The national intermediary and network for voluntary health organisations in Scotland

Briefing Paper

voluntary health scotland

VACCINE INCLUSION: REDUCING INEQUALITIES ONE VACCINE AT A TIME

April 2020

Introduction

Voluntary Health Scotland is the national intermediary and network for voluntary health organisations across Scotland. Our mission is to work to improve people's health and wellbeing by providing an effective national network for health charities and other third sector organisations actively supporting people's health and wellbeing. Our members and network include a range of medium and large condition specific organisations, smaller community organisations, as well as social enterprises.

We use our role to act as a conduit between policy makers in Scottish Government and Public Health Scotland and our member organisations as well as our wider community and voluntary sector network – ensuring we share grassroots level information to better shape policies, strategies and actions.

The intention of this briefing is to provide useful information to policy makers in the Scottish Government, Public Health Scotland and to other agencies responsible for shaping policy and interventions during the continued COVID-19 outbreak. We hope this will foster stronger collaboration and partnership working between policy and decision makers and our sector.

Background

As the COVID-19 vaccination programme was picking up momentum VHS decided to conduct some research to help ensure the distribution of the vaccine would not widen health inequalities, by missing vulnerable groups. We must also recognise that the vaccine programme provides us with an opportunity to reach and support some really vulnerable groups who have fallen through the gaps of public service provision – whilst ensuring they get vaccinated we must also seize the opportunity to ensure they have access to other forms of support and services.

We wanted to ensure that the vaccination process was made as easy as possible for everyone, including those who are furthest away from public services and those who face a wide range of inequalities.

We know that Scotland is a vaccine confident nation and that the uptake of vaccines is generally high, however it is lower in areas of deprivation, and among certain ethnic minority groups[1]. We wanted to test how this vaccine confidence would translate to the COVID-19 vaccine and how pronounced the impact of inequalities would be on its uptake.

[1] http://www.healthscotland.scot/health-topics/immunisation/overview-of-immunisations

We also became aware of the term, ‘vaccine hesitancy’ being widely adopted to describe those who may not access the vaccine when offered and we felt it was necessary to unpack this term. We now know that it encompasses a spectrum of issues including physical barriers, health literacy issues as well as a natural reticence towards new technological or medical advances. However, underpinning vaccine hesitancy is a range of social, economic and health inequalities. This includes the level of resources such as financial power, knowledge and social capacity that are available to people to help them access the support and services they need.

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Methodology

In February 2021, VHS conducted a qualitative study in the form of an online consultation of our member organisations and wider network asking:

- Who are the key demographics, communities and groups of interest who may not access the vaccine when offered it?
- What are the barriers they face?
- What are the enablers to uptake of the vaccine?
- How effective has the public facing communication been regarding the vaccine?
- What is the role of third sector in promoting the vaccine and supporting uptake?

We received a total of 170 responses and a number of the organisations who responded, such as RNIB and Waverley Care, had conducted their own consultations in order to provide us with rich and detailed information.

The research has provided us with a very rich source of data, as organisations were generous in their responses, for which we thank them. In principle, we are happy to share the raw data with others, so please contact us if you would like to discuss this further.

Since collating the data we have been feeding back our results to the Public Health Scotland Evaluation of the Flu Vaccination COVID Vaccination (FVCV) programme and to the Scottish Government teams co-ordinating the COVID-19 Vaccination programme, as well as the newly developed COVID-19 Vaccine: Inclusive Programme Steering Group. We have also shared information with the Lead on Diversity and Human Rights at NHS Lothian for his work for the NHS Lothian COVID-19 Vaccination Programme Board, and with the Third Sector Interface mini-conference on health inequalities. The data was also shared with a group of Deep End GPs through the Deep End GPs roundtable for vaccine deployment for hard to reach groups.

