Vaccine Uptake

THE CHANCELLOR OF THE DUCHY OF LANCASTER said that the paper before the Committee looked at how vaccine uptake could be increased among disproportionately impacted groups.

THE MINISTER FOR COVID VACCINE DEPLOYMENT said that although vaccine confidence was running at an all-time high with 85 per cent of people very likely to take up the vaccine, up six per cent from previous polling, the 15 per cent of people who were vaccine hesitant skewed towards Black, Asian and Minority Ethnic (BAME) communities. Although 6.5 million jabs had already been administered, further action would be necessary. Work would continue with the Secretary of State for Housing, Communities and Local Government to minimise issues across hard to reach groups, to support specific communities, to engage with faith leaders, local community practitioners and other local leaders. There were concerns with the level of anti-vaccination messaging in communities with recent evidence suggesting around 55 per cent of people had seen anti-vaccination messages. The governance around driving uptake should encompass local government. Local community champions would be used across communities, but there would be a need for the UK government to share best practice and to unlock barriers. The data required to understand the extent of uptake would be important and further data would be required at a granular level such as by worker type and ethnicity.

Concluding, THE MINISTER FOR COVID VACCINE DEPLOYMENT said that he would welcome colleagues' views on the paper presented and discussion to identify any further barriers and what more government could do in this space. Safety concerns, lack of access to health services, translation into different languages had all been barriers identified. Evidence suggested positive messaging should be used to increase confidence. Using local and trusted voices within different communities would have an impact. As pointed out by the Government's Chief Medical Officer during the recent press conference, if hesitancy skewed so heavily to particular groups and if there were communities which were not vaccinated, that could cause concern.

THE GOVERNMENT'S CHIEF MEDICAL OFFICER said that there would be the ability to link vaccine data to ethnicity data. For those over 80 years old, approximately 90 per cent of records would include the required data on ethnicity. In addition, from the following day the check-in questions required for the vaccination would include questions on ethnicity.

In discussion the following points were made:

a) great work had already been completed in this space, but there was

a need to go further;

b) data was necessary to monitor the effectiveness and check whether actions worked as intended. It would be important to learn from previous elements of the COVID response to ensure that implementation of measures aligned with policy intent and plans. Data should be reviewed and monitored in real time to understand how the Government may need to further adjust responses;

c) it was important to tap into local communications and use trusted voices. Further work would be needed to ensure trusted voices were genuinely trusted by the communities we were seeking to influence. A specific point was raised in respect of one group mentioned on page eleven in the papers and concerns that this group had been actively hostile to the Government;

d) engagement at local level would be imperative and supported the drive to go local in the communications. An example was provided of a local community group using YouTube videos to spread messages;

e) the figures raised were concerning. There were known issues in black churches and the level of COVID-secure compliance;

f) the messaging needed to come from local communities, not just the Government;

g) venues being used for vaccine deployment needed to be fully accessible;

h) the reason for vaccine reluctance varied across different people, but the figures were stark in the BAME community and it was important to examine what more could be done to communicate that this vaccine was like any other vaccine;

i) the vaccine deployment would be done in accordance with the agreed cohort lists and no one was jumping the queue;

j) prisoners would be vaccinated in line with the agreed approach and cohorts. Legal consent would be obtained at the time of the vaccination. In prisons the approach would be to disseminate information via prison posters, radio and peer to peer conversations. This had proved successful so far in encouraging take up. A recent story in the news regarding early vaccination of prisoners was inaccurate;