CVDR/S6/21/14/3

COVID-19 Recovery Committee

14th Meeting, 2021 (Session 6), Thursday, 9 December 2021

Panels on the Vaccination Programme

The committee will be taking evidence on the vaccination programme and, specifically, uptake of vaccines by ethnicity and deprivation. This note sets out some of the statistics on vaccine uptake, and some of the issues Members may wish to pursue. As many of the issues appear to be common for both panels these have been grouped together.

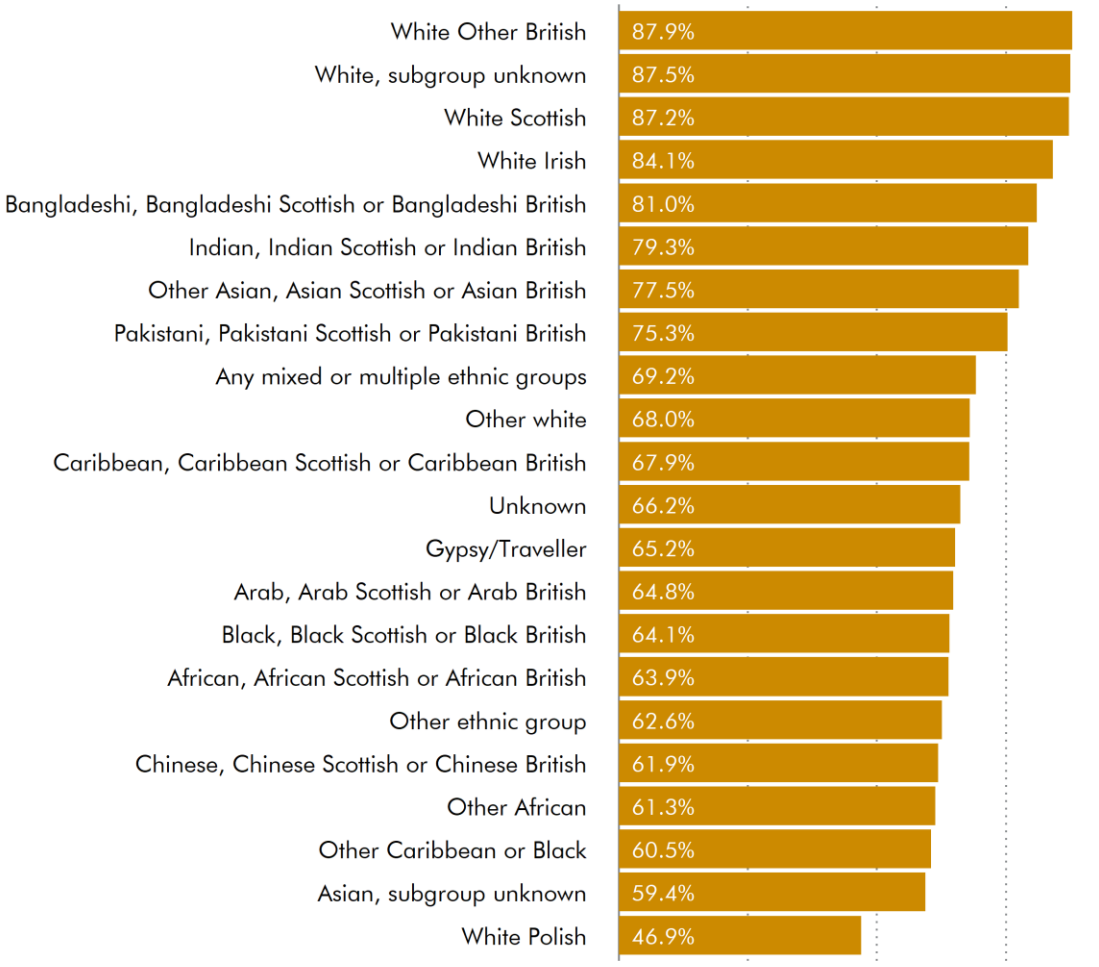
Background information on the panels has been provided in the clerk's covering paper, along with two submissions, from COPE Scotland, and from Grampian Health and Diversity Network.

