Equality Hub

Race Disparity Unit

Research and analysis

Final report on progress to address COVID-19 health inequalities

Published 3 December 2021

Contents

This publication is available at https://www.gov.uk/government/publications/final-report-on-progress-to-address-covid-19-health-inequalities/final-report-on-progress-to-address-covid-19-health-inequalities

Introduction

Following publication of the Public Health England (PHE) report COVID-19: review of disparities in risks and outcomes (https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes) in June 2020, the Prime Minister and the Secretary of State for Health and Social Care asked the Minister for Equalities, Kemi Badenoch MP, with support from the Cabinet Office Race Disparity Unit (RDU), to lead cross-government work to address the report's findings.

Under the terms of reference for this work, which are set out in Appendix A (https://www.gov.uk/government/publications/final-report-on-progress-to-address-covid-19-health-inequalities/appendix-a-terms-of-reference), the Minister for Equalities was tasked with submitting quarterly progress reports to the Prime Minister. This is the fourth and final progress report, following those published on 22 October, 26 February and 25 May.

This final report provides a further update on cross-government work to address the disparities highlighted by the PHE report. It looks back to previous quarters and sets out how our understanding of and response to the pandemic changed over the lifecycle of this work. The report also includes a summary of progress against recommendations from previous reports (Appendix B (https://www.gov.uk/government/publications/final-report-on-progress-to-address-covid-19-health-inequalities/appendix-b-progress-implementing-recommendations-and-next-steps-from-first-3-reports)), lessons learnt from this work and an action plan for addressing some of the longer-term issues identified during the course of this project.

This report should be read alongside the government's forthcoming response to the report of the Commission on Race and Ethnic Disparities, which will include actions to address longer-term health inequalities which are likely to have been a contributory factor to the disproportionate impact COVID-19 has had on ethnic minority groups.

Overview and executive summary

In June 2020, the Prime Minister and the Secretary of State for Health and Social Care asked the Minister for Equalities to look at why COVID-19 was having a disproportionate impact on ethnic minority groups and to consider how the government response to this could be improved.

At that time, we knew that ethnic minorities were more likely to be infected and to die from COVID-19, but we did not know why. In order to shape the government's response, our first priority was to work with universities, other government departments, the Office for National Statistics and other experts to understand the drivers behind these disparities. This included new research projects backed by over £7 million in government funding.

Thanks to this work, our understanding of the risk factors affecting ethnic minorities became much clearer. We now know:

- the main factors behind the higher risk of COVID-19 infection for ethnic minority groups include occupation (particularly for those in frontline roles, such as NHS workers), living with children in multigenerational households, and living in densely-populated urban areas with poor air quality and higher levels of deprivation
- once a person is infected, factors such as older age, male sex, having a disability or a pre-existing health condition (such as diabetes) are likely to increase the risk of dying from COVID-19
- while ethnicity itself was not thought to be a risk factor, recent research by Oxford University identified the gene responsible for doubling the risk of respiratory failure from COVID-19, carried by 61% of people with South Asian ancestry – this goes some way to explaining the higher death rates and hospitalisations in that group

These insights have been crucial in shaping the government's response to COVID-19.

Our early efforts, informed by the emerging data and scientific advice, focused on preventing the risk of infection and protecting key frontline workers who were most at risk. This included risk-assessing over 95% of frontline NHS staff by September 2020 and publishing guidance on how to make workplaces secure for those who were not able to work from home.

Our approach evolved as our understanding of the risk factors developed. For example, in the second wave of the pandemic, the risk of dying from COVID-19 was much higher for the Bangladeshi and Pakistani ethnic groups. In response, we introduced measures designed to protect those from South Asian groups. This included guidance on preventing household transmission, which was particularly important given the higher percentage of people from the Bangladeshi and Pakistani ethnic groups living in multi-generational homes, and measures to protect taxi drivers, over half of whom are from an ethnic minority background.

The most significant measure to protect ethnic minorities from the risk of COVID-19 infection and to save lives has been the vaccination programme. The government led the world in terms of the scale of our programme to approve, procure and deploy the COVID-19 vaccines. The largest mass-vaccination programme in British history has been delivered through an unprecedented partnership approach between national and local government, health agencies, and the voluntary and community sector.

This began with early measures ahead of deployment to build trust with ethnic minority groups, recognising that they were more likely to be reluctant to be vaccinated. This included funding a project that developed a framework to support inclusion of ethnic minority participants in COVID-19 research, and 2 ethnic minority government ministers taking part in vaccine trials.

Once deployment began, the government worked with national and local partners to promote vaccine uptake among ethnic minority groups and to tackle misinformation through a series of targeted and highly innovative interventions including:

- using around 50 places of worship as vaccination centres, with many more acting as pop up venues
- taking the vaccines into the hearts of local communities through initiatives such as vaccination buses and taxis
- reacting quickly to lower vaccine uptake rates within particular ethnic groups with targeted campaigns to address vaccine concerns and promote uptake, linking in with key religious festivals such as Easter and Ramadan
- providing over £7 million of government funding to local sustainability and transformation partnerships to support and enable locally-led community engagement in all areas with health inequalities
- working with trusted voices such as faith leaders and prominent ethnic minority celebrities and influencers to build trust and encourage vaccination uptake
- tackling vaccine misinformation through myth-busting content and targeted approaches on social media channels, such as clarifying concerns around vaccine ingredients (which was important on religious grounds) and perceived links to fertility and pregnancy

A key element of this is the government's Community Champion scheme launched in January 2021 and backed by over £23 million in funding. Independent analysis shows that the scheme had a positive impact on vaccination rates, as well as other benefits such as a better understanding of barriers to support faced by communities.

Through these combined efforts we have seen increases in both positive vaccine sentiment and vaccine uptake across all ethnic groups since vaccine deployment began.

There are a number of wider public health lessons to be learned in relation to ethnic minorities including:

- ensuring the success of vaccination deployment is carried over to other public health programmes, such as winter flu and COVID-19 booster vaccinations – this includes continuing to use respected local voices to build trust within ethnic minority groups and to help tackle misinformation
- not treating ethnic minorities as a homogenous group – COVID-19 has affected different ethnic groups in different ways throughout the pandemic and a 'one size fits all' approach is not an effective way of tackling public health issues
- avoiding stigmatising ethnic minorities by singling them out for special treatment, which could be taken to imply that they are vulnerable or, in the case of COVID-19, were somehow at fault for the spread of the virus
- improving the quality of health ethnicity data so that patterns and trends can be spotted quicker in future

To ensure that we learn these lessons and that we improve the health outcomes for ethnic minorities, we make a number of recommendations.

Many of these are for the Department of Health and Social Care (DHSC) and the new Office for Health Improvement and Disparities (OHID), who will lead this work

going forward.

Recommendations

This report makes the following recommendations, which the Prime Minister has accepted in full.

The government and health agencies must build on the success of the COVID-19 vaccination deployment programme in reaching ethnic minority groups and apply this to future vaccination programmes, including COVID-19 booster vaccinations, winter flu vaccination and childhood immunisation programmes.

In order to reassure ethnic minority groups and encourage uptake, the government must ensure there is clarity in the communications about the need for COVID-19 boosters and the longer-term plan for COVID-19 vaccination.

To reassure pregnant women that the COVID-19 vaccine is safe, the government should continue to deliver clear messaging through trusted voices and via social media.

Government departments, their agencies and the NHS must continue to build trust in health services within ethnic minority groups through optimising and building on the local partnerships and networks established under the vaccination programme.

The successful elements of the vaccination programme must also be applied to the work to tackle longer-standing health disparities. This must be a priority for the new Office for Health Improvement and Disparities and its partners.

To build confidence in future vaccination schemes and other health interventions, the National Institute for Health Research and the NHS Race and Health Observatory should seek to increase ethnic minority participation in clinical trials and research through methods such as promoting the INCLUDE Ethnicity Framework.

The government should continue to monitor the impacts of COVID-19 by ethnicity as the virus evolves. This may include:

- measuring survival analysis over time
- monitoring vaccine uptake among 16 to 18 year olds and 12 to 15 year olds and uptake of the booster vaccine

The findings and recommendations from this series of reports should be applied to the government's response to future COVID-19 variants.

DHSC should continue to consider the set of interdependent UISPC recommendations proposed by NHS England to improve the quality of ethnicity data coding, and should outline responsibilities to relevant leads.

ONS should collaborate with the other relevant health departments and consider how linking health and Census data could be improved and extended to facilitate

more reliable, timely and detailed estimates of ethnic health disparities on a regular basis.

Relevant health departments and agencies should review and action existing requests for health data, and undertake an independent strategic review of the dissemination of healthcare data and the publication of statistics and analysis.

NHS Digital should include the proportion of records coded as not known, not stated, an 'other' group and 'any other ethnic group' in the NHS Data Quality Maturity Index.

RDU will discuss ways to improve guidance and signposting for health statistics with the English Health Statistics Steering Group.

A Programme Board, involving representatives of the user community and other relevant stakeholders (including the devolved administrations), should oversee implementation of these priorities and should publish regular reports of progress.

The government and health agencies must implement the lessons learnt from the COVID-19 insights work and in particular:

- address specific ethnic minority groups rather than a homogenous group (through for example use of the term 'BAME')
- ensure that public health communications do not stigmatise ethnic minorities when explaining that they may be more vulnerable or at higher risk

The government should carry out a review of language and terminology around ethnicity to understand how to target messaging without stigmatising any particular group.

The government should use the COVID-19 experience of reaching ethnic minority groups for future public health campaigns. This should include activities to:

- develop and provide materials in multiple languages and formats, including BSL, easy read and audible formats, to ensure content addresses any difficulties to reach diverse audiences
- build on community partnerships and work closely with local networks to improve understanding and gain insight into the audience
- use community partners to co-create content and tailor communications that resonate with key audiences
- communicate key messages through community partners and specialist media and digital channels, using trusted voices to land messaging where necessary

1. Measures to address COVID-19 disparities

This chapter summarises government work to address COVID-19 disparities since the end of May 2021. This work has continued to focus on improving vaccine confidence and promoting vaccine uptake among ethnic minorities through a range of measures, including the Community Champions scheme. Tackling the higher

levels of COVID-19 infection in deprived communities through initiatives such as enhanced testing has been a primary focus.

This chapter also considers the government's overall approach to tackling COVID-19 disparities since this review commenced in June 2020, summarising and assessing the effectiveness of government interventions, considering lessons learned over this period and making recommendations for how this work should be taken forward.

Update on new measures since May 2021

Promoting vaccine uptake

The government's efforts to tackle COVID-19 disparities have continued to focus on building vaccine confidence and promoting vaccine uptake. Key measures over the last period include:

- producing videos with faith and business leaders from the Bangladeshi community and delivering a webinar in partnership with Bangladesh Caterers Association (with contributions from the Minister for COVID-19 Vaccine Deployment and the Minister for Small Business, Consumers and Labour Markets) to increase vaccine uptake amongst the Bangladeshi group
- activity around the Eid al-Adha celebrations in July, including a 'Safe Eid' Webinar facilitated by the British Islamic Medical Association and featuring the Minister for COVID-19 Vaccine Deployment, the Chief Medical Officer and a range of faith and clinical leaders – this was live-streamed via Facebook
- producing a video promoting vaccine uptake among healthcare workers – this featured a broad range of ethnic minorities and was shared on social media (https://twitter.com/NHSEngland/status/1414857189307691014) with almost 5,000 views
- measures to increase uptake in Indian groups including a webinar with Dr Binita Kane, South Asian Heritage Month co-founder and respiratory consultant, and Dr Harpreet Sood, GP and NHS England Clinical Advisor for the COVID-19 Vaccine programme
- developing co-branded videos with messaging from black-majority churches across NHS channels, Churches Together in England and community-specific media channels
- producing videos aimed at young black audiences at the end of August to address lower uptake among this group
- to encourage as many people as possible to come forward for vaccination in order to protect local communities, Public Health England produced 2 animations explaining migrants' entitlement to vaccination, while pop-up clinics in a Holiday Inn vaccinated those without permanent residency or an NHS number
- a youth vaccination campaign partnering with The Shade Borough and youth radio stations such as Pai.Radi, Unity Radio and Rinse targeting ethnic minority groups

- a new NHS video, Winter Vaccines Explained[footnote 1] with Dr Amir Khan and Dr Karan Ranj, which explains to the public how COVID-19 and flu spread – they reiterate the need for the annual flu vaccine and the COVID-19 booster vaccine
- England's Chief Midwifery Officer shared videos in October 2021 reassuring pregnant women that the COVID-19 vaccine is safe, as research shows pregnant women are more likely to become seriously ill from COVID-19 (https://www.england.nhs.uk/2021/10/nhs-encourages-pregnant-women-to-get-covid-19-vaccine/)

'Bridging the Uptake Gap' toolkit

To address lower vaccine uptake rates among the Black African and Black Caribbean groups, the NHS – in partnership with the Caribbean and African Health Network – produced the 'Bridging the Gap' toolkit. Based on the latest evidence and best practice, the toolkit was launched in June and comprises 6 components:

- data and population behavioural insights to help users gain a detailed understanding of local Black African and Black African Caribbean populations, identify gaps in uptake and facilitate targeting of initiatives
- encouraging vaccine uptake in these groups by removing barriers
- sharing what works via the NHS Connect and Exchange Hub and encouraging users to post useful material
- using high-profile and trusted voices to support vaccine uptake, with advice on how to communicate clearly with target audiences
- using targeted conversations to boost vaccine confidence – for example, hosting a series of clinically-led, online dialogues using trusted voices to engage black groups
- encouraging use of venues for mobile and pop-up vaccination centres that the target audience feel comfortable with and frequently visit, such as places of worship, community organisations and schools

The toolkit was shared with system partners to support their work to reach all communities. 160 stakeholders attended the launch event.

Community Champions

One of the main elements in the programme to drive vaccine uptake is the Community Champions scheme, announced in the first of these reports last year and formally launched in January. Local authorities report that over 14,000 Community Champions have been recruited under this scheme.

These Champions continue to support a range of interventions to build upon, increase or improve existing activities to work with residents who are most at risk of COVID-19.

Initiatives over the last period include:

- in Great Yarmouth, Community champions knocked on over 900 doors ahead of a Vaccination Bus visiting the community, helping the NHS team vaccinate those who might not otherwise have come forward
- in Leeds, Community Champions supported and promoted a roving vaccination bus which vaccinated close to 3,000 people – they also supported enhanced testing resulting in over 27,000 tests being completed
- in Salford, engagement work to support the local vaccination bus led to 150 residents per day being vaccinated – these were people who had not previously taken up invitations to large-scale vaccination sites
- in Sunderland, the local authority has been rolling out a COVID-19 myth-busting programme, developed by the Community Champions, via all schools in the area

NHS Test and Trace

As restrictions were eased over the summer, NHS Test and Trace has ensured that those who have been worst hit by COVID-19 are protected and supported. Measures include the following.

The Pharmacy Collect service. Providing an additional route to regular testing, the service facilitates access to testing for people without COVID-19 symptoms. Over 97% of pharmacies across England are now providing tests, having handed out over 159 million tests so far. 80% of the population in England has access to a community pharmacy within a 20 minute walk and there are now 2 to 3 times more such pharmacies in deprived areas than in more affluent areas.

Increasing targeted community testing in disproportionately impacted groups and among employees of small businesses, and conducting workforce testing in higher-risk occupations. Since 1 July, over 1 million supervised tests have been carried out under targeted community testing. Community testing has proven to have a 4-times-higher positivity rate than other types of asymptomatic testing.

The Department for Education worked with the Cabinet Office marketing team to deliver an autumn term return campaign targeting students in higher education and further education, encouraging asymptomatic testing.

Review of medical devices

In November 2021, the Secretary of State for Health and Social Care launched an investigation into the effectiveness of medical equipment on different races. This followed concerns raised about pulse oximeters, which can be useful for monitoring patients at risk from COVID-19, and the accuracy of readings for those with darker pigmentation and skin tones.

Summary of government's approach since June 2020

This section considers the government's overall approach to tackling COVID-19 disparities since June 2020, when this review commenced, and assesses the effectiveness of the interventions put in place.

Actions to prevent the spread of infection

In the early stages of this review, departments and their agencies acted quickly to address the disproportionate impact of COVID-19 on ethnic minority groups. Initially, government activity focused on preventing the spread of the virus across the population, and on protecting the most at-risk workers.

Frontline NHS workers were one of the groups directly at risk. Having an appropriately fitting mask is essential for effective protection. Early measures to protect them included the NHSEI (NHS England and NHS Improvement) FFP3 mask fit-testing project led by the Deputy Chief Nursing Officer. This collected data from over 5,500 participants from a range of backgrounds and across 47 NHS Trusts. Since this project was initiated, a further 8 types of masks have been made available, and over 16 different models are now supplied, providing a portfolio of different shapes and sizes to cater to a diverse range of users. The increased range and diversity of FFP3 masks makes it easier for NHS staff to find a mask that fits.

