

Closing the COVID 19 data gap

Assessing the initial phase of the vaccine rollout

Robert Ede and Sean Phillips



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Executive Summary

We are now into the eighth week of the national vaccine rollout. The programme has in many ways already been hugely successful with 6.5 million people, more than one in ten adults in the UK, receiving their first dose, at a rate that is unmatched in Europe. The Government and NHS England have continued to ramp up deployment and are on course to meet an ambitious target of offering the first dose of the vaccine to cohorts 1-4 by mid-February. However, there are several areas where further action must be taken, including a redoubling of efforts to vaccinate harder-to-reach groups such as the most disadvantaged and ethnic minorities.

The initial phase of the rollout suggests a number of problems are on the horizon:

- Anecdotal evidence from local Directors of Public Health that a significant proportion of people are declining the offer of a vaccine.
- Early data at a regional level showing substantial variation in vaccination rates, notably areas with the most ethnically diverse populations such as London featuring at the bottom of the list.
- Reports of the circulation of false news, such as misinformation about the presence of alcohol or meat products in the vaccine.
- An onus on local authorities to lead outreach, with a national communications campaign appearing to take a secondary role.
- Concerns that a lack of data being collected will inhibit the ability to evaluate and monitor the rollout.

Taken together, this could prompt a re-assessment. The NHS has indicated that uptake will need to reach 80% in each local area for the benefits of the vaccine to be felt – with the consequent prospect of eased lockdown restrictions. Yet it appears that achieving this goal with the current strategy could be challenging among the very groups who stand to benefit most from vaccination. If uptake remains low in poorer, more ethnically diverse neighbourhoods, there will be reasonable public health grounds to keep these areas under tighter restrictions while measures ease elsewhere. This would be a deeply undesirable situation that would amplify the health inequalities already found in society.

The Government is aware of the challenges. Nadhim Zahawi, Minister for COVID-19 Vaccine Deployment, has commented that his “big worry” is that high national uptake is contrasted by lower rates of acceptance of the offer of the vaccine among the BAME community. Our paper offers several practical suggestions which should be considered by the UK

Government, the NHS and the relevant devolved administration bodies as attention turns to the next stage of the vaccine deployment. These include:

- 1. Better and more granular data collection.** The data must be published weekly and include breakdowns of the offer for vaccination based on ethnicity, sex, precise age, and whether the vaccine was accepted or declined.
- 2. Regular monitoring and evaluation of interventions.** The Government should publish ongoing, monthly assessments of the impact of interventions to tackle vaccine hesitancy.
- 3. Dedicated ethnic minorities communications strategy.** If uptake data reveals lower rates of acceptance among some minority ethnic groups, there should be a much more concerted effort to reach these communities in the communications strategy, with additional resource from a national level directed towards a digital and conventional media campaign which brings trusted ethnic minority voices to the fore. This should adopt the principles of a general election campaign with sophisticated targeting of particular groups dependent on data held in the uptake.
- 4. Re-assess the current cohort prioritisation.** The JCVI should re-assess its current prioritisation methodology and consider making changes to its recommendations to reflect new data regarding higher mortality risk. This should be cross-referenced with the data on refusal rates once made available.

Introduction

“My big worry is if 85% of the adult population get vaccinated, if the 15% skews heavily to the BAME community, the virus will very quickly infect that community.”,

Nadhim Zahawi MP,

Minister for Covid-19 Vaccine Deployment on BBC
Radio 4 Today Programme, Monday 18th January 2021

We are now into the eighth week of the national vaccine rollout. The programme has in many ways already been hugely successful with 6.5 million people, more than one in ten adults receiving their first dose across the UK, at a rate that is unmatched in Europe. The Government and NHS England have continued to ramp up deployment and are on course to meet an ambitious target of having cohorts 1-4 vaccinated by mid-February. However, there are several areas where further action must be taken, including a redoubling of efforts to vaccinate harder-to-reach groups and ethnic minorities.

