



Deep End Report 37

COVID-19 Vaccine Deployment for Marginalised Groups in Scotland

This report summarises key themes from a virtual ‘roundtable’ meeting on COVID-19 vaccine deployment for marginalised groups in Scotland. The meeting was hosted and facilitated by the Deep End GP group, with participants from Scottish Government, Public Health Scotland, several Health Boards, and Third Sector representatives.

April 2021

SUMMARY

The COVID-19 vaccine offers a path out of the national lockdowns we have been living with for the past year. The current vaccine rollout is based on age and underlying medical conditions. The speed of rollout has been impressive and the uptake high, but we need to ensure that those who are also at known higher risk by virtue of socio-economic deprivation or ethnicity do not get 'missed'. More proactive approaches will be needed to increase vaccine confidence and uptake in these groups. Failure to do so risks a resurgence in Covid cases in our most deprived areas as lockdown eases.

On Wednesday 10th March 2021, the Deep End GP group hosted a virtual round table meeting regarding ongoing national COVID-19 vaccine deployment. In attendance were key stakeholders from Scottish Government, Public Health Scotland, several NHS Health Boards, and the voluntary sector, as well as members of the Deep End GP Steering Group.

The key themes from the discussion related to: 1) data collection, 2) adapting delivery models, and 3) adapting communications material. The following recommendations are made:

1) Data collection

- Collect ethnicity data at time of vaccination.
- Collect primary care data (via Vision, EMIS) in addition to via TURAS software systems.
- Use data to compare vaccination uptake in different sites.

2) Adapting delivery models

- Identify local leads to facilitate and 'authorise' the local flexibility described by the JCVI around vaccine delivery to address health inequalities.
- Agree national core principles to facilitate consistency – with local flexibility in how to deliver.
- Consider how best to support the role of general practice in vaccine deployment to under-served groups – from providing patient lists, to reviewing DNAs, to promoting vaccination through their established communication channels, to delivering the vaccine.
- Consider how best to utilise the current Direct Enhanced Service (DES) which is designed to facilitate and support general practice involvement as able, in negotiation with Boards, LMCs and local Public Health.
- Consider an authorised priority role for Community Link Practitioners CLPs in vaccine confidence-building and attendance for vaccination over the coming months.
- Teams that are best-placed to offer opportunistic vaccination to under-served groups (e.g. GPs and community pharmacies) should be prioritised for single-dose vaccines when they become available. Particularly useful for outreach for the 'hard to reach'.
- Agreement that these should only be used when necessary, as multi-dose vials more cost-effective.
- Clearer public steer that the homeless population, those from Black, Asian and Minority Ethnic (BAME) communities, and those living in deprived neighbourhoods are also priority groups. DPH to lead the push on this public messaging for all three reasons (individual clinical risk, public health risk, ethical).

3) Adapting communications material

- Resources that have been developed to be collated and shared widely, e.g. Lothian community videos in 11 languages.
- Consideration should be given to having a central repository for all these resources.

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BACKGROUND

The Joint Committee on Vaccination and Immunisation (JCVI) produced UK guidance on prioritisation of vaccine roll-out (based primarily on age and underlying health conditions) [1], which is being followed in Scotland:

1. Residents in a care home for older adults. Staff working in care homes for older adults.
2. All those 80 years of age and over. Frontline health and social care workers.
3. All those 75 years of age and over.
4. All those 70 years of age and over Clinically extremely vulnerable individuals (not including 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 (Includes those with various chronic diseases, immunosuppression, unpaid carers and learning disability).¹
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.

Health Boards in Scotland have established mass vaccination centres which have been highly successful in accelerating the roll-out, but there are various reasons why some people may have difficulty in accessing them. These include practical barriers such as transport, poverty, digital poverty and insecure postal addresses, but also psychological and social reasons. General Practices have also been responsible for vaccinating certain groups, in particular the over 75 age groups and those in the shielded categories. The contractual arrangements for general practice involvement in vaccination allow for local flexibility to adapt to local circumstances and capacity, and the extent to which general practice has been involved varies across Health Boards in Scotland.

We know that some groups are more likely to face barriers in accessing the vaccine and/or have traditionally had low levels of vaccine uptake for multiple complex reasons [2].

- Black, Asian and Minority Ethnic (BAME) communities.
- Vulnerable migrants.
- Communities of higher deprivation and poverty.
- Vulnerable Migrants.
- Gypsy, Roma and Traveller communities.
- People experiencing homelessness.
- People with substance misuse problems.