In April 2020, NHSEI asked the leaders of local organisations to risk-assess their staff who were at potentially greater risk of serious illness from COVID-19, including ethnic minority staff. Trusts and staff then agreed to make appropriate arrangements to protect employee health, safety and welfare. By September that year, the NHS was reporting that over 95% of staff from ethnic minority backgrounds had taken up such an assessment and agreed any necessary mitigations.

Reducing workplace risk:

As the government's understanding of the risk factors changed, so did its approach to addressing COVID-19 disparities, particularly in relation to workplace risk. In summer 2020, the Scientific Advisory Group for Emergencies (SAGE) commissioned PHE, the Faculty of Occupational Medicine and the Health and Safety Executive (HSE) to look specifically at mitigating the risk of COVID-19 for ethnic minority workers. The consensus was that risk assessments should be applied equally and consistently across the workforce, in any workplace. Controls put in place must consider all relevant risk factors, and not just a person's ethnicity. The group concluded that singling out all ethnic minority staff for additional risk assessments could be stigmatising and could deny them opportunities in the workplace. Unnecessarily removing them from all frontline duties could risk impinging on career progression.

This approach was reflected in updated guidance to employers on how to make workplaces COVID-secure. HSE issued this guidance in September 2020, updating it in October 2021. The Safer Workplace guidance has received over 3.73 million unique page views since May 2020. Across all business sectors, 97% of businesses said they were aware of the Safer Working guidance (https://www.ons.gov.uk/economy/economicoutputandproductivity/output/datasets/businessimpactofcovid19surveybicsresults).

Targeted initiatives that would disproportionately benefit ethnic minorities kept a focus on avoiding stigmatisation. For example, the government made face

coverings for passengers in taxi and private hire vehicles (PHV) mandatory from September 2020. Taxi and PHV drivers were considered to be particularly at risk from COVID-19, as 98% are male and 53% are from an ethnic minority background. In November 2020, the Department for Transport issued guidance to taxi and PHV drivers, owners and operators on protective actions they can take against COVID-19, followed by further guidance in March 2021 on installing safety screens in vehicles.

NHS Test and Trace:

Since June 2020, NHS Test and Trace data has shown a 53% increase in uptake of testing services by ethnic minorities.

Early NHS Test and Trace measures included piloting community-led, localised, asymptomatic testing at places of worship in areas with larger ethnic minority populations. These initiatives aimed to remove some of the main barriers identified to engaging with Test and Trace, including trust and access. These reported significant successes.

NHS Test and Trace has also driven locally-led activity to support the people and places most affected by COVID-19, using measures such as monthly update webinars for community organisations, and faith and voluntary sector leaders, which has helped spread messages about test and trace through trusted local voices. This has been a particularly effective way of reaching disproportionately impacted groups who may otherwise feel mistrustful of 'official' channels.

In recognition of the scale of the impact of COVID-19, translation services in more than 200 languages via the 119 call centre have been provided and accessed tens of thousands of times to date. The Test and Trace Support Payment scheme was also launched in September 2020 to help people on low incomes who will experience financial hardship if they have to self-isolate. To date, NHS Test and Trace has made £176 million available to local authorities in England to run the scheme.

Measures to protect those impacted by the second wave:

Throughout the pandemic, the government's approach has been driven by the emerging data. As the early data from the second wave began to show a disproportionate impact of COVID-19 on the Bangladeshi and Pakistani groups, the government took measures to protect these groups from the risk of infection.

As well as measures to protect taxi drivers, the government published new guidance to those living in shared and overcrowded housing on reducing the risk of infection. This is particularly important for those living in multi-generational homes, which may be a factor behind the higher death rates seen in the Bangladeshi and Pakistani ethnic groups. The guidance was translated into a range of languages, including Bengali and Urdu. NHSEI also trialled group family vaccinations, aimed at those living in multigenerational households. This innovative approach was an example of how to design an intervention which benefits the entire eligible population but stands to disproportionately benefit ethnic minorities because they are more likely to live in a multi-generational home. This experience reinforced how

important local engagement and conversations are key to building vaccine confidence.

Vaccine deployment

It was always known that vaccines would be the best way out of the pandemic and the best way to protect people from COVID-19. That is why the government moved fast and early, supporting ground-breaking research from January 2020. The Vaccine Taskforce then procured and delivered vaccines to support the largest mass-vaccination programme in British history.

Past experience of vaccination programmes indicated that uptake was likely to be lower amongst ethnic minorities. That is why in July 2020, well before vaccine deployment, the government provided funding for Professor Shaun Treweek's project testing a framework to support inclusion of ethnic minority participants in COVID-19 research. This led to development of the INCLUDE Ethnicity Framework (https://www.trialforge.org/trial-forge-centre/include/), which aims to help trial teams think carefully about which ethnic groups should be included in their trial for its results to be widely applicable, and what challenges there may be to making this possible.

Lower ethnic minority participation in vaccine trials was also the driver behind the Minister for Equalities and the former Minister for COVID-19 Vaccine Deployment both taking part in the Novavax vaccine trial. Their participation was highly symbolic and was reported by the media at the time and the Minister for Equalities and former Business Secretary wrote to all MPs encouraging them to promote ethnic minority participation in COVID-19 vaccine trials.

DHSC published the UK COVID-19 vaccines uptake plan (https://www.gov.uk/government/publications/uk-covid-19-vaccines-delivery-plan) in January, setting out the government's approach to vaccination. This was based on advice from the Joint Committee on Vaccination and Immunisation (JCVI) on prioritising the roll out. JCVI advised that good vaccine coverage in ethnic minority groups would be the most important factor in reducing disparities in outcomes for these groups.

The strategy announced that a dedicated team would support effective communication with ethnic minority healthcare workers, headed by the NHSEI Medical Director of Primary Care and NHS Chief People Officer. This was in recognition of healthcare workers' roles as advocates and leaders within their own communities.

Also in January, in response to the emerging data that showed lower levels of uptake among ethnic minority groups, NHS England established a Vaccine Deployment 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, the Committee advised and guided the vaccine deployment programme on addressing inequalities.

This group has led work on a number of initiatives, including:

- the guide to vaccination in places of worship
- the Ramadan guide
- the 'Bridging the Uptake Gap' toolkit
- a national bank of resources including best practice, case studies and patient stories that can be used at a local level to promote vaccine uptake – the Vaccine Equalities Connect and Exchange Hub – which has over 2,000 members across the country

Other significant initiatives to promote vaccine uptake and tackle misinformation include:

- an extensive communications campaign, which is summarised in Chapter 4
- allocating over £7 million of funding to local sustainability and transformation partnerships to support and enable locally-led community engagement in all areas with health inequalities
- working with faith leaders to promote vaccine uptake, including setting up vaccination centres in around 50 places of worship and using many more as pop-up venues
- bespoke programmes to increase COVID-19 vaccine confidence in Black African, Black Caribbean, Bangladeshi and other groups, working with religious leaders, other trusted community voices and ethnic minority healthcare workers
- initiatives targeting religious events such as Easter and Ramadan to address vaccine concerns and promote uptake
- supporting and advocating the use of mobile and community vaccine pop-ups to increase access to underserved communities, culminating in the launch of the national 'Grab-A-Jab' programme from July
- use of vaccination buses that travelled to specific locations, agreed through partnerships with the community, to support increased confidence and outreach, such as the bus in Crawley used to drive uptake in the Hindu community
- a number of measures to improve uptake among ethnic minority healthcare professionals including webinars and question and answer sessions with ethnic minority medics – the government has also recently announced that health and social care providers in England will be required to ensure workers are fully vaccinated against COVID-19, unless they are exempt, as a means of protecting both patients and workers
- producing a video with the Chief Midwifery Officer, Professor Jacqueline Dunkley-Bent and midwives around the country to address pregnancy and infertility concerns

By the end of May, these initiatives had led to increases in both positive vaccine sentiment and vaccine uptake across all ethnic groups, with vaccine confidence increasing in 3 consecutive research periods. This trend has continued. For example, between 31 May and 31 October, the percentage of over-50s who received both doses of the COVID-19 vaccine increased in all ethnic groups. The largest percentage point increases were in the Pakistani ethnic group (from 54.2% to 78.8%, up by 24.6 percentage points) and Bangladeshi ethnic group (from 63.7% to 87.0%, up by 23.3 percentage points).

Improving vaccine uptake among the Bangladeshi ethnic group

In January and February 2021, uptake in the Bangladeshi group was lower than all other Asian or Asian British groups. This was a particular concern given the disproportionate impact the second wave of the pandemic was having on this group.

The lower rate appeared to be down to a range of factors including a lack of confidence in the vaccine, general complacency about the need to be vaccinated (often linked to language barriers) and an inability to access the vaccine in local areas.

This was tackled through a combination of national communications and engagement efforts, coupled with local activity including:

- a national awareness campaign lead by Great British Bake Off winner Nadiya Hussain, Asma Khan from Netflix's Chef's Table and BBC Masterchef winner Saliha Mahmood
- the 100 Faces campaign, which used images of influential Bangladeshi personalities including clinicians, Imams or Islamic scholars, community activists, restaurant and business owners and other trusted local voices, and was amplified through social media channels and BBC Asian Radio
- regular open and transparent dialogue and live information sessions with trusted voices using community media channels
- 50 Bangladeshi freedom fighters giving 50 vaccinations on the 50th anniversary of Bangladeshi independence
- using the premise of 'Jab for Jalfrezi' as takeaway tokens, Bengali restaurateurs encouraged uptake in the community – led by the Bangladeshi Catering Association, this reached over 12,000 UK based Bangladeshi-owned takeaways and restaurants and aired on Bangladeshi community TV
- recording information videos in Sylheti by GPs on Ramadan and the COVID-19 Vaccination, and a faith-based video that formed the basis of a national WhatsApp campaign
- using Bangladeshi Community TV stations Channel S and TV One to air vaccination information and dialogue sessions

In late February and March 2021 there was a marked increase in vaccination rates among the Bangladeshi ethnic group, and rates have continued to rise since then.

National and local partnerships

A central part of the government's work to address COVID-19 disparities and to drive up vaccination rates has been the partnership with local authorities and local communities. Key to this is the Community Champions scheme. The first of the Minister for Equalities' quarterly reports announced the scheme, which was then launched in January 2021. The scheme allocated £23.75 million in funding to 60

councils across England to build on or improve existing activities with at-risk residents from each local authority. In addition, surge funding was provided to 'Strengthening Faith Institutions' and 'Near Neighbours' in order to utilise their established access into 'hard-to-reach' communities. This extended the Community Champions scheme beyond the 60 participating councils.

In-depth analysis of some areas has shown positive outcomes and demonstrates how government funding has amplified local initiatives and produced greater coordination between local authorities, the third sector and community organisations in these areas. Reported benefits include increased trust and cohesion between local authorities and community organisations, greater coordination of voluntary sector activities, increased understanding of communities' barriers to access support, and agile provision of support aligned with community needs.

Analysis of some areas has shown increased vaccination uptake This is likely to have been down to coordinated activities such as setting up vaccination hubs, circulation of translated materials in multiple languages, and online, face-to-face, and 'foot-patrol' visits to neighbourhoods.

For those local authorities that did not receive direct funding through the scheme, voluntary community sector (VCS) surge funding was provided to Strengthening Faith Institutions (SFI) and Near Neighbours (NN) in order to utilise their network into hard- to-reach communities.

The first COVID-19 disparities quarterly report also committed to a review of activity at a local authority level and to sharing the lessons learned from this. The review was undertaken ahead of, and summarised in, the second quarterly report. It focused on local authority areas identified under the Community Champions applications process, with larger proportions of at-risk communities and entrenched community transmission of COVID-19. The review found 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, fared better in supporting those communities who had been disproportionately impacted by COVID-19.

Knowledge, resources and practical solutions have been shared by local authorities through a series of webinars and via the NHS Vaccine Equalities Connect and Exchange Hub.

Lessons learned

One of the early findings of this review is that interventions directly aimed at ethnic minority groups can be stigmatising by implying that they are more vulnerable to COVID-19 or that they are more likely to transmit the virus. Work to assess workplace risk last summer concluded that singling out ethnic minorities as an at-risk group could be stigmatising and harmful (in terms of workplace progression).

A more nuanced approach is to implement measures targeted at the population as a whole that disproportionately benefit ethnic minorities, without singling them out, such as guidance on preventing household transmission which was particularly

important for families in Bangladeshi and Pakistani ethnic groups who are more likely to live in multigenerational homes. This important insight also means future vaccination programmes (including COVID-19 boosters) will start from a better place.

This better place also relies on continuing to building trust within ethnic minority groups in health services more broadly, to overcome some of the barriers seen during the vaccination programme. Our response to COVID-19 has demonstrated that one important way to do this is by harnessing the relationships between government, national organisations and local, trusted voices in the community.

Principles of community engagement

Some of the lessons learned from the Community Champions on community engagement include:

- the decentralised structure of Community Champions enabled local schemes to be responsive to new challenges and for resources and funding allocations to be re-diverted as required
- flexibility within the programme meant Community Champions were well positioned to respond, at pace, to unanticipated challenges such as concerns relating to the AstraZeneca vaccine
- this flexibility also resulted in more young adults, men and minority groups becoming Community Champions as the autonomy and trust given to Champions instilled more confidence that this was a model of shared decision-making
- the decentralised structure meant that groups experienced a positive and enabling relationship with central government
- this relationship was one of support, resulting in greater trust in national policy and procedures between local and central government

Other initiatives that have worked well, in terms of increasing vaccine confidence and promoting uptake, include:

- using community buildings, such as places of worship, pharmacies and community centres as vaccination sites, helped to build trust and overcome reluctance
- providing a choice of community facilities, such as pharmacies, walk-in centres and pop-up venues, as well as mobile solutions (such as vaccination buses and ‘vaxi taxis’) can help to overcome barriers to vaccination
- partnerships with local religious leaders and other trusted voices played a key role in helping to understand and overcome concerns about the COVID-19 vaccines
- similarly partnerships with third sector organisations (such as Churches Together England, British Red Cross and the Caribbean and African Health Network) helped to encourage people to get vaccinated

Recommendations

The government and health agencies must build on the success of the COVID-19 vaccination deployment programme in reaching ethnic minority groups and apply this to future vaccination programmes, including COVID-19 booster vaccinations, winter flu vaccination and childhood immunisation programmes.

In order to reassure ethnic minority groups and encourage uptake, the government must ensure there is clarity in the communications about the need for COVID-19 boosters and the longer-term plan for COVID-19 vaccination.

To reassure pregnant women that the COVID-19 vaccine is safe, the government should continue to deliver clear messaging through trusted voices and via social media.

Government departments, their agencies and the NHS must continue to build trust in health services within ethnic minority groups through optimising and building on the local partnerships and networks established under the vaccination programme.

The successful elements of the vaccination programme must also be applied to the work to tackle longer-standing health disparities. This must be a priority for the new Office for Health Improvement and Disparities and its partners.

To build confidence in future vaccination schemes and other health interventions, the National Institute for Health Research and the NHS Race and Health Observatory should seek to increase ethnic minority participation in clinical trials and research through methods such as promoting the INCLUDE Ethnicity Framework.

2. Data and evidence of disparities

This chapter summarises the government's approach to understanding the drivers of COVID-19 disparities. It sets out the latest data and evidence including updates on vaccine confidence and uptake, differences between the first 3 waves of the pandemic and the impact of 'long COVID'. Appendix D (https://www.gov.uk/government/publications/final-report-on-progress-to-address-covid-19-health-inequalities/appendix-d-further-data-and-evidence) provides a more in-depth analysis of this data.

It also summarises the lessons learned from this activity and recommendations for future work.

Summary of the latest data and evidence (since May 2021)

This section summarises the government's analysis of the latest data on the impact of COVID-19 on ethnic minorities.

Differences between the first, second and third waves

This final report continues to explore the differences between the first wave of the pandemic (24 January 2020 to 11 September 2020) and the second wave (12 September 2020 to 31 March 2021) using ONS analysis of COVID-19 mortality. This analysis has developed since the last report, including updates to the following data sources:

- the latest ONS analysis incorporating COVID-19 deaths during February and March 2021[footnote 2][footnote 3]
- PHE analysis of the deaths of individuals who had a laboratory-confirmed positive COVID-19 test between 31 July 2020 and 31 July 2021, which calculated mortality rates per 100,000 of the population for each broad ethnic group[footnote 4]

This updated analysis confirms that after adjusting for age, in the first wave of the pandemic, people from Black African, Black Caribbean, Bangladeshi and Pakistani ethnic backgrounds were at a greater risk of death from COVID-19 than the White British group.

