NIHR | Health Determinants Research Collaboration

Evaluation of the Coventry Family Hub Vaccination Pilot:

Phase 2 Findings (January-June 2026)

Dr Chloe Ryder
Research Fellow in Quantitative and Mixed-Methods
Health Psychologist
NIHR Health Determinants Research Collaboration (HDRC) Coventry

Rayyan Nasser and Karen Thomas
Health Protection
Coventry City Council

Coventry City Council

Table of Contents

Executive Summary *3*

Background: An introduction to Coventry Family Hub Vaccination Clinics *5*

Contextual background and strategic alignment **6**

Policy Framework 6

Operational Model and Clinic Locations **7**

Core service mechanisms 7

Shared responsibility framework **7**

Clinical framework, academic evaluation, and behavioural insights **8**

The NIHR HDRC Coventry Research Partnership 8

The Evaluation *9*

Methodology **9**

The Results – Phase 2 ..... **11**

Engagement in the Family Hub Vaccination Clinics 11

Participant demographics 14

Quantitative Data: The results 17

Qualitative Data: Thematic Analysis 31

Practitioner feedback and reflections **38**

Conclusions and future recommendations *40*

Recommendations 40

Overall conclusion 43

Executive Summary

This report evaluates Phase 2 of the Coventry Family Hub Vaccination Pilot, delivered from January to June 2026 at family hubs located in Hillfields (Harmony Family Hub) and Foleshill (Families for All). The pilot was developed in response to declining childhood immunisation coverage and ongoing inequalities in vaccine access, particularly among communities experiencing deprivation and other barriers to healthcare engagement. Building on learning from Phase 1, the model evolved from vaccination drop-in clinics to twice-monthly "Ask, Talk, Decide" sessions, placing greater emphasis on trusted conversations, informed decision-making, and behavioural support. While on-site vaccination remained available where appropriate, the revised approach prioritised engagement with parents and/or carer givers through non-judgemental discussions that addressed concerns, built confidence, and supported informed choices about vaccination.

The pilot was delivered through a multi-agency partnership involving Coventry City Council Public Health and Family Hubs, NHS Coventry and Warwickshire Integrated Care Board, Kenilworth and Warwick Primary Care Network, and NIHR HDRC Coventry. This report examines the implementation, reach, outcomes, and learning from Phase 2, and considers its contribution to improving vaccine confidence and addressing inequalities in access to immunisation services.

Across the six-month period, 446 people discussed vaccination with a nurse and 31 vaccinations were administered. Harmony Hub accounted for 257 engagements and recorded the great majority of vaccinations; Families for All Hub engaged 189 people but recorded only two on-site vaccinations. Vaccines delivered were predominantly maternal: 13 RSV doses in pregnancy and 13 pertussis doses, alongside three adult influenza vaccinations, and one COVID-19. No MMR, pre-school booster, child influenza or older-adult RSV vaccinations were administered. Although no childhood vaccinations were delivered directly in Phase 2, six families were supported to book childhood vaccination appointments with their GP, and one family self-reported successful vaccination.

Of 288 participants who completed the evaluation survey (participation rate of 64.57%), four under-18 responses were excluded, leaving 284 participants data for analysis. The sample was predominantly female (92.30%), young (95.10% aged 18-39) and ethnically diverse: 35.80% Asian/Asian British, 32.60% Black/African/Caribbean/Black British and 22.10% White. Self-reported uptake was high with 92.60% of participants stating they were fully vaccinated and 76.10% said all their children were fully vaccinated but 21.50% reported that their children were not fully vaccinated. Among 21 adults who were not fully vaccinated themselves, 71.40% also reported under-vaccinated children, indicating an important association for targeted engagement.

Quantitative findings were strongly favourable of the Family Hub ‘Ask, talk, decide’ sessions. 88.00% of participants reported perceived social approval for childhood vaccination as an

influential factor for vaccination uptake, 84.60% felt able to access it, 93.40% expected vaccination to prevent illness, 81.30% felt adequately informed and 82.10% reported support from healthcare professionals. Most importantly, 92.60% considered Family Hubs useful places to discuss vaccination and, if they chose, protect their child; only 0.80% disagreed.

Positive attitudes nevertheless coexisted with concerns: 94.70% thought side effects were at least slightly likely, 50.10% disliked injections to some degree and 50.30% expressed some worry, mainly mild. Media provided at least some vaccination information for 58.80%, reinforcing the need for accessible, credible advice.

Qualitative analysis identified six themes: broad trust in immunisation; hesitancy and safety concerns; the importance of professional support; the accessibility of Family Hubs; social, cultural and family influence; and persistent MMR/MMRV-Autism narratives. Participants valued respectful discussions with nurses and the convenience of receiving advice alongside other family services. Several reported greater confidence or willingness to vaccinate after these conversations. However, anecdotal accounts, social media and family views remained influential, particularly in relation to MMR/MMRV, Autism, fertility, pregnancy vaccination and natural immunity. Practitioners similarly judged the partnership model valuable, while highlighting inconsistent attendance-data sharing and the need for clearer operational responsibilities.

Overall, Phase 2 demonstrates that Family Hubs are a trusted and accessible setting for engaging populations at greatest risk of under-immunisation, including families experiencing deprivation, language barriers and lower uptake of routine vaccination services. The results from this Phase should be generalised to a wider population with caution due to limitations of the evaluation. Limitations include: the evaluation relied largely on self-report; the participant profile was skewed towards younger women; follow-through after GP referral was usually unconfirmed; and delivery varied by site.

The findings support continued use of the Coventry Family Hub vaccination model as a valuable approach to engaging diverse and underserved communities in trusted, accessible settings. Future delivery could build on this strength by offering a wider range of clinic days and locations, improving access to childhood vaccines where feasible, strengthening referral and follow-up arrangements, and providing clear, culturally responsive information about expected side effects and vaccination misinformation. It would also be advisable to introduce a more robust and proportionate method of data collection, agreed by partners before delivery, to capture engagement, vaccinations, referrals and subsequent outcomes. This would improve evaluation and help demonstrate the model's impact while preserving the trust, convenience and personalised support valued by participants.

Background: An introduction to Coventry Family Hub Vaccination Clinics

The Family Hub Vaccination Pilot in Coventry is a targeted, multi-agency public health initiative designed in response to declining childhood immunisation rates and to help address health inequalities across the city. Operated under a partnership between the NHS Coventry and Warwickshire Integrated Care Board (ICB), Coventry City Council Public Health and Family Hub teams, and Kenilworth and Warwick Primary Care Network (PCN), these clinics deliver free, low-barrier, drop-in immunisation services directly within community-trusted settings.

During Phase 1 (May to September 2025), the programme delivered drop-in vaccination clinics designed to support families with children who had missed their routine childhood immunisations, particularly MMR and pre-school booster vaccinations. The primary aim was to increase vaccination uptake among children approaching school age by offering convenient, accessible vaccination opportunities within family hubs, helping families to catch up on missed vaccinations and reduce the number of children entering school unprotected against vaccine-preventable diseases.

Building on the learning from the first pilot phase, Phase 2 (January to June 2026) adopted a broader engagement and behaviour-change approach. Whilst improving vaccination uptake remained an important long-term objective, it was recognised that Family Hub clinics alone were unlikely to drive significant changes in population-level vaccination coverage. In phase 1, the clinics successfully engaged local families, and around 6% of individuals engaged went on to receive a vaccination, highlighting the need for a broader approach that addressed the underlying factors influencing vaccination decisions. Consequently, the clinics were rebranded from Vaccine Drop-in Clinics to "*Ask, Talk, Decide*" sessions, reflecting a shift from vaccination delivery towards creating opportunities for parents and/or care givers to have open, informed conversations with healthcare professionals in a trusted, non-judgemental environment. Following strong engagement and positive feedback received during Phase 1, the sessions frequency was increased from one a month to twice-monthly clinics.

The longer-term ambition of the programme is to improve health literacy, strengthen confidence in vaccination, and encourage positive vaccination behaviours across families and communities, ultimately contributing to increased uptake. Recognising that confidence and trust are key drivers of vaccination behaviour, the programme has prioritised engagement with communities disproportionately affected by health inequalities focusing heavily on areas experiencing acute socioeconomic deprivation and low vaccine uptake.

Through the NIHR Health Determinants Research Collaboration (HDRC) in Coventry, the project was developed utilising psychological health models designed to systematically address vaccine hesitancy and underpinned by academic evaluations undertaken regularly throughout each phase of the pilot.

Contextual background and strategic alignment

National childhood vaccination coverage in the United Kingdom has experienced a steady, decade-long decline. Since 2017, Coventry has consistently underperformed compared to national averages, presenting significant vulnerabilities to vaccine-preventable diseases like measles, mumps, rubella, polio, and tetanus.

Public health data (Coventry Joint Strategic Needs Assessment [JSNA], 2025a) highlights persistent inequalities in childhood vaccination uptake across Coventry, with particular challenges evident in Hillfields and Foleshill. In Hillfields, uptake remains below the 95% threshold for several routine childhood vaccinations, with substantial variation between GP practices serving the area. For example, uptake of the second MMR dose by age five ranges from 69.7% to 92.1%, while rotavirus vaccination ranges from 76.2% to 91.8% (Coventry JSNA, 2025b). The picture is particularly concerning in Foleshill and Longford, where childhood vaccination uptake is generally lower than the Coventry average: MMR uptake at age two ranges from 63.0% to 97.9% across local practices, and second-dose MMR uptake at age five ranges from 69.7% to 93.4% (Coventry JSNA, 2025c). These inequalities sit within a wider context of high deprivation and considerable population diversity, while the profiles emphasise the importance of language, cultural accessibility, trust in public health messages and understanding of healthcare services.

Notably, geographical access to primary care is relatively good in both areas, suggesting that physical proximity to services alone does not explain lower uptake (Coventry JSNA, 2025b,c). The evidence therefore supports moving beyond reliance on traditional primary-care routes alone, using community-informed, culturally competent and accessible approaches, delivered in partnership with trusted voluntary, community faith and social enterprise (VCFSE) organisations, to build confidence, reduce barriers and improve childhood vaccination uptake.

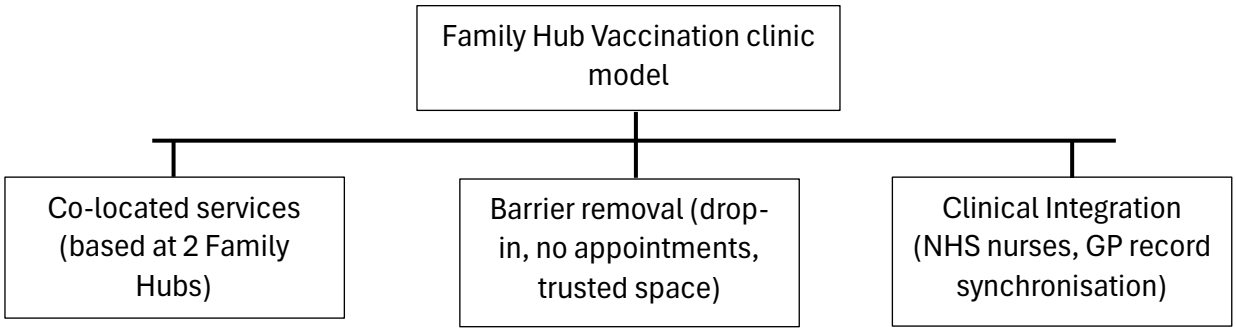
Policy Framework

To address these structural gaps, local service delivery was reframed around an integrated, neighbourhood-based model that aligns national guidance with local health protection and immunisation priorities, while directing support towards communities experiencing the greatest inequalities. This alignment leverages the following policies:

- The National Family Hub and Start for Life Framework: Using central funding to co-locate healthcare, early-years education, and social care.
- Coventry Local Plan (2026–2029): Securing sustained funding from the Department for Education (DfE) and the Department of Health and Social Care (DHSC) to sustain comprehensive place-based early intervention.
- Core20PLUS5 Infrastructure: Prioritising the poorest 20% of the population and specific ethnic minority groups facing severe health disparities.