¹ Homeless populations were added to cohort 6 in March. <https://www.scotsman.com/health/coronavirus/coronavirus-in-scotland-homeless-scots-added-to-jcvi-vaccination-priority-group-six-3163881>

- Prison population.
- People with learning disabilities.
- Unpaid carers.

More recent research into attitudes towards the COVID-19 vaccine reinforce these findings around low vaccine confidence within these groups [3].

There are some people within these groups who fall into the highest priority JCVI categories but may have been 'missed' due to inability to access the mainstream vaccination route. There are also those who do not fall clearly into one of the JCVI priority groups but are nevertheless at significantly increased risk of death from COVID-19 (e.g. increased risk due to ethnic background or socio-economic status [4,5]). The JCVI has agreed there should be local flexibility to prioritise vulnerable groups and have urged local delivery partners to consider potential inequalities within each of its prioritised vaccination groups. However, there is as yet no currently agreed national steer on how this should happen.

For these groups, the mainstream vaccination route may not be accessible, and alternative means of delivery may need to be considered. Unless we develop tailored and proactive approaches to ensure that these groups are not 'missed', we will fail to protect those most at risk of serious illness or death from COVID-19 and will have reduced population vaccine coverage.

The importance of established relationships of trust and ease of access should not be underestimated. There is a vital role for general practice, community pharmacies, community link workers, faith leaders, substance misuse teams, third sector colleagues and others to promote vaccination, address peoples' concerns about vaccination, and build trust.

Aims of the Meeting

This meeting builds on previous discussions at both national and local levels. The aims of the meeting were:

- To bring together key stakeholders and representatives.
- To collaborate, share ideas, best practice, evidence, and levers for change (by way of individual positions / organisations).
- To make recommendations for next steps and future meetings.
- For the Deep End group to write up the discussions as a report.

The meeting was conducted under Chatham House rules, with the understanding that participants could speak freely and openly about challenges faced. Comments are not directly attributed.

MAIN THEMES

The meeting began with consideration of current barriers to vaccine uptake. Results of a recent survey of voluntary sector groups (by VHS) were summarised. Key barriers identified include:

- **Transport issues** (e.g. travel costs, knowing how to get to vaccination centres)
- **Low Vaccine confidence** – Need for clear, accurate and trustworthy information, in a range of languages, and available via mainstream and social media.
- Those with severe and enduring **mental health issues** identified as another group with low vaccine uptake.

Participants agreed that success would require **innovation, flexibility** and **joint working** to ensure those most at need of vaccination were included in the national vaccine rollout.

The Scottish Government has identified three categories of work needed, recognising the many potential barriers to following various steps in the process:

- 1) **Recording of data** at vaccine centres (e.g. ethnicity) – to allow better understanding of who is turning up and who is not. Postcode is used as a proxy marker for deprivation.
- 2) **Adapting delivery models/mechanisms** – using stated JCVI flexibility to target those not taking up posted appointment letter invites.
- 3) **Adapting communications material** for particular groups – not just locally but nationally too, e.g. What is the role of faith leaders vs clinicians giving messaging?

These formed the three themes under which the main discussion points have been grouped.

1. DATA COLLECTION

Ethnicity is not currently captured at point of vaccination and it was widely recognised that this is not ideal if we are to fully understand the demographic characteristics of who is missing. Public Health Scotland (PHS) include ethnicity data in their COVID-19 Statistical reports, with data sourced from various NHS hospital activity datasets [6]. The Ono-map software, which attributes ethnicity based on forename and surname (developed by Prof Raj Bhopal), was felt to be a potentially helpful proxy, in the absence of ethnicity status.

Participants agreed with the need to understand not just who is attending for vaccination, but also who is missing, both in hubs, community settings, and in GP practices. Postcode is currently captured, which can be used as a marker of area-based deprivation status. Public Health Scotland have been working on this and are doing analysis by SIMD. The National Scheduling System picks up DNAs and the Scottish Government are exploring 'do-not-attend' (DNA) rate data across different sites (e.g. mass vaccine centres versus local hubs, versus local practices).

GP practices in general do not use the Turas vaccine management tool (used in non-GP settings). Vaccines are instead recorded on GP software systems (EMIS and Vision). Data is automatically downloaded from these systems to Turas, and vice versa, via the National clinical data store.