Compared with the first wave, data from the second wave showed:

- a decrease in the excess risk of mortality for Black African and Caribbean groups (compared with the White British ethnic group)
- an increase in excess risk of mortality for Bangladeshi and Pakistani ethnic groups (compared with the White British ethnic group)[footnote 5][footnote 6]

Previous reports have explained how new data sources and latest estimates have helped to understand the evolution of the pandemic. Recent data from the third wave suggests another change in trend. Data on infections from October 2021 shows that the white population currently has the highest case rate. During most of the pandemic to date, the white population has generally had lower case rates than most other ethnic groups.

Excess deaths

Updates to PHE's excess deaths analysis (https://app.powerbi.com/view?r=eyJrIjoiYmUwNmFhMjYtNGZhYS00NDk2LWFlMTAtOTg0OGNhNmFiNGM0IiwidCI6ImVlNGUxNDk5LTRhMzUtNGIyZS1hZDQ3LTVmM2NmOWRlODY2NiIsImMiOjh9) have enabled further comparisons over the waves of the pandemic. Excess deaths refer to number of deaths which have occurred in addition to the deaths expected for that time of year, as determined by mortality rates from earlier years. This metric gives a broader sense of the impact of the pandemic, because it considers all deaths, not just those attributed directly to COVID-19.

Excess deaths were highest among the black ethnic group for the period between week ending 27 March 2020 to week ending 11 September 2020. In comparison, for the period between week ending 18 September 2020 to week ending 2 April 2021, excess deaths were highest in the Asian ethnic group. Excess deaths were lowest in the white ethnic group in both time periods.

COVID-19 risk factors

The government has continued to analyse ethnic minorities' risk of COVID-19 infection and mortality, aiming to understand the factors at play for groups who were at increased risk during the second wave of the pandemic.

The latest analysis shows that risk factors associated with a higher risk of COVID-19 infection include occupation, living in larger and/or multigenerational households with school-age children, and living in high population density areas with poor air quality and higher levels of deprivation.

These factors, or a combination of them, are likely to explain the disproportionate impact of COVID-19 on certain ethnic groups, such as Pakistani and Bangladeshi ethnic groups. Once infected with COVID-19, factors such as older age, male sex and having a disability or pre-existing health condition continue to be risk factors for mortality.

Long COVID

The National Institute for Health and Care Excellence (NICE) has identified 3 phases post COVID-19 infection, the latter 2 of which are commonly described as 'long COVID':

- acute COVID-19 – signs and symptoms of COVID-19 for up to 4 weeks
- ongoing symptomatic COVID-19 (signs and symptoms of COVID-19 for between 4 and 12 weeks)
- post COVID-19 syndrome – signs and symptoms of COVID-19 that continue for more than 12 weeks (https://www.nice.org.uk/guidance/NG188) and are not explained by an alternative diagnosis

The ONS publishes data on self-reported prevalence of long COVID. Between April and October 2021, the prevalence rate of long COVID (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/datasets/alldatarelatingtoprevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk) was higher among white people compared with Asian people, in line with the findings of the government's third quarterly report. This finding, of the likelihood of self-reported long COVID following confirmed infection being lowest among the Asian ethnic group, contrasts with rates of clinically diagnosed post-COVID-19 syndrome, which highest in people of South Asian and Black ethnic backgrounds (https://www.medrxiv.org/content/10.1101/2021.05.06.21256755v2). The evidence regarding the role of ethnicity in long COVID (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/4june2021#prevalence-according-to-socio-demographic-characteristics) therefore remains mixed.

Vaccinations

Vaccine uptake has increased over time among all ethnic groups. The largest increase in vaccine uptake in over-50s was among the Pakistani and Black African

ethnic groups between April and October 2021. Vaccine uptake rates (https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/) remain highest among the White British population and lowest among black ethnic groups.

Vaccine confidence has increased in every ethnic group from the period between December to January and June to July 2021 .[footnote 7][footnote 8] 96% of adults aged 16 and over in Great Britain (England, Scotland and Wales) reported a positive vaccine sentiment between 23 June and 18 July 2021, according to the latest survey data from ONS (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/coronavirusandvaccinehesitancygreatbritain/9august2021). Vaccine confidence (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/datasets/coronavirusandvaccinehesitancygreatbritain) ranged from 93% to 96% in the mixed, Asian, other and white ethnic groups, and was lowest among the black ethnic group at 79%. Recent ONS analysis (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/coronavirusandchangingattitudestowardsvaccinationengland/7to16september2021) shows that among adults who were previously vaccine hesitant, a similar percentage of black (47%) and white (42%) adults had received at least one dose of the COVID-19 vaccine by September 2021. 54% of Asian, 53% of other and 33% of mixed-ethnicity adults who were vaccine hesitant went on to receive at least one dose.

Research suggests that the risk of COVID-19 infection after a first dose of the vaccine (https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(21)00460-6/fulltext) is associated with age, deprivation and obesity (age is less associated with ethnic diversity than deprivation or obesity).

Summary of approach since June 2020

The PHE review summarised what was known at the time about COVID-19 and ethnicity. It highlighted ethnic disparities in risks and outcomes, but did not explain why they had arisen. For this reason, since June 2020, the RDU has focused on understanding the key drivers of these disparities and the relationships between different risk factors.

This section summarises how the government's understanding of the risk factors changed, and how the data evolved because of the vaccination programme.

COVID-19 risk factors

In June 2020, the RDU identified a list of likely risk factors for COVID-19 infection, hospitalisation, and mortality. The RDU then determined potential gaps in data on risk factors. The RDU focused on obtaining missing data to improve the government's understanding of the disproportionate impact of COVID-19 on certain ethnic minority groups. Prior to the pandemic, overall mortality (adjusted for age) was lower in most ethnic minority groups compared with the white group. This

mortality pattern was reversed during the pandemic (https://www.bmj.com/content/375/bmj-2021-068537) for certain ethnic groups.

The first quarterly report in October 2020 concluded that a range of socioeconomic and geographical factors, coupled with pre-existing health conditions, contributed to higher infection and mortality rates for ethnic minority groups. Part of the excess risk, however, remained unexplained for some groups. Since then, the RDU has worked to get a better understanding of these drivers and to address, where possible, the gaps in our understanding.

Over the course of this project, a substantial body of epidemiological and statistical analysis has developed across academia and government. This research has sought to improve our understanding of COVID-19's impact and to identify new risk factors for different ethnic groups to inform government and health interventions. In addition, by controlling for different factors and characteristics in analytical models, for example pre-existing health conditions or deprivation, research has identified the effect that certain risk factors have on COVID-19 disparities, with many explaining some but not all of the differences between ethnic minority groups and white people.

RDU has worked with data providers and researchers such as OpenSafely, the SAGE working group on ethnicity, VirusWatch, Policy Lab, the King's Fund, UK-REACH, the REACT survey, ONS, and NHSEI. RDU also commissioned PHE to perform survival analysis. PHE studied the outcomes for people of different ethnicities diagnosed with COVID-19 to isolate the risk of becoming infected from the risk of dying. In October 2021, RDU won an ONS Research Excellence Award for their work on COVID-19 disparities .[footnote 9][footnote 10]

Gaps in data about risk factors remain. Either the data does not exist, or is not available for individuals in sufficient detail to use in risk models. This includes, for example, transport use, the detail of some occupations and some aspects of social exclusion such as migratory status or other possibly vulnerable populations. It is likely that the residual risk of COVID-19 infection (unexplained risk) for some ethnic groups, and subsequent mortality, will be because of these factors. There is also some evidence to suggest that genetic differences may play a role for some ethnic groups. Annex E elaborates on the relationship between ethnicity and risk factors.

This table summarises how our understanding changed as the available data and analysis on the risk factors in the UK evolved.

Understanding of COVID-19 risk factors

Age and sex:

Understanding in June 2020:

Male sex and older age were known factors associated with COVID-19-related mortality and diagnosis.

Understand of first and second waves:

Age is the most significant risk factor for severe illness and mortality from COVID-19.[footnote 11]

Male sex is a risk factor for mortality.[footnote 12] Research suggests that a difference in immune system response could be an important factor in explaining this, .[footnote 13][footnote 14]

Geography and population density:

Understanding in June 2020:

Local authorities with the highest diagnoses and death rates were mostly urban.

COVID-19 death rates in London were more than 3 times higher than in the region with the lowest rates (the South West).

Understand of first and second waves:

Living in areas of high population density, and the local authority district where someone resides, explained a large part of the disparities in COVID-19 mortality ethnic minorities experienced.[footnote 15]

Areas with high population density, such as major urban conurbations, had the highest COVID-19 death rates.[footnote 16]

Deprivation:

Understanding in June 2020:

COVID-19 survival rates were lower in the most deprived areas, particularly among those of working age where the risk of death was almost double than in the least deprived areas .[footnote 17][footnote 18]

Understand of first and second waves:

Higher deprivation was a risk factor for COVID-19 infection and mortality .[footnote 19][footnote 20] The variance in mortality rate by deprivation was greater during ‘peaks’ of infections.

Between 1 January and 31 December 2020, among those living in the most deprived areas, age-adjusted mortality rates for the Pakistani, Bangladeshi, Indian, Black African, Black Caribbean and Other ethnic groups were significantly higher than for the White British ethnic group.[footnote 21]

Comorbidities (including obesity, diabetes, hypertension, and others):

Understanding in June 2020:

Our understanding on the role of comorbidities was limited. Among deaths with COVID-19 mentioned on the death certificate, a higher percentage mentioned diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia than all cause death certificates did.

Understand of first and second waves:

Among people with pre-existing health conditions such as diabetes, hypertension, chronic kidney conditions, cardiovascular conditions and respiratory conditions the age-standardised mortality rates were higher for all ethnic minority groups compared with the overall death rate for all people with the same conditions . [footnote 22][footnote 23] This analysis only controls for age so it is likely the mortality rates would be lower if also adjusted by other factors.

In quarter 2 of 2020[footnote 24] (during the first wave of infection and deaths in the UK) COVID-19 age and sex standardised mortality ratios increased among people living with mental health disorders in London, when compared with London's population (3.8 for people with dementia, 3.3 for people with schizophrenia-spectrum disorders, 4.8 for eating disorders, 5.0 for pervasive developmental disorders, 9.2 for people with learning disabilities and 4.6 for personality disorders). By the last quarter of 2020[footnote 25] mortality ratios were no longer elevated across most psychiatric diagnoses except for dementia, where an increased risk of COVID-19 mortality was still evident (1.5).[footnote 26]

Sickle cell disease and trait were observed to be associated with increased risks of severe COVID-19. Sickle cell disease was associated with a 4.1-fold increased risk of COVID-19 hospitalisation, and a 2.6-fold increased risk of dying due to COVID-19, adjusting for age, ethnicity and sex[footnote 27]. Sickle cell disease is particularly common in people with an African or Caribbean family background .[footnote 28] [footnote 29]

Lifestyle factors:

Understanding in June 2020:

Our understanding was too limited to draw firm conclusions.

Understand of first and second waves:

A government-funded research project, led by Professor Thomas Yates, found new insights about obesity and walking pace (a proxy measure of physical fitness) that suggest both factors are independently associated with the risk of severe COVID-19 infection and COVID-19 mortality.[footnote 30]

Former and current smokers had higher rates of hospitalisation and death than people who had never smoked[footnote 31][footnote 32] with current smokers experiencing risk of mortality almost 5 times higher than people who had never smoked. There was no evidence to suggest that current smoking increased risk of infection compared with those who had never smoked.[footnote 33]

Due to a lack of available data, our understanding remains limited on the impact factors such as public transport use and international travel have on COVID-19 infections.

Occupation:

Understanding in June 2020:

Our understanding was too limited to draw firm conclusions.

Understand of first and second waves:

Healthcare workers, indoor trade or transport and mobile machine workers had at least twice the total odds of seropositivity (presence of antibodies) compared with people employed in other professional occupations.[footnote 34]

In April 2021, analysis of UK BioBank data and PHE infections data from March to August 2020 found again that there were significant differences in the odds of getting severe COVID-19 for healthcare workers compared with people who weren't.[footnote 35]

ONS analysed which occupations have the highest potential exposure to COVID-19 and found that those working within the security industry have a higher risk of infection.[footnote 36] A significant proportion of these workers are from an ethnic minority background (for example, 11% of male security officers and related occupations are from a Bangladeshi or Pakistani ethnic background).

Household size, including multi-generational households:

Understanding in June 2020:

Our understanding was too limited to draw firm conclusions.

Understand of first and second waves:

ONS data shows that over-70s in the Bangladeshi and Pakistani ethnic groups are much more likely to have contact with other adults and school age children within the same household (56.4% and 34.7% respectively, compared with 1.5% of white adults).[footnote 37]

There were larger increases in the R rate (reproduction rate) when schools were open and so over-70s in the Pakistani and Bangladeshi ethnic groups may be disproportionately impacted by this increased source of transmission.

Analysis of OpenSAFELY data found that in the first wave, there was no association between living with children and COVID-19 outcomes in all people aged over 65, but in the second wave there was an associated increased risk of infection, ICU admission and COVID-19 mortality for adults aged over 65 living with children,[footnote 38] possibly related to schools being opened in the second wave (until end December 2020 and then again in March 2021).

During the second wave of the pandemic, analysis of OpenSAFELY data also found living with younger generations to be associated with an increased risk of infection among people aged 67 years and over. OpenSAFELY data indicates that a larger proportion of South Asian people aged 67 years and older lived in households with 1 or more other generations than white people aged 67 years and older (69% compared with 31%).[footnote 39]

Data from the ONS COVID-19 Infection Survey[footnote 40] shows that as household size increased, COVID-19 positivity increased. This association was stronger for ethnic minority people (excluding white minorities) than for white people.

The data also shows that among ethnic minority people (excluding white minorities), living in a multigenerational household was associated with a higher likelihood of testing positive for COVID-19 compared with not living in a multigenerational household. However, this difference was not statistically significant.

PHE analysis of cumulative COVID-19 case rates from March 2020 to October 2021[footnote 41] shows that as age increases from 0 to 24 years to 65 years and over, the risk of COVID-19 infection increases for most ethnic minority groups relative to the white ethnic group.

Among people aged 0 to 24, those from the Pakistani and Bangladeshi ethnic groups were 0.9 and 0.8 times as likely to become infected with COVID-19 as white people. Among people aged 65 and over, those from the Pakistani and Bangladeshi ethnic groups were 3.1 and 2.5 times as likely to become infected as white people.

Vitamin D:

Understanding in June 2020:

We did not know whether lower Vitamin D levels might explain higher COVID-19 infection rates.

Understand of first and second waves:

Studies did not find any relationship between vitamin D and COVID-19, suggesting that a lack of vitamin D among ethnic minorities did not explain the disparities in infection and mortality rates.

Air pollution:

Understanding in June 2020:

Our understanding of the impact of air pollution was limited.

Understand of first and second waves:

Between March and July 2020, COVID-19 mortality rates were 1.7 times higher in neighbourhoods with worse overall air quality than areas with better air quality, after accounting for socio-demographic factors. Poor air quality was also strongly associated with the ethnic diversity of an area – this analysis shows that on average, neighbourhoods with less diverse ethnic minority populations had worse air quality.[footnote 42]

Care home residents:

Understanding in June 2020:

Our understanding of ethnic disparities in care home deaths was limited.

Understand of first and second waves:

Early analysis of deaths concentrated on private households. Subsequently, data on deaths in care homes became available. Analysis of data including care home residents shows that, after adjusting for residence type, the risk of dying from COVID-19 for all ethnic minority groups increased or remained similar (compared with the risk when not controlling for residence type). This is contrary to what we expect to see when adding in a control to a risk model. Because the population of care homes is predominantly White British, when we control for the risk associated with living in a care home, the estimated risk of dying for most ethnic minority groups is higher than when not controlling for it.[footnote 43]

Behavioural factors:

Understanding in June 2020:

Our understanding of the role of behavioural factors (such as “following the COVID-19 rules”) was limited

Understand of first and second waves:

Analysis of the Opinions and Lifestyle survey (OPN) shows that between 21 July and 15 August 2021, higher proportions of white people socialised indoors and outdoors with people who were not in their household than black or Asian people . [footnote 44][footnote 45] However, this analysis refers to a short period of time and sample sizes do not allow for analysis of detailed ethnic groups.

Our understanding remains limited on the uptake of behavioural factors such as “following the COVID-19 rules by ethnicity” and whether any of the barriers or reasons for not following rules differ by ethnicity, RDU has recommended that ONS improve the ethnicity representation in their surveys.

