



HM Government

# **Second quarterly report on progress to address COVID-19 health inequalities**

**February 2021**

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## Introduction

In June 2020, the Prime Minister and the Secretary of State for Health and Social Care asked the Minister for Equalities, Kemi Badenoch MP, to lead cross-government work following publication of the Public Health England (PHE) report *COVID-19: review of disparities in risks and outcomes*<sup>1</sup>.

The Minister for Equalities published her first progress report on 22 October. This is the second report in this year-long project, which has been submitted to the Prime Minister and the Secretary of State for Health and Social Care in line with the terms of reference<sup>2</sup>.

The first report concluded that a range of socioeconomic and geographical factors coupled with pre-existing health conditions were contributing to the higher infection and mortality rates for ethnic minority groups, with a part of the excess risk remaining unexplained for some groups. This second report looks at those causes in more detail and sets out some of the work undertaken to fill the gaps in our understanding and to mitigate the risks of COVID-19 infection. It sets out the progress made under the terms of reference and in implementing the recommendations from the first report (set out in **Annex A**).

The focus of this work has been the disproportionate impact COVID-19 has had on ethnic minorities. There is wider work underway across government to consider the impact the virus has had on other groups, such as disabled people.

**Race Disparity Unit, Cabinet Office**  
**February 2021**

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<sup>1</sup> <https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes>

<sup>2</sup> <https://www.gov.uk/government/news/next-steps-for-work-on-covid-19-disparities-announced>



# Executive summary and next steps

## Summary

In June 2020, the Prime Minister and Secretary of State for Health and Social Care commissioned the Minister for Equalities, with support from the Cabinet Office Race Disparity Unit (RDU), to take forward work on the disproportionate impact of COVID-19 on ethnic minority groups. This commission included developing the understanding of the drivers of disparities in infection and death rates of COVID-19, reviewing the effectiveness of current actions being undertaken by the government to lessen disparities, and modifying or developing policy where needed. This report details the work undertaken across government since the minister's first quarterly report was published on 22 October.

It is clear that government departments have made significant efforts to address disparities in outcomes from COVID-19. In order to improve public health communications with those communities most at risk from COVID-19, the government released £23.75 million in funding to local authorities last month under the Community Champions scheme, following an expressions of interest exercise. This funding is enabling local authorities to work with grassroots advocates to tailor public health communications and to use trusted local voices to promote healthy living, encourage vaccine uptake and counter misinformation. The government will monitor the impact of the scheme and share the findings with other local authorities.

To improve our understanding of the health, social, cultural and economic impacts of COVID-19, the government has just invested a further £4.5 million of funding in new research projects looking at ethnic minority groups. In order to prevent the spread of the virus and to protect frontline workers, many of whom are from an ethnic minority background, the Department for Transport, and the Department for Health and Social Care included transportation workers in mass testing pilots covering the Christmas travel period. These are now being rolled out more widely. The government also successfully piloted community-led, localised, asymptomatic testing at places of worship in ethnically diverse areas, building trust within the community and enabling a higher number of positive cases to be detected.

Efforts need to continue into the next quarter, driven by the latest data and evidence and focused on those most affected by the second wave of the virus.

A light-touch review of local authority actions has shown that there are also considerable efforts underway at a local level to address COVID-19 disparities for ethnic minority groups, led by local authorities and Directors of Public Health, and using trusted voices in the community. For example, Birmingham City Council has established 645 Champions across the 69 wards in the City, and has established a system of 19 community partners to support wider dissemination of accessible information and engagement with specific minority communities. Other examples include utilising local data and insights on the communities that have been disproportionately impacted by COVID-19 to tailor and target messaging.

This exercise has shown that some areas with strong existing links to community groups, and with access to relevant and up-to-date data, have fared well in supporting those communities who have been disproportionately impacted by COVID-19. However, some

areas have cited difficulties around adapting to the virtual delivery of services, and engaging communities in a COVID-19 secure manner. The government will share with local authorities examples of good practice and solutions to overcome some of the barriers identified by the review.

This report sets out our increased understanding of the drivers of these disparities. In particular, the impact of COVID-19 on certain ethnic minority groups has changed between the first wave and the early second wave; changes within such a short time period strongly suggest that ethnic inequalities in COVID-19 outcomes are driven by risk of infection, as opposed to ethnicity itself being a risk factor for severe illness or death from COVID-19.

The direct impacts of COVID-19 improved for ethnic minorities as a whole during the early second wave. For example, in the first wave, Black African men were 4.5 times more likely to die from COVID-19 than White British men of the same age, but in the early part of the second wave the risk of death was the same for Black African and White British men. At the same time, however, the second wave has had a much greater impact on some South Asian groups. Work is underway to consider why the second wave to date has had such a disproportionate impact on Pakistani and Bangladeshi groups. Relevant considerations include regional patterns in first and second waves of the virus, household occupancy and multigenerational households, deprivation, and occupational exposure.

These findings strengthen the argument that ethnic minorities should not be considered a single group that faces similar risk factors in relation to COVID-19. Different ethnic groups have experienced different outcomes during both waves of the virus.

This report also summarises the findings of the research commissioned by the RDU into a small group of ethnic minority people's personal experiences of COVID-19. Some important themes emerged from this work. For example, participants felt that communications tended to frame ethnic minorities as a homogeneous group that is vulnerable to COVID-19, which they found stigmatising. The research also showed the challenges some participants had in navigating public health advice and applying it to everyday situations, as well as adapting to the pace of change with the guidance. These insights will be shared with other government departments to improve policy-making.

The data also shows that deprivation continues to be a major driver of the disparities in COVID-19 infection rates for all ethnic groups and this will be a particular focus of government work in the third quarter.

A significant development since the first quarterly report is the approval and roll out of COVID-19 vaccines. This report summarises how the vaccination programme is being prioritised and the implications of this for ethnic minority groups, as well as the analysis of likely take up rates for these groups. In addition, on 13 February the government published its *UK COVID-19 vaccine uptake plan*<sup>3</sup>. This highlights a range of barriers to uptake and some of the work taking place across government and at a local level to minimise the impact of these.

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<sup>3</sup> <https://www.gov.uk/government/publications/covid-19-vaccination-uptake-plan/uk-covid-19-vaccine-uptake-plan>



Data from the UK Household Longitudinal study, the Office for National Statistics (ONS), and REACT-2 suggest lower levels of vaccine uptake among some ethnic minority groups. The government has put in place a programme of work to understand and address this. This includes establishing NHS vaccination centres in suitable sites in the community, such as places of worship.

The report also sets out the measures the government has taken through communications campaigns to encourage uptake of vaccines among ethnic minority groups and to counter misinformation, both nationally and locally. This has included use of digital advertising on Facebook and Twitter, traditional media, social media posts featuring well-known medical professionals and disseminating important messaging to hundreds of local contacts, such as faith leaders. These efforts will continue over the coming weeks, linking in with the new Community Champions to target those areas most at risk.

In addition, over the last quarter the Minister for Equalities and the RDU have engaged within government and externally to share the findings from the first report and any new data, to encourage development of new government interventions to tackle COVID-19 disparities for ethnic minority groups and to identify any barriers and solutions to vaccine uptake. This includes holding roundtables with those representing the adult social care sector, independent pharmacists and South Asian groups, and further work to address maternal health disparities for ethnic minority women. This engagement work will continue in the next quarter, with a particular focus on promoting vaccine uptake.

## **Next steps**

This report sets out the following next steps:

### **Central and local government interventions**

1. Ministry for Housing, Communities and Local Government (MHCLG) to share with local authorities examples of good practice from the review of local authority activity
2. MHCLG to share with local authorities the findings from the initial, one-month review of returns from Community Champions

### **Vaccination programme**

3. Minister for Equalities to write to the Joint Committee on Vaccination and Immunisation (JCVI) summarising the latest data and evidence set out in this report, to inform future advice on vaccine prioritisation.
4. The government will continue to monitor data on vaccine uptake among ethnic minority groups and, if necessary, take further steps to address any barriers among these groups.

### **Data and evidence**

5. The RDU will share the findings from the qualitative research into people's personal experiences of COVID-19 across government, particularly in relation to the

stigmatisation felt by a number of participants in relation to being singled out as 'BAME'.

6. Departments and other agencies should publish a statement on GOV.UK outlining their plans to move their data collections to the Government Statistical Service's (GSS) harmonised ethnicity data standard. Harmonisation is hugely important as it allows analysts to gain deeper insight and value from data.
7. NHS England (NHSE) and NHS Improvement (NHSEI), working with the Department of Health and Social Care (DHSC) and others, should publish a quarterly report on progress in improving the recording of ethnicity in health care records.
8. Departments should provide updated datasets on COVID-19 risk factors and secondary impacts for publication on the *Ethnicity facts and figures*<sup>4</sup> website in line with the schedule in Annex C. This provides transparency of process to users, promoting trust and authority, as well as informing them when the most up-to-date data will be made available.

## Engagement

9. The Minister for Equalities, the government advisers on COVID-19 and ethnicity, and the RDU will continue a programme of engagement over the next quarter. This will include work to promote vaccine uptake, alongside the engagement led by the Minister for COVID-19 Vaccine Deployment.

## Communications

10. The government will continue to tailor its communications strategy on vaccine roll out to reflect the latest evidence on vaccine uptake among ethnic minority groups.
11. The government will work closely with the new Community Champions to disseminate important public health messages, promote uptake of vaccine and tackle misinformation
12. Government communications will reflect the findings of the qualitative research into people's personal experiences of COVID-19 and will ensure that ethnic minorities are not treated as a single group and that public health messaging is not stigmatising.

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<sup>4</sup> <https://www.ethnicity-facts-figures.service.gov.uk/>

# 1. Measures to address COVID-19 disparities

## Summary

1. The first quarterly report recorded the actions government departments and their agencies had implemented in the early stages of the pandemic to mitigate impacts of COVID-19. This section updates on progress with some of these initiatives, highlights new measures and summarises the outcome of the light-touch review of local authority actions.
2. This section also provides an update on progress departments have made in creating appropriate systems for monitoring the impacts their policies are having.

## Approach and results

### Central government

3. The RDU has continued to work closely with other government departments and agencies, and in particular the Department of Health and Social Care (DHSC), Public Health England (PHE), the wider Cabinet Office and MHCLG, to assess current initiatives to reduce COVID-19 disparities amongst ethnic minority communities. The RDU has also worked closely with the Disability Unit, also located within the Cabinet Office Equality Hub, which is leading similar work in relation to the impact of COVID-19 on disabled people.
4. The RDU established a cross-Whitehall working group in November in order to share the latest evidence from the review to inform policy development. The RDU commissioned updates through this group and a letter from the Minister for Equalities to relevant ministerial colleagues on 18 December 2020. A summary of these returns is at **Annex B**.
5. Overall, departmental returns have highlighted the ongoing commitment to tackle the disparities through a number of means, from guidance to relevant industries to establishing funds to support disproportionately impacted groups, including ethnic minority groups.
6. Some important initiatives include:
  - MHCLG has released £23.75 million in funding to local authorities under the Community Champions scheme (see next section).
  - DHSC and MHCLG collaborated to run pilots of community-led, localised, asymptomatic testing at places of worship in ethnically diverse areas such as Brent and Wolverhampton with the aim of removing some of the main identified barriers to engaging with Test and Trace, including trust and access. These have reported significant success. For example, a pilot at a Gurdwara in Wolverhampton, which ran during a Sikh religious festival, used local volunteers to open up testing to a cohort of people who might not otherwise have engaged. This drove up testing rates, with almost 3,000 kits registered which showed a much higher prevalence



rate (5.3%) than other pilot sites. This enabled a higher number of COVID-19 cases to be detected and the pilot was extended at the request of religious leaders and the local council. Further pilots are planned.

- NHS England is using the Al-Abbas Islamic Centre in Balsall Heath, Birmingham, as a vaccination centre, which is helping to build trust within the local community and encourage vaccine uptake among groups more at risk from COVID-19 and whom the data show are more reluctant about being vaccinated.
- DfT and DHSC worked together to secure the inclusion of transportation workers, a significant proportion of whom are from an ethnic minority background, in mass testing pilots covering the Christmas travel period. These are now being rolled out more widely.
- Providing additional funding to the Public Health England *Better Health Campaign* in order to target Black African, Black Caribbean, Indian, Bangladeshi and Pakistani ethnic groups. This campaign, which runs until March, aims to reduce obesity and other comorbidities within these groups, which are associated with worse COVID-19 outcomes.
- Following engagement with trade associations, DfT issued new guidance to private hire vehicle (PHV) and taxi drivers in November (and updated in January) about how to protect themselves from COVID-19. 53% of such drivers are from an ethnic minority group and 98% are men.
- UK Research and Innovation has invested a further £4.5 million in funding for 4 new research projects looking at the health, social, cultural and economic impacts of COVID-19 on ethnic minority groups<sup>5</sup>.
- The RDU continues to assist the DHSC and NHSE in improving outcomes for pregnant women from ethnic minority backgrounds during the pandemic. This remains a priority due to the pre-existing health inequalities in this area, and a commitment to ensure that COVID-19 does not exacerbate these (see section 3).

### Community Champions

The Community Champions scheme was announced on 22 October to enhance existing communication strategies in a target group of councils and to fund work with grassroots advocates from those communities most at risk from COVID-19. The scheme is backed by up to £25 million in government funding.

MHCLG, which is sponsoring the scheme, developed a longlist of 65 local authority areas with larger proportions of at-risk communities and entrenched community transmission of COVID-19, using a variety of data sources. Expressions of interest have been received from 60 of these local authorities, summarising the measures they have already implemented to reduce COVID-19 disparities and how additional funds would be used to enhance and expand their interventions. MHCLG evaluated these and released funding in January.

All funded local authorities are expected to implement the following:

- A community connection, outreach and engagement strategy, with a steering group, involving local community leaders, public health providers, voluntary

<sup>5</sup> <https://www.ukri.org/news/researching-factors-affecting-ethnic-minority-groups-during-covid-19/>

groups, and organisations in each area.

- Community Champions, including from within the disproportionately impacted ethnic minority and disabled groups or local hard to reach communities, to undertake one-to-one support, build trust and counter misinformation.
- Engagement activities with residents from disproportionately impacted ethnic minority and disabled groups in greatest need of local support.
- Creation and delivery of practical sustainable tools to increase outreach, communication and engagement which are tailored, appealing, visual and multi-language messages to reach diverse populations, who may be digitally excluded, and mobilise local communities.

By implementing the scheme in this way, community leaders and voluntary and community groups who specialise in working with the communities most at risk from COVID-19 will be able to deliver appropriate communications to their communities. This will increase personalised and localised communications in relation to COVID-19.

To reach disproportionately impacted communities beyond these 60 areas, MHCLG has funded 2 national voluntary, community and social enterprise (VCSE) partners who have a proven track record of engaging harder to reach communities to carry out communications and engagement activities, including health promotion and encouraging vaccine uptake.

MHCLG will monitor the success of the Community Champions scheme by requiring returns at one, 3 and 6 month intervals and holding regular meetings with funded partners.

7. While good progress has been made to address COVID-19 disparities, government departments must redouble their efforts, taking account of the latest available data and evidence. In particular, departments must consider measures that will benefit those most affected by the second wave of the virus, and in particular those from the Bangladeshi and Pakistani ethnic groups.

#### **Local government**

8. In the first quarterly progress report, the Minister for Equalities committed to a rapid, light-touch review of actions taken by local authorities and Directors of Public Health to support people from ethnic minority backgrounds, in order to understand what works at a local level. To minimise the burden on local authorities at this particularly challenging time, the RDU worked with MHCLG and DHSC to develop an approach that provided rich data on actions undertaken to date, but without imposing reporting burdens.
9. RDU conducted this rapid review by focusing on local authority areas, identified by MHCLG under the Community Champions applications process, with larger proportions of at-risk communities and entrenched community transmission of COVID-19, using a variety of data sources. The longlist of local authority areas was developed using DHSC/PHE data on COVID-19 incidence (the data used for assessing tiers) alongside social integration data (higher residential segregation and lower English language skills) and higher levels of disability to identify areas with larger proportions of at-risk

communities and entrenched community transmission of COVID-19. Each local authority was asked to provide examples of the actions it had taken to minimise the disparities, such as promoting public health messaging. This enabled a rapid review of local authorities where COVID-19 disparities remain particularly pertinent, whilst capturing the broad range of ideas and practices across a variety of geographical locations.

10. It is clear that there is a huge effort underway to break down barriers at a local level. Some common themes emerging from this work include:

- utilising existing partnerships and networks, including faith organisations and the voluntary community sector.
- providing targeted communications messaging. This is being undertaken through a number of means including translating important messages, distributing information in alternative locations and formats, and providing messaging that is appropriate for specific community events/activities that have a higher proportion of ethnic minority participation.
- collecting, mapping and utilising data and insights on the communities within their area that have been disproportionately impacted by COVID-19.

11. This exercise has shown that those areas with strong existing links to community groups, and those with access to significant quantities of high quality, relevant and up-to-date data, have fared better in supporting those communities who have been disproportionately impacted by COVID-19. Directors of Public Health have provided similar views, indicating for example that health messages on vaccines have been best received when delivered by individuals respected by the communities they are seeking to influence. This includes trusted health professionals and leaders in the faith communities. Some examples follow.

#### **Examples of local government actions**

- Birmingham City Council has established 645 Champions across the 69 wards in the City, and has established a system of 19 community partners to support wider dissemination of accessible information and engagement with specific minority communities. This has ensured that information is accessible to those with language barriers. The Council has also developed social media campaigns on TikTok and Instagram for young people.
- Bassetlaw has utilised local partnerships with the District Council, community and voluntary service and health to maintain community engagement through distanced engagement methods and new Facebook Live events, as well as undertaking several thousand 'safe and well' calls to vulnerable residents.
- Hackney Council is currently running 2 one-year programmes to proactively engage and communicate with residents who are disproportionately affected by COVID-19. This includes a Public Health Community Champions programme, which currently works with 75 Champions who have been trained in 'Making Every Contact Count' and given messages about COVID-19, which



has provided valuable insight about how to adapt and adjust public health messaging to maximise reach.

- Newcastle City Council has a programme of work to address COVID-19 disparities including creating an ethnic minorities Community Leaders WhatsApp group to allow delivery of timely messages and enable a 2-way dialogue, and producing COVID-19 message videos in Bengali, Urdu, Hindi, Arabic, Romanian, Czech and Romani, which reached 106,000 people.
- Oldham council has a community engagement network that works closely with community leaders to gather insight and engage with communities. It uses targeted door-to-door engagement led by intelligence about hotspots of COVID-19 cases, and targeted communications using insight from the community engagement network (such as broadcasting messages through Mosque radio and creating accessible graphics distributed via WhatsApp).
- Stoke on Trent has facilitated community groups to provide practical support and ensure community venues are COVID-secure. To date over £215,000 has been invested in such groups.
- Wirral has utilised 'connectors' within its local communities, allowing the council to react and respond to local needs. The connectors undertake a range of activities including wellbeing calls, delivering food, supporting, local contact tracing and delivering leaflets. More importantly they act as the voice of the community, allowing the Council to understand people's fears and behaviours and to tailor its communications accordingly.

12. At the same time, some areas cited difficulties around adapting to the challenges of COVID-19 such as through the virtual delivery of services. This was reported as particularly challenging when delivering in partnership with third sector organisations that had previously relied on a physical presence within the community, and whose members did not necessarily have the technological skills and capability to adapt to the changing circumstances. Some have also reported difficulty in engaging directly with communities in a COVID-19 secure manner, such as through online services, where these groups have traditionally relied upon face-to-face council and third sector engagement. The reasons for this prior reliance on face-to-face engagement are multifaceted, but some reasons cited were: low levels of English language within the community, lack of access to suitable technology, and reluctance to engage with the council directly.

13. The RDU will work with MHCLG to draw up a list of examples of good local authority practice and suggestions on how to overcome some of the barriers identified in this review and will share these widely. MHCLG will also share feedback from the regular reviews of progress with the Community Champions scheme.

## Individual risk and the clinically extremely vulnerable

14. The last report summarised work to develop a new COVID-19 predictive risk model (“QCOVID”). This has been developed by an expert group commissioned by the Chief Medical Officer and takes into account a wide range of factors now known to increase risk of infection and serious outcomes from COVID-19. The associated research was peer-reviewed and published in the British Medical Journal in October 2020, approved by the Medicines and Healthcare products Regulatory Agency (MHRA) in December and independently validated by the ONS in January 2021.
15. DHSC is working at pace to apply the model in the NHS, incorporating the feedback from private testing of a clinical decision support tool. The RDU (and wider Cabinet Office Equality Hub) has fed into this work. The clinical tool was made available across primary and secondary care as a secure public beta webtool from 16 February.
16. Through providing detailed data about clinical risk, the QCOVID model has enabled DHSC to incorporate the findings from the research into national policy and has used it to identify a new cohort of patients at equivalent risk to the Clinically Extremely Vulnerable. This group is being added to the Shielded Patient List as a precautionary measure, and is entitled to advice and support, including priority access to the COVID-19 vaccine if they have not already been offered it. The Joint Committee for Vaccination and Immunisation (JCVI) has also reviewed the underlying data from the QCOVID model in shaping its advice on COVID-19 vaccine prioritisation.
17. Future plans include exploring embedding the clinical tool in GP systems, and the potential development of a citizen-facing tool. As more is learnt about why the threat posed by COVID-19 varies across the population, the QCOVID risk model will be updated with the latest evidence and individuals will be given more nuanced advice on risk.

