interview. Interviews lasted up to an hour, with in-depth discussions taking place.

Community Vaccine Champions were invited, via Voluntary Action Leeds, to participate in two focus group discussions. One in-person focus group took place (n=5 participants), but the second was cancelled due to low uptake. An in-person interview (n=1) and two on-line individual interviews (n=2) were conducted instead.

In addition to the data generated via interviews and focus groups, the evaluation team attended a ‘listening session’ led by the programme steering group. Participants (n=9), including the steering group, VCSE organisations and volunteers, reviewed programme progress and discussed emerging issues.

[1] Beneficiaries / people who received the intervention were not included within this evaluation, due to budgetary / scope constraints

## Monitoring forms and data

A monitoring form was developed collaboratively by the programme organisers and evaluation team at the outset of the programme and sent to community organisations that received a small grant. Completed forms were included within the evaluation (n=16).

Anonymised monitoring data about programme delivery was shared with the evaluation team by programme organisers. This included: numbers of volunteers/Community Champions and demographic data (e.g. age, gender, language(s) spoken, nationality); number of community events attended; and volume and value of small grants given.

## Analysis

Interviews, focus groups, and the listening session were recorded and anonymous transcripts produced. These, and the monitoring forms, were uploaded to NVivo (software for qualitative research), coded, and key themes were generated. Descriptive statistics were produced from numerical data and integrated with the qualitative findings.

In this report, an anonymised code is used to indicate the source of data and the number within that group. These are: VOL (Volunteer Community Covid Champions), SG (Small Grant recipients), PO (programme organisers), WS (wider stakeholders), and LS (listening session). INT denotes the data came from an interview, FG from a Focus Group, LS from the listening session and MDF from the Monitoring Data forms provided by small grant recipients.

## Research ethics

This evaluation was reviewed and approved via the Leeds Beckett University Research Ethics process. All participants received information (written and spoken) about the evaluation, their involvement and data management. Participants gave written and/or verbal (recorded) consent to confirm their understanding and agreement to take part. All names of individuals were removed from transcripts, prior to analysis, to ensure anonymity.

Small grant organisations and Champions received a £25 voucher to recognise their time and effort in taking part.

# 3. Results

This section presents the results of the evaluation. The results are organised around the key questions guiding the analysis: 1) How is the programme delivered? 2) What contribution has the programme made? And 3) What needs to be taken forward?

The section begins with a short summary about why people in Leeds may not get vaccinated. Although not an explicit aim of the evaluation, this rich data helps contextualise the value of the programme approach and outcomes.

## What are the reasons for low vaccine uptake in Leeds?

There is not a singular reason why people do not get vaccinations and people who do not get vaccinated are not necessarily 'anti-vax'. Rather, they are likely to be navigating a complex combination of individual, social, cultural, and structural factors – which all affect people differently.

### Confusion, awareness, and understanding

People may not know what vaccines they are entitled to and how to get a vaccination. They also may not be aware of what vaccinations they have already had, particularly as children. This is potentially more pronounced for people newly arrived in the UK with either unreliable or difficult to transfer vaccination records. Confusion about how vaccinations work and the potential risks and benefits of vaccinations creates fear and hesitancy.

> *"I don't think they understand, a lot of people don't really understand what's available to them in terms of preventative health, particularly vaccines" (SG10 Int)*

> *"...people are quite wary of injecting stuff into their bodies. They don't, if they don't know what it is and what are the benefits, what's the point of doing it?" (SG9 Int)*

### Lack of access to services and information...and abundant misinformation

Many people struggle to access the health and care services (e.g. primary care) where they can have a vaccination, get reliable information about vaccines, and receive follow-up care. Language barriers can be a significant obstacle.

> *"The response of the GP is it's discouraging. You know, they don't get quick response. So that has really discouraged them a lot from getting vaccinated... when they have issues with the vaccination, once they are children or the elderly one get them vaccinated and they have issues, you know, maybe temperature, high temperature" (VOL4 Int).*

> *"One of the major reasons was because some of them had different languages. And then they were not really understanding the English very well" (VOL2 Int)*

Instead, people in marginalised and disadvantaged communities are often exposed to abundant misinformation. Negative 'community information' about vaccinations – scare stories of people's

adverse experiences – can spread fast and overpower more positive narratives. Social media and new media amplify misinformation.

> *"...when you've got like 100 people and there's that one that has like come out or like, you know, had a negative impact or negative something from the MMR vaccine, that one makes the biggest noise, the loudest noise. And that's what people are going, like, believing" (SG4 Int)*

## Cultural and religious norms and beliefs

Various cultural and religious norms and beliefs can, at worst, actively discourage people from getting vaccinated or, at least, be ambivalent to vaccinations. Communities that credit divine intervention as the causes of, and solutions to, illness may not value vaccinations. Some beliefs may not be against vaccinations *per se* but there are concerns that their ingredients or how they are delivered go against religious teachings.

> *"Some people just normally don't want to have conversations about vaccines due to, I think generally it's cultural" (VOL2 Int)*

> *"...I explained to him that this is what it is about and why is important. And his answer was 'we have God to protect us. We don't need vaccines'" (SG6 Int)*

Gender norms can intersect with cultural beliefs to influence vaccination uptake. For example, in relation to the HPV vaccine, concerns that young women would become sexually active if they had the vaccine discouraged uptake.

> *"...one of the big parts of feedback that we got was that there was a huge amount of judgement from parents or kind of carers who had signed the consent form to allow their children or at this point it was their daughters...to have to receive the jab...they believed it would open the doors for them to be more sexually active at a younger age" (SG2 Int)*

## (Histories of) oppression, lack of trust, fear

Histories of oppression and exploitation mean many within ethnic minority communities may be distrustful and/or fearful of vaccinations, and of statutory services generally. Contemporary political discourses and narratives around migration, nationalism, and identity further challenged people's trust and discourage vaccination. Personal experience of (perceived or actual) racially or culturally biased healthcare, including previous vaccinations, informed negative perception of vaccinations now.

> *"Now we have a lot of the racial tension that is going on...So, we've had people come and say like stuff, especially with GPs and stuff, like "why should I go there and get my jabs when, like the don't respect me"...again it's, it's that trust" (LS1)*

### Poverty

A cross-cutting issue affecting low-vaccine uptake is poverty. Individuals and families struggling to pay bills and provide for their children have many other priorities. They may not be able to afford to take time off work to attend an appointment or have the mental energy to consider vaccinations.

> *"The relationship is poverty. A lot of it is poverty. It's not a priority for families when they're struggling to feed the children…They're not thinking about going to the GP most of the time" (LS1)*

> *"…asylum seekers, refugee, homeless, we deal with single mums. These are families that they don't even have time. They just want to make sure they can pay their bill. So, their focus is actually shifted away from these messages" (SG3 Int)*

## RQ1: How is the Leeds Community Vaccine Champions programme delivered? What works well and not so well?

This section describes how the programme has been delivered, highlighting what appears to have worked well about the programme and what appears to have worked less well.

### Overall programme structure and delivery

The programme was managed and delivered as a partnership between Forum Central, Voluntary Action Leeds (VAL) and Leeds City Council Public Health. Each had a complementary role (see Figure 1), and all took part in regular steering group meetings to discuss and agree strategic and operational issues.

Within the overall programme aim of supporting awareness and increasing uptake of vaccines, during the evaluation period the programme was split into two 'rounds', each with a different focus. Round 1 (May 2025 - Aug 2025) was focused on childhood vaccinations and Round 2 (Oct 2025 - Mar 2026) on Winter Vaccinations. Across each round, systematic efforts were made to target activity towards communities with low vaccination uptake, using GP practice level data and local insight.