Disability:[footnote 46]

Understanding in June 2020:

Our understanding of COVID-19 and disability was limited

Understand of first and second waves:

Disabled people in England have had an increased risk of mortality involving COVID-19 compared with non-disabled people.[footnote 47][footnote 48]

There are some explanations available for this: disabled people are on average older, more likely to become infected as a result of contact in care homes or with carers ,[footnote 49][footnote 50] experience other known risk factors such as diabetes, [footnote 51] live in socioeconomically disadvantaged conditions or areas[footnote 52] and experience barriers in accessing care.[footnote 53][footnote 54]

Including other risks such as pre-existing health conditions in the analysis did reduce the excess mortality rates for disabled people, but some risk remains unexplained.

Between 21 March and 5 June 2021, data suggests that the proportions of COVID-19 deaths among people with learning disabilities for Asian (6.5%) and black (3.3%) people with learning disabilities were around 3 times higher than the proportions of average deaths in 2018 and 2019 (2.1% and 1.3% respectively) . [footnote 55][footnote 56]

Ethnicity:

Previous quarterly reports stated that ethnicity is not considered a risk factor in and of itself. We have explored this further and considered whether ethnicity should be viewed as a risk factor in Appendix E (https://www.gov.uk/government/publications/final-report-on-progress-to-address-covid-19-health-inequalities/appendix-e-is-ethnicity-a-risk-factor-for-infection-or-mortality-from-covid-19).

Vaccination

The UK's COVID-19 vaccination rollout programme began in December 2020, with older adults, care home residents and frontline health and social care workers prioritised for vaccination. From June 2021, all adults aged 18 and over were eligible for a COVID-19 vaccination in England. This was extended to those aged 16 and over in August.

Early data from the UK Household Longitudinal study, the ONS, and REACT-2 showed lower levels of vaccine uptake among some ethnic minority groups following the launch of the COVID-19 vaccination programme. Similarly, previous national vaccination programmes have seen lower uptake in Black African and Black Caribbean groups. The government put in place a programme of work to understand and address this.

RDU's subsequent reports provided the latest picture of vaccine sentiment, including, reasons for hesitancy and vaccine uptake statistics. For example, RDU showed the high proportions of people who had been hesitant but later accepted a vaccine.

Vaccine confidence has increased in every ethnic group from the period between December to January and June to July 2021 .[footnote 57][footnote 58] Although the data shows black ethnic groups consistently have greater vaccine hesitancy than other broad ethnic groups, the gap in confidence between black people and people from other broad ethnic groups has narrowed since December.

Figure 1: Percentage of people who said they were likely to accept or had already accepted the COVID-19 vaccine, by ethnicity and research period

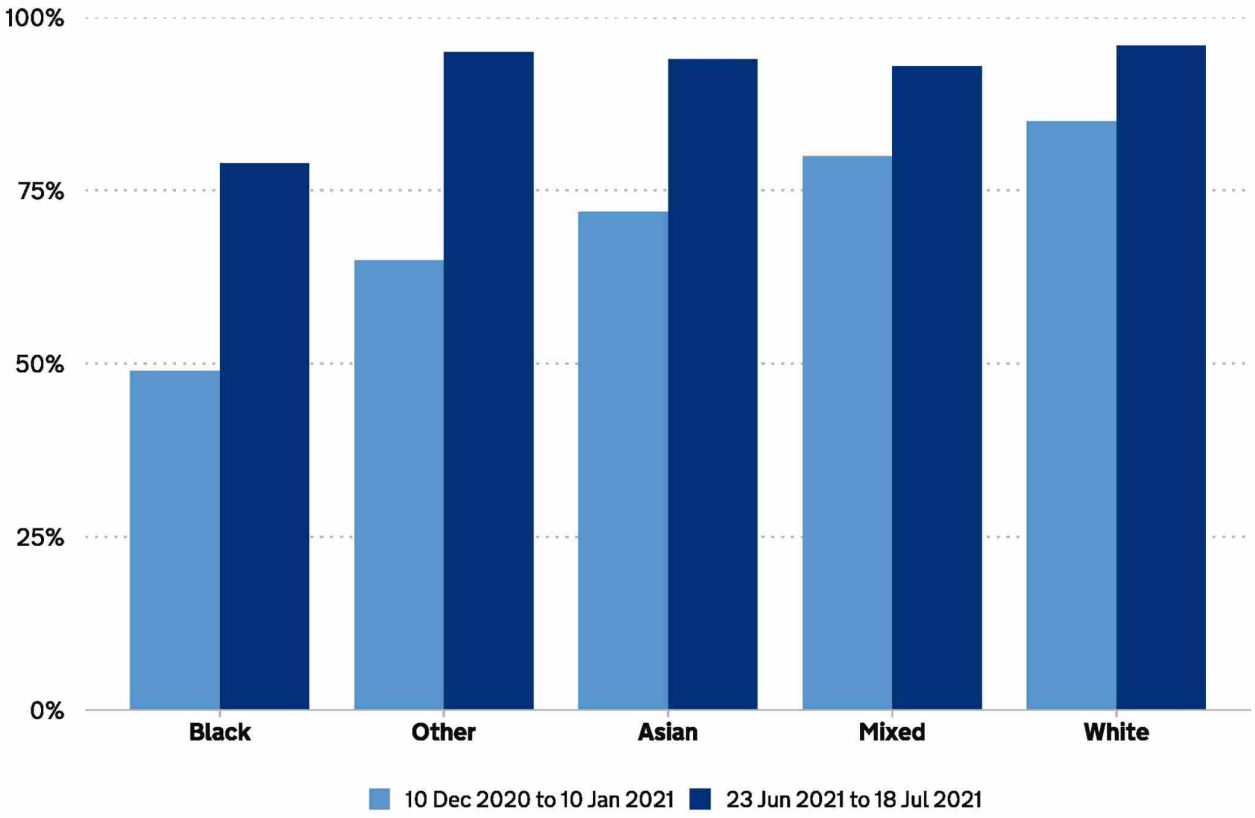


Figure 1: see this data in a table (https://www.gov.uk/government/publications/final-report-on-progress-to-address-covid-19-health-inequalities/data-tables-for-figures-1-to-8b#figure-1).

> Source: Office for National Statistics

Recent ONS analysis (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/coronavirusandchangingattitudestowardsvaccinationengland/7to16september2021) shows that among adults who were previously vaccine hesitant, a similar percentage of black (47%) and white (42%) adults had received at least one dose of the COVID-19 vaccine by September 2021. 54% of Asian, 53% of other and 33% of mixed-ethnicity adults who were vaccine hesitant went on to receive at least one dose.

In the second quarterly report, OpenSAFELY analysis showed lower vaccine rates for some ethnic minority groups. Among the over 80s population, 82.8% of White British people had received at least one dose of a vaccine by 4 February 2021, compared with uptake rates of between 45.1% and 55.2% in Black African, Mixed White and Black African, Black Other, Bangladeshi and Pakistani ethnic groups.

Similarly, the third quarterly report showed that among over 80s, ethnic minority groups had lower rates of vaccine uptake as at 14 April 2021. However, between 4 February and 14 April, uptake rates among over 80s in all ethnic groups increased. Early evidence of vaccine uptake among over 50s from NHS England was broadly

consistent with the analysis of over 80s. At 7 April 2021, vaccine uptake rates (https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/) ranged from 61.6% in Black Caribbean over-50s to 93.8% in White British over-50s.

Since the third quarterly report, NHS England has continued to publish monthly vaccine uptake data (https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/). Between 7 April and 30 October 2021, the percentage of over-50s who had received at least one COVID-19 vaccine increased in all ethnic groups. The largest percentage point increases were in the Pakistani ethnic group (from 73.1% to 83.7%, up by 10.6 percentage points) and Black African ethnic group (from 64.9% to 75.1%, up by 10.2 percentage points).

Similarly, between 31 May and 31 October 2021, the percentage of over-50s who had received both doses of the COVID-19 vaccine increased in all ethnic groups. The largest percentage point increases were in the Pakistani ethnic group (from 54.2% to 78.8%, up by 24.6 percentage points) and Bangladeshi ethnic group (from 63.7% to 87.0%, up by 23.3 percentage points).

Lessons learned

The lessons learned over the course of this project include the following.

The importance of understanding rapidly evolving data – and not jumping to conclusions about causes and effects – in order to inform policy decisions. For example, understanding the data available on vaccine sentiment and vaccine uptake has enabled vaccine messaging and measures to be tailored in order to mitigate the impact of the second wave of the pandemic on people in the Pakistani and Bangladeshi ethnic groups

The importance of data linkage, and to develop quick processes to allow others to access linked data away from the secure office facilities

The need to develop a culture across the NHS of sharing information with government departments, and being more open to suggestions about publishing data that would help people to understand the spread of the virus and the roll out of the vaccine programme

Different ethnic groups have experienced different outcomes during the pandemic. 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

Recommendations

The government should continue to monitor the impacts of COVID-19 by ethnicity as the virus evolves. This may include:

- measuring survival analysis over time

- monitoring vaccine uptake among 16 to 18 year olds and 12 to 15 year olds and uptake of the booster vaccine

The findings and recommendations from this series of reports should be applied to the government's response to future COVID-19 variants.

3. Data quality

This chapter explains the government's approach to understanding the most important factors that impact on ethnicity health data quality. Focussing primarily on how the ethnicity of patients is requested by health professionals and recorded in their health records, it outlines next steps to improve ethnicity data in different data collections and analyses. It also summarises progress on projects such as recording ethnicity as part of death certification and making ethnicity categories more consistent ("harmonisation") across different datasets.

Approach since June 2020

RDU has assessed the quality of ethnicity coding in health datasets, and the quality of analysis used to measure the impact of COVID-19 on different ethnic groups. These datasets have included NHS datasets, Hospital Episode Statistics, and survey data such as the ONS COVID-19 Infection Survey (CIS) and Opinions and Lifestyle Survey (OPN). The reports have given recommendations to improve the quality of health ethnicity data collection, analysis and reporting.

The recommendations are leading to higher quality, more consistent ethnicity health data, closing gaps in our evidence base, supporting users to find, understand and interpret data better and ultimately better informed policy interventions. Longer-term, this will help the government boost wider health outcomes, not just those from COVID-19.

Some of these recommendations have work already in progress.

Collecting ethnicity as part of death certification process

Work is progressing to make ethnicity a mandatory question for healthcare professionals to ask patients. That ethnicity data will then be transferred to a new, digitised Medical Certificate Cause of Death which can then be used in ONS' mortality statistics. This was a recommendation from the first quarterly report now led by DHSC. As part of this process, it is important to confirm that the ethnicity of the person who has died will come from patient records.

Harmonising datasets across government and the agencies

Following a recommendation from the second quarterly report (https://www.gov.uk/government/publications/second-quarterly-report-on-progress-to-address-covid-19-health-inequalities/second-quarterly-report-on-progress-to-address-covid-19-health-inequalities), work is underway to ensure departments and agencies

commit to using the Government Statistical Service (GSS) harmonised ethnicity standard (https://gss.civilservice.gov.uk/policy-store/ethnicity-harmonised-standard/) in their data collections, and publish their commitment to doing so, including timescales. Harmonised standards set out how to collect and report statistics to ensure comparability across different data collections.

The RDU is currently working with departmental representatives from the Harmonisation Champions Network to further progress this, pending a new harmonised ethnicity standard being produced by the GSS, led by ONS.

Reporting on data analysis methods and data quality

In their report on ethnicity data in health records (https://www.nuffieldtrust.org.uk/research/ethnicity-coding-in-english-health-service-datasets), The Nuffield Trust recommended that methods to address data quality issues in the analysis of ethnic differences must be clearly reported. Describing aspects of these methods such as their strengths and limitations (and publishing them in the interests of transparency) will help users understand and interpret the data correctly and ensure that appropriate conclusions are drawn from it.

More generally, all analyses of healthcare activity should routinely include ethnicity, and should include an assessment of the overall quality. This is a responsibility for all departments and agencies reporting on health data.

RDU believes these are crucial steps to improve data quality. Progress in this area has been made in the analysis and descriptive information for the linked Census and Hospital records produced by ONS, for example, and Public Health England's new method of determining ethnicity using Hospital Episode Statistics (HES) (https://www.gov.uk/government/publications/third-quarterly-report-on-progress-to-address-covid-19-health-inequalities/appendix-b-quarterly-progress-report-on-improvements-to-health-datasets).

Increasing representation of ethnic minority groups in surveys

Progress has been made in increasing the number of people in surveys (the "survey sample size") used to measure COVID-19 outcomes, for example in the Coronavirus Infection Survey (CIS) that was described in the second report. Further increases in sample sizes will help produce more robust statistics for detailed ethnic groups, and help to move away from (binary) white and other than white breakdowns, such as those presented in the recent CIS reinfection statistics. The proportion of people from ethnic minority groups is often lower in surveys than in the general population. This means that people using the data might have less confidence that the results reflect the overall population for those groups. Also, if the survey sample size is not large enough, it can be more difficult to decide whether observed differences between ethnic groups or time periods are reliable and reflect real differences in the whole population ("statistically significant differences"), or whether they are due to natural variations in the data that has been collected.

The first quarterly report described a project by ONS to improve how it engages with under-represented groups. As part of this project, ONS is also going to consider its approach to how surveys are designed to investigate whether they could be more representative of minority groups.

As well as increasing ethnic minority representation in (statistical) surveys, greater ethnic minority participation in clinical trials will help ensure that new treatments and vaccines being trialled are effective and safe for everybody. This is recommended in Chapter 1 and discussed later in this section.

Increasing and improving the use of long COVID codes

There is significant work happening between NHS-X and GP suppliers to improve the capture of data about long COVID. The GP Enhanced Service for long COVID has supported training and education, and activity around reducing inequalities (https://www.england.nhs.uk/wp-content/uploads/2021/06/C1302-Update-to-GP-contract-arrangements-for-2021-22-.pdf). It has also supported GPs in recording long COVID codes in databases when the condition is diagnosed.

Developing the ONS database for health and care statistics in England

There are many data sources that are being used to analyse the impact of COVID-19, rates of vaccination uptake and vaccine sentiment, and long COVID. In order to bring these datasets together for the benefit of users, the ONS has been developing a website tool (https://gss.civilservice.gov.uk/dashboard/tools/health-and-care-statistics/database.html) that compiles official statistics relating to health and care in England into one location.

This is good progress in helping users better understand the range of health datasets available. The tool has enormous potential to lead to higher quality research and analysis.

Latest work on data quality improvements

The third quarterly report recommended that RDU engage with the Office for Statistics Regulation (OSR) and others about priorities for improving the quality of ethnicity data on health records.

In August 2021, RDU and OSR held a joint roundtable discussion with owners, providers and users of English healthcare data. The outcome of this discussion is summarised in this chapter, with further detail included in Appendix F (https://www.gov.uk/government/publications/final-report-on-progress-to-address-covid-19-health-inequalities/appendix-f-prioritisation-and-progress-of-data-quality-recommendations). We set out in this section the next steps that should be taken forward as priorities. Collaboration between several departments, agencies and arms-length bodies will be required to progress many of the priorities. To do this, the main organisations associated with improvements to health ethnicity data should create a Programme Board to take these next steps forward.

There will be significant benefits to implementing this data quality improvement programme. The government, public sector bodies, and academic and research organisations will have a better understanding of the health impacts of COVID-19 and other aspects of the pandemic for different ethnic groups. The programme will mean different data collections use consistent ways of requesting and recording ethnicity from patients. The work has the potential to increase the amount of analysis and research available, fill gaps in the evidence base and increase trust in the data. People interested in health data will be able to access it more easily, understand it better, and draw more appropriate conclusions from it.

Also, many of the data improvements will also have wider benefits for understanding other health outcomes in the future.

The data quality improvements that were discussed at the roundtable are listed here, with the lead departments shown.

Higher priority improvements

Improving ethnicity coding (DHSC to outline responsibility to relevant leads). This should consider recommendations designed to improve the coding of ethnicity in health datasets, which could include:

- developing an ethnicity information standard for the NHS
- new guidance that specifies how ethnicity data should be collected and recorded, and the ethnicity classifications used
- ensuring coherence of the standard with any new Government Statistical Service harmonised ethnicity standard
- an ongoing review of implementation
- data linkage to (for example) GP records, hospital records, or NHS Digital's central records
- reviewing data access and sharing, and dissemination of microdata for research, and aggregated statistical data, led by relevant health departments

Lower priority improvements

Reporting unknown ethnicity led by health statistics departments – the Data Quality Maturity Index should include the proportion of records coded as not known, not stated, an 'other' group and 'any other ethnic group'.There should also be wider reporting of levels of unknown ethnicity in all analyses.

Increasing representation of ethnic minority groups in trials, led by the National Institute for Health Research and the NHS Race and Health Observatory.