There are particular challenges in data collection for Gypsy/Traveller communities, as many will not disclose their personal information due to fear of stigma or discrimination. Challenges also exist for those without a CHI number.

It was agreed that this could be an opportunity to promote the importance of GP registration and support patients to do so, with reminders to practices that there is no requirement for photo ID (or having a registered fixed abode) in order to register. GP Practices are viewed as the “*gateway to the rest of the system*”, offering the potential for more co-ordinated care, in contrast to attending the Emergency Department, which “*doesn’t offer continuity of care*”. However, GP registration must **not** be used as a barrier to vaccination.

Recommendations:

- Collect ethnicity data at time of vaccination.
- Collect primary care data (Vision, EMIS) in addition to TURAS.
- Use data to compare vaccination uptake in different sites.
- Promote GP registration.

2. ADAPTING DELIVERY MODELS

Much of the discussion centred on adapting delivery models and mechanisms, to improve uptake among potentially marginalised and under-served groups. This included consideration of governance issues, the role of general practice, the role of community links practitioners, the role of single dose vaccines, and the particular issues related to reaching the homeless population.

a. Local governance and accountability

Participants discussed the JCVI priority groups and the need for local leadership, accountability and governance to enable the flexibility endorsed by the JCVI. Each Health Board has an immunisation co-ordinator (Consultants in Public Health) who would be key to facilitating JCVI flexibility. Scoping work could first be done with Directors of Public Health (DPH), in collaboration with Health Boards and Health and Social Care Partnerships (HSCPs). Public Health Scotland (PHS) have representation from Local Authorities on their national planning group, which covers coordination of the Local Authority support for local vaccination services.

Core guiding principles around assertive outreach would be helpful to facilitate consistency, with governance and clinical safety developed through existing community relationships (third sector,

councils, housing, addictions, etc.). There is a real opportunity here to develop preventative and proactive programmes of care, based on trusted relationships.

Recommendations:

- Identify local leads to facilitate and ‘authorise’ the local flexibility described by the JCVI around vaccine delivery to address health inequalities (general agreement that DPH most appropriate with support from medical directors and Board immunisation coordinators).
- Agree national core principles to facilitate consistency – with local flexibility in how to deliver.

b. THE ROLE OF GENERAL PRACTICE

Research from PHS suggested that some older people may prefer to attend their GP practice, or another local, familiar venue. The current system feels inflexible (mass vaccination centres not always well matched to postcode) and the single national number for changing appointments does not always work for everyone. A striking finding from the VHS survey was the concern for people with long term conditions who were or are shielding, voluntarily or otherwise, who are now very fearful of leaving home, never mind getting public transport and attending mass vaccination centres.

There was concern, therefore, that we may be “*missing those that need it most*” and potential ways for GP practices to support vaccine uptake in these groups was discussed:

- There is scope to make better use of GP practice local knowledge to engage non-attenders. For instance, practices could review lists of DNAs and advise on how best to engage based on local knowledge. As one GP put it, “*you can send them 20 appts for the Louisa Jordan, they’re not going to go*”.
- GPs could engage more in vaccine promotion – for instance, using MJOG text messages, practice Facebook/websites, waiting room posters, messages on prescriptions.
- GPs could be involved in vaccination of further JCVI cohorts or ‘mop up’ of those missed in initial roll-out of cohorts 1-9.

Participating GPs were keen to debunk the myth that GPs did not want to be more involved in vaccine roll out. For many, delivering the Covid vaccines had been one of the most professionally satisfying activities for many years. Current barrier was felt to be the

Recommendation:

- Consider how best to support the role of general practice in vaccine deployment to under-served groups – from providing lists, to reviewing DNAs, to promoting vaccination through their established channels, to delivering the vaccine.
- Consider how best to utilise the current Direct Enhanced Service (DES) which is designed to facilitate and support general practice involvement as able, in negotiation with Boards, LMCs and local Public Health.

requirement for a contract to enable it.

c. THE ROLE OF COMMUNITY LINK WORKERS AND THE 3RD SECTOR

Participants discussed the potential role that Community Link Practitioners (CLPs) could play in the ongoing support of the vaccine roll out, especially for those marginalised or under-served groups who may struggle to participate through the mainstream national vaccination programme. CLPs are well placed as embedded members of GP teams, with existing relationships with many local 3rd sector organisations, and most importantly have trusted relationships with patients.