> *"I'm able to see on a map these particular areas of the city have lowest uptake…we can then target the work to say, 'right, we want to be delivering in these particular areas to these particular parents, in these particular languages, or these ethnicities'…So we've been really kind of coordinated, I suppose, and driven in terms of, these are the people that we really need to be engaging with." (PO5 Int)*

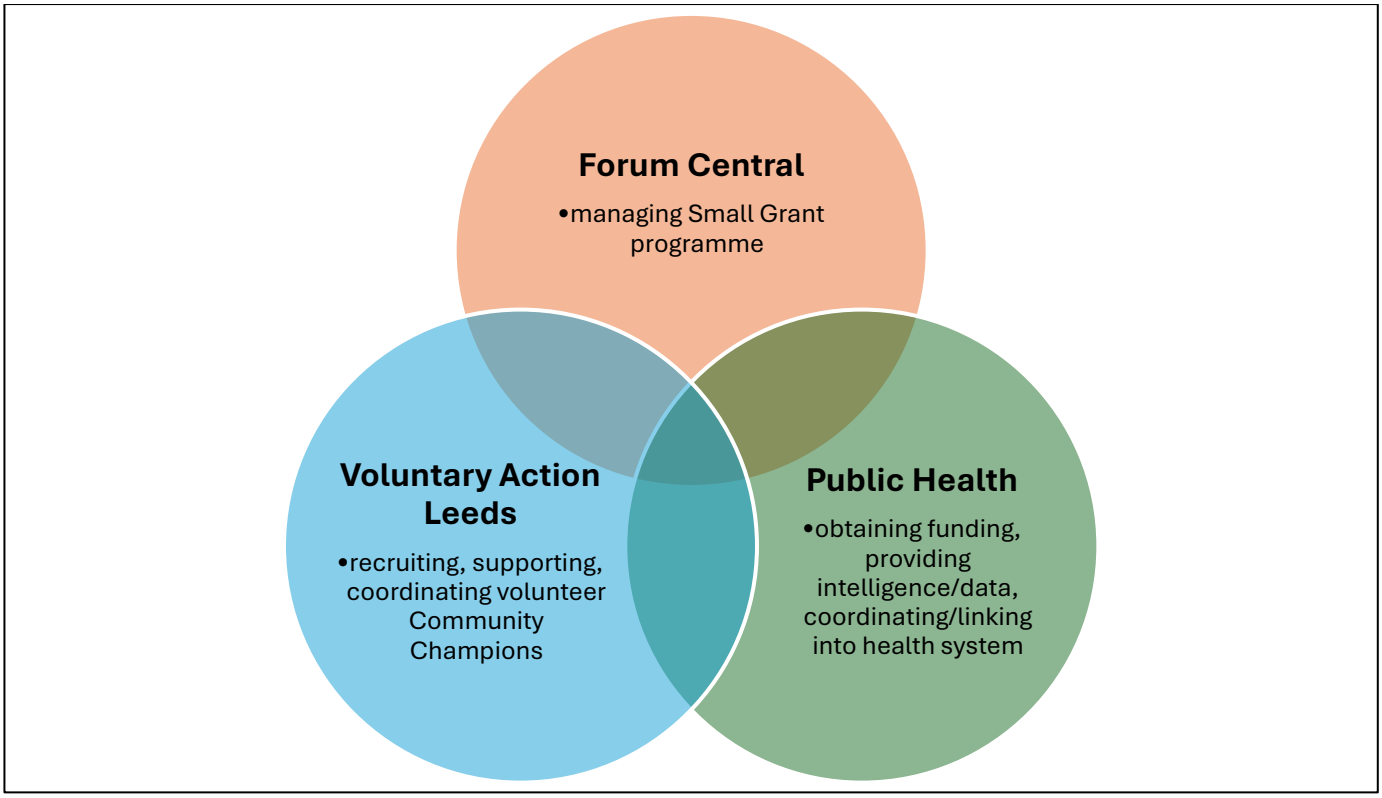



*Figure 1 Complementary roles of each programme partner*

In terms of delivery, the programme had two key components: volunteer Community Champions and a Small Grants programme.

- *Volunteer Community Champions* – A network of volunteers was actively recruited, trained and supported by VAL (134 signed-up in total, 53 completed induction). While there was a focus on recruiting volunteers from priority communities or who spoke specific languages, volunteers also joined from other parts of the city (e.g. students). There was wide diversity in terms of ethnicity and ages, and twenty-two languages spoken. Most were aged 18-25 years and 64% were female. Some volunteers also had pre-existing health or social care knowledge and experience. (see Appendix 3 for volunteer demographic details). Volunteers received training in effective and meaningful communication and information/training about specific illnesses and vaccines. They were coordinated and supported by VAL to attend forty-three community events and neighbourhoods identified via uptake data which were identified and prioritised by the steering group (e.g. community fun-days, schools). Attempts were made to 'match' volunteers to communities that they were already part of, although this was not always possible due to availability or short timescales. VAL staff usually accompanied volunteers at events (and VAL staff attended twelve events without volunteers). During events, volunteers (and VAL staff) talked to community members about vaccinations and distributed resources (e.g. leaflets). Up to date, valid information and resources about vaccines and illnesses were provided through Public Health and adapted to be more engaging and relevant for particular communities.

- *Small Grants* – The Small Grants scheme was included as a mechanism to work with groups and organisations already engaging with low uptake communities. Coordinated by Forum Central, up to £1,500 were made available for community organisations working in priority areas of the city or with communities of interest. A streamlined process made application more accessible to small/grass roots organisations and a multi-stakeholder panel made funding decisions. Grant recipients were asked to complete a simple monitoring form at the end of the funding period, describing their activities, perceived impact and key learning points. Twenty-one Small Grants were allocated (ten in Round 1, eleven in Round 2) to seventeen different organisations[2]. Some focused on a community-of-interest (e.g. Roma people, the Nigerian community, South Asian women), whilst others focused on a particular neighbourhood (e.g. a community centre). Their size and level of formality varied. Some had dozens of employees and great expertise in community engagement, funding and delivery. Others were far smaller –- just one or two key individuals or led by volunteers – with limited experience of grant funding. Funded organisations used a range of strategies; a mix of activities with their existing 'members' (e.g. workshops, presentations) and outreach to people who may not normally engage with the organisation (e.g. distributing leaflets, attending other community events). Small Grant holders also regularly supported community members to access statutory health-care services for vaccine-specific and general health support, including registering with primary care, registering for repeat prescriptions, making appointments (via online and telephone), accompanying community members and interpreting during appointments. A synthesis of available numerical data (in the returned monitoring forms) showed that Small Grant holders ran twenty-nine community events and engaged with at least 200 families and 906 individuals.

## What has worked well about the programme?

Multiple features of the programme were thought to have contributed to its apparent success. While some were specific to one facet of the programme – volunteers or Small Grants – others were shared.

At an organisational level, the partnership managing the programme had a strong and positive working relationship, working effectively together towards programme aims. The collaborators trusted each other – built over time through different iterations of Champions programmes – and shared a belief in the importance and effectiveness of the approach. The programme also built on existing infrastructure, relationships and expertise. After the Community COVID Champions funding ended, some much reduced Community Champions activity was maintained until the current funding was available, meaning the programme could be rapidly implemented.

[2] A third round of Small Grants was issued Feb 2026 – June 2026 but reporting (July 2026) fell outside of the evaluation window.

> *"It was easier because we had a model that worked and we, so it wasn't as if we were starting from scratch with an idea and a proposal…So the fact that they'd worked together and delivered something similar meant that we were able to get something up and running quite quickly. So yeah, I definitely think the evidence base massively helped from COVID, yeah."* (PO5 Int)

In terms of operational characteristics, flexibility was a key theme. The programme overall was flexible enough to respond to emerging needs. Small Grant holders appreciated the flexibility given to them when delivering their activities, while volunteers valued being able to have flexible individualised conversations with community members and the flexibility of the role. VAL, in turn, were flexible in filling any gaps in service delivery (e.g. attending community events when no volunteers were able).