Continuing to hold statistics producers to account to ensure the quality of ethnicity data and statistics meet users' needs, led by the Office for Statistics Regulation.

Investigating feasibility for better guidance and signposting of health statistics, led by RDU, ONS and other health departments.

Improvements in progress

Collecting ethnicity as part of the death certification process, led by DHSC.

Statements on harmonisation of (health and non-health) datasets to any new Government Statistical Service ethnicity harmonised standards, led by RDU and ONS.

Increasing and improving descriptions of analysis methods used to address data quality issues, led by health statistics departments.

Increasing and improving reporting on the quality of coding of ethnicity, led by health statistics departments.

Increasing sample sizes and representation of ethnic minority groups in surveys, led by health statistics departments and ONS.

Improving use of COVID-19 codes during clinical diagnosis of the long COVID condition, led by NHSX, supported by GP Enhanced Service.

Continuing to develop the database for health and care statistics in England, led by ONS.

Improving ethnicity coding in health datasets

It was agreed between departments and agencies at the roundtable that improving the recording and coding of the ethnicity of patients in health records is the highest priority data quality action. Currently, issues with ethnicity coding disproportionately affect ethnic minority patients' records.

Analyses to further understand COVID-19 and other health disparities between ethnic groups will significantly improve if the coding of ethnicity for patients improves. This will also help identify ethnicity on death certificates, and an emphasis on improving coding was noted in RDU's previous reports and the Nuffield Trust report on ethnicity data in health records (https://www.nuffieldtrust.org.uk/research/ethnicity-coding-in-english-health-service-datasets).

DHSC is thus considering a number of interdependent recommendations proposed by NHS England to improve coding of ethnicity on receipt of which responsibility will be outlined to relevant leads by DHSC in due course.

This long-term data quality programme is a significant, new next step in improving ethnicity data in health datasets. The programme would include developing an ethnicity 'information standard' for the NHS and a plan for implementing the new standard. An information standard is a document explaining the types of data collected, how they should be collected and processed, the technical (IT) standards that should be used to collect and store the data, and how the data will be managed.

The programme of work will also include:

- new, up-to-date guidance on ethnicity coding for health service providers and GPs covering all NHS-funded care and covering how patients are asked for their ethnicity and how it is recorded in their health records
- which categories are used when people are asked for their ethnicity – these might be derived from recommendations in the Unified Information Standard for Protected Characteristics (UISPC) project, described in the first quarterly report

Subsequently, and to ensure that the information standard is implemented correctly and consistently, and on a continuous basis:

- integrated care system leaders should ensure that the updated guidance on ethnicity coding is used
- boards and leaders of NHS providers and commissioners, and GP practices, should take ownership of the quality of ethnicity coding for their patients, ensure that the updated guidance is used and routinely monitor coding quality

The RDU has previously noted the importance of harmonisation of ethnicity classifications to increase consistency with other health and non-health datasets. ONS is also in the process of planning what work must go into developing a new harmonised standard for ethnicity, which will involve discussions across the GSS and with other users. There must be dialogue between DHSC, NHS England and the ONS Harmonisation team to ensure that any new NHS and GSS classifications can be reconciled.

Data linkage is also a powerful tool when used to better understand the quality of ethnicity recording in different datasets and to improve the robustness of data. For example, NHSEI recently stopped the collection of ethnicity data when people receive their coronavirus vaccine. This is now derived by linking to, and using ethnicity from, GP records.

The quarterly reports have noted issues with ethnicity coding in GP records, for example, the inconsistent use of codes and a lack of harmonisation, so there is merit in NHS England considering additional data sources to supplement GP records when ethnicity data is missing in the latter.

The ONS has also demonstrated that it is possible to use an anonymised process to link hospital and GP records to the 2011 Census ethnicity data for England in the ONS's internal secure analysis environment.

A similar approach could be taken using the 2021 Census records when they become available. As a next step, ONS should collaborate with the other relevant health departments and consider how linking health and Census data could be improved and extended to facilitate more reliable, timely and detailed estimates of ethnic health disparities on a regular basis. Any work of this kind should respect the legal and ethical constraints around Census and patient data, while seeking every opportunity to achieve the overarching objective of improved data quality.

Reviewing data dissemination

The RDU recommends 2 new next steps on data dissemination for this report:

First, that relevant departments should review and action existing requests for health data from RDU and others for the purposes of analyses of the pandemic.

As part of this next step, some data should be published that would add significant value to the evidence base. These include, for example:

- information on the number of COVID-19 deaths of healthcare workers, by ethnicity
- the number of hospital-acquired COVID-19 infections and deaths
- uptake and use of the NHS COVID-19 app by different ethnic groups from the PIRU Tracker Survey

Second, the RDU recommends an independent strategic review of the dissemination of healthcare data and the publication of statistics and analysis. This review should consider 2 aspects in particular:

- changes to processes that might facilitate and streamline data sharing and access in the future, while respecting legal and ethical constraints of the data
- that all useful and relevant microdata and aggregate statistics pertaining to the pandemic should be released in the future

The review must consider the importance of leadership in developing a culture in which data are shared and statistics published unless there are compelling reasons not to do so. The basis of the review should be underpinned by a complete commitment to transparency in all instances unless patient confidentiality is threatened.

There are significant benefits to the implementation of these 2 recommendations around data access and sharing including:

- more and better quality research being possible in the future and
- increased transparency and trustworthiness in outputs

RDU recommends that relevant departments act on these 2 next steps.

Reporting unknown ethnicity

The proportion of records that have a valid ethnic group code – and are not unknown or missing, for example – can vary between different areas and providers. This is shown in management information for Clinical Commissioning Groups (CCGs) (https://digital.nhs.uk/data-and-information/publications/statistical/mi-ethnic-category-coverage/current) published by NHS Digital. The coverage of ethnicity data for providers is also part of the NHS Data Quality Maturity Index (DQMI) (https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/data-quality), a monthly publication about data quality in the NHS.

The Nuffield Trust report recommended that the DQMI should include the proportion of records coded as not known, not stated, an ‘other’ group and ‘any other ethnic group’. RDU believes this is a good approach to better understand the

data quality of NHS datasets and for monitoring how data quality changes over time. This work should be progressed by NHS Digital.

More generally, RDU supports including information about levels of unknown ethnicity in all other datasets and analyses (for example, of vaccine uptake) and an assessment of how this might affect the interpretation for different ethnic groups. This allows users to gain a better understanding of data quality across different datasets and aids interpretation of data and analysis, including over time.

Increasing representation of ethnic minority groups in clinical trials

Research by the National Institute for Health Research (NIHR) (https://www.nihr.ac.uk/news/nihr-research-ethnicity-data-provides-insight-on-participation-in-covid-19-studies/26460) shows that ethnic minority groups are under-represented in clinical trials. The reasons for this are not clear, but a University of London research paper noted that the underrepresentation of ethnic minority groups in COVID-19 trials might be due "to a combination of personal and structural factors". Social factors may include social deprivation limiting access to health services, and in turn, participation in health research. Participant-related factors (https://www.sciencedirect.com/science/article/pii/S2589537021001838#bib0004) may include language and cultural barriers, and mistrust towards researchers and research institutions.

It is essential that samples are (at least) representative of ethnic minority populations, so that new treatments and vaccines being trialled are effective and safe for everybody. There is also a strong argument for targeted over-representativeness to ensure significant differences between groups can be identified.

As recommended in Chapter 1, the National Institute for Health Research and the NHS Race and Health Observatory should seek to increase ethnic minority participation in clinical trials and research through methods such as the INCLUDE Ethnicity Framework.

Quality of health ethnicity data and statistics

The Office for Statistics Regulation will continue to hold statistics producers to account to ensure the quality of ethnicity data and statistics meet users' needs. They encourage DHSC to keep users informed on the progress with the priority next steps.

Developing better guidance for health statistics

There might be benefits in improving guidance and signposting of health statistics to help a layperson navigate their way through the health data landscape (with a wider focus than health data about ethnicity). As a new next step, RDU will discuss options for this with the English Health Statistics Steering Group.

Lessons learned

The key findings from this strand of work are as follows.

In different datasets there are issues with ethnicity coding, different levels of representation of ethnic minorities, differences in the ethnicity classifications used and relatively high levels of missing ethnicity. These factors (and others) can have a significant impact on the overall quality of the data and analyses based on that data. The impact will vary depending on the analysis that is being undertaken.

The recording of ethnicity data, the use of consistent ethnicity categories across datasets, and linking datasets to improve data quality or to facilitate further analysis are both crucial to improving ethnicity data quality to understand the impact of the virus on different ethnic groups.

Some datasets have supported more complex analyses by allowing analysts to control for other factors such as age, deprivation, economic status, housing tenure and pre-existing health conditions.

The application of these analytical techniques on existing data, along with data linking by ONS and others has improved data quality and enabled innovative new analysis. For example, ONS has linked Census data on the ethnicity of individuals to NHS health records and death registrations to produce estimates of deaths from COVID-19 for different ethnic groups.

Recommendations

DHSC should continue to consider the set of interdependent UISPC recommendations proposed by NHS England to improve the quality of ethnicity data coding, and should outline responsibilities to relevant leads.

ONS should collaborate with the other relevant health departments and consider how linking health and Census data could be improved and extended to facilitate more reliable, timely and detailed estimates of ethnic health disparities on a regular basis.

Relevant health departments and agencies should review and action existing requests for health data, and undertake an independent strategic review of the dissemination of healthcare data and the publication of statistics and analysis.

NHS Digital should include the proportion of records coded as not known, not stated, an ‘other’ group and ‘any other ethnic group’ in the NHS Data Quality Maturity Index.

RDU will discuss ways to improve guidance and signposting for health statistics with the English Health Statistics Steering Group.

A Programme Board, involving representatives of the user community and other relevant stakeholders (including the devolved administrations), should oversee implementation of these priorities and should publish regular reports of progress.

4. Stakeholder engagement and insights

This chapter summarises engagement activity since the last report. It focuses on the vaccination roll out, the government's overall approach since the start of this review, and wider work to address maternal health disparities.

Insights gained from RDU-commissioned research into ethnic minorities' personal experiences of the pandemic are summarised here. This includes the recent Perceptions of the Pandemic project, which gathered views across a wide range of government interventions.

Latest engagement since May 2021

The main focus of the Minister for Equalities' engagement work since the start of the year has been on promoting vaccine uptake among ethnic minorities. Most recently, she has:

- hosted a roundtable with High Commissioners from countries with large diaspora networks in the UK, in order to promote vaccine uptake among those groups with lower rates of vaccination
- held meetings with the NHS Director of Health Inequalities, the Chair of the British Medical Association and the newly-appointed interim deputy Chief Medical Officer for England
- given the keynote speech at an event to discuss progress implementing the recommendations from the Turning the Tide report (https://www.eastlondonhcp.nhs.uk/downloads/ourplans/Maternity/Turning%20the%20Tide%20Maternity%20Report%20-%202020.pdf), which assessed the disproportionate impact COVID-19 was having on ethnic minority staff and patients in NHS maternity services

The former Minister for COVID-19 Vaccine Deployment also continued a programme of visits and engagement to promote vaccine uptake including:

- London Vaccines Summit with The Greater London Authority (GLA), Mayoral Office and NHS London focused on the challenges of the vaccine roll out, planned activity and innovative approaches from across the capital to improve confidence and uptake
- a roundtable event with NHS Youth Forum to discuss how to encourage vaccine uptake amongst younger cohorts (attendees from different ethnic minority, disability and LGBT groups)
- speaking at the Bangladeshi Caterers event to thank catering restaurants for their support to drive vaccine uptake in the Bangladeshi ethnic group

The former Minister for Faith and Communities had a number of engagements including:

- meeting the National Zakat Foundation to discuss the role of faith groups during the pandemic

- a meeting of the Places of Worship Taskforce to consider the updated government COVID-19 guidance and how to ensure places of worship remained safe
- a roundtable with leaders from the Christian, Jewish, Muslim, Hindu and Sikh faiths on the government's guidance for places of worship, and what faith communities can do to encourage vaccine take up and compliance with test and trace

Summary of approach to engagement since June 2020

Government ministers have led a programme of engagement since the PHE review concluded in June 2020. In the early stages, the Minister for Equalities shared the emerging findings from the data on COVID-19 health disparities across government, and encouraged departments to develop interventions to address these. The Minister also wrote to all stakeholders who contributed to PHE's Beyond the data report (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf), to see which of them wished to be involved in future engagement activity.

Early engagement also focused on improving public health communications. Initiatives included the Minister for Equalities prompting an ethnic minority engagement communications plan in time for the Eid Al Adha holiday at the end of July 2020 and the then Ministry for Housing, Communities and Local Government (MHCLG) appointing a 'Places of Worship Taskforce' of senior faith leaders to advise on guidance to re-open places of worship safely.

Engagement activity since the autumn has focused on promoting vaccine uptake among ethnic minorities. The Minister for Equalities worked alongside the then ministerial colleagues to tackle misinformation and encourage uptake through a targeted series of roundtable discussions, webinars, conference speeches, and high-profile visits by senior Cabinet Ministers and meetings with specialist bodies, such as the National Pharmacy Association. Ministers and clinicians have met over 250 multicultural organisations and faith leaders to brief them about vaccine efficacy and safety, covering Muslim, Jewish, Hindu and Sikhs, Evangelical and black-majority churches and Somali, Bangladeshi and Nigerian organisations.

The insights from this engagement have been fed into the vaccination roll out programme.

Developing qualitative insights

Ethnic minority experiences of the pandemic

As summarised in the second quarterly report, RDU commissioned the Policy Lab 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 provided deep insight into the impact of COVID-19 on participants' everyday life in the autumn of 2020.

The stakeholders involved in the PHE Beyond the Data report were from organisations (national, regional and local) representing various sectors and disciplines that work with and for people from ethnic minority groups. The RDU wanted to know more about how individuals responded and adapted to the pandemic socially, financially, in their homes and workplaces. This research of ethnic minority individuals was undertaken to provide a nuanced understanding of the motivations, interpretation and experience of the differential impact of COVID-19 on select people in the population.

A full summary of the project is included at Appendix C (https://www.gov.uk/government/publications/final-report-on-progress-to-address-covid-19-health-inequalities/appendix-c-ethnic-minority-experiences-of-covid-19). Important findings, particularly in terms of shaping communications, included:

- trust in the sources of information was crucial for participants to accept public health messages
- some participants felt stigmatised as transmitters of COVID-19, due to photographs and articles in the media implying ethnic minority groups were to blame
- the term BAME (black, Asian and minority ethnic) was unhelpful in understanding disparities between ethnic minority groups

Perceptions of the Pandemic research

The Perceptions of the Pandemic project gathered ethnic minority members of the public's views on the pandemic response across a wide range of government interventions. The results help to identify areas of good practice in terms of support services, communications and engagement activity. The results provide lessons for the future, applicable beyond pandemic responses. How to bring a more nuanced understanding of ethnic minorities into wider public policy and communications, including levelling up activity, will be a crucial takeaway.

The research used a mixed methods approach:

- the first stage was qualitative and largely exploratory investigating people's experiences of the pandemic, government interventions and the impact on individuals and their communities
- the information from the first stage led directly into the drafting of the survey questionnaire for stage 2
- the second stage collected quantitative data from a nationally (GB) representative sample of 1,500 ethnic minority people

The research took place during July and August 2021, when the vaccination programme was well under way and shortly after almost all restrictions had been lifted.[footnote 59] When asked if the "government did everything I would reasonably expect", ethnic minorities consistently agreed more than disagreed. This support

may help explain why 67% of ethnic minorities were very or quite concerned about the impact of the pandemic in its early months, substantially fewer were as concerned when the research took place (41%). Those not very or not at all concerned more than doubled from 12% to 25%.

The reasons why people from ethnic minorities were concerned about the pandemic in July and August was because they feared catching COVID-19 (48%), were worried that the NHS is or will be overstretched (40%), or were worried for someone else (32%).[footnote 60] Being vaccinated (57%) was the main reason for respondents being less concerned about the impact of the pandemic when the research took place, suggesting that the availability of the vaccine was a significant factor in reducing ethnic minorities' concerns. This is further supported by the finding that the plan, speed, communications and booking of vaccines was rated good or very good for the majority of ethnic minorities.

Overall, only 21% of respondents agreed with the statement "I feel that my overall experience of the pandemic has been shaped by my ethnicity rather than other factors" (53% didn't agree and 26% said they did not know). These factors might include their health, finances and where they work, especially if they are key workers. The government has taken a comprehensive, evidence-based approach to understanding these factors and how they have shaped ethnic minority experiences and outcomes during the pandemic. This evidence-led approach has been an important part of the quarterly reports and has informed recommendations on health interventions.

