COVID-19 in Slough

An investigation of the reasons for high case numbers, barriers to vaccine uptake and low testing uptake

March 2021
(Version 2.0 May 2021)

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AIM OF THIS CONSULTATION

The aim of this consultation was to objectively review current actions to assess if additional or different approaches are required to further drive down COVID-19 case rates in Slough.

INTRODUCTION

Cases of COVID-19 in Slough have been consistently higher than the UK national average, and higher than surrounding regions, throughout the pandemic. In late 2020, cases were 400 per 100,000 population, putting Slough within the highest rate band for the UK; cases rose further, to a high of more than 1000 per 100,000, in late January 2021[1] (though they had fallen to below 100 per 100,000[2] by March 2021). At the time of the consultation, cases were particularly high in the over 60s age group (just prior to the UK vaccine roll-out), and in the 17-24 age group. Three-quarters (75%) of cases were in individuals classified as BAME, against a Slough population of around 64% BAME, suggesting that BAME individuals and communities are particularly vulnerable. Media reports pointed to large gatherings, particularly of young adults, in the city centre and poor mask compliance as drivers of infection. A social insights survey conducted in late 2020 indicated confusion over some of the terms used in public health messaging, such as whether a 'household' referred only to people in the same house or also extended family who live in other houses close by; or why it is acceptable to go shopping but not to visit an elderly family member.

In November 2020, Slough Borough Council reached out to Royal Holloway, University of London, for a consultation on what might be driving higher case numbers within the borough, and what might be done to address any challenges identified. Dr Jennifer Cole (hereafter JC), a biological anthropologist in the Geography Department[3], was assigned to the consultation.

[1] 1044.5 per 100,000 on 21st January reported in the Project Proposal for Slough to Reduce COVID Rates Feb 2021.
[2] Report by Heather Cook in Community Champions Zoom Call, 18 March 2021.
[3] https://pure.royalholloway.ac.uk/portal/en/persons/jennifer-cole(bfb50003-0f58-451a-a46b-5273796a2aa4).html

She has a background in public health messaging research and application; she is an accredited World Health Organisation Infodemic Manager[4], and has previously sat on the UK Cabinet Office's Communicating in a Crisis Steering Committee Advisory Board.

In early 2021, JC was commissioned to provide a more formalized consultation, undertaken between 1-19 March 2021. Slough had seen a sharp fall in cases throughout January and February 2021 (and, it should be noted, a sharper decline compared to surrounding areas including Reading and West Berkshire), but cases seemed to have plateaued by mid-February (see Fig 1) and this was continuing into March.

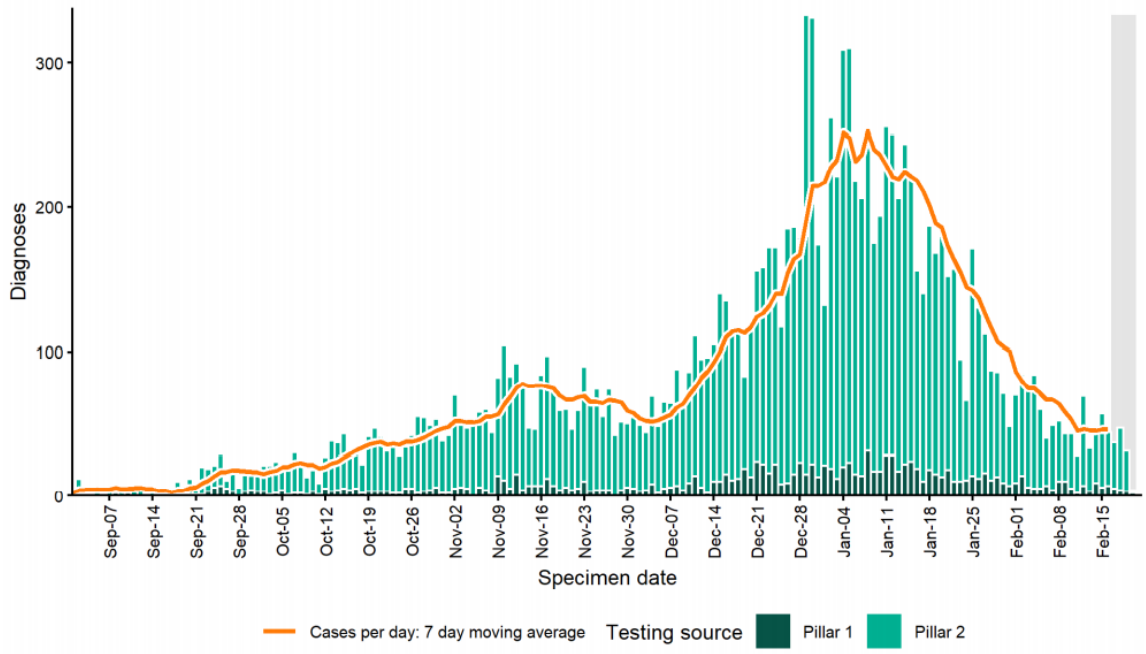

Fig 1: Epidemic curve of confirmed COVID-19 cases in Slough since September 1, 2020, by specimen date and pillar. A reported rate on 17 March of 98.3 per 100,000 indicated this plateau had continued.