> *"So I think the fact that they were very flexible and they were like, basically you can do whatever you want and approach your groups however you think is best. And we're here to support with the volunteers and everything. That was really helpful. Yeah, I think they're a great funder. I'm really happy with the way that they do things."* (SG9 Int)

Another key theme was trust and relationships; between the programme organisers, between the programme organisers and Champions, and between Champions and community members. Across both aspects of the programme – volunteers and Small Grants – trust enabled meaningful, individualised, two-way conversations about vaccinations. Such communication occurred in non-judgemental, informal, and sometimes indirect way, so community members felt comfortable (e.g. to reveal their lack of knowledge, scepticisms, or fears about vaccinations). Being a two-way conversation also meant that insight from communities could be fed back via Champions to the steering group, NHS partners responsible for improving uptake and into city/regional vaccination strategies. This mechanism allowed communities that had especially low vaccination uptake to be identified and work to be carried out to understand their barriers and concerns and identify ways to improve engagement and co-develop solutions.

Who *'the messengers'* were was key. Community members were more receptive to messages delivered by people that were like them, spoke the same language and understood their culture and beliefs. Community Champions were able to have culturally appropriate conversations. Being "non-medical" also helped; community members were less intimidated and less distrustful of lay people and therefore more willing to discuss their views on vaccination openly. Small Grant holders, in particularly, were embedded within their neighbourhoods and held deep, long-standing relationships with the communities, meaning they were able to reach people who were unlikely to interact with statutory services.

> *"Because it's, it's not just the messages that it's, it's the, it's the messenger. It's the coming from a cultural awareness background. It's the language. Somebody who looks like you, understands you. So yeah, I think that for me really, really helps if you've got Champions that can go out and share those messages in their own communities."* (PO2 Int)

> *"But sort of that not that lack of awareness around why people may refuse a vaccine or why parents or caregivers may say that actually we're going to opt out of that one without really finding out the root cause of why and or having people in a room having parents in a room with somebody who speaks the language with somebody who understands the culture to be able so they do feel safe to voice their concerns as well."* (SG2 Int)

The way the message was delivered was also key. Discussing vaccinations directly was thought to be appropriate where Champions had a preexisting trusting relationship with community members. Where no such relationship existed or where community members were particularly sceptical, approaching vaccinations indirectly as part of a more holistic discussion about health and wellbeing was thought to be more effective (although there was some variation depending on context).

> *"So when we're at the community centre, it's quite easy to just have something that's direct and specific. But I think it's much better if you do it subliminally with people that you don't necessarily know that well. It's one of those, isn't it, where it just goes in the bag and then it gets home and it probably goes in the bin. So if you can engage them around something else, so for example, the Centre of Warm Stuff, or we might go to (venue) and promote our community pantry, then it might be, oh, look what you can get for six pounds each week, and then the conversation turns into something around community health and vaccines."* (SG10 Int)

Finally, the training and on-going support provided by VAL to volunteer Champions was greatly appreciated; it helped make the Champions feel valued.

> *"They look after you, your person. They want to also know how you are also doing. That's one thing I also appreciate. It's not just coming to fill in the space, fill in to do the work (...) they also care about your being before the work itself."* (VOL FG)

## What worked less well about the programme?

Participants felt that better integration with primary care, at a local level, would increase programme effectiveness. Specifically, having someone able to deliver vaccinations during a community session, as opposed to having to signpost people to their GP surgery for an appointment. This would not always be appropriate – if, for example, community members were very sceptical of vaccines or distrustful of NHS staff – but in other situations it would reduce barriers to uptake.

Whilst the volunteer cohort had some level of diversity – and spoke many languages – it was not representative of all the communities in Leeds. This led to language difficulties and less effective engagement at some events / in some neighbourhoods.

Volunteer Champion availability was also highlighted as an issue – it was not always possible to match the most appropriate people to events and sometimes no volunteers were available. On a

related note, many champions had a transient status (e.g. asylum seekers, refugees, students), which adversely affected retention.

The short-term nature of the Small Grant programme was highlighted as an issue. Community engagement is not instantaneous and only having a few months to deliver was a challenge. This was problematic when trying to align Community Champions activity with various cultural practices within communities (e.g. holidays).

## RQ2: What contribution has the *Leeds Community Vaccine Champions* programme made to supporting awareness of the NHS vaccination programme and improving vaccine uptake across the life course?

The available data is not evidence of a direct causal link between the Community Vaccine Champion programme and increased vaccine uptake, although there were anecdotal examples of behaviour change. The findings demonstrate how the programme directly and indirectly contributed to supporting awareness of the NHS vaccine programme and improving vaccine uptake across the life course. Spillover effects on other issues effecting health inequalities were also evident.

### Direct and indirect impact in communities

In some instances, Community Champions' activity appears to have led to increased vaccine uptake (although the evidence is anecdotal).

> *"I provided Person A with Flu vaccination information and informed her where she could get the flu jab...The following week at the Stay and Play session, Person A shared she had been to the chemist to have her Flu vaccination...and she would now have her Flu Vaccination annually"* (SG10 MDF)

> *"We, we spoke about the pros, the cons and why it's important and what do you think...We had people go back to say 'we're going to go make an appointment'"* (SG4 Int)

The most significant contribution of the programme has been in helping to progress community members towards getting vaccinated. Through Community Champion activities community members gained knowledge, understanding, and confidence around illnesses, vaccinations, and health services, with better comprehension of their choices and options. Those new to the UK, became more informed about the overlaps and differences between their home country vaccinations and the UK schedule. Community members became more empowered to make informed decisions about vaccinations and take more control of their own health and wellbeing.

> *"what we really try to do here is encourage people and facilitate the, like, facilitate people being able to make their own choice. We're just giving information, but ultimately the decision is up to them...to make decisions for themselves around their own body around their own health, and especially around vaccinations."* (SG2 Int)

> *"One participant attending the session shared that she had previously heard of measles but did not fully understand what the illness was or the purpose of vaccination…By the end of the session, she reported feeling more confident in her knowledge of measles and vaccination and valued receiving information in a setting that felt culturally and socially comfortable."* (SG4 MDF2)

Community Vaccine Champions were particularly powerful in countering misinformation about vaccinations. Because of the holistic approach taken, community members also often gained information about other issues, benefiting their broader health and wellbeing. Generally, Champions reinforced health communications from statutory services.

> *"We were able to change some myths that were implemented into people's minds through the social media with fake news about the high risk of vaccines, causing death between children and adults, causing deformities in embryos, using them is against Sharia law in Islam*." (SG8 MDF)

> *"I also think we hit a lot more because it is about that whole thing of conversation around vaccinations might prompt conversation about something else…it prompts wider conversations around community health and what else we can do to support people"* (SG10 Int)

Community members becoming more connected with health services, including helping individuals register with a GP, book appointments, and facilitate phone conversations with healthcare professionals, was a key outcome. The programme also increased community member's confidence to talk, and ask questions, about health – for themselves and family members. Community members showed a greater willingness to engage in dialogue and action about vaccinations for their children, if not for themselves. The activities also reduced social isolation and meant individuals felt valued and cared for.

> *"The discussions encouraged people to talk more openly with each other about health, which helped reduce hesitation or embarrassment around asking questions."* (SG9 MDF2)

> *"They feel that support. They feel, 'oh, the council thinks about us' or maybe 'our community thinks about us'" (Vol2 Int)*

Multiple participants talked about the 'ripple effect' of the programme, as community members shared their newly gained insights with family and friends. By having conversations in communities about vaccination, the programme was thought to be breaking taboos around vaccinations and (re)building trust with services.