Headline findings

The research generated a considerable amount of information that will continue to shed light on how people from ethnic minority groups perceived and experienced the pandemic. However, initial analysis has identified the following actionable insights:

Good practice that should be replicated

Both the COVID-19 testing and vaccination rollout were rated positively and can be considered examples of good practice. For example, the majority of ethnic minorities viewed each aspect of COVID-19 testing implementation as good or very good.

- the vaccination rollout plan and the communications around the rollout were rated highest of all government measures (rated very or quite good by 63% compared with around 10% quite poor or terrible) – at least 70% of people from the Indian, Mixed White and Asian and Asian Other groups rated the communications around the rollout as very or quite good
- in addition, 72% of Pakistani and 71% of Black African respondents rated the availability of COVID-19 tests as very or quite good, 74% of respondents in the Asian Other group and 68% of respondents in the Indian ethnic group rated the communications around how and where to get a COVID-19 test as very or quite good, and 64% of respondents from the Pakistani ethnic group and 63% of Black

African respondents rated the speed of getting the results back from a COVID-19 test as very or quite good

Furthermore, there was strong agreement[footnote 61] with the mitigation measures such as social distancing (77% agreed with the measure), self-isolation (78%), wearing facemasks (78%), and only traveling if essential (76%), and 45% of respondents agreed that "the government did everything I would reasonably expect to protect my health". Awareness of the 'test and trace' system was also very high, with only 5% of respondents saying they had not heard of it, though almost half (49%) agreed that it was started too late.

Effective communications

When asked which sources they used to get information about COVID-19 and the UK's pandemic response, over half of respondents said they used news on British TV (69%) and/or the daily press conferences from government officials (52%). These sources of news were also the most trusted (55% and 40% respectively). There have been well over 100 press conferences at 10 Downing Street in response to coronavirus, making them the principal means of informing and updating the public.

Respondents were also asked to rate the how well they thought the government communicated about 7 aspects of the pandemic response,.[footnote 62][footnote 63] For each aspect, a higher percentage of respondents rated the government's communications as quite good or very good than quite poor or terrible. One way to build on this success is by providing as much information as possible about why decisions are taken and why new measures are being introduced, particularly when they may have a disproportionate impact on specific ethnic or religious groups.

The communication of the vaccination strategy and rollout was the highest rated, with 60% of all respondents rating it very or quite good. This was followed by the communication of the national and local measures to reduce the spread of COVID-19 (49%).

- 68% of respondents from the Indian group and 67% from the Mixed White and Asian group rated the communication around the vaccination strategy and roll out as very or quite good
- 62% of respondents from the Bangladeshi ethnic group rated the communication of the measures to reduce the spread of COVID-19 as very or quite good

Even the lowest rated communication aspects saw more ethnic minority people positively reviewing them than negatively reviewing them. Communicating health risks specific to ethnic minority groups and the reasons for those risks were rated very or quite good by 37% with 25% saying they were quite poor or terrible and as were communications around measures specific to ethnic minority groups to address those health risks (37% rating very or quite good compared with 24% quite poor or terrible)

- 47% of respondents from the Indian ethnic group rated the communication around health risks specific to their ethnic group and the reasons for those risks as very or quite good compared with 16% rating it quite poor or terrible
- in contrast, 33% of respondents from the Black Caribbean group rated the communication around health risks specific to their ethnic group and the reasons for those risks as quite poor or terrible, compared with 32% rating it very or quite good
- 37% of respondents from the Black Caribbean group rated the communication around measures specific to their ethnic group to address those health risks as quite poor or terrible compared with 29% rating it very or quite good

These differences between how communications were rated clearly illustrate the need to balance recognising ethnic group diversity, and not use umbrella terms such as BAME, with preventing stigmatisation and implications of blame:

- the term BAME was considered unhelpful with between 38% of respondents (Black African and Chinese ethnic groups) and 59% of respondents (Bangladeshi ethnic group) agreeing with this statement
- 40% of respondents said their ethnic group had been more affected by racism or racist abuse during the pandemic, and while 37% said their ethnic groups had been stigmatised, 41% considered other ethnic groups to have been stigmatised

The measures put in place to reduce transmission of COVID-19 were strongly supported with at least two-thirds of respondents saying they agreed or totally agreed with each measure.[footnote 64] Face masks and self-isolation had the highest support with 78%, followed by social distancing with 77%

- there were no significant differences between ethnic groups in support of face masks
- respondents from the White Other, (86%), Asian Other (85%) other (84%) and Indian (81%) groups were most likely to agree or totally agree with self-isolation requirements. In contrast, respondents from the Mixed White and Black African group were most likely to disagree or totally disagree (11%)
- respondents from the Asian Other (86%), Chinese (84%) and Indian (83%) groups were most likely to agree or totally agree with social distancing, whereas respondents from the White Other (14%) Mixed White and Black African (13%), Mixed White and Asian (12%) and Bangladeshi (11%) groups were most likely to disagree or totally disagree

The lowest levels of support were for school closures (65%), restrictions to religious worship (66%) and local lockdown and tier systems (68%)

- 17% of respondents from the Mixed White and Black African group, 13% of respondents from the Mixed White and Black Caribbean group, and 11% of respondents from the Pakistani ethnic group ‘totally disagreed’ with the restrictions on regular religious worship
- 14% of respondents from the Mixed White and Black African group, 16% of respondents from the Mixed White and Black Caribbean group ‘totally disagreed’ with school closures

- 9% of respondents from the Mixed White and Black African group ‘totally disagreed’ with local lockdowns and tier systems

Furlough support (17%), payment deferrals (14%) and mental health support (14%) were the government support schemes used the most. Of those who used the schemes, over half said they were quite or very important to helping them manage the pandemic. Raising awareness of the financial support schemes and mental health support available is important as a large minority of people in some ethnic groups were not aware of them.

Around 1 in 5 Black African respondents (19%) were not aware of the furlough scheme, 41% of respondents in the Bangladeshi and Chinese ethnic groups were not aware of the protection from eviction scheme, and 34% of Indian and 32% of Pakistani respondents were not aware of any mental health support schemes.

Of respondents who were still concerned about the pandemic, 1 in 4 (25%) were concerned about finances and the potential impact on their mental health if there is another lockdown Of all respondents, 26% do not trust the vaccine and 16% disagree that we all have a duty to vaccinate. For the respondents who are still hesitant about the vaccine (9% of the total sample), reassurance is needed about side effects and the speed with which it was developed.

The groups with the highest percentage of respondents likely to be hesitant about the vaccine were the Bangladeshi (19%), and Black African (18%) ethnic groups, people aged under 35 (15%) and parents of young children (15%).

Of all respondents who were hesitant or not planning on having the vaccination (17% of the total sample), the main concerns were around the side effects (31%), the speed with which it was developed (32%), not trusting the vaccine (33%) and believing vaccination should be a personal choice (35%).

Address strong negative perceptions

People from the mixed ethnic groups were more likely to feel negatively about government actions – the inherent heterogeneity of these groups and their lower levels of identification with faith communities[footnote 65] may make them harder to reach out to.

- the way the government responded to the pandemic was rated as quite poor or terrible by 41% of respondents from the mixed ethnic group
- similarly, 34% rated the government’s general communications as quite poor or terrible and 39% rated the government’s communications specific to this ethnic group as quite poor or terrible

Those not planning on having the vaccination were less likely to be concerned about the pandemic and more likely to rate the government’s response poorly, so they may be more difficult to reach or influence.

- the 2 groups most likely to say they did not plan on having the vaccination were the Mixed White and Black African group (19%) and people who were not concerned about the pandemic at its start (18%)

- Other groups with a high proportion of respondents saying they were not planning on having the vaccination were those who are not concerned about the pandemic now (14%), those who rated the government communications (16%) and strategy (14%) poorly and people aged under 35 (14%)

Lessons learned

As noted, there are some key lessons to be learned from the insights work, many of which support the findings from work on other terms of reference. These are:

- ethnicity is not the driving factor in how most ethnic minorities understood their experience of the pandemic – there is a need, therefore, not to assume anything about an ethnic minority individual's experience based solely on their ethnicity
- treating ethnic minorities as a single group is counter-productive and can be stigmatising
- trust in sources of information is essential for participants' acceptance of public health messaging
- ethnic minorities felt stigmatised when they were singled out in communications to imply that they are somehow more vulnerable or are at fault for the spread of the virus
- there is still work to be done, in terms of building trust with those who are generally negative about the government's response to COVID-19, optimising vaccination uptake amongst different ethnicities and reaching out to those who are not adhering to guidance on self-isolating
- non-traditional media and communications are an important way of sharing government messaging and reaching people who might otherwise be less engaged

Recommendations

The government and health agencies must implement the lessons learnt from the COVID-19 insights work and in particular:

- address specific ethnic minority groups rather than a homogenous group (through for example use of the term 'BAME')
- ensure that public health communications do not stigmatise ethnic minorities when explaining that they may be more vulnerable or at higher risk

The government should carry out a review of language and terminology around ethnicity to understand how to target messaging without stigmatising any particular group.

5. Communications

Over the last period, the vaccination rollout programme has continued to be the main focus of COVID-19 public health communications. Alongside this, the government communicated the changes people needed to make at Step 4 of the 'COVID-19 Response – Spring 2021' Roadmap. Communication activities have continued to support tactical operations and engagement. While broader campaigns are ongoing, some of the additional activities for this quarter are outlined in this chapter. It also discusses how the government approach to COVID-19 communication evolved since June 2020 and offers lessons learned.

Communication activity since May 2021

Vaccination rollout

Since May 2021, activity has continued to focus on the vaccination rollout. Communications aimed to help address concerns of those hesitant about the vaccine. Allowing space to answer questions supported continued take-up of messaging.

To drive vaccine confidence among those communities with the lowest take-up, including black, South Asian, Muslim and Orthodox Jewish groups, communications took a 'by the community for the community' approach, and delivered activities across 3 tactical pillars:

- community engagement and outreach (sessions with trusted voices)
- media relations and community media partnerships
- marketing activities, including through tailored content creation

Insight-based, tailored content and campaign messaging that resonated with different ethnic minority audiences drove marketing reach and frequency. The government's approach has continued to consider diverse audiences and clear language. Due to the public health emergency, information was disseminated in multiple languages,[footnote 66] and through trusted stakeholders and media channels.

Strategic media planning across the mainstream campaigns has increased awareness of our key messages, reaching over 95% of ethnic minority audiences. The recall of these mainstream advertising campaigns is higher than average among ethnic minority audiences, including for the 'get your shot' youth campaign and the 'every vaccine gives us hope' campaign.

Top performing content this period includes 2 videos[footnote 67] developed in June, featuring black and South Asian voices, showcasing the reasons they got vaccinated, despite their initial concerns. This was launched in the media, urging those concerned to speak to their vaccinated friends and family about their experiences. The videos received 78 pieces of media coverage through the course of July, with a combined reach of approximately 4 million. It was also shared on black and South Asian TV networks and radio stations, playing across 16 TV stations, with a combined reach of 3.8 million, and 14 radio stations, with a combined reach of 1.2 million.

Information sessions and videos resolving vaccine misconceptions were used to build trust, provide clarity and encourage uptake. Content was developed with the theatre, entertainment and sports industries to generate cultural interest. Top videos include the NHS and arts focused 'Rhythm of Life',[footnote 68] football focused 'Best Defence',[footnote 69] and for boxing 'Best Jab'.[footnote 70] These had a combined reach of more than 1.5 million on the NHS channel. The videos featured industry talent representative of diverse ethnic and faith backgrounds, and received additional broad coverage in national and ethnic minority press, such as the Guardian, BBC Breakfast, the Eastern Eye and Asian Image.

Tackling vaccine mis and disinformation

This quarter, communication activities were tailored to address the specific risks of false information about the COVID-19 vaccine amongst ethnic minority audiences, including misinformation about the vaccine being linked to infertility.

To tackle this, a number of virtual events were organised with healthcare professionals for women of childbearing age, and those from ethnic minority backgrounds. Dr Kiran Rahim hosted a Facebook Live with Muslim Mamas covering the vaccine, pregnancy, fertility and breastfeeding. Dr Olamide Savage also answered questions on the vaccine and fertility in an Instagram Live session with The Motherhood Group, a community for black mothers.

These virtual live sessions were promoted across various channels and platforms, generating over 10,000 views and resulting in strong engagement rates averaging around 40%. To date, DCMS's social media toolkit developed for their disinformation campaign has reached an additional 7 million people through stakeholders and partners. Organisations and individuals continued to push assets and key messaging out through their social media channels including Twitter, Instagram and Facebook and through community newsletters and daily bulletins, and within community forums and webinars.

Partner co-creation – communities and media channels

Strategic partnerships with multicultural TV partnerships, community radio partnerships and print partnerships with community titles have continued to further drive engagement and understanding. This period, the government partnered with 18 new community radio stations, delivering messages in 13 languages, including new content in Somali, Greek and Italian, reaching 1.6 million people. TV partnerships with 21 ethnic minority TV networks delivered bespoke adverts using well known talent shown across 44 TV stations, such as Colours and ROK, in 6 languages, reaching approximately 8.3 million people. Print and online material, including interviews and practical advice has appeared in over 600 national, regional, local and specialist titles including media for Bangladeshi, Gujarati and Pakistani communities, achieving a combined reach of 20 million. All content was tailored and delivered through leading voices to drive awareness of the government's key messages focused on Twice Weekly Testing, Hands Face Space Indoors, Back on the High Street, and Step 3 Weddings and Wakes.

Stakeholder partnership

Stakeholder partnership activities saw the government continue to work closely with ethnic minority communities through co-creation and tailored content. This supported those receiving a vaccine and helped those with questions about COVID-19, the vaccination process, government advice and measures more broadly. For example, multilingual vaccine ambassadors have been deployed across 61 local authorities to encourage vaccine uptake through outreach and direct communication. Operating in over 20 languages, the team addressed questions and concerns on COVID-19 vaccines – as well as on testing, the NHS App, 'Hands, Face, Space and Fresh Air', and provided government guidance materials. Businesses including hair salons, restaurants and supermarkets were also offered advice on how to keep their business COVID secure. The teams were equipped with mobile printers, and helped businesses access and display QR codes, posters and encourage customers to check-in via the COVID-19 app.

Since this activity began in April 2021, the ambassadors have visited over 3,700 businesses, and had over 125,000 interactions with diverse communities in large cities including London and Manchester. The team noted a considerable increase in those that have had the vaccine since the activity began, with the conversations also assisting with the gathering of qualitative insights.

Broader communication messaging

Communication in this period continued to inform the public about Step 4 of the government's roadmap out of lockdown. Messaging informed the public of what they need to do to keep safe, get tested or receive the support they need while restrictions were lifted. A tailored, multi-channel approach continued to deliver this, utilising marketing, PR, partnerships and engagement. Evaluation of campaigns consistently show that those from ethnic minority groups are more likely than average to recall seeing or hearing the ads, including the 'Hands, Face, Space, Fresh Air' and rapid COVID-19 testing ads.

Other highlights in this period

Other highlights include:

- tailored content in mainstream COVID-19 campaigns, to make them more relevant for ethnic minority communities, including NHS animated content in a range of languages, with a total reach of over 87,000 people
- an inclusive approach to press partnerships, reaching 20 million across 500 titles and 300+ outlets on themes including Twice Weekly Testing, Hands, Face, Space, Air, Back on the High Street, and Weddings and Wakes at Step 3 of the Roadmap
- press partnerships with community titles, featuring 4 sponsored content pieces, in 12 languages, published in more than 23 community titles with a weekly reach of over 500,000
- radio partnerships with 15 community stations and an additional 18 new stations. Increasing reach with syndicated content in 13 languages, such as Bengali,

Chinese, English, Filipino, Gujarati, Hindi, Mirpur, Punjabi, Urdu and Somali – this has doubled our combined reach to 1.5 million

- new partnerships continue with multicultural TV channels, including 44 channels broadcasting in 6 languages, with a reach of 8.3 million
- partnered with 6 healthcare professionals explaining the importance of twice weekly testing in English, Urdu, Hindi, Bengali, Somali and Polish across 18 TV channels and social media with an estimated 5.8 million reach
- briefings were arranged with 20 ethnic minority medics, which has been shared on broadcast slots including Dr Nighat on BBC Breakfast (2.13 million reach) and This Morning (1.5 million), Dr Emeka on GB News, Dr Ranj on This Morning, and Dr Amir on Lorraine (1.3 million)

Summary of approach to communications since June 2020

Government communication efforts initially focused on providing advice, guidance and supporting the public in managing behaviours to reduce the risks of COVID-19 infection and transmission. National marketing campaigns initially targeted the population as a whole. Though a significant amount of activity was delivered at low or no-cost, an estimated £446,517,000 was spent on the national cross-government COVID-19 Public Information Campaign (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/963166/Supplementary_Estimates_2020-21_web.pdf) in the 2020 to 2021 financial year, to promote the latest public health guidance to around 66 million citizens in the UK to save lives and protect the NHS. This campaign was aimed at the whole population. As a result, the campaign reached 95% of adults on average 16 times per week. Communications spend also took place through the Community Champions scheme.