[4] https://www.who.int/docs/default-source/coronaviruse/risk-comms-updates/update43-infodemic-management.pdf?sfvrsn=1237275f_6

BACKGROUND TO THE CONSULTATION

Slough is ranked 78th out of 152 unitary upper tier unitary authorities within England[5] on the Index of Multiple Deprivation (IMD). Several neighbourhoods score in the lowest deciles. At the time of the consultation, this intersected with high levels of people claiming unemployment-related benefits (Slough had the 7th highest percentage of claimants in the UK, at 8.4%, according to research from the Centre for Cities, and the 5th highest rate of workers 'furloughed' on the Job Retention Scheme (16.8%)[6]. This suggested a high level of income precarity in Slough. Job precarity usually goes hand-in-hand with high levels of workers employed in gig or grey economies, which is known to make compliance with safety regulation, access to sick pay and other in-job benefits more challenging (Clark et al, 2019)[7].

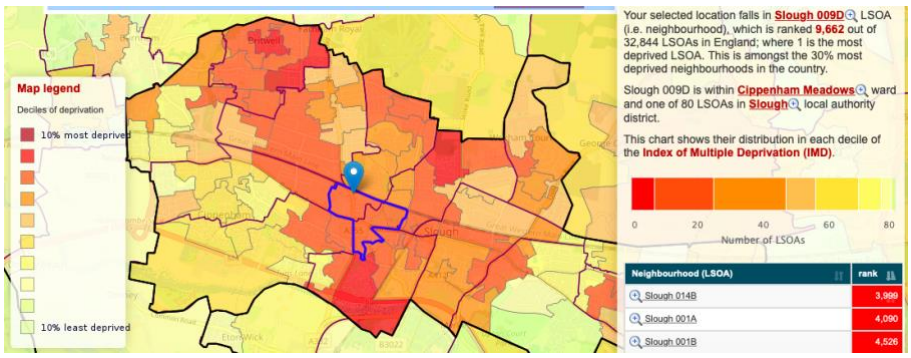

Fig 1: Index of Multiple Deprivation (IMD) shows Slough neighbourhoods against deciles of deprivation; several neighbourhoods fall in the lower deciles.

Top 10 - JRS

Crawley	18.9
Blackpool	18.1
Brighton	17.3
Bournemouth	17.1
Slough	16.8
York	16.4
London	16.3
Luton	15.6
Dundee	15.5
Edinburgh	15.5

Bottom 10 - JRS

Middlesbrough	12.5
Plymouth	12.5
Telford	12.4
Wigan	12.4
Hull	12.3
Swansea	12.3
Doncaster	11.9
Peterborough	11.9
Newport	11.6
Barnsley	11.4

Methodology - Job Retention Scheme
The **Job Retention Scheme (JRS) take up rate** measures the number of eligible employments on the furlough scheme at any given time.

Fig 2: Workers in Slough experienced particularly high levels of furlough, with 16.8% of local workers relying on the Job Retention Scheme in March 2020.

[5] http://www.sloughboroughcouncil.net/council/joint-strategic-needs-assessment/deprivation.aspx
[6] https://www.centreforcities.org/data/uk-unemployment-tracker/
[7] Clark, I., 2019. Informalisation in Work and Employment: A Permissive Visibility or Another (Hidden) Inequality?. In *Inequality and Organizational Practice* (pp. 199-219). Palgrave Macmillan, Cham.

As of March 2020, Slough was a densely populated area with a larger than average percentage of multi-generational households and high (13%) recorded levels of overcrowded homes,[8] defined as having one bedroom too few. This was nearly three times the UK national average at the time. As in-household transmission is known to be a major driver of infection[9], this could be one reason for Slough's relatively high rates of infection. The level of rented (24%) rather than privately owned homes was also higher than the national average of 16%, and there was a high level of Households of Multiple Occupancy (HMO), particularly in the South of the borough[10]. There had been no analysis of the data to determine whether areas with particularly high rates of infection, such as Chalvey (34%), also had higher densities, or more overcrowded households, than areas with lower infection rates.

It would be useful to examine data on case rates per borough matched against housing conditions, in particular overcrowded housing, to identify very granular regions – perhaps down to street level – where households may require additional support or prioritisation for vaccination, e.g. vaccination of younger adults, as well as elderly, in multi-generational homes.

Slough's population is highly diverse; in 2020, 39.7% were recorded as Asian/Asian British, 35.7% white British, and 24.6% other. Represented ethnicities included Pakistani, Indian, Bangladeshi, African, Caribbean, Somali, Arab, Chinese and Roma[11]; some families and communities were well established, others were more recent arrivals. An equally diverse faith community intersected with these ethnic groups, including Christian, Muslim and Sikh. Whilst the communities live side-by-side within the city, many also exercise community identity through shops, restaurants and takeaways catering to specific diets or preferences, places of worship, community centres, barber's shops and beauty parlours. This offered opportunities for identifying places where members of a specific community come together and which could be targeted for interventions unique to that community, as vaccine concerns are often embedded in historical and cultural legacies or norms.