> *"It will go beyond our centre and this group because they all go back to their families, their children and grandchildren and talk to them about it, especially like the stuff they learned about shingles and everything, they will have those discussions outside of the centre and that has a bigger impact then. It's not just contained within our sessions"* (SG9 Int)

> *"...we may not end up speaking to hundreds of people in that community. But the important thing is that people are being spoken to. The awareness is being created. They, on their own, can also relay that message to a relative, to a friend, to somebody else out there"* (VOL1 FG)

The programme was thought to be particularly impactful in the most disadvantaged communities, helping to tackle health inequalities. Champions' activities, particularly Small Grant holders, were able to reach further into communities than traditional health services and offered community members potentially their only accessible source of reliable vaccine information.

> *"they don't really have any other way of finding out...A lot of them are socially isolated. Coming to our centre is the main sort of activity for the week...I am quite sure that they wouldn't have known about any of this unless we had told them."* (SG9 Int)

> *"I do think it complements what goes on as routine practise [in the NHS]. But I also think in a lot of these communities it's key and like I say, I think we would struggle to get some of the messages out there if we didn't have these type of roles available to us" (WS3 Int)*

## Voluntary, community and social enterprise organisations

The programme was thought to positively impact both the VCSE organisations holding Small Grants and the sector more broadly across the city.

The programme strengthened organisational relationships and partnership working within the VCSE sector and with the local authority and statutory health services (e.g. GP surgeries). As a collaborative activity, the programme increased the visibility and credibility of VCSE organisations, which was thought to lead to increased and improved activities in the future. The programme also gave the VCSE sector – Small Grant holders and programme partners (VAL, Forum Central) – a mechanism to influence vaccine and wider health inequalities strategies in the city.

> *"I think it's been really good for us as a centre in terms of our building on our reputation as an organisation who delivers projects of this nature. So are looking at preventative work, are looking at health needs, are looking at reducing health inequalities...we've started to be seen by the local GP surgery as a go to place who can support their wider work."* (SG10 Int)

> *"This has strengthened our capacity to deliver activities effectively and raised the profile of our organisation within the wider network. The collaborative environment has also ensured that smaller organisations like ours have a platform to share our experiences and influence local discussions"* (SG1 MDF)

For Small Grant holders, the programme provided a (small) financial resource to help them deliver their mission and aid sustainability. The grant helped build organisational capacity and potentially their future growth as community leaders. Small Grant holders also talked about how

the programme supported them to strengthen relationships with their communities and gain greater insight into community need around vaccinations and other concerns.

> *"That can be critical to small organisations that might be just one person and enabling them to evolve and grow so the next opportunity they might go for a £5000 pot, and they've got that track record of delivering on grants"* (PO1 Int)

> *"we had really strong engagement from people who had never previously had access to health events...we built that trust, improved our understanding around what our community would like to hear more of" (SG2 Int)*

## Statutory (health) services

For statutory services, including local authority public health, primary care networks, and GP practices, the programme had several benefits. By supporting prevention, the programme may help reduce future demand. This view was expressed particularly by volunteer Community Champions.

> *"So, by us feeding that information in and working in our sector, then we're making things better for the NHS"* (VOL1 FG)

The programme provided statutory services with a route into communities and a mechanism to engage with people most at risk of experiencing health inequalities. Community need became better understood by statutory services, challenged preconceptions and informed evidence-based decision making.

> *"A byproduct of the grants is building those bridges between public health, the NHS and [VCSE organisations], and ultimately communities*...it's about bridging that gap...and providing some resources to raise awareness, share messaging" (PO1 Int)

> *"One of the things that's really improved, I think, within the space, is the communication between the volunteers themselves...insights that come through the volunteers around the needs of specific communities being taken back to and quite directly as well without too many layers in between, taken back to people that can influence change and then the development of services and approaches as a result of that feedback"* (PO4 Int)

However, limited examples of misunderstandings of the programme prevented more embedded and sustained collaboration.

> *"Sometimes it is very dependent on the staff in the medical practice. So, if you've got somebody who sees the benefit of community organisations doing this type of work, then you can work with them...there would be so much more we could do if we actually sat around the table more regularly and discussed it"* (SG10 Int)

### Impacts on volunteers

Those who volunteered – either as Champions or as part of the organisations receiving Small Grants - benefitted in multiple ways, potentially supporting reduced inequalities.

> *"People from diverse communities that, people with limited English can really struggle to engage in volunteering, but really benefit from it when they're able to find the volunteer in terms of, sort of, yeah, improving, improving spoken English"* (PO4 Int)

Volunteers became more informed about illnesses and vaccines. They also became more informed about, and understanding of, different cultures and peoples. Mirroring the 'ripples' of information flowing through communities, volunteers talked about sharing what they had learned with family and friends.

Volunteers' wellbeing improved. They talked about satisfaction, fulfilment, fun, enjoyment, identity, and a sense of belonging from the experience.

> *"Just that self-satisfaction and self-fulfilment that you have, that you're contributing to a cause...So, it's just to be able to have something else to do outside just going to work and just coming back, living beyond the work home life cycle"* (VOL1 FG)

Volunteering in the programme was also thought to improve individual's communication skills and support their employability. Volunteers gained new or refreshed experience of different public health settings/delivery.

> *"So, in terms of communication, in terms of approaching people, in terms of being more informed on vaccinations myself. So, and then also having a community where I also feel like I'm doing something to support the community. And then looking at my own career path...I feel I'm getting the kind of experience that I need to do that"* (VOL2 Int)

## RQ3: What needs to be taken forward in embedding the programme in future strategies to improve awareness and uptake across the life course?

Participants were enthused about continuing the programme and possibly extending using Community Champions across other public health areas.

In this section, ideas about what needs to be taken forward are grouped into those about improving vaccine uptake specifically and then applying community-centred approaches in public health more generally.

### To improve vaccine awareness and uptake across the life course

There was universal agreement that the programme was having a positive impact, but that a sustained and ongoing commitment was necessary to tackle the complex, deeply entrenched barriers to low vaccine uptake. A longer-term commitment would enable the programme to operate more strategically.

> *"A last observation that I would like to do is that it has to be ongoing work. The support can't just be a one off… the problems are still there, so the support has to be ongoing. The raising awareness has to be ongoing"* (SG6 Int)

A future programme should enable VCSE organisations (e.g. via Small Grants) to integrate vaccination work into their ongoing practice in a more holistic and longer-term way. This would better reflect how community members, particularly those most at risk of inequalities, seek support and the ongoing commitment that VCSE organisations have to their communities. Currently, Small Grant holders were consistently providing vaccine support to community members beyond the limits of grants received.

> *"…all of the time when you apply for a grant, they would say deliver from December until March. You could deliver from March until July. It's not like easy because you come across questions after July…will I say to them, 'well, we stop the programme now, you go to the GP'. I'm not, I'm not doing that…it shouldn't be actually a one-off project and stops and then because we come across questions all the time."* (SG8 Int)

More targeted interventions and tailoring of support could also help meet community need. VCSE organisations receiving Small Grants were already good at doing this by leveraging their position in communities, but with more time and resources they could do more. It was proposed that Community Vaccine Champions could lead events in target communities (and invite other partners) rather than being participants in others' community events.

> *"So, at the moment the way that they do it is that they identify events that are already happening and they'll go to it, where actually what I'd quite like is that we identify that [local area name] is really low uptake. Go and set up an event, run it and kind of you be the driver"* (PO5 Int)

Recruiting more community leaders was proposed, including faith leaders, local businesses, and influential people within communities that could support 'drip feeding' information and changing the narrative about vaccinations in communities. This may include creating a new Champions role alongside volunteer Community Champion and Small Grant holder.

> *"It goes a long way when people hear from their own, yeah, saying these things…so it is more of reaching to the roots of each community. When we work with these leaders within the community" (PO3 Int)*

Greater collaboration with clinical services, particularly primary care, was thought to be a key next step. While the programme had success at raising awareness and empowering community members about vaccinations (and health services more generally), there remained a gap to vaccinations being administered. Vaccinations being more accessible in community settings, supported by Community Champions, was repeatedly suggested. One established Small Grant holder had started dialogue with a local GP to provide a vaccine pop-up. Although such an approach does not align with current commissioning models for vaccination, the added value

would be increasing the likelihood of vaccinating those that would otherwise be the least likely to engage – which may be more impactful in preventing outbreaks.