Vaccine Uptake and Ethnicity and Deprivation: statistics

The graphic below sets out the proportions of all people (18+) who had received the vaccine as at 23 November 2021, broken down by ethnicity. This indicates that most of the White sub-groups had the highest vaccination rates, though with White Polish recording the lowest rate.

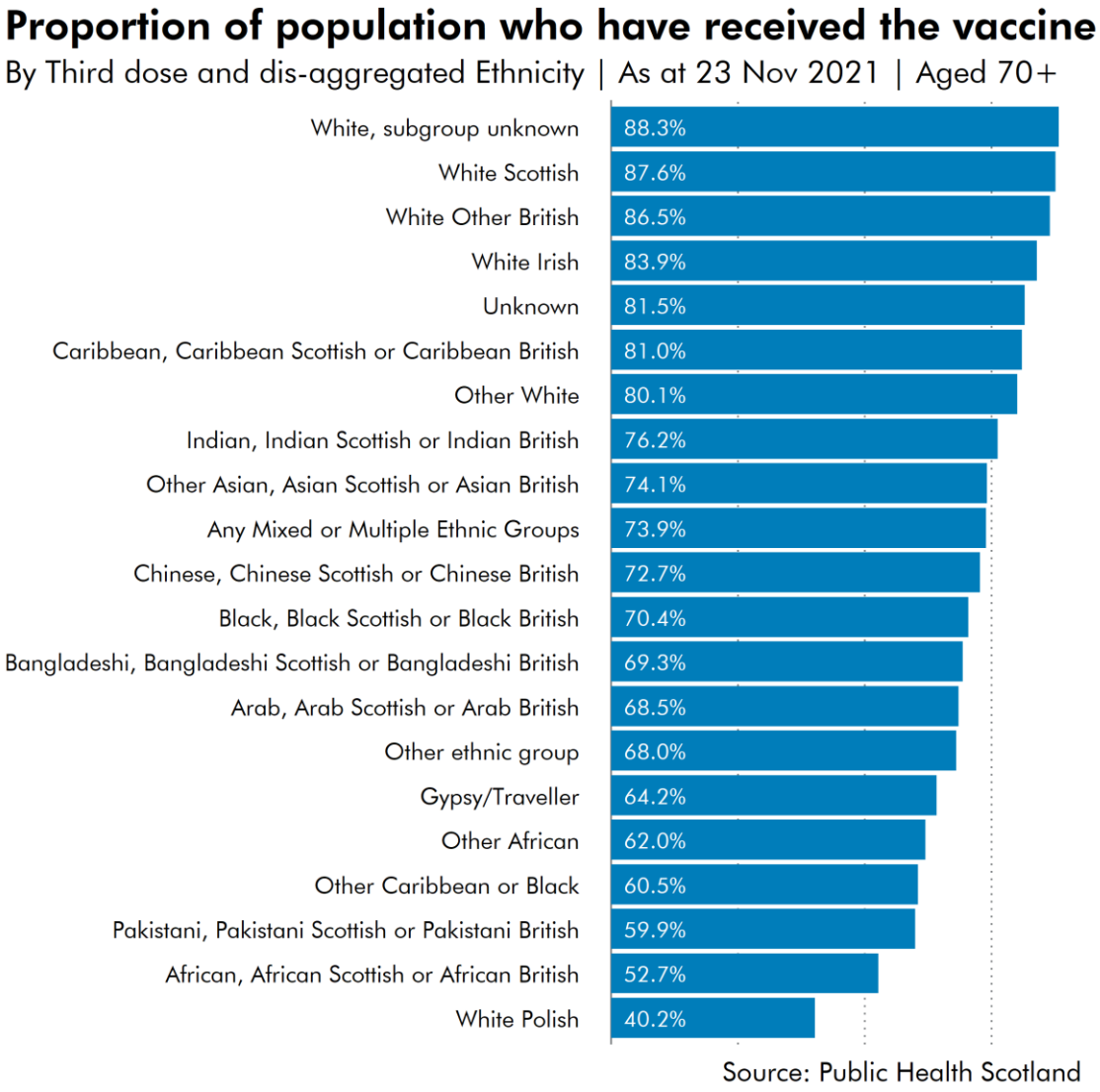
Proportion of population who have received the vaccine