This paper assesses the current Government and NHS vaccination strategy and sets out practical proposals for enhancing efforts to vaccinate people living in areas where there is a much higher likelihood of dying from the virus. It does not investigate manufacturing and supply constraints in detail, but instead focuses on the prioritisation methodology agreed by the Joint Committee on Vaccination and Immunisation (JCVI), the NHS-led rollout and the accompanying communications campaign. A majority of these proposals can be implemented immediately, whereas others are focused on the next stage of the vaccination programme, which is due to commence from mid-February. We have predominantly focused on the programme in England, however much of the content and recommendations are relevant to the entire United Kingdom.

It is hard to overstate the complexities involved in administering a population level vaccination programme under this ambitious timetable. This is the biggest vaccination rollout ever undertaken in the NHS, and among the most complex logistical challenges facing a peacetime Government. It also requires a sophisticated communications campaign on a par with general elections, to counter both disinformation and misinformation and also to achieve the right tonal balance in creating hope whilst maintaining strong public adherence to current guidelines.

In other countries such as France, the rollout of the vaccines has been

deliberately delayed so that an information campaign to target vaccine scepticism can take effect.¹ Both NHS England and the UK Government should be praised for taking a different route and deciding to proceed with the roll out immediately. Yet as the programme evolves and attention begins to turn towards vaccinating wider cohorts, it will be important to reflect and learn lessons from the opening weeks of the rollout. Central to this must be efforts to ensure that the vaccination programme is structured in a way that addresses the deeper inequalities found in our society, rather than reinforcing them.

1. <https://www.euronews.com/2021/01/04/french-government-heavily-criticised-over-slow-covid-19-vaccination-roll-out>

The rollout so far

Despite the complexities of the task, initial fears of a sluggish rollout have been largely allayed.² To date, the NHS has administered a first dose of a vaccination to over six million people and to eighty percent of those aged 80 and above. At a current rate of over 10 per 100 people vaccinated, the UK has managed – thus far – to out-pace many of the world’s leading advanced economies in its rollout. The current rate is more than twice that of many European countries for instance where – as of last week – only Malta and Denmark had vaccinated more than 3 in every 100 people.³ The government has been able as a result to begin contacting those aged 70 and over in England – individuals which make up the third and fourth priority groups for vaccination as listed in the recently published Vaccine Delivery Plan and recommended by the JCVI. This picture of success is reflected in recent public polling, with the latest figures showing that 61% of the UK public believe the rollout was being handled well so far.⁴

A number of factors have contributed to the rollout’s success thus far. The swift approval of the Pfizer and BioNTech vaccine on the 2nd December 2020 by the Medicines and Healthcare Products Regulatory Agency (MHRA) demonstrated the benefits of pursuing a ‘rolling review’ of the scientific data – an approach which allowed for the use of clinical trial data from studies which were ongoing to inform regulatory decision-making. On the 30th December 2020 meanwhile, the UK became the first country to announce that it would adapt its vaccination strategy, a move which extended dosing intervals up to 12 weeks, so as to provide the maximum number of people in the most at-risk groups with the minimum-required coverage to stimulate the necessary immune response.⁵ This approach has generated substantial controversy given it was an adaption to the dosing schedule originally issued by the manufacturer, Pfizer, but has since been considered for replication by health services in Denmark, Germany, France and British Columbia.⁶

The rapid scaling up of a vaccine delivery infrastructure has also helped. Built into the Vaccine Delivery Plan is a flexible approach to delivery sites which now include mass vaccination centres, such as the ten large-scale sites recently announced by the government_which include Taunton Racecourse and Norwich Foodcourt alongside the thousand-strong list of hospital hubs and local vaccination hubs, set up to ensure no citizen lives more than ten miles from a site they can receive vaccinations.⁷ These government-organised initiatives will also be supported increasingly in the coming weeks from the high-street – most notably an enlargement in the number of pharmacies who will support the rollout alongside ASDA,