> *"Unless we get this greater alignment with primary care delivering in communities and having that kind of extended access offer, I don't think Champions on their own can change the data and the narrative"* (PO5 Int)

> *"We've built a bit of a relationship with [local medical centre]...they've actually said, In future, if we can get enough people, they will do a pop-up clinic. So we can either go to them or they will come to us and do the vaccinations where people feel comfortable having them done"* (SG10 Int)

Another area of collaboration would be to provide more detailed information about the science around illnesses and vaccinations to enhance the general information available through Public Health.

> *"Generally, people were like very happy with, with like the information we were giving them. But then when there were a couple of people who were like, 'well, if you don't have the answer, then why are you telling us this?' So maybe that's something that if we were to do this again, it would be good to have more specific sort of answers to things"* (SG9 Int)

Finally, more data is needed to evidence the impact of Community Champions. Future programmes should incorporate a greater range of outcome measures, including quantitative, qualitative, longitudinal, experiential and 'objective', to evidence to different audiences the social and financial value of the model. A mechanism to follow-up community conversations to see if any behaviour change had occurred was suggested.

> *"I think that would be amazing to have that kind of evidence which connected this work to ultimately whether people were getting vaccinated...With longer term resources, with longer term evaluation resource, evaluation we could do that."* (PO1 Int)

## Community Champion models and other community-centred approaches

Based on the perceived success of the programme – and the experience of past programmes – there was a strong belief in establishing Community Champions as a long-term, 'core' public health programme in Leeds with work streams supporting different public health priorities. A longer-term perspective would allow the necessary relationships to be built and embedded between operational/delivery partners and with strategic stakeholders across the city, and for the programme to become recognised.

> *"And I think there are so many more opportunities now, because we've proven that the vaccination programme works...But I just think there is so much more we could do with the right level of funding and support around preventative health work"* (SG10)

> *"...to have a much bigger Community Champion programme of which incorporated a whole range of support for people who are struggling to access services or who were just wanting to look at, kind of, how to improve their lives and their health"* (WS2 Int)

Essential to developing and embedding Community Champions in Leeds is longer-term and secure funding. Relying on non-recurrent funding has been resource intensive and distracted from delivery. Financial security should be extended to VCSE collaborators as well. Precarity of funding was talked about as an existential threat to community-centre approaches in Leeds; once VCSE organisation go, they can not easily come back. As well as funding, embedding the programme would require a collective commitment or 'buy-in' to the model from across local Public Health, NHS, and VCSE.

> *"...to really reach people and to do it properly and well, we, it has to have that investment, that time investment to, yeah, to properly do it... people that make it happen are the important part, you know, and that requires a resource investment for the people"* (PO4 Int)

> *"You cannot create third sector that easy...The problem is third sector are looked in a very lower way by the government... but if you want to look about something professional in the long term, the government has to put some extra grants, extra support for charities, for CICs, for companies, charitable companies like us"* (SG8 Int)

At an operational level, an essential ingredient to developing Community Champions in Leeds is establishing clear governance procedures, including data sharing between partners, to create frictionless collaboration. Talking about difficulties in sharing volunteers' details, one participant said:

> *"So, we just tried to connect up the grant delivery with the volunteers...but in order to make that connection, you need to share contact information. You need to share information around what that project involves, with [VCSE organisation name] as an external organisation."* (PO1 Int)

From a volunteer perspective, future programmes should continue to provide flexible volunteer roles and support that aligns with the complexity of peoples' lives. This is particularly important for enabling volunteers from disadvantaged communities. Volunteers felt there needed to be better advertising of Community Champions roles and it was suggested that a mechanism for volunteers to transfer between roles across the city (and between cities) could support recruitment and retention, particularly for more transient populations (e.g. students, newly arrived people).

> *"Better promotion of a Community Champion programme, because I only found out through Leeds Older People's Forum because I got an e-mail...but if people are not aware of that, maybe something on social media or something to promote Community Champions"* (VOL1 FG)

# 4. Discussion

This section discusses the evaluation findings in relation to wider evidence, strategies, and priorities about Community Champions and vaccine uptake.

## How is the *Leeds Community Vaccine Champions* programme delivered and what has worked well (and not well)?

The partnership approach between the voluntary sector (Forum Central, Voluntary Action Leeds), local authority public health teams, and NHS colleagues was fundamental to the success of the Leeds Community Vaccine Champions programme. Each partner brought complementary skills/resources, with no partner able to deliver in isolation. This is an example of the collaboration advocated in the NHS Vaccine Strategy between statutory health providers and the voluntary sector, maximising the contribution of volunteers, and working with community leaders to build trust to increase vaccination uptake and coverage over time [9].

Effective inter-sector collaboration does not just happen. Partnership working in the Leeds Community Vaccine Champions programme was strengthened through clear divisions of roles and responsibilities and mechanisms for information sharing and joint-decision making (e.g. regular steering group meetings). The collaboration has developed over time as the programme has evolved from previous iterations – enabling processes, relationships, and trust to build and be refined – although this had been strained by relying on a series of short-term grants. Successful collaboration with the voluntary sector has arguably only been possible because of the relative maturity and strength of the sector in Leeds, which needs to be nurtured to ensure the ongoing feasibility of this and other community-centred programmes. However, an area of collaboration that could be strengthened is with primary care, which is a key feature in the NHS Vaccine Strategy [9].

Two related attributes running through the Leeds Community Vaccine Champions programme were trust and flexibility. Volunteers and Small Grant holders were largely trusted to engage communities their own way, while volunteers were flexibly deployed to complement statutory services in responding to emerging needs. This reflects previous evidence about the strengths of Community Champions models [10] and satisfies principles in the NHS Vaccine Strategy to design flexible services that meet community need [9]. The downside of this flexibility within the programme was occasional misunderstandings between programme stakeholders about Community Champions' role and remit, although this was less frequent than in previous versions of the programme [see 20]. Volunteers appreciated the flexibility of the role, although their varying availability created operational challenges – as per previous versions of the programme [20].

As with the previous Community Champions programmes locally [20] and more widely [18], the current evaluation found that both the messenger and the message are key to success. Firstly, Community Champions are better connected, accessible 'messengers' that communities are

more likely to be receptive too. VCSE Small Grant holders, in particular, are embedded in their communities and able to reach community members unlikely to engage with other (statutory) services. However, if and how variation in organisational characteristics of Small Grant holders effected programme delivery and success is unclear. Equally, while shared characteristics helped create trust and rapport, it is unclear how instances of volunteer Champions not being from the specific community in which they were working affected the programme. Secondly, Community Champions shared a culturally sensitive, less judgemental, more holistic 'message'. Very often the programme provided a safe space for people to discuss *their* thoughts and concerns. This reflects ideas in the NHS Vaccine Strategy that the most effective ways to engage people at risk of health inequalities is not to lead with discussions about vaccinations, but start with other issues that matter to people [9].

## What contribution has the *Leeds Community Vaccine Champions* programme made to supporting awareness of the NHS vaccination programme and improving vaccine uptake across the life course?

The programme successfully achieved or exceeded many of its stated objectives/deliverables – recruiting diverse volunteers, delivering small grants, and engaging in community conversations to promote vaccinations – and produced multiple positive outcomes across stakeholder groups.