By Second dose and dis-aggregated Ethnicity | As at 23 Nov 2021 | Aged 18+

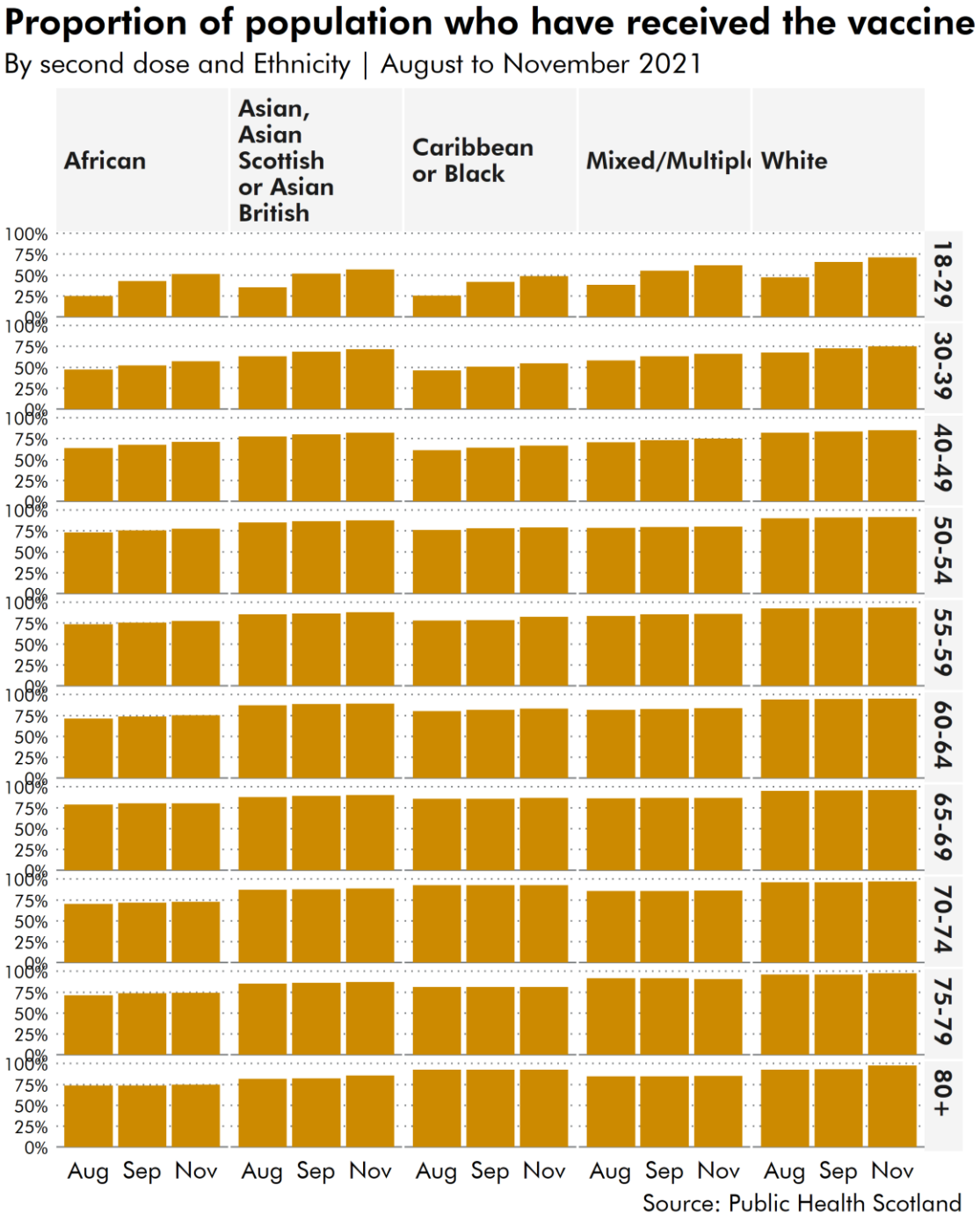


Source: Public Health Scotland

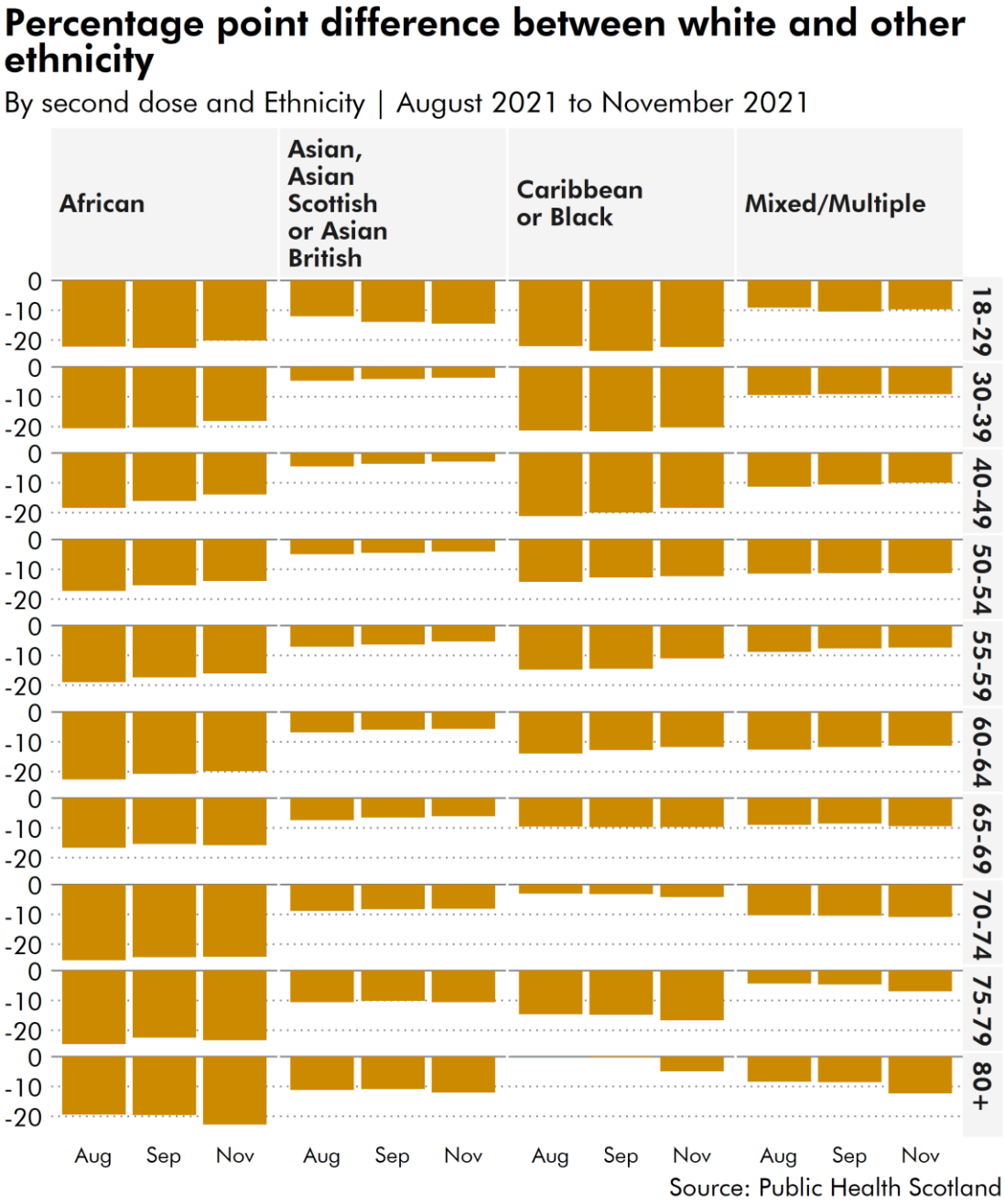
The graphic below, provides a similar breakdown by ethnicity but looks at proportions who have received a third dose, and applies to all those aged over 70.



