Covid-19 Vaccination Programme Phase 3 Equalities and Health Inequalities Impact Assessment

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Covid-19 Vaccination Programme phase 3 outline

Phase 3 of the Covid-19 vaccination programme, primarily focused on the delivery of a booster vaccine, is due to begin in September 2021, with the aim to maximise protection in those who are most vulnerable to serious Covid-19 ahead of the winter months. Influenza (flu) vaccines are also delivered in the autumn months. The Joint Committee on Vaccination and Immunisation (JCVI) have considered this and state that where possible, a synergistic approach to the delivery of Covid-19 and influenza vaccination could support the delivery and maximise uptake of both vaccines.

The latest guidance details the groups eligible for booster vaccination in phase 3 (priority groups 1 to 9), which alongside those most vulnerable to serious Covid-19 includes all adults over 50 and frontline health and social care staff.

Important to note within phase 3 of the programme is the offer of a first dose of the Covid-19 vaccine to 12-15 year olds, and the continuation of an evergreen offer to those who are eligible but are yet to take up a first or second dose of the vaccine.

Please note there are currently some gaps in the guidance and information on phase 3, and some of the details around delivery are still being planned.

Aims and objectives

The initial objectives for winter 2021/22 are:

- those eligible for a Covid-19 booster receive their influenza and Covid-19 vaccines in good time.
- the evergreen offer is continued for those yet to take up a first or second does
- 12-15 year olds receive their first dose of the vaccine

In line with national guidance, the vaccination programme will plan local coordination and delivery of the COVID-19 vaccine across Surrey.

This document will provide a review of equalities and a strategic plan for addressing inequalities in vaccination delivery.

Further information and national guidance

On the 14th of September 2021, the government published the **COVID-19 Response: Autumn and Winter Plan 2021**[1], of which ‘Building our defences through pharmaceutical interventions’ is the key section related to vaccines. It states:

The Government has three priorities for the COVID-19 vaccination programme in England for the autumn and winter:

a. Maximising uptake of the vaccine among those that are eligible but have not yet taken up the offer.

[1] https://www.gov.uk/government/publications/covid-19-response-autumn-and-winter-plan-2021

b. Offering booster doses to individuals who received vaccination in Phase 1 of the COVID-19 vaccination programme (priority groups 1-9, see Appendix E for details).
c. Offering a first dose of vaccine to 12-15 year olds.

Also on the 14th of September 2021, the JCVI updated its advice on the COVID-19 vaccine booster programme[2]. The advice states:

- The COVID-19 vaccines provide high levels of protection against hospitalisation or dying from the virus. To maintain this high level of protection through the coming winter, the JCVI is advising that booster vaccines be offered to those more at risk from serious disease, and who were vaccinated during Phase 1 of the vaccine programme (priority groups 1 to 9).

- This includes:
    - those living in residential care homes for older adults
    - all adults aged 50 years or over
    - frontline health and social care workers
    - all those aged 16 to 49 years with underlying health conditions that put them at higher risk of severe COVID-19, and adult carers
    - adult household contacts of immunosuppressed individuals

- The JCVI advises that the booster vaccine dose is offered no earlier than 6 months after completion of the primary vaccine course, in the same order as during Phase 1.
- People vaccinated early during Phase 1 will have received their second dose approximately 6 months ago. Therefore, it would be appropriate for the booster vaccine programme to begin in September 2021, as soon as operationally practical.
- The JCVI advises a preference for the Pfizer-BioNTech vaccine for the booster programme, regardless of which vaccine brand someone received for their primary doses. This follows data from the COV-BOOST trial that indicates the Pfizer-BioNTech vaccine is well tolerated as a third dose and provides a strong booster response.
- Alternatively, a half dose of the Moderna vaccine may be offered. Where mRNA vaccines cannot be offered, for example due to allergies, the AstraZeneca vaccine may be considered for those who received it previously.
- The ComFluCOV trial indicates that co-administration of the influenza and COVID-19 vaccines is generally well tolerated with no reduction in immune response to either vaccine. Therefore, the two vaccines may be co-administered where operationally practical.
- As most younger adults will only have received their second COVID-19 vaccine dose by late summer or early autumn, the benefits of booster vaccination in this group will be considered at a later time.

Guidance was issued by NHSEI on the1st July 2021 to all NHS organisations and Local Authorities on COVID-19Vaccination Autumn / Winter Phase 3 planning[3]. Information on this guidance is contained within Appendix D.

[2] https://www.gov.uk/government/news/jcvi-issues-updated-advice-on-covid-19-booster-vaccination
[3] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/07/C1327-Covid-19-vaccination-autumn-winter-phase-3-planning.pdf

An enhanced Service Specification to inform GP practices planning to support phase 3 of the COVID-19 vaccination deployment programme has also been published.

On the 2nd of September, guidance was published by JCVI on vaccinating immunosuppressed individuals with a third primary dose. This offer is separate to any potential booster programme and is not superseded by the updated guidance on boosted published on the 14th of September.

- JCVI advises that a third primary dose be offered to individuals aged 12 years and over with severe immunosuppression in proximity of their first or second COVID-19 vaccine doses in the primary schedule. Severe immunosuppression at the time of vaccination is defined using the guidance below.
- The specialist involved should advise on whether the patient fulfils the eligibility criteria and on the timing of any third primary dose. In general, vaccines administered during periods of minimum immunosuppression (where possible) are more likely to generate better immune responses.
- The third primary dose should ideally be given at least 8 weeks after the second dose, with special attention paid to current or planned immunosuppressive therapies guided by the following principles:
    - where possible, the third primary dose should be delayed until 2 weeks after the period of immunosuppression, in addition to the time period for clearance of the therapeutic agent
    - if not possible, consideration should be given to vaccination during a treatment 'holiday' or at a nadir of immunosuppression between doses of treatment"
- It is important to note that JCVI have advised this forms part of the primary vaccination schedule for an individual and therefore further advice will be provided on a booster vaccination in due course for these individuals.

Additionally, it was anticipated that all 12 – 15 year olds will be offered a Covid-19 vaccine in the next phase, and local planning is underway to facilitate this. On the 3rd of September, the UK's vaccine advisory body has refused to give the green light to vaccinating healthy children aged 12-15 years old on health grounds alone.

- The JCVI said the government should consider wider issues including disruption to schools.
- Ministers across the UK have asked chief medical officers to look at whether that tips the balance.
- An extra 200,000 teens with underlying conditions will now be eligible for two doses.

On consideration of the wider issues, the UK Chief Medical Officers published an letter to ministers on the 13th of September on Universal vaccination of children and young people aged 12 to 15 years against COVID-19. The letter stated:

- Overall however the view of the UK CMOs is that the additional likely benefits of reducing educational disruption, and the consequent reduction in public health harm from educational disruption, on balance provide sufficient extra advantage in addition to the marginal advantage at an individual level

identified by the JCVI to recommend in favour of vaccinating this group. They therefore recommend on public health grounds that ministers extend the offer of universal vaccination with a first dose of Pfizer-BioNTech COVID-19 vaccine to all children and young people aged 12 to 15 not already covered by existing JCVI advice.

- If ministers accept this advice, issues of consent need to take this much more balanced risk-benefit into account. UK CMOs recommend that the Royal Colleges and other professional groups are consulted in how best to present the risk-benefit decisions in a way that is accessible to children and young people as well as their parents. A child-centred approach to communication and deployment of the vaccine should be the primary objective.
- If ministers accept this advice, it is essential that children and young people aged 12 to 15 and their parents are supported in their decisions, whatever decisions they take, and are not stigmatised either for accepting, or not accepting, the vaccination offer. Individual choice should be respected.

Eligibility for the flu vaccine

According to the letter from the DHSC, PHE and NHS England dated 5th August 2020, the ambition for flu vaccine take up is at least 75%.[4] Although there is a lot of crossover, it is important to note the eligibility criteria for the flu vaccine and the Covid-19 booster do not completely align. A mapping exercise has been undertaken to clearly understand the overlap.

Eligible group for influenza	**Uptake ambition**
Aged 65 years and over	At least 75%
In clinical at risk group (see appendix A) New eligibility announced May 2020 to include • those aged six months to under 65 years in clinical risk groups;[5] and • those in long-stay residential care homes and • Carers • Those in close contacts of immunocompromised individuals New eligibility announced July 2020 to further include: • people who are on the shielded patient list and members of their household; • all school year groups up to year 7;[6] • those with some pre-existing conditions including at-risk under 2s; • people aged 50 to 64.[7]	At least 75%
Pregnant women	At least 75%
Children aged 2 and 3 years old (New eligibility announced May 2020 to include all children aged two to ten (but not eleven years or older) on 31 August 2020)	At least 75%

[4] The national flu immunisation programme 2020 to 2021- update, 5/8/20, NHS England, DHSC, PHE, https://www.england.nhs.uk/wp-content/uploads/2020/05/Letter_AnnualFlu_2020-21_20200805.pdf
[5] This includes people with learning disabilities
[6] Year 7 is the first year of secondary school in England, pupils will be aged 11-12.
[7] People aged 50 – 64 will be able to access the free flu vaccine once the vaccination programme for 'the most 'at-risk' groups is well underway' and the DHSC has worked with clinicians to decide when to open the programme to people aged 50 -64. Letter re' The national flu immunisation programme 2020/21' published 24 May 2020, DHSC and PHE, https://www.england.nhs.uk/wp-content/uploads/2020/05/national-flu-immunisation-programme-2020-2021.pdf

All primary school aged children and school year 7 in secondary school	At least 75%
Frontline health and social care workers[8] o a registered residential care or nursing home o registered domiciliary care provider o a voluntary managed hospice provider o Direct Payment (personal budgets) and/or Personal Health Budgets, such as Personal Assistants	100% offer
50 to 64 year old's (guidance published July 2021 this group as a temporary measure[9]	

The letter also noted that 'household contacts of people on the NHS Shielded Patient list will not be subject to call and recall arrangements but will be offered the vaccine opportunistically, with the aim to offer to all identified[10].

The groups recommended for the 'Shielding Patient List' was revised and released on 16/2/2021 which now take account of Body Mass Index, Sex, Ethnicity, post code, living arrangements. These added people will now be included within priority group 6.

Local planning for phase 3

Planning is still ongoing for phase 3 and the delivery models will depend on PCN and Community Pharmacy involvement in Covid-19 vaccine deployment.

A concern which has been identified is the potential for geographical differences in access for co-administration of Covid-19 vaccine alongside the flu vaccine. The impact of this will vary depending on the area, and how often overall co-administration ends up being offered. For example, some areas may only be offering flu vaccine within their PCNs / Community Pharmacy and patients would be signposted to the national booking website to book their Covid-19 booster at a vaccination centre elsewhere. Conversely, some patients may visit their GP and be offered both within the same appointment. Depending on the personal circumstances, location, access to transport and views of the patient, this difference in offer could impact on take up of Covid-19 vaccine booster. This may inadvertently impact negatively on communities in most deprived areas.

The timelines for the phase 3 Covid-19 vaccination programme may not align to flu vaccination supplies and may lead to delays in people booking either vaccines. Currently the first tranche of flu jabs is not due until the 25th of October. This may inadvertently lead to higher rates of Covid-19 or flu (or both) if people think it may be better to await a single appointment. Messaging not to delay either jab is important to ensure the best health outcomes. Messaging over vaccinations also needs to be as clear as possible to avoid confusion as eligibility for the two vaccines does not completely align.

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[8] https://www.gov.uk/government/publications/national-flu-immunisation-programme-plan/national-flu-immunisation-programme-2021-to-2022-letter
[9] https://www.gov.uk/government/publications/national-flu-immunisation-programme-plan/national-flu-immunisation-programme-2021-to-2022-letter
[10] The national flu immunisation programme 2020 to 2021- update, 5/8/20, page 4, NHS England, DHSC, PHE, https://www.england.nhs.uk/wp-content/uploads/2020/05/Letter_AnnualFlu_2020-21_20200805.pdf

As with the Covid vaccine, we also see disparity in uptake for the flu vaccine. This needs further understanding if we want to co-administer flu with Covid-19 vaccine, as this may negatively impact on Covid vaccine uptake. Conversely, learning from Covid-19 vaccination work may help to support flu vaccine uptake.

To support Covid-19 vaccination for 12-15 year olds if required, regions have been encouraged to establish partnership arrangements with ICS and their School Immunisations Service Providers and Education partners and commence local briefing and rapid preparation. Locally:

- Plans are being prepared predominantly based on delivery in a School or Education provider site, but will be complimented as required through other partnerships in Primary Care and at large vaccination sites
- This work is positioned as contingency planning for a vaccination date of 6th September for all 12-15 year olds
- A national series of external public facing communications products will follow and be ready to roll out by the 3rd September
- Communication with parents on the information on the vaccine, consent, booking and vaccination process will need to be undertaken in advance of vaccinations
- Operating models are being evaluated, including utilising or increasing capacity within the School Age Immunisation Service, pop ups on school sites, alternative vaccination sites with transport provided and vaccination at existing PCN LVS.

Delivery models

To date vaccines have been delivered through a variety of settings. The uptake at Vaccination Centres (VC) varied by ICP depending on location, e.g. higher levels of activity for NW Surrey when the VC moved to Sandown, from 7.9 to 25.1%.

Total vaccinations delivered by vaccination site (as of 19th of July)	
Vaccination Centre	174,577
Hospital Hubs	74,720
Local Vaccination Sites	801,617
Community Pharmacies	175,521
TOTAL Delivered:	1,228,831

Locally the Vaccination Centre will close on the 31st August 2021, therefore will not be available for phase 3. Community pharmacies will likely play an increasingly important role in ensuring vaccine accessibility. Four additional community pharmacy sites are now available, bringing the total to 18 in Surrey.