Following the PHE review, the central COVID-19 Communication Hub worked closely with colleagues across other government departments and agencies to reach those most disproportionately impacted by COVID-19, including ethnic minorities.

The government ensured a multichannel communication strategy to address language and cultural barriers, with a particular emphasis on targeted community engagement to reach those who may be at greatest risk. Beyond the paid-for marketing campaign, government communications also delivered low or no-cost activities, working with partners, local authorities, and specialist marketing agencies to develop tailored messaging, shared through strategically chosen channels and trusted voices to reach ethnic minority audiences.

Content – format and languages

Core marketing materials, communications assets and guidance materials were translated into multiple languages, such as Bengali, Chinese, Gujarati, Hindi, Punjabi, Urdu and Somali, with additional translations supported where local authorities required them to reach their residents. Translation was a priority for government communication, given the extraordinary public health imperative in this

instance,[footnote 71] to reach those whose first language is not English and/or who have other accessibility needs. The government provided accessible versions of communications content, including videos in British Sign Language and guidance and communications in Easy Read and Large Print formats. Feedback highlights that the Easy Read formats have also been a helpful resource for those without proficiency in English.

Media partnerships

As part of 'government first' partnerships with trusted community media outlets, the government began working with specialist ethnic minority titles across different languages, which have proven reach with ethnic minority audiences.

Partnership content featured leading experts from the national COVID-19 Public Information Campaign, as well as relevant local GPs to create bespoke double page spreads focusing on key messages such as Hands, Face, Space and Fresh Air and Test, Trace and Isolate. The success of this tailored and targeted approach to media partnerships was replicated through expansions to other channels over the course of the year, such as multicultural TV broadcast channels and radio partnerships with community titles, increasing reach with syndicated content in various languages.

The government also worked with existing influencers and continued to recruit new ones who could communicate public health messages with credibility and impact among those less likely to trust or respond to government sources. Evaluation of influencer activities found that micro-influencers were more relevant at the local level, delivering more targeted communications. Following the success of activities in Leicester as part of the local lockdown campaign, micro-influencers now form a key part of the government's influencer communication strategy. Alongside this, long-term partnerships were developed with the Premier League and English Cricket Board to reach priority audiences, particularly young people and those from South Asian groups. Sports was an important interest point that helped increase reach and will continue to feature in influencer and partnership activity going forward.

Religious relevance

Reiterating health messaging around key calendar moments, such as religious festivals or cultural events for all audiences, also formed a core pillar of the central COVID-19 marketing strategy. Bespoke creative content and messaging was developed factoring in linguistic, cultural and religious holiday interests. For example, dedicated festivals guidance was developed for gov.uk, with advice on how to celebrate safely. This was supported by roundtables chaired by the Minister of Faith, held regularly with faith leaders to advise on, co-create and share communication for specific festivals to their wider communities. These included translations of safe worshipping and gathering guidance ahead of festivals, including Yom Kippur, Sukkot, Shavuot, Ramadan, Eid, Vaisakhi, Diwali, Easter and Christmas. This secured on-the-ground insight into the audience, and informed

tailored messaging according to grassroots-level concerns of the diverse communities. Messaging was religiously relevant and helped build trust.

Evidence-based approach

Wider communication campaigns were tailored to tackle some of the underlying causes of COVID-19 disparities amongst ethnic minority audiences. PHE developed a Better Health campaign in July 2020 to reduce obesity and other comorbidities more prevalent within these groups and associated with worse COVID-19 outcomes. Though the campaign focused on different audience segments, research and insights helped target specific ethnic minority audience segments who had higher rates of obesity or prevalence of diabetes. These audiences included Black African, Black Caribbean, Indian, Bangladeshi and Pakistani ethnic groups, with campaign advertising being translated into Arabic, Bengali, Gujarati, Hindi, Somali and Urdu.

Audience insights were central to the government's strategic communication efforts. There has been a continued focus on improving understanding of ethnic minority audiences, as well as the interests of different specialist media channels.

Audience insight established robust benchmarks that helped understanding of specific behaviours and attitudes towards COVID-19 amongst people from ethnic minority backgrounds. This insight was then used to develop a tailored behaviour change approach, with messaging focused on shifting these attitudes and behaviours, and any changes being measured against the baseline.

This research provided detailed analysis on awareness of social distancing guidance and recognition of public health campaigns, and perceptions of localised campaigns. Insights gained from this workstream were fed into future communication to improve awareness of health messages and compliance, with activities targeting groups who were most at risk. This also enabled further disaggregation of the audience analysis underpinning communication targeting, building on the nuances in attitude and behaviours between different groups that were observed in Leicester lockdown research.

Audience segmentation

Government communication reflected the findings of this research through an updated communication strategy, ensuring that ethnic minority audiences were not treated as a single group and that public health messaging was not stigmatising. For example, in the second wave, the risk of mortality was reduced for some black ethnic groups (when compared with the white group), and was increased for the Bangladeshi and Pakistani ethnic group. Government communication focused on promoting messaging that was tailored and based on this insight.

For example, the government issued new and updated guidance on preventing transmission of COVID-19 within households. This included the PHE guidance How to stop the spread of coronavirus (COVID-19) (https://www.gov.uk/government/publications/how-to-stop-the-spread-of-coronavirus-covid-19) published in February 2021, which was translated into 30 different languages,

including Bengali and Urdu. This was particularly important as South Asian ethnic groups are more likely to live in large and multigenerational households.

However, it was important to ensure that South Asian groups were not stigmatised, particularly as new variants of COVID-19 emerged, and the government continued efforts to build trust among these groups. Communications ensured that messaging was sensitive to the communities, and that the variant was referred to as the Delta variant and not the Indian variant. The government also continued work with the BBC Asian Network and BBC World Service to produce COVID-19 videos to address important questions from South Asian groups, delivered through trusted voices and outlets.

NHS Test and Trace messaging, and COVID-19 communications for mass gatherings such as religious festivals, were coordinated through a cross-government working group, working particularly closely with MHCLG and Cabinet Office to ensure messages were culturally sensitive and relevant. The Places of Worship Taskforce and Faith Leader roundtables provided insight on festivals and events, which were used to communicate COVID-19 messaging and any step changes in the PM's roadmap. For example, dedicated guidance was developed and shared on gov.uk's Places of Worship page and Festival guidance page to advise on restrictions and best practice, shared and updated ahead of specific religious festivals and events.

In May 2021, the Minister for Equalities reached out to Embassies and High Commissions from countries whose nationals were most at risk. Their recommendations allowed the government to build on its communications approach among diaspora groups, improving reach and addressing their needs.

Vaccine communications

In the second quarter, as the new vaccines were announced, a concerted effort was made to understand and overcome concerns about the vaccines among ethnic minority audiences. To improve its understanding of vaccine concerns, the government worked with over 90 faith and healthcare provider networks, influencers and experts from a range of communities. As a result of these new relationships, further sessions and engagements were developed to address specific concerns, and these relationships have continued to be utilised to test and inform the approach to communication for ethnic minority audiences.

Research gathered insight on the barriers to trust and uptake of vaccines. Findings suggested that ethnic minority audiences were concerned about suspected side effects, vaccine ingredients, and safety. The government implemented a tailored approach to counter misinformation, both nationally and locally, focusing on the safety and efficacy of the vaccine. Faith leaders then assisted by mitigating concerns about ingredients and the permissibility of the vaccines.

The focus of public health communication then changed to launch an integrated government campaign to improve understanding and awareness of COVID-19 vaccinations, including among ethnic minority audience segments and increase their confidence to take up the vaccination. This involved using effective media

channels and building on relationships established with influencers and local communities to reach ethnic minority audiences. Content included information about vaccines in multiple languages and advertising used specialist and traditional media, as well as social media, including Facebook and Twitter, featuring well-known medical professionals and disseminating important messaging to hundreds of local contacts, such as faith leaders.

For example, government communications worked with Muslim faith leaders to develop messaging to encourage testing, around social distancing and to encourage vaccinations during Ramadan and in light of congregational prayers. As a result of these relationships, communications around vaccines are continuously improved and tailored, to reflect learning and insights from communities.

The government has worked with specialist agencies to hold a series of roundtables for ethnic minority healthcare professionals and religious leaders to act as ambassadors within their communities. Dr Raghib Ali, one of the government advisers on COVID-19 and ethnicity, and other healthcare experts have played important roles in supporting this effort alongside ministers.

Audience mis- and disinformation

To tackle mis and disinformation among ethnic minority audiences, the government regularly produced myth-busting content, utilising trusted platforms and messengers within communities and taking specific targeting approaches on social media channels. For example, government communications developed answers to specific 'myths' about the vaccine to engage women from the Ultra-Orthodox Jewish community, clarifying concerns and questions around the vaccine being kosher, and perceived links to fertility, pregnancy and breastfeeding.

Partnerships with respected community figures and organisations, including places of worship, were used to help build trust in the Test and Trace service and dispel existing myths and alternative narratives on the vaccinations.

The Department for Digital, Culture, Media and Sport also developed a campaign to help tackle the spread of false information about the COVID-19 vaccine, following Scientific Advisory Group for Emergencies (SAGE) research showing low vaccine uptake amongst people from ethnic minority backgrounds. Similarly, an Ofcom study showed that people from ethnic minority backgrounds were twice as likely as white respondents to rely more on people they knew, people in their local area or people on social media for information about Coronavirus and vaccines.

To tackle vaccine disinformation, the government worked with various stakeholders and community organisations to launch a social media toolkit, with shareable content designed to encourage people to check the authenticity and credibility of information before passing on and sharing it online, as well as educating and empowering target audiences with knowledge on how to spot misinformation and stop its spread online.

The campaign was developed with and fronted by trusted local community figures such as imams, pastors and clinicians, who featured in short, shareable videos

which include simple tips on how to counter misinformation within their communities. The assets were designed to be shared via WhatsApp and Facebook community groups, as well as Twitter, YouTube and Instagram, to tackle false information spread through private channels.

Social media toolkits continued to be developed and updated further throughout the campaign to address narratives that insight showed were being shared widely across social media at certain times, for example misinformation about not being able to take the vaccine during Ramadan, or about the vaccine being linked to infertility. Specific communication strategies were developed to address fertility concerns among women, especially from ethnic minorities, including a series of videos with midwives, health visitors and expectant mothers on the benefits of vaccination.

ONS data showed that vaccination rates were lowest among those who identified as Muslim, and communication was shared through local Muslim health professionals and networks to enhance trust and credibility in the vaccination programme and messaging, and address concerns around the vaccines breaking fasts. These included advertising multi-lingual messages on local faith-based community radio stations, increased visibility in the mainstream media of vaccinations being delivered in places of worship, and advertising vaccine information in Eid magazines and Ramadan timetables that were developed at regional and local levels.

The concept of family vaccinations was also reflected in communications issued by the NHS to support vaccine uptake during Ramadan 2021, and content was provided and sponsored through the local council of mosques (or equivalent) and delivered coordinated daily messages and Friday sermon campaigns. Other activities included a series of videos with Dr Amir Khan, a GP from Yorkshire, whose video on the vaccine being halal reached more than 330,000 people.

Trusted voices

In addition to paid-media partnerships, a number of prominent ethnic minority celebrities and influencers stepped forward, with calls to their communities to take up the vaccine. This included an 8-week engagement programme focused on the Bangladeshi ethnic group, summarised in Chapter 1.

Likewise, communications were developed to increase COVID-19 vaccine confidence in Black African and Caribbean groups in London. This included a partnership with predominantly African and Caribbean churches and others to develop a series of online community dialogues to provide factual information about the vaccine and create a safe place for questions and challenge. An open letter from Sir Lenny Henry and a range of other high-profile celebrities encouraged black audiences in the UK to make informed decisions about the vaccine. Supported by the NHS, the letter was turned into a short film which was aired across various channels. Another video featured black Members of Parliament from the Conservatives and the Labour Party, who came together to share personal stories of losing loved ones, warning against the spread of misinformation and encouraging communities to take the vaccine.

Communications worked with over 200 community, faith and health care professionals, organisations, community and social influencers, including 20 black-majority church leaders to encourage vaccine uptake across England through tailored content creation and PR outreach. There has been a continued focus on building trust amongst the audience and developing deeper engagement through these community partnerships – mobilising over 120 trusted voices across events and media, with a collective reach of approximately 3 million.

Overall findings from these initiatives suggest increases in both positive vaccine sentiment and vaccine uptake over time across all ethnic groups, although variances still remain. While positive vaccine sentiment has increased over time, residual hesitancy continues to be addressed. The increase in vaccine confidence amongst the black population is substantial but it is still lower in this group than any other. The black ethnic group reports the highest vaccine hesitancy at 18% compared with the 4% national average. The government has continued to tailor its communication strategy on vaccine rollout to reflect the latest evidence on vaccine uptake among ethnic minority groups.

Lessons learned

The government's three-pronged approach to communication helped raise awareness, further understanding by engaging through partnerships and embedded deeper engagement with the community to build trust amongst the target audience. There are 6 key learnings to take forward for communication:

Build on existing networks for continuous information sharing

Working together with diverse networks provides trusted, open forums to discuss concerns and allows credible experts to explain the science and facts. This helped to communicate specific messages tailored to each community, through a 'by community, for community' approach. This also helped develop bespoke content that recognised groups within groups, with multiple ethnicities and age groups that need tailored communication.

Making communications specific and relevant to the audience

Ensuring content is relevant to and representative of communities, with no stereotyping or stigma, is vital to its impact. Tailored assets with relevant voices and faces help with awareness, recall and outtake. This also aids cut-through of messages which are competing with other content targeting our audiences. The use of translations into multiple languages also helped land the messaging with target audiences. The government also worked closely with local authorities to ensure communications were provided to best support their residents.

Going beyond traditional media and communications

Using a wider range of channels and approaches to communications were crucial to reaching audiences who might not always engage with traditional media.

Tailoring content and partnering with specialist media helped to cut through and to land messages.

Co-creation was the most effective way to harness trusted brands and voices

An important way that the government delivered specific and relevant communication was through co-creation with key community partners. This ensured content resonated with their communities. The campaign co-created content with other organisations to ensure engagement on their channels and through media. Multicultural TV partnerships used influential and recognisable voices to share simple messages. Community radio partnerships provided an opportunity to use local voices, while print partnerships with community titles enabled more in-depth content to be delivered.

Partnering directly with social media platforms enables reach through relevant content

Working directly with platform owners ensured our content, such as videos featuring black and South Asian experiences getting the vaccine, could be shared with the specific audience alongside relevant content they already consume on those platforms, allowing for better reach and audience targeting.

Grass root activation enables further reach

Communications mobilised multilingual street ambassadors to build trust and directly engage with those who may not have engaged with other media and content online. The Community Champions scheme helped to tap into local networks and worked with councils to identify barriers to accessing accurate information and to provide tailored support and communication. These activities engaged audiences through trusted voices who could tackle any misconceptions about the vaccine, encourage vaccinations, testing and other safe behaviours.

Providing people with communications tools and materials

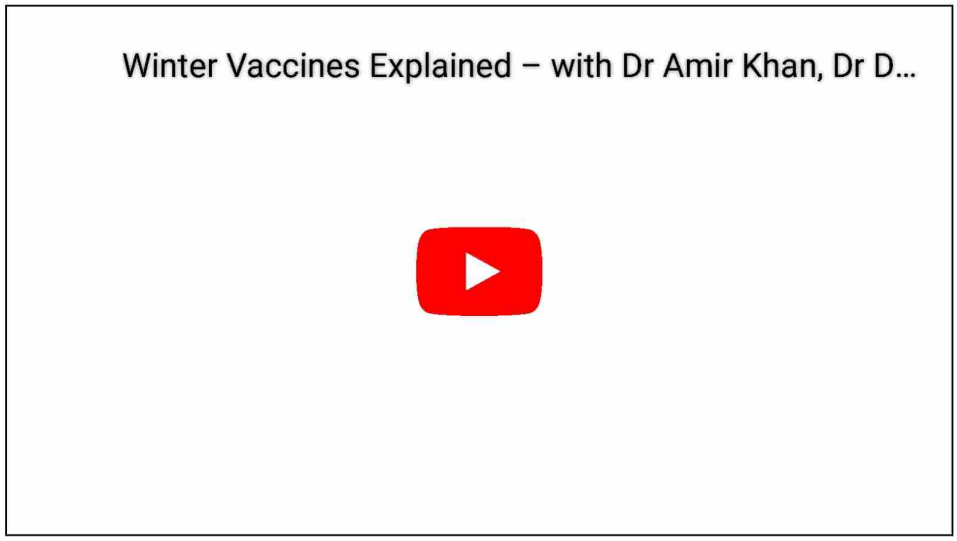
Providing a ready-made and easy to use vaccine misinformation social media toolkit gave people the tools to be able to share information across their channels. MHCLG helped support the cascade of the DCMS toolkit through a network of 200 faith leaders, ensuring that briefing could take place with local sector organisations to ensure broader reach with local government, as well as working with the Local Government Association to set up a webinar to discuss the toolkit with local government. A simple toolkit including ready-made downloadable assets in different formats plus example social media and newsletter copy made it much easier for stakeholders to share who may have little time or resources to create their own. Providing this information allows concerns to be raised and questions to be asked, and empowering trusted voices to hold that conversation and respond to concerns directly.