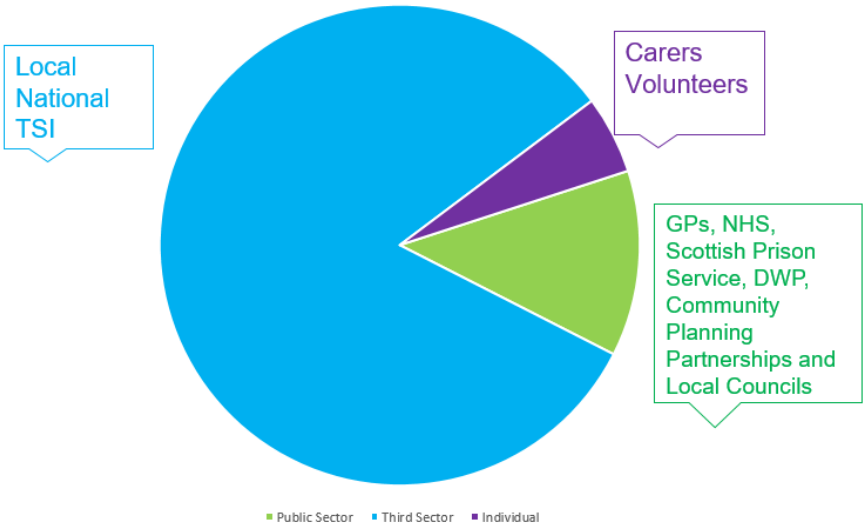
In this briefing we will present a typology of dominant themes to show the weight of opinion under each question and provide a brief summary to explain the theme and relevance.

Analysis of respondents

An analysis of the respondents shows that the vast majority of responses we received were from third sector organisations, including national and local organisations, community groups, social enterprises and Third Sector Interfaces. These organisations are national, local, small and large and between them provide a wide range of direct health, social care and community services and support, often for the most vulnerable of people.

Over 12% of responses were from the public sector including GPs, NHS Health Boards, Scottish Prison Service, Department for Work and Pensions, Community Planning Partnerships and Local Authorities. Around 5% of responses we received were from individuals: this included carers and volunteers.

Figure1: Analysis of respondents



Key demographics, communities and groups of interest and barriers they face

Our consultation corroborated much of the anecdotal evidence around the key demographics who might be less likely to access the vaccine when offered it. Table 1 below sets out a matrix of key demographics, primary barriers faced and solutions to support people to access the Covid-19 vaccine.

Table 1: Matrix of key demographics, primary barriers faced and solutions

Key demographic	Primary barriers faced	What works
BAME and traveller communities	• Misinformation • mistrust of vaccine and health system • lower health literacy • lack of access to credible information	• Clear information in different languages and formats, • reassurance regarding the side-effects of vaccine • assertive outreach from trusted sources such as GP and local community groups
People with mental or physical health issues which would prevent them from engaging with the vaccine programme	• Lack of information regarding side-effects of vaccine • practical barriers such as poor access to transport • lack of support to attend appointments • perceived higher risk in taking the vaccine due to concerns regarding how it will affect long term conditions	• Tailored information that is specific to conditions • assertive outreach and support to help people understand information • targeting myths about side-effects and interactions with medications • more flexibility with appointments to align with social care • better transport options
People living in poverty	• Lower health literacy • lack of access to information • unable to afford to take time off work • cannot afford taxi fares to travel to get the vaccinations	• Access to clear and accessible information • support to access appointments • flexible appointments available • better wrap around support
People who are homeless	• Not registered with a GP • lack of access to formal or informal support and necessary wrap around support, information and services	• More assertive outreach • support to register with GP services • better access to wrap around support pre and post vaccine • clear and accessible information from a single trusted point of contact
People living with disabilities	• Lack of support to access vaccine from formal/informal carers • lower health literacy, • fear of travelling outside their home and taking public transport (previously shielding) • misinformation	• Assertive outreach from GPs • flexibility in arranging appointments at a time that coincides with social support • Better access to information