South East Communications Toolkit

NHS England and NHS Improvement's (NHSEI) South East regional team is working hard to ensure the safe delivery of the flu vaccination/ Covid-19 booster programmes for the region this autumn, in line with national planning requirements.

Locally, we are waiting for the national PHE campaign to drop between the 6th and 13th of September, however in the interim a toolkit has been put together. The toolkit brings together information from various accredited sources and offer suggested text to aid consistency and understanding of the latest position for communications. Website copy, internal comms for primary care, social media content and other helpful resources have been shared.

This year, the regional flu communications campaign will be run by the South East regional flu comms team which comprises representation from each ICS/STP who will coordinate activity in their local areas. The NHSEI regional comms lead and PHE regional comms lead meet with the group regularly.

Elements that present risk of widening health inequalities

Broadly, the main elements of vaccination that present a risk of widening health inequalities relate to:

- The ability of patients (this includes staff who are being vaccinated) to access the vaccination (convenience and accessibility)
- The ability of patients to receive and understand information, and make an informed decision about the vaccinations (confidence, complacency and communication)
- The need for those delivering the vaccination programme to understand the psychological aspects of vaccination (needle phobia, confidence)
- The Covid booster vaccine and co-administration with the flu vaccine is unique to this phase, which add different nuances to an individual's decision making. (consent, convenience)

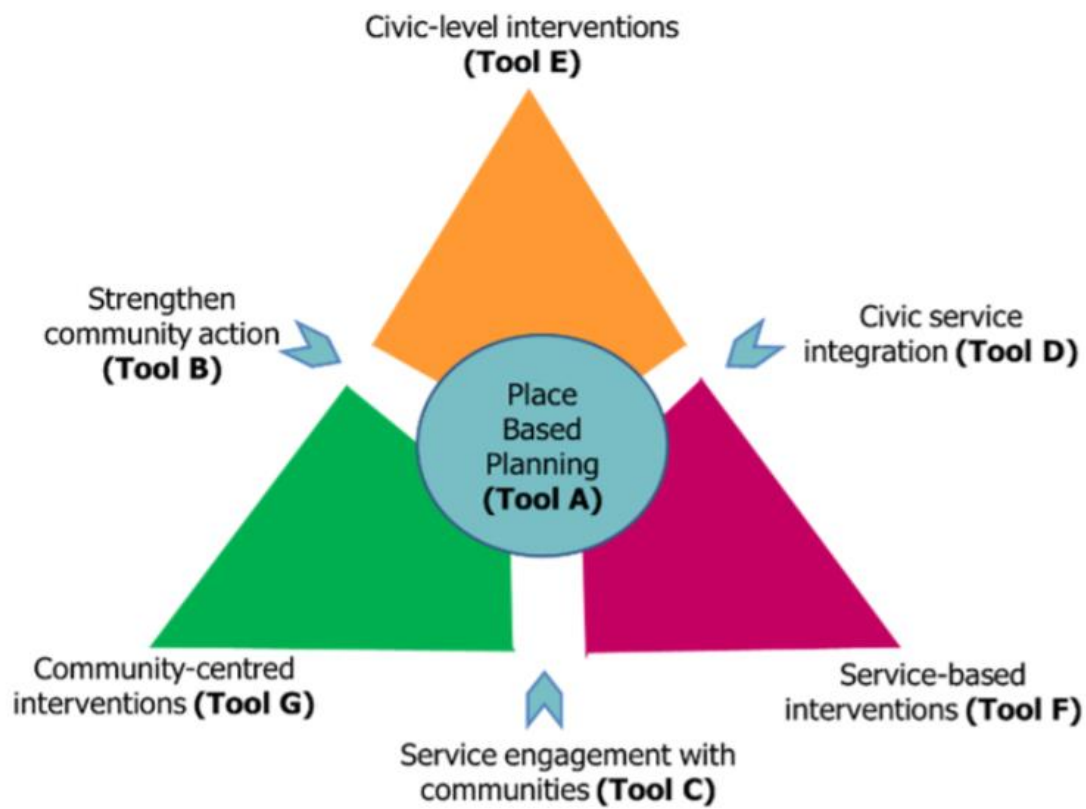
Application of the Health Inequalities Framework

To address potential inequalities in uptake, the place-based approaches to addressing health inequalities will be adopted.

This includes three key steps:

1. Equalities insights used to support development of vaccination programme and communications.
2. Tailored outreach provision and communications for sub-populations who have been identified as having lower uptake due to known challenges with accessibility (i.e. homeless) or low vaccine confidence (i.e. faith groups).
3. On-going review of the disparity between expressed need (vaccine uptake) and actual needs (numbers eligible for vaccination). In sub-populations or geographical areas (MSOAs) identified with lowest uptake, the Service *Engagement with Communities* toolkit will be adopted to further engage communities. This will be enabled by an outreach community engagement provision which will be put in place to work with communities on the ground to understand the barriers in the community and where appropriate deliver alternative models of vaccination delivery and/or messaging and wraparound support (i.e. support with travel).

These steps will be applied to the strategic plans which will aim to address possible inequalities in the uptake of the vaccination programme.



Place Based Approaches to Addressing Health Inequalities PHE July 2019

Evidence

National overview

During the pandemic, there has been a spotlight on the impact of health inequalities. Further research is still ongoing to understand the direct and indirect impact of Covid-19, but we know that risk factors such as ethnicity, deprivation, occupation and disability / ill health relate to prevalence.

A review of research into vaccine uptake in the UK by the Local Government Association found the following groups are on average less likely to get a Covid vaccination than others[11];

- BAME communities (Note: BAME is an umbrella term for a highly heterogeneous population. This means that not all the findings presented below will apply to the entirety of the BAME community)
- Groups experience economic deprivation
- Mentally ill and those with learning disabilities
- Women
- Young people
- Populations with English as a second language
- Transient and migrant workers
- Homeless populations
- People not registered with a GP
- Those living in less accessible geographical areas
- Traveller communities
- Key workers
- Semi-skilled and unskilled workers and unemployed people
- Orthodox religious groups
- Pregnant women
- Parents and people living with children

Within other national vaccination programmes such as flu, there are disparities in uptake between different groups within communities and geographically. Understanding of these will be required to help address barriers and ensure that any co-administration of a Covid booster with a flu vaccine does not have an adverse effect.

Flu vaccine and ethnicity

The recommendations on vaccine uptake from the House of Commons Select Committee noted 'the high geographical and demographic variation in uptake in some groups.'[12] The Government's response recognised that there was a need for tailored activity to meet the needs of BAME communities 'where there was low take-up' and for those with disabilities.[13] A study in Scotland also suggested that there

[11] A review of research into vaccine uptake in the UK https://www.local.gov.uk/our-support/coronavirus-information-councils/Covid-19-service-information/Covid-19-vaccinations/behavioural-insights/resources/research

[12] House of Commons Science and Technology Committee Report on Flu Vaccination in England: Ninth Report of Session 2017-19 , https://publications.parliament.uk/pa/cm201719/cmselect/cmsctech/853/853.pdf

[13] Government Response to the House of Commons Science and Technology Committee Report on Flu Vaccination in England: Ninth Report of Session 2017-19 , DHSC, January 2019, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/769777/government-response-to-report-on-flu-vaccination-in-england.pdf

was significantly lower take-up from the Polish community and other minority ethnic groups.

Flu vaccine ingredients

Guidance from PHE indicated that the 'nasal vaccine contains a highly processed form of gelatine (porcine gelatine), which is used in a range of many essential medicines. The gelatine helps to keep the vaccine viruses stable so that the vaccine provides the best protection against flu.'[14] NHS England issued guidance in 2013/14 which noted that 'some groups within the British Muslim community may consider the porcine product to be forbidden' but that people in this position would be unable to accept many pharmaceutical products unless there was no suitable alternative and/or the product was considered life-saving.[15]

Learning disabilities

People with learning disabilities have been identified as being particularly at risk of complications from flu. This risk informed the development of a targeted flu programme[16] for people with learning disabilities and their carers.[17] These groups align to cohort 6 of the Covid-19 vaccination programme.

Surrey population overview

According to the 2011 census, Surrey has a population of 1,132,400.

- The largest 5 year cohort is aged 45 - 49 with a population of 89,700. The fastest growing cohort since 2001 is the 60-64 age group which increased by 35% between 2001 and 2011
- Overall, 51% of the Surrey population is female and 49% male
- White was the majority ethnic group at 1,023,700 in 2011 (90.4 per cent). Within this ethnic group, White British was the largest group at 945,700 (83.5 per cent). Indian was the next largest single ethnic group with 20,232 people (1.8 per cent) followed by Pakistani (1.0 per cent)
- Across the districts in Surrey, Woking was the most ethnically diverse area, and Waverley the least
- The majority of the population in Surrey is Christian (62.8%). Muslim is the next biggest religious group (2.2%)
- English is the main language of 94% of Surrey residents. Polish and Chinese languages are the most common other languages. 88.5% of people whose main language is not English can speak English well or very well

[14] The flu vaccination Winter 2020/21, PHE, July 2020, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806856/PHE_Flu_Vaccination_12pp_A5_booklet_2019.pdf

[15] The flu vaccination Winter 2020/21, PHE, July 2020 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806856/PHE_Flu_Vaccination_12pp_A5_booklet_2019.pdf

[16] Guidance Flu vaccinations: supporting people with learning disabilities: PHE, Updated 25 September 2018, PHE, https://www.gov.uk/government/publications/flu-vaccinations-for-people-with-learning-disabilities/flu-vaccinations-supporting-people-with-learning-disabilities

[17] Learning Disabilities Observatory People with learning disabilities in England 2015: Main report, PHE November 2016, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/613182/PWLDIE_2015_main_report_NB090517.pdf

- The day to day activities of 13.5% of Surrey's population are limited by a long-term health problem or disability. This proportion is unchanged since 2001
- The activities of 88,600 (5.7%) are limited "a lot"
- 108,400 (9.6%) Surrey residents are providing unpaid to care to a friend or relative

Local flu vaccination uptake

2020/21 flu vaccine uptake

Eligible groups	2020/21 ambition	National uptake	SE uptake	Frimley	Surrey
Aged 65 years and over	At least 75%	81%	81.80%	82.10%	80.20%
Under 65 clinical at-risk group	At least 75%	52%	56.50%	57.40%	56%
Pregnant women	At least 75%	44%	47.50%	45.30%	47.90%
Aged 50 to 64 years	N/A	34%	36.60%	35.70%	35.20%
Children aged 2 and 3 years old*	At least 75%	58%*	64.80%	64.20%	66.20%

* based on the higher 3-year-old uptake

In 2019/20 the proportion of those aged 65 and over who took up the vaccine in Surrey was 70.8%

Compared to 19/20, 20/21 uptake across the Surrey Heartland NHS trusts increased slightly overall, with variability in size of increase across sites. In children aged 2 to 3 years old in Surrey Heartlands, uptake in 20/21 was comparable to 19/20. Data is not currently available to look at local disparity in uptake by most protected characteristic or health inclusion groups.

There is a big national focus on maternity units signing up to deliver the flu vaccine to pregnant women this year.

Local Covid-19 vaccination uptake

Surrey-wide, 873,182 first doses have been administered between 8th December 2020 and 16th August 2021. 67% of individuals in Surrey have received first dose COVID-19 vaccinations. This is the above the South East and national averages (66% and 64% respectively).

In total, 768,922 second doses (59% of individuals) have been administered across Surrey between 8th December 2020 to 16th August 2021.

Although the vaccination programme has been effective and in line with or exceeding national progress, there are still disparities in who is taking up the vaccine offer that need to be considered and focused on in phase 3.

Ethnicity and deprivation

Ethnic groups with the lowest uptake observed in decile 2 (higher deprivation) are;

- Black – Caribbean
- Mixed - White and Black African
- Chinese

Black/Black British Background have the lowest uptake within the lowest uptake areas (MSOA) in Surrey - Woking, Runnymede, Guildford, Spelthorne, Elmbridge and Reigate and Banstead. We also observe lower uptake for individuals with Any Other White, and White and Black Caribbean ethnic groups.

Age

As of the 8th of August, across Surrey, uptake by PCN ranges from 92% to 98% for cohorts above 70 and Clinically Extremely Vulnerable (CEV). Uptake in the cohorts aged 50 to 69 years is variable, ranging from 83% to 95%. Uptake in the 40 to 49 years cohort ranges between 76% and 88%.

Lower uptake is seen in under 30s, where complacency towards to vaccine is higher.

Geographical location

There has broadly been high uptake across Surrey, but lower uptake is observed within parts of 8 of our districts and boroughs, including Runnymede, Spelthorne and Elmbridge.

1st dose uptake in Surrey districts and boroughs, South East and England between 8th of September 2020 and 15th August 2021

Area	Under 18	18-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+	Total	Since 1st August
England	3%	63%	62%	65%	70%	76%	82%	86%	89%	93%	64%	1%
South East	3%	68%	66%	70%	75%	80%	85%	89%	91%	94%	66%	0%
Surrey	3%	70%	68%	72%	77%	81%	85%	88%	90%	94%	67%	1%
Elmbridge	4%	68%	67%	72%	78%	80%	82%	84%	86%	91%	64%	1%
Epsom and Ewell	3%	71%	67%	73%	79%	83%	86%	89%	90%	93%	66%	0%
Guildford	4%	67%	69%	72%	75%	82%	86%	89%	91%	95%	67%	0%
Mole Valley	4%	75%	73%	73%	79%	83%	86%	90%	91%	95%	71%	1%
Reigate and Banstead	2%	72%	69%	72%	77%	82%	86%	89%	90%	94%	66%	1%
Runnymede	3%	60%	57%	67%	72%	77%	81%	84%	87%	92%	63%	0%
Spelthorne	2%	70%	67%	69%	73%	78%	83%	87%	90%	92%	65%	0%
Surrey Heath	3%	78%	72%	74%	78%	83%	87%	89%	91%	95%	69%	0%
Tandridge	3%	73%	70%	74%	81%	84%	87%	90%	91%	94%	68%	0%
Waverley	4%	71%	71%	77%	81%	85%	89%	91%	92%	95%	69%	0%
Woking	3%	70%	70%	70%	73%	77%	82%	85%	89%	92%	64%	1%

Note: The table above is colour-coded to help with interpretation. The colours show the uptake from lower (yellow) to higher (dark green). The colours are applied for each column separately, rather than across the whole table. Looking across a row will give an indication of how a district/borough compares to the others in Surrey.