Operational Model and Clinic Locations

The operational hallmark of the Family Hub Vaccination Clinics is the deliberate removal of systemic friction.



Core service mechanisms

- **No-Appointment Infrastructure**: Clinics operate entirely on a drop-in basis. This supports families unable to conform to strict, pre-scheduled medical appointments due to chaotic schedules or employment constraints.
- **Catch-Up Provision**: Focuses on critical milestones in phase 1 of the intervention, notably the 4-in-1 pre-school booster (DTaP/IPV) and the Measles, Mumps, and Rubella (MMR) second dose. Phase 2 encouraged vaccinations more broadly (as evidenced in Table 1).
- **Automated Data Synchronisation**: Experienced NHS immunisation nurses deliver the vaccines and instantly route clinical data to the patient's permanent primary care record, preserving data integrity across the NHS network.
- **Integrated Environments**: Clinics run alongside existing family support sessions (e.g., Bump, Baby and Beyond, toddler stay-and-play), normalising the vaccination experience within a non-clinical, supportive space.

Shared responsibility framework

Key stakeholders include (in alphabetical order):

- **Coventry City Council Family Hubs**: Provides the physical real estate of the Coventry Family Hubs and integrates internal early-help teams to actively promote the service to attending families.
- **Coventry City Council Public Health:** Coordinate and oversee the programme providing strategic leadership and performance monitoring. Public Health facilitates stakeholder engagement and ensures that delivery aligns with local vaccination priorities.
- **Kenilworth and Warwick Primary Care Network**: Provide the frontline clinical personnel (immunisation nurses), oversee the clinical delivery of vaccinations on site, established a robust data access and recording process to enable safe and effective

community-based delivery, and manage data governance arrangements including notification and reporting mechanisms to patients registered GP records.

- **NHS Coventry and Warwickshire Integrated Care Board (ICB)**: Allocates clinical funding, commissions the vaccination provider to the engagement and administer vaccines and establishes the overarching clinical governance guidelines.

Clinical framework, academic evaluation, and behavioural insights

To move towards a valid, reliable and robust evaluation, Coventry has integrated a formal academic evaluation framework into the Family Hub Vaccination Clinic model.

The NIHR HDRC Coventry Research Partnership

Working alongside the NIHR Health Determinants Research Collaboration (HDRC) Coventry, a designated Research Fellow in Quantitative and Mixed-Methods conducts ongoing, real-time evaluations of the clinic cohorts. This framework utilises established psychological health theories such as the Theoretical Domains Framework (TDF) and the COM-B model (Capability, Opportunity, Motivation, and Behaviour) to profile the parents utilising the hubs.

Research objectives
The evaluation collects mixed-methods data directly within the clinics to explore:

- Behavioural Drivers: Uncovering the root reasons why parents and/or care givers choose the informal hub environment over standard general practice clinics.
- Attitudinal Profiling: Measuring parental and/or care giver knowledge, perceptions, and deep-seated attitudes regarding the safety and necessity of the pre-school booster and MMR schedules.
- Information Ecosystems: Investigating where parents and/or care givers source their medical data (e.g., localised peer networks and social media platforms versus official NHS channels), allowing public health teams to refine their communication strategies.

The aim of this evaluation report is to provide an in-depth analysis and results from the evaluation conducted.

The Evaluation

Methodology

The questionnaire was designed to explore parental knowledge, attitudes, beliefs, and intentions regarding childhood vaccination, alongside capturing demographic characteristics and experiences of accessing vaccination services within Family Hub settings. The survey used a mixed-methods approach, combining structured quantitative questions with an open-ended qualitative question to provide both measurable data and richer contextual insights.

The first section of the questionnaire collected demographic information. Participants were asked about their gender, age, ethnicity, vaccination status, relationship to the child or children attending the Family Hub, number of children, and the ages of those children. These questions provided important contextual information that allowed researchers to understand the background characteristics of participants and explore whether attitudes towards vaccination varied across different demographic groups.

The second section focused on participants' personal and family vaccination status. Participants were asked whether they considered themselves fully vaccinated and whether their children had received recommended vaccinations. Additional questions explored whether children had already received vaccinations during Family Hub visits and whether families intended to seek future vaccinations. These items helped establish current vaccination behaviours and identify any gaps in uptake.

A further section explored future vaccination intentions and service access preferences. Participants were asked about their intentions to take their child for vaccinations in the future and where they would prefer to access vaccination services, such as through their GP practice or alternative community-based settings. For participants who were hesitant or unwilling to vaccinate their children, the questionnaire included questions about reasons for non-vaccination. Response options covered a range of concerns, including vaccine safety, effectiveness, potential side effects, worries about harm to children, fertility concerns, cultural or family influences, and beliefs about natural immunity. These questions enabled researchers to identify key barriers to vaccine uptake and understand the factors contributing to vaccine hesitancy.

The survey also incorporated a series of attitudinal statements based on constructs commonly associated with health behaviour theories, particularly the Theory of Planned Behaviour and related models. Participants were asked to indicate their level of agreement with statements concerning:

- Social influences and perceived expectations from family and significant others regarding childhood vaccination.
- Confidence in their ability to access vaccinations and obtain appropriate information.
- Perceived benefits of vaccination, including protection against illness.
- Perceived risks and concerns, such as side effects or potential harm.

- Availability of information and support from healthcare professionals.
- Personal feelings and anxieties related to vaccination and injections.
- The influence of media sources on vaccination beliefs.
- Overall confidence and trust in vaccination services.

These questions provided quantitative measures of key psychological and social factors that influence vaccination decisions. By using Likert-scale response options ranging from strong agreement to strong disagreement or varying levels of likelihood, the survey was able to capture the strength and direction of participants' beliefs.

The questionnaire also assessed perceptions of the Family Hub vaccination initiative itself. Participants were asked whether they felt it was useful to have opportunities to discuss vaccination in Family Hub settings and whether access to information, advice, and vaccination services within the community was beneficial. This component was important for evaluating the acceptability of delivering vaccination support and outreach through community-based settings rather than relying solely on traditional healthcare environments.

A significant feature of the questionnaire was the inclusion of an open-ended question at the end of the survey, inviting participants to provide comments about vaccinations or their experiences of the Family Hub clinic. This question was particularly valuable because it allowed participants to describe issues, experiences, concerns, and opinions in their own words rather than being restricted to predetermined response categories.

The open-ended responses provided important qualitative data that complemented the survey's quantitative findings. Participants frequently used this space to discuss personal experiences with childhood vaccinations, concerns about side effects, information needs, cultural influences, family pressures, logistical barriers to accessing appointments, and experiences of discussing vaccination with healthcare professionals. Many participants also reflected on positive experiences of receiving support, reassurance, and information within the Family Hub environment. Others described more complex circumstances, including vaccine hesitancy, misinformation, concerns about autism or vaccine safety, language barriers, and challenges linked to pregnancy, migration, or social isolation.

The inclusion of this open-ended question strengthened the overall methodology for several reasons. First, it enabled researchers to identify themes and issues that may not have been anticipated when designing the questionnaire. Second, it provided contextual detail that helped explain patterns observed in the quantitative responses. Third, it gave participants an opportunity to express their individual perspectives and experiences, promoting a more participant-centred approach to data collection. Finally, qualitative responses offered valuable insights into the effectiveness of Family Hub-based vaccination engagement and highlighted opportunities for service improvement.

The Results – Phase 2

Engagement in the Family Hub Vaccination Clinics

Between January and June 2026, the Family Hub Vaccination Clinics engaged a total of 446 individuals in conversations about vaccination and administered 31 vaccinations across the Harmony Hub in Hillfields and Families For All Hub in Foleshill. Engagement levels increased steadily throughout the period, rising from 31 individuals in January to a peak of 98 in April, before remaining relatively high in May (n = 64) and June (n = 104). This demonstrates sustained interest and ongoing opportunities to discuss vaccination with local communities (see table 1 for full engagement data).

Most engagement activity took place at Harmony Hub, which accounted for 257 individuals engaged (58.00%) and all 31 vaccinations administered during the six-month period. In comparison, Families For All Hub engaged 189 individuals (42.00%) but only recorded 2 vaccinations administered on-site (March). This suggests that the clinics in Foleshill were successful in providing information and raising awareness, while Hillfields was more effective in converting discussions into vaccination uptake.

Format of Family Hub Vaccination Clinics

Engagement patterns varied across the two Family Hub locations and were influenced by both operating models and the populations accessing each site. Sessions delivered at Harmony Family Hub, Hillfields were held as full-day clinics on alternate Tuesdays, providing increased opportunities for families and other Hub users to engage with the Immunisation Nurse. Reception staff played an important role in supporting engagement by actively signposting visitors and responding to enquiries, contributing to the higher levels of engagement observed at this site. In contrast, sessions at Families for All, Foleshill were delivered as half-day clinics from midday on alternate Tuesdays. While overall engagement activity was lower, the setting provided valuable opportunities to engage with a broader range of vulnerable adults, including individuals experiencing homelessness or insecure housing who accessed the venue for support services. Although these individuals generally declined vaccination, interactions increased awareness of available vaccination services and established opportunities for future engagement.

Vaccinations administered in the Family Hub Vaccination Clinics

31 vaccinations were administered during the six-month period. The majority of the vaccinations were given at Harmony Hub (29 vaccines, 93.50%). In comparison, Families For All Hub only recorded 2 vaccinations administered on-site.

Vaccination activity at the hub in Hillfields increased from February onwards, with the highest numbers recorded in March (n = 9 vaccinations) and April (n = 8 vaccinations). The most common vaccinations delivered were RSV vaccinations in pregnancy (n = 13 doses) and pertussis vaccinations (n = 13 doses), reflecting a strong focus on maternal immunisation. Additional vaccinations included adult flu vaccinations (n = 3 doses), and COVID-19 vaccination (n = 1 dose). Unlike Phase 1, no MMR, pre-school booster, child flu, or older adult

RSV vaccinations were administered during the reporting period. Although no childhood vaccinations were administered directly 6 families were supported to book GP appointments for their child's vaccinations. All of these families were from an ethnic minority background including India, Somalia, Sri Lanka and Hong Kong. Attendance at these GP appointments could not be confirmed.

Table 1. *Engagement and vaccination data from the Family Hub Vaccination clinics from January 2026 to June 2026.*

Month	Location	Number of individuals engaged*	Number of vaccinations administered	Total number of vaccinations administered							
				MMR1	MMR2	Pre-school booster	Flu (child)	Flu (adult)	RSV (older adult)	RSV (pregnancy)	Other (amount)
January	Hillfields	10	0								
	Foleshill	21	0								
February	Hillfields	24	3					1			Pertussis (2)
	Foleshill	35	0								
March	Hillfields	59	9					2		4	Pertussis (3)
	Foleshill	31	2					1			Comirnaty 30mcg (1)
April	Hillfields	74	8							3	Pertussis (5)
	Foleshill	24	0								
May	Hillfields	32	6							4	Pertussis (2)
	Foleshill	32	0								
June	Hillfields	58	3							2	Pertussis (1)
	Foleshill	46	0								

*Please note: *number of people speaking about vaccinations with the nurse.*

Participant demographics

A total of 288 individuals who engaged in the Family Hub Vaccination clinics completed the mixed-methods evaluation survey.