Key demographic	Primary barriers faced	What works
People with alcohol and drug dependency issues	• Not registered with a GP • lack of access to formal or informal support, information and services	• Assertive outreach from GPs • better access to formal and informal wrap around support pre and post vaccine, • support to engage with statutory services through trusted organisations
Unpaid Carers	• Unable to access support and services for themselves • may not be able to access their appointment due to caring responsibilities • many are unknown to public services as carers	• flexibility in being able book appointments themselves • ability to choose local location for vaccine • Access to clear and accessible information
People unofficially shielding	• Fear and anxiety about having to leave their home after shielding	• Providing option to allow people to access the vaccine more locally
People living in rural areas or areas with a lack of access to appropriate and affordable transport	• Cost of transport • lack of direct transport • fear and anxiety in accessing public transport	• More affordable, accessible and direct transport provision • ability to choose more convenient venues for vaccine • Subsidised cost of taxis, better information about local transport and initiatives.
Young people	• Misinformation regarding the long term side effects • perception that COVID-19 is an older persons issue so it doesn't affect them • lower health literacy • lack of access to transport • timings of appointments might clash with work and studies	• Clear and accessible information • better use of social media to share information • simple and relevant messaging • support to access vaccine centres including opportunities to re-book appointments to a more convenient time • subsidising cost of transport • not relying on purely digital methods of communication
Prison population or those who have been in prison	• Needle phobia • Misinformation • a general lack of access to information • not registered with a GP or unknown to public service to get the wrap around support needed	• More assertive outreach • better wrap around support pre and post vaccine • support to register with a GP • clear and accessible information and support to engage with it.

A respondent to the research recalled the intersectional issues and barriers faced by people with disabilities and mental health conditions, "*People with learning disabilities may not understand the letters calling them in for vaccination. At the moment many have had care support withdrawn or reduced, meaning that there may be no one to read the letter to them and help them understand what they need to do. There may be similar issues for people with mental health issues - the isolation of lockdown may have exacerbated existing conditions and increased feelings of anxiety, paranoia or agoraphobia. These feelings may prevent them from taking up vaccination due to fear. BAME disabled people are probably subject to the same misinformation as other members of the BAME community and, as they may be dependent on family members who have also been subjected to misinformation, they may have no practical means to attend even if they wanted to. Finally, there are thousands of disabled people with severe mobility impairments who have lost their Enhanced Mobility Component on moving from DLA to PIP. This means thousands have also lost their Motability vehicles. Thus they have no means of independently attending vaccination centres and yet they may be highly vulnerable to infection and scared to travel via public transport.*"

Shared barriers

The research identified that there were some overarching barriers shared amongst the different groups. These barriers can be divided up into issues of vaccine confidence and vaccine convenience.

Vaccine Confidence

Respondents to our research shared that issues such as widespread misinformation relating to the vaccine were a barrier as these added to the fear or mistrust of the vaccine. They highlighted that people did not know where to get credible and accessible information, leaflets or advice regarding the vaccine, and that NHS Inform was not known to them. There were also issues around having capacity to engage with the information relating to vaccines: even though the language was simple, the concept of the pandemic and vaccinations is still foreign and complex which makes it harder to resonate with.

The research found that there was still a lack of clarity and understanding of the long and short term side effects of the vaccine and the possible interactions with medication. People who have been managing long term mental and physical health conditions feel a lot of uncertainty and perceived risk in taking the vaccine, due to its possible interactions with their conditions and medication.

Many of the respondents highlighted the fear and hesitancy at having to leave the house for those who may be unofficially shielding, but also the general population who have become accustomed to the 'stay at home' or 'stay local' messages. Respondents felt this was adding to people's confusion, due to the mixed messaging of prioritising staying at home whilst also asking people to travel, at times, large distances to mass vaccination centres.

The research also found that the concept of mass vaccination centres was intimidating to some people. Historically, vaccines are delivered in local GP practices or within the community, and the public messaging asking people to avoid crowded places was making people feel hesitant.

Vaccine Convenience

There were also a range of practical issues identified within the research that affect a range of demographics.

There was a range of groups identified who may not have a fixed address and are therefore missing out on both information regarding the vaccine and a chance to access it. There was also a number of groups that are not currently registered with a GP as they do not have a fixed address, do not know how to do this, don't know about their rights to access services, or are hesitant in accessing statutory services.

An issue that cuts across a large number of groups and demographics identified was a lack of access to transport. This included a lack of simplified routes, accessibility and affordability of public transport. Many respondents mentioned that the people they work with could not afford taxis, or that there was no clear public transport or route to get to mass vaccination centres.