The graphic below breaks down some of the analysis by age group, and also looks at trends since the summer. This clearly shows the lower rates of vaccination amongst younger age groups, but also how vaccination rates have risen since August, as well as the differences by ethnicity.

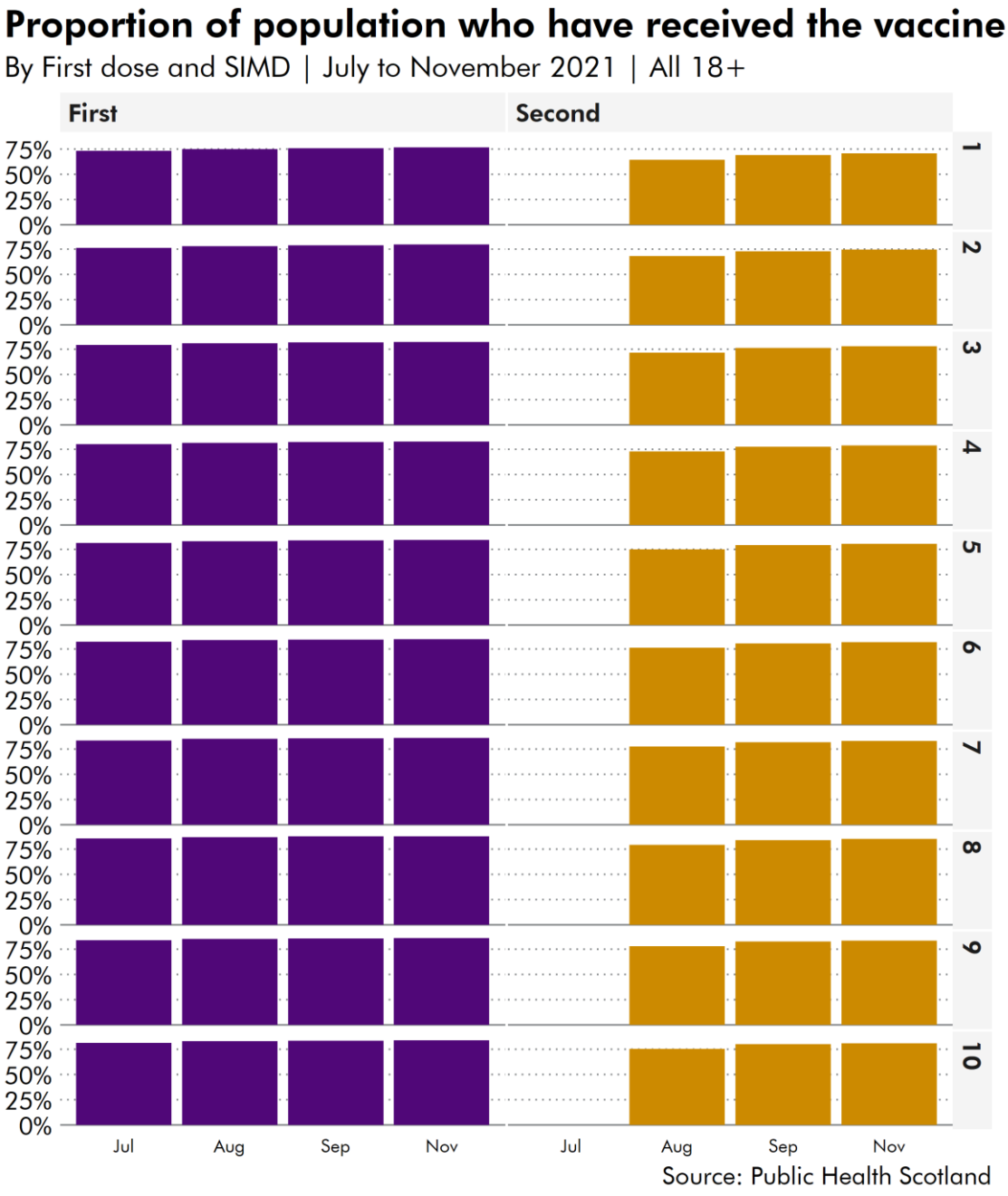


The chart below is based on exactly the same data as above but highlights the variation in vaccination rates between white and other ethnicity groups. Some significant differences are seen when comparing African people of all ages with White people, and comparing Caribbean or Black people, particularly among the lower age groups.