Please note: Upon examination of the age of participants, it became apparent that 4 individuals had selected 'under 18'. For complete transparency, and ensuring adherence to ethical guidelines and policies, the two participants were removed from the dataset, and their responses are not represented in the quantitative or qualitative findings. Therefore n = 284 participants data was analysed.

Gender

A total of 282 individuals completed the gender question within the survey, 260 participants (92.30%) identified as female and 22 participants (7.70%) identified as male. Two participants did not complete the gender question correctly, responding with their ethnicity, or providing an incorrect response of "*genuinely*" which could not be attributed to a gender.

For full transparency of data reporting, several participant responses contained apparent typographical errors (for example: "*Make", "Frmale", "Femaly",* and *"Femalea*"). These were reviewed and recoded to their most likely intended gender category for the purpose of analysis. No responses indicated a gender category other than male or female.

Age

The largest age group was 22-29 years, representing just over half of all adult participants (54.90%). Participants aged 30-39 years accounted for a further 26.4% of the sample. Together, participants aged 18-39 years comprised 95.10% of participants, indicating that the survey predominantly captured the views of younger adult parents and/or care givers. Representation from older age groups was relatively low, with 3.50% of participants aged 40-49 years, 1.10% aged 50-59 years, and 0.40% aged 60-69 years (see table 2 for visual analysis of age of participants).

Table 2. *Age of participants*

Age Group	Number of participants	Percentage of participants (%)
18-21	39	13.70
22-29	155	54.90
30-39	75	26.40
40-49	10	3.50
50-59	3	1.10
60-69	1	0.40

Ethnicity

The participant group was ethnically diverse, with participants representing a wide range of ethnic, cultural and national backgrounds. For reporting purposes, individual responses were coded into broad ethnic categories consistent with census-style groupings where possible. The largest ethnic group was Asian/Asian British, accounting for 35.80% of participants (n = 102). This category included participants identifying as Indian, Pakistani, Bangladeshi, Afghan, Sri Lankan, Chinese and related Asian backgrounds. The second largest group was Black/African/Caribbean/Black British (32.60%, n = 93), encompassing participants identifying as Black British, African, Caribbean and a range of African nationalities.

Participants identifying as White ethnic groups represented 22.10% of the sample (n=63), including White British and other White European backgrounds. A smaller proportion of participants identified with other ethnic groups (8.40%, n=24), including Arab, Iranian, Iraqi and Syrian backgrounds. Two participants (0.70%) identified as being of mixed ethnicity, and one participant (0.40%) did not state their ethnicity (see table 3 for visual analysis of ethnicity).

Table 3. *Ethnicity of participants*

Ethnicity Group*	Number of participants	Percentage of participants (%)
Asian/Asian British	102	35.80
Black / African / Caribbean / Black British	93	32.60
White	62	22.10
Other Ethnic Group	24	8.40
Mixed / Multiple Ethnic Group	2	0.70
Not stated	1	0.40

**Please note: Broad ethnic categories were derived from self-reported responses*

Important - Data Quality Note

Participants provided ethnicity information in a free-text format, resulting in a mixture of ethnic identities, nationalities, and, in a small number of cases, religious identities (for example: "Sikh" and "Muslim"). To facilitate reporting, responses were grouped into broader ethnic categories matching the census groupings which are frequently reported in data and research.

Vaccination status

Self-reported vaccination uptake was high among participants, with 92.60% (n = 263) stating that they were fully vaccinated. Childhood vaccination coverage was lower: 76.10% (n = 216) reported that all their children were fully vaccinated, while 21.50% (n = 61) reported that one or more of their children were not fully vaccinated. Taken together, these findings indicate broadly favourable parental attitudes towards vaccination, but the lower uptake among children

suggests that acceptance does not always translate into completed childhood vaccination, potentially reflecting residual hesitancy or practical barriers to access.

Participant Vaccination Status
Most participants (92.60%, n = 263) reported that they were fully vaccinated, while 7.40% (n = 21) stated that they were not fully vaccinated. This suggests that vaccination is widely accepted amongst those engaging with the Family Hub vaccination conversations and outreach activity.

Child Vaccination Status
Most participants (76.10%, n = 216) reported that all their children were fully vaccinated. However, approximately one in five participants (21.50%, n = 61) indicated that their child or children were not fully vaccinated, and a small number (1.40%, n = 4) reported that only some of their children had received all recommended vaccinations. Three responses were not applicable or did not provide sufficient information.

Relationship between parental and/or care giver vaccination status and child vaccination status
Of the 21 people who completed the evaluation and reported that they were not fully vaccinated themselves, the majority also reported that their children were not fully vaccinated (see table 4 for full breakdown of data). This suggests a strong association between parental vaccination status and childhood vaccination uptake within this participant group.

Table 4. *Summary of children vaccination status among parents and/or care givers who reported to not be fully vaccinated themselves*

Child vaccination status among participants not fully vaccinated themselves	Number of participants	Percentage of participants (%)
Child(ren) not fully vaccinated	15	71.40
All children fully vaccinated	4	19.00
Not applicable / missing data	2	9.50

Quantitative Data: The results

The survey examines participants' beliefs, understanding and intentions in relation to vaccinating their school-aged children. This section considers each survey question in turn, summarising the responses given and highlighting the key patterns emerging from the quantitative data.

Question: Most people who are important to me think I should take my child(ren) for vaccinations

Responses indicate a strong positive social influence in favour of childhood vaccination among participants (see table 5 and figure 1 for visual analysis of results). The largest group selected "Agree", comprising 123 participants (43.30%), while 85 participants (29.90%) selected "Strongly Agree". Together, these two categories accounted for 208 participants (73.20%), showing that nearly three-quarters clearly believed that people important to them thought they should take their children for vaccinations. An additional 42 participants (14.80%) slightly agreed. When all three levels of agreement are combined, 250 participants (88.0%) expressed a positive view, demonstrating a broad perception of support from family members, friends, or other influential people.

Only 16 participants (5.60%) gave a neutral response, suggesting that relatively few were uncertain or perceived no clear opinion from important people in their lives. Negative responses were uncommon: n = 8 participants (2.80%) slightly disagreed, n = 5 (1.80%) disagreed, and n = 5 (1.80%) strongly disagreed. In total, 18 participants (6.40%) expressed some level of disagreement. Positive responses therefore outnumbered negative responses by more than thirteen to one, highlighting a substantial imbalance in favour of perceived social approval.

Table 5. Participant responses ranging from strongly agree to strongly disagree

Response	Number of participants	Percentage (%)
Strongly Agree	85	29.90
Agree	123	43.30
Slightly agree	42	14.80
Neutral	16	5.60
Slightly disagree	8	2.80
Disagree	5	1.80
Strongly Disagree	5	1.80

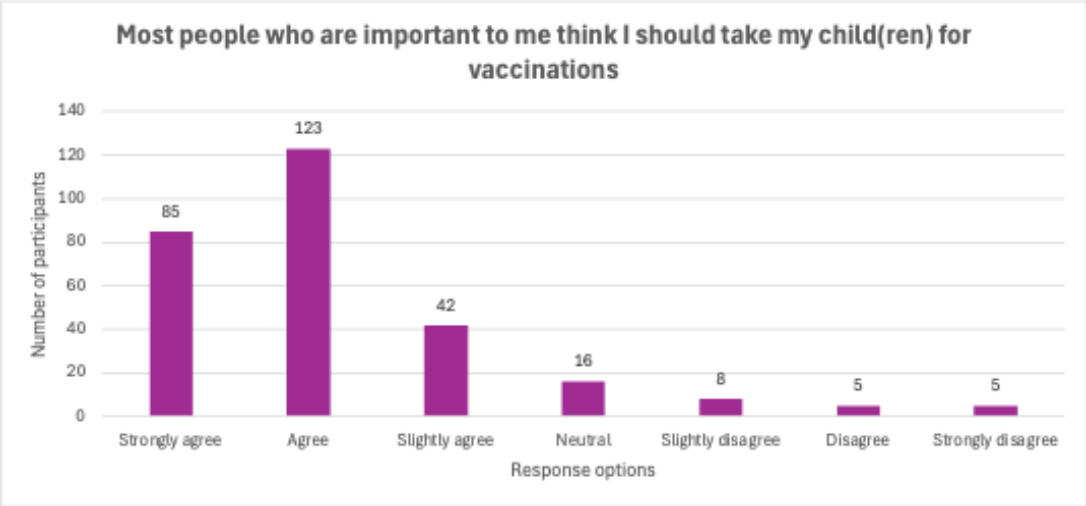


Figure 1. *Visual representation of participant responses for the question 'Most people who are important to me think I should take my child(ren) for vaccinations'.*

Question: When deciding to take my child for vaccinations, I want to do what my family thinks I should do

Responses suggest that family opinions influenced vaccination decision-making for most participants (see table 6 and figure 2 for visual analysis of results). The largest individual response category was "Slightly agree", selected by 81 participants (28.50%), followed closely by "Agree", selected by 78 participants (27.50%). A further 36 participants (12.70%) strongly agreed. Combined, these three agreement categories represented 195 participants (68.70%), indicating that more than two-thirds wanted to act in accordance with what their family thought they should do when deciding whether to take their children for vaccinations.

Neutral responses were recorded for 39 participants (13.70%), suggesting that a notable minority were either uncertain about the role of family opinion or did not express a clear preference. Negative responses were less common: n = 14 participants (4.90%) slightly disagreed, n = 17 (6.00%) disagreed, and n =19 (6.70%) strongly disagreed. Together, these categories accounted for 50 participants (17.60%).