Recommendations

The government should use the COVID-19 experience of reaching ethnic minority groups for future public health campaigns. This should include activities to:

- develop and provide materials in multiple languages and formats, including BSL, easy read and audible formats, to ensure content addresses any difficulties to reach diverse audiences * build on community partnerships and work closely with local networks to improve understanding and gain insight into the audience
- use community partners to co-create content and tailor communications that resonate with key audiences
- communicate key messages through community partners and specialist media and digital channels, using trusted voices to land messaging where necessary

---

1. 

2. Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England: 24 January 2020 to 31 March 2021 (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/updatingethniccontrastsindeathsinvolvingthecoronaviruscovid19englandandwales/24january2020to31march2021), ONS
3. Model estimates of deaths involving COVID-19 by ethnic group and sex, for those aged 30 to 100 years of age, in the first and second waves of the pandemic, England: 24 January 2020 to 31 March 2021 (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/death

s/adhocs/13485modelestimatesofdeathsinvolvingcovid19byethnicgroupandsexforthoseaged30to100yearsofageinthefirstandsecondwavesofthepandemicengland24january2020to31march2021), ONS

4. COVID-19 confirmed deaths in England (to 31 July 2021): report (https://www.gov.uk/government/publications/covid-19-reported-sars-cov-2-deaths-in-england/covid-19-confirmed-deaths-in-england-to-31-july-2021-report#ethnicity), GOV.UK
5. Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England: 24 January 2020 to 31 March 2021 (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/updatingethniccontrastsindeathsinvolvingthecoronaviruscovid19englandandwales/24january2020to31march2021), ONS
6. Model estimates of deaths involving COVID-19 by ethnic group and sex, for those aged 30 to 100 years of age, in the first and second waves of the pandemic, England: 24 January 2020 to 31 March 2021 (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/13485modelestimatesofdeathsinvolvingcovid19byethnicgroupandsexforthoseaged30to100yearsofageinthefirstandsecondwavesofthepandemicengland24january2020to31march2021), ONS
7. Coronavirus and the social impacts on Great Britain: attitudes to vaccines (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/datasets/coronavirusandthesocialimpactsongreatbritainattitudestovaccines), ONS
8. Coronavirus and vaccine hesitancy, Great Britain: 9 August 2021 (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/coronavirusandvaccinehesitancygreatbritain/9august2021), ONS
9. ONS Research Excellence Awards (https://www.ons.gov.uk/aboutus/whatwedo/statistics/requestingstatistics/onsresearchexcellenceaward), ONS
10. Race Disparity Unit commended for pandemic research (https://www.gov.uk/government/news/race-disparity-unit-commended-for-pandemic-research), GOV.UK
11. Deaths registered weekly in England and Wales, provisional (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/weeklyprovisionalfiguresondeathsregisteredinenglandandwales)
12. Excess mortality in England (https://app.powerbi.com/view?r=eyJrIjoiYmUwNmFhMjYtNGZhYS00NDk2LWFlMTAtOTg0OGNhNmFiNGM0IiwidCI6ImVlNGUxNDk5LTRhMzUtNGIyZS1hZDQ3LTVmM2NmOWRlODY2NiIsImMiOjh9), PHE
13. Sex differences in immune responses that underlie COVID-19 disease outcomes (https://www.nature.com/articles/s41586-020-2700-3), Nature
14. Sex differences in severity and mortality from COVID-19: are males more vulnerable? (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7498997/), NCBI

15. Model estimates of deaths involving COVID-19 by ethnic group and sex, for those aged 30 to 100 years of age, in the first and second waves of the pandemic, England: 24 January 2020 to 31 March 2021 (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/13485modelestimatesofdeathsinvolvingcovid19byethnicgroupandsexforthoseaged30to100yearsofageinthefirstandsecondwavesofthepandemicengland24january2020to31march2021), ONS
16. COVID-19 Health Inequalities Monitoring for England (CHIME) tool (https://analytics.phe.gov.uk/apps/chime/), PHE
17. COVID-19: review of disparities in risks and outcomes (https://www.gov.uk/government/publications/covid-19-review-of-disparities-in-risks-and-outcomes), GOV.UK
18. After adjusting for sex, age group, ethnicity and region
19. REACT-2: real-time assessment of community transmission – prevalence of coronavirus (COVID-19) antibodies in June 2020 (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), GOV.UK
20. Factors associated with COVID-19-related death using OpenSAFELY (https://www.nature.com/articles/s41586-020-2521-4), Nature
21. Provisional age-standardised mortality rates for all-cause mortality, deaths due to COVID-19, and deaths due to other causes by ethnic group, sex, and Index of Multiple Deprivation (IMD) quintile, England: 1 January 2020 to 31 December 2020 (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/13360provisionalagestandardisedmortalityratesforallcausemortalitydeathsduetocovid19anddeathsduetoothercausesbyethnicgroupsexandindexofmultipledeprivationimdquintileengland1january2020to31december2020), ONS
22. Analysis of deaths between 21 March and 17 July 2020 – dementia was also included as a pre-existing health condition however there were no significant differences in COVID-19 mortality rates between ethnic minority people with dementia and all people with dementia
23. Analysis of the relationship between pre-existing health conditions, ethnicity and COVID-19 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942091/Summary_report_ethnicity_and_comorbidity.pdf), GOV.UK
24. 28 March to 26 June 2020
25. 26 September to 25 December 2020
26. All-cause and cause-specific mortality in people with mental disorders and intellectual disabilities, before and during the COVID-19 pandemic: cohort study (https://www.thelancet.com/action/showPdf?pii=S2666-7762%2821%2900214-3), The Lancet

27. Sickle Cell Disorders and Severe COVID-19 Outcomes: A Cohort Study (https://www.acpjournals.org/doi/10.7326/M21-1375), Annals of Internal Medicine

28. Sickle cell disease: overview (https://www.nhs.uk/conditions/sickle-cell-disease/), NHS

29. Sickle cell disease: managing acute painful episodes in hospital (https://www.nice.org.uk/guidance/cg143/chapter/Introduction), NICE

30. Obesity, walking pace and risk of severe COVID-19 and mortality: analysis of UK Biobank (https://www.nature.com/articles/s41366-021-00771-z), Nature

31. Smoking and COVID-19 outcomes: an observational and Mendelian randomisation study using the UK Biobank cohort (https://thorax.bmj.com/content/thoraxjnl/early/2021/09/12/thoraxjnl-2021-217080.full.pdf), BMJ

32. Model adjusted for age, sex, ethnicity, deprivation, relevant pre-existing health conditions and body mass index.

33. Using data for participants from UK Biobank that was collected between 2006 and 2010, who were still alive in January 2020 and lived in England. COVID-19 exposure and outcomes based on data up to 18 August 2020.

34. Occupation, Work-Related Contact, and SARS-CoV-2 Anti-Nucleocapsid Serological Status: Findings from the Virus Watch prospective cohort study (https://www.medrxiv.org/content/10.1101/2021.05.13.21257161v1), medRxiv

35. Association of working shifts, inside and outside of healthcare, with severe COVID−19: an observational study (https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-021-10839-0), BMC Public Health

36. Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered between 9 March and 25 May 2020 (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand25may2020), ONS

37. Why have Black and South Asian people been hit hardest by COVID-19? (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/whyhaveblackandsouthasianpeoplebeenhithardestbycovid19/2020-12-14), ONS

38. Association between living with children and outcomes from covid-19: OpenSAFELY cohort study of 12 million adults in England (https://www.bmj.com/content/372/bmj.n628), BMJ

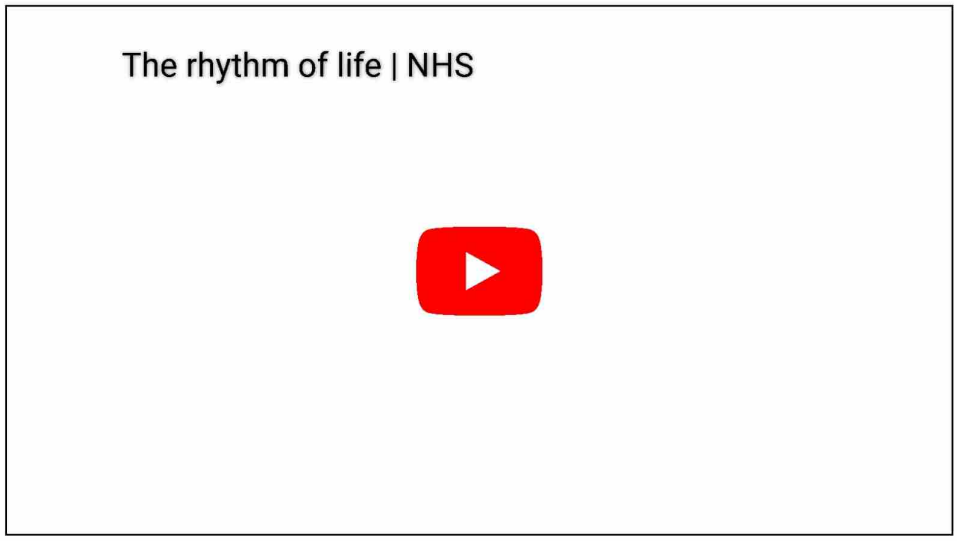
39. Association between living with children and outcomes from covid-19: OpenSAFELY cohort study of 12 million adults in England (https://www.bmj.com/content/372/bmj.n628), BMJ

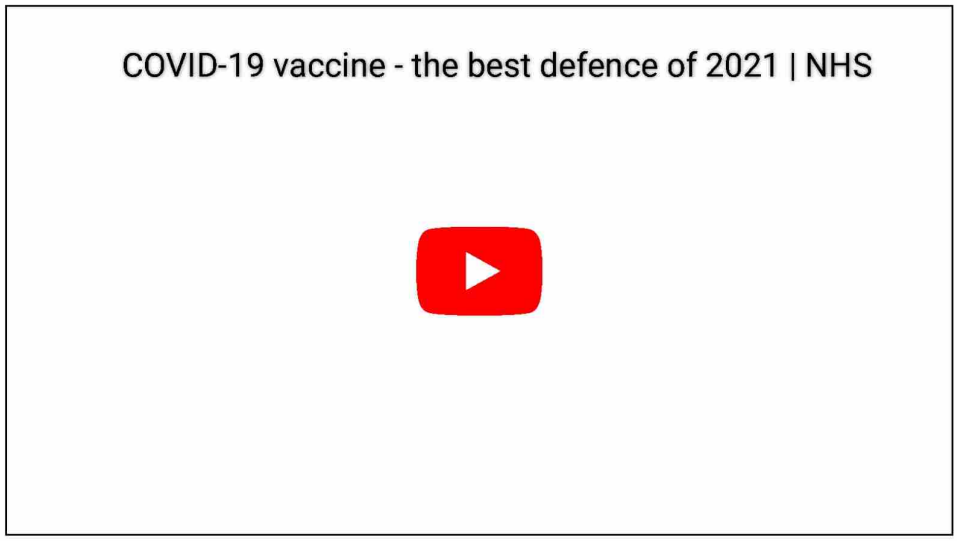
40. Monitoring populations at increased risk for SARS-CoV-2 infection in the community (https://www.medrxiv.org/content/10.1101/2021.09.02.21263017v1)

41. COVID-19 Health Inequalities Monitoring for England (CHIME) tool (https://analytics.phe.gov.uk/apps/chime/), Office for Health Improvements and Disparities
42. COVID-19 Mortality in English Neighborhoods: The Relative Role of Socioeconomic and Environmental Factors (https://www.mdpi.com/2571-8800/4/2/11/htm), MDPI
43. Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England: 24 January 2020 to 31 March 2021 (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/updatingethniccontrastsindeathsinvolvingthecoronaviruscovid19englandandwales/24january2020to31march2021)
44. Socialising indoors and outdoors, by five-category ethnicity breakdown: March to August 2021 (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/adhocs/13648socialisingindoorsandoutdoorsbyfivecategoryethnicitybreakdownmarchtoaugust2021), ONS
45. Analysis is presented only for the most recent time period as changes in socialising over time broadly reflect changes to guidelines – see source data for previous time periods starting March 2021.
46. The impact of COVID-19 on disabled people continues to be monitored across government as part of a separate strand of work to ensure the needs of disabled people are considered in the government's response to, and recovery from COVID-19.
47. Based on self-reported disability status collected in the 2011 Census
48. Deaths involving COVID-19 by disability status: a retrospective analysis of 29 million adults during the first two waves of the Coronavirus pandemic in England (https://www.medrxiv.org/content/10.1101/2021.06.10.21258693v1), medRxiv
49. Mortality associated with COVID-19 in care homes: international evidence (https://ltccovid.org/wp-content/uploads/2021/02/LTC_COVID_19_international_report_January-1-February-1-2.pdf), International Long Term Care Policy Network
50. Between 20 March 2020 and 15 January 2021, care home residents accounted for 33% of all COVID-19 deaths in England
51. Deaths involving COVID-19 by disability status: a retrospective analysis of 29 million adults during the first two waves of the Coronavirus pandemic in England (https://www.medrxiv.org/content/10.1101/2021.06.10.21258693v1), medRxiv
52. Socioeconomic inequalities in disability in Europe: contribution of behavioral, work-related and living conditions (https://pubmed.ncbi.nlm.nih.gov/30753498/), European Journal of Public Health
53. Disability, Ethics, and Health Care in the COVID-19 Pandemic (https://pubmed.ncbi.nlm.nih.gov/32816541/), American Journal of Public Health
54. Based on research from the United States

55. COVID-19: deaths of people with learning disabilities (https://www.gov.uk/government/publications/covid-19-deaths-of-people-with-learning-disabilities), GOV.UK
56. Using unadjusted numbers for adults only from the Learning Disabilities Mortality Review (LeDeR). COVID-19 deaths include both suspected and confirmed deaths from COVID-19. There is no mandatory requirement to report the deaths of people with learning disabilities to the review, therefore the total number of deaths is significantly lower than other datasets.
57. Coronavirus and the social impacts on Great Britain: attitudes to vaccines (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/datasets/coronavirusandthesocialimpactsongreatbritainattitudestovaccines), ONS
58. Coronavirus and vaccine hesitancy, Great Britain: 9 August 2021 (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandwellbeing/bulletins/coronavirusandvaccinehesitancygreatbritain/9august2021), ONS
59. The length of time that had elapsed since the pandemic began, together with more recent events, may have affected respondents' recall and feelings.
60. There are some variations within ethnic groups, however the sample sizes of 'people concerned now' are small and therefore only the results for the total group have been commented on
61. Respondents rated their agreement with each measure on a 6-point scale: agree totally, agree somewhat, neutral, disagree somewhat, disagree totally, or don't know. The neutral and don't know category has not been presented in these results.
62. Vaccination strategy and rollout, National or local measures to reduce the spread (for example, isolation, social distancing, handwashing, wearing face masks), National or local support interventions (for example, furlough support, tenant protection, business grants), The steps to ease lockdown (that is, the roadmap out of lockdown), Public health risks generally, Public health risks to [ETHNICITY] and the reasons for this, Measures to address health risks posed to [ETHNICITY]
63. Respondents rated each intervention on a 5-point scale: very good, good, neutral, quite poor, terrible. The neutral category has not been presented in these results.
64. Respondents rated their agreement with each measure on a 6-point scale: agree totally, agree somewhat, neutral, disagree somewhat, disagree totally, don't know. The neutral and don't know category has not been presented in these results.
65. 40% of respondents from the mixed group stated they had no religion compared with 16% of Asian respondents and 14% of black respondents.
66. Translation into foreign languages is discouraged except in extraordinary circumstances because it conflicts with the government's approach to integration which relies on English language use.

67. https://youtu.be/OCSameEcCil and https://youtu.be/cWwYcTpJUW4

68. 

69. 

70. 

71. Translation into foreign languages is discouraged except in extraordinary circumstances because it conflicts with the government’s approach to integration which relies on English language use.

↑ Back to top