While the evaluation did not show the same increase in vaccination uptake as some other Community Champions programmes [19], this may be because of the type of (mostly qualitative) data gathered rather than the programme itself. The Leeds Community Vaccine Champions programme was successful at starting to address the complex and entrenched reasons for low-vaccine uptake in disadvantaged communities and progressing community members towards vaccinations. However, structural issues impacting vaccine uptake (e.g. material deprivation, closure of community centres) remained. The greatest success of the programme comes perhaps from considering *who* in the community was impacted by the programme. Like other Community Champions programmes, the Leeds programme provided a mechanism to engage marginalised groups, build trust and tackle misinformation [16-18], satisfying an appeal in the NHS Vaccine Strategy for outreach services that particularly engage those experiencing health inequalities [9]. Whilst the UK Vaccine Strategy [9] promotes needing an accessible 'doorway' into vaccinations services, the success of Leeds Community Vaccine Champions programme comes at an earlier stage in helping community members to know that a door exists, why it is there, and why it's important to go through it. The 'ripple effect' is to build trust, awareness, resilience, and empowerment within communities.

For the VCSE organisations involved, the programme provided access to financial resources, albeit only small amounts and the short-term nature of funding was an issue. VCSE organisations also strengthened relationships with their communities and intersectoral collaborations; the programme helped to further legitimise the complementary role of the VCSE sector in addressing public health challenges, including low vaccine uptake.

For statutory health services, the Community Vaccine Champions programme provided flexible additional capacity in support of addressing public health priorities and a mechanism to reach previously unreachable places in support of addressing inequalities. Like other programmes [7, 18], Community Champions were also a mechanism for statutory services to gain new insights into communities, challenging preconceptions and supporting effective evidence-based decision making. This satisfies calls in the NHS Vaccine Strategy to develop partnerships with underserved communities to ensure strategies utilise community insights [9]. As a preliminary stage in advancing disadvantaged communities towards vaccine uptake, Community Champions will ultimately support prevention and reduce the likelihood of outbreaks and future demand on services, although more specific evidence for this is needed. The programme might also have a cyclical effect in building statutory services confidence in further community-centred approaches.

Finally, the Leeds Community Vaccine Champions programme positively impacted individual volunteers, including improved interpersonal and professional skills and wellbeing. This reflects established evidence of the beneficial effect of volunteering [22]. However, given that few volunteer Champions were from the disadvantaged communities targeted through the programme, strategies are needed to address the complex barriers to volunteering [23] to increase the diversity of volunteers and ensure the beneficial effects of volunteering can be more equitably shared.

## What needs to be taken forward in embedding the programme in future strategies to improve vaccines awareness and uptake across the life course?

There was near universal support for embedding Community Champions in future vaccine strategies in Leeds. This appears wise given the broader evidence that Community Champions, as part of a strong community infrastructure, are a key asset in emergencies and a feature of resilient communities [13, 14]. Embedding Community Champions in Leeds would also satisfy guidance in the NHS Vaccine Strategy to include outreach services as part of a local systems vaccination delivery network [9] and would build on wider learning from programmes like NHS England Core20PLUS Community Connectors around addressing healthcare inequalities with target groups [8].

A feature of the programme that should be developed in the future was collaboration with primary care, which was a key success factor in increasing vaccine uptake in previous Community Champions programmes locally [20] and nationally [19]. This would align with aspirations in the NHS Vaccine Strategy for more ‘joined-up’ working and to use community facilities to deliver vaccinations and maximise uptake in people who may be less likely to access mainstream healthcare services. However, there are systemic, organisational, and individual barriers that need to be overcome for this to occur. Other specific features/aspects of the programme that should be developed in the future are: sustained and ongoing work (not just seasonal), long-term funding to embed activities into VCSEs general offer/services, more

targeted support in response to emerging need, engaging more and diverse community leaders (not just 'health and 'wellbeing' organisations), and focusing on children's vaccinations as a 'hook' for parents and other community members.

Beyond just vaccine uptake, there were aspirations to make Community Champions a 'core' public health programme with long-term funding to support a breadth of priorities. However, within a broad Community Champions programme it would be important to ensure clearly articulated aims and scope are maintained to support deliver [20]. If secure funding for a future programme was found, this security should be extended to VCSE sector partners; the relatively high capacity of the sector in Leeds is a strength that needs to be, at least, maintained and, at best, enhanced. Community Champions programmes (and other community-centred approaches) require active volunteer management to ensure they are accessible to a diversity of volunteers, for governance, and to support retention, longevity, and development of volunteers.

## Evaluation limitations

Like the majority of Community Champions research, the evaluation has largely relied on qualitative evidence. While this has helped build a detailed picture of the experience of involved organisations and the mechanisms, it is not a complete picture. Firstly, the sample of stakeholders included in the evaluation was limited – there were very few NHS stakeholders and volunteer Champion numbers were limited. In addition, no community members were included within the evaluation. Involving more of these participants would enable a broader perspective of the programme to be achieved. Secondly, the largely qualitative design, means there is a lack of measurable impacts within communities (e.g. awareness, empowerment, perceptions of vaccine, behaviour change/intention). Such data would mean the progress of the programme could be tracked and the reach into different communities assessed. Incorporating this would fit with the aim of NHS England (2023) to *"refine a streamlined set of outcomes and standards"*. Finally, the programme does not incorporate follow-up conversations with communities / community members that have engaged with the messaging. Including a longitudinal / follow-up aspect to the evaluation would allow actual behaviour change, as a result of the programme, to be understood more fully.

# Conclusion and recommendations

The Leeds Community Vaccine Champions programme aimed to support awareness of vaccinations and increase uptake across the life-course in low-uptake communities. The programme was a partnership between Leeds City Council Public Health, Forum Central, and Voluntary Action Leeds and involved volunteer Community Champions and a Small Grants scheme for VCSE organisations working with target communities. Through gathering the views of different stakeholders and existing monitoring data, this evaluation has demonstrated the positive impact of the programme in addressing the complex barriers to vaccine uptake, empowering community members to make informed decisions about vaccines, building inter-sector relationships, and further legitimising community-centred approaches to public health challenges. While it was not possible to evidence an increase in vaccine uptake due to the evaluation methodology, the programme was particularly impactful engaging those in the most disadvantaged communities at the greatest risk of health inequalities.

The success of the programme is attributed to the collaborative approach and the inherent flexibility and trust running throughout the programme. The informal, two-way, culturally sensitive conversations that Community Champions had (the message) was as important as the Champions embedded in, and representative of, the communities engaged with (the messenger). There was a desire to embed Community Vaccine Champions as a longer-term public health programme, and possibly expand the remit to include other public health priorities. Greater collaboration with statutory health services, particularly primary care, is needed in the future. Additional evidence is also needed to further demonstrate the varied impacts of Community Champions to different audiences.

## Recommendations

Building on the findings of the evaluation, and aligned with the NHS Vaccination Strategy and wider community-centred public health guidance, the following recommendations are made for local policy, practice and implementation, and future research. Together, they aim to strengthen vaccination awareness and uptake across the life-course while embedding sustainable community-centred approaches in Leeds.

### For Local Policy

**Embed Community Vaccine Champions within core local vaccination and prevention strategies –** Community Vaccine Champions should be recognised as a core component of local vaccination delivery infrastructure, rather than a time-limited or add-on intervention. Local policy should explicitly position community-centred approaches as complementary to primary care and public health, particularly for reaching communities at highest risk of low uptake and health inequalities and addressing the complex barriers to vaccine uptake.

**Commit to longer-term, recurrent funding for community-centred approaches –** The evaluation demonstrates that trust, engagement, and behaviour change require time. Local

commissioners and system leaders should move away from short-term, seasonal or pilot funding and instead commit to multi-year funding for Community Vaccine Champions and associated VCSE infrastructure. This would enable trusted relationships to be built and sustained, long-term community presence, volunteer retention, and rapid mobilisation during emerging public health needs (e.g. outbreaks or seasonal vaccination campaigns).