2. <https://www.theguardian.com/world/2020/dec/22/nhs-leaders-raise-concerns-pace-covid-vaccine-rollout>

3. <https://www.politico.eu/article/8-reasons-why-uk-leads-europe-coronavirus-vaccination-race/>

4. <https://yougov.co.uk/topics/politics/articles-reports/2021/01/21/what-do-britons-think-governments-handling-covid-1>

5. <https://www.gov.uk/government/news/oxford-universityastrazeneca-vaccine-authorised-by-uk-medicines-regulator>

6. <https://www.ft.com/content/7161dea0-4966-442b-9876-29cdf1b246f8>

7. <https://www.england.nhs.uk/2021/01/nhs-covid-jabs-available-at-rugby-ground-race-course-food-court-and-cathedral/>

who this week became the first supermarket chain to provide in-store vaccinations seven-days a week from morning till night.⁸

Responsibility for the rollout has sat primarily with the Department of Health and Social Care (DHSC) who have worked in collaboration with NHS England, NHS Improvement and Public Health England. In December, the Prime Minister appointed Nadhim Zahawi as Minister for Covid-19 Vaccine Deployment (sitting as a junior minister in the DHSC). Early concerns that Zahawi's appointment would complicate responsibility for the rollout – blurring the lines between his own role and that of Kate Bingham, chief of the government's Vaccines Taskforce (VTF) since May 2020 for instance – have not materialised.⁹ On the contrary, the appointment has provided ministerial oversight and has proven complementary to work being carried out across government departments and the NHS. Some lessons learnt from the early stages of the pandemic in 2020, where the lack of PPE proved a real issue for health and social care professionals on the frontline have supported the rollout. Alongside the timely procurement of the vaccine doses required, equipment, such as syringes were also purchased en-masse over the Summer in preparation for a mass rollout by 2021.¹⁰

This centralising approach has proven of utility in some areas of the delivery programme, allowing for the coordination of a range of expertise, such as that of the logistical capabilities of the Ministry of Defence, through which ten military planners have been deployed to assist the Vaccine Task Force, whilst hundreds of personnel currently support the rollout in England, Scotland and Wales, such as the Royal Navy medics currently delivering vaccines at Bristol's Ashton Gate Stadium.¹¹ Flexibility has also underpinned the approach to the rollout allowing Public Health directors across the country and general practitioners at large, working in consultation within local communities to devise strategies for the rollout which suit the particular needs of the communities they serve.

These collective efforts have been significantly boosted by the fact that Brits have been shown in research to be amongst the most willing in the world to accept vaccination.¹² Civil society continues to play a vital supporting role. NHS Volunteer Responders which was set up by NHS England and NHS Improvement in partnership with the Royal Voluntary Service in March 2020 are able for instance to draw upon 360,000 on-duty volunteers across the country who continue to support the scheme's rollout.¹³

Clouds on the horizon?

However, there is evidence to suggest that problems are coming into view. Data reveals that among certain groups there is a high proportion of vaccine hesitancy which may begin to bear itself out in uptake figures. This has been especially commented on in the context of ethnic minorities but also applies to poorer communities compared to higher levels of vaccine support in wealthier ones. At the same time, analysis by the Office for National Statistics of deaths in England has found that those living in

8. <https://www.england.nhs.uk/2021/01/high-street-pharmacies-deliver-nhs-covid-jabs/>

9. <https://www.instituteforgovernment.org.uk/blog/minister-vaccine-responsibilities>

10. <https://www.ft.com/content/cdfb7b28-8306-4db2-8dd6-4f85a92b1778>

11. <https://www.forces.net/news/covid-navy-medics-deliver-hundreds-vaccines-bristol-ashton-gate-stadium>

12. <https://yougov.co.uk/topics/health/articles-reports/2021/01/15/international-study-how-many-people-will-take-covi>

13. <https://www.gov.uk/government/news/british-public-urged-to-play-their-part-in-historic-vaccine-roll-out>

the most deprived areas are 2.5 times more likely to die from COVID-19 - further underlining the imperative of achieving high uptake in these groups.