The great value in having “trusted intermediaries” to support patients access the vaccine was affirmed (e.g. [MECOPP](#) for gypsy/travellers). This could be 3rd sector colleagues too, with CLPs having a more co-ordinating role, referring onto other agencies for patient support as a route to vaccination. CLPs would need to be consulted and a national steer given to allow and support CLPs to concentrate efforts on this in the weeks and months ahead.

Anecdotal evidence of people cancelling vaccine appointments via the national helpline as ‘don’t know enough about it’ was discussed. It was noted by one Deep End GP that “*often it can take a few conversations with patients before they feel confident in being vaccinated.*” This is another benefit of having a locally embedded service, with trusted, embedded staff giving clear information, over serial conversations if required.

The third sector currently undertake a range of activities to support vaccine take up:

- Creating and disseminating targeted information for the people they support
- Facilitating engagement with health professionals
- Supporting people to register with GPs
- Providing transport to vaccination centres
- Using print, radio and social media to get targeted messages out
- Doing day to day job of supporting vulnerable groups

Recommendation:

- Consider an authorised priority role for CLPs in vaccine confidence-building and attendance for vaccination over the coming months.

These activities would be further supported by having clear, up-to-date information at an early stage. As noted above, Public Health Scotland can provide materials to support these conversations (with link workers, faith leaders, etc).

d. THE ROLE OF SINGLE-DOSE VACCINES

Single-dose vials (pre-filled syringes) are unlikely to be available for some time, due to issues with global demand and ease of manufacture of multidose vials, but it is likely that they will be available in due course. Pfizer will also hopefully be producing smaller box sizes soon.

It was felt that community pharmacies are ideally placed to vaccinate those engaged with their service if these single-dose vials became available, e.g. on oral replacement therapy (ORT) for drug dependency.

Recommendation:

- Teams that are best-placed to offer opportunistic vaccination to under-served groups (e.g. GPs and community pharmacies) should be prioritised for single-dose vaccines when they become available. Particularly useful for outreach for the 'hard to reach'.
- Agreement that these should only be used when necessary as multi-dose vials more cost-effective.

e. HOMELESS SERVICES

There was specific discussion around the lack of vaccines available for the homeless population in Edinburgh. It was agreed this has to be high priority because of their Covid-19 risks.² Examples were shared from elsewhere in UK and Scotland where homeless populations have been prioritised, e.g. in Plymouth – drop in clinic, largely volunteers – vaccine given alongside BBV screening, STI screening, outreach vet. 260 people attended.

² On 11 March 2021, the JCVI announced that homeless populations were to be added to cohort 6 in recognition of their increased risk, and probable underlying health conditions, many of which are under-diagnosed.

Recommendation:

- Clearer public steer that, as well as the homeless population, those from Black, Asian and Minority Ethnic (BAME) communities, and those living in deprived neighbourhoods are also priority groups. DPH to lead the push on this for all three reasons (individual clinical risk, public health risk, ethical).

Discussed local inclusion group set up to reach homeless population. Some patients only known to 3rd sector organisations, but not known to e.g. NHS Blood Borne Virus (BBV) teams.

3. ADAPTING COMMUNICATIONS MATERIAL

Some people are confused by what they experience as mixed public health messages, i.e. told on the one hand to stay home, on the other to leave home to get their vaccination. More reassurance and encouragement may be needed for these people.

Understanding specific reasons for low vaccine confidence in different local communities is recognised as key. Equalities leads for NHS Boards meet every two weeks and have many examples of innovative approaches (e.g. Vaccine selfies from South Asian and Roma communities, targeted TV and radio campaigns addressing common concerns). Some Health Boards are proactively identifying communities with predicted low uptake and approaching them before vaccine appointments – in one Health Board, the team have spoken with 300 people, in 11 languages, sharing resources with other HBs as well. National translated resources are available at www.nhsinform.scot/covid19vaccine.

For those with low health literacy, Public Health Scotland have Easy Read materials which cover vaccine ingredients, safety and other concerns people have. Responses to the VHS survey recommended text messages being used to supplement letters, but that assumes the NHS has people's mobile numbers, which is not always the case. In terms of public-facing information, especially for groups with low vaccine confidence, it was noted that inclusion of [testimonials](#) from 'people like me' could be a useful addition.

Recommendation:

- Resources that have been developed around public messaging to be collated and shared widely, e.g. Lothian community videos in 11 languages.
- Consideration should be given to having a central repository for all these resources.

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