Insight and engagement

All locally completed and planned behavioural insight work is based on the COM-B model for behaviour change to understand the wide-ranging barriers faced by

individuals. This model is used when reviewing services, and when looking at how these services operate within the community.

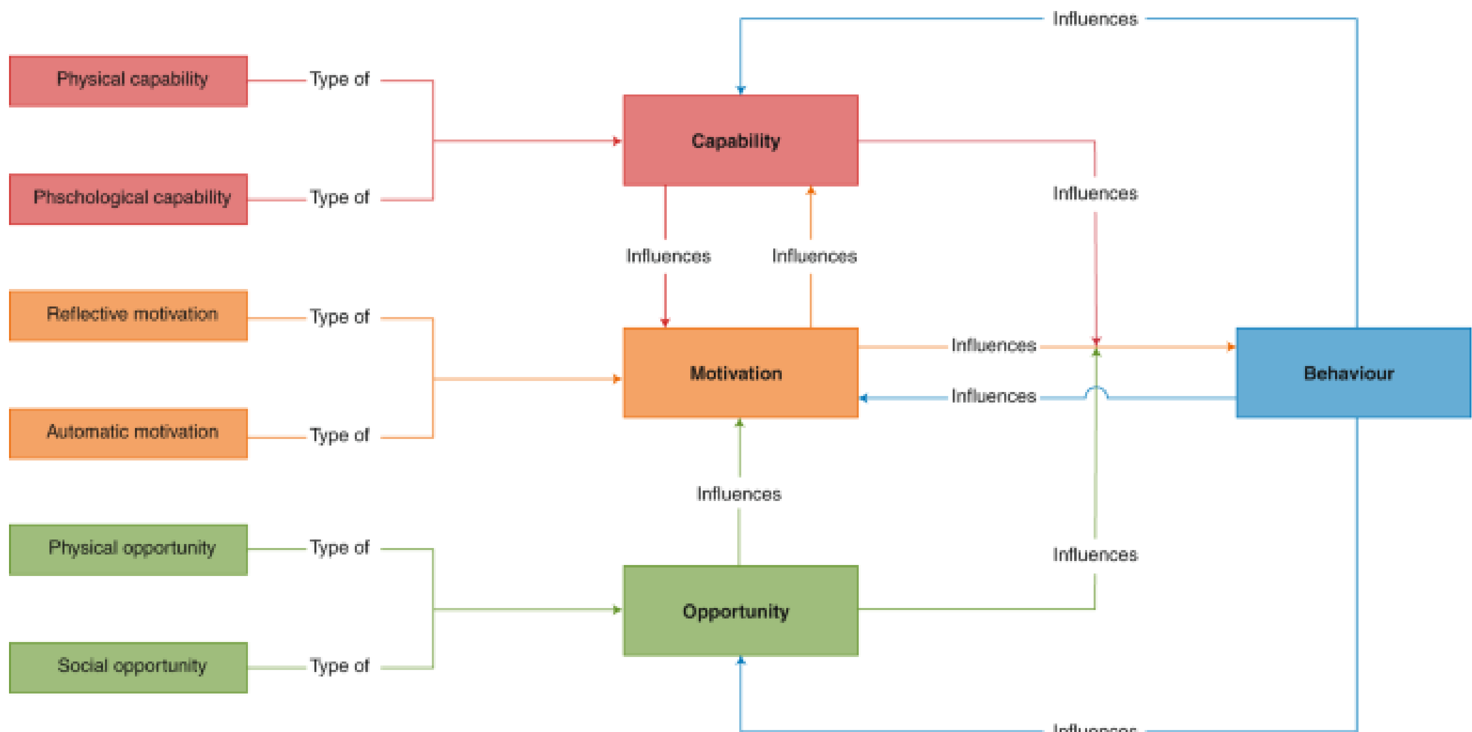
Extensive and wide-ranging engagement work has been undertaken locally to better understand barriers, concerns and challenges faced by low uptake and vulnerable groups and to inform decision making and future work. Through this work there has been engagement and analysis of barriers to vaccination uptake applying the COM-B model with:

- Care homes
- BAME forums/networks
- Eastern European communities
- Black/African and Caribbean Community
- GRT Community
- Parents
- Young people, including 12-19 year olds
- MSOAs with lowest uptake geographies (Local community groups, taxi drivers, maternity groups etc)

There are key themes that influence uptake have been identified across different groups and communities:

- Convenience (accessibility and improving access for those seldom heard)
- Confidence (community engagement and communications)
- Complacency (this is of particular relevance to younger populations and Eastern European communities)

COM-B model for behaviour change



Protected characteristic and health inclusion groups: barriers, local insight, recommendations

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
All groups	**Potential positive impact** A Covid booster jab will provide reassurance to vulnerable groups, hopefully giving them greater confidence to not restrict their day to day activities. Co-administration of the flu vaccine and Covid booster will allow those in the eligible groups for both to potentially combine two appointments in to one, which may help to improve uptake, particularly if there is hesitancy or apathy for an individual around one of the vaccines. Practically it is more efficient and also reduces travel time and cost if the two are co-administered. **Potential adverse impact** • Inequalities seen in earlier phases will persist if barriers are not addressed • If/ where co-administration is possible, this may have a mixed response from patients depending on their prior experiences of flu and Covid vaccines. Some patients may be concerned over side effects and prefer the vaccines separately. It is important to note that it increasingly appears that in due to practicalities co-administration will not be a common option, and the focus will more be on joined up communications and promoting the two vaccine together. • Where sites and care homes are deemed as suitable for co-administration of both vaccines in one appointment, flu vaccine may not be available at the same time as the Covid vaccine. Booster vaccination should start in September and GPs may not receive their flu supplies in time to start this. • In cases of delayed vaccine supplies and where people wait for a combined appointment for flu or Covid vaccine– this would potentially put vulnerable groups at clinical risk of Covid and/or flu.

<table>
<tr><th>Protected characteristic/ health inclusion groups</th><th>Barriers, insight and recommendations
• Convenience
• Confidence
• Complacency</th></tr>
<tr><td></td><td>• Flu eligibility does not completely align to Covid vaccine eligibility and different vaccines suitable for different age cohorts makes delivery and planning complex. Clear messaging will be required for staff coordinating and communicating with patients on the offer.

Recommendations and considerations for phase 3

• Ensure accessibility of information provided (such as parking information and list of sites offering walk-in clinics where no appointment is needed).
• Continue actions made during earlier phases in terms of practical/ logistical adjustments to improve accessibility alongside flexible delivery models to enable targeting for communities with lower update, e.g. vaccination bus at Caterham, pop up sites, walk in sites.
• Ensuring vaccination sites are inclusive to all groups, both physically and in terms of the environment/ reception. (EIA Phase 1 checklist)
• Continue or establish two-way dialogue with low uptake communities, to better understand attitude towards boosters and co-administration and be able to effectively plan the phase 3 offer and the provision of information and support to meet their needs.
• Clear messaging is needed on eligibility of flu vaccine – as there may be an expectation that everyone is eligible for flu vaccines. This needs to be communicated through a diverse range of channels in a variety of formats, to provide information to all communities through their trusted channels.
• Messaging where appropriate for potential concerns for receiving Covid booster alongside flu due to a range of factors – such as side effects, ingredients, existing hesitancy issues relating to Covid vaccine.
• Monitoring data on flu and Covid vaccine uptake will be crucial to aid action planning throughout phase 3, we have seen significant shifts in public attitudes throughout the Covid pandemic and also need to be conscious of and reactive to this.</td></tr>
<tr><td>Age: older people; middle years; early years; children and young people.</td><td>• Older people are more likely to experience neurological conditions such as dementia, sensory impairments as sight loss/ hearing loss and experience mobility problems. These issues need consideration when planning vaccination communications, as well as the vaccination sites themselves and their suitability for older people (see disability section for further information).</td></tr>
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Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
	• Invites for attending vaccinations, such as the online National Booking System, text messages and emails, could potentially lead to digital exclusion for patients don't have access to mobile phone to receive an invite, as with earlier phases other methods such as letters with information should be available. • Older people and young age groups (18-24) are less likely to have access to a car and may rely on public transport. • Older groups that access via car will require parking facilities, issues of lack of parking and parking costs may represent a potential barrier. • Older people may feel anxious to attend appointments[18], this may be exacerbated in areas where there is a surge of cases. • Access to information through social media and internet may differ between different age groups. Older people may be less likely than younger groups to engage confidently with digital technology, whereas younger groups may be more likely to come across vaccine misinformation on social media. • Young people are more likely to be complacent in regard to Covid vaccination, due to less of a concern about becoming severely unwell. • For the 12 – 15 cohort, processes around parental consent need to be considered. • A national qualitive study with 17 young people aged 16 – 29 years old who had previously indicated they were either fairly or very unlikely to get the vaccine found: o Primary factors for increasing vaccine hesitancy included distrust of vaccine (safety and content); distrust of government and of those encouraging vaccine take up; concern about known and unknown side effects (including on fertility); and belief it was unnecessary for those at low risk of harm from the virus. o Changes in vaccine hesitancy appeared related to media influences, experiences of others having the vaccine, and opinions of those in close social networks; the impact of vaccine passports was mixed and could result in encouraging some participants to be vaccinated but discouraging others completely. o Generally, vaccination in the future was considered by participants, but this was often far in the future because of a wish to know more about long-term side effects, and dependent on more information, research, and medical studies being available. o There were subtle differences between some demographic characteristics; the youngest participants were more influenced by negative social media narratives, female participants were more concerned about fertility related side effects, while Black participants indicated higher levels of generalised distrust.

[18] https://www.ageuk.org.uk/information-advice/coronavirus/staying-safe-and-well-at-home/coronavirus-anxious/

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
	Local population insight • Greater numbers of people in living in care homes in Reigate & Banstead and in Waverley which will present more of a need for community health service provision in these areas. • Elmbridge followed by Reigate & Banstead and Waverley have significantly greater numbers of people in the older age groups that are prioritised first. • In the **at risk** 12-17 year old cohort it is estimated that there are 1,352 eligible patients, excluding 235 who have already been vaccinated (this does not include all 16 – 17 year olds that are now eligible). • Insight work undertaken by Surrey Heartlands with young people highlighted concerns around the safety of the vaccine, mixed views on getting the vaccine and a desire to have reduced restrictions for those who have been vaccinated. • Findings from a survey of 500 12 – 23 year olds in Surrey to understand their knowledge and perception of the vaccine included: o 8.2% felt negative about the vaccine, 79% positive and 12% on the fence. White British young people and those from a C2DE background were more likely to feel negative. o Young people from ethnic minority groups are more positive about the vaccine than expected. o 12% are unlikely to have the vaccine, 19% are undecided o Changing guidance and speed of development are key concerns around the vaccine o The top three things that may discourage young people from getting the vaccine were: government blame on young people for spreading the virus, lack of translated information and systemic racism o 9% felt uninformed on the vaccine o The government, the media (news) and social media featured highly in where young people get information on the vaccine. White British young people are less likely to get information from trusted sources and more likely to get it from social media. Doctors and specialists are the most trusted forms of information • Council Digital Network survey of 557 Surrey parents found: o Overall positivity towards the vaccine 3.72 (out of 5) o 78% had both doses, 5% 1 dose, 16% no vaccination o 67% would book a vaccination for their child

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
	○ 57% would not opt out if it was rolled out in school ○ Opinions very polarized. Negative feelings driven by: Side effects, myocarditis, clots, fertility, “experimental” vaccine, new/unknown. Positive feelings driven by: Desire to protect children from Covid, first-hand experience of severe Covid within family, less time off school, very positive about vaccine in general **Recommendations and considerations for phase 3** • Learning from Covid vaccination programme to date in terms of booking systems, digital literacy, accessibility and location of vaccination sites. • People that are classed as ‘housebound’ need to be provided for and communicated to about this provision. • Vaccination sites used to delivery phase 3 to consider being well lit and prepared for adverse Autumn and Winter weather, as older people especially vulnerable to falls and slips/ trips. • Vaccination sites need to accommodate people who work and might find daytime hours difficult to attend vaccination appointments. • Consideration of planning age cohorts above age 12 within risk groups that are now eligible for the Covid vaccine. Issues of consent need to be considered for people under the age 16 who would require parental/ guardian consent. • Continue walk in sites and pop up clinics in areas targeting certain age cohorts, e.g. the centre of Guildford for younger cohorts. • Utilise PHE literature to be designed for children. • Aim to have one consistent support offer to all children and young people in 12-17 year old cohort to avoid confusion. • Focus on messaging to lower socio-economic areas to grow confidence in the vaccine in young people. • Work with younger cohort to understand what would motivate them to get vaccinated, and disseminate this through appropriate communication channels.
Disability: physical, sensory and learning impairment; mental health condition; long-term conditions.	In relation to disability, the potential co-administration plans of delivery of flu with Covid booster could provide some positive impacts for the following groups (if logistics of delivery were worked out): ○ Older people living in residential settings as the delivery could be similar or same as that of phase 1 and 2 of the Covid vaccine programme. Many of these residents may fall under the protected characteristic of disability