Table 6. Participant responses ranging from strongly agree to strongly disagree

Response	Number of participants	Percentage (%)
Strongly Agree	36	12.70
Agree	78	27.50
Slightly agree	81	28.50
Neutral	39	13.70
Slightly disagree	14	4.90
Disagree	17	6.00
Strongly Disagree	19	6.70

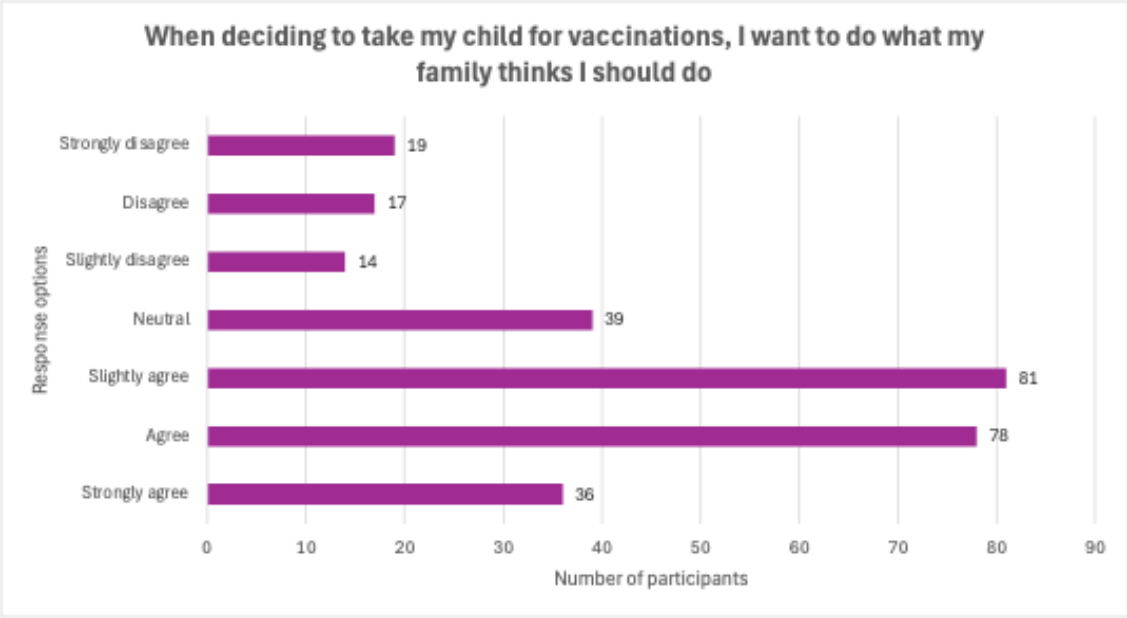


Figure 2. *Visual representation of participant responses for the question 'When deciding to take my child for vaccinations, I want to do what my family thinks I should do'.*

Question: I feel confident that I am able to take my child for vaccinations

Responses indicate a high level of confidence among participants in their ability to take their children for vaccinations (see table 7 and figure 3 for visual analysis of results). The largest response category was "Agree", selected by 105 participants (37.00%), followed by "Slightly agree", selected by 76 participants (26.80%). A further 59 participants (20.80%) strongly agreed. Combined, the three agreement categories accounted for that more than 80.00% of participants expressed at least some confidence in their ability to take their children for vaccination.

Only 12 participants (4.20%) selected a neutral response, indicating that relatively few were uncertain about their ability to access vaccination for their children. Negative responses were also uncommon: n = 18 participants (6.30%) slightly disagreed, n = 8 (2.80%) disagreed, and n = 6 (2.10%) strongly disagreed. Together, these categories represented 32 participants (11.20%). Positive responses therefore outnumbered negative responses, showing a clear overall tendency towards confidence.

Table 7. Participant responses ranging from strongly agree to strongly disagree

Response	Number of participants	Percentage (%)
Strongly Agree	59	20.80
Agree	105	37.00
Slightly agree	76	26.80
Neutral	12	4.20
Slightly disagree	18	6.30
Disagree	8	2.80
Strongly Disagree	6	2.10

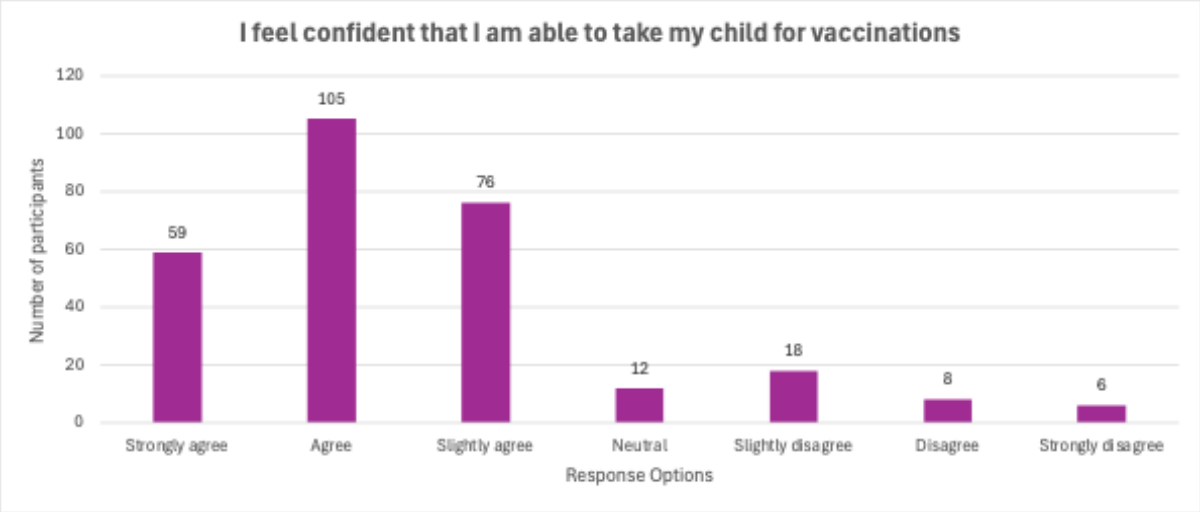


Figure 3. *Visual representation of participant responses for the question 'I feel confident that I am able to take my child for vaccinations'.*

Question: I think that taking my child for vaccinations would stop them getting ill

Responses indicate that most participants believed vaccination was likely to prevent their children from becoming ill (see table 8 and figure 4 for visual analysis of results). The largest response category was "Very likely", selected by 132 participants (46.50%), followed by "Likely", selected by 103 participants (36.30%). A further 30 participants (10.60%) selected "Slightly likely". Combined, these three categories accounted for 265 participants (93.40%), showing that more than nine in ten participants perceived vaccinations as having a protective effect against illness.

6 participants (2.10%) were neutral. Negative responses were infrequent with n = 3 participants (1.10%) considered this outcome unlikely and n = 10 (3.50%) considered it very unlikely, giving a combined unlikely response of n = 13 participants (4.60%).

Table 8. Participant responses ranging from very likely to very unlikely

Response	Number of participants	Percentage (%)
Very likely	132	46.50
Likely	103	36.30
Slightly likely	30	10.60
Neutral	6	2.10
Unlikely	3	1.10
Very unlikely	10	3.50

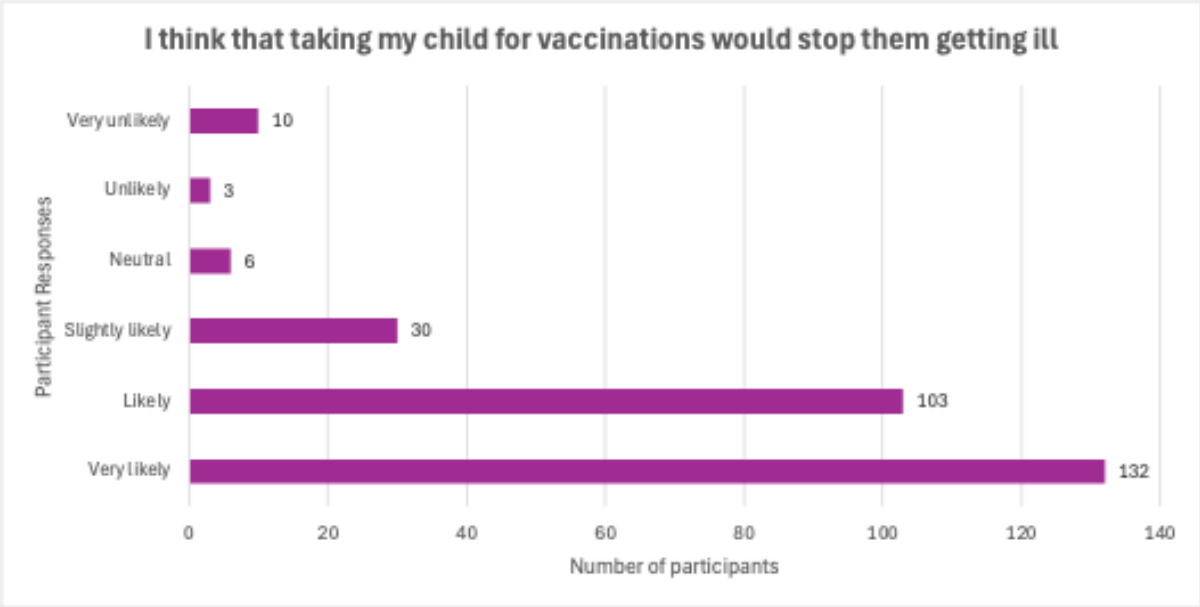


Figure 4. *Visual representation of participant responses for the question 'I think that taking my child for vaccinations would stop them getting ill'.*

Question: I think that taking my child for vaccinations would result in side effects

Responses show that most participants believed vaccination was likely to result in side effects for their children (see table 9 and figure 5 for visual analysis of results). Of the participant responses, 98 (34.50%) selected "Likely", which was the largest category, while 90 (31.70%) selected "Very likely". N = 81 participants (28.50%) considered side effects slightly likely. Together, these three categories represented 94.70% of participants, indicating that perceptions of some likelihood of side effects were almost universal within the sample.

Only 13 participants (4.60%) were neutral, while just 1 participant (0.40%) selected "Unlikely" and n = 1 (0.40%) selected "Very unlikely". The combined unlikely group therefore comprised only 2 participants (0.80%), demonstrating that parents and/or care givers are aware of side effects from vaccinations.

Table 9. Participant responses ranging from very likely to very unlikely

Response	Number of Participants	Percentage (%)
Very likely	90	31.70
Likely	98	34.50
Slightly likely	81	28.50
Neutral	13	4.60
Unlikely	1	0.40
Very unlikely	1	0.40

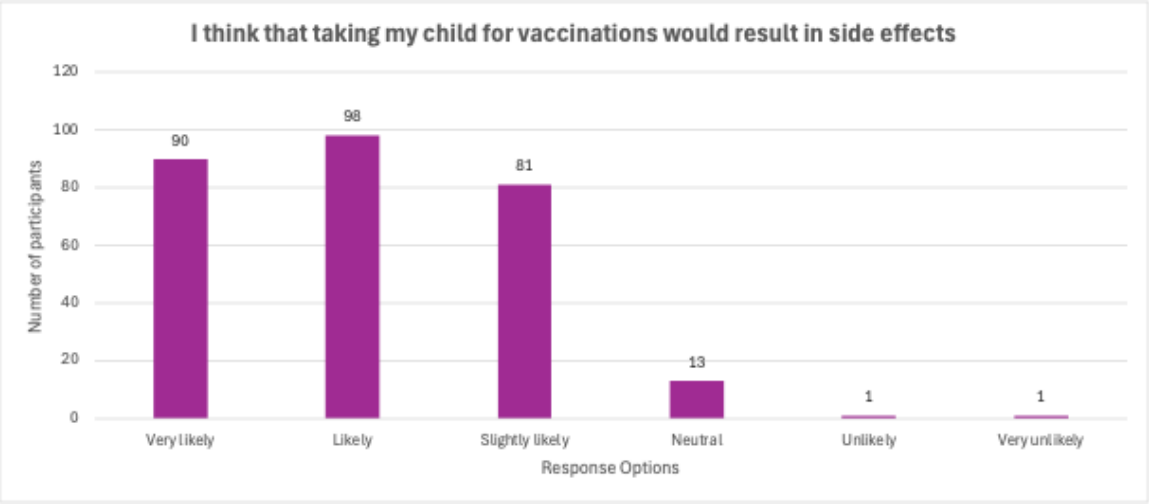


Figure 5. *Visual representation of participant responses for the question 'I think that taking my child for vaccinations would result in side effects'.*

Question: Taking my child for vaccinations would damage the way my child feels about me

Responses indicate that most participants did not believe taking their children for vaccinations would damage how their children felt about them (see table 10and figure 6 for visual analysis of results). The largest category was "Unlikely", selected by 91 participants (32.00%), followed by n = 69 participants (24.30%) who selected "Very unlikely". Combined, these categories accounted for 160 participants (56.30%), showing that more than half of participants rejected the likelihood of a negative effect on the parent–child relationship.