One of the biggest obstacles to assessing the progress of the rollout is the lack of available vaccination data. Within England, the situation has started to improve with data now available showing the number of vaccines delivered at a national, regional, and local level. It has enabled policymakers to assess differing rates of progress at each of the 42 sustainability and transformation partnership areas, and seven administrative regions in England. The latest data of uptake to 17th January in each region is shown in Fig 1.¹⁴ This information has already been used to inform interventions - such as the decision to halve the supply of vaccines for the North East and Yorkshire region to allow poorer performing parts of the country to catch up.¹⁵

Fig 1: Map showing the share of over 80s who have received one dose of a COVID-19 vaccine among England's regions (up to the 17th January 2020)



Source: <https://www.hsj.co.uk/coronavirus/revealed-huge-local-variation-in-covid-vaccination-rates/7029355.article>

14. <https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/>

15. <https://www.hsj.co.uk/primary-care/exclusive-leading-regions-vaccine-supply-to-be-halved-so-others-can-catch-up/7029342.article>

However currently the data available only provides updates in relation to the proportion of the eligible population in each category area that has received their first and second dose. No breakdowns are provided based on the characteristics (precise age, sex, or ethnic group) of the recipient, the number of vaccines declined, the setting in which the vaccine was given, nor the take-up per cohort as set out by the JCVI. In recent days there has been speculation reported in the Health Service Journal that NHS England will introduce the collection of ethnicity data into the IT system in due course.¹⁶ Whilst this is encouraging, it nonetheless raises questions over why this was not considered prior to the commencement of the rollout.

Deficiencies in data collection are also found in the devolved administrations (which have broadly adopted a common approach based upon the recommendations from the JCVI on priority groupings in the first phase of the rollout, although with some differences in the sequencing – see table below).

The Office for Statistics Regulation has formally set out its request for more detailed data as soon as possible, in a letter sent on 20 January to those responsible for statistics across the UK.¹⁷ The letter urges those collecting data to align with colleagues in other administrations so that an accurate picture for the entirety of the UK can be presented.

16. <https://www.hsj.co.uk/primary-care/record-ethnicity-of-those-getting-covid-vaccine-to-fight-stigma-nhse-told-/7029364.article>

17. <https://osr.statisticsauthority.gov.uk/correspondence/ed-humpherson-to-producers-of-health-related-statistics-across-the-uk-number-of-covid-19-vaccinations-administered-in-the-uk/>

Table 1: Currently available data and information on the priority vaccine cohorts in each of the four countries of the United Kingdom.

Country	What data is currently available?	Who is being vaccinated as part of the initial rollout?
England	<p>Daily data</p> <ul style="list-style-type: none"> - Total number of COVID-19 vaccinations as reported by midnight prior to publication. <p>Weekly data – Covering</p> <ul style="list-style-type: none"> - All NHS COVID-19 vaccinations administered in the reporting period. - Count of vaccinations by age band, defined as 80+ and under 80 years old. - Count of vaccinations by dose. - Count of vaccinations by NHS Region. - Count of vaccinations by Integrated Care Systems (ICSs)/Sustainability and Transformation Partnerships (STPs). 	<p>By 15th February:</p> <ul style="list-style-type: none"> - All residents in a care home for older adults and their carers. - All those 80 years of age and over and frontline health and social care workers. - All those 75 years of age and over. - All those 70 years of age and over and clinically extremely vulnerable individuals.
Scotland	<ul style="list-style-type: none"> - Weekday daily summary – Total number of COVID-19 vaccinations. - Weekly summary of COVID-19 vaccinations as part of the weekly statistics report issued by Public Health Scotland. 	<p>By 5th February:</p> <ul style="list-style-type: none"> - All those over 80 years of age and over. - Patient facing, frontline healthcare workers. - Social care staff directly involved in the care of their service users. - Non-clinical but patient facing staff in secondary or primary care/community healthcare settings. - Laboratory and pathology staff.
Wales	<p>Public Health Wales has published weekly and weekday daily data, in its COVID-19 rapid surveillance dashboard.</p>	<p>By mid-February:</p> <ul style="list-style-type: none"> - All care home residents and staff; frontline health and social care staff; those 70 years of age and over; and clinically extremely vulnerable individuals.
Northern Ireland	<p>Information is provided towards the UK dashboard which is published daily. However, the Office for Statistics Regulation has noted that “official statistics have yet to be released in an orderly and transparent way”.</p>	<p>By the end of January:</p> <ul style="list-style-type: none"> - Older adults resident in a care home and care home workers (12k residents and 16K staff). - All those 80 years of age and over (<72K) and health & social care (70K) and domiciliary care workers (><25K).