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
	○ Young people living in residential settings as the delivery could be similar or same as that of phase 1 and 2 of the Covid vaccine programme. Many of these residents may fall under the protected characteristic of disability • Uptake of flu vaccination is historically lower for people with a Learning Disability, and within this is especially linked to lower socio-economic backgrounds and ethnic minority backgrounds. Co-administration of flu with COVID-19 vaccination booster may help to boost flu or conversely may reduce booster uptake. • Long standing queues will be not suitable for people with mobility issues or /and frailty problems, and outside waiting will be not suitable for people with disabilities/ long term health conditions during cold/ wet weather • Disability (including physical, sensory, LD and long-term mental illness) has a significant impact on how people access health services. The NHS implemented the Accessible Information Standard (AIS)[19] in 2016 to ensure that communication needs of patients with a disability were met, learning from phase 1 and 2 of the vaccination programme will help in meeting communication needs of the population. • Neurological conditions such as Dementia, Alzheimer's and Stroke may impair patents understanding of the vaccine programme. For vaccination for people with dementia, consideration will need to give in circumstances where the patient no longer has capacity (this will especially apply to phase I). • People with needle phobias and procedural anxiety may be a barrier for some attending vaccination appointments[20] – estimated 10% of the population may have a needle phobia. Trypanophobia is term for extreme fear of medical procedures • People on the Autistic Spectrum are not a standalone priority group within JCVI for phase 3. They may fall into cohort 4 or 6 during phase 1 of the programme if they have other conditions. The needs of this group will need consideration for the vaccination work. • People with disabilities are more likely to rely on public transport, therefore location of sites is important. Also, consideration of disability parking and mobility scooter parking. • Patients with poor mental health, may experience significant anxiety to access the vaccination in a public space which may be acerbated by large and busy vaccination centres[21] • Some people with a disability may be excluded from digital information and online methods of booking appointments

[19] https://www.england.nhs.uk/ourwork/accessibleinfo/
[20] https://www.uhs.nhs.uk/Media/UHS-website-2019/Patientinformation/Tests/Blood-injury-and-needle-phobias-and-procedural-anxiety-patient-information.pdf
[21] https://www.verywellmind.com/fear-of-leaving-the-house-2583915

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency

	Local population insight
	
	• The day to day activities of 13.5% of Surrey's population are limited by a long-term health problem or disability. The activities of 88,600 (5.7%) are limited "a lot".
	• More people are in supported living in the west of county compared to care homes being more populous in the east of the county.
	
	Recommendations and considerations for phase 3
	
	• Vaccination plans to be delivered within community settings need to continue consider accessibility issues. This was addressed in earlier phases in which all site completed a checklist. There is a requirement within equality legislation to make 'reasonable adjustments' for people with a disability to address potential barriers to access the vaccine – this includes considerations over the physical environment such as:
	  ○ access for people with reduced mobility and wheelchair users, (alternatives for stairs), accessible toilets, signage, hearing loops, Assistive / guide dogs allowed (signage that this is allowed), reception areas – height accessible for wheelchair users, Doors accessible and help with heavy doors (wide/entry buttons in accessible positions) Ideally sliding doors are more accessible
	• Consider vaccination sites for health and social care staff that have a disability, location of vaccination sites for staff may need to consider this for disability parking and physical environment to support access.
	• People that are classed as 'housebound' need to be provided for and communicated to about this provision
	• The needs of people with invisible disabilities will need consideration for the vaccination work. The needs of different disabilities are far ranging, and vaccination work may be required to make reasonable adjustments to meet the needs of individuals with a disability (whether visible or invisible)
	• Significant work has been undertaken to ensure appropriate provision for those with mental ill-health:
	  ○ Workshop on SMI SPI-B
	  ○ Identification of target populations groups, including SMI, personality disorder, depressive impairing functionality, server depression, PF, prescribed anti-psychotics
	  ○ Gap analysis (SMI register work, demographic information on SMI, more local information, support for bookings)
	  ○ Actions identified: protocol to communicate with practices, expansion of definitions, work on inpatient vaccinations

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
	○ An inpatient vaccination programme is delivered by the NHS Mental Health Trust. Further work is required to develop an outreach programme with private Tier 4 providers and all those who are vulnerable due to mental ill health is underway. • Similar work has also been untaken to provide for people with learning disabilities to identify target population groups and undertake a gap analysis. This has resulted in: ○ An outreach model in all residential settings for adults with learning disability and/or Autism. Quiet Time appointment slots are available at the vaccination sites for those with ○ Learning Disability and/or Autism accessing the vaccinations in the community. ○ Health Checks are offered at the time of second doses. ○ Support webinar with Dr David Williams – aimed at people with LD to increase uptake • Information and communication about the vaccination programme needs to consider the communication needs of people with disabilities, such as information within accessible formats such as easy read, larger font, audio, BSL where appropriate. Learning from early COVID-19 planning showed there was a delay in accessible easy read materials being developed by NHSE. • Consider promoting the phase 3 vaccination programme across specific mental health services to engage with people with mental health conditions that may face barriers to attend vaccination appointments. • National Easy Read leaflet/assets need to be cascaded; including copies printed locally and distributed to sites. • Phase 1 produced Needle phobia materials including links to IAPT online and materials for frontline and the public
Gender Reassignment and/or people who identify as Transgender	No public data is available on take up of flu vaccine and Covid vaccination in relation to Gender Reassignment / Transgender, therefore no differences in uptake have been able to be assessed. Some evidence on healthcare more broadly is available from LGBT rights charity Stonewall: • A published report on transgender experiences in 2018 highlights that a significant number of trans people face inequalities and discrimination when accessing healthcare services.[22] **Recommendations and considerations for phase 3**

[22] https://www.stonewall.org.uk/system/files/lgbt_in_britain_-_trans_report_final.pdf

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
	• Considerations for vaccination sites include staff training, representative messaging and the use of non-clinical settings which may be a source of negative experiences for this group. • Explore opportunity for promotion at Pride of Surrey in September
Marriage & Civil Partnership: people married or in a civil partnership.	No current impacts have been identified relation to people with this protected characteristic.
Pregnancy and Maternity: women before and after childbirth and who are breastfeeding.	• Data on flu vaccine uptake indicates it is generally low in women who are pregnant. • Lower uptake during phase 2 of Covid vaccination may result in this group coming forward to receive their first and second vaccine (evergreen offer) when they make an appointment for receiving their flu vaccine[23] • Phase 3 is unlikely to include the majority of pregnant women due to them being vaccinated in line with their age group and that they will largely be under the age of 50. There may be small numbers of people in pregnancy who are eligible for phase 3 due to being part of cohort 6 within the JCVI priority groups. • In terms of breastfeeding people, JCVI advises that breastfeeding people may be offered vaccination. Although this updated information now enables pregnant women to access the vaccination, there may be some hesitancy. **Recommendations and considerations for phase 3** • To promote the vaccine, trusted organisations and healthcare workers could be used to promote vaccination messages – such as midwives, RCOG[24], and National Childbirth Trust. JCVI guidance states suitability of vaccine during pregnancy and breastfeeding[25].

[23] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/04/c1259-jcvi-announcement-regarding-Covid-19-vaccination-during-pregnancy-and-next-steps.pdf

[24] https://www.rcog.org.uk/globalassets/documents/guidelines/2020-10-14-coronavirus-Covid-19-infection-in-pregnancy-v12.pdf

[25] https://www.gov.uk/government/news/jcvi-issues-new-advice-on-Covid-19-vaccination-for-pregnant-women

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
	• Risk factors of exposure to COVID-19 and Flu should be taken into account to consider vaccination for pregnant NHS workers / Social Care workers • Monitoring uptake of people receiving COVID vaccine and flu vaccine during pregnancy and ensuring that access for clinical discussions is available for this group accessing vaccine.
Race and ethnicity	• There is clear evidence that ethnicity is a risk factor for Covid-19[26] with higher mortality and morbidity rates amongst different Black and Asian groups. • Trust in communities regarding the vaccine is variable with persistent concerns about the ingredients, number of doses and the process. • The movement of Gypsy, Roma and Traveller community may pose an issue for engaging on the vaccine and receiving timely booster vaccinations.[27] • Nationally the government has recognised a need to tailor flu vaccination activity to better meet the needs of BAME communities. **Local population insight** • Ethnic groups with the lowest Covid vaccination uptake in Surrey observed in decile 2 (higher deprivation) are Black - Caribbean, Mixed - White and Black African, and Chinese. Black/Black British Background have the lowest uptake within the lowest uptake areas (MSOA) in Surrey - Woking, Guildford, Spelthorne, Elmbridge and Runnymede. We also observe lower uptake for individuals with Any Other White and White and Black Caribbean ethnic groups. • There is lower uptake in the Black /Black British category across mid to lower deprivation deciles. • As of the 2/8/2021 in order to achieve equity for the Chinese population in Surrey, 2,090 additional Chinese residents would need to be vaccinated (total eligible population 7,512).

[26] Addressing racial inequalities is about identifying any ethnic group that experiences inequalities. Race and ethnicity includes people from any ethnic group incl. BME communities, non-English speakers, Gypsies, Roma and Travelers, migrants etc.. who experience inequalities so includes addressing the needs of BME communities but is not limited to addressing their needs, it is equally important to recognise the needs of White groups that experience inequalities. The Equality Act 2010 also prohibits discrimination on the basis of nationality and ethnic or national origins, issues related to national origin and nationality.
[27] https://www.england.nhs.uk/ltphimenu/improving-access/improving-vaccination-uptake-in-gypsy-roma-and-traveller-and-other-inclusion-health-groups-via-the-world-health-organization-who-tailoring-immunisation-programmes-tip-model/

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency

	• It is estimated that the actual GRT population in Surrey is approx. 5 to 6 times higher than official figures (between 10,000 and 12,000).
	• Insight work has shown complacency to be particularly prevalent in local Eastern European communities.
	
	Recommendations and considerations for phase 3
	
	• Incorporate learning from work to engage with Gypsy, Roma and Traveller community into delivery plan:
	  ○ Working with the GRT liaison team, continue to offer a bespoke service to known sites across Surrey Heartlands arranging for roving teams to outreach. This is supported by a co-produced video to promote and enhance confidence in the vaccination programme.
	• Consider mix of flexible delivery models to encourage good uptake from different ethnic backgrounds, such as the use of pop up vaccination sites to be targeted at communities of lower take up.
	• Continue SASH BAME roving model, there is a twilight clinic based at East Surrey to address vaccine hesitancy in frontline staff
	  ○ Discussions are taking place with Ashford St Peters and The Royal Surrey Hospital, who are very interested to participate in this initiative and further talks are being held with Care Homes to see if this model may be adapted for them.
	• Link outreach community workers with GRT leads to ensure confidence in the system and joined up efforts
	• Ongoing engagement of ethnic minority communities through trusted community and faith leaders for example the Surrey Minority Ethnic Forum, Mosques, churches and workplace forums.
	• Insights into the challenges in confidence in the vaccination and convenience are, and will continue to be, addressed using evidence based and co-designed messages through appropriate channels and temporary clinics. These insights and responses are developed at individual ethnic minority cohort level.
	• Information on phase 3 should be available in different languages and bi-lingual workers/staff should support the delivery of vaccinations within care homes and vaccination sites.
	• Re-engage work to co-design video with University students and Black African Caribbean society supporting family, include #diditfor
	• Monitoring work to continue to have a focus on ethnicity in phase 3, including looking to improve data where ethnicity is not recorded or unknown.

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
	• Continue weekly task and finish group set up to monitor data at MSOA by cohort and ethnicity for districts and boroughs with the lowest uptake for first and second doses
Religion and belief: people with different religions/faiths or beliefs, or none.	• The Covid vaccines developed do not contain animal products, egg or foetus material[28]. • Possible co-administration with the flu vaccine may raise issues/ confusion regarding ingredients, ○ Newly developed flu vaccine injections do not generally contain porcine[29], however, Porcine trypsin is used in some injected influenza vaccines, and in other vaccines against rotavirus, chickenpox and polio. Its use, and subsequent elimination from the vaccine, has been considered acceptable by some Muslim scholars[30] and the Catholic Church in England and Wales[31]. ○ Religious scholars (excluding veganism) feel that vaccinations with animal ingredients is acceptable where the vaccine has a benefit to protecting life. The Muslim Council of Britain (MCB) state that vaccines need to be developed that are halal but have never advised that Muslims should automatically refuse vaccinations. Vegan Friendly organisation notes that vegans should not refrain to taking vaccines where ingredients contain animal products due to the overriding health benefits of vaccination programmes[32]. • Religion and belief can influence take up of preventative health care such as vaccination programmes. This may relate to and strong belief in self-reliance and fatalism about health[33]. ○ Fatalism, (is the belief that an individual's health outcome is predetermined or purposed by a higher power and not within the individual's control) may affect take up. • Philosophical beliefs (personal belief) may lead to differing views affecting take up, there is a growing social media presence of anti-vaccine belief which may affect take up. • Within certain religions such as Islam and Judaism, there are requirements for women regarding the uncovering of their skin. Ideally, where possible health care treatment should be given by female health care staff, or in cases where this is not possible,

[28] https://www.gov.uk/government/publications/regulatory-approval-of-pfizer-biontech-vaccine-for-Covid-19/information-for-healthcare-professionals-on-pfizerbiontech-Covid-19-vaccine
[29] https://www.nhs.uk/conditions/vaccinations/flu-influenza-vaccine/
[30] https://www.gov.uk/government/publications/use-of-human-and-animal-products-in-vaccines/guide-to-the-use-of-human-and-animal-products-in-vaccines
[31] https://www.cbcew.org.uk/home/our-work/health-social-care/coronavirus-guidelines/update-on-Covid-19-and-vaccination/ (note that this statement incorrectly states that vaccine contains Fetal matter
[32] https://www.veganfriendly.org.uk/health-fitness/vaccines/
[33] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4144788/#:~:text=A%20person%20with%20fatalistic%20beliefs,luck%2C%20fate%2C%20or%20God.&text=We%20use%20this%20term%20to,their%20religious%20beliefs%2Fspiritual%20practices

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency

to only bear skin for the duration of time needed. Planning of vaccination work therefore needs to consider dignity of patients and women that may not wish to bear skin to male (should be addressed as over 70% of NHS staff are female)[34].