How barriers might affect younger cohorts

We know the cohorts so far have been older age groups for whom practical barriers might be more pronounced, but it is important to probe deeper into how the identified barriers might affect new cohorts going forward. The data and information gathered show that issues of vaccine confidence are a bigger issue for younger cohorts, with concerns around side effects, the speed of development of the vaccine and a general feeling that the pandemic doesn't affect them so why should they need to take the vaccine.

There are also concerns around vaccine convenience for younger cohorts: respondents pointed out that the language of the information leaflets was really complex and needs to be simplified. The research showed that better use of social media to disseminate targeted information is needed. Issues around digital literacy and digital inclusion were highlighted; for example, the idea that younger groups may be better able to use digital to access information or change their appointments should not be taken for granted. Respondents also highlighted that financial barrier,s such as not being able to take time off from work to access the vaccine as well as transport barriers may be more pronounced in younger cohorts.

What would increase uptake?

Many of the barriers to accessing the vaccine relate to issues of vaccine confidence and vaccine convenience. In order to improve people's confidence in the vaccine respondents asked for clear and accessible information and messaging. This included having simple and reassuring messages that alleviate people's concerns about having to travel to get the vaccine and that help to familiarise people with the concept of mass vaccination centres. It is also important to tell people how things will improve for them if they get vaccinated, to help incentivise people.

A respondent highlighted the importance of immediate and holistic support that people require, *"Help now - before the vaccine is offered with information, advice and reassurance. Vaccinate me at home then help me learn how to negotiate all the new social rules and how to access support that I need."*

Respondents noted the importance of using a range of means of communication, such as radio, text messaging (which was a successful tool used for those who are shielding) and social media. The research also highlighted the positive impact that the use of communicating through community leaders, celebrities and trusted figures could have on vaccine uptake.

Respondents suggested that the official Helpline service should provide more information and answer concerns about the vaccine, as well as practical questions about things like local transport provision and offer clear options regarding rescheduling appointments.

In terms of improving vaccine convenience respondents noted that they wanted more assertive outreach by health professionals including GPs and link workers. This included going to where people are – especially vulnerable groups such as those who are homeless, or have issues with drugs and alcohol, older people, those who may have been shielding and BAME communities.

Respondents asked for vaccines to be provided within local communities or to at least offer people options of where they could go to receive it. The research identified the need for support with transport in terms of better information about community transport provision, improved local transport routes (setting up services for locations that currently do not have appropriate provision) and subsidising transport for those that need it. Respondents also raised concerns about following up with vulnerable groups to help ensure that they access the vaccine and return for the second dose of the vaccine.

Communication

The research asked respondents about the public facing communication regarding the vaccine: this included the TV campaign, as well as the range of information leaflets produced to support various groups. Respondents felt that the communication was useful for those who could access it and had capacity to engage with it. It was noted that the different accessible formats and languages were helpful as well as pictorial leaflets and videos.

However, respondents raised concerns that more support was needed to help those who had no access to the resources and were falling through the gaps. That there was a need for a coherent and coordinated process of how and where people can access information. A respondent pointed out that there needs to more awareness of the fact that, "*not everyone is able to use the internet, especially if they have a neurological condition like Huntington's disease. Letters and leaflets are good but once again, if people live on their own and have difficulties reading information, it would be important that they had support to understand the information in the form of a package of support and care.*"

Whilst it was agreed that the range of communication resources produced were useful it was highlighted that some groups still find the content hard to understand or engage with and require further assistance. Therefore, signposting to local third sector organisations, who are often trusted partners, is a useful way to ensure people can engage with the content. Moreover, effective deployment of the Helpline to support people to answer questions or concerns they may have.

Respondents highlighted that there is a need for clearer targeting of myths regarding the vaccine and emphasised the need for much greater clarity and practical information generally. It needs to be clearer how can you could access the vaccine if you don't have a GP and whether and how you can book an appointment if you have not received an appointment letter.

There were also concerns that information on side-effects is not clear and may deter people from taking the vaccine or returning for their second dose. Therefore, improving communication regarding this by using information leaflets and discussion during the vaccination appointment was considered an important way to reassure people. People also wanted to see clear information for people about potential interactions with medications and long term conditions.