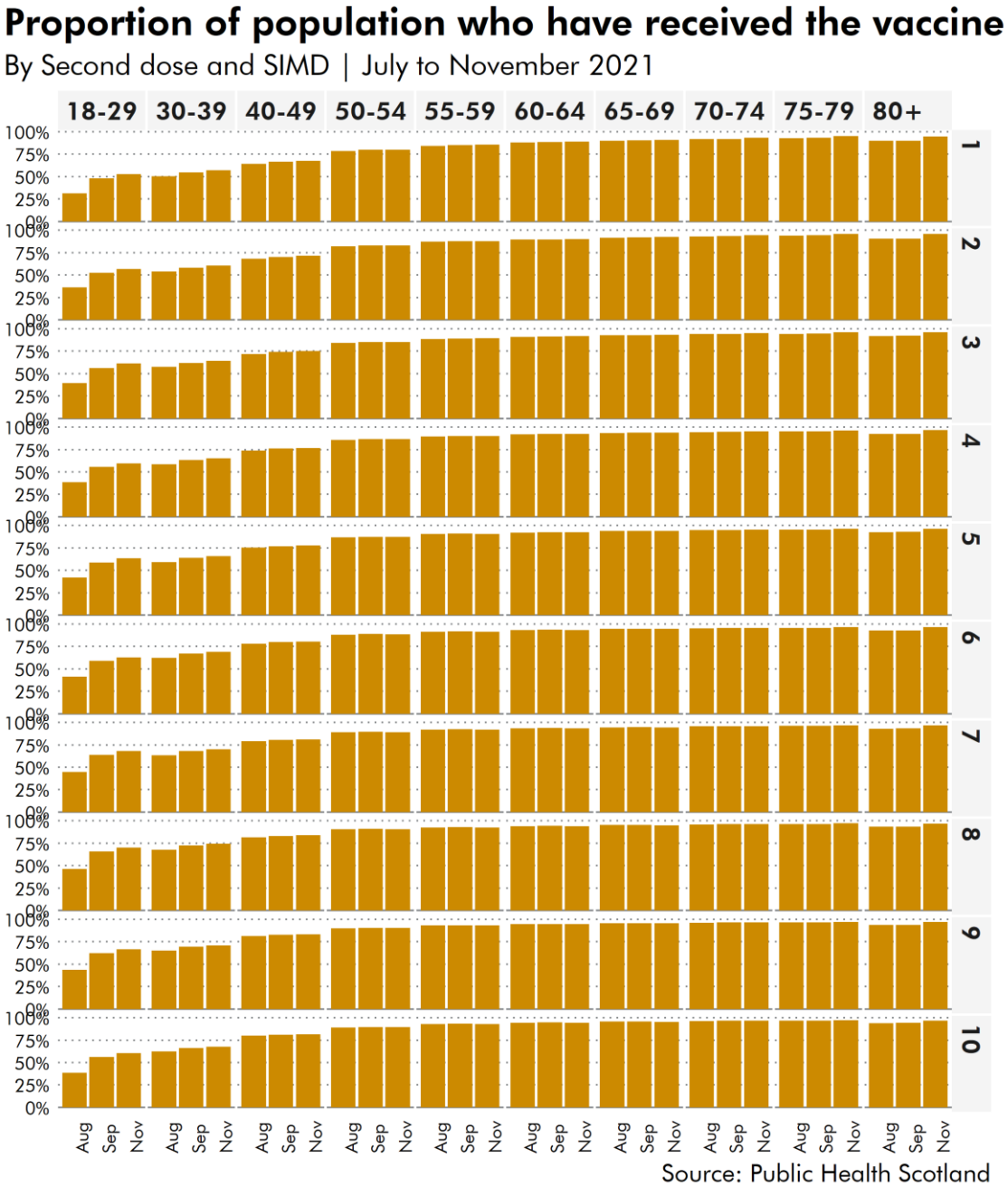


The chart below shows changes in the proportions who have received both the first and second doses in communities in the ten Scottish Index of Multiple Deprivation (SIMD) categories (1 = communities with, statistically the highest levels of deprivation, and 10 = the least deprivation). This chart shows communities with the highest levels of deprivation according