## COVID-19 vaccinations

18. The JCVI is an independent expert committee which provides expert scientific advice on prioritisation of COVID-19 vaccines. In its interim advice published on 2 December<sup>6</sup>, updated on 30 December, the JCVI advised that for Phase 1, the vaccine deployment programme should prioritise care home residents and their carers, followed by people over 80 and health and social care workers, then to the rest of the population over 50 years of age in order of age and clinical risk factors. This is because the current evidence strongly indicates that the single greatest risk of mortality from COVID-19 is increasing age and that the risk increases exponentially with age. Prioritising in this way will protect those most at risk of morbidity and mortality, and to protect the NHS. Phase 2 will follow, covering adults under 50 who are not health or social care workers, clinically extremely vulnerable or who have underlying health conditions.

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[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/948353/Priority\\_groups\\_for\\_coronavirus\\_COVID-19\\_vaccination\\_-\\_advice\\_from\\_the\\_JCVI\\_\\_2\\_December\\_2020.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/948353/Priority_groups_for_coronavirus_COVID-19_vaccination_-_advice_from_the_JCVI__2_December_2020.pdf)



19. The JCVI, which will keep its advice under review, found that there was evidence that certain ethnic minority groups have higher rates of infection, and higher rates of serious disease, morbidity and mortality. It concluded that: "There is no strong evidence that ethnicity by itself (or genetics) is the sole explanation for observed differences in rates of severe illness and deaths. What is clear is that certain health conditions are associated with increased risk of serious disease, and these health conditions are often overrepresented in certain [ethnic minority] groups. It is also clear that societal factors, such as occupation, household size, deprivation, and access to healthcare can increase susceptibility to COVID-19 and worsen outcomes following infection. These factors are playing a large role in the inequalities being seen with COVID-19".
20. The JCVI concluded that good vaccine coverage in ethnic minority groups will be the most important factor within a vaccine programme in reducing disparities in outcomes for these groups. It added that prioritisation of persons with underlying health conditions will also provide for greater vaccination of ethnic minority groups, who are disproportionately affected by such conditions.
21. The JCVI recognises that tailored local implementation to promote good vaccine coverage in ethnic minority groups will be the most important factor within a vaccine programme in reducing health inequalities in these groups. The NHS, PHE and DHSC will provide advice and information at every possible opportunity, including working closely with ethnic minority communities, to support those receiving a vaccine and to anyone who has questions about the vaccination process.
22. The JCVI's advice also highlights the need for good vaccine uptake and coverage in ethnic minority groups as the most important factor in reducing the inequalities in infection rates and outcomes. The Minister for Equalities is working closely with the Minister for COVID-19 Vaccine Deployment to encourage take up (see section 4 for further detail). The Minister for Equalities is also personally participating in the Novavax clinical vaccine trial at Guys' and St Thomas' and has encouraged other ethnic minority MPs to do the same in order to break down barriers and to help increase the very low participation levels of ethnic minorities in clinical research.
23. The Minister for Equalities wrote to the JCVI in December to share the main findings from the first quarterly report. She will write again to the Committee shortly, summarising the evidence gathered in this report.
24. In addition, NHS England has established a Vaccine Equalities Committee, bringing together government departments with national representatives from the Association of Directors of Public Health, Local Authorities, Fire and Police services and third sector organisations to advise and guide the vaccine deployment programme on addressing inequalities. This Committee is considering data on vaccine uptake by different ethnic minority groups, and supporting targeted work to address concerns about uptake within particular communities.

### **Next steps**

- MHCLG to share with local authorities examples of good practice from the review of local authority activity
- MHCLG to share with local authorities findings from the initial, one-month review of returns from Community Champions
- Minister for Equalities to write to the JCVI summarising the latest data and evidence set out in this report, to inform future advice on vaccine prioritisation.
- The government will continue to monitor data on vaccine uptake among ethnic minority groups and, if necessary, take further steps to address any barriers among these groups.

## 2: Data and evidence

### Summary

25. The disproportionate impact on ethnic minorities - apparent during the first wave and continuing for some ethnic groups during the second wave to date - is largely a result of higher infection rates for some ethnic groups.
26. Based on critical care data, deaths in hospital data, mortality rates and hazard ratios analysis from ONS and OpenSAFELY, the direct outcomes of COVID-19 have improved for all ethnic minority groups between the first and early second waves of the virus, except people from South Asian backgrounds, in particular Bangladeshi and Pakistani groups. For these particular groups, the risk of dying from COVID-19 compared with White British increased between the first and second waves, possibly driven by high infection rates in the early second wave.
27. General health inequalities are complex; while all are entitled to access primary care services, people from ethnic minority groups are more likely to report poorer experiences using health services. Prior to the pandemic, overall mortality (adjusted for age) was lower in most ethnic minority groups but COVID-19 has reversed the mortality advantage in some ethnic minority groups.
28. It is vital to understand the differences between ethnic groups, rather than using "BAME" as an aggregate, and to consider the circumstances that may have contributed to health inequalities from COVID-19, as different ethnic groups experience different outcomes.
29. Uptake of previous national vaccination programmes has been lower in Black African and Black Caribbean groups and REACT-2 data suggests that while likelihood to accept has increased, Black adults are still least likely to get the COVID-19 vaccine. OpenSAFELY analysis has found that vaccine uptake is lower in Black and South Asian over 80s.
30. Some initial analysis of the impact of COVID-19 on disabled people is set out in Annex C. Further analysis and research is planned over the coming months.
31. A Statutory Instrument and accompanying Directions were laid in December which make changes to the regulations governing GP contracts. When ethnicity data is provided by the patient, the GP is now mandated to record that information in general practice.
32. There is further quality review work ongoing: the harmonisation of ethnicity data, including the UISPC review of NHS classifications; and other reviews suggesting how the quality of ethnicity data in health datasets such as Hospital Episode Statistics might be improved.

33. A publication schedule of updates to datasets on the RDU's 'Ethnicity facts and figures' website has been created, to facilitate the timely provision of data related to COVID-19 risk factors and secondary impacts.

## Approach

34. The first quarterly report concluded that a range of socioeconomic and geographical factors coupled with pre-existing health conditions were contributing to the higher infection and mortality rates for ethnic minority groups, with a part of the excess risk remaining unexplained for some groups. During the second quarter, the RDU has worked with ONS, other government departments, academics and the SAGE ethnicity subgroup to get a better understanding of these drivers and to address, where possible, the gaps in our understanding.

35. Work undertaken following the first report includes:

- Commissioning analysis by PHE of the relationship between ethnicity, pre-existing health conditions and COVID-19 infection and mortality.
- Working closely with ONS analysts, who have published more data and analysis on infections<sup>7</sup>, the social and economic impacts of COVID-19<sup>8</sup>, the relationship between occupation, ethnicity and COVID-19, and a plain English explanation of the disparities<sup>9</sup>. ONS has also introduced a regularly updated COVID-19 Dashboard<sup>10</sup> (including a section about ethnicity), which provides an easily-accessible and up-to-date summary of the main statistics about COVID-19.
- Supporting research by helping academics to access data and information vital for their research and meeting those leading the NIHR-funded projects.
- Commissioning *Policy Lab* to undertake a study of ethnic minority people's lived experience, building on the wider stakeholder engagement in the PHE 'Beyond the Data' report.
- Advising ONS colleagues in their development of a larger scale qualitative investigation into the compliance behaviours of different population groups, including ethnic minority communities.

## Results

- **Drivers of disparities for ethnic minority groups**

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<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronaviruscovid19infectionsinthecommunityinengland/december2020#likelihood-of-testing-positive-for-covid-19-from-nose-and-throat-swabs-by-ethnicity-in-england>

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<https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/coronavirusandthesocialimpactsindifferentethnicgroupsintheuk/2020>

9

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/whyhaveblackandsouthasianpeoplebeenhithardestbycovid19/2020-12-14>

10

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/coronaviruscovid19/latestinsights#ethnicity>



36. Previous reports revealed<sup>11</sup> that people from ethnic minority groups faced a disproportionate impact from COVID-19 during the first wave of the pandemic in the UK. However, recent analysis of the first wave from PHE<sup>12</sup> and evidence from the second wave of COVID-19 intensive care admissions<sup>13</sup> in the UK has shown that some ethnic minority groups did not face increased risk of death from COVID-19 once infected.

37. According to Public Health England<sup>14</sup>, comparing survival rates (once tested positive) with those of people from the White group:

- people belonging to the Mixed and Other ethnic (aggregate) groups, and the Black African, Black Caribbean and Asian Other (detailed) groups did not have poorer survival rates than White people. The high death rates reported previously by ONS for these groups are therefore likely to be largely determined by a high risk of getting COVID-19 rather than a higher risk of dying once infected.
- Bangladeshi, Chinese, Pakistani, Black Other and Indian ethnic groups had an increased risk of death. This difference is reduced with longer follow up after death and therefore PHE suggests that the analysis be repeated with a longer follow-up period in order to draw more reliable conclusions about poorer survival in some ethnic groups.

**Figure 1: Adjusted odds<sup>15</sup> of dying after getting infected with COVID-19 by detailed ethnic group compared with White ethnic group, positive tests occurring between 20 March and 13 July 2020**

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<sup>11</sup>

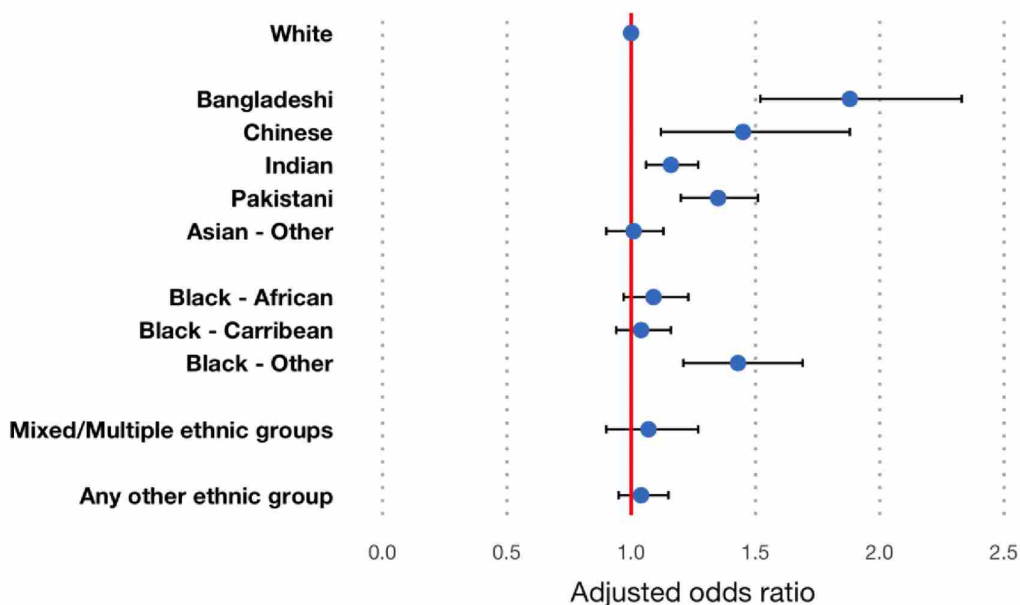
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/908434/Disparities\\_in\\_the\\_risk\\_and\\_outcomes\\_of\\_COVID\\_August\\_2020\\_update.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf)

<sup>12</sup> <https://www.gov.uk/government/publications/covid-19-pre-existing-health-conditions-and-ethnicity>

<sup>13</sup> <https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports>

<sup>14</sup> <https://www.gov.uk/government/publications/covid-19-pre-existing-health-conditions-and-ethnicity>

<sup>15</sup> Odds ratios can be treated as a percentage increase or decrease in risk of the outcome under investigation. An odds ratio in excess of 1 indicates raised risk while an odds ratio less than 1 indicates reduced risk compared with the reference population



Source: Public Health England

Note: adjusting for age, sex, socioeconomic characteristics and pre-existing conditions,

38. This is consistent with research from the International Severe Acute Respiratory and Emerging Infection Consortium (ISARIC), which found that, compared with the White group and accounting for age, sex and geography, South Asian people had a higher risk of mortality (hazard ratio (HR) 1.19) but this was not the case for East Asian, Black or Other ethnic groups (HRs 1.00, 1.05, 0.99 respectively)<sup>16</sup>.

39. Risk factors for being critically ill or dying from COVID-19 include factors such as age, sex, pre-existing health conditions and disabilities. Further information about these risk factors is shown in Annex C.

40. The disproportionate impact on ethnic minorities - apparent during the first wave and continuing for some ethnic groups during the second wave to date - is largely a result of higher infection rates for some ethnic groups.

41. Ethnicity itself is not a risk factor for infection but people from ethnic minority groups are more likely to experience various risk factors for infection. SAGE reported that "Modifiable social factors such as poverty and occupation make a large contribution to the greater burden of COVID-19 in ethnic minorities"<sup>17</sup>. Infection risk factors include geography, age, deprivation, overcrowding, multigenerational households, certain occupations (in particular those that are public-facing) and lifestyle factors.

<sup>16</sup> <http://eprints.gla.ac.uk/219444/1/219444.pdf>

<sup>17</sup>

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/925135/S0778\\_Drivers\\_of\\_the\\_higher\\_COVID-19\\_incidence\\_morbidity\\_and\\_mortality\\_among\\_minority\\_ethnic\\_groups.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/925135/S0778_Drivers_of_the_higher_COVID-19_incidence_morbidity_and_mortality_among_minority_ethnic_groups.pdf)



42. In addition, the interaction between risk factors needs to be considered, where the impact to risk could be additive or multiplicative, as many of the risk factors are interrelated. If a household at increased risk of infection includes people with disabilities, pre-existing health conditions including obesity, or older people, there is also an increased risk of mortality once infected.
43. The likelihood of experiencing different risk factors varies by ethnic group, just as infection rates and mortality rates vary by ethnic group.
44. Finally, as different ethnic groups experience different outcomes, it is not analytically useful to aggregate all ethnic minority groups under a heading of “BAME” or to draw conclusions about COVID-19 outcomes by looking only at aggregated data for all ethnic minorities. It is vital to understand the differences between ethnic groups and to consider the circumstances that may have contributed to health inequalities from COVID-19.
45. According to a study from academics affiliated to St George’s University of London<sup>18</sup>, migrants in high-income countries are at high risk of exposure to, and infection with, COVID-19. In general, migrants have higher levels of many risk factors and vulnerabilities relevant to COVID-19, including increased exposure due to high-risk occupations and overcrowded accommodation, and barriers to health care including inadequate information, language barriers, and reduced entitlement to healthcare coverage related to their immigration status.
46. This study had limited evidence for the UK. However, academics from University College London (UCL) are preparing an analysis using the *Million Migrants* study<sup>19</sup> to understand the relationship between migration and COVID-19 health outcomes. Further details of this analysis will be reported when the analysis is complete.

### **Differences between the first wave and the early second wave**

47. Overall the direct outcomes of COVID-19 have improved for all ethnic minority groups except people from South Asian background, in particular the Bangladeshi and Pakistani ethnic groups, between the first and early second waves of the virus to date, according to evidence from the Intensive Care National Audit and Research Centre (ICNARC), NHS England, ONS and OpenSAFELY.
48. For the purpose of this analysis, the first wave is deemed to be the period up to 31 August, and the early second wave is the period from 1 September to 28 December. Recent PHE data on mortality for January 2021, the approximate peak of the second wave, reveals higher mortality rates for the Black ethnic group than research on the early second wave suggests<sup>20</sup>. However, these data do not show a detailed ethnicity breakdown and because there has not been any analysis of hazard ratios, it is difficult

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<sup>18</sup> <https://www.medrxiv.org/content/10.1101/2020.12.21.20248475v1>

<sup>19</sup> <https://doi.org/10.12688/wellcomeopenres.15007.1>

<sup>20</sup> <https://www.gov.uk/government/publications/covid-19-reported-sars-cov-2-deaths-in-england/covid-19-confirmed-deaths-in-england-report#ethnicity>

to come to conclusions about specific ethnic groups such as Black African and Black Caribbean.

49. Research by ONS analysts and academics uses both age standardised mortality rates (ASMRs) and Hazard ratios (HRs) to explore risk of death<sup>21</sup>. ASMRs allow for comparison of mortality between ethnic groups, or over time. It is worth bearing in mind that the differences in ASMRs between the first and second wave may be impacted by the different lengths of the 2 waves (see Annex C); in a longer time period more deaths may have occurred. Hazard ratios, as employed in paragraphs 54-57, quantify the risk of death from COVID-19 for ethnic minorities, relative to the risk experienced by White British people. This supports exploration of the role played by different risk factors in the excess risk in wave 1 and wave 2 faced by different groups. ASMRs measure absolute mortality, while HRs measure relative risk of mortality.

### **Age standardised mortality rates**

50. The most notable improvements are the outcomes for the Black African ethnic group<sup>22</sup>. In the first wave, age-standardised mortality rates (ASMRs) of COVID-19 mortality were greatest among individuals identifying as Black African (402.5 and 174.1 deaths per 100,000 population in men and women respectively); however, during the second wave ASMRs of COVID-19 mortality fell sharply for Black African people (79.7 and 32.0 deaths per 100,000 population in men and women respectively). Comparing annualised mortality rates from the first and second waves - see Annex C - both Black African men and Black African women show a decrease of over 60% compared with the first wave. However, the second wave mortality rates have risen by 124% and 97% for men and women from Pakistani backgrounds, respectively.

51. During the first wave ASMRs were lowest among those identifying as White British (119.1 and 65.1 deaths per 100,000 population in men and women, respectively) and risk of death was greater among all ethnic minority groups compared with the White British population. In the second wave, the risk was similar among ethnic minority groups compared with the White British population, with the exception of Pakistani, Indian and Bangladeshi people, where it remained higher.

52. In the second wave, the ASMRs of COVID-19 mortality were highest among men and women identifying as Pakistani (339.9 and 166.8 deaths per 100,000 population in men and women) and Bangladeshi (318.7 and 127.1 deaths per 100,000 population in men and women). Comparatively, the ASMRs of COVID-19 mortality were low for White British populations (77.8 and 42.6 deaths per 100,000 population in men and women) and lowest of all for people identifying as Chinese (43.7 and 44.0 deaths per 100,000 population in men and women). High Pakistani and Bangladeshi mortality may reflect the high infections during the second wave for these groups. Pakistani infection rates have historically been higher than other ethnic minorities (with the exception of the Other ethnic groups population, which is likely inflated by misclassification (see

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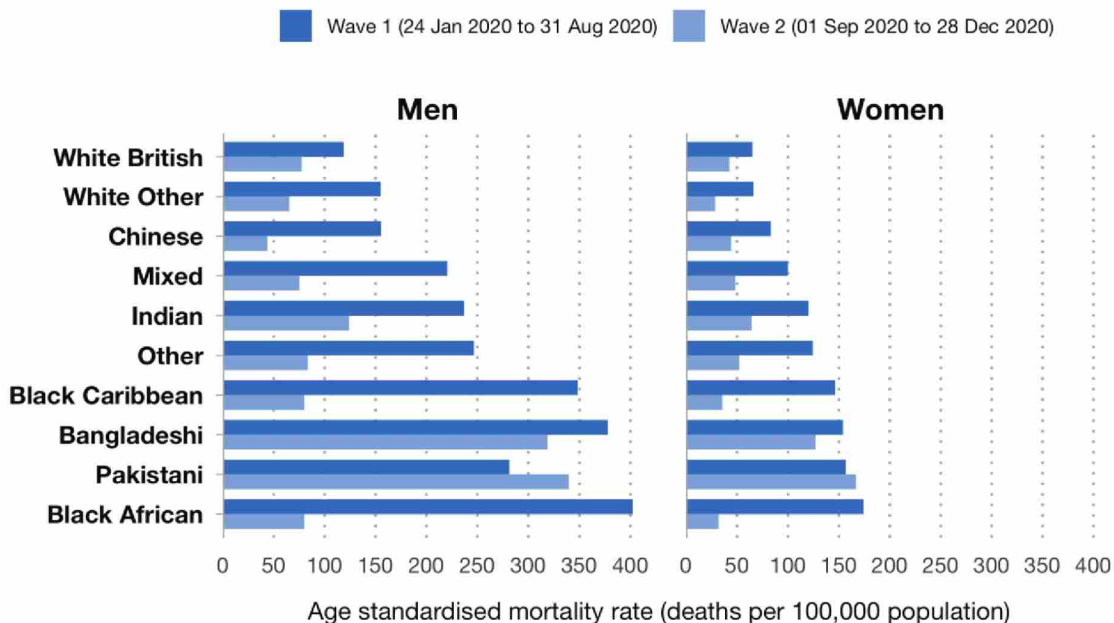
<sup>21</sup> <https://www.medrxiv.org/content/10.1101/2021.02.03.21251004v1.full>

<sup>22</sup> When referring to ASMRs for different ethnic groups for a specific wave, we quote the ASMR figures as published by ONS. When calculating % change between waves, we have used the annualised ASMRs for each wave

paragraph 93)) but increased sharply, compared with most other ethnic groups, from early October to early December<sup>23</sup>.