Sources: [Office for Statistics Regulation](#)

In the absence of more granular national data, anecdotal and often contrasting reports on whether vaccine hesitancy among certain groups is being reflected in uptake have begun to be reported in the media. The Director of Public Health for the London Borough of Newham, Jason Strelitz, has suggested that “a significant number of people are not taking it up”.¹⁸ This was supported by remarks made by Dr Justin Varney, Director of Public Health in Birmingham who recently revealed to a group of Community Champions, aiding the rollout, that “up to 50 percent” had declined the offer of an appointment in some parts of the city – principally those which were the most deprived and which had the highest proportion of ethnic minority residents.¹⁹ The early figures from local regions appear to support this – with ethnically-diverse London the weakest performing region in England, having just vaccinated 50 percent of its 80+ population compared to 80 percent in the highest-performing regions. Countering this view, other commentators, such as Dr Winston Morgan of the University of East London have questioned whether BAME people on the high priority list will refuse the vaccine if offered by healthcare professionals they know and trust.²⁰ Elsewhere, the Race Equality Foundation has warned that ethnic groups could be at risk of stigmatisation, if misconceptions about lower uptake take hold.²¹

Lower uptake in London, where 35% of the community is BAME, could be driven by other factors beyond refusals, such as supply issues or slower-than anticipated vaccination infrastructure. However, the lack of concrete information means that we are becoming reliant upon anecdotal evidence and speculation.

This uncertain situation is disappointing given the national significance of the programme. The lack of robust, centrally held information on the rollout contrasts to better and more reliable data sets held nationally which detail the circulation of the virus, hospitalisations and deaths among particular groups. The latest figures from the Imperial College REACT study reinforce evidence that increased virus prevalence is associated with large household size, living in deprived neighbourhoods, alongside areas with higher numbers of black and Asian ethnicity individuals.²²

It is also legitimate to assess the strength of the accompanying national communications campaign. In late November, it was reported that NHS England and Ministers were preparing a major national PR drive to persuade people to have a vaccine, drawing on the support of celebrities and ‘influencers’.²³ This was to be combined with efforts to tackle vaccine disinformation, with an agreement brokered between the Government and social media companies Google, Twitter and Facebook to reduce vaccine disinformation online.²⁴ Yet this has not prevented reports of misinformation being circulated among communities, such as false claims of the presence of alcohol and animal products in the vaccine. Efforts have been made by officials in recent weeks to challenge this - but as has been shown in research on ‘false news’ undertaken by MIT, the spread of misinformation dramatically outpaces efforts at rebuttal.²⁵

We should also note that the origins of vaccine hesitancy are complex

18. <https://www.standard.co.uk/news/london/covid-vaccine-newham-london-numbers-b871758.html>

19. <https://www.birminghammail.co.uk/news/midlands-news/up-half-those-offered-vaccine-19629960>

20. <https://www.standard.co.uk/news/health/ethnic-minorities-covid-vaccine-trusted-doctors-b900284.html>

21. <https://raceequalityfoundation.org.uk/health-care/covid-vaccination-programme-the-need-for-data-to-understand-take-up-by-black-asian-and-minority-ethnic-communities/>