- Standard Operating Procedure document states that patients that require additional support such as chaperone should be met.

Summary of the key concerns of commonly hesitant groups and which messages should be highlighted in communications to which groups (Insight from PHE and Multicultural Marketing Consultancy, insights from Surrey County Council Engagement):

Community	Key Concern(s)	Key areas to highlight in communications
Black African / Caribbean - Christian	General mistrust, intentions of the vaccine, side effects, concerns regarding fertility	Details on who was involved in clinical trials Clarity on side effects and safety
Muslim	Ingredients in the vaccine	Clarity on ingredients
Polish	General mistrust, fertility concerns, intentions of the vaccine, complacency wellness	Details on MHRA approval Details on how the vaccine was developed so quickly
Ultra-orthodox Jewish	Ingredients in the vaccine and permissible by religion	Clarity on ingredients Support from faith leaders

Local population insight

- The top three religions across Surrey are Christianity, Islam and Hinduism.
- There is a known scientology community in East Grinstead – worth noting as this borders Surrey.

Recommendations and considerations for phase 3

- Utilise learning from phase 1 and 2 of the COVID vaccination programme for religion / belief and areas of good practice of linking in with faith leaders and running vaccine clinics from places of worship e.g. Hindu Society.

[34] http://www.imamfaisal.com/2011/11/05/can-a-muslim-woman-be-treated-by-a-male-doctor/

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
	• Pop-up vaccination sites have been set up within mosques and in areas where there is a greater percentage of Muslim community. These have been run by staff of different ethnic backgrounds. ○ E.g. Pop-up Pfizer clinic for Ahmadiyya Muslim Community- a bespoke clinic has been set up at G-live, Guildford to drive uptake focusing on the Muslim Community where uptake has been lower. (a model which has been adopted across the county) • The British Islamic Medical Association issued a position statement on 06 December 2020 recommending the Pfizer/Biontech vaccine for eligible at-risk individuals in the Muslim community. They cite that 'trust in public health messaging from Government sources is low, especially amongst minority communities' that poses a risk to vaccination uptake. They recommend that 'it is imperative individuals are given sufficient information regarding vaccination'.
Sex: men; women	• Learning from the phase 1 and 2 of the COVID Vaccination Programme highlights that although there is no significant variation in take up of vaccine across sex overall, there may be some local variations across specific communities in relation to ethnicity and religious belief. • The majority of health and social care staff are female (77% of NHS workforce are females), who will be asked to have the booster and flu vaccines[35]. A flexible approach to vaccination of Health and Social Care staff is needed as women are more likely (compared to men) to work part time and or have childcare / care responsibilities **Local population insight** • In over 40s, men in Surrey are less likely to be vaccinated than women, this trend is not seen in under 40s. **Recommendations and considerations for phase 3** • Vaccination work to be carried out in private spaces to ensure dignity and privacy. • Communications need to appeal to all genders, and depending on trends in uptake, may need to focus on a particular gender.

[35] https://www.nhsemployers.org/engagement-and-networks/health-and-care-women-leaders-network/women-in-the-nhs#:~:text=77%20per%20cent%20of%20the%20NHS%20workforce%20are,Gender%20in%20the%20NHS%20infographic%20for%20more%20information.

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
Sexual orientation: Lesbian; Gay; Bisexual; Heterosexual.	• No public data is available on take up of flu vaccine and Covid vaccination in relation to sexual orientation. • National research notes that the LGB community face barriers and disadvantage when accessing health and social care which may relate to lack of understanding from healthcare staff regarding LGB health needs[36]. **Recommendations and considerations for phase 3** • Explore opportunity for promotion, questions and answers sessions and vaccination pop up at Pride of Surrey in September
Groups who face health inequalities[37]	Summary explanation of the main potential positive or adverse impact of your proposal
Looked after children and young people	A 2017 evidence review found that[38]: • Looked-after children and young people in the UK are less likely to be 'up-to-date' with their immunizations than children in the general population. • Looked-after children and young people are less likely to receive timely immunizations, and older LACYP are less likely to be 'up-to-date' than younger LACYP. • Barriers to immunization include failure to attend health checks, absence from school and frequent placement moves. Unknown and discrepant immunization histories, name changes, sharing of information between organizations and obtaining consent for immunizations are also challenges. **Recommendations and considerations for phase 3**

[36] https://www.stonewall.org.uk
[37] Please note many groups who share protected characteristics have also been identified as facing health inequalities.
[38] Walton S, Bedford H. Immunization of looked-after children and young people: a review of the literature. Child Care Health Dev. 2017 Jul;43(4):463-480. doi: 10.1111/cch.12452. Epub 2017 Mar 19. PMID: 28317146.

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
	• This is a new cohort for this phase of the vaccination programme and the motivations and reasons for getting vaccinated will differ compared to older age groups with great complacency likely, particularly for the 16 – 17 year old cohort where all are eligible. Additional support for looked after children and young people will be needed. • Nationally, and locally, incentives are being explored which may be more important for some of these groups, along with vaccination becoming mandatory for things like clubs and other venues.
Carers of patients: unpaid, family members.	• Vaccination of health and social care staff and unpaid carers needs to consider flexible times, and vaccination locations to consider travel and access to public transport – as a large proportion of carers are older and may not have access to a car. Travel costs may be greater for carers that have caring responsibility for more than one person and need to support multiple attendances. • In phase 3, carers who are an adult household contact of immunosuppressed individuals should be offered booster revaccination with allowance for operational flexibility. Guidance notes that this group should be offered a third dose of COVID-19 booster vaccine as soon as practicable, with equal emphasis on deployment of the influenza vaccine where eligible. Carers who are eligible for flu vaccine and co-administration may help flu uptake for this group. • The Carers Trust carried out a survey on impact of COVID-19 and found impact on wider wellbeing of carers in terms of increased time spent caring and impact on mental health. This was especially felt for young carers[39,40] • Unpaid carers are more likely to be older and low incomes but may also include young carers[41] • Many people may not identify as a 'carer' but will have caring responsibilities and should be made aware that they can/encouraged to take up the vaccine as part of priority group 6 • Carers living in rural areas will need to be assured that they can access the vaccination appointment locally. **Local population insight**

[39] https://carers.org/we-care/measuring-the-impact-of-Covid-19-on-young-carers
[40] https://www.carersuk.org/news-and-campaigns/news/state-of-caring-report-2019
[41] https://www.england.nhs.uk/commissioning/comm-carers/carer-facts/

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
	• According to the 2011 census, 108,400 (9.6%) Surrey residents reported that they provide unpaid care. The proportion has changed little since 2001 when 9.4% were providing care. Most carers are providing less than 20 hours per week, but 11,000 are providing 20 to 49 hours per week and 18,500 are providing more than 50 hours per week. • A lot of work has been undertaken with health and social care staff. In the case of staff in care homes there are still small pockets of unvaccinated individuals that will be faced with a vaccine mandate in September, with termination possible for those who remain unvaccinated. Unvaccinated individuals need to continue to be supported during this time. Learning from phases 1 and 2 showed White British health and social care staff were less likely to take up the vaccine. • Care Home session has taken place with those with low uptake, insights will be gathered and synthesised. • As at 24 August, in CQC registered Care Homes, 97% of residents, 89% of staff and 71% of agency staff have received their first vaccination. 95% of residents, 80% staff and 58% of agency staff have received their second vaccination. • The range across PCNS shows that between 92% to 97% of NHS Health Care Workers (with ESR record) have received their first dose, and, of these, 94% to 98% have received their second dose vaccination. 85% of domiciliary care providers and 77% of Social Care staff not working in registered care homes or domiciliary care providers have received their first dose vaccination. **Recommendations and considerations for phase 3** • Continue to implement Guidance for deploying vaccine for unpaid carers[42] • Encourage carers to register for the Emergency Carers Card with Surrey County Council • Care homes are still facing challenges around getting staff their first does of the vaccine where they have been hesitant or not taken up the offer, roving teams will be utilised to help pick up this group. • Clear messaging around eligibility criteria, to help people identify themselves as eligible. • Information to be given for carers that need to accompany someone they care for to their vaccination appointment. • Signpost carers to information and support services available: www.surreycc.gov.uk/social-care-and-health/adults/looking-after-someone/your-role-as-a-carer • Currently looking into case study- implications of what happens if carehome staff do not get vaccinated for the whole carehome.

[42] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/03/C1182-sop-Covid-19-vaccine-deployment-programme-unpaid-carers-jcvi-priority-cohort-6.pdf

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
Homeless people. People on the street; staying temporarily with friends /family; in hostels or B&Bs.	• This group often face poor health outcomes, and these are acerbated by the physical and mental toll of being homeless. Rough sleepers die (on average) 30 years younger than the general population.[43] • Research shows that this group have disproportionately low levels of engagement with preventative health services. **Local population insight** • Working with housing organisations, we developed a survey for frontline staff to inform our thinking and service model to address vaccine hesitancy in the homeless community. Feedback suggested there were no access issues for obtaining a vaccination as the vaccination services were providing outreach services to this community. This universal offer has continued. **Recommendations and considerations for phase 3** • Any staff working for homeless organisations have received an open vaccination offer, without NHS registration, which will continue. • The Homeless and Rough Sleepers return has been compiled and updated weekly by SCC colleagues to monitor the rates of vaccinated homeless people, providing assurance that every homeless person identified has been offered a vaccination and this work will continue. • Continue close partnership working to provide information and access to vaccination to this group, including utilising Homeless network for districts and boroughs e.g.York Road project in Woking and one in Leatherhead. • Adapt NHS Vaccine rollout flyer to prevent misunderstanding for homeless and asylum. • The Outreach working group has met weekly since February 2021 and will continue to support vaccine roll out for the homeless population.
People involved in the criminal justice system: offenders in	• Prisons tend to have large numbers of people living close together which is a risk for COVID transmission and limited space for social distancing.

[43] https://www.midlandsandlancashirecsu.nhs.uk/download/publications/equality_and_inclusion/Homelessness-guidance-2019.pdf

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
prison/on probation, ex-offenders.	• People in prison have a higher prevalence of respiratory illness (including asthma), immunosuppression (for example, due to HIV infection) and other chronic illnesses (such as cardiovascular disease, diabetes or liver disease) than their peers in the community. • Increasing numbers of older people in prison have a high level of physical health needs which may put them at risk of complications of flu, and now Covid-19. • Ministry of Justice and Public Health England produced specific guidance[44] on Flu in prisons and secure settings. • There is no current national guidance on vaccination prioritisation but current outbreaks pose a high risk in terms of maintaining safe staffing numbers, mental impact on prison population and transmission rates causing serious ill health and death • This population may not feel safe or welcome in vaccination centres. • This population may not be registered with a GP if only recently released. • If they have moved to a different address on release and not informed their GP practice, letters from their GP practice will not be received. **Local Population Insight** There are 5 closed adult (18+) prisons in Surrey: • HMP High Down – male prison, approx. 1100 capacity; category B (including remand • prisoners) • HMP Downview – female prison, approx. 350 capacity • HMP Send – female prison, approx. 282 capacity • HMP Coldingley – male prison, approx. 513 capacity; category C resettlement • HMP Bronzefield - female prison, approx. 572 capacity – run by Sodexo

[44] https://www.gov.uk/government/publications/seasonal-flu-in-prisons-and-detention-centres-in-england-guidance-for-prison-staff-and-healthcare-professionals/flu-in-prisons-and-secure-settings-adult-guidance

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
	There is low churn in inmates in Surrey prisons and vaccination uptake in prisons has been good. Low vaccination confidence has been expressed by Prison officers. **Recommendations and considerations for phase 3** • Continue internal Health Care Staff administering vaccinations to eligible cohorts detained in prison. • Explore options around probation appointments to do outreach and offer vaccination. • Provide a program of support to prison officers, first understanding the barriers to uptake and addressing them
People with addictions and/or substance misuse issues	• Presenting to a timescale may be more difficult for this group such as for high impact complex drinkers. Their GPs would know if any are CEV so they will get flagged; the challenge is in getting these patients to the vaccination centres especially if it is not their own GP practice, which is highly likely. • Mental capacity may be an issue. • Stigma and illegality may disincentivise engagement with statutory organization **Local population insight** • On any given day, approximately 1,600 people are in substance misuse care plan treatment. • Projected 8,106 alcohol misusers in the county. • Projected 2,600 substance misusers in the county. • SABP have added standard question for all 1,600 users on vaccination status and have identified 200 for outreach support • Barriers to access have been identified as difficulties accessing and booking vaccination and concerns about the content of the vaccination **Recommendations and considerations for phase 3**

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
	• Roll out approach to standard asking of vaccination status to all alcohol service providers through the treatment providers group and offer easy access into local vaccination providers i.e. Pharmacy • Take learnings from Phase 1 SABP and roll out to all Drug and Alcohol service providers in CVFS. This can be achieved through the treatment providers group. • Continue to offer outreach phone calls to those identified in above and support to overcome concerns about vaccination
People or families on a low income	• There may be associated cost with travel / parking to receive the vaccine which will have a disproportionate burden on low income households, including carers. • Access to information through social media and internet may be limited due to costs of IT equipment and connection / data costs therefore other methods of communication will be needed. • There is a need to consider barriers beyond just the cost associated with attending a vaccine, this group will likely have significant external pressures and stressors that impact their attitude towards and ability to take up the vaccination offer. **Recommendations and considerations for phase 3** • The Equality and Inclusion group review data on uptake of the vaccination by IMD (by ethnic minority and age) and GIS mapping to understand where communities are. This informs the Engagement and Insight sub-group in partnership with the GP Federations to understand the barriers to access and inform the development of an appropriate place-based response. • Community outreach workers are being deployed to areas of low uptake. These outreach workers are implementing Public Health England guidance for addressing Health inequalities using the Tools to support 'Place Based Approaches for Reducing Health Inequalities' • Location of vaccination sites to be at place of work or 'close to home' to mitigate potential barrier of travel costs, also need to consider that many Health and Social Care staff may be on low incomes.
People with poor literacy or health Literacy: (e.g. poor understanding of	• Health literacy is linked to literacy and entails people's knowledge, motivation, and competence to access, understand, appraise, and apply health information in order to make judgments and take decisions in everyday life concerning healthcare, disease prevention, and health promotion to maintain or improve quality of life during the life course. ○ People with low levels of literacy and/or health literacy are likely therefore to be under-vaccinated.