**Adopt trust-based funding models for VCSE partners –** Policy approaches to funding should recognise the expertise of VCSE organisations as trusted community anchors embedded in their communities. Where possible, block grants or trust-based funding models should be adopted to reduce administrative burden and enable organisations to flex delivery in response to community need. This reflects the evaluation's finding that flexibility and local autonomy were key enablers of effective engagement and builds on a key enabling factor in Community Champions' contribution to the Covid-19 response [19].

**Strengthen strategic alignment between public health, primary care, and the VCSE sector –** Local policy should provide clearer frameworks and incentives for collaboration between primary care networks, public health teams, and VCSE organisations. This includes recognising community settings as legitimate and valuable spaces for prevention activity and addressing structural barriers (e.g. commissioning, governance, data sharing) that currently limit integrated working.

## For Practice and Implementation

**Integrate vaccination delivery into community settings where appropriate –** To reduce the gap between awareness and uptake, future programmes should strengthen operational links with primary care to enable community-based vaccination delivery, such as pop-up or outreach clinics supported by Community Champions.

**Sustain Community Vaccine Champions activity beyond discrete campaigns –** Implementation should move away from narrowly defined, time-limited vaccination campaigns and towards an ongoing, embedded model of engagement. This would enable Champions, particularly VCSO organisations, to respond to questions and concerns as they arise and reflects the reality that vaccine conversations are often intertwined with wider health and social issues.

**Continue prioritising culturally appropriate, relational approaches –** Practice should maintain a focus on who delivers messages as much as what is delivered. Recruiting Champions who reflect community languages, cultures, and experiences should remain a priority, alongside continued investment in training on culturally sensitive communication, active listening, and myth-busting. Where gaps in representation exist, targeted recruitment and partnership with trusted community leaders (e.g. faith leaders, community organisers) should be pursued.

**Support flexible and inclusive volunteering models –** Volunteer roles should remain flexible, well-supported, and accessible to people from diverse backgrounds, including those with complex lives or insecure circumstances. Such approaches are essential both for sustaining the

volunteer cohort and for ensuring Champions reflect the communities with whom they are supporting.

**Strengthen governance and information-sharing arrangements –** Clear and proportionate governance arrangements (e.g. around data sharing, safeguarding, and communication) should be established across partners to reduce friction and enable smoother collaboration between programme partners. This will be particularly important where volunteers and VCSE organisations are expected to work more closely with clinical services.

### For Research and Evaluation

**Develop a proportionate, mixed-methods evaluation framework for future programmes –** Future Community Vaccine Champions programmes should incorporate an agreed evaluation framework from the outset, co-developed with commissioners and delivery partners. This should balance the value of qualitative insight with a limited number of meaningful quantitative indicators (e.g. referrals, follow-up actions), avoiding overly burdensome monitoring requirements, that would negatively impact delivery and / or evaluation participation.

**Strengthen evidence on pathways to uptake, not only uptake itself –** Given the complexity of vaccine decision-making, future research should continue to focus on intermediate outcomes (e.g. increased knowledge, reduced fear, registration with primary care, intention to vaccinate), rather than seeking simple causal attribution to uptake alone. Developing logic models or theories of change would help demonstrate how Community Vaccine Champions contribute to achieving public health goals.

**Explore mechanisms for follow-up and longer-term outcome tracking –** Where feasible and ethical, systems should be tested for light-touch follow-up with community members to better understand what happens after initial conversations.

**Extend research to include community member perspectives –** Future evaluations should seek to include the perspectives of community members themselves. This would strengthen understanding of how Community Champions are experienced, what builds trust, and how vaccination messages are interpreted and acted upon within everyday life.

**Contribute to the national evidence base on community-centred vaccination approaches** – Finally, learning from Leeds should be disseminated regionally and nationally to contribute to the growing evidence base on Community Champions and vaccination equity. This includes sharing insights on partnership models, funding approaches, and the role of VCSE infrastructure in supporting resilient, prevention-focused systems.

# Appendices

## Appendix 1: Evaluation questions

1. How is the *Leeds Community Vaccine Champions* programme delivered and what has worked well (and not well) in delivering the programme?
    a. What works well (and not well) about the volunteer programme?
    b. What works well about the small grants programme?

2. What contribution has the *Leeds Community Vaccine Champions* programme made to supporting awareness of the NHS vaccination programme and improving vaccine uptake across the life course?
    a. How does the programme build capacity within individuals, communities, and organisations to improve awareness and understanding of vaccinations?
    b. How does the programme help low uptake communities to identify and overcome barriers to vaccination across the life course?

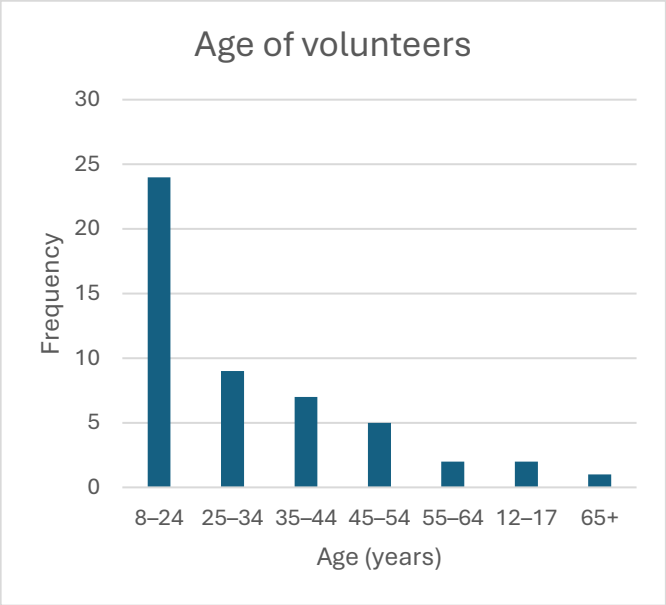
3. What needs to be taken forward in embedding the programme in future strategies to improve vaccines awareness and uptake across the life course?

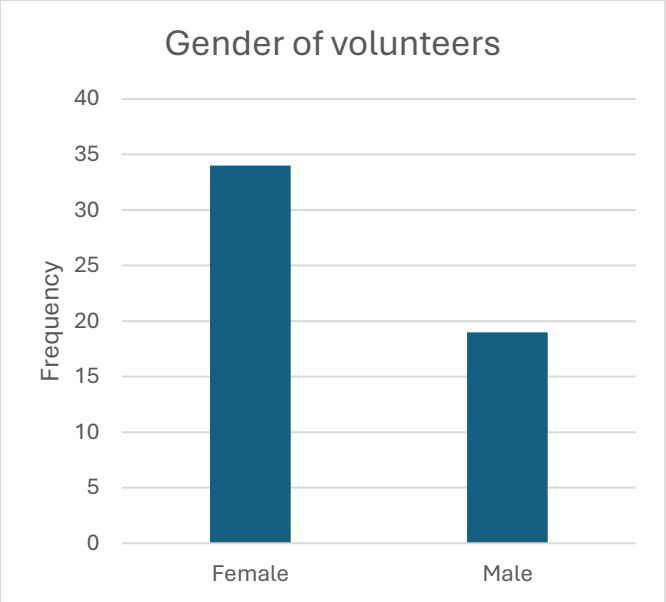
## Appendix 2: Evaluation data collection: participants and numbers