22. <https://www.imperial.ac.uk/medicine/research-and-impact/groups/react-study/real-time-assessment-of-community-transmission-findings/>

23. <https://www.theguardian.com/society/2020/nov/29/nhs-enlist-sensible-celebrities-coronavirus-vaccine-take-up>

24. <https://www.gov.uk/government/news/social-media-giants-agree-package-of-measures-with-uk-government-to-tackle-vaccine-disinformation>

25. <https://news.mit.edu/2018/study-twitter-false-news-travels-faster-true-stories-0308>

and do not necessarily neatly link to contemporary conspiracy theories or anti-vaxxer sentiment. For example, reluctance towards vaccination in some sections of the black community may be rooted in a deeper mistrust of clinical trials and medical experimentation due to historic abuse. One regularly cited instance is the Tuskegee experiment, an unethical study into untreated syphilis conducted between the 1930s and 1970s in the United States.²⁶ There may also be language and cultural barriers among these groups, which mean that pro-vaccination messages may not resonate as anticipated. And by the same token, care must be taken to ensure that any strategies to target higher uptake among certain groups are not misinterpreted as stigmatisation. This has been acknowledged in a paper prepared by the ethnicity sub-group of the Scientific Advisory Group for Emergencies (SAGE) which concluded that culturally-tailored communication, shared by trusted sources would be vital for minority communities.²⁷

Key figures within the NHS such as Director of Primary Care GP Nikita Kanani have indicated that uptake will need to reach 80% in each local area in order for the benefits of the vaccine to be felt. Yet if the anecdotal reports are to be believed, there may be significant barriers to achieving this target among certain groups – ironically the very groups who stand to benefit most from vaccination. This may become even more pronounced as the rollout extends down through the age-based cohorts, where personal motivation for vaccination could be lower given that the severity of disease is most closely linked to age.

Looking further ahead, low uptake rates will have significant implications for the pace of the easing of lockdown restrictions. The Government has suggested that it will initially return to a regional, tier-based approach. If vaccine uptake remains low in poorer, and more ethnically diverse neighbourhoods, there will be reasonable public health grounds to keep these regions under stricter restrictions whilst measures ease elsewhere. Given the broader economics and societal burden inflicted on the restrictions, this could mean that these areas have more pronounced and long-term scarring effects.

Taking these elements together, there is cause for concern. The risk is that the vaccine rollout reaches its interim objective of vaccinating 15 million people in the UK by mid-February but fails in an equally important public health objective: protecting the poorest and those from ethnic minorities. The result would be that the virus continues to circulate in higher levels in the most deprived areas and amongst some of the most at-risk groups, consequently leading to a higher proportion of hospitalisations and deaths from these groups.

26. <https://www.standard.co.uk/comment/ethnic-minorities-mortality-rate-vaccinate-priority-b900451.html>

27. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/952716/s0979-factors-influencing-vaccine-uptake-minority-ethnic-groups.pdf

A plan for change

We appreciate that several measures are already being taken to address some of the specific challenges outlined in this paper - and acknowledge the efforts of the health and social care community in working diligently to reach, invite and then vaccinate their eligible population as quickly as possible.

As we look to the coming weeks and months however, there is an opportunity to make changes to the current approach to the rollout to strengthen the vaccine programme. This will require action from NHS England, the UK Government and devolved administrations.

Our recommendations will supplement other initiatives across the devolved nations which are underway, such as the following:

- In Scotland, a national campaign called ‘Roll Your Sleeves Up’ has been launched and will run until the end of March 2021 on TV, radio, press, billboard, and digital channels.²⁸
- According to press reports, Public Health England has enlisted the multicultural marketing agency MMC which has previously worked on community-specific marketing campaigns for the Government on female genital mutilation and prostate cancer.²⁹
- At a local level, regional Directors of Public Health and local authorities have been energetic in establishing the Community Champions Programme, supported by £23.75 million in funding from MHCLG.³⁰
- Places of worship are being converted to act as temporary vaccine centres, with the Al-Abbas Islamic Centre in Balsall Heath, Birmingham becoming the first mosque in the UK to offer the vaccine.³¹