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[8] http://www.sloughboroughcouncil.net/council/joint-strategic-needs-assessment/housing-and-homelessness.aspx
[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/933225/S0824_SARS-CoV-2_Transmission_routes_and_environments.pdf
[10] http://www.sloughboroughcouncil.net/council/joint-strategic-needs-assessment/housing-and-homelessness.aspx
[11] https://slough.berkshireobservatory.co.uk/population/ plus additional ethnographic observation

This consultation followed demographic groupings used by Slough Borough Council and other Local Authorities in wider research, including the 'British Caucasian' and 'Ethnic Minorities' comparison used by Berkshire Public Health in their Social Insights Survey from November 2020. However, some individuals in the OneSlough online meetings and at the Lateral Flow Testing Centre queried the necessity of such distinctions and considered them to drive divisions between communities that did not help in building trust. Where ethnicity is recorded and comparisons between different groups is highlighted, reasons for why such distinctions have been made should be clearly articulated to the communities to help to build cohesion.

The borough had experienced some challenges with communicable disease in general in recent years, particularly tuberculosis (which is frequently a challenge amongst homeless and undocumented communities), though seasonal influenza excess deaths had been in line with UK averages. Influenza vaccine uptake was high in younger groups though slightly lower than average in the over 65 age group[12], suggesting systematic issues with vaccine uptake that ran deeper than the COVID-19 pandemic.

Homelessness and undocumented individuals

The available data and ethnographic observations suggested that there may be a number of adults in Slough who were either undocumented or insufficiently documented. There were known to be homeless groups (particularly young men of Eastern European origin, identified to be sleeping rough and working cash-in-hand[13]); and there was anecdotal evidence from the consultation that there were undocumented adults within some Asian, Somali and Roma populations who were not currently registered with a GP and were thus likely to encounter barriers to doing so should they attempt to. This was likely to be impeding their ability to access vaccination and testing services and was considered worthy of further consideration.

[12] http://www.sloughboroughcouncil.net/council/joint-strategic-needs-assessment/communicable-diseases.aspx
[13] http://www.sloughboroughcouncil.net/council/joint-strategic-needs-assessment/housing-and-homelessness.aspx

Challenges identified prior to the consultation period:

- There was anecdotal evidence for Slough being busy and non-compliance being an issue, but there was no systematic flow of local insights or robust observational records.

- The highest new case infection rates were in the working age population. However data granularity did not indicate whether this was 'working population who are currently working' or 'working population who are currently furloughed'. Unpacking this may give insights into what activities/actions are driving infections. Is it bored young adults hanging out together with nothing else to do; people taking on additional, cash-in-hand work with insufficient safety protection in place, as they try to make ends meet; or workers with insufficient sick leave provision continuing to work even if infected?

- Ethnic groups with the highest case rates were White, Indian, Pakistani and Other Ethnic groups; data analysis was being conducted to differentiate groups in this indicator but the analysis was unavailable at the time of this study.

- Uptake of rapid testing had been low despite extensive investment and marketing but reasons the why were unclear.

BAME populations and trust

Some resentment was expressed by individuals that 'BAME' was used as a catch-all term and that this set the 'BAME' community apart, which did not help with building trust and cohesion.

Feelings were also expressed that there was a particular lack of trust in the system from the African and Afro-Caribbean 60+ age group – the children of the generation that first emigrated to the UK. They and their parents were promised a better life, good education, opportunities etc but many feel that they have long been treated as second-class citizens (compared with Asians as well as the white population). Mistrust of the system is deep-seated in this community and could be particularly hard to dislodge.

METHODOLOGY

JC was tasked with developing a methodology to undertake a rapid, two week project that could:

- Based on the review of current information, plans, insights and actions, devise and implement an effective and speedy methodology to gather insight (particularly into behaviour change) to inform action to drive reductions in community transmission of Covid in Slough. For example:
    - Co-run small focus groups to understand the issues and identify the changes people are open to making, with the right support in place attempting to answer the questions above. *This was achieved.*
    - Obtain systematic insights from Thames Valley Police, community champions etc to understand the realities of the who, where and when of Covid prevention. *This was achieved with all groups listed bar Thames Valley police, with whom it was not possible to engage due to administrative barriers around security concerns.*
    - Integrate effective actions from Slough's neighbouring administrative regions into the work. *These were considered where appropriate.*
- Make recommendations to the Council and partners that will bring significantly more benefit and effect than current actions, bearing in mind the scarce resources (human and finance) that are currently available.

  These are set out in the Recommendations section.
- Report re: recommendations to Silver mid-March 2021.

  Version 1.0 of this report and an accompanying Powerpoint presentation fulfilled this.

RESEARCH QUESTION

The data available at the start of the project and from the previous period of consultation suggested the following research question should take priority:

Why is vaccination uptake in Slough low in the populations most at risk from COVID-19?

There is considerable focus on vaccine conspiracies in the media, but academic investigation into vaccine hesitancy suggests that the issue is often more complex[14]. Human behaviour can be explained through the Theory of Reasoned Action[15] and Theory of Planned Behaviour[16], which state that individuals rationalise their actions based on attitudes, subjective norms and outcomes that are expected to emerge from the actions they take, all of which drive the intention to act. Understanding these underlying norms and perceptions can help to understand why people sometimes choose to take actions that may seem irrational to others, such as avoiding vaccination, or continuing to work when showing signs and symptoms of infection without seeking a test.