A significant number of participants (n = 75, 26.40%) selected a neutral response, suggesting uncertainty or an absence of a firm view. By contrast, only 9 participants (3.20%) considered such damage slightly likely, n = 3 (1.10%) considered it likely, and n = 6 (2.10%) considered it very likely. Together, these categories represented n = 18 participants (6.40%).

Table 10. Participant responses ranging from very likely to very unlikely

Response	Number of participants	Percentage (%)
Very likely	6	2.10
Likely	3	1.10
Slightly likely	9	3.20
Neutral	75	26.40
Unlikely	91	32.00
Very unlikely	69	24.30

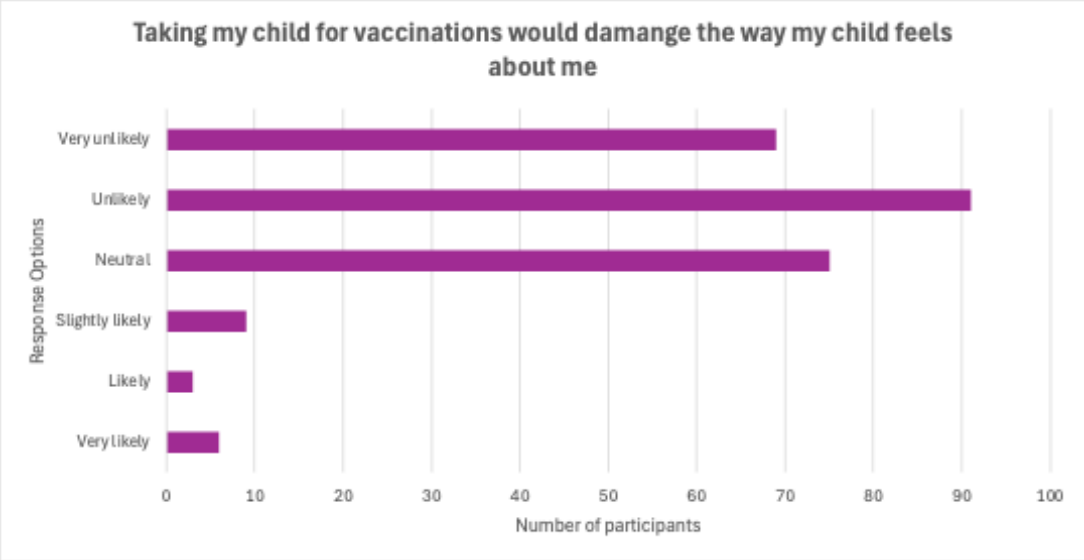


Figure 6. *Visual representation of participant responses for the question 'Taking my child for vaccinations would damage the way my child feels about me'.*

Question: I have enough information about vaccinations

Responses indicate that most of the 284 participants felt they had sufficient information about vaccinations (see table 11 and figure 7 for visual analysis of results). The largest category was "Slightly agree", selected by 93 participants (32.70%), followed by "Agree", selected by 89 participants (31.30%). A further 49 participants (17.30%) strongly agreed. Combined, the three agreement categories 81.30% of participants, showing that more than 80.00% reported at least some confidence in the information available to them. Neutral responses accounted for 27 participants (9.50%).

Negative responses were relatively small amongst participants: 18 participants (6.30%) slightly disagreed, 7 (2.50%) disagreed, and 1 (0.40%) strongly disagreed, giving a combined disagreement total of 26 participants (9.20%).

Table 11. Participant responses ranging from strongly agree to strongly disagree

Response	Number of participants	Percentage (%)
Strongly Agree	49	17.30
Agree	89	31.30
Slightly agree	93	32.70
Neutral	27	9.50
Slightly disagree	18	6.30
Disagree	7	2.50
Strongly Disagree	1	0.40

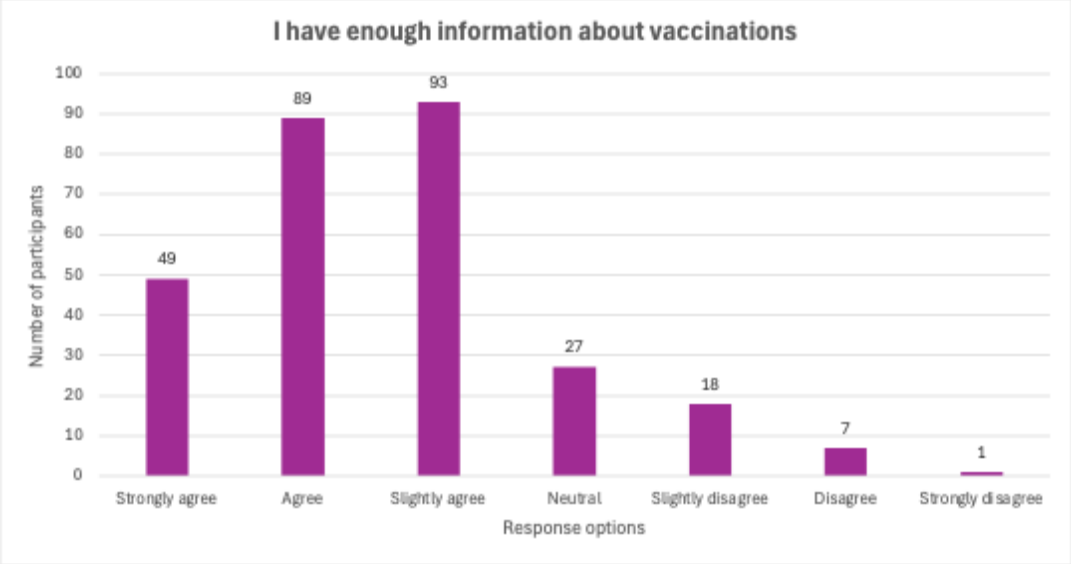


Figure 7. *Visual representation of participant responses for the question 'I have enough information about vaccinations'.*

Question: I have support from healthcare professionals about taking my child for vaccinations

Responses show that most participants perceived support from healthcare professionals regarding childhood vaccination (see table 12 and figure 8 for visual analysis of results). "Strongly agree" and "Agree" were each selected by 80 participants (28.20%), while 73 participants (25.70%) slightly agreed. Together, these three categories accounted for 233 participants (82.10%), indicating that more than four-fifths experienced at least some professional support.

A further 35 participants (12.30%) were neutral. Only 9 participants (3.20%) slightly disagreed, n = 6 (2.10%) disagreed, and n = 1 (0.40%) strongly disagreed, producing a combined disagreement total of n = 16 participants (5.70%).

Table 12. Participant responses ranging from strongly agree to strongly disagree

Response	Number of participants	Percentage (%)
Strongly Agree	80	28.20
Agree	80	28.20
Slightly agree	73	25.70
Neutral	35	12.30
Slightly disagree	9	3.20
Disagree	6	2.10
Strongly Disagree	1	0.40

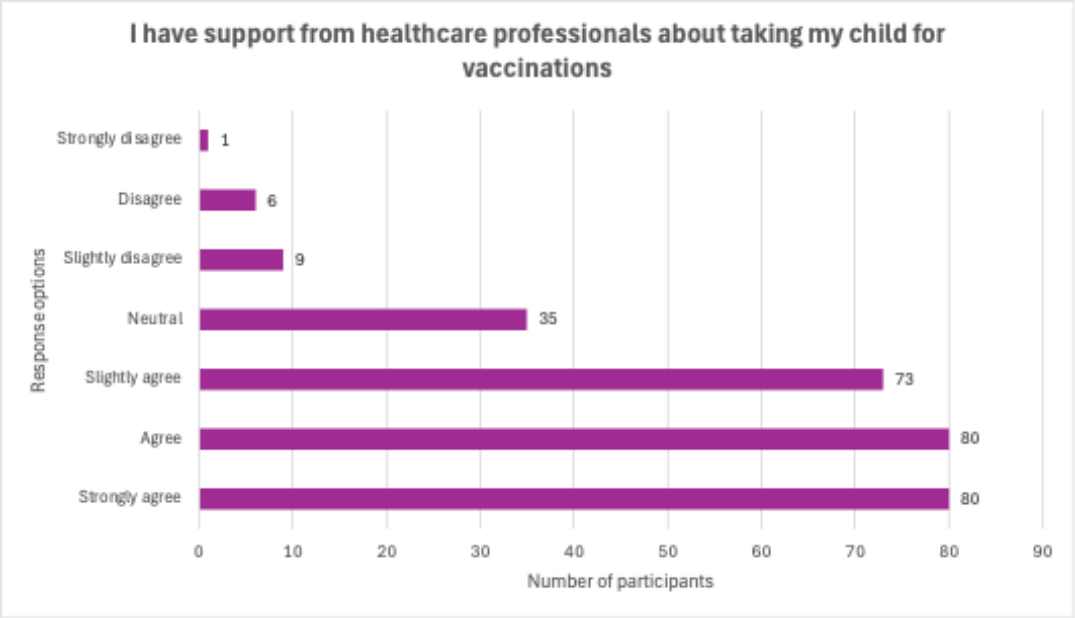


Figure 8. *Visual representation of participant responses for the question 'I have support from healthcare professionals about taking my child for vaccinations'.*

Question: I hate having injections myself

Responses to the statement about disliking injections were more varied than those for the preceding questions (see table 13 and figure 9 for visual analysis of results). The largest category was "Slightly agree", selected by 96 participants (33.80%), followed by a substantial neutral group of 81 participants (28.50%). A further 26 participants (9.30%) agreed and 20 (7.00%) strongly agreed.

Combined, 142 participants (50.10%) expressed some degree of dislike of injections. Negative responses were reported by a total of 61 participants (21.50%): n = 20 (7.00%) slightly disagreed, n = 24 (8.50%) disagreed, and n = 17 (6.00%) strongly disagreed.

The large neutral group also indicates considerable variation or uncertainty in participants' attitudes, and the responses do not establish whether personal dislike influenced decisions about their children's vaccinations.

