Message

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Sent: 08/01/2021 5:11:52 PM
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Subject: Readout: Ministerial Roundtable on Vaccine Uptake and Engaging Harder to Reach Groups - 08 Jan 21

OFFICIAL-SENSITIVE

Good afternoon all,

Many thanks for joining this afternoon's roundtable, particularly at such short notice. Please see my read out below. I have listed the specific actions which I recorded, however there was significant information-sharing between attendees which should shape work going forward.

Please add to this chain should I have missed anything.

Attendees

Minister Nadhim Zahawi (NZ); Lord Bethell (LB); Minister Kelly Tolhurst (KT); Baroness Dido Harding (DH); Emma Dean (ED); Antonia Williams (AW); James Sorene (JS); Amy Bowen AB); Nikita Kanani (NK); Laura Lucking (LL); Helen Alderton; NR; NR; Richard Chapman

Agreed Actions

1. MHCLG point of contact for deployment effort agreed. @laura.lucking *Can you confirm you will be acting as the point of contact?*

2. Analyse existing data on flu programmes and BAME age distribution to ensure that interventions are targeted as we progress deployment through cohorts.

3. Explore role of CMO and weekly call with Local Authority Directors of Public Health for cascading information and receiving updates. *@Collet-Fenson, Luke to note.*

Discussion

NZ – While initial roll-out takes into account deprivation, we need to ensure that we do not miss out BAME communities, vulnerable groups and others as we progress through the cohorts. Keen to hear from LB and DH on their experiences of rolling out Test-and-Trace to harder-to-reach groups – we need to ensure we operationalise this best practice in vaccine roll out. From KT's perspective, Local Government knows where these hard-to-reach groups are. How can we flex MHCLG infrastructure/fora to best reach them?

LB – Two big lessons from Test and Trace roll-out. 1) People who need to be tested were often not the people that stepped forward, and vice versa. 2) People that make the most noise about needing tests often don't. Requires political structures in place to make these tough decisions, as you often have to direct resource away from the most vocal groups to those who actually need it.

DH – Some further lessons. 1) On the ground, we faced a huge amount of disinformation – particularly on social media. Found it was often circulating in problematic places – Bolton; Oldham – and able to feed on any distrust of Government or local authority. 2) Wish we had been more proactive with Local Authorities and involved them at an earlier stage. 3) Local politicians are very useful and often know which community/faith leaders to talk to – e.g., Keith Vaz was fantastic for reaching into Goan community in Leicester. 4) Third Sector crucial, as is utilising faith networks. 5) GP and community pharmacists are by far the most trusted health professionals in their communities.

ED – In addition to BAME communities and vulnerable groups, we must also give due regard to social/geographic areas of social deprivation which traditionally have low vaccine take up.
DH – Agree. Found disinformation prevalent among these groups – traveller communities, white working class. Need to be addressing all areas of deprivation.

LB – Mistakes travel a very long way. Must be conscious of this when utilising the military, for example, with community deployment.

KT – On homeless and rough sleepers, we have specific deployment issues regarding GP registration to ensure access. On Local Authorities more widely, they can pick up information quickly and deploy it well throughout their area. Were very responsive with Test and Trace once brought on board. Need for a xHMG strategy on engaging with all these hard-to-reach groups. **MHCLG keen to work with DHSC / NZ on deployment and utilising MHCLG's networks to ensure vulnerable individuals are not left behind.**

AB – Hard-to-reach individuals/communities cut across JCVI cohorts. Needs to be a constant drumbeat within the context of a broader framework with local relationships embedded. Must strike a balance between ambitious national pace through cohorts, while recognising that some communities will take more time and require more effort.

NK - Cohort flexibility twinned with specific community targeting crucial. Excessive emphasis on pace through cohorts will mean communities are left behind. Some people will need time to absorb the information and feel comfortable and need to be sensitive to this. Equally, must use this opportunity to address past imbalances in our health system and ensure it works for these communities in the longer-term – getting individuals vaccinated, but also registered. On the information itself, the material needs to be accessible. Couched in culturally sensitive language and translated into multiple languages.

ED – Question: have we run analysis on proportion within each JCVI cohort who are from these groups? Will allow us to target our interventions as we progress deployment through cohorts.