53. Researchers affiliated to the Office for National Statistics, University of Oxford, London School of Hygiene and Tropical Medicine, and University of Leicester behind the ASMRs analysis state that “An appreciable reduction in the difference in COVID-19 mortality in the second wave of the pandemic between people from Black ethnic background and people from the White British group is reassuring, but the continued higher rate of mortality in people from Bangladeshi and Pakistani backgrounds is alarming and requires focused public health campaign and policy response”.

**Figure 2: COVID-19 age-standardised mortality rates (ASMR) by ethnic group and sex separately for the first (24 January 2020 to 31 August 2020) and the second (1 September 2020 to 28 December 2020) waves of the pandemic**



Source: Office for National Statistics

## Hazard ratios

54. In the first wave, Black African, Pakistani and Bangladeshi men were 4.5, 2.7 and 3.5 times more likely to die from COVID-19 respectively than White British men of the same age. In the second wave (to date) the mortality risk remained high for Pakistani and Bangladeshi men (4.8 and 4.1) but not for men from Black ethnic groups who had the same rate as White British men. A large part of this continued disparity for South Asian populations can be explained from geographic, socioeconomic and health factors.

<sup>23</sup> <https://www.gov.uk/government/statistics/national-flu-and-covid-19-surveillance-reports>



55. In both waves, adjustment for geographical factors, socio-demographic characteristics and pre-pandemic health substantially reduced the estimated disparities between most ethnic groups and the White British population<sup>24</sup>. This suggests that the differences in mortality between ethnic groups are partly mediated by these factors. However, these factors reduced the hazard ratios (HR) more strongly in wave 1 than in wave 2 (to date). In addition, the factors that most strongly affected the HRs differed in the 2 waves.
56. In wave 1, adjusting for geographical factors more than halved the estimated hazard ratios for all ethnic minority groups. For most groups, the HRs were further reduced by adjusting for socio-demographic factors and pre-pandemic health status, especially amongst women. After adjusting for all these factors, women from Bangladeshi and Mixed backgrounds were no longer at greater risk of COVID-19 related death than White British people. For women from all other groups except Black African, the fully adjusted hazard ratios were below 1.4. However, despite the reduction of the HRs after adjusting for all these factors, men from all ethnic minority groups except Other White remained at greater risk, but with hazard ratios greatly reduced.
57. In wave 2 (to date), adjusting for geographical factors did not substantially reduce the HRs in men and women from Bangladeshi background, but reduced the HRs for people from Pakistani background. Adjusting for socio-demographic factors reduced the elevated risks of people from Bangladeshi and Pakistani backgrounds similarly in the 2 waves. Further adjustment for pre-pandemic health status also attenuated the relationship. However in wave 2, even after adjusting for all these factors, people from Pakistani and Bangladeshi backgrounds remained at substantially greater risk of COVID-19 death than White British people, with HRs of 2.7 and 2.0 in men and women from a Pakistani background, and 2.5 and 2.2 in men and women from a Bangladeshi background, respectively. The adjustments had little impact on the HRs for people from an Indian background.
58. Analysis from OpenSAFELY<sup>25</sup> found similar results: "Ethnic inequalities in the risk of dying from COVID-19-related death appear to have changed between the first and early second wave of the epidemic in England. In the period between September and early November 2020, South Asian ethnic groups (in particular those of Bangladeshi and Pakistani ethnicity) were at markedly increased risk compared with people of White ethnicity, while people of Black and other ethnicities had similar risks to White [people]".
59. Based on this evidence, the changes observed in COVID-19 outcomes among ethnic groups within such a short time period strongly suggest that ethnic inequalities in COVID-19 outcomes are driven by risk of infection as opposed to ethnicity itself being a risk factor for severe illness or death from COVID-19.
60. According to ONS researchers "The widespread dissemination of research findings and government reports published during the first wave of infection, that highlighted that people from ethnic minority groups were disproportionately affected by COVID-19, may have helped raise the awareness of these disparities amongst the general public."<sup>26</sup>. The information provided by academia and government, in combination with the

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<sup>24</sup> <https://www.medrxiv.org/content/10.1101/2021.02.03.21251004v1.full-text>

<sup>25</sup> <https://www.medrxiv.org/content/10.1101/2021.02.02.21250989v1.full.pdf>

<sup>26</sup> <https://www.medrxiv.org/content/10.1101/2021.02.03.21251004v1.full#T5>

government response to address disparities, may have led to reduced disparities during wave 2, especially for the Black African and Black Caribbean ethnic groups. Different geographic 'hotspots' throughout the pandemic may also have contributed to the changing risk experienced by different populations, for example, Black people in London during the first wave or Pakistani and Bangladeshi people in the North West during the early second wave.

61. There is work underway to consider why the second wave to date had such a disproportionate impact on South Asian groups, led by the SAGE ethnicity subgroup. Relevant considerations include:

- The early part of the second wave was particularly evident in the North West, North East, Yorkshire and Midlands (regions that they have high proportions of people from the Pakistani group<sup>27</sup>). From December onwards, leaving the early second wave and entering the peak, COVID-19 infection rates in London, East of England and the South East increased<sup>28</sup>. At the same time, COVID-19 infection rates for Indian, Other Asian and Black populations notably increased, similar to the infection rate seen for Pakistani people. Different regional patterns in how the waves have emerged may contribute to the differing patterns of infections by ethnic group.
- Bangladeshi and Pakistani households in England have the highest rates of overcrowding at 24% and 18% respectively<sup>29</sup>. They also have the highest rates of large households; 33.6% of Pakistani adults and 32.0% of Bangladeshi adults live in households of 6 or more people<sup>30</sup>
- There is higher excess mortality risk for South Asian women when compared with other minority groups, which is partially explained through higher rates of living in multigenerational households - less than 10% of White women aged 65 and above are estimated to live in a multigenerational household, compared with 60.0% of Bangladeshi women and 58.4% of Pakistani women<sup>31</sup>. These were similar proportions to Pakistani and Bangladeshi men aged 65 and above. However this does not explain the excess mortality experienced by South Asian men or other ethnic groups. According to SAGE "This may be associated with the different circumstances in which women live in intergenerational households, for example, they are more likely to reside with other family members once widowed, and potentially more vulnerable. This may in part be because for minority ethnic groups household composition is more strongly correlated with other factors which are already adjusted in the analysis".

<sup>27</sup> <https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/regional-ethnic-diversity/latest>

<sup>28</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/956709/Weekly\\_Flu\\_and\\_COVID-19\\_report\\_w4\\_FINAL.PDF](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/956709/Weekly_Flu_and_COVID-19_report_w4_FINAL.PDF)

<sup>29</sup> <https://www.ethnicity-facts-figures.service.gov.uk/housing/housing-conditions/overcrowded-households/latest#by-ethnicity>

<sup>30</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/943178/S0923\\_housing\\_household\\_transmission\\_and\\_ethnicity.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943178/S0923_housing_household_transmission_and_ethnicity.pdf)

<sup>31</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/943178/S0923\\_housing\\_household\\_transmission\\_and\\_ethnicity.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943178/S0923_housing_household_transmission_and_ethnicity.pdf)

- Additionally, COVID-19 infection<sup>32</sup> and risk of mortality<sup>33</sup> are both associated with deprivation. Asian populations are over-represented in deprived areas in England, with 15.7% of Asian people living in the most deprived 10% of neighbourhoods<sup>34</sup>. This is more evident in certain Asian populations; 31.1% of Pakistani people and 19.3% of Bangladeshi people live in the most deprived 10% of neighbourhoods.
- The COVID-19 rate of mortality is also higher in urban areas and highest in major urban conurbations - this category includes areas such as London, Birmingham, Oldham and Bradford<sup>35</sup>, all of which have large South Asian populations.
- Differences in occupational exposure could also account for some of the differences in mortality between groups, as a higher proportion of Pakistani and Bangladeshi men work as taxi drivers, shopkeepers and proprietors than men in any other ethnic backgrounds<sup>36</sup>. For example, 33.0% of male taxi and private hire vehicle (PHV) drivers and chauffeurs and 10.9% of male security guards and related occupations are Bangladeshi or Pakistani men, compared with 3.1% of men in all occupations<sup>37</sup>. Both occupations have higher mortality rates, 101.4 and 100.7 per 100,000 respectively, compared with 31.4 per 100,000 for working age men in England and Wales.<sup>38</sup>

## Health Inequalities

62. This section looks beyond inequalities in the impact of COVID-19, and at health inequalities by ethnicity more generally. The material here is a relatively high-level summary.

63. A recent briefing from The King's Fund<sup>39</sup> considers how selected outcomes in health differ between different ethnic groups in England. Some summary points from the briefing are as follows:

- Access to primary care health services is generally equitable for ethnic minority

<sup>32</sup> <https://www.gov.uk/government/publications/react-2-study-of-coronavirus-antibodies-june-2020-results/react-2-real-time-assessment-of-community-transmission-prevalence-of-coronavirus-covid-19-antibodies-in-june-2020>

<sup>33</sup> <https://www.nature.com/articles/s41586-020-2521-4>

<sup>34</sup> <https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/people-living-in-deprived-neighbourhoods/latest#overall-most-deprived-10-of-neighbourhoods-by-ethnicity>

<sup>35</sup> <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19bylocalareasanddeprivation/deathsoccurringbetween1marchand31july2020#rural-and-urban-areas>

<sup>36</sup> <https://www.medrxiv.org/content/10.1101/2021.02.03.21251004v1.full.pdf>

<sup>37</sup>

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand25may2020#coronavirus-covid-19-related-deaths-by-occupation-data>

<sup>38</sup>

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand28december2020>

<sup>39</sup> <https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england>



groups, but less consistently so across other health services<sup>40 41</sup>. However, people from ethnic minority groups are more likely to report being in poorer health than their White counterparts<sup>42 43 44</sup> and to report poorer experiences of using health services.<sup>45 46 47</sup>

- Despite this, prior to the COVID-19 pandemic, overall mortality (adjusted for age) was lower among most ethnic minority groups than the White population.<sup>48 49 50 51 52</sup> This underlines the complexity of the picture and the importance of distinguishing between the inequalities experienced by different ethnic groups:
  - People from the White Gypsy or Irish Traveller, Bangladeshi and Pakistani communities have the poorest health outcomes across a range of indicators<sup>53</sup>.
  - Compared with the White population, disability-free life expectancy is estimated to be lower among several ethnic minority groups<sup>54</sup>.
  - While the incidence of cancer is highest in the White population<sup>55</sup>, rates of

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<sup>40</sup> <https://pubmed.ncbi.nlm.nih.gov/19622520/>

<sup>41</sup>

<https://library.oapen.org/bitstream/handle/20.500.12657/22310/9781447351269.pdf?sequence=4&isAllowed=y>

<sup>42</sup>

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/730917/local\\_action\\_on\\_health\\_inequalities.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730917/local_action_on_health_inequalities.pdf)

<sup>43</sup> <https://jech.bmj.com/content/70/7/653>

<sup>44</sup> <https://www.ethnicity-facts-figures.service.gov.uk/health/physical-health/health-related-quality-of-life-for-people-aged-65-and-over/latest#data-sources>

<sup>45</sup> <https://www.ethnicity-facts-figures.service.gov.uk/health/patient-experience/patient-experience-of-primary-care-gp-services/latest#by-ethnicity>

<sup>46</sup> <https://www.ethnicity-facts-figures.service.gov.uk/health/patient-experience/patient-satisfaction-with-gp-out-of-hours-services/latest>

<sup>47</sup> <https://www.ethnicity-facts-figures.service.gov.uk/health/patient-experience/inpatient-satisfaction-with-hospital-care/latest>

<sup>48</sup> <https://doi.org/10.1371/journal.pmed.1002515>

<sup>49</sup> <https://pubmed.ncbi.nlm.nih.gov/23740930/>

<sup>50</sup>

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/908434/Di\\_sparities\\_in\\_the\\_risk\\_and\\_outcomes\\_of\\_COVID\\_August\\_2020\\_update.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Di_sparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf)

<sup>51</sup> <https://pubmed.ncbi.nlm.nih.gov/23740930/>

<sup>52</sup> ONS are due to publish comprehensive national data on mortality rates by ethnicity later this year.

<sup>53</sup>

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/730917/local\\_action\\_on\\_health\\_inequalities.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730917/local_action_on_health_inequalities.pdf)

<sup>54</sup> <https://doi.org/10.1080/13557858.2014.921892>

<sup>55</sup> <https://www.cancerresearchuk.org/health-professional/cancer-statistics/incidence/ethnicity#heading-Zero>

infant mortality<sup>56</sup>, cardiovascular disease (CVD)<sup>57 58</sup> and diabetes<sup>59</sup> are higher among Black and South Asian groups. CVD and diabetes cause significant morbidity among these groups, much of which can be prevented by public health measures aimed at tackling risk factors such as obesity, poor diet, inadequate physical activity and smoking.

- The COVID-19 pandemic has had a disproportionate impact on ethnic minority groups, reversing the mortality advantage in some ethnic minority groups<sup>60</sup>.
- The King's Fund briefing provides contextual information for some of the factors driving these ethnic differences in health.

## Non-COVID-19 deaths

64. An OpenSAFELY study<sup>61</sup> found that, between 1 February and 9 November 2020, people from ethnic minority groups were more likely to die from COVID-19 than their White counterparts. After adjusting for age and sex, the odds ratios for the South Asian, Black, Mixed and Other ethnic groups for dying from COVID-19 were 2.33, 2.20, 1.75 and 1.54 respectively. However, during the same period, ethnic minority groups had lower odds than the White ethnic group of non-COVID-19 death (odds ratio for South Asian: 0.78, Black: 0.88, Mixed: 0.86, Other: 0.65).

65. The study reports that “the evidence from both the internal comparison in the present study, and related data from other studies, suggests that the higher risk of poor COVID-19 outcomes reflects unique features of the pandemic rather than a generalised higher risk of death in non-White groups.” Other evidence suggests that prior to the COVID-19 pandemic, deaths from infectious diseases - as well as non-infectious disease deaths - were lower among ethnic minority groups compared with the White population<sup>62</sup>. The disproportionate deaths from COVID-19 experienced by ethnic minorities may be due to something more specific to COVID-19, rather than infectious diseases more generally. The OpenSAFELY study continues “reasons might include a high likelihood of working in at-risk occupations with high exposure risk, such as health and social care, hospitality and public transportation; and a high likelihood of living in large, high-density or multigenerational households, which might act

<sup>56</sup>

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/childhoodinfantandperinatalmortalityinenglandandwales/2018#inequalities>

<sup>57</sup>

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/733093/HOF\\_Health\\_Equity\\_Report.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733093/HOF_Health_Equity_Report.pdf)

<sup>58</sup> <https://academic.oup.com/jpubhealth/article/29/2/191/1505208>

<sup>59</sup> <https://bjcardio.co.uk/2018/09/diabetes-cvd-supplement-2-diabetes-and-cardiovascular-risk-in-uk-south-asians-an-overview/#:~:text=Like%20CHD%2C%20stroke%20is%20also%20more%20common%20in,in%20studies%20from%20the%20USA%20and%20India.%2028%2C29>

<sup>60</sup>

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/908434/Disparities\\_in\\_the\\_risk\\_and\\_outcomes\\_of\\_COVID\\_August\\_2020\\_update.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf)

<sup>61</sup> <https://www.medrxiv.org/content/10.1101/2021.01.15.21249756v2>

<sup>62</sup> <https://www.medrxiv.org/content/10.1101/2020.07.27.20162354v1>



individually or in combination to increase the risk of infection, and thus the overall risk of COVID-19 death, particularly if a high exposure risk in younger people leads to increased infection in older people via households and community settings”.

66. Looking at the specific causes of death, the OpenSAFELY study found that people from Mixed and Asian backgrounds were more likely to die from cardiovascular disease than their White counterparts, whilst the Black ethnic group were more likely to die from Dementia or Alzheimer's than White people. For all other types of non-COVID-19 death (for example, cancer, respiratory), people from the White ethnic group were more likely to die than those from the Black, Asian, Mixed or Other groups. In all age groups the risk of death from cancer and cardiovascular disease was higher than the risk of COVID-19 death. In individuals over 80, dementia/Alzheimer's was also a leading cause of death.

## Vaccinations

67. According to analysis published by SAGE<sup>63</sup>, in previous national vaccination programmes in the UK, reported uptake has been lower in areas with a higher proportion of minority ethnic group populations. There is a risk that vaccine uptake for COVID-19 may also be lower among minority ethnic groups.
68. Primary care data analysed by QResearch indicates that, in the case of several viruses, Black African and Black Caribbean groups are less likely to be vaccinated compared with White groups; over-65s from the Black Caribbean population are half as likely to have had the influenza vaccine, compared with over-65s from the White group<sup>64</sup>. Furthermore, for vaccines for viruses that have emerged since 2013, all adults in minority ethnic groups were less likely to be vaccinated compared with those in White groups (by 10 to 20%).
69. Recent survey data from the UK Household Longitudinal study shows that Black groups are the most likely not to be vaccinated, the next group being the combined Pakistani and Bangladeshi group. White groups are the most likely to be vaccinated.
70. According to ONS<sup>65</sup>, from early December 2020 to early January 2021, less than half (49%) of Black or Black British adults reported that they were likely to have the vaccine. Higher percentages were reported amongst people from White (85%) and Mixed ethnicity (80%) backgrounds.
71. The ONS study mentions that of those who said they were unlikely to have the vaccine:

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<sup>63</sup> <https://www.gov.uk/government/publications/factors-influencing-covid-19-vaccine-uptake-among-minority-ethnic-groups-17-december-2020>

<sup>64</sup>

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/952716/s0979-factors-influencing-vaccine-uptake-minority-ethnic-groups.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/952716/s0979-factors-influencing-vaccine-uptake-minority-ethnic-groups.pdf)

<sup>65</sup>

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/coronavirusandthesocialimpactsongreatbritain/29january2021#attitudes-to-covid-19-vaccination-by-different-sub-groups-of-the-population>

- over 6 in 10 adults of ethnic minority background (64%) reported they were worried about the side effects of the vaccine, compared with 45% of adults of White ethnic background
- around 2 in 10 adults of White ethnic background (21%) reported they did not feel COVID-19 was a personal risk, compared with 11% of ethnic minority background.

72. More recent research from REACT-2, undertaken from 26 January to 8 February 2021, suggests that 72.5% of Black adults would accept a vaccination<sup>66</sup>; an increase on the ONS estimate but still lower than the figures for adults from the Mixed, Other, Asian and White groups (83.1%, 84.4%, 87.6% and 92.6% respectively).

73. Lower COVID-19 vaccine uptake is evident for some ethnic minority groups in vaccines administered to over 80s as at 4 February<sup>67</sup>. The vaccine rates for eligible Black African, White and Black African, Other Black, Bangladeshi and Pakistani people are notably low (45.1%, 51.5%, 53.4%, 54.6% and 55.2% respectively). This compares to 82.8% of eligible White British people having received a vaccine.

74. A further study of vaccine uptake among all staff at University Hospitals of Leicester NHS Trust found that ethnic minority healthcare workers are far less likely to take up COVID-19 vaccination than those of White ethnicity<sup>68</sup>. This has implications for delivery of the COVID-19 vaccination programme.

### **Understanding people's personal experiences of COVID-19**

75. As noted in the first report, RDU commissioned the Policy Lab<sup>69</sup> to undertake a deep dive into the experiences of 12 people from different ethnic minority backgrounds. Using in-depth interviews and observing daily activities over 8 weeks, the research provides deep insight into the impact of COVID-19 on participants' experience of everyday life in the autumn of 2020, changes in views as circumstances change and brings quantitative studies to life. The study was designed to include people from a variety of ethnic groups and circumstances with which to compare experiences and perspectives (see Annex C); however, participants are spokespeople only for their own lives and should not be considered as representative of their ethnic minority community or any other communities that they belong to.

76. 6 themes were identified (see Annex C) which cut across all ethnic groups, economic circumstances and geographic locations. The most noteworthy points for the RDU are:

- Participants felt that their ability to adapt and adjust, along with their degree of hope and pragmatism, was largely dictated by the social and economic resources available.