Another behavioural model, the COM-B model[17] of behaviour change, has been cited as a particularly useful lens through which to approach vaccine hesitancy[18]. The COM-B model considers an individual's capability of being vaccinated (which may depend on them having knowledge of the vaccination programme, and the local availability of vaccine doses and vaccination centres); opportunity for being vaccinated (including social influences such as cultural or religious acceptance of vaccination, ability to access available vaccination centres, language or digital skills required to book a vaccination); and motivation to be vaccinated (e.g. beliefs about personal risk profile and consequences, perception of advantages and disadvantages of vaccination). Such a model can also be used to understand attitudes towards testing and compliance with other COVID-19 management and mitigation actions, such as social distancing and mask-wearing. Previous research undertaken by academics at Royal Holloway has used the COM-B model to show, for example, that M (motivation) is the strongest influence on compliance with hygienic practices during COVID-19[19].

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[14] Williams, L., Gallant, A.J., Rasmussen, S., Brown Nicholls, L.A., Cogan, N., Deakin, K., Young, D. and Flowers, P., 2020. Towards intervention development to increase the uptake of COVID-19 vaccination among those at high risk: Outlining evidence-based and theoretically informed future intervention content. *British Journal of Health Psychology*, *25*(4), pp.1039-1054.

[15] Fishbein, M. (1979). A theory of reasoned action: some applications and implications. Nebraska Symposium on Motivation, 27, 65-116.

[16] Ajzen, I. (1985). From intentions to actions: A theory of planned behaviour. In Action control (pp. 11-39). Springer Berlin Heidelberg.

[17] Michie, S., Atkins, L. and West, R., 2014. The behaviour change wheel. *A guide to designing interventions. 1st ed. Great Britain: Silverback Publishing*, pp.1003-1010.

[18] Bish, A., Yardley, L., Nicoll, A. and Michie, S., 2011. Factors associated with uptake of vaccination against pandemic influenza: a systematic review. *Vaccine*, *29*(38), pp.6472-6484.

[19] Gibson Miller, J., Hartman, T.K., Levita, L., Martinez, A.P., Mason, L., McBride, O., McKay, R., Murphy, J., Shevlin, M., Stocks, T.V. and Bennett, K.M., 2020. Capability, opportunity, and motivation to enact hygienic

Adopting a COM-B model was hypothesised to enable a deeper dive into the question of what was driving vaccine hesitancy in Slough and to help determine if the underlying issue(s) causing low vaccine uptake was indeed vaccine hesitancy (which would be considered a motivational, M, issue) or instead down to lack of capability (C) and/or opportunity (O) that was creating barriers to uptake amongst those who would otherwise be willing.

Within this framework, the same approach was applied to the question of why testing uptake and compliance with other suggested actions was also low.

METHODS USED IN THE STUDY

In the time available, the only methodology feasible was a Rapid Ethnographic Assessment (REA)[20]. Considering that an RAE might take as long as six months for a standard academic study and one month for a policy research project, it has to be stated that this was *extremely* rapid and the results should, therefore, be approached in light of this. In an ideal world, sample sizes would have been much larger, sampling frames would have been more robust and statistical significance more certain. The insights provided are limited by the limitations of the study's extremely constrained time period.

The limited timeframe favoured a mixed methodology of ethnographic observations (including shadowing Community COVID Wardens on their daily patrol), formal and informal interviews with key informants from the Community Champions and OneSlough groups, quantitative surveys collected using the online software Survey Monkey, online focus groups and desk-based research. A timetable of the research activity is set out in Table 1, on the next page.

Challenge: There was, at the time of the consultation, no systematic social listening[21] programme underway in Slough to capture information on attitudes to and understanding of

practices in the early stages of the COVID-19 outbreak in the United Kingdom. *British journal of health psychology*, *25*(4), pp.856-864.

[20] Sangaramoorthy, T. and Kroeger, K.A., 2020. *Rapid ethnographic assessments: A practical approach and toolkit for collaborative community research*. Routledge.

[21] https://sentione.com/resources/social-listening

vaccination and testing amongst the diverse populations or to easily identify circulating narratives. A Social Insight Survey was conducted in November and December 2020, but this was not ongoing. There was nowhere for those who heard rumours to report them, or to find trusted information that could help them to debunk misinformation and conspiracy theories, or to better educate themselves about what was and was not known about vaccines and the disease before doubts and uncertainties took hold. A dedicated COVID-19 Information Hub, maintained by the Local Authority, a local newspaper or local radio station could provide a single platform for local information to be pushed out, local questions answered and local concerns aired. This could potentially be hosted on the OneSlough platform as an addition to section at https://oneslough.org.uk/faqs/?

Activity	Date	Actions	No of Respondents
Zoom meeting with Community Champions	4 March	Discussed existing knowledge of likely reasons for low vaccine and testing take up. Online survey instigated	60+ respondents to SurveyMonkey online survey, presented at Annex I
Day/evening patrol with COVID Community Wardens	9 March	On patrol with Community Wardens from 2-9pm; city centre, major supermarkets and Farnham Road	n/a
Zoom meeting with Community Champions	11 March	Updated community champions on observations; tested some potential solutions	n/a
Day/evening shift at The Centre Lateral Flow Testing Centre	11 March	Semi-structured interviews with centre users.	17 respondents. Survey is presented at Annex II
OneSlough community meeting	11 March	Discussed likely reasons for low vaccine and testing take up.	n/a
Focus Group with OneSlough	17 March	Discussed observations and possible recommendations to determine community acceptability	n/a

Table 1: Activities undertaken, 1-18 March 2021

RESULTS AND SUGGESTED ACTIONS

Results are presented under three themes:

- Reasons for low vaccine take-up
- Reasons for low testing take-up
- Reasons for general poor compliance

Suggested actions are presented alongside each set of results and then discussed together in later sections.