Role of the Voluntary and Community Sector

Third sector respondents to the consultation spoke about the actions they were taking to support people to access the vaccine. Adherence to the stay at home requirement means that most organisations are having to provide such support remotely. Many organisations spoke about creating and disseminating targeted information to the people they support, in the form of leaflets, accessible videos, and social media posts, as well as having phone calls.

Organisations spoke of the positive impact they were having by facilitating engagement between health professionals and those they support through online meetings and phone calls. They highlighted the importance of allowing people to ask questions and raise concerns.

A lack of access to GP services was raised as a major barrier to getting the vaccine and a number of organisations said they are working with vulnerable groups to support them to register with GPs and access the wider health care that they require.

Transport was also raised as an area where the sector is working to address the barriers affecting a range of demographics. Voluntary and community sector organisations have been providing transport to vaccination centres, and disseminating information about public transport or local transport initiatives. Some subsidised or free transport is being provided by both private enterprises and community transport providers.

An organisation spoke about the range of support that they were providing to help people access the vaccine, "*We have done a lot of work on this. Having pages on our website, answering calls and emails. Researching and reassuring people. Having someone to talk the options through with has been key and that was missing for many people who had to turn to charities like us for this."*

It is important to recognise the vital role that the voluntary and community sector plays in supporting really vulnerable groups to stay safe and access the support they need in their daily lives. These organisations have developed a trusted relationship and are often in a position to have difficult conversations with people in a way that statutory services may not be able.

However, many of the respondents also highlighted that the voluntary and community sector itself needs access to clear information at an early stage, particularly as they are finding their service users and clients are turning to them first with questions or concerns about the vaccine.

Conclusions

The message from our survey respondents is that our health system has a clear moral and human rights duty to those vulnerable groups who fall through the gaps of public service provision, to ensure that they are not failed by this crucially important public health intervention. Some of the groups our respondents highlighted are at very high risk if they do contract COVID-19, including homeless people, prisoners, chaotic drug users, black and ethnic minority groups, gypsy travellers, refugees and asylum seekers. We cannot afford to view the Covid-19 vaccine programme as a silo: the programme has to be part of a whole-system, preventative approach to public health and to health inequalities. This requires a joined up suite of interventions that not only help people access the vaccine but supports them to stay well afterwards and enables them to adhere to the Covid-19 regulations safely.

This research has generated significant interest within the public health community as well as within the Scottish Government, at the planning, execution and reporting stages. We believe VHS can take some credit for having focused policy makers' attention on the urgent need to implement a much wider equalities approach in the roll-out and delivery of the vaccine programme. The initial and ongoing lack of any comparable public health data gave added weight to the importance of our research. Our headline findings were presented to a number of events in March and are already proving influential. Speed in the production of data and analysis is proving of the essence, as the roll-out of the vaccine programme has been fast moving and on an industrial scale, but vulnerable and 'missing' groups are in danger of being left behind if data about them is not known.

From the onset of our research in February 2021 to the publication of this report in early April 2021, there has been a pronounced and very positive shift in approach on the part of those involved in the planning and delivery of the vaccine programme. The Deep End group of GPs convened a round table to discuss vaccine deployment for hard to reach groups and subsequently put out a press statement about the importance of reaching these groups. The Lead on Equalities and Human Rights in NHS Lothian has set up a stakeholder group with the four Lothian Third Sector Interfaces, so as to harness third sector local knowledge and trusted relationships with communities and help ensure an inclusive vaccine roll-out across Lothian.

NHS Forth Valley are collaborating with Scottish Ambulance Service, local authorities and the third sector to implement an assertive outreach vaccine programme for homeless groups, asylum seekers and refugees, and gypsy travellers. This collaboration meant that in late March NHS Forth Valley was able to take the vaccine to three supported accommodation sites and a gypsy traveller site. Over the course of three days they vaccinated 105 individuals, facilitated 4 new GP registrations, issued 11 take-home Naloxone kits, helped arrange urgent mental health support and signposted to services like addictions support, food banks and financial aid. 95% of the individuals vaccinated had never previously engaged with an immunisation programme, e.g. flu vaccine or shingles vaccine.