<sup>66</sup> <https://www.imperial.ac.uk/media/imperial-college/institute-of-global-health-innovation/REACT-2-round-5-preprint.pdf>

<sup>67</sup> [https://github.com/opensafely/nhs-covid-vaccination-coverage/blob/master/released-outputs/opensafely\\_vaccine\\_report\\_overall.pdf](https://github.com/opensafely/nhs-covid-vaccination-coverage/blob/master/released-outputs/opensafely_vaccine_report_overall.pdf) (accessed 15/02/2021)

<sup>68</sup> <https://www.medrxiv.org/content/10.1101/2021.02.11.21251548v2.full.pdf>

<sup>69</sup> <https://openpolicy.blog.gov.uk/about/>

- Participants' beliefs, exposure to media and personal experiences of COVID-19, among other factors, influenced their perceptions of risk. As such, management strategies were based on each individual's assessment and interpretation of these complex and cumulative risks.

77. These findings align with supporting evidence which shows that some ethnic minorities are likely to experience occupation related risks, such as working in health and social care<sup>70,71,72</sup> SAGE reported that "Modifiable social factors such as poverty and occupation make a large contribution to the greater burden of COVID-19 in ethnic minorities (high confidence)".<sup>73</sup>

78. These findings point to the need to understand individual risk and support the development of, and wider access to, objective risk assessment tools as discussed in the first report<sup>74</sup>.

79. Further noteworthy findings from this research include that:

- Participants from various ethnic minority groups felt that the use of the term 'BAME' in communications framed ethnic minority groups as a homogeneous group that is vulnerable to COVID-19. This association of higher risk with ethnic minorities exacerbated participant's feelings of being stigmatised and distrusted; particularly when generalised statements were made about this group's risk without providing the appropriate rationale behind the statement.
- The RDU did not observe a consistent narrative around perceptions of compliance. Policy Lab found that most participants had experienced instances where they felt avoided, blamed or berated about their lifestyles and alleged non-adherence to the rules. One participant felt that although he and his family were compliant, his ethnic minority group (in the abstract) were not, while other participants felt that they or their communities were more stringently following social distancing to avoid further blame for spreading COVID-19.
- This also influenced how some participants felt about the vaccines. While most participants were positive about the vaccines and a return to 'normal', some participants reported distrust of the vaccines. These feelings were influenced by their life experiences, encounters with misinformation, confusion over media narratives surrounding risk to ethnic minorities, and pre-existing feelings of trust towards institutions.
- Most participants reported receiving their news from official sources such as government announcements or 'gov.uk' and all were very aware of the guidelines and tiers as a result; however, nearly all encountered misinformation. Most participants did not believe the content and some perceived it as dangerous.

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<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/articles/coronavirusandkeyworkersintheuk/2020-05-15>

71 <https://www.tuc.org.uk/sites/default/files/2020-06/Dying%20on%20the%20job%20final.pdf>

72 <https://www.ifs.org.uk/inequality/chapter/are-some-ethnic-groups-more-vulnerable-to-covid-19-than-others/>

73

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/925135/S0778\\_Driver\\_s\\_of\\_the\\_higher\\_COVID-19\\_incidence\\_\\_morbidity\\_and\\_mortality\\_among\\_minority\\_ethnic\\_groups.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/925135/S0778_Driver_s_of_the_higher_COVID-19_incidence__morbidity_and_mortality_among_minority_ethnic_groups.pdf)

74 <https://www.gov.uk/government/publications/quarterly-report-on-progress-to-address-covid-19-health-inequalities>



- Some reflected on the difficulty in navigating the advice and applying it to everyday situations, as well as adapting to the pace of change of the guidance. This, coupled with influences outside of the reliable news sources (such as information from the influence of close relations), led to one participant expressing views that COVID-19 could be viewed as a belief rather than fact, although they still followed restrictions carefully as a precaution.
- Furthermore, many of the conversations with participants centred around discussions on what they did or did not believe in relation to COVID-19. This highlights the variety of views and different perceptions surrounding COVID-19 across participants

80. Research from SAGE and SPI-B highlights the impact of messaging on behaviour. For example SPI-B's report explains, "For health messages to be effective, they need to reflect evidence on the relationship between cognitions such as beliefs and attitudes and specific behaviour. When messages target how people think about the target behaviour, they are more effective in changing that behaviour"<sup>75</sup>.

81. RDU will share Policy Lab's findings, as appropriate, with officials across government to allow policy makers to see the real time and longitudinal impacts of policy interventions.

### **Improving data quality**

82. The RDU and others have been working to improve the quality of data used to measure the impacts of COVID-19 on people in ethnic minority groups.

#### Improving the recording of ethnicity in GP practices

83. The DHSC laid a Statutory Instrument and accompanying Directions in December which made changes to the regulations governing GP contracts. When ethnicity data is provided by the patient (or someone lawfully acting on their behalf where the patient is a child or someone who lacks capacity), the GP is now mandated to record that information in general practice. This Amending Regulation was made to the GP Contract in response to perceived problems in capturing and recording patient ethnicity data that was highlighted by a PHE report on COVID-19. It is a permanent change to GP Regulations.

84. The amendment seeks to improve recording of ethnicity data to enable NHS services and programmes to be more effective for patients. The information may be used by NHS England and other healthcare commissioners in the future to gain a better understanding of population demographics and assist in public health management and the identification and monitoring of public health inequalities.

#### Data harmonisation

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<sup>75</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/914924/s0649-public-health-messaging-bame-communities.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/914924/s0649-public-health-messaging-bame-communities.pdf)

85. The preferred standards for the collection and publication of data for the protected characteristics (including ethnicity) are the Government Statistical Service (GSS) harmonised standards.
86. Harmonisation is hugely important as it allows analysts to gain deeper insight and value from data and the RDU has already set out its commitment to the harmonisation of ethnicity data across government in its Quality Improvement Plan<sup>76</sup>.
87. For ethnicity, the GSS harmonised standard is currently based on the 2011 Census and has 18 groups. The GSS Harmonisation Team will update the harmonised standard soon, reflecting the approaches adopted for the 2021 Censuses in England, Wales and Northern Ireland, and 2022 in Scotland.
88. Data owners in departments and agencies should commit to aligning their ethnicity data collections to the harmonised ethnicity standard as defined by the GSS, and publish their commitment to doing so, including timescales. As the harmonised standard may change over time, data owners are advised to consult with ONS Best Practice and Impact Division and the RDU before making any change.
89. A significant harmonisation priority is the publication of recommendations from the Unified Information Standard for Protected Characteristics (UISPC) project. This is a commission from DHSC to NHS England designed to enable the DHSC and the wider NHS to identify viable options for improving the consistency, detail and overall quality of equality data, including ethnicity. The UISPC recommendations could help to move NHS classifications from the 2001 harmonised Census ethnicity categories to an updated set of classifications.
90. The full set of UISPC recommendations is being considered within NHS England and NHS Improvement, and advice will be given to DHSC in due course. This activity should be prioritised.
91. While respondents to the Census have always had the option of writing in their ethnicity, moving data collection to the new Census classifications (or something similar) could facilitate the capture of better quality data for some groups. This could be through the new 'Roma' tick box and new write-in option for 'Black African' in England, for example.

#### The quality of ethnicity data in health datasets

92. Ethnicity information on COVID-19 cases and deaths following a positive test for COVID-19 is obtained through linkage to Hospital Episode Statistics (HES) and determined by the most recent ethnicity given by a person - people might give their ethnicity a number of times during different visits to hospital. There are several limitations with this approach:
- Ethnicity is presumed to be self-reported by the patient in hospital records, but this may not always be the case.

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<sup>76</sup> <https://www.gov.uk/government/publications/quality-improvement-plan-government-ethnicity-data/quality-improvement-plan-government-ethnicity-data>

- Patients may also report different ethnicities in different episodes of care (and the recording of different ethnicities could also happen if staff ascribe ethnicity for some episodes)
- People from certain ethnic backgrounds may be less likely to have complete records with which to complete the linkage to hospital data.

93. Previous analysis has shown higher population-based diagnoses and death rates in the Other ethnic group due to a mismatch between ethnicity assigned in the population data (based on the 2011 Census) and hospital records. Further work is ongoing within PHE to improve the allocation of ethnicity to COVID-19 cases and deaths, and improvements will be implemented over the coming months.

94. In October 2020, The King's Fund and UCL Institute of Health Equity submitted a paper to NHS England and NHS Improvement highlighting some of the limitations in both the coverage and quality of ethnicity recording of people using NHS health and care services in England and suggesting how this can be improved.<sup>77</sup>

95. Improvements to data might come in a number of ways. One way is through harmonisation. Others include improvements through data linkage or applying analytical techniques on data that have already been collected, an example being reclassifications by PHE. Finally, improvements can, and should, come through data collection.

96. The King's Fund and UCL Institute of Health Equity paper suggested ways that data might be improved when ethnicity is collected from patients.

97. It also recommended that "to ensure that ethnicity recording in health records is fit-for purpose to support the many key functions it is designed to do ... DHSC, NHSEI and NHS Digital (should) take steps to ensure that NHS organisations and staff, and GPs, are aware of how this information should be collected from patients and recorded". The RDU endorses this recommendation. The publication of a project plan for this work by NHSEI (with DHSC and others), along with regular progress updates, would be welcome.

98. A further project being undertaken by the Nuffield Trust will examine the completeness, validity, and consistency of ethnicity coding within NHS health datasets in England (excluding GP records). The project aims to establish the extent and nature of data quality issues, and understand the implications for analysis and decision making about ethnicity and health. The project is expected to report in April 2021, and is being undertaken in collaboration with the NHS Race and Health Observatory.

99. This report will provide additional information to inform action to improve the quality of ethnicity data in health records. The recommendation from the first quarter report to collect ethnicity information during death certification is dependent on ethnicity being taken from health records. It is therefore critically important that ethnicity data in health records are fit-for-purpose.

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<sup>77</sup> <https://www.kingsfund.org.uk/publications/ethnicity-coding-health-records>

100. This report also considers ongoing improvements to, and limitations of, 2 other ONS surveys, the COVID-19 Infection Survey (CIS), and the Opinions and Lifestyle Survey (OPN). Both surveys are important in measuring different aspects of the impact of COVID-19.
101. There have been a number of quality improvements to both of these surveys. For example:
- the sample size of the CIS has increased. In the 12 months from the start of the survey, it is expected that ONS will recruit approximately 500,000 individuals from approximately 240,000 households in total across the 4 countries of the UK.
  - The time between the OPN survey fieldwork closing and results being published has also reduced to allow more timely analysis of how attitudes and experiences are changing through the pandemic.
  - Starting with data collected between 21 and 25 October, the sample size for the weekly OPN has approximately tripled in England, to around 3,000 people.
102. However, while the sample size of the CIS has increased, small sample sizes in each of the 4 aggregate ethnic minority groups (and the 18 detailed groups) remain too small to produce robust estimates for these groups.
103. Also, there is an underrepresentation of ethnic minority groups in the OPN. Ethnic minorities constitute around 6% of the sample in the OPN, compared with 14% in the 2011 Census.
104. RDU will continue to work with ONS analysts to improve the quality of data for ethnic minority groups from these (and other) surveys.
105. ONS has also recently initiated a wider project to improve how they engage with under-represented groups. The project will develop evidence-based recommendations to ensure that future mixed-mode social survey designs are more representative.
106. As part of this project ONS are also going to consider their approach to sample design to investigate whether the samples drawn could be more inclusive and representative of minority groups than at present.

#### Quality of vaccinations data

107. The Office for Statistics Regulation has recently called for producers of COVID-19 vaccine statistics across the UK to address some data quality issues with vaccinations data<sup>78</sup>. These include providing more detailed characteristics of recipients, for example their ethnicity, age, and sex.
108. RDU will provide an assessment of the quality of data about vaccinations among ethnic groups in the next quarterly report.<sup>79</sup>

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<sup>78</sup> <https://osr.statisticsauthority.gov.uk/wp-content/uploads/2021/01/Ed-Humpherson-to-all-producers-Numbers-of-COVID-19-vaccinations-administered-in-the-UK.pdf>

<sup>79</sup>

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/coronavirusandthesocialimpactsongreatbritain/29january2021>



## Data publication and access

109. It is important that the datasets are as timely as possible to facilitate analysis within and outside of government. To this end, a publication schedule of updates to datasets on the RDU's Ethnicity facts and figures website that relate to risk factors and secondary impacts will be published (on the website) and is presented in Annex C<sup>80</sup>. Departments should provide the datasets to the timescales set out in that schedule.

110. The datasets listed in the schedule are highlighted in the Ethnicity and COVID-19 part of the website<sup>81</sup>. RDU is maintaining this page as a way to collect data and analysis from across government. This page provides links to data about:

- deaths and disparities in outcomes among people, disaggregated by ethnicity
- risk factors associated with getting and dying from COVID-19
- economic, educational and emotional impacts

111. To enable users to have access to up to date data, ONS has also made available a number of the most important micro-level datasets for the analysis of COVID-19 disparities between different ethnic groups. These are available from the ONS Secure Research Service on application and are listed in Annex C.

### **Next steps**

- The RDU will continue to share the findings from the qualitative research into people's personal experiences of COVID-19 across government, particularly in relation to the stigmatisation felt by a number of participants in relation to being singled out as 'BAME'.
- Departments and other agencies should publish a statement on GOV.UK outlining their plans to move their data collections to the Government Statistical Service's (GSS) harmonised standard.
- NHSEI, working with DHSC and others, should publish a quarterly report on progress in improving the recording of ethnicity in health care records.
- Departments should provide updated datasets on COVID-19 risk factors and secondary impacts for publication on the Ethnicity facts and figures website in line with the schedule in Annex C. This provides transparency of process to users - promoting trust and authority - as well as informing them when the most up-to-date data will be made available.

<sup>80</sup> <https://www.ethnicity-facts-figures.service.gov.uk/>

<sup>81</sup> <https://www.ethnicity-facts-figures.service.gov.uk/covid-19>



### 3. Stakeholder engagement

#### Summary

112. Over the last quarter, the Minister for Equalities, the government advisers on COVID-19 and ethnicity and RDU officials have led a programme of engagement both within government and with external stakeholders. This has comprised working groups, bilateral meetings, conference speeches and targeted roundtables. This work will continue in the next quarter.

#### Approach

113. Within government, the Minister for Equalities shared the findings from her first quarterly report with other ministers through meetings and correspondence. This included updating ministerial colleagues on the likely drivers behind the higher COVID-19 infection and mortality rates for ethnic minority groups. The minister stressed the importance of not mistaking risk factors that are prevalent among ethnic minorities with portraying ethnicity itself as a risk factor, and potentially stigmatising ethnic minority groups. The Minister for Equalities also set out the importance of measuring the impact of policy interventions and shared with other ministers the technical annex prepared by the RDU.

114. The RDU also established a cross-government policy working group in November as a means of sharing the main findings from the research into why COVID-19 has had such a disproportionate impact on ethnic minority groups, and to encourage development of new policy interventions to address these findings. The RDU has also worked closely with DHSC, MHCLG, PHE and other parts of the Cabinet Office on a range of issues including new guidance and accompanying, targeted communications on preventing household transmission of COVID-19, particularly within multigenerational households.

115. The Minister for Equalities also met the Minister for COVID-19 Vaccine Deployment in January to discuss how data relating to ethnicity would be collected during the vaccination programme and how to promote vaccine uptake among ethnic minority groups.

116. In terms of external engagement, the Minister for Equalities has met a number of important stakeholders including the British Medical Association and the Health Foundation. She met the BAME Communities Advisory Group (representing the adult social care sector) to consider their report on the impact of COVID-19 on ethnic minority people who are in receipt of social care services or work in the social care sector<sup>82</sup>.

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[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/919156/1\\_BAME\\_Advisory\\_Group\\_report\\_accessible.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/919156/1_BAME_Advisory_Group_report_accessible.pdf)

117. The Minister for Equalities, alongside the Minister for COVID-19 Vaccine Deployment and the Minister for Prevention, Public Health and Primary Care also attended a round table with the National Pharmacy Association (NPA), a network of 14,000 pharmacies across the UK. This was an opportunity to share the findings of her work, to hear directly from pharmacists about tackling health inequalities and to consider how to encourage understanding and uptake of the COVID-19 vaccines. The NPA is a particularly important advocate as ethnic minority workers represent 43% of the pharmacy profession.
118. The Minister for Equalities gave the keynote speech at the Westminster Health Forum conference on tackling ethnic minority inequality in health and social care, held on 9 December.
119. The RDU and the Minister for Equalities have continued engagement with maternal health stakeholders over the last quarter. Following a joint Ministerial roundtable event in September 2020, the RDU has supported DHSC in driving positive actions in maternity services to improve outcomes for ethnic minority women. This includes the recently launched NHS campaign 'Help us Help You' informing pregnant women about the importance of attending check-ups, and providing reassurance that the NHS is there to see them safely.
120. The RDU and DHSC have also engaged with midwives from Birmingham and East London NHS Trusts who are on the frontline of the local COVID-19 response, in order to identify best practice as well as areas for improvement.

#### **Reducing maternal health disparities during the pandemic**

An example of best practice is the 'Birmingham Pathway'. Midwives in the University Hospitals Birmingham NHS Trust identified that local ethnic minority women in the top ten percentile of deprivation were at higher risk for COVID-19. In response, the Trust convened a multidisciplinary team and launched a maternity surveillance programme to share data and monitor pregnant women testing positive.

The programme aimed to detect at an early stage COVID-19-related problems in pregnant women. COVID-19 phone lines made daily calls to patients, guaranteeing rapid access to midwives. 45% of women on the surveillance programme were from ethnic minority groups. Women's feedback to midwives was that they felt supported and reassured by calls. This initiative provided a swift, data-informed response to prevent poor outcomes for women at higher risk of COVID-19 complications.

Additional actions undertaken by maternity services in areas with higher ethnic minority populations include conducting community outreach to address misinformation and disinformation, hosting weekly online Q&A forums for pregnant women, and engaging with local faith leaders who provide trusted avenues for myth-busting.

It is vital that best practices like these continue to be shared across maternity services networks to ensure that women and their babies receive appropriate care and present early to hospital during COVID-19.

121. The Minister for Equalities also gave a keynote speech at *Action on Pre-eclampsia's* Annual Expert Meeting in November and met the Chief Midwife for England on 15 December.
122. In February, No.10 and the RDU hosted 2 roundtables on promoting vaccine uptake amongst South Asian groups. These groups were selected because of the disproportionate impact COVID-19 has had on them in the second wave and because of concerns about vaccine uptake amongst these and other ethnic minority groups.
123. The events generated a number of ideas and insights on how to improve vaccine uptake in the South Asian cohort such as:
- expanding the use of places of worship as vaccination centres;
  - the significant role women can play in countering misinformation and encouraging uptake; and,
  - the importance of high profile appearances and interactions with the community in order to improve vaccine uptake, such as the Prime Minister's visit to the Al Hikmah centre in Batley on 2 February which was cited as particularly impactful.
124. The work to promote vaccine uptake among ethnic minority groups, and particularly those that have been disproportionately impacted by the second wave, will continue in the next quarter

#### **Next steps**

- The Minister for Equalities, the government advisers on COVID-19 and ethnicity and the RDU will continue a programme of engagement over the next quarter. This will include work to promote vaccine uptake, alongside the engagement led by the Minister for COVID-19 Vaccine Deployment.



## 4. Communications

### Summary

125. The government has continued work to build on the way that public health messages are effectively delivered to ethnic minority people. There have been ongoing improvements within this multichannel communications strategy to address language, cultural and accessibility barriers, with a particular focus on targeted community engagement to better inform communications through bespoke creative content and messaging.
126. In the second quarter, as the new vaccines were announced, a concerted effort is being made to understand and overcome concerns about the vaccines among ethnic minority people. This has had a particular focus on encouraging uptake of vaccines and countering misinformation. Ministers, Dr Raghav Ali (government adviser on COVID-19 and ethnicity) and other healthcare experts have played important roles in supporting this effort.

### Approach

127. To improve vaccine confidence and uptake among ethnic minority people, a multi-channel approach is being taken which includes but is not limited to the following activity:
- The government has worked with specialist agencies to hold a series of roundtables for ethnic minority healthcare professionals and religious and community leaders to act as ambassadors within their communities. These sessions provided an opportunity to feed back concerns, recommend approaches and have specific questions answered by health experts such as Dr Ali and Dr Mary Ramsey, the Head of Immunisation from Public Health England.
  - To improve its understanding of vaccine concerns, the government is now working with over 90 faith, healthcare provider networks, influencers and experts from a range of communities. As a result of these new relationships, further Q&A sessions have been confirmed with the Sikh Council, NHS Muslim Network, Sarwat Tasneem who are networked into various Muslim women's groups, the Polish Vaccine Foundation, Oxford Polish Association and the National Pharmacy Association.
  - Editorial content packages are being developed with trusted voices among healthcare professionals, who will feature in media opportunities and digital content.
  - Utilising the ethnic minority radio partnership, the government has played out 29 3-minute pre-recorded interviews with local NHS community members on vaccine confidence, running across 13 community radio networks in 14 different



languages.<sup>83</sup> This activity has also been carried on social media channels.