Table 13. Participant responses ranging from strongly agree to strongly disagree

Response	Number of participants	Percentage (%)
Strongly Agree	20	7.00
Agree	26	9.30
Slightly agree	96	33.80
Neutral	81	28.50
Slightly disagree	20	7.00
Disagree	24	8.50
Strongly Disagree	17	6.00

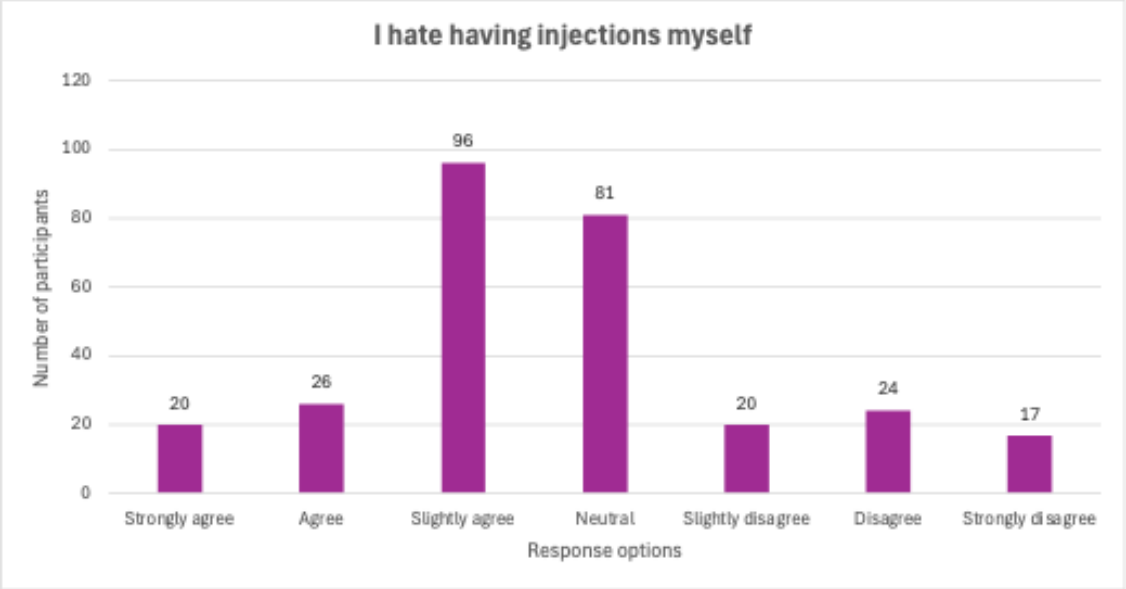


Figure 9. *Visual representation of participant responses for the question 'I hate having injections myself'.*

Question: I get information from the media about vaccinations

Responses indicate that the media was a source of vaccination information for most participants, although the strength of agreement was generally modest (see table 14 and figure 10 for visual analysis of results). The largest category was "Slightly agree", selected by n = 102 participants (35.90%), followed by "Agree", selected by n = 55 participants (19.40%), and "Strongly agree", selected by n = 10 participants (3.50%). Combined, n = 167 participants (58.80%) reported obtaining at least some vaccination information from the media.

Neutral responses were recorded for 46 participants (16.20%). In contrast, n = 22 participants (7.70%) slightly disagreed, n = 21 (7.40%) disagreed, and n = 28 (9.90%) strongly disagreed, giving a combined disagreement total of n = 71 participants (25.00%).

Table 14. Participant responses ranging from strongly agree to strongly disagree

Response	Number of Participants	Percentage (%)
Strongly Agree	10	3.50
Agree	55	19.40
Slightly agree	102	35.90
Neutral	46	16.20
Slightly disagree	22	7.70
Disagree	21	7.40
Strongly Disagree	28	9.90

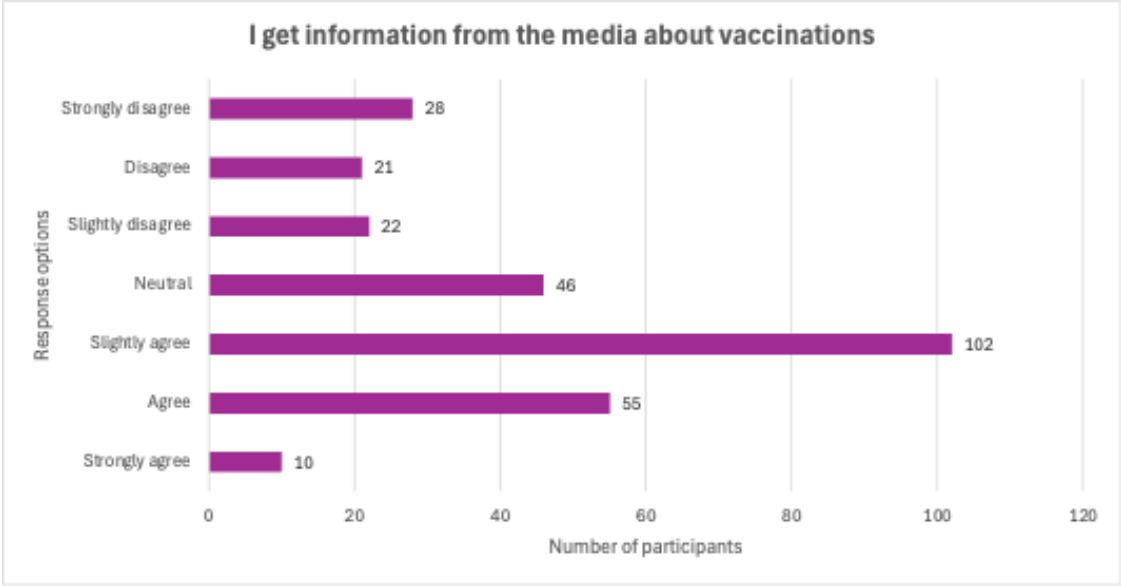


Figure 10. *Visual representation of participant responses for the question 'I get information from the media about vaccinations'.*

Question: I worry about taking my child for vaccinations

Responses show a mixed pattern of worry about taking children for vaccinations (see table 15 and figure 11 for visual analysis of results). The largest category was "Slightly agree", selected by 117 participants (41.20%), while n = 16 participants (5.60%) strongly agreed and n = 10 (3.50%) agreed. Combined, n = 143 participants (50.30%) expressed some degree of worry, although most of this concern was mild. Neutral responses accounted for n = 35 participants (12.30%).

A total of 106 participants (37.30%) expressed disagreement: n = 24 (8.50%) slightly disagreed, n = 41 (14.40%) disagreed, and n = 41 (14.40%) strongly disagreed.

Table 15. Participant responses ranging from strongly agree to strongly disagree

Response	Number of participants	Percentage (%)
Strongly Agree	16	5.60
Agree	10	3.50
Slightly agree	117	41.20
Neutral	35	12.30
Slightly disagree	24	8.50
Disagree	41	14.40
Strongly Disagree	41	14.40

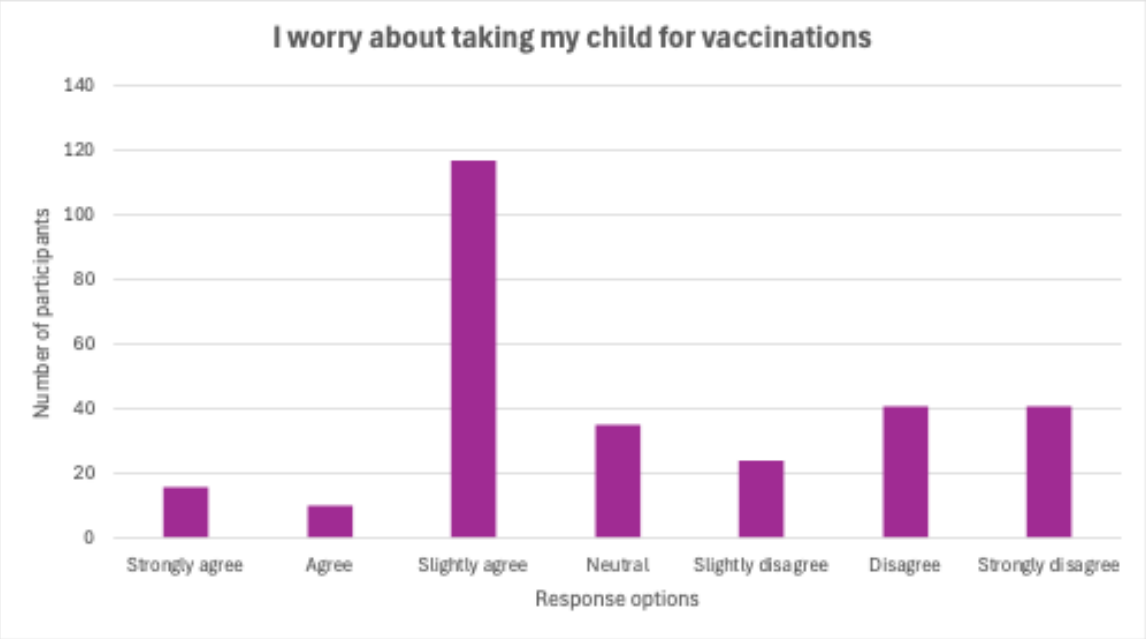


Figure 11. *Visual representation of participant responses for the question 'I worry about taking my child for vaccinations'.*

Question: It is useful to have the opportunity to talk about vaccinations in Family hubs and get my child protected if I choose.

Responses indicate very strong support for having opportunities to discuss vaccinations in Family Hubs and, if parents and/or care givers choose, to have their children protected (see table 16 and figure 12 for visual analysis of results). The largest category was "Agree", selected by 130 participants (45.80%), followed by "Strongly agree", selected by n = 81 participants (28.50%). A further 52 participants (18.30%) slightly agreed. Combined, these three categories accounted for n = 263 of the 284 participants (92.60%), demonstrating that more than nine in ten regarded this opportunity as useful.

Neutral responses were recorded for 19 participants (6.70%), suggesting that a small minority were uncertain or did not express a clear view. Negative responses were exceptionally rare: n = 1 participant (0.40%) slightly disagreed and n = 1 (0.40%) strongly disagreed. No participants answered 'disagree' for this question.

Overall, the results demonstrate overall positivity of Family Hubs as a setting in which parents and/or caregivers can receive vaccination information, discuss concerns, and access protection for their children when they choose to do so.

Table 16. Participant responses ranging from strongly agree to strongly disagree

Response	Number of participants	Percentage (%)
Strongly Agree	81	28.50
Agree	130	45.80
Slightly agree	52	18.30
Neutral	19	6.70
Slightly disagree	1	0.40
Strongly Disagree	1	0.40

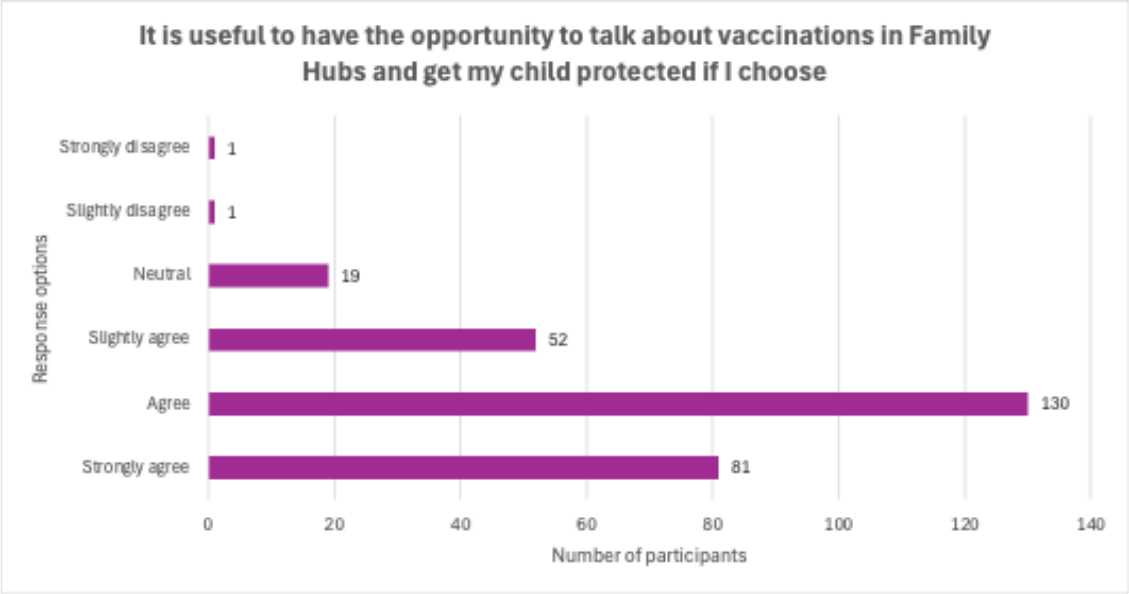


Figure 12. *Visual representation of participant responses for the question 'It is useful to have the opportunity to talk about vaccinations in Family hubs and get my child protected if I choose'*

Overall summary of quantitative findings

Overall, the findings demonstrate predominantly positive attitudes towards childhood vaccination among the 284 parents and/or caregivers surveyed. Most participants perceived strong social approval for vaccination: 88.00% believed that people important to them thought they should vaccinate their children, and 68.70% wanted to act in accordance with their family's views. Confidence was also high, with 84.60% reporting that they felt able to take their children for vaccination. These results suggest that vaccination decisions were generally supported by favourable family and social expectations, alongside a strong sense of personal capability.