to the SIMD, generally experience lower levels of vaccination.

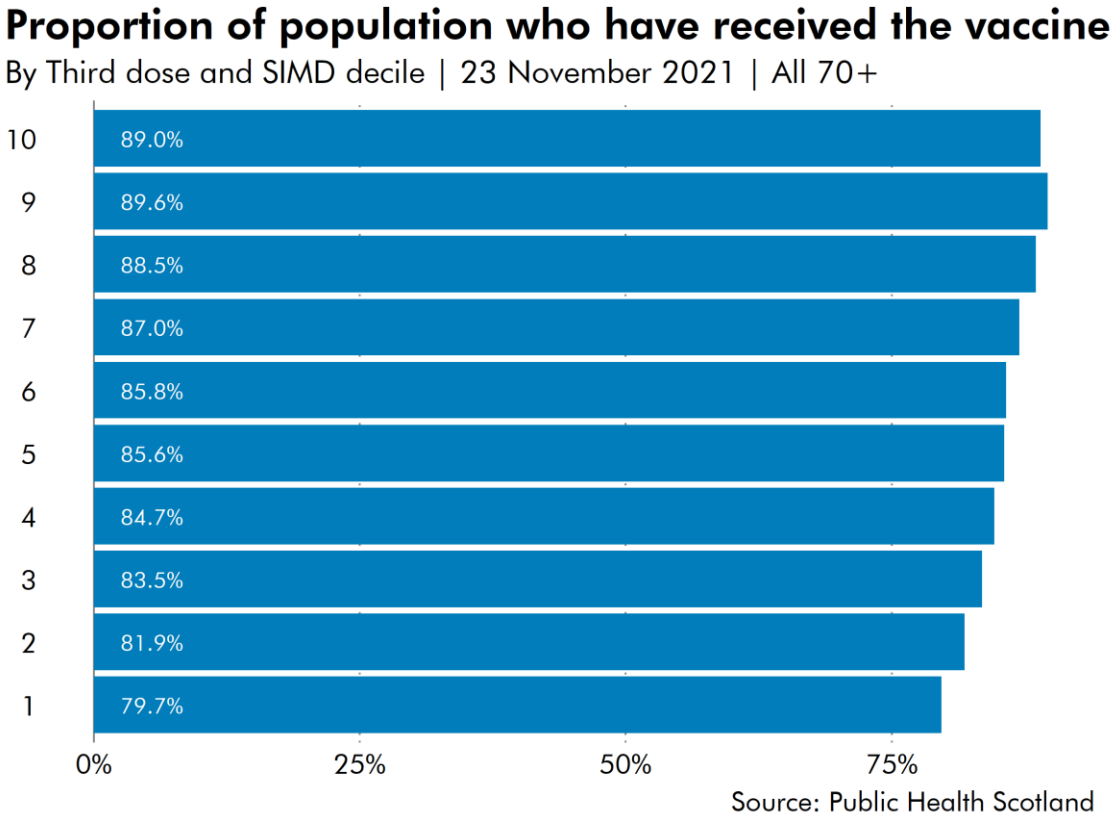
For example, vaccination uptake in SIMD 1 was 70.9%, (the 10% of communities with statistically the highest levels of deprivation) whilst vaccination uptake for each of the five least deprived deciles was over 80% (ie the communities in, statistically, the least deprived half of Scotland).