- Additionally, vaccines confidence activity is planned to run on 42 multicultural stations in 12 languages. Phase 1 includes 5 stations in 3 languages producing 30 second TV ads with some of their best known talent. These video pieces went live on 18th Jan. A second phase has followed as more content has been produced.
- Since the start of the pandemic, specialist government units have been working at pace to identify and rebut false information about coronavirus, including the vaccines. The cross-government Counter Disinformation Unit (CDU) brings together different monitoring teams across Whitehall including teams in the Home Office, Foreign Commonwealth and Development Office and the Rapid Response Unit (RRU).
- RRU identifies important emerging narratives and, where they identify content that could breach platforms' terms of service, are dangerous or misleading, they flag these to the platforms for review and removal via established processes. Monitoring covers all the major open platforms and the government has trusted flagging relationships in place with Twitter, Facebook/Instagram, and YouTube. The government has close relationships with Facebook and continues to work with them to identify potential solutions to mis- and disinformation across all their platforms.
- To tackle mis- and disinformation among ethnic minorities, the government is regularly producing myth-busting content and utilising trusted platforms and messengers within communities and taking specific targeting approaches on social media channels (such as Facebook and Instagram which allows for better targeting). We are also using native language publisher sites and targeting specific media outlets (Asian Voice, Leader, The Nation, JC and Desi Express) as part of ongoing partnership work.

128. Translation continues to be a priority to reach those whose first language is not English and/or who have other accessibility needs. This includes translation of videos into British Sign Language and posters into Easy Read and Large Print as well as language translation. In addition to the translation of national assets, local authorities can request translations of their own assets.

129. Materials translated this quarter include a leaflet for parents advising what to do if their child contracts COVID-19 and guidance on self-isolation. This particular piece was translated into 26 community languages, based on insight from the Local Authority. Translated materials are also shared in editable formats so they can be used by as wide an audience as possible.

130. The government continued to reiterate health messaging around important calendar moments such as Diwali and Christmas. The approach has included work with faith leaders to advise, co-create and share communications on safe worship for these

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<sup>83</sup> Live until 21 January 2021

festivals.

131. Additionally, campaigns around universities and the COVID-19 app have included elements targeting ethnic minority people. Campaign approaches include press partnerships and the use of micro influencers to communicate important messages.
132. Innovative government-first partnerships with specialist ethnic minority media use regular, tailored advertorial content that helps get messages and guidance across.
133. The government has continued to prioritise collection of insight into diverse audiences to better understand and serve their communication needs. Through ongoing polling and focus groups, we now have a better understanding in areas such as media channel consumption and propensity to take up vaccines.
134. The government has been gathering insight on sentiment towards vaccinations, focusing on a variety of groups including ethnic minorities. When understanding the barriers to trust and uptake, it appears people including ethnic minorities are concerned about suspected side effects, ingredients used in the vaccines and safety.
135. Therefore, an integrated government campaign was launched to improve understanding and awareness of COVID-19 vaccinations among ethnic minority people and increase their confidence to take up the vaccination when offered it.
136. As part of the 'government first' partnerships with trusted community media outlets, the government is now working with more than 50 ethnic minority titles across 10 different languages (see **Annex D** for detail). These titles have proven useful to reach the Asian, Afro-Caribbean, African, Bangladeshi, Roman Catholic, Methodist, Russian, Pakistani, Turkish, Jewish, Chinese and Polish communities. The reach of ethnic minority print titles is approximately 446,000 and content features leading experts from the national content as well as relevant local GPs to create bespoke double page spreads.
137. In addition, the government has partnered with 43 ethnic minority TV channels within a combined reach of 9 million and 14 community radio stations that broadcast in 13 different languages and reach 881,000 ethnic minority people every week.
138. Work is also in hand with the BBC World Service who support COVID-19 communications by producing videos on important questions from South Asian communities in Urdu, Punjabi, Tamil, Gujarati, and Sylheti, which are produced by the BBC bureau in Delhi and the UK BBC News team. These are shared on BBC websites and social channels.
139. To meet the needs of people with disabilities, marketing materials continue to be regularly translated into Easy Read, British Sign Language, Braille, Audio and Large Print. The partnership with the BBC continues, giving access to their BSL interpreter feed for live broadcasts of the press conference on government owned social media channels.
140. A letter about shielding that was sent to all clinically extremely vulnerable people as part of the Tier 4 announcement, was translated into 13 languages as well as Easy

Read and Large Print.

141. Partnerships with respected community figures and organisations like places of worship are being used to help to build trust in the Test and Trace service and dispel existing myths and alternative narratives. To this end, on-site community-led testing, supported by community volunteers has been offered in these communities to learn and address the barriers to engagement and increase take up of testing.
142. The Test and Trace programme is also reaching diverse communities via social enterprises following a bottom up, community-based approach, to educate, inform and advance understanding of COVID-19 test/trace/isolate requirements as well as tackle concerns about the vaccines.

#### **Highlights from the vaccines campaign (up to Jan 2021)**

- Organic content on NHS.uk channels has reached over 208 million people, generating 479K likes, 178K comments, 224K shares on Facebook and 5.2 million impressions on Twitter.
- Digital advertising has generated 120 million impressions on Facebook, 34 million impressions on Twitter and 28.5 million impressions via digital display; moderators are hiding comments that propagate misinformation to limit its spread and Facebook adverts are being translated and served to those who have the channel set in another language.
- Over 20 pieces of traditional media coverage and 40 social media posts featuring medical professionals, including Dr Ranj Singh on ITV's This Morning, Dr Nighat Arif on BBC Breakfast and Dr Amir Khan on Lorraine and Islam Channel.
- Cabinet Office weekly bulletin and toolkit including clear, accessible messages, creative content and Q&A sent out to over 100 local partners and over 70 national partners; additional weekly stakeholder outreach from DHSC to over 176 organisations from across the health, charity and adult social care sectors and from MHCLG to over 600 contacts that include more than 120 faith leaders and 343 Local Authorities.
- Black Members of Parliament from the Conservatives and the Labour Party came together to produce a video to encourage people to take the vaccine. In the video MPs told moving personal stories of losing loved ones and warned against the spread of misinformation.

**Next steps**

- The government will continue to tailor its communications strategy on vaccine roll out to reflect the latest evidence on vaccine uptake among ethnic minority groups.
- The government will work closely with the new community champions to disseminate important public health messages, promote uptake of vaccines and tackle misinformation.
- Government communications will reflect the findings of the qualitative research into people's personal experiences of COVID-19 and will ensure that ethnic minorities are not treated as a single group and that public health messaging is not stigmatising.



## Annex A: Summary of progress against recommendations from the first quarterly report

### Recommendation 1: NHS England must ensure that Trusts implement NHS plans for the next stage of the pandemic, and that these plans continue to reflect the latest evidence about ethnic disparities and risk factors

NHSEI published Phase 3 of its COVID-19 response at the end of July. This urged all NHS Trusts to work collaboratively with local communities and partners to take urgent action to increase the scale and pace of progress of reducing health inequalities and regularly assess this progress. It recommended urgent actions, developed by an expert national advisory group including:

- Protect the most vulnerable from COVID-19, with enhanced analysis and community engagement, to mitigate the risks associated with relevant protected characteristics.
- Restore NHS services inclusively, so that they are used by those in greatest need, guided by new, core performance monitoring of service use and outcomes among those from the most deprived neighbourhoods and from Black and Asian groups.
- Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes.
- All NHS organisations should proactively review and ensure the completeness of patient ethnicity data.

Over the last quarter, significant progress has continued to be made against these actions. All NHS systems (Integrated Care Systems) have been implementing the actions and monitoring performance. Analysis requires appropriate information, quality assurance and governance before publication and will be released in due course.

The impact of the second wave of COVID-19 will continue to be monitored on these and other indicators. Enhanced monitoring of the completeness of patient ethnicity data is also being undertaken. Executive Leads for Health Inequalities are in place in the majority of NHS organisations and the Director-Health Inequalities post in the national team is now filled. Primary care objectives have continued to emphasise the importance of addressing health inequalities despite the enormous pressures from the pandemic.

The recent letter to NHS systems from NHS England and NHS Improvement on priorities for 2021 to 2022<sup>84</sup> reiterated the importance of addressing health inequalities. This includes auditing progress against the 8 actions, as well as reducing

<sup>84</sup> <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/12/important-for-action-operational-priorities-winter-and-2021-22-sent-23-december-2020.pdf>

variation in outcomes across the major clinical specialties and making progress on reducing inequalities for people with learning disabilities or serious mental illness, including ensuring access to high-quality health checks.

**Recommendation 2: Departments must put in place arrangements for the effective monitoring of the impacts their policies are having on people from ethnic minority backgrounds including:**

- the uptake of particular COVID-19 policies or grants of funding by ethnic minority individuals and groups;
- monitoring and assessing the level of infection, hospitalisation and mortality rates across ethnicities, where appropriate; and
- assessing how effectively these policies have been understood by those people at whom they are targeted.

The RDU has been working with departments to assist them in putting effective monitoring arrangements in place. This includes preparing a technical annex setting out how to measure ethnicity impacts.

DHSC already has a strong history of monitoring impacts of health policies over time. The Chief Medical Officer (Professor Chris Whitty's) first annual report published on 18 December 2020, presents an overview of the health of England's population. Including discussing initial insights of COVID-19 policies including the impact of Non-Pharmaceutical Interventions on general population impacts.

Other examples include MHCLG building in monitoring structures into the Community Champions scheme to ensure that the programme delivers assistance to those groups who most need it.

Further detail on this and other similar measures can be found in section 1 and in Annex B.

**Recommendation 3: there should be a rapid, light-touch review of action taken by local authorities and Directors of Public Health to support people from ethnic minority backgrounds, in order to understand what works at a local level.**

This work is summarised in paragraphs 8-13 in section 1.

In addition, DHSC officials have engaged with Directors of Public Health to discuss the disproportionate impact of COVID-19 on certain groups, providing insights into how different local areas are responding to the virus.

This has provided valuable feedback regarding vaccine roll out plans, local concerns (particularly for certain communities such as different faith groups and health and care workers) and access/uptake of testing. Valuable feedback was also gained into the communication channels proved most effective in reaching specific communities, such



as through faith groups using WhatsApp networks, video messaging and trusted community organisations (such as English Football League clubs).

**Recommendation 4: Departments should continue to work at pace to develop new policy interventions to mitigate COVID-19 disparities, informed by the latest evidence.**

This work is summarised in paragraphs 3-7 in section 1 and in Annex B.

**Recommendation 5: Support should be given to the development and deployment of a risk model to understand individual risk that is being developed from research commissioned by the CMO by an expert subgroup of academic, scientific and clinical experts and the University of Oxford.**

The QCOVID Predictive Risk Model has been developed and the associated research was peer-reviewed and published in the British Medical Journal in October 2020<sup>85</sup>, approved by the MHRA in December 2020 and independently validated by the ONS in January 2021. DHSC is working at pace to apply the model in the NHS, incorporating the feedback from private testing of a clinical decision support tool. The clinical tool was made available across primary and secondary care as a secure public beta webtool from 16 February.

**Recommendation 6: Ensure that new evidence uncovered during this review relating to the clinically extremely vulnerable is incorporated into health policy.**

Through providing detailed data about clinical risk, the QCOVID model has enabled DHSC to incorporate the findings from the research into national policy and has used it to identify a new cohort of patients at equivalent risk to the Clinically Extremely Vulnerable. This group is being added to the Shielded Patient List as a precautionary measure, and is entitled to advice and support, including priority access to the COVID-19 vaccine if they have not already been offered it.

As more is learnt about why the threat posed by COVID-19 varies across the population, the QCOVID risk model will be updated with the latest evidence and individuals given more nuanced advice on risk.

The Minister for Equalities wrote to the JCVI with the findings from the first quarterly report and will do so again with the findings from this report. The JCVI also reviewed the underlying data from the QCOVID model in shaping its advice on COVID-19 vaccine prioritisation.

<sup>85</sup> <https://www.bmj.com/content/371/bmj.m3731>

**Recommendation 7: Government departments and academics should prioritise linkage between health, social and employment data to build a complete picture of ethnic group differences in COVID-19 risk and outcomes.**

There is excellent collaborative work underway across DHSC, PHE and NHSE linking in with the ONS and their work on core data sets. This proactive cross-system working is ensuring maximum knowledge is available in the advice given to inform policy decisions.

PHE has linked data on COVID-19 cases and deaths to more than 20 years of Hospital Episode Statistics data in order to determine presence of pre-existing conditions and ethnicity, as population registers for people with pre-existing health conditions or access to primary care data for the whole population has not been available to PHE to date.

PHE was commissioned by the RDU to prepare a report on COVID-19, ethnicity and pre-existing health conditions. This was published on 18 December 2020<sup>86</sup>. PHE and ONS have jointly published a blog explaining these latest analyses of COVID-19 ethnic inequalities.<sup>87</sup>

RDU facilitated conversations between ONS and OpenSAFELY about the possibility of sharing occupation data from the 2011 Population Census - although this did not proceed because of sensitivities about sharing Census data. RDU also facilitated discussions with HMRC about the possibility of sharing (with OpenSAFELY) data that might give insights into the nature of people's occupations. However, HMRC does not hold data about tax payers' occupations, or about (for example) whether they might work in a public-facing role. ONS analysts will publish an analysis of mortality rates by ethnicity including occupation as a risk factor in due course.

**Recommendation 8: RDU should introduce and publish a new "Summary of evidence about COVID-19 and ethnicity" report, working collaboratively with external experts, which would be updated every time (significant) new statistics and research are published.**

RDU commissioned PHE analysis of the role of pre-existing health conditions in ethnic inequalities in diagnosis, deaths and survival from COVID-19. This was published on 18 December 2020<sup>88</sup>.

<sup>86</sup> <https://www.gov.uk/government/publications/covid-19-pre-existing-health-conditions-and-ethnicity>

<sup>87</sup> <https://blog.ons.gov.uk/2020/12/18/what-do-the-latest-analyses-from-ons-and-phe-tell-us-about-ethnic-inequalities-in-covid-19/>

<sup>88</sup>

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/942091/Summary\\_report\\_ethnicity\\_and\\_comorbidity.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942091/Summary_report_ethnicity_and_comorbidity.pdf)



In addition, ONS published a 'long read' about ethnicity and COVID-19 in an accessible form on 14 December<sup>89</sup> and has included ethnicity in its COVID-19 "latest data" dashboard.

Links to these reports, the dashboard and other relevant information are included on a specific 'Ethnicity and COVID-19' page on RDU's Ethnicity Facts and Figures website<sup>90</sup>.

**Recommendation 9: The recording of ethnicity as part of the death certification process should become mandatory, as this is the only way of establishing a complete picture of the impact of the virus on ethnic minorities. This would involve making ethnicity a mandatory question for healthcare professionals to ask of patients, and transferring that ethnicity data to a new, digitised Medical Certificate Cause of Death which can then inform ONS mortality statistics.**

As the first quarterly report acknowledged, this is a longer-term objective given the need for legislation to enable this change. Recording ethnicity as part of the death certification process will also be dependent on improvements to NHS data. The DHSC has commissioned NHSEI to propose how ethnicity data can be produced and utilised using the Unified Information Standard for Protected Characteristics (UISPC). NHSEI's report will be submitted to DHSC shortly.

In advance of this, DHSC laid a Statutory Instrument and accompanying Directions in December which made changes to the regulations governing GP contracts. When ethnicity data is provided by the patient (or someone lawfully acting on their behalf where the patient is a child or someone who lacks capacity), the GP is now mandated to record that information in general practice.

The amendment sought to improve recording of ethnicity data to enable NHS services and programmes to be more effective for patients.

**Recommendation 10: Minister for Equalities to work with ministerial colleagues to establish metrics for assessing the impact of their policies to tackle COVID-19 disparities**

The Minister for Equalities wrote to colleagues in December encouraging departments to establish metrics for assessing the impact of their policies, accompanied by a technical annex setting out some of the important considerations when developing metrics based on ethnicity. She also met the Minister for COVID-19 Vaccination

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<sup>89</sup>

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/whyhaveblackandsouthasianpeoplebeenhithardestbycovid19/2020-12-14>

<sup>90</sup> <https://www.ethnicity-facts-figures.service.gov.uk/covid-19>

Deployment to consider how ethnicity data should be collected as part of the vaccination programme.

**Recommendation 11: There should be a series of roundtables over the coming months involving faith leaders and other community representatives and focussing on those groups that are most at risk from COVID-19.**

Over the course of the last few weeks the focus has turned to promoting uptake of COVID-19 vaccines. The Minister for Equalities, alongside the Minister for COVID-19 Vaccine Deployment and the Minister for Prevention, Public Health and Primary Care, attended a roundtable with the National Pharmacy Association in January to encourage understanding and promote uptake of vaccines.

Dr Raghib Ali, one of the government's independent advisers on COVID-19 and ethnicity, has also participated in a number of events promoting vaccination through information and question and answer sessions with a number of communities. This included a briefing session with healthcare workers in December and events with the Sikh Council, the NHS Muslim Network and Muslim Doctors in January.

The MHCLG has led on engagement with faith groups throughout the pandemic and the Minister for COVID-19 Vaccine Deployment has also attended a number of stakeholder events in recent weeks to promote vaccine uptake among ethnic minority groups and to combat misinformation about the COVID-19 vaccines.

In February, No.10 and the RDU hosted 2 roundtables on promoting vaccine uptake amongst South Asian groups. Participants included faith leaders and other community representatives and generated a number of ideas and insights on how to improve vaccine uptake in the South Asian cohort.

**Recommendation 12: work must continue on improving public health communication to enable the successful delivery of existing and new interventions to all parts of the community including hard-to-reach groups, especially those at greatest risk in areas of local lockdown and rising concern.**

**This should include:**

**Increasing and diversifying a programme of activities for ministers across government to improve engagement with people from ethnic minority backgrounds.**

**Continuing to improve our understanding of ethnic minority audiences and interests of each ethnic minority outlet to ensure messaging is targeted and nuanced, and build on the existing communications programme with respected third-party voices to improve reach, understanding and positive health behaviours. Disaggregation of audience and channel approach will support this aim.**



A more streamlined approach across government and locally to improve local translations so that those who do not have English as a first language are more likely to be able to understand and act on public health advice.

More emphasis on promotion of existing NHS guidance on minimising transmission within households, sharing these messages widely and in the range of languages and formats needed. Recent figures show that in-house transmissions have played a significant part in the increase in infections we are seeing this autumn and as we head into winter people will spend more time indoors.

A full update is included in Section 4. Highlights include:

The Minister for COVID-19 Vaccine Deployment, Nadhim Zahawi, has taken part in various media opportunities to speak directly to the public about the vaccines programme. He has also taken part in roundtable sessions to onboard community ambassadors who will improve vaccine confidence among ethnic minorities.

In his role as Business and Industry Minister, Nadhim Zahawi, ran a business support webinar with British Business leader, Yvonne Thompson. The audience included around 100 ethnic minority business owners. Additionally Minister for Small Businesses, Paul Scully, interviewed 3 ambassadors of the 'Small Biz Sat' campaign – one with a focus on diversity.

The government now has richer insight into reach, awareness, understanding and media consumption among ethnic minorities which has enabled improved tailoring and targeting of public health messaging. A specific effort is underway to understand beliefs, attitudes and behaviours among ethnic minority people to the vaccine, feeding into an integrated vaccines confidence campaign.

In addition to the translation of national assets, local authorities can request translations of their own assets.

A specific communications strategy has been developed to promote safe behaviours within multigenerational households and houses of multiple occupancy. The approach - which includes engagement via community, faith and business leaders to co-create and disseminate marketing materials - will be implemented through local authority partners and in the languages each area requires.

PHE has received new funding to boost the *Better Health Campaign* to target Black African, Black Caribbean, Indian, Bangladeshi and Pakistani groups. The work will run until March 2021 and will include out-of-home advertising, specific community media on radio and in print, targeted PR using culturally relevant health care professionals and online and social media advertising. The advertising and content will be upweighted in geographical areas with a high proportion of populations from minority ethnic backgrounds and will be multilingual where appropriate.

**Recommendation 13: Further work is needed to dispel myths, reduce fear and build confidence among ethnic minority people. Over the coming months, the COVID Communications Hub in the Cabinet Office will need to keep sharpening its focus on rebuilding trust in government messaging, tackling misinformation and anti-vaccination narratives and encouraging engagement with NHS service**

A full update is included in Section 4.

As part of the vaccine confidence campaign, briefing sessions are being held with community and faith leaders with an expert panel of speakers taking questions and countering misinformation. This is part of a wider, fully integrated campaign being implemented on multiple channels to improve public knowledge, perceptions and motivations to vaccines, issuing credible content which addresses identified barriers.

The campaign includes radio, television and press partnerships incorporating community radio stations and publications carrying messages in over 10 different ethnic languages using strong, credible, relevant case studies and personalities that help get important messages and guidance across.