Participants also showed a strong belief in the benefits of vaccination. More than 9 in 10 (93.40%) considered vaccination likely to prevent illness, while only 4.60% considered this unlikely. Most did not believe vaccination would damage their relationship with their child: 56.30% considered this outcome unlikely or very unlikely, compared with 6.40% who considered it at least slightly likely, although 26.40% were neutral. Participants generally felt informed and supported about vaccinations, with 81.30% reporting sufficient vaccination information and 82.10% perceiving that they receive support from healthcare professionals. Media sources also appeared to play a role in shaping vaccination information, with 58.80% of participants reporting that they obtained at least some information from the media; however, the relatively weak level of agreement suggests this was often a supplementary source rather than the main source of information.

Despite this broadly positive outlook, the results also show more negative perceptions around side effects, injections and worry about taking children for vaccination. Almost all participants (94.70%) believed side effects were at least slightly likely, although the question did not distinguish mild, expected reactions from serious effects. Half (50.10%) reported some dislike of injections, and 50.30% expressed some worry about taking their child for vaccination; however, most of this worry was slight, while 37.30% disagreed that they were worried. This pattern suggests that favourable attitudes towards vaccination can coexist with anxiety, discomfort and expectations of side effects.

Clear, balanced discussions about common reactions, safety, pain management and practical access may therefore help parents and/or caregivers make informed choices with greater confidence.

The response to the proposed Family Hub offer was especially positive. In total, 92.60% agreed that it was useful to discuss vaccinations in Family Hubs and to have the option of protecting their child there, while only 0.80% expressed disagreement. This was among the strongest positive findings across the survey and indicates that Family Hubs are viewed as an acceptable and valuable setting for vaccination conversations and delivery.

Qualitative Data: Thematic Analysis

A thematic analysis was undertaken on the responses provided to the open-ended survey question: *"If you would like to provide any comments on vaccinations or this clinic at the Family Hub, please use this space."* Responses ranged from brief comments to detailed narratives about vaccination experiences, beliefs, service accessibility, and family circumstances.

Analysis identified six overarching themes (see table 17 for the Thematic Table including participant quotations):

- Trust in vaccination and positive attitudes towards immunisation,
- Vaccine hesitancy and safety concerns,
- Value of healthcare professional support and information,
- Accessibility and convenience of Family Hub services,
- Social, cultural and family influences on vaccination decisions, and
- MMR/MMRV-specific concerns and Autism narratives.

Please note: For some responses, participants gave a verbal response to the Practitioner Nurse leading the clinics which is reflected in some quotes being in third person.

Theme 1: Trust in Vaccination and Positive Attitudes Towards Immunisation

The dominant theme throughout the responses was strong support for childhood and maternal vaccination. Many parents and/or caregivers reported that they and their children were fully vaccinated and expressed confidence in vaccines as a means of protecting health and preventing serious diseases. Vaccination was frequently viewed as a responsible parental behaviour and an important contribution to community wellbeing.

Several participants specifically described continuing vaccination despite mild side effects because they recognised the protective benefits. Others referred to vaccination as a normal practice within their family or culture. Positive comments were especially common among parents and/or caregivers who had received accurate information from healthcare professionals and had positive previous experiences with immunisation.

Many participants also demonstrated high levels of awareness about upcoming vaccinations and actively planned to attend future appointments.

Theme 2: Vaccine Hesitancy and Safety Concerns

Although most participants were supportive of vaccination, a notable minority expressed varying degrees of hesitancy. Safety concerns were the most common barrier. Participants worried about side effects, believed vaccines might cause developmental disorders such as autism, or expressed concerns regarding long-term health consequences.

The MMR and MMRV vaccines emerged repeatedly as a specific source of anxiety (see theme 6 for further information). Several participants referred to stories from friends, family members, online forums, or social media suggesting links between these vaccines and autism or

developmental delays. Others preferred delaying vaccination or administering vaccines separately.

Some participants also reported concerns about pregnancy vaccinations, fertility, vaccine ingredients, or the perceived risks of causing harm to a child. In a smaller group of responses, participants rejected vaccination altogether, believing that natural immunity provided sufficient protection. These accounts demonstrate that vaccine hesitancy was rarely based on a single factor; rather, it reflected a combination of fear, misinformation, anecdotal evidence, and uncertainty.

Theme 3: Importance of Healthcare Professional Support and Information

A key finding was the significant role of healthcare professionals in addressing concerns and building vaccine confidence. Numerous participants described positive conversations with immunisation nurses, health visitors, practice nurses, and midwives.

Participants valued opportunities to ask questions, discuss side effects, gain reassurance, and receive practical advice about managing post-vaccination reactions. Many specifically commented that healthcare professionals listened respectfully to their concerns rather than dismissing them. This appeared especially important for individuals who were initially hesitant.

For some participants, conversations with nurses resulted in increased willingness to vaccinate, delayed refusal becoming acceptance, or greater confidence in attending future appointments. Parents and/or care givers frequently mentioned learning about the updated childhood vaccination schedule, understanding side effects, and receiving evidence-based information to counter myths and misinformation. The findings suggest that trusted healthcare relationships play a critical role in supporting informed vaccination decisions.

Theme 4: Accessibility and Convenience of Family Hub Services

Participants consistently highlighted the benefits of discussing vaccination within the Family Hub environment. The co-location of vaccination advice alongside midwifery, health visiting, and family support services was viewed positively.

Participants described Family Hubs as accessible, welcoming, and convenient. For pregnant women, the ability to receive vaccination information or pregnancy vaccines during existing appointments reduced barriers to access. Parents and/or care givers with multiple children also appreciated avoiding additional journeys or appointments. Many comments indicated that parents and/or care givers valued the opportunity for informal conversations in a familiar community setting. Several participants expressed disappointment that childhood vaccines themselves were not always available at the Family Hub, suggesting that direct vaccine delivery would further improve convenience and uptake. Overall, Family Hubs appeared to function as effective locations for both engagement and health promotion.

Theme 5: Social, Cultural and Family Influences

Vaccination decisions were frequently influenced by social and cultural contexts. Family members often played a major role in shaping attitudes. Some participants described strong family support for vaccination, while others reported pressure from relatives who opposed vaccines.

Partners, grandparents, religious beliefs, and wider community networks all emerged as influential factors. Several women described situations where family expectations either encouraged vaccination or contributed to hesitancy. Cultural traditions and experiences from countries of origin also affected beliefs.

Social media and online sources appeared particularly influential among hesitant participants. Misinformation surrounding autism, vaccine safety, and fertility was commonly referenced. In contrast, participants who had positive support networks often described being encouraged by family members, healthcare professionals, or trusted community groups. These findings highlight that vaccination decisions occur within broader social systems rather than being solely individual choices.

Theme 6: MMR/MMRV-specific Concerns and Autism Narratives

A prominent theme emerging from the qualitative comments was persistent concern about the MMR/MMRV vaccine, particularly its perceived association with autism and developmental difficulties. Although most participants expressed general support for childhood vaccination, the MMR/MMRV vaccine was frequently singled out as a source of anxiety. Parents and/ or care givers commonly referred to information encountered through social media, internet searches, friends, family members, and community networks, with several recounting anecdotal stories of children who had reportedly “stopped talking,” experienced developmental regression, suffered serious illness, or developed autism following vaccination.

These personal narratives often appeared more influential than official health information, leading some parents and/or care givers to delay, decline, or seek alternatives to the combined vaccine. Concerns were also reinforced by mistrust of government and healthcare sources among a minority of participants, who questioned the transparency of vaccine safety information. Nevertheless, the data also demonstrated that open, non-judgemental discussions with healthcare professionals could influence decision-making.

Many parents and/or care givers engaged in conversations about the lack of evidence linking MMR/MMRV vaccination to autism, were reassured about vaccine safety and side effects, and reported reconsidering their position, including delaying rather than refusing vaccination altogether or agreeing to vaccinate before school entry. Overall, the findings suggest that autism-related narratives remain a significant driver of MMR/MMRV-specific vaccine hesitancy, despite widespread awareness that scientific evidence does not support a causal relationship, highlighting the enduring impact of misinformation and anecdotal accounts on parental decision-making.

Table 17. *Thematic Table highlighting key theme, description and participants quotes*.

Theme	Description	Example quotations
1. Trust in vaccination and positive attitudes towards immunisation	Many participants expressed strong confidence in vaccines and viewed them as an important way of protecting children, families and communities from disease.	*"I believe we should all be vaccinated. Children and adults. Keep everyone safe."* (Participant 169) *"Mother was very positive about ensuring she and her child are vaccinated."* (Participant 189) *"Very compliant with all vaccines happy for child to have all that's offered."* (Participant 112)
2. Vaccine hesitancy and safety concerns	Participants who expressed hesitancy most commonly cited concerns about side effects, autism, vaccine safety, fertility concerns, or a preference for natural immunity.	*"Mother does not want her child to have the MMR vaccine at 18 months. Listened to her concerns - what she'd read on Google."* (Participant 66) *"I do not believe vaccines are effective; I do not worry that they become ill as they have their own immunity system."* (Participant 193) *"She believes that the vaccines cause harm to the body."* (Participant 132) *"Mother herself has never been vaccinated because parents didn't agree with vaccination. Her child is 2 and unvaccinated."* (Participant 191)
3. Importance of healthcare professional support and information	Participants valued the opportunity to discuss concerns with healthcare professionals and often reported	*"It's been very helpful to have a chat with the nurse. I know that I could ask for advice if needed."* (Participant 165)

	greater confidence after receiving information and reassurance.	*"Lovely to be able to spend time with Mum listening to her concerns and going through the benefits of the vaccinations due."* (Participant 81) *"I was reassured that this was the right thing to do. I wouldn't hesitate to give it to her when she has her next vaccines."* (Participant 167)
4. Accessibility and convenience of family hub services	Participants highlighted the value of receiving information and support in a familiar, community-based setting and often requested direct vaccination provision within the hubs.	*"This hub is the best place in Coventry."* (Participant 171) *"It saved me a lot of time because I have other children to look after."* (Participant 171) *"It would have been very convenient to have her child vaccinated today."* (Participant 257) *"Having her child/children vaccinated here would be a great help with regards getting to appointments."* (Participant 254)
5. Social, cultural and family influences on decision-making	Vaccination beliefs were strongly influenced by family expectations, cultural norms, migration experiences, community narratives and social media.	*"My husband from Africa wasn't fully vaccinated and influenced by media that vaccines are harmful."* (Participant 28) *"Her in-laws are anti-vaccination … but her husband is very supportive and agrees with vaccination."* (Participant 195) *"I do what my family think is right and best."* (Participant

		201) *"Mum understands the need for vaccinations and explained that in Guyana vaccination is compulsory."* (Participant 83)
6. MMR/MMRV-specific concerns and autism narratives	A sub-theme that emerged repeatedly involved anxiety surrounding MMR/MMRV vaccines and perceived links with autism, despite participants often acknowledging contradictory evidence.	*"Older child aged 20 years had MMR vaccine as a child but went on to develop ADHD and autism which mum believes was due to the vaccine."* (Participant 117) *"She is solely concerned that it will give him autism."* (Participant 206) *"Asked specifically about risk of autism and a friend whose child stopped talking after their 18-month vaccinations."* (Participant 50) *"Mother is very apprehensive about taking child for her one-year vaccines. It is the MMRV vaccine that worries her."* (Participant 211)

Conclusion of qualitative analysis

The thematic analysis demonstrates that most participants held positive views towards vaccination and regarded immunisation as an important means of protecting children and families. However, concerns about safety, side effects, autism, and pregnancy vaccination remained evident among a minority of participants. The findings emphasise the importance of trusted healthcare professionals, accessible community-based services, and ongoing opportunities for dialogue. Family Hubs appear particularly effective in creating supportive environments where concerns can be discussed, misinformation addressed, and confidence in vaccination strengthened.