ISSUE I: Reasons for vaccine hesitancy

Attitudes on vaccine hesitancy from early discussions with the Community Champions and OneSlough online group meetings suggested that there were a number of different reasons for vaccine hesitancy, and that different communities were hesitant for different reasons. Some concerns were primarily due to lack of understanding or misconceptions regarding the vaccine; some were due to deep-seated issues around lack of trust in authority or the Government; and others were due to practical difficulties with accessing vaccination services. An online SurveyMonkey questionnaire survey was initiated to capture this understanding from across the groups. Reasons given for vaccine hesitancy will be considered in turn.

Vaccine Concern	Mentioned in online survey
Can a vaccine that has been developed so quickly be safe?	42.5%
Don't have enough information	20%
Vaccine causes infertility	20%
Vaccine causes side effects	15%
Ingredients	12.5%
General fears	12.5%
Lack of trust	10%
Tracking	7.5%
Too difficult/inconvenient to get vaccinated	7.5%

Table 2: Reasons given for vaccine hesitancy reported by respondents (n=60) to the SurveyMonkey online questionnaire.

Testing Concern	Online survey	In-person	Reported
Loss of earnings if test positive	55%	18%	By Community Champions
Don't take it seriously	2.5%	0%	By Community Champions
Accessibility	2.5%	6%	By Community Champions

Table 3: Reasons given for testing hesitancy in the SurveyMonkey online survey (respondents n=60) and users accessing the testing service at The Centre Lateral Flow Testing Centre (n=17). Additional insights and responses to suggested solutions were recorded in the Community Champions Zoom meetings and observed in the OneSlough online meetings.

Whilst several respondents to the online and in-person surveys reported having seen some of the more outlandish misinformation about the COVID-19 vaccines circulating (e.g. that the vaccines contain microchips designed to track or control the population), the majority of the concerns were driven by more logical considerations. The most prevalent were:

1. How can a vaccine developed so quickly be safe? (All communities)

Just under half (42.5%) of the respondents to the online survey referred to concerns over the speed with which the vaccines had been developed. Similar concerns were voiced in the online discussion groups and by staff at The Centre Lateral Flow Testing Centre, at least one of whom had declined vaccinations available to the staff because of these concerns.

Educating people about how it is possible to speed up the vaccination process (which has largely been achieved by removing administrative barriers, the ease with which willing volunteers were recruited, prioritisation for funding and research etc, rather than the safety trials themselves) is possible but requires time – often in lengthy one-to-one conversations that allow the concerned person to ask further questions and receive further explanations of scientific language they may not easily understand. There are a number of online resources available that provide easy-to-understand explanations of the vaccine trial process – e.g. at https://www.reddit.com/r/Coronavirus/wiki/faq/#wiki_how_is_it_possible_to_create_a_safe_vaccine_in_such_a_short_period_of_time.3F Such resources can help to inform the

Community Champions, and to provide support and further information to help them explain the science to community members and answer their questions when the issue is raised.

2. Vaccines cause infertility (Undefined community)

This narrative was widely reported in the online survey but was not linked to a particular community or group, and it is unclear whether people had just seen it circulating or if anyone actually believed it. There is no indication of where this information is coming from.

It might be useful to try to find out which communities this narrative is circulating in and whether anyone actually believes it.

3. The vaccines can cause severe side-effects and even death (All communities)

Approximately one fifth (20%) of the online survey respondents mentioned concerns over side-effects, including fear that people might die. Specific side-effects mentioned were hair loss (which is a genuine side-effect that seems to affect some people 2-3 months after they have otherwise recovered from COVID-19 and is hypothesised to be linked to stress); complications during pregnancy; and reactions severe enough to require a day or two off work.

Mild side-effects are not uncommon with COVID-19 and WHO infodemic management advice is to be honest and open about what side effects might be expected. Mild headache, muscle fatigue, mild fever and soreness in the arm that was injected are all common but generally last for only a few hours, or overnight at most, and can be relieved by standard pain relief medicine such as paracetamol or neurofen.

It will be helpful for Community Champions and other key figures within the community to inform themselves of the common side effects and be willing to discuss these with concerned community members. Reliable information regarding likely side effects can be found here:

www.nhs.uk/conditions/coronavirus-covid-19/coronavirus-vaccination/coronavirus-vaccine/
https://www.bbc.co.uk/news/health-56375307

A question and answer session with volunteers who took part in the Pfizer and Moderna trials, in which they discuss their experiences including side effects experienced, can be found here:

https://www.reddit.com/r/COVID19_support/comments/jw587x/im_a_participant_in_the_pfizer_vaccine_trial_ama/

Topics such as this, which are dependent on education and further information to help build vaccine confidence are ideal topics for local radio shows and newspaper articles, or for talks given during faith services; support should be given to local trusted voices – including the Community Champions – who can help to dispel concerns using information which is readily available but which they may need support to understand and to discuss with others.

4. What ingredients are in the vaccine? Does my religion permit them? (Muslim communities)

A relatively small but significant number of survey respondents (12.5%) referred to concerns over the ingredients vaccines contain. This was most often linked to religious dietary restrictions and concerns over whether or not the vaccines contain pork gelatine (which is often used as a stabilising agent in vaccines, including influenza vaccines) and whether it is therefore permitted by Islam and Sikh religions.