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
health services poor language skills).	• This also raises safeguarding issues for those who have lower literacy levels and may be reliant on others to guide them – which could lead to exploitation and/or reducing their ability to access services they need. • This group may not understand information around co-administration and or booster vaccinations. • Information provision needs to be clear, simple and accessible for those with low literacy levels, as well as being provided through different formats, e.g. use of Covid champions and not an over-reliance on written communication. **Local population insight** • English is the main language of 94% of Surrey residents. Polish and Chinese languages are the most common other languages. 88.5% of people whose main language is not English can speak English well or very well. 1,000 residents of Surrey cannot speak English at all. • Lower vaccination uptake has correlated with areas of lower economic investment • Non-text video information which can be easily passed on via whatsapp has greater reach than traditional channels of communication. **Recommendations and considerations for phase 3** • Consideration of this group needs to be embedded within the phase 3 communication plan, however there should not an over-reliance on translated/easy read materials as it may be that a different channel of communication, such as community leaders or a conversation with a healthcare professional may be needed, this will be facilitated through the community outreach posts. • Circulate Youtube disinformation clips available in Polish, Romanian and Chinese • Inclusion of links with social prescribing to ensure wider access to support with health literacy with engaged residents, social prescribing leads are included in Phase 1 Multi-agency response meetings for areas with low vaccination uptake, these should continue.
People living in deprived areas	• During Phase 1 and 2 of the COVID Vaccination programme, there are indications that take up has been lower in areas of highest deprivation, there are also links with deprivation and lower take up of flu vaccination.

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
	• Travel costs may be a barrier for people that are retired, unemployed, students, on low incomes or have limited incomes such as Asylum Seekers. A significant number of working age will have faced financial difficulties due to COVID and may have reduced incomes due to being furloughed or losing their jobs • Consideration of barriers beyond just the cost and potential transport needs associated with attending a vaccine, this group may have significant external pressures and stressors that impact their attitude towards and ability to take up the vaccination offer. **Local population insight** • Although broadly Surrey has relatively low levels of deprivation compared to other parts of the country, a link with low uptake and areas of deprivation has been seen. This also intersects with and is exacerbated within certain ethnic groups. **Recommendations and considerations for phase 3** • Ensure areas of high deprivation are covered when mapping vaccination sites. • Co-administration messaging needs to be clear as socio-economic status is not a category for eligibility for free flu vaccine, however there is no cost for the COVID-19 vaccination and booster, and it is free to receive. • Community meeting opportunities e.g. Food Banks may in some cases be a good opportunity to support and engage with this group, opening up two -way dialogue to inform programme. • In younger groups there is a link between socioeconomic status and a less positive attitude towards vaccination, this suggest target work in these areas is needed.
People living in remote, rural and island locations	• It is more likely that people in rural areas may need to travel to vaccination sites either by car or public transport, therefore increasing travel time and potentially cost. • Well thought through locations of vaccination sites in needed, and mitigations for this in terms of the transport offer where this isn't possible. **Local population insight** • Four of Surrey's boroughs are predominantly rural and approximately a quarter of Surrey's population are living in rural areas.

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
	Recommendations and considerations for phase 3 • Good geographical coverage for phase 3 will need to take into account public bus routes and rural / urban access • Transport support (non-cost) put in place for rural communities and areas known to have transport issues. • Phase 3 delivery sites should include rural areas to enable rural communities to access vaccinations. The different ways to access the vaccine should help mitigate access issues for rural communities. • Any vaccination sites need to be accessible within the given target travel time and include car parking facilities for those travelling by car. • Vaccination sites need to also be accessible for public transport with nearby bus stops. • Rural communities should not be disadvantaged to receive the vaccination, Primary Care and Community Pharmacies will play a key role to help to address this. • Community outreach to work with communities of less economic investment
Refugees, asylum seekers or those experiencing modern slavery	• This group may be at higher risk of transmission of COVID due to communal living arrangements. Young men ASR are more likely to live in a house of multiple occupancy (HMO). • Research indicates that this group have difficulties in accessing health care due to limited understanding our NHS and language barriers. ASR are more likely to experience poorer health outcomes, both physical ill health and mental ill health[45] • There may be a reluctance of coming forward for the vaccine due to fear of deportation. The government has stated that the vaccine is free regardless of immigration status. This was announced within BBC news dated 08/02/2021[46]. Ensuring that staff are aware of free access for ASR regardless of their immigration status and immigration should not be checked **Recommendations and considerations for phase 3**

[45] https://www.midlandsandlancashirecsu.nhs.uk/download/publications/equality_and_inclusion/Asylum-Guidance.pdf
[46] Covid: 'No deportation risk' for illegal migrants getting vaccination - BBC News

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
	• A mixed 'all age' (risk assessed) operating model to ensure reach is available for Homeless and Asylum Seekers in Surrey. A roving model of vaccinations is available in two settings, Renewed Hope and a Hotel in Horley. Local Housing teams support clients in emergency accommodation to access vaccinations through these two settings by providing taxi transport. • Successful work with ABC (provider for East Surrey ICP) supporting migrants to register with a GP. Teams visiting Quadrant House and SkyLane to provide vaccines: o Supporting primary care regarding Quadrant House (127 women and children) with registrations and sharing of information between practices, SH and partners. Worked closely with the Inclusion Health team regarding info sharing, reducing the conveyance rate and vaccines providing several roving team visits to QH. o Similarly involved with the new arrivals to SkyLane, coordinating between practices (Horley PCN plus Woodlands and Clerklands practice) and the hotel regarding registrations, access to healthcare and vaccines. This is a different cohort of 127 people (96 males and 7 families including babies/infants) and area liasing with the inclusion health team, partners and CCG. o QH is classified as an interim dispersal unit whereas SkyLane is taking new arrivals seeking asylum directly from their entry port to the UK, meaning the response regarding Covid, as in SkyLane there is no prior health information available and there is a difference in need. o Advised that SkyLane will accommodate people for 3 months although given the current pressures on housing and NHSE guidance it seems likely that this will be longer and people will be registered permanently, ensuring a record is created. • Need to be aware of changing/ dynamic situation with refugees from Afghanistan. o ABC will be responsive to any vaccines that are requested. Depending on where they are accommodated, we will support primary care in their response regarding registration of people- we have learnt a lot from the experience of QH and SkyLark. o There has been a significant number of arrivals into the quarantine hotels but these are largely in Sussex. o In response to this ABC is going to do trial doing basic assessments for one hotel and will then know if this approach works and can be scaled up.
People experiencing domestic abuse	• One partner in a relationship may be prevented from attending for vaccinations due to fear of repercussions. • Women in refuges: o Will not receive any appointment letter o May not feel safe attending a public space for a vaccination o May have moved out or into area for place of safety

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency

	Recommendations and considerations for phase 3
	
	• Continue work to:
	  o Provide a mixed delivery model and outreach on site to women in refuges to administer the vaccine. Liaising with the domestic abuse health group Safer Communities and Family Resilience lead to develop appropriate model, this will need to support the delivery of vaccine 1 and 2 from different sites)
	  o On a case by case basis engage all refuges and women's support services, including monthly meetings with them to check on any of the women who had moved area to ensure access to vaccination including when across county boundaries.
	  o Supported removal of patient information so information doesn't go back to home residence detailing that they'd had a vaccination somewhere.
	  o Work on supported conversations with team for managers to support staff to get vaccinated.

Armed forces	• This group are termed as a group of interest – rather than health inclusion group. Within this group access for the phase 3 will depend on their JCVI prioritisation group and flu eligibility. • Long term health of veterans tends to be worse compared with non veterans of the same age.[47] **Recommendations and considerations for phase 3** • To date this group have had their own programme, which is expected to continue.
Sex workers	• A vulnerable group that may engage less with healthcare for fear of stigma. • Sex workers are at heightened risk of ill health, substance misuse, and violence. • Agencies have criticised the lack of action to protect the health needs of sex workers during the pandemic, with the English Collective of Prostitutes (ECP) warning of a "ticking time bomb of health problems." [48] **Local population insight**

[47] https://www.midlandsandlancashirecsu.nhs.uk/wp-content/uploads/2019/04/VETERANS-GUIDANCE-2019.pdf
[48] Howard S. Covid-19: Health needs of sex workers are being sidelined, warn agencies BMJ 2020; 369 :m1867 doi:10.1136/bmj.m1867

Protected characteristic/ health inclusion groups	Barriers, insight and recommendations • Convenience • Confidence • Complacency
	• Approximately 140 female sex workers in Surrey, not clustered in one area. • Male sex workers are much harder to engage so less is known about this group. • Locally we have engaged voluntary sector organisation (Street Light) which goes through all listings for sex workers and offers outreach. This is done via text to offer a pregnancy test, sexual health information, support on getting another job and vaccination. • Response to/ engagement with outreach is low. **Recommendations and considerations for phase 3** • Continue outreach work and work to provide information on the ability to access vaccination without GP registration/ an NHS number and support them to present at a clinic and be seen as health worker to reduce stigma. • Taxi transport also available to attend vaccination appointments.

System Reference Group discussion

Actions identified in phases 1 and 2

The below actions were all implemented in phases 1 and 2 and will continue in phase 3.

Action
Share information that enables people to access community transport
Establish a central hub for enquiries
Clear explanation regarding different types of sites
Publicise access to The Big Word at vaccinations sites to provide interpretation support; include in invitation information and on website
Develop a video that explains the patient journey at a LVS
Pull-up banners that explain support that is available - entrance to each site
Develop Accessibility Guide for each LVS - publish on website and share link when patients book in. To include access by public transport.
Arrange for accessibility assessments to be carried out at each site and publish results
Publicise the parking arrangements for each site (including whether it is free or not/access to disabled parking/how far from LVS)
Work with SMEF to organise radio interviews at different radion stations to reach various ethnic groups via own language clinicians.
Work with SMEF to continue Covid Conversations over coming months with different groups.
Work with Maternity Voices Chairs to ensure clear information is cascaded on vaccination for pregnant women and women who are breastfeeding
FAQ on content of the vaccines with links to relevant statements
Meet with multi-faith group of Guildford Diocese to map out approaches needed
Programme of discussions with different faith leaders to explore what support they require to help increase vaccine acceptance
FAQ on vaccination for patients taking PREP
Communications on vaccination safety procedures to minimise fears regarding HIV/AIDS
Publicity to encourage unpaid carers to register as a carer with their GP
Carer awareness training for GP Feds and LVS teams
Clear messaging on priority group 6 including unpaid carers
Publicity to encourage Young Carers to register at GP - work with Surrey Young Carers
Infographic to explain the vaccination process

Actions required
Install hearing loops in all sites to enable people who are hearing impaired to provide informed consent
Ensure each site has stock of patient information in different languages
Ensure each site has face shields and/or face masks with clear panel to ensure people with hearing impaired are able to offer informed consent
Booking system allows patients to indicate support they require e.g. wheelchairs; Sighted Guides; quiet time; Braille; interpreter etc.
Easy read information available at each site
Make specific arrangements for certain groups e.g. people with LD - working with CCG and provider specialist in LD
Training for volunteers at sites on how to appropriately offer assistance
Engage trusted community leaders to work with each PCN/GP Federation to develop programme of activities that build trust and enhance confidence
Form links with the GRT Outreach Team to develop programme that enables discussion of any fears or concerns that members of this community may have.
Make links with homeless shelters and refuges to design vaccination
Review need for mobile vaccination vehicle to reach remote areas or to target specific areas with low uptake
Make links with i-Access Adult Substance Misuse Treatment Services and Catalyst High Impact team to encourage uptake of vaccinations.