Significantly, in mid-March and at the behest of Scottish Ministers, the Scottish Government set up the Covid-19 Vaccine Inclusive Programme Steering Group which meets weekly and comprises key stakeholders from across the public and third sectors, including VHS. The purpose of this group is to:

- advise on particular groups that should have a greater focus for vaccination delivery
- advise on issues to be addressed in relation to (i) the collection of data, (ii) bespoke or adapted delivery mechanisms and (iii) targeted communication and engagement
- facilitate participation and the co-production of solutions.

Further very positive developments during March have included the Scottish Government's open invitation to unpaid carers to apply to be vaccinated. Then, on 11th March, the JCVI amended its guidance to health authorities to include homeless people and rough sleepers in the Priority 6 group for the vaccine.

Scotland's Third Sector Interfaces have held a mini-conference on the issues raised by VHS's research, with a view to better equipping themselves with the knowledge to take action at a local level. Public Health Scotland has now published data on vaccine take up (to date) by ethnicity.

Other third sector initiatives were already underway before VHS's research was published. Work of note includes that of BEMIS, the national umbrella body supporting the development

of the Ethnic Minorities Voluntary Sector in Scotland, who are running a vaccine inclusion fund, to support local BAME organisations and groups to engage their communities in the vaccine programme. And Scottish Refugee Council is using its New Scots platform to raise awareness and harness the involvement of 180 volunteer and refugee led groups to support their communities to take up the vaccine. Through the detailed responses to our survey, we know that a wide range of third sector organisations, for example Waverley Care and RNIB Scotland, are working actively with their particular constituencies to break down barriers and support vulnerable people to take up the vaccine.

Finally, we draw attention to an English exemplar of the kind of joined-up, whole system preventative approach that we think is beneficial not only in the short term but the longer term. Somewhat like the NHS Forth Valley initiative, in Plymouth a day-long event provided homeless people not only with the opportunity to be vaccinated but with hot food and opportunities for advice and practical support in relation to Hepatitis C and sexually transmitted diseases, housing, GP and dentist registration, and even a vet service for pet dogs. We commend this forward thinking, assertive outreach to colleagues in Scotland.

Recommendations

We have six areas of recommendation.

1. Communications

Whilst the communication has been useful for those who are able to access it and have the capacity to engage with it concerns remain about the need for more targeted messaging and support for particular population groups that will struggle to understand existing communications. There is a strong requirement for a coherent and coordinated approach to how and where people can access information. The language and content of the communications need to be simplified and to contain clear and reassuring content to build people's confidence in the vaccine and the delivery method. We do not doubt that cognisance has been taken of the 2017 Making It Easier health literacy action plan in the design of the vaccine communications. However, more needs to be done to embed health literacy into the communications plans, including developing more health literacy responsive organisations and communities, and designing supports and services so as to better meet people's health literacy levels. third sector organisations have an important role to play in communicating accurate and reassuring messages to people, but they need to have clear, accurate and early information themselves in order to do this.

2. Prioritise collection and analysis of local data about uptake of Covid-19 vaccine by different communities and groups

Assessing the needs of local population groups with complex needs is a priority. The existing lack of local data about those population groups who are in danger of falling through the gaps must be addressed. Health boards and their partners need data to understand where health inequalities are arising in the vaccination programme, devise plans to address those inequalities, and evaluate the effectiveness of any interventions implemented to optimise uptake. Local data should include third sector intelligence where available, as the sector's trusted relationships and local knowledge will be invaluable. Public health analytical services should be allocated to monitor and report on trends.

3. Conduct active research into the ongoing vaccination programme

Ongoing research is needed to keep pace with the rapid pace of the roll-out of the vaccine programme and to learn the lessons quickly so that they can be applied in future. Research should identify improvements that could be made for particular communities and groups in the communications about the vaccine, the mass vaccination sites, bespoke appointments and assertive outreach work. Research should capture qualitative data that includes voices of lived experience, as well as quantitative data. Whilst maintaining pace is of enormous importance in the roll-out of the vaccine, getting it right for vulnerable groups means taking the time to engage, listen and understand what works for them. This is especially important if there is a commitment to making sure assertive outreach is designed so as to deliver longer term individual health and wellbeing and hence sustained public health outcomes.