The vaccines used in the UK do not contain pork gelatine or other animal products. Islamic associations and Islamic scholars across the world have been united in the message that the vaccines are acceptable within religious dietary restrictions. Both the Muslim Council of Britain[22] and the Islamic Medical Association of North America[23] have been consistent that vaccination and testing is permitted in general, and is permitted during Ramadan, as the restrictions relate to food and drink that is ingested. As the vaccine is not eaten and does not pass through the stomach, it is not restricted. In any case, the Quran allows exceptions for the greater good, under which vaccination to protect oneself and others from harm would qualify.

[22] https://mcb.org.uk/resources/opvac/
[23] https: //imana.org/covid-19/all-covid-19-updates/

Public Health England has a service that will design and print (for free) specific COVID-19 resources for Local Authorities and Public Health agencies that ask for them, which can be accessed here: https://www.healthpublications.gov.uk/Home.html

On request, they drafted three designs which could be used in Slough, shown below (larger versions in Annex III):

Fig 4: Posters designed by Public Health England to help build vaccine confidence, particularly during Ramadan.

The posters were well received in the OneSlough Focus Group and the Community Champions meeting. There was a suggestion that the message could be strengthened from a softer, "You can have the vaccines/vaccines are acceptable" to a stronger, "It's your duty to have the vaccine/Vaccination is a blessing" narrative, but exact wording would need to be further tested in focus groups with faith communities to find an ideal wording.

The poster(s) as they stand are ready to print and can be ordered from PHE.
The liaison contact is Chertsyn Hurley
cherstyn.hurley@phe.gov.uk
https://www.healthpublications.gov.uk/Home.html

These posters could, once printed, be placed in community locations frequented by Muslims including shops and restaurant/takeaways displaying 'Halal Products' signage, Mosques and Islamic community centres, hairdressers and beauty salons with Muslim clientele.

When discussed in the Community Champions meeting, a further suggestion was made that even with institutional and religious cleric support, some Muslims may still remain hesitant about receiving a vaccine during the fasting periods of Ramadan, which last from sunrise to sunset each day. A request was made to make vaccination centres available during non-fasting hours, even if this would require them to open earlier or remain open later than usual. This is a reasonable request that should be given consideration.

5. General fears/lack of trust (All communities)

General but unspecified fears and lack of trust around vaccines and vaccinations were mentioned by 15% and 10% of the survey respondents respectively; but what the person was afraid of was not always clear. As this was reported information, usually regarding someone who had expressed vaccine hesitancy to the respondent, rather than the respondent being hesitant themselves, this could indicate a need to encourage Community Champions and others to be more empathetic and understanding regarding people's fears and to be willing to listen and discuss concerns with them and to guide them towards information that can ease their concerns.

Several of the survey respondents replied in ways that were very dismissive of others' concerns, giving the reason for vaccine hesitancy as "stupid" or "stupidity". This doesn't help to overcome the hesitancy: understanding why people are nervous and helping to better inform them is more likely to help them to change their mind than belittling their fears.

There are many online resources that can help Community Champions to respond effectively to vaccine hesitancy, including:

https://www.euro.who.int/__data/assets/pdf_file/0004/329647/Vaccines-and-trust.PDF

https://ajph.aphapublications.org/doi/10.2105/AJPH.2020.306087

https://www.apa.org/topics/covid-19/equity-resources/building-vaccine-confidence.pdf

There were felt to be particular trust issues within African and Afro-Caribbean communities, driven by long-standing systematic marginalisation and feelings of being second-class citizens who might be used as 'guinea pigs' for untested vaccines or other medical experiments. Higher levels of cases, severe illness and death amongst this community was pointed to as fuelling these fears, and that building vaccine confidence will be hard even when working through trusted community leaders, such as faith leaders.

It is always worth making the effort to work with communities to address fears but if challenges are particularly persistent and hard to overcome it is worth considering that an alternative approach may to be valuable, such as strengthening compliance with non-pharmaceutical interventions (NPIs) such as face-coverings and social distancing. The ultimate goal – to bring down infections – may still be achievable through alternate means.

6. The Government (or others, unspecified) want to track me (Undefined community)

A small number of respondents (7.5%) mentioned tracking as a concern. While the temptation is to dismiss this as microchipping conspiracies, a more practical concern emerges around individuals who might – for a number of reasons – not want to register with a GP or take a test that registers the individual's name and address, and reports this, and the result, to the NHS.

As was covered in the background section earlier in this report, data and anecdotal discussions suggested that there may be a number of undocumented individuals in Slough who were currently 'under the radar' of the authorities and may prefer to stay that way. This does not mean they are unwilling to be vaccinated.

It does, however, mean that in order to enable them to be vaccinated, it might be necessary to instigate a system that allows people to receive a vaccination without registering their identity – a 'no questions asked' approach.

This was discussed with Community Champions, first as a suggestion arising from a comment that it is not possible to access vaccination without being registered with a GP, and then in regard to likely levels of acceptance of a 'no questions asked' strategy by communities.