## **Annex B: Summary of government actions to address disparities**

### **Department for Work and Pensions (DWP)**

#### **Update on actions in first quarterly report**

The quarterly ethnic minority employment data published in November showed that the ethnic minority employment rate reached a record high of 67.6% for the year ending September 2020, up 0.4% from June 2020.

The ethnic minority unemployment rate was at 6.7%, up 0.4% from June 2020.

In response to this data and the broader impact of COVID-19, DWP will utilise £3.6 billion of additional funding in 2021 to 2022 to deliver labour market support.

#### **New initiatives**

The DWP's initiatives have focussed on providing financial support, which while not directly related to addressing health disparities have helped to support those most at risk from COVID-19.

The DWP launched the Kick-start Scheme in Great Britain on 2 September 2020, which provides a £2 billion fund to create hundreds of thousands of high quality 6-month work placements for 250,000 young people, including ethnic minorities on Universal Credit who are deemed to be at risk of long term unemployment.

The UK Shared Prosperity Fund will provide £220 million bridge funding in 2021 to 2022 to help level up and create opportunity across the UK by helping vulnerable local communities respond to, and recover from, COVID-19.

As part of the government's COVID-19 support measure, the Minimum Income Floor has been suspended until the end of April 2021, allowing self-employed people to continue to receive crucial financial support from Universal Credit based on their current actual earnings, providing additional protection for those who see a drop in earnings due to the impact of COVID-19.

DWP has expanded the Sector-based Work Academy Programme to allow unemployed people, including ethnic minorities, to pivot into priority sectors, including construction, infrastructure and social care.

### **Department for Business, Enterprise and Industrial Strategy (BEIS)**

#### **Update on actions in first quarterly report**

BEIS continues to monitor the impact of the guidance previously updated to assist employers to identify higher risk groups and consider them in their risk assessments. Extensive industry engagement also continues.

The higher-risk groups include older men, those with a high BMI, those with health conditions such

as diabetes, those from some ethnic minority backgrounds.

## **New initiatives**

BEIS supported targeted economic support for those who need it most. For example, rolling out unprecedented levels of economic support worth over £280 billion has provided a much-needed lifeline for those working in closed sectors such as retail and hospitality, the workforces in which are disproportionately young women and from an ethnic minority background.

BEIS and ACAS are working together to establish advice on employment rights for disabled people. BEIS is aware that those from ethnic minority backgrounds often struggle to access disability services and that this group has been particularly affected by mental health issues arising from COVID-19. This will improve access to appropriate, easily-accessible information and advice for disabled people who are looking for, or already in, employment.

## **Department for Transport (DfT)**

### **Update on actions in first quarterly report**

DfT continues to monitor the impact of COVID-19 on the transport industry, including monitoring the impact of measures around workplace risk.

DfT has also continued with sector-specific engagement to ensure guidance is updated and disseminated efficiently. For example, DfT worked with the 3 main trade associations (Licensed Private Hire Car Association; National Private Hire and Taxi Association; Licensed Taxi Drivers Association) to refine the guidance and gain approval.

DfT is also working with other government departments to determine where mass testing would be beneficial.

Through this collaborative approach, DfT has been able to work with operators to roll out testing pilots at important transport locations during the Christmas period and use lessons learnt to feed into a future rollout of asymptomatic mass testing.

## **New initiatives**

On 18 November DfT published sector specific *Coronavirus COVID-19 Taxis and PHVs* guidance<sup>91</sup> on actions that drivers, operators and owners of taxis or PHVs can take to protect against COVID-19.

DfT has prepared and will shortly publish technical guidance to assist drivers, operators and local government licencing offices with the installation and approval of protective screens in taxis and PHVs.

DfT is working with transport operators to set up workplace test sites to help break the chain of transmission. So far, approximately 50 operators have been referred to DHSC to set up approximately 100 test sites. For more dispersed workers, such as taxi and private hire vehicle drivers, DfT continues to work to unlock barriers to provide regular testing through other means,

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<sup>91</sup> <https://www.gov.uk/guidance/coronavirus-covid-19-taxis-and-phvs>

such as community test centres or home testing. DfT is engaging with such groups to support their access to testing.

## **Department for Education (DfE)**

### **Update on actions in first quarterly report**

DfE continues to monitor guidance put in place for educational settings. This includes ensuring that guidance remains consistent with approaches taken for other education settings, including advice on carrying out risk assessments for staff.

### **New initiatives**

DfE maintains regular engagement with higher education trade unions and the Universities and Colleges Employers Association to understand COVID-19 related concerns and ensure DfE guidance helps employers prioritise safety. Minority ethnic staff continue to be overrepresented in higher risk, front-line roles such as cleaning, estates, and catering.

The government has already provided £4.6 billion grant funding to support councils through the COVID-19 crisis. At the recent Spending Review, the Chancellor announced an additional £1.55 billion to support local authorities with the immediate and longer-term impacts of COVID-19 spending pressures next year, including children's services.

The government is also putting £300 million more into the adult and children's social care grant next year – giving councils a total of £1.7 billion in grant funding for social care in the 2021 to 2022 financial year.

DfE is working closely with DHSC to ensure children's social care workers are prioritised for testing and vaccination. Children's homes already have access to DHSC's National Testing portal to order home test kits, to support stability of placements.

DfE provided £6.5 million from the Adoption Support Fund to help families under pressure during COVID-19. DfE also invested significantly in adopter recruitment to ensure children from minority ethnic backgrounds do not wait longer to be placed with families.

DfE has made £220 million available to local authorities to expand The Holiday Activity and Food Programme to cover 2021. Designed to mitigate the impact of absence from school over holidays that can disproportionately affect disadvantaged children, it will be available to Free School Meal-eligible children in every local authority in England.

The government has provided over £11 million to a consortium of national and local organisations to deliver the See Hear Respond (SHR) programme for children and young people whose usual support networks were impacted by pandemic restrictions. The programme began in June 2020 and will continue until the end of March 2021. To date, the programme has supported over 50,000 children and young people, including 6,000 children from an ethnic minority background.

# Department for Health and Social Care (DHSC)

## Update on actions in first quarterly report

### NHSEI Phase 3:

NHSEI published Phase 3 of its COVID-19 response at the end of July. This urged all NHS Trusts to work collaboratively with local communities and partners to take urgent action to increase the scale and pace of progress of reducing health inequalities and regularly assess this progress.

All NHS systems have been implementing Phase 3 actions and monitoring performance. The impact of the second wave of COVID-19 will continue to be monitored on these and other indicators. Enhanced monitoring of the completeness of patient ethnicity data is also being undertaken.

NHS-EI's top priorities for 2021 to 2022 are to reduce health inequalities despite added pressures of the pandemic. Progress will be evaluated against Phase 3's 8 urgent actions (see first quarterly report). Executive Leads for Health Inequalities are in place in the majority of NHS organisations and the Director of Health Inequalities post in the national team is now filled.

### Risk assessments:

The NHS is required to undertake a workplace risk assessment in all operational locations. In preparation for further increases to COVID-19 rates over the latter part of 2020, a directive was sent to healthcare leaders stating that risk assessments are a continuous process to keep staff safe.

### PPE:

DHSC updates on the NHS-EI project led by the Deputy Chief Nursing Officer state that by December 2020, a further 8 types of FFP3 mask were made available to the NHS taking the total to 16. The increased range will provide diversity of choice for ethnic minority staff. DHSC is ensuring that NHS trusts are receiving their choice of masks and ensuring staff on the frontline can access masks they have successfully fit-tested to.

### Comorbidities:

DHSC Equality Matters Network held a roundtable to hear from colleagues affected by the PHE disparities report and feed into the DHSC draft Race Equality Plan.

Update: DHSC plans to expand the Better Health Campaign to target ethnic minority groups. DHSC's focus will be on tackling obesity and other comorbidities, which are underlying risk factors associated with COVID-19.

DHSC's particular focus will be on Black African, Black Caribbean, Indian, Bangladeshi and Pakistani ethnic groups, with the advertising and content upweighted in geographical areas with a high proportion of populations from minority ethnic communities. DHSC will measure impact and effectiveness using quantitative tracking (YouGov) and qualitative mixed method research with specialist multi-cultural research agencies.



## **New initiatives**

### **COVID-19 vaccinations**

DHSC is tailoring local implementation to promote good vaccine coverage in ethnic minority groups.

The NHS, PHE and DHSC will provide advice and information at every possible opportunity, including working closely with minority ethnic communities, to support those receiving a vaccine and to anyone who has questions about the vaccination process.

DHSC is prioritising people with underlying health conditions, which will provide for greater vaccination of ethnic minority communities who are disproportionately affected by such health conditions.

### **NHS Test and Trace**

DHSC is working to improve, standardise and join-up its evaluations to allow for comparability, transfer of lessons learned, and drive evidence-based policy-making and intervention design. It is using performance management information and bespoke monitoring and evaluation evidence to inform future policy and interventions to address the disproportionate impact of COVID-19 on high-risk groups.

DHSC partnered with the City of Liverpool to pilot community open-access testing for people without symptoms of COVID-19. DHSC published evaluation findings from the Liverpool pilot. Overall, positivity rates were 3 times higher for the most deprived quintile compared with the least deprived. Digital exclusion was a substantial barrier to uptake, more than deprivation alone.

DHSC piloted on-site, locally-led testing in a Wolverhampton Gurdwara which was extended at the request of the local authority and the Gurdwara management due to its success. Further pilots are planned in collaboration with MHCLG's Places of Worship Taskforce.

### **NHS workforce**

NHS-E/I's operational priorities for winter and 2021 to 2022 is the delivery of the NHS People Plan and ongoing improvements on equality, diversity and inclusion of the workforce. The National People Plan Delivery Board will provide scrutiny and oversee monitoring and evaluation. Actions include:

- The appointment of a named inequalities champion in every NHS organisation
- Ensuring all trusts have a thriving ethnic minority network
- A 5-year plan to ensure organisations reflect the communities they serve
- Overhauling recruitment and promotion practices to ensure that staffing reflects the diversity of communities and labour markets
- Resources training and guidance to support line managers to discuss equality diversity and including
- Stretching targets to reduce the likelihood of entry into disciplinary process
- Competency frameworks for every board level position that will reinforce that responsibility for leading and making progress on equality diversity and inclusion

- The Care Quality Commission (CQC) placing increasing emphasis on whether organisations have made real and measurable progress on equality, diversity and inclusion
- Joint training for Freedom to Speak Up Guardians and WRES leads, with more ethnic minority staff recruited to Freedom to Speak Up Guardian roles.

### **Adult Social Care workforce**

The Workforce Race Equality Standard (WRES) in social care will be initially implemented in 18 local authority social work departments from April 2021. WRES requires organisations to demonstrate progress against indicators of workforce race equality.

The CQC published Equality Objectives (2019-2021) to help improve equality for staff and service users across health and social care sectors.

### **PHE Guidance for Occupational Settings**

PHE, the Health and Safety Executive and the Faculty of Medicine issued a consensus statement in November 2020 on Mitigation of risks of COVID-19 in occupational settings with a focus on ethnic minority groups<sup>92</sup>.

PHE is supporting the RDU and the Food Standards Agency to develop simplified resources for employers in the food industry to help reduce employee exposure and mitigate risk. PHE worked with DEFRA to develop COVID-19 guidance for food business, employers with high proportions of ethnic minority workers, which states that communication with all employees must be a high priority.

PHE is supporting the RDU to support other government departments around risk management to protect their staff from COVID-19.

## **Ministry of Defence (MOD)**

### **Update on actions in first quarterly report**

The Joint Medical Group released guidance in relation to the medical risk assessment for defence personnel working on tasks involving COVID-19 medical related processes or with COVID-19 patients in June 2020.

This includes advice on work process based risk assessments with the option to seek suitably qualified advice in order to better assess and mitigate risk where appropriate, as well as return to work processes post a COVID-19 infection.

Having released guidance on this, the MoD continues to monitor the situation, including COVID-19 cases by ethnicity.

COVID-19 Cases in UK Armed Forces: There have been a total of 3,291 positive cases of COVID-19 amongst the UKAF<sup>93</sup>. Of these, 2722 (83%) were of White ethnicity and 468 (14%) were from an ethnic minority background.

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<sup>92</sup> <https://www.gov.uk/government/news/consensus-statement-emphasises-importance-of-covid-19-secure-workplaces>

<sup>93</sup> <https://www.gov.uk/government/collections/coronavirus-in-defence>

COVID-19 Hospitalisations UKAF: A total of 40 personnel were admitted to hospital with COVID-19. 28 (70%) were of White ethnicity, 11 (28%) were of a minority ethnicity.

## **New initiatives**

MoD provided medical Risk Assessment Guidance for Defence Personnel working on tasks involving COVID-19 medical-related processes or with COVID-19 patients. MoD introduced a requirement for COVID-19 Risk Assessments to be carried out for every employee if required to attend the workplace.

MoD provided a reference in the Risk Assessment Policy to ethnicity, amongst other factors (such as gender, age, comorbidities), as a possible association to increased vulnerability to COVID-19; hence it informs the reader of this important link.

## **Ministry of Housing, Communities and Local Government (MHCLG)**

### **Update on actions in first quarterly report**

MHCLG continues to actively engage the faith community. For example, the Places of Worship Taskforce has continued to hold regular roundtables with leaders from major faiths, chaired by Faith Minister Lord Greenhalgh. Meetings have shifted focus from re-opening of places of worship to cover Test and Trace and the vaccination programme rollout.

MHCLG is also engaging with the Devolved Administrations to discuss the approach to housing and COVID-19 across the UK nations, including data on housing conditions, ethnicity and overcrowding, and steps to improve outreach and communication on public health guidance.

This seeks to strengthen prior government guidance for landlords, tenants and local authorities published on 1 June, which offers advice to tenants who are vulnerable or shielding and who are in overcrowded or shared accommodation.

## **New initiatives**

MHCLG has responded to a SAGE report on 'Housing, household transmission and ethnicity' published in December by providing updated guidance for tenants, landlords and local authorities to reduce in-household transmission. This guidance advises that local authorities may be able to use their enforcement powers to require a landlord to remedy a serious overcrowding hazard.

MHCLG is using Community Champions project networks to ensure that guidance on limiting household transmission reaches disproportionately impacted groups.

MHCLG created a longlist of 65 local authority areas to support through the Community Champions Scheme using DHSC/PHE data on COVID-19 incidence.

MHCLG is monitoring the success of the Community Champions scheme by requesting returns at one, 3 and 6-month intervals and holding regular meetings with funded partners.

MHCLG invested £400,000 into education and training programmes to help Gypsy, Roma and Traveller (GRT) children catch up on lost learning during the pandemic.

MHCLG is working across government departments to gather intelligence on the impacts of local lockdowns on community tensions.

MHCLG facilitated a community-led Test and Trace pilot in a Gurdwara in Wolverhampton with excellent outcomes, and is currently in discussion with Test and Trace about holding more.

MHCLG's Places of Worship Taskforce will assess the results of a survey on the places of worship guidance to understand how well the guidance is used and understood. MHCLG is hosting roundtables on challenges to sharing guidance with 'fringes' of their faiths and compliance issues.

## **Department for Digital, Culture, Media and Sport (DCMS)**

### **Update on actions in first quarterly report**

The Civil Society and Youth Directorate is working with the Cabinet Office and voluntary and community sector to improve engagement and disseminate effective health messages and support for people from ethnic minority communities. A particular focus has been on engaging disproportionately impacted groups with the vaccine roll out through comms (providing vaccine comms toolkits), using the VCSE sector as trusted intermediaries to drive vaccine uptake.

Engagement has continued with ethnic minority VCSE representatives and the Minister for Civil Society.

The group has focussed on 3 deep dive themes already in relation to ethnic minority communities of; financial inclusion, youth, and the ethnic minority VCSE sector. Planned future focus is on mental health in ethnic minority communities and how the VCSE sector can respond proactively.

### **New initiatives**

Across the £750 million VCSE funding package, a total of £61.8 million has gone to 2,421 organisations who specifically target BAME people or groups.

9 organisations were awarded funding from the COVID-19 Loneliness Fund to support the main target groups at risk of loneliness. This included ethnic minority communities and refugees.

As part of the loneliness fund we are supporting The Reading Agency with £3.5 million to expand 2 of its impactful programmes. Reading Friends is a programme which tackles loneliness through reading. In addition, Reading Well Books on Prescription will deliver 3 clinically-curated mental health collections (targeted to adults, young people and children) to all public libraries (over 2,800) in England, enabling those experiencing poor mental health to access self-directed support.

£665,000 funding has been confirmed for support for small commercial radio stations and their transmission costs between now and the end March 2021 as part of a wider package agreed with Arqiva, the UK's broadcasting transmission operator. An additional £200,000 has been made available to the Community Radio Fund to support community stations. This funding will help ensure that community stations, including those serving ethnic communities, can fully support the CO/DH led campaigns targeting these communities with new messaging - in multiple languages - about COVID-19 restrictions and influencing vaccines take up.

DCMS is working with digital inclusion and disability charities to design and deliver a £2.5 million digital inclusion programme. This will provide tablets, connectivity and digital support to around 5000 people with learning disabilities, enabling them to connect virtually with others and access online services, in a safe and secure way.



The Counter-disinformation Unit in DCMS has responsibility for monitoring and analysis of mis/disinformation narratives online, including those related to the COVID-19 vaccines, and engagement with social media platforms to tackle this issue. DCMS works closely with the Vaccine Taskforce in BEIS and DHSC, who are responsible for vaccine development and deployment, and delivering effective communications around the vaccine. DCMS is also creating new bespoke shareable assets for vulnerable audiences to misinformation, based on the principles of the SHARE checklist, which aims to increase resilience to misinformation.

A £16.5 million 'Youth COVID-19 Support Fund' launched on 15 January, which will protect the immediate future of grassroots and national youth organisations across the country. The Fund will help to mitigate the impact of lost income during the winter period due to the pandemic, and ensure services providing vital support can remain open. £1.7 million of the £16.5 million has been allocated to vital youth work qualifications and training. The fund closed to applications on 19 February.

## **Ministry of Justice (MoJ)**

### **Update on actions in first quarterly report**

HMPPS (Her Majesty's Prisons and Probation Service) COVID emergency fund consisting of £300,000, administered by Clinks, has proactively sought applications from small ethnic minority-led organisations.

HMPPS's strategy for the management of COVID-19 in prisons has built on PHE and Public Health Wales advice and includes the following measures:

- the implementation of effective isolation
- shielding vulnerable prisoners
- restricting regimes to prevent social contact in custody
- introduced a comprehensive testing regime

HMPPS continues to actively monitor this to ensure effectiveness in reducing COVID-19 cases amongst staff.

### **New initiatives**

Quarterly HMPPS (Her Majesty's Prisons and Probation Service) workforce statistics included experimental data on staff deaths, positive COVID-19 test results and numbers of staff absence due to COVID-19 broken down by business area and ethnicity. The information was included in a separate Annex to that publication.

MoJ has produced wellbeing guidance for all line managers, to inform one to one conversations with staff. The guidance covers the disproportionate COVID-19 impacts for ethnic minority staff and the potential heightened anxieties this can cause. This guidance is clear that a full individual risk assessment should be completed when underlying health conditions are disclosed or if the employee requests one, but these are not mandatory.

## Annex C - Further data and evidence

### Work streams

**Term of Reference 3: Commission further data, research and analytical work by the Equality Hub to clarify the scale, and drivers, of the gaps in evidence highlighted by the report**

### Ethnicity and risk factors

- Infection risk factors include a wide network of contacts a person is exposed to or a limited ability to distance from those who may pose a risk to them; both increase chances of transmission. These risk factors include geography, deprivation, overcrowding, multigenerational households, certain occupations (in particular those that are public-facing) and lifestyle factors.
  - Someone with COVID-19 may not be able to effectively distance within an overcrowded household, increasing transmission risk for members of their household.
  - Someone whose occupation requires them to work at close quarters with others outside of their household is linking the contact networks of 2 or more households, increasing transmission risk across multiple groups of people.
  - People living in economically deprived areas may be less equipped to remotely educate and may need to send their children into school as 'vulnerable' pupils, increasing contact with other households.
  - People living in service deprived areas may need to travel further to access services they need, increasing contact and networks between locations, particularly if they are reliant on public transport to do so.
  - Someone living in a dense urban area may be at increased risk of contact and limited distancing from others while conducting essential travel, shopping or exercise in public.
- To verify the impact of risk factors it is necessary to conduct multivariate regression modelling using infection data and a rich set of individual level characteristics. In some cases this is not possible as the data are not collected or are based on 2011 Census data, which are ten years old. These limitations in measurement contribute to the "unexplained" proportion of the disparities, though future data linkage efforts, such as the linkage of comorbidity and occupation data from the 2021 Census, could provide further insights. Alongside the unquantifiable, there are likely further, unknown, risk factors (or combinations of factors) driving the disparities, that cannot be modelled.
- It is also important to bear in mind that ethnicity is a multi-dimensional concept which includes culture, language, religion, migrant status and race, with considerable diversity within and between ethnic minority groups. Some of these dimensions of ethnicity may have contributed to higher infection rates for some ethnic minority groups, and for that reason the RDU will monitor closely new evidence and will work on improving data quality across government.