Recommendations

Policy Exchange believe that the following supplementary steps should now be taken as part of efforts to ramp up the vaccination programme:

1. **More detailed data.** As an immediate priority, data should be collected and made publicly available by NHS England and the relevant bodies within each devolved administration. The data must include breakdowns of the offer for vaccination on the basis of ethnicity, sex, precise age, and whether this was accepted or declined. The data should be published weekly, and be presented

28. <https://www.gov.scot/news/vaccination-information-campaign/>

29. https://www.huffingtonpost.co.uk/entry/pr-firm-black-asian-minority-ethnic-vaccine_uk_60059b65c5b697df1a07b640

30. <https://www.gov.uk/government/news/community-champions-to-give-covid-19-vaccine-advice-and-boost-take-up>

31. <https://www.bbc.co.uk/news/uk-england-birmingham-55752056>

in a consistent way across administrations to enable UK-wide comparisons.

2. **Regular monitoring and evaluation of interventions.** The Government should publish ongoing, monthly assessments of the impact of interventions to tackle vaccine hesitancy. Being able to evaluate the success or failure of government spending and effort in this area is essential - and can only be enabled by more detailed data.
3. **Dedicated ethnic minorities communications strategy.** If uptake data reveals lower rates of acceptance among some minority ethnic groups as feared, then communications efforts to reach these groups should be immediately scaled up. This should include the following:
 - **Coordinating local and national.** At the moment the Government has encouraged “local authorities to lead the way”.³² This has delivered a number of successes, such as local religious centres in Salisbury and Birmingham being converted to offer vaccinations. However, it is not providing the necessary detailed data required by councils to intervene in specific communities – the Gov should instead move to a ‘local and national together’ strategy which combines place-based approaches led by councils and local authorities with a much more energetic national communications campaign that specifically targets inequalities in uptake.
 - **Broadening the advocacy base.** The national communications campaign should commence on both digital and conventional media. It should bring trusted ethnic minority voices to the fore. It must be coordinated centrally by NHS England, with political oversight from Vaccines Minister Nadhim Zahawi MP, and ensure that a balance is achieved between political representatives, public health experts, frontline healthcare professionals, notable community figures such as religious leaders, celebrities and influencers. This should build upon current local efforts, such as the Community Champions Programme.
 - **Harnessing social media to counter misinformation.** The rollout communications should adopt the principles of a general election campaign with hyper-focused targeting towards particular groups, including advertisements on Facebook, Instagram and Twitter. This will become especially important as the rollout extends to younger age groups. It should also make use of assets which can be easily shared on key private messenger platforms such as WhatsApp, Telegram and Signal, to counter the known dissemination of misinformation on so-called ‘dark-social’.
 - **Making use of trusted experts.** The media effort should be ramped-up to promote the key scientists involved in

32. <https://www.gov.uk/government/publications/uk-covid-19-vaccines-delivery-plan/uk-covid-19-vaccines-delivery-plan>

developing the science to banish myths and ensure that the public hears about the vaccine development process ‘from the horse’s mouth’.

- 4. Reassess current cohort breakdown.** As the rollout among the first four priority cohorts concludes, and attention turns towards the next phase, the JCVI should re-assess its current prioritisation methodology, and consider making changes to its recommendations to reflect new data regarding higher mortality risk. This should be cross-referenced with the data on refusal rates once it is made available. Whilst the JCVI has already concluded that there is limited evidence that genetics alone contribute to the higher burden of COVID-19, the increased environmental risks facing certain groups, combined with possible higher refusal rates should be factored into thinking. If any changes are made to the current grouping of nine, largely age based cohorts (for example to include a dedicated cohort based upon ethnicity) then due care must be taken to avoid any unintended consequences such as stigmatisation of particular groups.



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