Community Champions reported that:

- *There are people within their communities, who they know of specifically, who are not in a position to register for vaccination and testing through official channels.*
- *When asked, the majority of these individuals indicated they would accept (and in fact would like) a vaccination if they could have it without any records being required.*
- *Individuals suggested local pubs as mobile vaccination centres, and it was also suggested that vaccinations could be administered by Community Health Workers who often know where such individuals live and could give the vaccinations in their home.*

This is a more controversial recommendation that risks 'what would the Daily Mail say?' but is clearly a factor in vaccine avoidance in Slough that could be solved by removing the need for official registration at vaccination centres. The 'last mile' of unvaccinated individuals may well contain an over-representation of this demographic and be dependent on such an approach.

7. It's too difficult/inconvenient to get vaccinated/tested (All communities)

An additional small but significant minority described the vaccination process as too difficult or inconvenient, though the reasons were not always specified.

Some of these respondents may include the group identified above, who are unable to easily access the system through which vaccines are delivered but may also include people with mobility issues or who have little available time, and who find it difficult to travel to vaccination centres.

One hypothesis (which there was not time within the consultation process to confirm) is that the high number of multi-generational households in Slough may contain several very elderly, frail and immobile individuals who are cared for by their children – who may themselves be in their late 60s or 70s – within a multigenerational household in which no family member has access to a car. If this is the case, it may be virtually impossible for such individuals to get to a vaccination centre but they may be happy to receive a vaccine if the vaccination can be carried out in their home.

This idea of taking the vaccine to the person, rather than expecting the person to go to the vaccination centre, might also be effective at improving vaccination levels amongst the younger generation who may consider themselves fit and healthy enough not to be at significant risk from COVID-19 should they contract it. Israel[24], for example, has tackled low vaccine uptake within their younger demographics by offering free vaccinations in bars, in exchange for a free soft drink. This has been a highly successful programme that has improved vaccine uptake among younger age groups considerably and was recommended to be worth considering when bars and restaurants start to reopen in Slough, particularly as cases were currently known to be rising in younger, working age adults.

Fig 5: Mobile vaccination that takes opportunities into people's homes and into bars and restaurants may remove barriers that are currently impeding access or motivation to vaccination amongst the groups in which infections are known to be rising.

ISSUE II: Testing hesitancy

This issue of accessibility also appeared to be an issue with low take-up of Lateral Flow Testing. As with vaccination, a test could not be accessed without registering one's name and address at the time the test was taken.

There was some suggestion, during the afternoon and evening spent at The Centre Lateral Flow Testing site, of issues with ability (or willingness) to easily travel to the testing centre. There was no on-street signage outside The Centre to indicate that it was a testing centre, and no obvious directions aimed at people who were trying to find it, or find their way in. It was some way out of the city centre and not particularly easily accessible. It was suggested that

[24] https://www.timesofisrael.com/care-for-a-shot-with-your-shot-tel-aviv-sets-up-vaccine-station-in-local-bar

positioning a number of smaller, more central or community-based testing centres at key strategic points may help to increase uptake, particularly as the tests were easily portable and required no particularly specialised equipment to administer and analyse.

The majority of the people who came to The Centre for testing during the observation period reported no challenges with finding the centre or accessing a test, however.

The Centre was intended to be a routine testing centre for people needing to demonstrate they are not infected for work or other purposes. Only those who were not experiencing symptoms should enter, and people displaying symptoms were tested elsewhere.

During the observation period, 17 people came to be tested and were invited to complete a semi-structured qualitative questionnaire. This questionnaire can be found at Annex II.

Of the people tested, the reasons for wanting a test were given as:

- Employer requires regular testing (n=7, 41%)
- Peace of mind/to stay safe, but no specific employment requirement (n=7, 41%)
- Colleague or contact has recently tested positive, test recommended (n=2, 12%)
- Proof of negative test required for travel (n=1, 6%)

The staff reported many 'regulars', who come to the centre frequently and who the staff had come to know.

Fewer test centre visitors than online respondents reported concerns over losing income should a test come back positive, but four (24%) reported hearing concerns that lost wages and income in the event of having to isolate following a positive test was a reason to avoid testing. Most felt that financial support for people in such circumstances would help to improve willingness to take a test.

Staff also remarked that while a significant proportion of The Centre users do come purely for peace of mind rather than because of a work requirement, they are surprised that this number

isn't higher – they saw no reason for people not to seek a test before planning to visit family, for example, or before seeing friends, and The Centre could cope with additional throughput.

There is capacity to increase throughput at The Centre. Encouraging more people to use it routinely could help to pick up asymptomatic infections (thought to be close to 40% of all cases) and encourage people to avoid family gatherings where they may spread the disease on. Most people were not aware that you can take a test without a specific employment requirement, or that walk-in tests without an appointment would be granted at quieter times.

Unrecorded testing

As with vaccination, there may have been a significant number of people who were not taking a test because they were 'off the radar' and knew that their name and address would be recorded when they registered. A further issue was that people knew test results are recorded and were concerned that the track and trace system would inform others of their status. This was a significant disincentive for adults in multi-generational households with more than one working adult, and in households of multiple occupancy with unrelated adults of working age, as if one person tests positive the others also have to isolate. This may not be a realistic option for workers in the gig economy or other precarious occupations that do not have sufficient sickpay provision or where time off work risks (or is perceived to increase the likely risk of) employment being terminated.

For such individuals, as with vaccination, unrecorded, unreported and anonymous testing may significantly improve testing uptake. An individual who knows they are positive – even if no-one else does – may be able to take significant steps to protect themselves and their family or housemates, and clients with whom they come into contact during their working day, from secondary transmission.