Practitioner feedback and reflections

The following section presents feedback gathered from practitioners involved in the Family Hub Vaccination Pilot. Not all practitioners provided a response, so the findings should be interpreted as personal insights from those who contributed rather than a complete account of all practitioner views. To support clear reporting and preserve confidentiality, responses have been aggregated to identify common reflections, learning points and areas for improvement across the pilot.

Successes

Practitioner feedback highlighted several important strengths in the delivery of the Family Hub Vaccination Pilot. Family Hubs were keen to support the pilot because it aligned closely with their wider service commitments, including the Best Start in Life programme and their role in providing accessible, integrated support for families. This strong strategic alignment meant the hubs were well placed to offer space, promote the sessions, and support engagement with parents and caregivers in familiar and trusted community settings.

Practitioners valued the opportunity to have informal, supportive conversations with families about vaccination outside a traditional clinical environment. Promotional items and soft toys provided to the vaccine team enabled them to create a more relaxed feel to clinics and acted as an aid to engagement. The model helped create a more approachable setting for discussing questions, uncertainty and misinformation, while also offering families the opportunity to access vaccination advice alongside other family support services.

The partnership approach between Public Health, Family Hubs, NHS partners and the vaccination provider was also seen as a key strength, helping to create a more joined-up offer for families. The Family Hubs were able to facilitate relationships between the vaccination team and other health services like health visitors and midwives which broadened the reach of the pilot further.

A key success identified by practitioners was the contribution of Family Hub reception staff in facilitating engagement with the clinics. Across both Harmony Family Hub, Hillfields and Families for All, Foleshill, reception teams actively promoted the presence of the Immunisation Nurse, directing parents, carers and other visitors to the sessions and encouraging informal conversations about vaccination. This proactive signposting helped maximise opportunities to engage individuals who may not have specifically attended for vaccination support, increasing the visibility and accessibility of the service within a trusted community setting. Practitioners reported that the close working relationship between reception staff and clinic staff was instrumental in generating enquiries, supporting opportunistic discussions about vaccination, and helping families access timely information and advice. This highlights the important role that wider Family Hub staff can play in supporting vaccination engagement and demonstrates the value of embedding healthcare professionals within existing community services.

Challenges

Practitioners also identified several practical challenges that should be considered in any future delivery model. These included the need for better promotion of the clinics, improved processes for sharing attendance, referral and outcome data and creating better links with local GPs in clinic locations. Some of these challenges reflected the fact that this was a new initiative. Another reported limitation of pilot was that the clinics were only available on certain days, and it would have been better to have more days and times so a wider range of people could be accessed.

Practitioners identified challenges relating to the accurate recording of vaccination status for some families. During delivery, several individuals were identified as appearing overdue or unvaccinated within NHS systems, despite having received vaccinations abroad. While this presented an important opportunity to improve the completeness and accuracy of vaccination records, practitioners reported that existing recording systems lacked the flexibility required to capture this information effectively within the clinic setting and were not designed for this specific purpose. Options for documenting overseas vaccinations were explored; however, logistical barriers, including the absence of an appropriate system for recording and sharing information, alongside concerns about relying on paper-based processes that would subsequently require manual entry by GP practices, limited the feasibility of this approach. Practitioners also highlighted uncertainty regarding whether information collected through alternative routes would be consistently transferred into primary care records. As a result, some individuals may have continued to be recorded as under-vaccinated despite having received the relevant vaccinations elsewhere. This highlights a wider systems-level challenge and suggests that future programmes would benefit from the development of more flexible recording processes and clearer pathways for validating and updating vaccination records for individuals vaccinated outside the UK.

Conclusions and future recommendations

The findings from Phase 2 demonstrate that Family Hubs are a highly acceptable and strategically valuable setting for vaccination conversations, particularly for families who may experience barriers to accessing traditional healthcare services.

The pilot generated strong engagement, with 446 individuals speaking with a nurse about vaccination and 92.60% of survey respondents agreeing that it was useful to have opportunities to discuss vaccination in Family Hubs. This suggests that the Family Hub model should be retained as part of Coventry's wider approach to improving vaccine confidence, supporting informed decision-making and reducing inequalities in access.

However, the evaluation also shows that engagement alone does not automatically translate into vaccination uptake, particularly for childhood immunisations. While 31 vaccinations were administered during Phase 2, these were predominantly maternal vaccinations, and no MMR, pre-school booster or child flu vaccinations were delivered on site. The future model should therefore strengthen the pathway from conversation to action, ensuring that families who are willing to vaccinate can be supported to do so as easily and quickly as possible.

Recommendations

1. Retain Family Hubs as trusted settings for vaccination conversations
Family Hubs should continue to be used as trusted community settings for vaccination advice, reassurance and informed decision-making. The high level of participant support for the Family Hub offer indicates that families value opportunities to speak with healthcare professionals in familiar, accessible and non-judgemental environments. This is particularly important for parents and caregivers who may feel uncertain, have practical barriers to attending GP appointments, or want more time to discuss vaccination than is usually available in routine clinical settings.

Future provision should preserve the strengths of the current approach, including informal conversations, flexible drop-in access and integration with existing Family Hub activity. The "Ask, Talk, Decide" model remains appropriate because it avoids a purely transactional focus on vaccination and instead supports trust, confidence and choice.

2. Strengthen the pathway from advice to vaccination
Future clinics should place greater emphasis on converting positive engagement into completed vaccination where families choose to proceed. Where feasible, future sessions should include the ability to deliver a broader range of key vaccines on site.
Where on-site vaccination is not possible, there should be a clear and reliable referral pathway into GP practices or other appropriate vaccination services. This should include agreed processes for booking appointments, confirming attendance and following up with families who do not attend. Without this, the impact of the intervention is likely to be under-recorded and opportunities to support under-vaccinated people may be missed.

3. Prioritise families most likely to benefit from targeted support
The evaluation identified an important association between parental and child vaccination status. Among participants who reported that they were not fully vaccinated themselves, 71.40% also reported that their child or children were not fully vaccinated. This suggests that parental vaccination status may be a useful marker for identifying families who could benefit from additional, supportive vaccination conversations.

Future delivery should therefore prioritise families where there is evidence of missed or delayed vaccination, parental hesitancy, uncertainty about vaccination history, or difficulty accessing routine services. This should be done sensitively and without stigma, using the Family Hub environment to offer practical help, reassurance and clear information rather than judgement or pressure.

4. Address side effects, injections and worry directly
Although overall attitudes towards vaccination were positive, the findings show that many participants continued to hold more negative perceptions around side effects, injections and worry about taking their child for vaccination.

Future sessions should therefore routinely include clear, balanced and practical information about what side effects are common, what is expected, what would be unusual, and when to seek advice. Conversations should also include simple reassurance about pain management, comforting children during vaccination, and what parents can do before and after appointments. Addressing these issues directly may help reduce anxiety and support parents to move from positive attitudes to action.

5. Develop a stronger response to misinformation and MMR/MMRV-specific concerns
The qualitative findings show that MMR/MMRV-specific concerns, particularly around autism and developmental difficulties, remain persistent despite wider positive attitudes towards vaccination. These concerns were often shaped by anecdotal accounts, family stories, online information and social media. This indicates that future provision should include a more structured approach to responding to misinformation.

Staff involved in the clinics should be equipped with clear, consistent and culturally responsive messages about MMR/MMRV, vaccine safety, autism narratives, fertility concerns, pregnancy vaccination and natural immunity. The aim should not be to dismiss concerns, but to acknowledge them respectfully, provide accurate information and support families to weigh up risks and benefits with confidence. This is especially important given the evidence that trusted conversations with healthcare professionals helped some parents reconsider their position or feel more reassured.

6. Recognise the influence of family, culture and community networks
Vaccination decisions were strongly shaped by family expectations, cultural experiences, community narratives and wider social influences. Survey findings showed that most

participants perceived social approval for childhood vaccination, and many wanted to act in line with what their family thought they should do. Qualitative findings also showed that family influence could either support vaccination or contribute to hesitancy.

Future communication and engagement should therefore consider the wider family and community context, not only the individual parent or caregiver. Where appropriate, Family Hub sessions could support conversations with partners, grandparents or other influential family members. Public health messages should also be designed with input from communities to ensure they are culturally relevant, accessible and responsive to the concerns families are hearing in their own networks.

7. Improve operational planning and partner responsibilities

Before future delivery begins, a comprehensive planning process should be undertaken for partners to agree roles, responsibilities and processes across Public Health, Family Hubs, NHS commissioners, the vaccination provider and GP practices.

Consideration should be given to broadening the operating model to include other locations within Coventry and offer more variation in clinic times.

8. Establish a shared monitoring and outcomes framework

Future delivery should include a shared monitoring framework that captures the full pathway from conversation to outcome.

This should include:

- number of people engaged;
- reason for engagement;
- vaccine discussed;
- vaccination status or eligibility where known;
- whether a vaccine was administered on site;
- whether a referral or appointment was made;
- whether attendance was confirmed;
- whether vaccination was completed; and
- any follow-up action required.

This would allow partners to evidence not only activity, but also the impact of the model on vaccine confidence, access and uptake.

9. Review site-level variation and adapt delivery accordingly

Rather than assuming one model will work in the same way across all sites, future provision should allow for some local adaptation. Each hub should have a delivery plan based on local population needs, existing Family Hub activity, vaccination coverage data and community insight.

10. Continue evaluation and learning over time

Future delivery should continue to include both quantitative and qualitative evaluation. The Phase 2 findings provide valuable insight into attitudes, beliefs and service acceptability, but

further evaluation is needed to understand whether the model contributes to measurable improvements in vaccination uptake over time.

Future evaluation should aim to include a broader range of participants, improve outcome tracking, and explore whether families who receive advice or support subsequently complete vaccination. It may also be helpful to collect practitioner feedback more systematically, ensuring that learning from delivery staff is captured throughout the programme rather than only at the end.

Overall conclusion

The Family Hub vaccination model should be viewed as a valuable community-based engagement and confidence-building intervention, rather than solely as a vaccination delivery clinic. Its greatest strength lies in creating trusted opportunities for conversation, reassurance and practical support among families who may otherwise face barriers to vaccination. To maximise impact, future provision should retain this relational and choice-based approach while strengthening the practical pathway into completed vaccination, improving data capture, and embedding clearer operational arrangements across partners.