Phase 3 discussion

Discussion of:

- *what has worked well to date*
- *where the gaps/barriers have been*
- *any specific considerations for protected characteristic/health inclusion groups with the different delivery of phase 3, particularly around willingness/appetite for a booster and co-administration with flu*

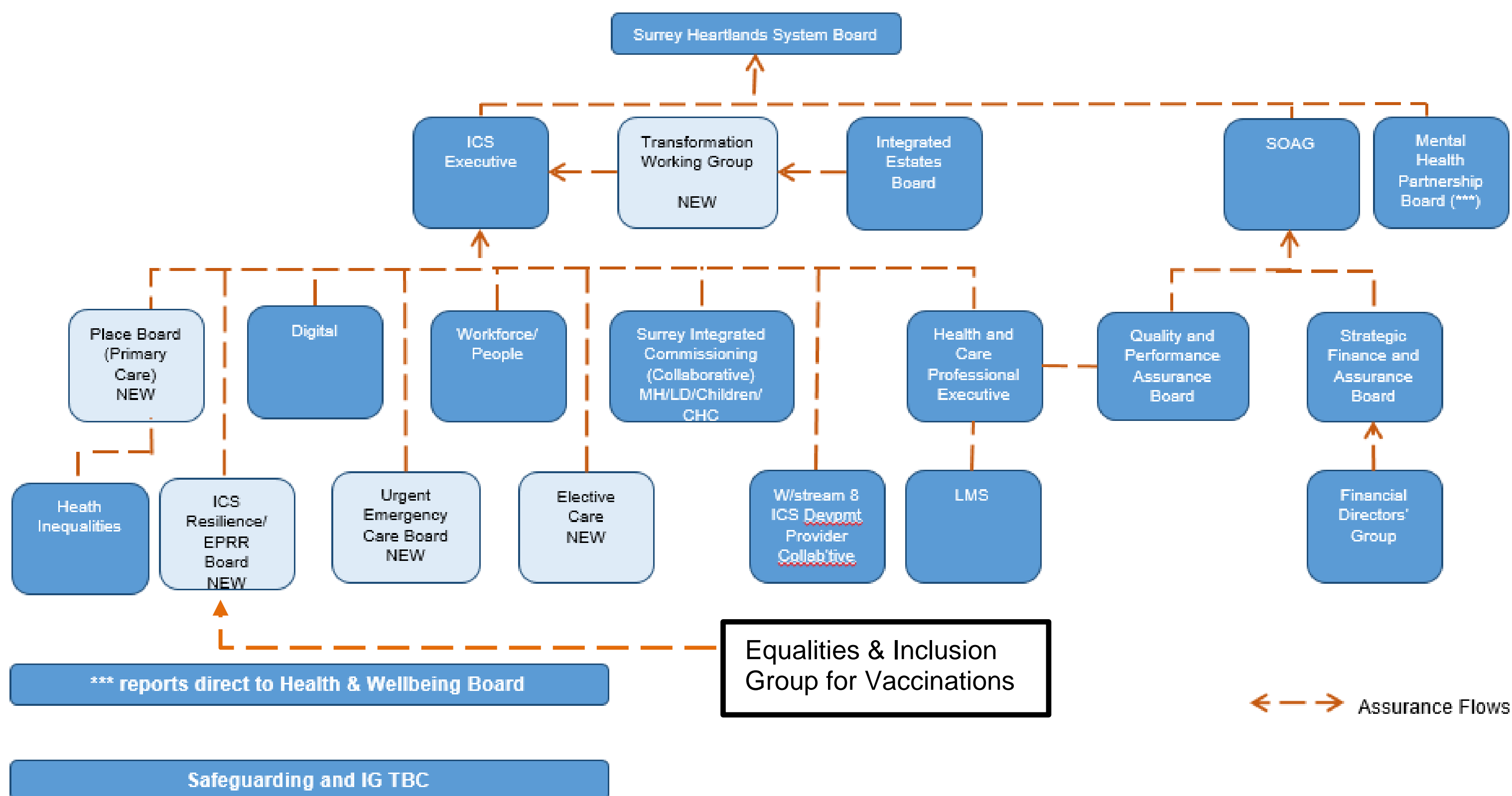
Attendees
Action for Carers
Healthwatch Surrey
Sight for Surrey
Surrey Coalition of Disabled People
Surrey County Council
Surrey Heartlands CCG
Surrey County Council User Voice & Participation Team, Children and Young People (sent insight in advance of meeting)

The full discussion notes can be found in Appendix B, and where appropriate actions have been added to the plan. Key themes that emerged included:

- **Coadministration**: some positivity in terms of efficiency however questions around consent and how this will be practically delivered.
- **Carers**: Clear need for clarity around whether there will be flexibility for carers to receive vaccines at the same time as the person/ people they care for.
- **Communication**: communication is crucial, particularly to combat misinformation, we need to be utilising specialist organisations, community groups and individuals to disseminate clear, accurate and consistent information. It has been clear that people are looking for information.
- **Accessibility**: Practical adjustments to the booking system and at vaccination sites to ensure accessibility need to continue to be front of mind.

Actions and next steps

Governance



Assurance of delivery of the actions EIA strategic plan will be overseen by The Equalities & Inclusion Group (EIG) for Vaccinations, chaired by Ruth Hutchinson. The EIG for vaccinations will directly report into the ICS Resilience/ EPRR Board.

The EIG reviews the data cell reports on vaccination uptake. Sitting underneath the EIG are;

- Two operational groups;
  - Equalities Communications, Insight and Engagement Sub-group
  - Operational Sub-Group for vulnerable groups

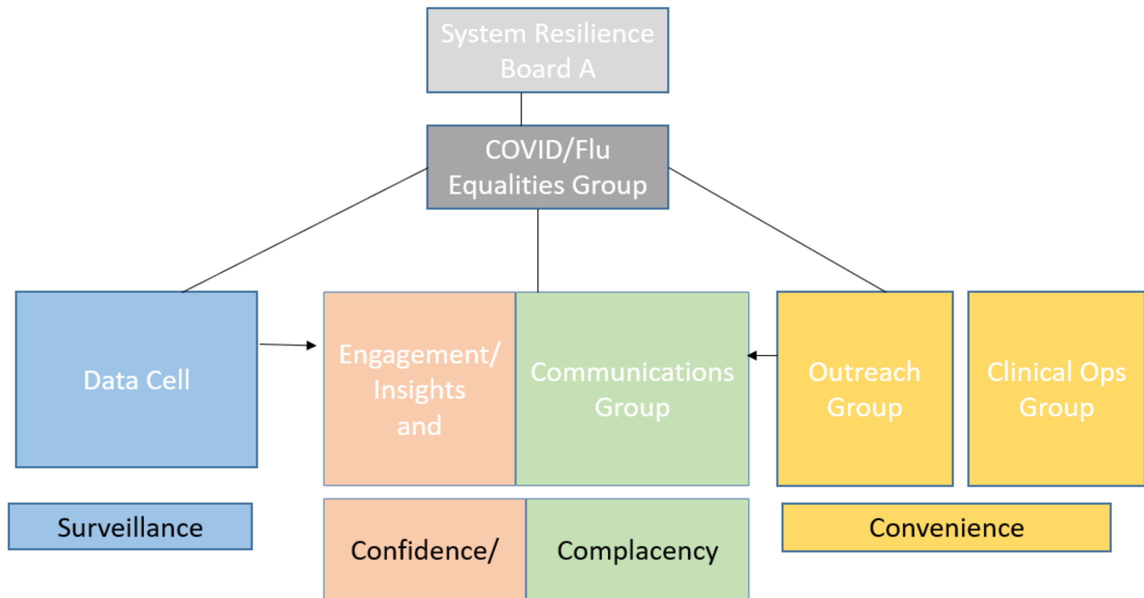
(ToR are available for both)

The operation groups below the Equalities and Inclusion Group for Vaccinations (Covid/Flu Equalities Group) and the areas of focus are outlined in the Strategic Delivery Plan graphic below.

- Multi-agency MSOA working groups for Middle Super Output Areas identified with low vaccination uptake. Groups have representation from; Public Health, Community Outreach Worker, ICP Vaccination Lead, D&B Health and Wellbeing Lead, SCC Engagement lead and Social Prescribing Lead.

The Equalities & Inclusion Group for Vaccinations will provide monthly update reports to the ICS Resilience/EPRR Board.

Strategic Delivery Plan



Overview of Phase 3 approach

Surveillance and data analysis

Qualitative insight and engagement

- Real time monitoring of progress, attitudes, and outcomes
- Increased understanding of barriers, gaps, and concerns to inform service delivery, with a focus on any additional/ unique barriers to phase 3
- Allowing an evidence based, agile and iterative approach to service delivery

BARRIERS	GROUPS DISPROPORTIONATELY IMPACTED	ACTIONS	OUTCOMES
Lack of convenience	Older adults, people with a disability, carers, homeless population, people living in deprived/ rural areas and/ or on a low income	**Practical/ logistical adjustments to delivery model**	**Increased accessibility of vaccination**
Lack of confidence	Certain ethnic minorities and faiths, Pregnant women, substance misuse, those in the criminal justice system, people with poor literacy/health literacy	**Comprehensive and effective community engagement and communications plan**	**Increased trust and ability to make an informed choice**
Complacency towards vaccine	Younger people (under 30), Eastern European communities	**Incentives, Emphasis on risks of Covid and benefits of vaccination**	**Increased motivation to get vaccinated**

Targeted work in areas of low uptake

In lowest 10 MSOAs by uptake:

- Community Engagement Officers (in each MSOA), Equity coordinator, Youth ambassador
- Multi-Agency MSOA Working Groups
- Analysis of Practices Uptake within PCN
- Community Engagement and Co-production

Phase 3 actions

Area	Action	Continue/ New to phase 3
Surveillance	Use of real-time data to aid action planning throughout phase 3, including segmentation by different groups/ geographies to understand where gaps are, where further work is needed and to work towards equitable access/ uptake	*Continue*
	Need to be conscious of and reactive to significant shifts in public attitudes throughout the Covid pandemic and identify when this is evident in the uptake data	*Continue*
	Reporting of Covid and flu vaccination data together in phase 3 to give a complete picture, though it is important to note that merging of the data is likely to have some challenges. This data will be refined throughout the season	*New*
	Learning from phases 1 and 2 of the COVID vaccination programme in terms of low uptake groups and areas, and how different communications can impact uptake, will inform work in phase 3	
	Learning from phases 1 and 2 of the Covid vaccination programme in terms of low uptake groups and areas, and how different delivery models can impact uptake, will inform work in phase 3	*New*
	Continue work to fill gaps in data, e.g. work to date where ethnicity was previously unknown to match this with other datasets	*Continue*
	Continue to monitor data at MSOA by cohort and ethnicity for districts and boroughs with the lowest uptake for first and second doses	*Continue*
	Real time monitoring uptake in Health and Social Care Workforce	
	Monitoring of delivery model to the 12 – 15 cohort, including mechanisms to gain parental consent. and segmentation of groups to identify inequalities in uptake	
	Monitoring of uptake for those with severe immunosuppression (12 and over) to receive their third dose as part of their primary vaccination provision and segmentation of groups to identify gap in uptake	
Qualitative insight and engagement	Incorporate learnings and actions taken following engagement work with different communities and groups to date • Surrey University providing monthly consultancy on approach and resource for evaluation	*Continue*
	Ensure two-way dialogue to understand and track how the service is engaging with communities, as well as shifts in public attitude/ feeling (applying evidence based behaviour insight models)	*Continue*
	Define communities and embed the workforce within communities to listen, understand barriers and attitudes to vaccination as well as external pressures that impact ability to engage with the vaccination programme	*Continue*
	Map assets currently available, including what we know about who makes up different communities and what they think	*Continue*
	Build on work to date to understand how the phase 3 service is interacting with the local communities, and their attitudes towards it. Answering the following questions will help to inform actions to reduce inequalities and improve equity of access:	*New*

	• What is public feeling, particularly in low uptake groups, on receiving a Covid booster as a standalone vaccine, and if co-administered with a flu vaccine? • What will encourage them to take up the phase 3 offer, and what are the barriers? • What are the solutions/interventions that can help to remove barriers? • What are the natural neighbourhoods, and how can the programme be embedded within and tailored to these? Some of this insight will be gathered though a survey to a representative sample of residents. This engagement will be ongoing and therefore we will have an agile approach to implementing measures to remove barriers, based on feedback from local communities.	
Increase convenience (Practical/ logistical adjustments to delivery model and improving access for those seldom heard)	Accessible booking systems and vaccine sites, building on what was implemented in earlier phases through a checklist (includes booking systems, digital literacy, accessibility and location of vaccination sites)	*Continue*
	Varied and flexible models of delivery e.g. walk in, booked appointments, local vaccination sites, community pharmacies, primary care • Consider areas of particular relevance to certain groups e.g. religious centres, probation appointments	*Continue*
	Inclusive environments through the pathway, from booking to being at a site. This may involve staff training and the use of non-clinical sites	*Continue*
	Provision for extremely vulnerable groups such as people classed as 'housebound'	*Continue*
	Reasonable adjustments made wherever possible, ensuring dignity and privacy for all attending sites	*Continue*
	Option of clinical discussions on taking up the vaccine where needed e.g. for pregnant or breastfeeding women	*Continue*
	Consider cost to access sites, and ensure geographical coverage is thought through	*Continue*
	Close partnership working with those embedded within and who have established trust with certain communities or groups e.g. homeless organisations	*Continue*
	Roving teams to meet groups with specific needs e.g. refugees, care home staff	*Continue*
	Raise issues with lack of two way texting offer about appointments to NHSE	*New*
	Explore funding support for Sight for Surrey Communicator Guides	*New*
	Vaccination sites used to delivery phase 3 to consider being well lit and prepared for adverse Autumn and Winter weather	*Continue*
	Incorporate learning from work to engage with Gypsy, Roma and Traveller community: Working with the GRT liaison team, continue to offer a bespoke service to known sites across Surrey Heartlands arranging for roving teams to outreach	*Continue*
	Continue SASH BAME roving model, twilight clinic based at East Surrey to address vaccine hesitancy in frontline staff • Discussions are taking place with Ashford St Peters and The Royal Surrey Hospital, who are very interested to participate in this initiative and further talks are being held with Care Homes to see if this model may be adapted for them	*Continue*