## Survival analysis by ethnicity

- Mortality rates from COVID-19 are based on the number of deaths involving COVID-19 in the population and these rates are determined by the combination of the risk of getting COVID-19 and the risk of dying once diagnosed with COVID-19. Survival rates isolate the 2 and are based on the number of deaths in people already diagnosed with COVID-19.
- In general, a large number of cases may be explained by high exposure or risk of infection. A large number of deaths may be explained by these factors, plus factors affecting survival such as timing of seeking testing and receiving treatment in the course of illness with COVID-19.
- According to Public Health England<sup>94</sup> people belonging to the Mixed and Other ethnic (aggregate) groups, and the Black African, Black Caribbean and Asian Other (detailed) groups had similar survival rates to White people following a positive test for COVID-19 in wave 1. The high death rates reported previously by ONS for these groups are therefore likely to be largely determined by a high risk of getting COVID-19 rather than a high risk of dying once infected.
- The poorest survival rates (or highest risk of dying once diagnosed), after adjusting for pre-existing health conditions and other factors, was seen in people from the Bangladeshi ethnic group who had 1.88 times the odds of dying once diagnosed than the White ethnic group. People from the Pakistani, Chinese, and Black Other ethnic groups had 1.35-1.45 times the odds of dying once diagnosed, and those from the Indian group 1.16 times the odds.
- With the exception of the Chinese ethnic group, the groups with the poorest survival rates (Bangladeshi, Pakistani, Indian, Black Other) also had higher numbers of cases than expected. This means that, in these groups, both a high risk of infection and a high risk of dying once infected were contributing to high mortality.
- The analysis will need to be repeated with a longer follow-up time for death, before being able to draw firm conclusions about the poor survival in ethnic minority groups amongst positive cases. It is also important to note that this analysis will not capture and control for all pre-existing conditions that could affect survival; for example obesity and those reported in primary care settings, as this analysis used hospital admission data.

## Annualised age standardised mortality rates

- Because wave 1 (24 January to 31 August 2020, 221 days) and wave 2 (1 September to 28 December, 119 days) are based on different lengths of time (and a longer time period will include more deaths, all things being equal), we have standardised them so that we can make valid comparisons. This process, called 'annualisation', involves dividing the age standardised mortality rates by the

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<sup>94</sup> <https://www.gov.uk/government/publications/covid-19-pre-existing-health-conditions-and-ethnicity>



proportion of the year that each wave lasted. This allows us to calculate the percentage change between the 2 waves.

- Deaths from COVID-19 have dropped for most ethnic minority groups - annualised mortality rates for both Black African men and Black African women are down by over 60% compared with the first wave. However, the second wave mortality rates have risen by 124% and 97% for men and women from Pakistani backgrounds, respectively.

## **Risk factors related to higher infections for ethnic minority groups**

Examples of some of the mechanisms for risk factors increasing transmission, and consequently risk of infection, are outlined in section 2. This section provides a summary of relevant statistics for different ethnic groups.

### **Household composition**

- When accounting for household size, the excess risk of testing positive, compared with the White British group, was reduced by 16% in Indian people, 22% in Pakistani groups and 10% in Bangladeshi groups, after also accounting for demographic characteristics, deprivation, region, and clinical comorbidities<sup>95</sup>.
- Adjusting for household size results in a reduced excess risk of COVID-19 mortality, compared with the White British group, of 12% in the Indian ethnic group, 32% in Pakistani and 39% in Bangladeshi groups, after also accounting for demographic characteristics, deprivation, region, and clinical comorbidities
- Ethnic minority groups are more likely to live in multigenerational households, particularly people from Pakistani, Bangladeshi or Indian ethnic groups<sup>96</sup>.
- Depending on individual interactions and networks outside of the house, which are likely to be larger in a denser urban area - a large household may be more likely to bring the virus home, an overcrowded household may not be able to minimise transmission within the home and a multigenerational household may put more vulnerable elders at risk.<sup>97</sup>
- Viral load is associated with risk of transmission, with the risk being higher for household contacts than for other types of contact; the age of the contact also has an effect, with older individuals being more at risk of becoming infected<sup>98</sup>.

### **Geography and deprivation**

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[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/943178/S0923\\_housing\\_household\\_transmission\\_and\\_ethnicity.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943178/S0923_housing_household_transmission_and_ethnicity.pdf)

<sup>96</sup>

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/whyhaveblackandsouthasianpeoplebeenhithardestbycovid19/2020-12-14>

<sup>97</sup>

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/943178/S0923\\_housing\\_household\\_transmission\\_and\\_ethnicity.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/943178/S0923_housing_household_transmission_and_ethnicity.pdf)

<sup>98</sup> <https://www.thelancet.com/action/showPdf?pii=S1473-3099%2821%2900005-0>

- 50.8% of Bangladeshi people live in just 9 local authorities, predominantly London boroughs and all urban areas. 18.2% lived in Tower Hamlets alone.<sup>99</sup>
- 50.5% of Pakistani people live in just 13 local authorities, predominantly metropolitan districts and all urban areas. The largest clusters were in Birmingham (12.9%) and Bradford (9.5%)
- 39.9% of Indian people live in just 11 local authorities, again, predominantly London boroughs and all urban but the largest clusters were in Leicester (6.6%) and Birmingham (4.6%)
- The first wave was seen acutely in London and other large cities like Birmingham, while the second wave was initially predominantly seen in more Northern urban areas. The new variant, though evident nationally, was initially particularly prevalent in London and the South East/East.
- Asian and Black ethnic minorities are most likely to live in urban areas, particularly Pakistani and Bangladeshi people at 99.1% and 98.7% respectively<sup>100</sup>. Urban areas are also the most likely to have household overcrowding, 7% of households in major urban conurbations were overcrowded, compared with 2% of households in rural areas<sup>101</sup>. Evidence at a regional level indicates that people from ethnic minorities are more likely to live in overcrowded households than White British people<sup>102</sup>
- After adjusting for age, population density, ethnicity and socioeconomic deprivation, there are still unexplained clusters of raised COVID-19 mortality across England and Wales. The evidence of clusters spanning both urban and rural populations could be due to travel connections between communities (for work, social or shopping purposes).<sup>103</sup>
- The next quarterly report on progress to address COVID-19 disparities will provide a greater focus on the spread of COVID-19 across areas of different levels of deprivation.

## Occupation

- Differences in occupation could have ramifications for the ability of different ethnic groups to work remotely or maintain safety in a workplace.
- 41% of employed Pakistani or Bangladeshi workers were Sales and Customer service, Process, Plant and Machine Operatives or Elementary workers, compared with 24% of workers of all ethnic groups<sup>104</sup>.

<sup>99</sup> <https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/regional-ethnic-diversity/latest#download-the-data>

<sup>100</sup> <https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/regional-ethnic-diversity/latest#ethnic-groups-by-type-of-location-urban-or-rural>

<sup>101</sup> <https://www.nomisweb.co.uk/census/2011/QS412EW>

<sup>102</sup> <https://www.ethnicity-facts-figures.service.gov.uk/housing/housing-conditions/overcrowded-households/latest#by-ethnicity-and-area>

<sup>103</sup>

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/analysisofgeographicconcentrationsofcovid19mortalityovertimeenglandandwales/deathsoccurringbetween22februaryand28august2020#main-points>

<sup>104</sup> <https://www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits/employment/employment-by-occupation/latest#by-ethnicity-and-type-of-occupation>

- The highest COVID-19 mortality rates for men were seen in Elementary workers<sup>105</sup> and Caring, Leisure and other Service occupations, followed by Process, Plant and Machine Operatives<sup>106</sup>.
- Of the 17 specific occupations among men in England and Wales found to have higher rates of death involving COVID-19, 11 of these have statistically significantly higher proportions of workers from Black and Asian ethnic backgrounds.
- Further analysis of the impact of occupation in COVID-19 infections is due to be published by ONS soon and will be explored in the next quarterly report.

## Risk factors related to critical illness and mortality

### Age

- Studies have shown that age alone is the most significant risk factor for severe illness and mortality from COVID-19<sup>107</sup>, and generally this is the same with other coronaviruses and influenza viruses<sup>108</sup>.
- This could be because of the increased likelihood that a person will have comorbidities in older age<sup>109</sup>, many of which are linked to poorer COVID-19 outcomes. However, it may also be due to the ageing immune system. As people age, the thymus produces fewer T cells. This in turn affects many other aspects of the immune system.<sup>110</sup>
- For these reasons, COVID-19 affects more older people. According to PHE,<sup>111</sup> 4% of those who died with COVID-19 before mid-July were aged under 55 and 42% aged 85 and above. The age profile of COVID-19 deaths in ethnic minority groups was younger than average, we have to bear in mind that people from ethnic minorities have a younger age profile than average.<sup>112</sup> PHE analysis shows that:
  - In the Black group, 12% were under 55 and 24% 85 and above. Deaths in the Black Caribbean group had an older profile than other Black groups with 6% under 55 and 34% 85 and above.
  - In the Asian group 10% were under 55 and 21% 85 and above. Deaths in the Bangladeshi group had a younger profile with 17% under 55 and 15% 85 and above.

<sup>105</sup> This major group covers occupations which require the knowledge and experience necessary to perform mostly routine tasks, often involving the use of simple hand-held tools and, in some cases, requiring a degree of physical effort.

Most occupations in this major group do not require formal educational qualifications but will usually have an associated short period of formal experience-related training.

<sup>106</sup>

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand25may2020>

<sup>107</sup> <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0241824>

<sup>108</sup> <https://academic.oup.com/jid/article/178/1/53/919896?login=true>

<sup>109</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6732845/#bibr7-2333721419874274>

<sup>110</sup>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3582124/#:~:text=The%20effects%20of%20aging%20on,as%20robustly%20as%20the%20young>

<sup>111</sup> <https://www.gov.uk/government/publications/covid-19-pre-existing-health-conditions-and-ethnicity>

<sup>112</sup> <https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/age-groups/latest>



- In the Mixed ethnic group 14% were under 55 and 25% 85 and above.
- According to ONS the number of deaths overall so far this year has been above the 5-year average for all age groups above 14 years.
- By the end of 2020, three-quarters of deaths involving COVID-19 in England and Wales were of people aged 75 years and over.

## Sex

- According to PHE<sup>113</sup> laboratory-confirmed COVID-19 case rates per 100,000 are higher in women compared with men, despite men accounting for 70% of ICU admissions during the first wave of COVID-19 hospitalisations and 66% during the second wave<sup>114</sup>.
- During 2020, 55.3% of all deaths involving COVID-19 were in men. There were more deaths in women aged 85 years and over (18,333) than men aged 85 years and over (15,984<sup>115</sup>). Higher death rates in men also occurred in other coronavirus diseases like severe acute respiratory syndrome<sup>116</sup>, caused by SARS-CoV, and Middle East respiratory syndrome<sup>117</sup>.
- A report in 'Nature'<sup>118</sup> published in August 2020 found that the reason men face higher risk of severe illness or dying from COVID-19 is because of biological factors during the early immune response. Men showed higher levels of cytokines that trigger inflammation, like IL-8 and IL-18, than women. Higher quantities of these cytokines are linked to more severe disease.
- compared with men, women had a higher number of T cells – essential for eliminating the virus – that were activated, primed and ready to respond to the SARS-CoV-2 infection. Men with lower levels of these activated T-cells were more likely to have severe disease<sup>119</sup>.

## Disability

ONS<sup>120</sup> published estimates of differences in COVID-19 mortality risk for disabled

<sup>113</sup>

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/952640/Weekly\\_Flu\\_and\\_COVID-19\\_report\\_w2\\_V2.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/952640/Weekly_Flu_and_COVID-19_report_w2_V2.pdf)

<sup>114</sup> <https://www.icnarc.org/Our-Audit/Audits/Cmp/Reports>

<sup>115</sup>

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregisteredweeklyinenglandandwalesprovisional/weekending1january2021>

<sup>116</sup> <https://www.frontiersin.org/articles/10.3389/fpubh.2020.00152/full>

<sup>117</sup> <https://www.jimmunol.org/content/198/10/4046>

<sup>118</sup> <https://www.nature.com/articles/s41586-020-2700-3>

<sup>119</sup> <https://www.nature.com/articles/s41586-020-2700-3>

<sup>120</sup>

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronaviruscovid19relateddeathsbydisabilitystatusenglandandwales/24januaryto20november2020#age-standardised-rates-of-death-involving-covid-19-by-learning-disability-status>

people and non-disabled people<sup>121</sup> for the period between 24 January and 20 November 2020.

- Indicative estimates suggest that compared with non-disabled people “more-disabled” women were 1.4 times more likely to die from COVID-19, “less-disabled” women 1.2 times more likely and “more-disabled” men 1.1 times more likely. Men and women with a medically diagnosed learning disability were 1.7 times more likely to die from COVID-19 than those with no learning disability. These estimates take account of factors such as underlying health conditions, socio-economic factors and geographical circumstances, but as yet no single factor can be identified to explain the increased risk.
- The relative differences in the risk of COVID-19 mortality between disabled and non-disabled people remained largely unchanged between the first and second waves of the pandemic.
- There is ongoing work into the impact of COVID-19 on disabled people. Future analysis from ONS will improve on the current analysis by establishing the proportion of disabled and non-disabled people testing positive for COVID-19. Research will also explore how different impairment types<sup>122</sup> among disabled people affect the risk of COVID-19 related death.

## Genetics

- According to existing research on genetics,<sup>123</sup> health disparities among ethnic groups are largely explained by underlying social differences rather than genetic differences.
- However, a gene cluster identified as a risk factor for severe coronavirus symptoms is carried by approximately 50% of people in South Asia, compared with 16% of people in Europe. This gene cluster is a risk locus for respiratory failure and may partially explain why the Bangladeshi population has the poorest survival rates (see figure 1).

## Pre-existing health conditions

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<sup>121</sup> Disabled people are identified according to a person's disability status as recorded in the 2011 Census; people are counted as disabled if they said their daily activities were limited a little (“less-disabled”) or limited a lot (“more-disabled”) by a health problem or disability lasting or expected to last at least 12 months.

<sup>122</sup> <https://eur03.safelinks.protection.outlook.com/?url=https%3A%2F%2Fgss.civilservice.gov.uk%2Fpolicy-store%2Fimpairment%2F&data=04%7C01%7CJosephine.Foubert%40ons.gov.uk%7Cc1161dd0bf6446be787908d8c467eda0%7C078807bfce824688bce00d811684dc46%7C0%7C0%7C637475297947393432%7CUknown%7CTWFpbGZsb3d8eyJWljoimC4wLjAwMDAiLCJQIjoiV2luMzliLCJBTiI6IkhWwiLCJXVCi6Mn0%3D%7C1000&sdata=aW68tTIL1SLgrTGt9gDtZiyoWidBCyWEG1L8MWldGmw%3D&reserved=0>

<sup>123</sup>

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/925135/S0778\\_Drivers\\_of\\_the\\_higher\\_COVID-19\\_incidence\\_\\_morbidity\\_and\\_mortality\\_among\\_minority\\_ethnic\\_groups.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/925135/S0778_Drivers_of_the_higher_COVID-19_incidence__morbidity_and_mortality_among_minority_ethnic_groups.pdf)

- According to PHE<sup>124</sup> in the first wave of the COVID-19 pandemic in England, among people with a similar history of previous hospital admission mentioning pre-existing health conditions, there were differences between ethnic groups in the numbers of cases and deaths involving COVID-19. In addition, ethnic inequalities in survival following diagnosis with COVID-19 were not explained by differences in such patterns of admission for pre-existing health conditions between ethnic groups. Obesity is one of the main factors in determining the outcome of COVID-19 infection, a factor known to vary by ethnic group, and diabetes may also contribute to excess risk of mortality, particularly in South Asian populations.<sup>125 126 127</sup>

## Progress of UKRI funded projects

- 6 projects to improve understanding of the links between COVID-19 and ethnicity, funded by UK Research and Innovation (UKRI) and the National Institute for Health Research (NIHR), were announced in July 2020.
- These projects seek to explain and mitigate the disproportionate death rate from COVID-19 among people from ethnic minority ethnic backgrounds, including health and social care workers.
- The projects, which total £4.3 million worth of funding, include:
  - Dr Robert Aldridge, UCL: the project, Virus Watch, aims to better understand the impact of COVID-19 on minority ethnic and migrant groups and how to tackle it in community settings. As of 21 January 2021, 45,839 people across England and Wales had joined Virus Watch. A total of 4,892 people from minority ethnic backgrounds are currently taking part and the study has recently started a new phase of participant recruitment working with NHS GP practices. A total of 541,061 weekly surveys had been completed by all participants and completion and retention of participants has been high with 29,379 participants completing over 75% of surveys. In addition to weekly surveys, surveys have recently been conducted on attitudes to vaccination and contact and activity data. The main findings by ethnicity will shortly be published, accompanied by policy briefings.
  - Professor Thomas Yates, University of Leicester, is using the UK Biobank cohort, which has been linked to national COVID-19 data. With this dataset, he is using statistical modelling to examine whether the increased risk of developing severe COVID-19 in minority ethnic groups is explained by differences in underlying health status, lifestyle behaviours such as physical activity, and environmental factors including measures of social inequality. His analysis looking at the impact of material deprivation is in the second round of review. His analysis within the large national in-hospital ISARIC dataset has shown that obesity disproportionately increases the risk of mortality and ICU admission in Black

<sup>124</sup>

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/942091/Summary\\_report\\_ethnicity\\_and\\_comorbidity.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942091/Summary_report_ethnicity_and_comorbidity.pdf)

<sup>125</sup> <https://www.medrxiv.org/content/10.1101/2020.08.12.20156257v3.full.pdf>

<sup>126</sup> <https://www.ethnicity-facts-figures.service.gov.uk/health/diet-and-exercise/overweight-adults/latest>

<sup>127</sup> <http://eprints.gla.ac.uk/219444/1/219444.pdf>



ethnicities compared with other ethnic groups. Therefore obesity may be a particularly important risk factor for adverse COVID-19 outcomes in Black ethnic groups.

- The United Kingdom Research study into Ethnicity And COVID-19 outcomes in Healthcare workers (UK-REACH) seeks to understand whether, how, and why, ethnicity affects COVID-19 clinical outcomes in healthcare workers (HCWs). It is led by the University of Leicester in partnership with other academic institutions, and with stakeholders from all the professional regulators, NHS and Healthcare Regulators. To investigate the relationship between ethnicity and COVID-19 clinical outcomes, registration data from the professional healthcare regulators and NHS HR databases are being linked with health outcome data from NHS Digital, Public Health Scotland, NHS Wales Informatics Service and NI Honest Broker service. Data sharing agreements are now in place with a number of the regulators, and data is currently being transferred to the SAIL safe haven for secure linkage and analysis. Alongside this UK-REACH is recruiting HCWs (both clinical and non-clinical) to complete surveys which aim to understand the risk of COVID-19 infection in different healthcare workers, changes in physical/mental health outcomes, social outcomes and the impact of ethnicity on this. Recruitment started in December 2020, and to date they have recruited over 13,000 HCWs, with approximately 30% being from an ethnic minority background. The survey was amended as the vaccine roll-out commenced to capture expected vaccine uptake amongst HCWs, and they will be in a position to perform an interim analysis of the data shortly. A qualitative study is underway to understand the impact of COVID-19 on HCWs from diverse ethnic backgrounds, and perceived risk factors, support and coping mechanisms, and views on emerging issues such as vaccine delivery. This is being conducted through online in-depth interviews and focus groups.
- Developing and delivering targeted COVID-19 health interventions to Black, Asian and Minority Ethnic (BAME) communities living in the UK (The COBHAM Study) - The overall aim of this one-year study by Prof Alla and Dr Vandrevalla is to reduce health inequalities and COVID-19 risk by delivering targeted, culturally appropriate health interventions to Black and South Asian communities. The study is being conducted in 3 phases, with Phase I now completed which consisted of qualitative interviews with the Black African, Caribbean and South Asian community. The team is currently undertaking Phase II of the study which involves co-producing a 2-minute film and informative guidance documents, delivering culturally appropriate health messages to the communities disseminated through community knowledge champions and knowledge advocates through trusted existing networks. The final phase will be used to evaluate the effectiveness of the interventions using mixed qualitative and quantitative methodology. As part of the co-production of interventions, the team has actively engaged with the community and pivotal stakeholders including representative community members, NHS professionals and community leaders across England. These interviews are currently feeding into the developing interventions (films and 'key guidance documents'). The team is in the process of filming, with a view to finalising this by the end of February.