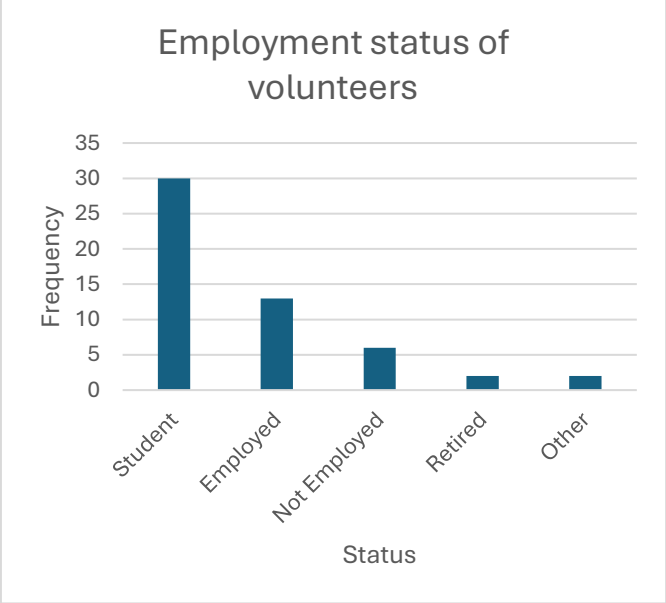
| Participants | Numbers / description | Topics covered |
|---|---|---|
| **Key stakeholders** | | |
| Wider stakeholder interviews (on-line) | 4 participants from public health, NHSE and Leeds Beckett University | Programme origins and development<br>Programme aims and operation<br>The impact and outcomes from the programme<br>Reflections on the programme<br>Thoughts / suggestions for the future / looking ahead |
| Programme organiser interviews (on-line) | 5 participants from voluntary sector organisations and public health | |
| **Small grant organisations** | | |
| On-line interviews | 8 participants<br>• 4 from Round 1 funding<br>• 4 from Round 2. | Background to the organisation / reason for applying<br>Activities delivered including target communities, approach and resources<br>Perceived impact and outcomes<br>Reflections on the programme<br>Looking ahead – learnings / advice / improvements |
| Monitoring forms | 16 completed<br>• 7 from Round 1 funding<br>• 9 from Round 2 | Pro-forma developed for programme management |
| **Volunteers** | | |
| Focus Group – in person | 5 participants | Role / motivation for applying<br>Experiences of delivery<br>Challenges and barriers<br>Perceived impact and reflections<br>Looking forward – advice and potential improvements |
| In-person interview | 1 participant | |
| On-line individual interviews | 3 participants | |

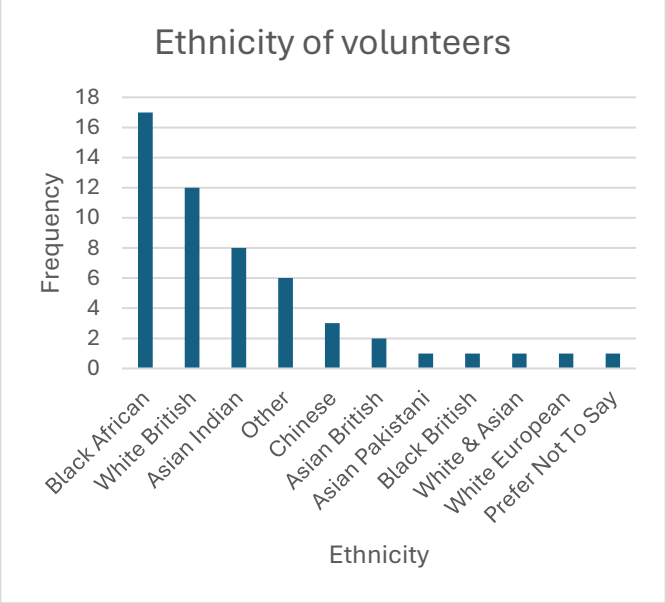
| | | |
|---|---|---|
| Demographic data | 58 participating Champions | Provided by Voluntary Action Leeds |
| **Listening Session** | | |
| With volunteers and steering group members | 9 participants | Conducted as part of programme management |
| | | |
| **Total number of participants** | **34** | |

## Appendix 3: Volunteer demographics



# References


1. Flatt, A., R. Vivancos, N. French, S. Quinn, M. Ashton, V. Decraene, D. Hungerford, and D. Taylor-Robinson, *Inequalities in uptake of childhood vaccination in England, 2019-23: longitudinal study.* MJ, 2024. 387: p. e079550.
2. UK Health Security Agency, *Immunisation Equity Strategy Commitments for 2025-2030*. 2025: London.
3. Office for Health Improvement & Disparities, *Community champions programme: guidance and resources*. 2022: London.
4. National Institute for Health and Care Excellence, *Community engagement: improving health and wellbeing and reducing healthinequalities.* 2016: London.
5. Public Health England and NHS England, *A guide to community-centred approaches for health and wellbeing.* 2015: London.
6. HM Government. *National effort to vaccinate vulnerable communities receives funding boost*. 2022 [cited 2026 May]; Available from: https://www.gov.uk/government/news/national-effort-to-vaccinate-vulnerable-communities-receives-funding-boost.
7. Gilburt, H., L. Lamming, D. Buck, and S. Mallorie, *Commissioning community champions: lessons from a pandemic*. 2024: London.
8. NHS England. *Core20PLUS5 Community Connectors*. 2026 [cited 2026 May]; Available from: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-community-connectors/.
9. NHS England, *NHS Vaccination strategy*. 2023: London.
10. Public Health England, *Community Champions: A rapid scoping review of Community Champions approaches for the pandemic response and recovery*. 2021: London.
11. Shepherd, J.L. and F. O'Caña, *Committed to the community: the Atlas HIV Prevention Program.* Health Promotion Practice, 2013. 14(6): p. 824-832.
12. Bedson, J., M.F. Jalloh, D. Pedi, S. Bah, K. Owen, A. Oniba, M. Sangarie, J.S. Fofanah, M.B. Jalloh, and P. Sengeh, *Community engagement in outbreak response: lessons from the 2014–2016 Ebola outbreak in Sierra Leone.* BMJ global health, 2020. 5(8).
13. South, J., J. Stansfield, R. Amlôt, and D. Weston, *Sustaining and strengthening community resilience throughout the COVID-19 pandemic and beyond.* Perspectives in Public Health, 2020. 140(6): p. 305-308.
14. Whittaker, J., B. McLennan, and J. Handmer, *A review of informal volunteerism in emergencies and disasters: Definition, opportunities and challenges.* International journal of disaster risk reduction, 2015. 13: p. 358-368.
15. HM Government. *Community Champions to give COVID-19 vaccine advice and boost take up*. 2021 [cited 2026 May]; Available from: https://www.gov.uk/government/news/community-champions-to-give-covid-19-vaccine-advice-and-boost-take-up.
16. Jenson, J., A. Pordes Bower, and J. Gregson, *Transformations in communitycollaboration: Lessons from COVID-19 Champions Programmes acrossLondon*. 2023: London.
17. Vanderslott, S., K. Joynes-Burgess, S. Kadambari, E. O'Dwyer, and L. Alidu, *Examining the role of community champions to promote vaccine uptake in under-served communities in the United Kingdom: Lessons from the COVID-19 pandemic.* SSM-Qualitative Research in Health, 2024. 5: p. 100436.
18. South, J., J. Woodall, J. Stansfield, T. Mapplethorpe, A. Passey, and A.-M. Bagnall, *A qualitative synthesis of practice-based learning from case studies on COVID community champion programmes in England, UK.* BMC Public Health, 2024. 24(1): p. 7.
19. IFF Research, *Community Vaccine Champions Evaluation Report*. 2023: London.
20. South, J. and K. Southby, *Leeds Community Champions: Evaluation & Report*. 2023: Leeds.
21. Voluntary Action Leeds, *Leeds Volunteering Strategy: Making Leeds the best city for volunteers*. 2023: Leeds.
22. Nichol, B., R. Wilson, A. Rodrigues, and C. Haighton, *Exploring the effects of volunteering on the social, mental, and physical health and well-being of volunteers: an umbrella review.* Voluntas: International Journal of Voluntary and Nonprofit Organizations, 2024. 35(1): p. 97-128.
23. Southby, K., J. South, and A.-M. Bagnall, *A Rapid Review of Barriers to Volunteering for Potentially Disadvantaged Groups and Implications for Health Inequalities.* Voluntas: International Journal of Voluntary and Nonprofit Organizations, 2019. 30(5): p. 907-920.