The chart below shows the variation in vaccine uptake (2nd dose) by SIMD level, for different age groups, and at different times since the summer. there are some particularly low levels of vaccine uptake amongst younger age groups, in areas with high levels of deprivation.



The chart below looks at the proportions of people who had received the third dose by 23 November. These figures apply to the over 70s. There is a ten percentage point difference between those communities experiencing the highest and lowest levels of deprivation.



Some issues to explore with the two panels

Members may wish to consider some of the barriers to vaccine uptake, as well as some of the solutions.

Potential barriers to Vaccine Uptake

Some of the issues relating to **perceptions and attitudes** may include:

- Specific concerns about safety and risks, for example, on women's health
- The extent that young people have different perceptions of risk
- Suspicion and a lack of trust in authorities, and perceptions of pandemic being exaggerated or a conspiracy
- Beliefs and rights - personal choice, as to what goes in body
- Stories of people falling ill and side effects

Some issues have been highlighted relating to **access to information**

- for example, the availability of translated and understandable material?
- Confusion and mixed messages – and for example whether there can be too much information from too many experts, and the role of social media in that

Some **practical issues** have also been highlighted

- For example relating to confusion around appointment letters, or miscommunications, made difficult because of reliance on online delivery.
- Lack of support network, and financial support, in case of side effects affecting employment.
- Costs of travel to centre, childcare, other caring. Zero hours contract, cant get away from work, other priorities, missed letter (eg in communal living space)

Members may also wish to discuss what **specific barriers** are experienced by specific groups

- For example, specific barriers in relation to people living in areas of higher **deprivation**, to those experiencing **homelessness**, or people with **no recourse to public funds**?
- Specific barriers in relation to those in **non-white ethnic** groups?
- Specific issues affecting **Polish people**, firstly to what extent the PHS figures are accurate, and secondly what are the specific issues in play?

Potential Solutions

Members may wish to explore what has worked so far in increasing vaccine uptake, and what is likely to work over coming months. based on some of the submissions Members may wish to explore

- Resources and information - including easy to read material to compare risks of the vaccine; information on the development and authorisation of the vaccine; information within the NHS for staff; information on the positive consequences of the vaccine (for example on international travel, or as a way of protecting future income.

- Practicalities – for example use of pop-up centres, and flexible communications methods

Members may wish to explore the use made so far of the BEMIS Vaccine information fund. This provides grants of up to £1,500 to create resources and run activities. Grants have been provided to FENIKS and the West of Scotland Regional Equality Council. BEMIS said that by the end of October, £37,000 had been provided to 41 organisations.

The Report of the Deep end GPs (April 2021) highlighted the need for, among other things, good quality data collection, the need for local leads to facilitate and 'authorise' the local flexibility described by the JCVI around vaccine delivery to address health inequalities, and for role of and community link practitioners and third sector, to be clear.

COPE Scotland highlighted a number of solutions in their submission, including:

- Working with young people, peer groups to co design short promo videos

- Identifying community leaders and social media influencers

- Guidance on coverage for the media which helps reduce mixed messages

- Some consistency across the 4 nations of the UK and across the globe

- Check the postcodes of people and where their vaccination centre is so it's easy to get to and doesn't involve costs to travel

- In the cold weather when people are queuing a long time, offer hot drinks when people are outside

- Follow up people who didn't attend for their vaccine and ask them what if anything could be done so they do accept the vaccine

- If there is some evidence of menstrual disruption, perhaps include in the questions before taking the jab

The scope for local flexibility (and potentially prioritising areas of high deprivation): The Scottish Government's equality impact assessment for the flu and covid winter 21/22 vaccination programme said that

> **"**biological age in the most deprived communities is significantly different from in the most affluent communities, [and the] onset of 'diseases of old age' is around 15 years earlier. Therefore an age based approach may disadvantage people from the most deprived neighbourhoods. JCVI advice allows for local flexibility to mitigate health inequalities"

Simon Wakefield, SPICe Research,

6 December 2021