- Professor Julia Hippisley-Cox at the University of Oxford and Dr Hajira Dambha-Miller at the University of Southampton have been working on the following 4 project themes to evaluate COVID-19 health inequalities in the UK from different angles: 1) A population-based study focusing on the extent of and factors contributing to ethnic differences in COVID-19 infection rates and mortality in the UK. This is being done in comparison to a population-based study from Ontario, Canada, and a meta-analysis is planned. 2) A study exploring COVID-19 outcomes in children (0-18 years) from different ethnic groups. They identified that, compared with children from White backgrounds and adjusting for important sociodemographic factors and medical conditions, children from certain ethnic minority backgrounds were more likely to test positive for COVID-19 and require hospital, as well as intensive care admissions. 3) A study that evaluated influenza, pneumococcal and shingles vaccine uptake, offer and refusal in over 65s by ethnic group. They are currently exploring how prior receipt of these vaccinations may affect risk of COVID-19 mortality, hospitalisation and intensive care admission in the population aged 65 and over, and if this is patterned by ethnicity. 4) In parallel, they are also investigating the impact of particular comorbidities (for example, sickle cell anaemia) and concurrent medications (for example, diabetes drugs) on COVID-19 outcomes among ethnic minorities.

## **Emerging qualitative evidence**

### **Policy Lab ethnographic research**

- The RDU commissioned Policy Lab to research the experience of people from different ethnic minority backgrounds, with a view to utilising the insights gained in the next phase of responding to COVID-19. Using remote digital ethnographic methods, researchers interviewed and observed a small number of participants (12), from a wide range of geographical locations across England and from a variety of ethnic groups, over an 8-week period.
- Ethnography is a rigorous type of social research where researchers immerse themselves in a person's daily life. It can produce rich accounts of everyday life and reveal participants' thoughts, perceptions, hopes and fears. However, the small number of participants means that findings should not be generalised: participants are spokespeople only for their own lives. They do not represent their ethnic minority communities or any other communities that they belong to.
- With a restricted number of participants it was important to include as much diversity in ethnicity, geography, socio-economic circumstances and age as possible. Policy Lab was also mindful to contact groups such as Gypsy, Roma and Traveller communities, and people who are less digitally literate and who might otherwise be excluded from such research. 12 people were recruited aged between 22 and 65 years old; 4 people from Black backgrounds, 3 from Asian backgrounds, 3 people of Mixed or Other ethnicity, one White British person and one person from the Gypsy community. Geographically, all participants were in England, ranging from West Yorkshire to London, Cambridge to Bath.

- Following the findings from the PHE 'Beyond the data' report,<sup>128</sup> the research focused on gathering insights on the following areas:
  - Stigma, racism and discrimination especially in healthcare, social care, and frontline services
  - Communications around COVID-19 from the media, government, and social media, as well as community and faith groups
  - Intersectional experiences including housing, finances, education and employment
  - Future impacts of COVID-19 particularly on economic, social and political arenas
- Fieldwork has now concluded and after thorough review and categorisation 6 broad themes have emerged:
  - Homogenising identities
    - Participants see their own identities as fluid and multiple, but use of the term 'BAME' has standardised experiences in a way ethnic minority participants viewed as unhelpful.
    - As a result, participants felt that narratives of a BAME identity that frame ethnic minority groups as vulnerable to COVID-19 led to stigmatisation.
    - 9 participants, including the White British person, noted that experiences of racism were worsened by the pandemic but 3 participants cited the increasing awareness of, or engagement with, anti-racism movements as a positive development
  - Disruption and adaptation
    - The ability to adapt and adjust, along with the degree of hope and pragmatism, is largely dictated by the resources available to participants
    - Lack of support (or perceived lack of support), including mental health services, meant participants were self-reliant and created strategies for self-care
    - The pandemic intensified participants' care networks and relationships, reducing support networks down to smaller units; for some this was a positive development but for others it created tensions within the unit.
  - Home, place, space
    - Participants experienced a diversity of home environments including homelessness and overcrowding.
    - The availability of space inside or outside the home impacted on participants' wellbeing and experiences through the pandemic

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[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/892376/COVID\\_stakeholder\\_engagement\\_synthesis\\_beyond\\_the\\_data.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf)



- It also impacted on participants' ability to comply with guidelines and manage risks
- Risk and perception of risk
  - Multiple factors influenced participants' perception of risks, including impacts of beliefs, exposure to media and existing individual experiences of COVID-19. As such, management strategies were based on each individual's assessment and interpretation of these complex and cumulative risks.
  - Participants felt that associating higher risk with ethnic minorities increased existing stigma; particularly when generalised risk statements were made on this group's risk without providing the appropriate rationale behind the statement.
- Communication and compliance
  - Government communication has effective reach with many participants having knowledge of the rules.
  - Some reflected on the difficulty in navigating the advice and complying with it in everyday situations, as well as adapting to the pace of change of the guidance.
  - Some participants also reported feeling stigmatised for the spread of COVID-19, due to photographs, articles and information about the virus that they felt singled out ethnic minorities and implied blame on ethnic minority groups.
- Histories and futures
  - People's understanding, interpretation and outlook was built on their personal cultural histories and experiences. The participants' existing social perceptions and divides along with awareness of racism have been adjusted in the context of COVID-19.
  - This re-evaluation of the 'now' and divergent ideas of the new normal has led to revised visions of the future.
- The RDU is currently in the process of triangulating the research findings with further qualitative and quantitative studies, to test the coherence of these insights. Initial scoping of supporting evidence shows some ethnic minorities are likely to experience occupation related risks such as working in health and social care or in

insecure employment.<sup>129,130,131,132,133</sup> This highlights some of the potential disruption and risks faced due to COVID-19 which is also mirrored by some of the participants' experiences.

- The strengths of this research are that it:
  - Is a rigorous form of inductive social research<sup>134</sup> that can often reveal things that quantitative work cannot, such as why and how patterns have emerged.
  - Involves observing and engaging with individuals and communities in their own environments, providing a different perspective from how participants might recall their behaviour in interviews
  - Provides in-depth and nuanced insights into the social realities, experiences and perspectives of people, including how they experience and respond to government policy.
- These should be set against some limitations, including that:
  - The small sample size means findings cannot be generalised across populations; participants can only speak of their own lives and experiences.
  - Some important populations were not directly included in this group of participants, particularly people aged over 70.
  - As with all qualitative research data collection, participants may be influenced by the presence of, and relationship with, social researchers, when taking part in research.

### **ONS COVID-19 compliance study**

- The Office for National Statistics has commissioned IFF Research to undertake a much larger scale investigation into the compliance behaviours of different population groups, including ethnic minority communities.
- Research questions include:
  - Why do some groups comply less?
  - How do different social groups understand the COVID-19 guidance?

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<sup>129</sup>

<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/articles/coronavirusandkeyworkersintheuk/2020-05-15>

<sup>130</sup> <https://www.tuc.org.uk/sites/default/files/2020-06/Dying%20on%20the%20job%20final.pdf>

<sup>131</sup>

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/925135/S0778\\_Drivers\\_of\\_the\\_higher\\_COVID-19\\_incidence\\_\\_morbidity\\_and\\_mortality\\_among\\_minority\\_ethnic\\_groups.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/925135/S0778_Drivers_of_the_higher_COVID-19_incidence__morbidity_and_mortality_among_minority_ethnic_groups.pdf)

<sup>132</sup>

<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/labourmarketeconomiccommentary/july2019>

<sup>133</sup> <https://www.tuc.org.uk/news/bme-workers-far-more-likely-be-trapped-insecure-work-tuc-analysis-reveals>

<sup>134</sup> [http://www.sxf.uevora.pt/wp-content/uploads/2013/03/Glaser\\_1967.pdf](http://www.sxf.uevora.pt/wp-content/uploads/2013/03/Glaser_1967.pdf)

- How do attitudes to compliance with COVID-19 guidance differ between social groups?
- What encourages/discourages compliance with COVID-19 guidance among different social groups?
- What barriers to compliance do different groups face?
- The research design provides for around 180 in-depth interviews comprising 30 interviewees across 6 social groups such as people in low-income, students and ethnic minority communities. In addition, 15 respondents from each social group will be asked to complete an online diary to record encounters with people outside their bubble and how they behaved.
- Fieldwork began in November 2020 and continued through January 2021. A full report of the findings is anticipated in April.

**Term of reference 4: Consider where and how the collection and quality of data into the disparities highlighted can be improved on, and take action to do so, working with the Equality Hub, government departments and their agencies**

#### Improving the recording of ethnicity in GP practices

- The main report describes the Statutory Instrument and accompanying Directions laid in December which make changes to the regulations governing GP contracts.
- Ethnicity data is already collected by practices for around 60% of their patients, but not systematically captured and recorded by all practices on the patient record.
- Following the PHE report, NHSE has encouraged practices to ensure that, where it is available (for example, when the patient provides such information), ethnicity data should be recorded on patients' records.

#### Data harmonisation

- RDU has already set out its commitment to harmonisation of ethnicity across government in its Quality Improvement Plan<sup>135</sup>. RDU continue to state the importance of harmonisation and have further outlined benefits of this recently in a published blog post<sup>136</sup>.
- The immediate harmonisation priority will be on Departments whose data collections are being used here to monitor the primary impacts of COVID-19 on different ethnic groups.
- This will include harmonisation of data collection (for example, NHS data potentially via the UISPC commission described in the main report). It will also include data

<sup>135</sup> <https://www.gov.uk/government/publications/quality-improvement-plan-government-ethnicity-data/quality-improvement-plan-government-ethnicity-data>

<sup>136</sup> <https://dataingovernment.blog.gov.uk/2021/01/29/why-data-harmonisation-is-important/>



outputs - for example working with ONS analysts to investigate whether analyses using the Opinions and Lifestyle Survey and the COVID-19 infection survey using more detailed harmonised ethnicity classifications might be possible.

- The benefits of harmonisation are increased if all Departments commit to using the harmonised standards, particularly when assessing secondary impacts in the future.
- Moving to a classification similar to the 2021 Census, for example, could facilitate the capture of more data for some ethnic groups, such as the Roma group. There has been Parliamentary interest in capturing more data for the Gypsy, Roma and Traveller groups.
- Harmonisation standards and guidance exist for other characteristics, such as disability<sup>137</sup> and impairments.<sup>138</sup> These are outlined for illustrative purposes.
- There are 2 harmonisation standards and guidance publications pertaining to disability. The first is the GSS harmonised guidance on measuring disability for the Equality Act 2010. This combines the long-lasting health conditions and illness (LLHCI) harmonised standard and the activity restriction harmonised standard to determine whether a person is classified as disabled under the Equality Act 2010 in Great Britain or the Disability Discrimination Act 1995 in Northern Ireland. A person is classified as disabled if they have a physical or mental health condition or illness lasting or expected to last 12 months or more and their condition or illness reduces their ability to carry out day-to-day activities.
- The second publication is the GSS impairment harmonised standard which aims to understand the functions that a person has difficulty performing, or cannot perform as a result of their condition or illness. This is designed to be consistent with the World Health Organisation International Classification of Functioning.

#### The quality of ethnicity data in health datasets

- This report considers 3 of the main sources of health data:
  - Hospital Episode Statistics
  - The COVID-19 Infection Survey
  - The Opinions and Lifestyle Survey

#### Hospital Episode Statistics (HES)

- The report outlines the work that is being undertaken to improve the allocation of ethnicity in the HES. It is critically important that ethnicity data in health records is fit-for-purpose for many reasons, including for data linkage now, and in the future to capture ethnicity in the death certification process.

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<sup>137</sup> <https://gss.civilservice.gov.uk/policy-store/measuring-disability-for-the-equality-act-2010/>

<sup>138</sup> <https://gss.civilservice.gov.uk/policy-store/impairment/>

- The King's Fund and UCL Institute of Health Equity paper mentioned in the main report described other ways that data collection might be improved. These included:
  - making it clear to NHS organisations and staff, and GPs, that ethnicity should be self-reported, using the official classifications of ethnicity
  - that "not stated" is a legitimate response (patients should have the option of declining to state their ethnicity)
  - that the "unknown" category should only be used when it wasn't possible to ask the patient their ethnicity
  - that there should also be an agreed set of rules to account for situations in which the patient has a temporary or permanent lack of capacity.

### COVID-19 Infection Survey (CIS)

- The CIS addresses an important clinical priority: finding out how many people across the UK have a COVID-19 infection at a given point in time, or at least test positive for it, either with or without symptoms; how many new cases have occurred in a given time period; and estimating how many people have had the infection. It also enables estimates of the rate of transmission of the infection, often referred to as "R".
- There have been a number of improvements in the survey since its launch. For example, since the start of the pandemic, the sample size of the survey has increased significantly<sup>139</sup> and the coverage has expanded to include Wales, Scotland and Northern Ireland.
- The goal for the CIS was to achieve a cohort of around 150,000 individuals sampled at least once a fortnight by October 2020 in England, around 15,000 in each of Wales and Scotland, and up to 15,000 in Northern Ireland.
- In total, in the 12 months from the start of the survey, ONS expects to recruit approximately 380,000 individuals from approximately 180,000 households in England, plus approximately 42,000 individuals and 20,000 households from each of Wales and Scotland, and up to 42,000 individuals and 20,000 households from Northern Ireland.
- ONS recently published analysis of COVID-19 infections by ethnicity.<sup>140</sup> In this release, because of the limitations of small sample sizes, the only breakdowns possible were White and Other than White. Analysis of other data sources has shown the differences between more detailed ethnic groups (for example between Black African and Black Caribbean people, and between people in the Indian, Chinese, Pakistani and Bangladeshi ethnic groups) and RDU encourages the use

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<https://www.ons.gov.uk/news/news/newinsightintocovid19tobegainedfromhugeboosttonationaltestingstudyledbytheofficeforationalstatistics>.

<sup>140</sup> Coronavirus (COVID-19) Infection Survey: characteristics of people testing positive for COVID-19 in England, September 2020

of detailed groups for analysis wherever possible.

- A recent RDU quality report<sup>141</sup> (that was more general than COVID-19 analysis) showed the extent of some differences between detailed (18+1) ethnic groups within the aggregate (5+1) groups, and demonstrated benefits and disbenefits of using aggregate groups over detailed groups.
- RDU are working with analysts in the ONS to see whether further analysis by more detailed ethnic groups is possible, taking into account the size of the sample for different groups, the representativeness of the survey, and whether the geographical spread of the data means that plausible results can be obtained.
- However, limitations on the sample sizes may mean that analyses for more detailed ethnic groups might not be possible.

#### ONS Opinions and Lifestyle Survey (OPN)

- The OPN<sup>142</sup> is an important source of data about the social impacts of COVID-19. Indicators from the OPN measure the impact of the pandemic on people, households and communities in Great Britain.
- The most recent statistics release included data on compliance with government regulations including:
  - Handwashing
  - Use of face coverings
  - Avoiding contact and self-isolating
  - Working at home and location of work
  - Leaving home
- Analyses of attitudes to vaccinations by ethnic group have also been published recently by ONS.
- There have been a number of improvements to the ONS Opinions and Lifestyle Survey in recent months to improve the quality of the data:
  - Starting with data collected between the 14 and 17 May, the data collection period for the Opinions and Lifestyle Survey has been reduced to 4 days from 10 or 11 days in previous waves.
  - The time between the survey closing and results being published has also been reduced to allow more timely analysis of how attitudes and experiences are changing through the pandemic.

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<sup>141</sup> <https://www.gov.uk/government/publications/ethnicity-data-how-similar-or-different-are-aggregated-ethnic-groups>

<sup>142</sup>

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/datasets/coronavirusandthesocialimpactsongreatbritaindata>



- Starting with data collected between 21 and 25 October, the sample size for the weekly OPN has approximately tripled in England, to around 3,000 people.
- While the sample size has been increased, the sample sizes for the 4 aggregate ethnic minority groups (Asian, Black, Mixed and Other) remain relatively small, and there is an underrepresentation of people in ethnic minority groups (around 6% of the sample, compared with 14% in the 2011 Census).
- Sample sizes can be increased by aggregating over more than one time period (more than one week) although this is dependent on the relevant questions being asked in each weekly wave of the survey.

#### Data publication schedule and data access

- This is the publication schedule that forms part of the recommendations.

<b>Measure title</b>	<b>Expected department publication</b>	<b>Expected publication on Ethnicity facts and figures</b>
Detentions under the Mental Health Act	October 2020	February 2021
Patient satisfaction with hospital care	August 2020	February 2021
Prison officer workforce	November 2020	February 2021
Fire and rescue services workforce	October 2020	February 2021
Domestic abuse	November 2020	February 2021
Use of NHS mental health, learning disability and autism services	January 2021	March 2021
GCSE results (Attainment 8)	January 2021*	March 2021
GCSE English and maths results	January 2021*	March 2021
Students getting 3 A grades or better at A level	January 2021*	March 2021
Average score for students taking A levels and other qualifications	January 2021*	March 2021
Social workers for children and families	February 2021	April 2021

<b>Measure title</b>	<b>Expected department publication</b>	<b>Expected publication on Ethnicity facts and figures</b>
Confidence in the local police	February 2021	April 2021
Physical activity	April 2021	May 2021
Overweight adults	May 2021	June 2021
Sources of household income	March 2021	June 2021
Household income	March 2021	June 2021
State support	March 2021	June 2021
Persistent low income	March 2021	June 2021
People in low income households	March 2021	June 2021
Self employment	May 2021	July 2021
Average hourly pay	May 2021	July 2021
Employment	May 2021	August 2021
Unemployment	May 2021	August 2021
Economic inactivity	May 2021	August 2021
Employment by occupation	May 2021	August 2021
Employment by sector	May 2021	August 2021
Travel by distance, trips, type of transport and purpose	September 2021	October 2021
Overcrowded households	September 2021	October 2021
Housing with damp problems	September 2021	October 2021
People without decent homes	September 2021	October 2021

\* DfE would usually publish revised attainment statistics in January but because of the special circumstances in 2020, only provisional data is available

- To enable users to have access to up to date data, ONS has made available a number of the most important micro-level datasets for the analysis of COVID-19

disparities between different ethnic groups. These are available from the ONS Secure Research Service (SRS) on application and include:

- COVID-19 Infection Survey
- Opinions and Lifestyle Survey
- Linked 2011 Census and mortality data
- Work is currently ongoing in ONS to link 2011 Census, hospital episodes and deaths data which they plan to make available to external researchers.
- The ONS Business Impacts of COVID-19 survey is also available on the SRS, although this does not collect ethnicity information.
- These datasets are being used to:
  - Identify which population groups (for example, by age, sex or ethnicity) were at higher or lower likelihood of experiencing COVID-19 related occupational risks
  - The data will also be used to help inform the infection fatality ratios applied to different strata of the population including ethnicity which determine the number of deaths that would be observed based on the outputs of the transmission modelling. The aim of this work is to aid the response to COVID-19 and its recovery.
  - Another project is assessing the extent to which excess mortality risks (COVID-19 and all causes) are due to ethnicity, residence or deprivation among health workers.
- The Ministry for Housing, Communities and Local Government (MHCLG) have now provided ONS with the Energy Performance Building Certificates (EPC) data to be linked with ONS' COVID-19 Infection Survey and the VOA data. This will also be made available to researchers through the SRS in due course.



## Annex D - Multicultural media partners and example content

### 1. Media partnership

The following titles share content with additional local titles, amounting to content featured in over 50 publications in print and online.

Content or advertorial	Language or community	Frequency	Total circulation
The Weekly Gleaner	English, Afro-Caribbean: London	Weekly	19,000
African Voice	English, African: UK	Weekly	25,000
Eastern Eye	English, South Asian: UK	Weekly	22,000
Garavi Gujarat	Gujarati: London, Midlands	Weekly	43,000
Asian Voice	English, Asian	Weekly	33,000
Gujarat Samachar	Gujarati, Asian	Weekly	33,000
Asian Standard (3 editions: Bradford, Kirklees, North East)	English, South Asian: UK	Weekly	28,000
Daily Jang	Urdu	Daily	20,000
The Bangla Post	Bengali	Weekly	10,000
Weekly Desh	Bengali	Weekly	13,000

Content or advertorial	Language or community	Frequency	Total circulation
Potrika	Bangladeshi: UK	Weekly	15,000
Surma News Weekly	Bengali: UK	Weekly	15,000
Asian Express (3 editions: Yorkshire, Midlands, Manchester and Lancashire)	English, Pakistani: whole of England	Weekly	42,000
Jewish Telegraph (3 editions: Leeds, Manchester, Liverpool)	English, Jewish	Weekly	14,000
Epoch Times	Chinese, Chinese: London	Weekly	10,000
Londra Gazete	Turkish: London	Weekly	15,000
Angliya	Russian, Belarusian, Ukrainian, and other Russian-speaking communities	Weekly	20,000
Cooltura	English, Polish: UK	Weekly	45,000
The Methodist Recorder	English, Christian: London	Weekly	4,000
Catholic Universe	English, Christian: UK	Weekly	20,000
Ziarul Românesc	Romanian	Weekly	10,000
Irish World	Irish	Weekly	22,000

## 2. Examples of print content