4. Develop a rolling programme of outreach vaccination clinics, services and events

Appropriate assertive outreach should be developed in each health board area in order to address systemic barriers to vaccine take up. NHS boards should also use other models for delivery that may readily available to them, such as community vaccination teams, Blood Borne Virus outreach teams, drugs and alcohol teams, and homeless clinic teams.

One assertive outreach model (e.g. the NHS Forth Valley model) is to take a mobile vaccine unit directly into communities where a defined target group is living, e.g. into homeless shelters/supported accommodation or gypsy traveller sites. An outreach bus could overcome convenience barriers and offer a community outreach option that overcomes logistical and cost issues that arise when using community venues. NHS in West Sussex already runs a Vaccine Bus in partnership with Metrobus and the Alliance for Better Care.

Another model (e.g. the Plymouth GPs model) is to organise a bespoke health and wellbeing event for a target groups at a venue that is known and trusted, and taking a whole system approach to the event's offerings. With this model, whilst the vaccine may be the immediate driver for holding the event, in practice is it just one element of what is on offer to people throughout the day.

As in Plymouth and NHS Forth Valley, assertive outreach should take the opportunity to support the targeted group's longer term health and wellbeing, by offering relevant advice, practical support and signposting, e.g. to facilitate GP and dentist registration, to give access to medication, to signpost help with housing, finance or food aid, and to build confidence in engaging with public services. Regardless of the model, assertive outreach should be designed and delivered on a partnership basis for maximum impact, e.g. involving local authority and third sector partners as well as NHS boards. Where possible, the design of assertive outreach should be based on consultation with people with lived experience. We expect new models of assertive outreach to emerge over the coming months.

5. Provide accessible, affordable transport to vaccine centres and clinics

It is crucial that people have accessible, affordable and convenient transport to vaccine centres and clinics. First, people should be sent to the most convenient site for their vaccine. There should be improved localised information on how to get to vaccination centres, including details of free and subsidised travel being provided by the voluntary and private sectors, and where there is no provision of public transport, specialist services should be provided. Where people have no option but to take taxis to access their vaccine there should be support available to subsidise the costs for those who are unable to afford the fares. Some people in Edinburgh, for example, face a £50 round trip taxi fare to access the large vaccine centres.

6. Involve third sector and community partners more in the planning, communications and delivery of public health interventions to help prevent, mitigate and reduce health inequalities

The importance of established relationships of trust should not be under-estimated in ensuring good vaccine uptake amongst the groups identified by this research. Public services that have built trusted relationships with excluded groups play an important role, including general practice, community link workers, community pharmacies, substance misuse teams and homeless/supported accommodation teams. But this research has above all established a strong case for the third sector being a key partner in the planning, intelligence gathering, communications, delivery and evaluation of this vaccine programme.

Our research findings did not strongly highlight the role of volunteers, but we wish to emphasise that third sector volunteers, including those deployed by British Red Cross, have played a vital role in meeting, greeting and supporting patients arriving at mass vaccine centres. Although the role of the third sector in the vaccine programme needs to be understood over and above its expertise in recruiting and deploying volunteers, there will be important lessons emerging from the involvement of volunteers to date. There is clearly considerable scope for volunteers to play a role in the more targeted approaches we have called for, especially in assertive outreach initiatives.

Health charities and other voluntary organisations providing information, support and services to clients within particular demographics, such as RNIB Scotland, Waverley Care, Scottish Refugee Council and Crisis, must be treated as key players in the wider public health workforce, able to contribute intelligence/data, disseminate information that will be trusted, and provide practical support in relation to access to services.

The 32 Third Sector Interfaces (TSIs) have a pivotal role for the third sector at the local strategic level, as representatives of the sector within CPPs and health and social care partnerships. National umbrella bodies with a particular demographic like BEMIS can contribute to clear communications and messaging across their networks, and to providing a national overview of needs, challenges and of what works for particular demographics.

Looking beyond the current pandemic and Covid-19 vaccine programme, the third and public sectors should collaborate more closely to deliver public health on an assertive outreach basis more often, targeting those who are in danger of falling through the gaps or of remaining 'missing' in health care, and with the objective of addressing Scotland's unacceptably high levels of health inequalities.

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