	Rural communities should not be disadvantaged to receive the vaccination, Primary Care and Community Pharmacies will play a key role to help to address this	*Continue*
	Continue successful work with ABC supporting migrants to register with a GP. Teams visiting Quadrant House and SkyLane to provide vaccines. • Coordination already in place between practices (Horley PCN plus Woodlands and Clerklands practice) and hotels on GP registration and access to healthcare/vaccines.	*Continue*
	Continue work to support those with mental ill-health, including protocol to communicate with practices, expansion of definition, work on in patient vaccinations	*Continue*
	Continue work to support access for people with learning disabilities	*Continue*
	Develop a social prescribing approach to access vaccination and support health literacy	*Continue*
	Review options for sessional workers sick pay. Review options for drop in access for staff to talk through concerns and book vaccination and use learnings to support private sector employers	*Continue*
	Ensure suitable and effective delivery model to the 12 – 15 cohort, including mechanisms to gain parental consent.	*Continue*
	Ensure suitable provision for those with severe immunosuppression (12 and over) to receive their third dose as part of their primary vaccination provision.	*New*
	Ensure communication, promotion and information provision is joined up with and embedded within the digital inclusion strategy	*New*
Increase confidence (Comprehensive, effective community engagement and communications)	Surrey Heartlands ICS leads communications for the vaccination roll out and in this instance around increasing the uptake of the COVID-19 vaccine uptake. This is a partnership piece of work and will require all key partners to engage and utilise their channels to ensure communications activity is effective. This will be done through two main types of communications activities: • to support vaccine avoidance and messaging about the benefits of having the vaccine/promotion of second vaccine etc • to work with key partners, responding to weekly data and behavioural insights to work in a targeted way to raise awareness and promote the uptake of the vaccine in settings where it is low, here is a few current examples: o in locations / communities such as boroughs or council wards o within areas where people are vulnerable such as young people with learning disabilities o areas with a high ethnically diverse population - particularly where there are known challenges with vaccine confidence (e.g. BAME, Eastern European) See protocol to be followed in Appendix D	*Continue*
	Clear, representative, and accessible messaging/ information on phase 3 roll out, including: • reason for booster • distinction to a third dose for people aged 12 and over with sever immunosuppression • eligibility	*New*

	• how this aligns/ doesn't align with the flu vaccine • possibility of coadministration where this is likely/ appropriate, issues of consent around this • what to do if you don't want co-administration (target to those where this is likely to be an option) • address concerns around feeling 'extra' unwell if receive both jabs together • concerns around receiving Pfizer if not had previously • options for co-delivery to carers with those they care for • community transport options • vaccine safety • what happens when you go for a vaccine (materials already created in phase 1 and 2, may need tweaking) Include the above in a FAQ doc to be disseminated and adapted for different audiences, e.g. Health and social care	
	Making Every Contact Count Training for frontline staff to have conversations on vaccinations	*New*
	Outreach support calls to those who have not received or declined Phase 1 2 or 3 of the vaccination programme	*New*
	Target community engagement utilising health inequalities toolkit C: Pilot sites approach to address equity of reach for 'Informed Choice' in lowest 10 MSOAs **Covid Outbreak Management Funds (COMF):** • Community Engagement Officers (MSOA) already working in Districts and Boroughs to Engage with communities regarding Vaccinations and COVID protective behaviours within target MSOAs to work through the equalities toolkit C (Woking, Spelthorne, Reigate &Banstead) • Equity Co-Ordinator (surrey wide) to support with PCN level data extraction where not available from PCN and operationalise appropriate vaccination service • Youth Ambassador (Borough wide) Engagement lead to mobilise messaging and delivery through existing youth partnerships charities and CVS (Guildford & Wavery) **Multi-Agency MSOA Working Groups** • ICP Leads (NWS, ES), Public Health SCC, Community Engagement Lead (D&B), D&B Health and Wellbeing Lead and/or community Engagement Leads, Social Prescribing Lead and SCC Engagement leads. **Analysis Practices Uptake within PCN** • Analysis of absolute uptake and Numbers remaining for vaccination who have not declined and not attended **Community Engagement and Co-production** • Engagement with the 'natural neighbourhoods' ask, listen, note, review, co-produce and do, opens the door for further strengthening of relationship with healthcare are local level and further place-based planning. **Aims:**	*Continue*

	1. **Defining communities:** working with the public sector boundaries, engage the communities and reframe, further define in relation to community boundaries and community infrastructure **2. Practical Asset Mapping**: Real time knowledge of key assets e.g. community leads, key community infrastructure assets 3. Community Centred approaches: Engagement and feedback to community leads to check findings and actions to ensure they resonate and are relevant, continued engagement and feedback. Engagements to understand vaccine confidence should be structured around the COM-B behavioural insights model COM-B template to understand vaccine hesitancy | Local Government Association **4. Shared Community Profile**: Continued development of insights profile, checked with the community **5. Vaccination/COVID action plan**: agreed contributions of the community and external stakeholders clear, formal mechanisms to feedback working to agreed principles **6. Outreach and in-reach plans**: peer workers recruited and trained and supported to provide an intermediary workforce, reducing cultural barriers to access and use. **7. Linking to the disengaged/excluded**: Targeted outreach to isolated / excluded groups. Credible first contact establishing trust, backed with multifaceted support options	
	Identify and add community, voluntary and faith network leads to any communications plan, to allow for consistency of messaging e.g. SMEF	*New*
	Ensure a variety of formats and channels are used, mapping on to where people go for trusted information including print, word of mouth, social media (particularly to combat 'fake news'), radio etc • Easy read, larger font, audio, BSL where appropriate • Different translations available and bi-lingual workers/staff should support the delivery of vaccinations within care homes and vaccination sites • Communications need to appeal to all genders, and depending on trends in uptake, may need to focus on a particular gender • Communication at vaccination sites around support	*Continue*
	Use trusted organisations and individuals to promote the vaccine, e.g. healthcare professionals, community leaders, faith leaders, Covid Champions, Police, clinicians, university	*Continue*
	Address key vaccine concerns, complacency/ apathy and questions, focusing on groups who are showing reluctance to engage with the vaccination programme	*Continue*
	Open up spaces for discussion, for people to voice concerns, frustrations and questions	*Continue*
	Issues of consent needs to be considered and communicated for people under the age 16 who would require parental / guardian consent	*New*
	Utilise PHE literature to be designed for children	*New*
	Focus on messaging to lower socio-economic areas to grow confidence in the vaccine in young people	*New*

	Food banks may provide an opportunity to better understand external pressures on certain groups, and what support is needed	
	Explore opportunity of Pride of Surrey to engage with LGBTQIA+ groups on vaccination	*New*
	Communications to support roll out of ‘quiet clinics’ for people with LD	*Continue*
	Set up webinars for Clinical leads to address challenges to update in low uptake care homes	*Continue*
	There will need to be a targeted, distinct piece of work with those aged 12 and over with severe immunosuppression to explain the third dose as part of their primary vaccination schedule, and the distinction with the booster vaccines. It may be expected that this group will be keen to take up the offer, however there is the potential for confusion with messaging around booster vaccinations.	*New*
Address complacency	Identify and support those who are reluctant to engage with vaccination or have non logistical barriers • Emphasis on relevant low uptake groups, such a younger people and Easter European communities, while also monitoring more broad trends in public attitude/willingness to engage	*Continue*
	Work with younger cohort to understand what would motivate them to get vaccinated and disseminate this through appropriate communication channels • This is a new cohort for the vaccination programme and the motivations and reasons for getting vaccinated will differ compared to older age groups with greater complacency likely, particularly for the 16 – 17 year old cohort where all are eligible	*Continue*
	Nationally, and locally, incentives are being explored which may be more important for some of these groups, along with vaccination becoming mandatory for certain social activities like clubs and other venues.	*New*

Appendixes

Appendix A Eligibility for under 18 cohort

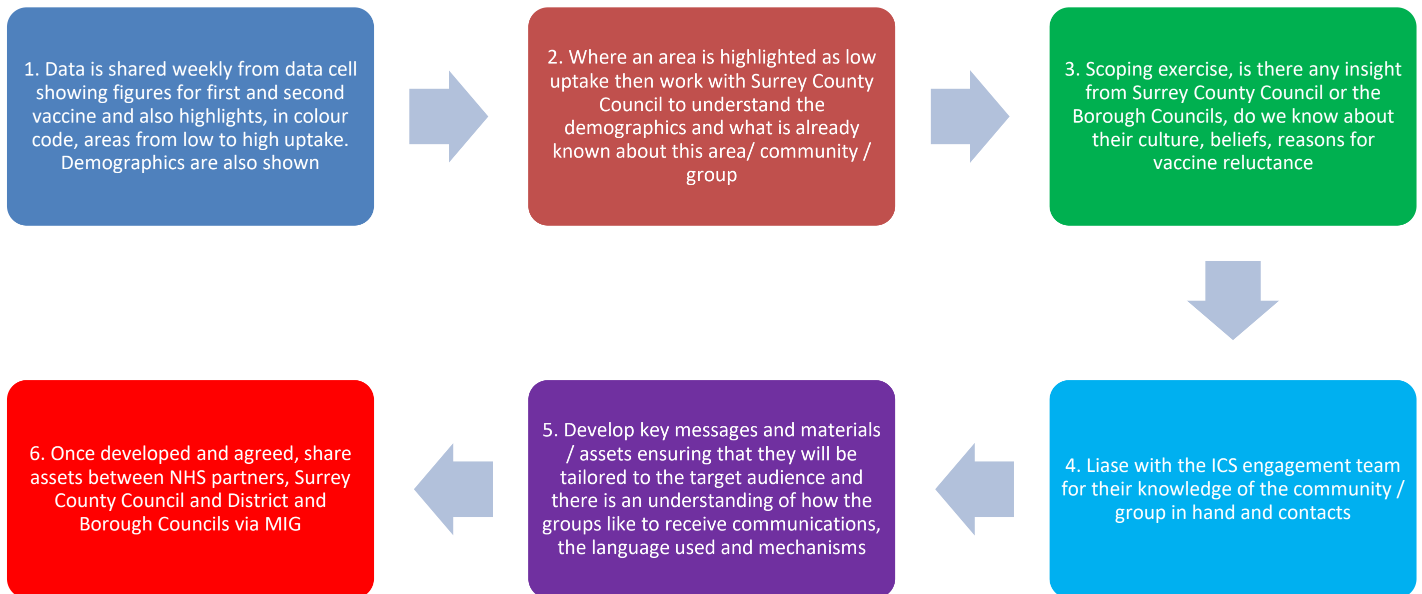
Cohorts	Valid Legal Mechanism	Number of Doses
17 and 9 months (‘18’)	Current PGD (6.8.21) and current National Protocol (13.4.21) or PSD.	2 doses
All healthy 16-17year olds	Current PGD (6.8.21) or PSD	1 dose currently (under review)
16-17-year olds clinically at risk or in the other at-risk groups (in cohorts 2, 4 and 6) as outlined in the Green Book	Current PGD (6.8.21) and National Protocol (13.4.21) or PSD	2 doses
Children 12-15 yrs old at risk and household contacts of immunosuppressed (as specified by JCVI)	Current PGD (6.8.21) or PSD	2 doses

Appendix B System Reference Group phase 3 discussion notes

Theme	**Notes/ points raised**
Convenience	• Some people who are visually impaired required assistance to take up the phase 1/ 2 vaccine offer but this need was met, e.g. help to make bookings • For those with hearing loss the lack of two-way text messaging with the NHS was a barrier • People with hearing loss/ who are deafblind benefit from communicator guides who can take people to appointments, but there is the issue of who can pay for this, as is an expensive offer • Hopefully it will be easier this time using lessons learnt already, and with the added benefit of face to face contact now available for those supporting residents • The earlier phases have had a big impact on carers registering with a GP, also to note for this phase is that time is very valuable for carers so the potential to tie in with the flu vaccine could be very appealing. Winter brings challenges and having the two together could help with this • Can carers have a booster/flu jab at the same time as the person they care for? • Where vaccination is happening at new sites accessibility needs to be front of mind – continue to use checklist • People who are housebound need to be planned for, seem to have been waiting a long time for second jab • Lots of older people don’t have smart phones • If getting the flu jab at GP surgery as usual this will be a lot easier, familiar territory

	• Frontline staff being vaccinated earlier is really helpful for VCS, allows them to support people better e.g. earlier this year was a coordinated effort by Community Action Surrey • Learning disabilities groups need focus, lower uptake across the country (feeding into vaccination equalities cell and workplan drawn up to ensure coverage to open up healthcare to this group)
Confidence	• IT and social media use good among those with hearing loss • Comment that work with SMEF to engage with different religions and ethnic minorities has seemed to work well, and been very inventive in terms of working with small minority groups and role models • How will invites work for coadministration? • To date carers have been worried about giving Covid to the person they care for and therefore isolating themselves until they are vaccinated • Communication needed around flu and Covid together if this is going to common, likely people will have concerns around feeling 'extra' unwell and will want the option to have them separately/ perhaps just have one • Will having had the Covid booster reduce uptake of flu this year? • Risk in homeless/ substance misuse populations and those involved in the criminal justice system that vaccine confidence is lower, need for things like pop ups in accessible places like town centres or at probation appointments • 'Fake news' a real issue, more pervasive in certain groups, need to not be met with silence from NHS, instead need continuity of messaging from trusted organisations • Communication piece is really important, carers have been accessing web information a lot more that prior to the pandemic, looking for guidance/info on Covid • Need to be collaborative on comms, including identifying and adding community, voluntary and faith network leads to any communications plan • Lower uptake for certain ethnicities in the first round, need comms for those who are eligible for a booster but haven't yet taken up the first or second dose. Themes for these groups include lack of trust in institutions and vaccine ingredients • Need to clearly explain to people the reason for the booster/ advantages of getting it • Concerns around new variants, could this be leveraged in communications around further protection – to combat apprehension for some • Prior reactions to jabs/ concerns around Pfizer if already had different vaccines need to be addressed
Other comments	• Where we are mentioning disability, be clear that this is physical and learning disabilities • Feeling that frontline staff will be generally very keen to have a booster • Feeling that a booster will help those who are still feeling apprehensive to leave the house and resume day to day activities, and help reassure them

Appendix C Surrey Partnership Communications Protocol for low uptake in Covid-19 vaccination



Appendix D Priority Groups 1 - 9

Priority	Risk group
1	Residents in a care home for older adults and staff working in care homes for older adults
2	All those 80 years of age and over and frontline health and social care workers
3	All those 75 years of age and over
4	All those 70 years of age and over and clinically extremely vulnerable individuals (not including pregnant women and those under 16 years of age)
5	All those 65 years of age and over
6	Adults aged 16 to 65 years in an at-risk group
7	All those 60 years of age and over
8	All those 55 years of age and over
9	All those 50 years of age and over
10	Rest of the population (to be determined)