It was suggested that anonymous testing should be carried out, accompanied by information leaflets on how to minimise the risks of in-home transmission (materials are available from the International Scientific Forum for Home Hygiene, for example, https://www.ifh-homehygiene.org and the International Occupational Hygiene Association, https://www.ioha.net) such as wearing a face-covering indoors, eating in a separate room from

other householders and sleeping alone where practical. High quality masks and hand gel could be provided; the relative cost of these to people on low incomes should not be underestimated.

As with anonymous vaccination, anonymous testing is undoubtedly controversial but was recommended as a likely significant tool in the attempt to bring down the 'last mile' of cases still circulating in Slough.

ISSUE III: Challenged communities and non-compliance with masks and social distancing

Observations during the day and evening spent on patrol with the COVID Community Wardens suggested that during daylight hours, including in shops and large supermarkets, compliance with social distancing and mask-wearing was relatively high but that this declined into the evening, particularly around the takeaways and food shops along the Farnham Road, where many delivery drivers were congregating and socialising as they waiting for orders to be placed and prepared.

Posters for shop windows

Many shops displayed posters asking customers to wear masks and social distance, and some proclaimed 'no mask, no service' but in many shops and food outlets, staff were not wearing face coverings (or were wearing them around their necks and made a show of replacing them when the Wardens walked by) and did not challenge customers who entered unmasked. The Community Wardens expressed frustration that repeated reports of violations to the Council do not result in any action being taken; they reported only one fine being issued since the beginning of lockdown and believed that in other areas, e.g. Hampshire, fines were issued much more regularly.

This was felt to give a message to the offending shopkeepers that the Council did not really care and would not punish them if they didn't comply, giving little incentive to do so. This was exacerbated by the shops having been left to source – and pay for – their own safety posters. Again, it was believed that in other regions, Councils have provided COVID safety posters while Slough Council has not, which was perceived to mean that Slough Council is not taking things

seriously; if the council doesn't, why should the shopkeeper? No centralised poster distribution meant that posters were inconsistent and that some shops displayed them while others didn't.

This offered two opportunities: a 'soft' incentive approach of providing consistent posters, free of charge to shops – and perhaps free face coverings to hand out to customers who did not have their own – which could be combined with the Ramadan posters discussed previously.

Fig 6: The council could provide consistent poster signage to busy shops to signal a serious intention to encourage compliance; this could include signage targeted at specific groups known to have vaccine concerns positioned alongside other cultural signage.

A 'harder' approach would involve mobile testing for shop and restaurant staff, with fines and closures imposed on outlets where staff tested positive. This was clearly not without controversy, but there was blatant lack of compliance in some outlets and a testing regime would provide some data on whether these apparently busy and 'problem' areas were indeed hotspots of spread. Knowing they were going to be tested could incentivise shop and takeaway staff, and delivery drivers, to improve compliance with mask-wearing and social distancing, particularly if they knew they would lose income if they tested positive.

There are various apps available that can allow citizens to report low-level public disorder to law-enforcement agencies or local authorities. These can be used off the shelf or, for a modest budget, with modifications specific to the context and environment, for example the TRILLION app developed under an EU Horizon2020 grant:

- *https://consert.eee.uniwa.gr/2020/02/23/quickreport-app*
- *https://youtu.be/o9L5zBYahbc*

It was suggested that a tightening up of compliance ahead of shops and restaurants re-opening after Easter 2021 could be important to ensure areas that were already problematic did not become hotspots of disease spread when movement was less restricted.

End of the school day

Some challenges were observed with parents collecting younger children from The Grove School, largely generated by the design of the school grounds and a bottleneck caused at one of the gates. It was difficult to suggest what could be done about this, as the small children needed their parents to be close enough to be seen in order to be handed over. The pavements were narrow and did not easily allow for socially distanced queueing. The parents were outdoors and most were masked, suggesting that the risk may in fact be low. The school Principal engaged with the Community Wardens and arranged to discuss options with them further, but also made it clear that school staff were not prepared to steward parents (though may be happy to have a higher presence of Community Wardens in evidence at key times).

Parents and children tended to congregate in groups of 3-4 adults and up to 10 children but this was outdoors and mask-wearing was reasonably high. Some gentle messaging around social distancing, and posters on school fences may improve the situation but this may not be particularly high risk.

Roma community

The streets around the school, which were inhabited by many members of the Roma community, were reported by the Wardens as being a difficult area to patrol. Groups of young adults congregated on street corners and though they did disperse when approached by the Wardens, they soon reconvened elsewhere or when the Wardens moved on. There was a perception that the community did not take COVID-19 seriously (which may impact on their low vaccine take-up, though low measles vaccination amongst Roma communities has been

shown to be more to do with not being registered with a GP than actual hesitancy, suggesting again the potential efficacy of an anonymous vaccination programme[25]).

The Roma community has proved particularly difficult to reach in the UK with regard to public health and other public service messaging, stemming from a deep-seated mistrust in authority. Effective communication with such communities comes primarily from identifying and working with trusted influencers from within the community to build trust and understanding, then working through these trusted influencers to reach other community members[26], [27].

It was suggested that if Slough Borough Council did not already have a community liaison for the Roma community, it would be worth trying to identify one. Older teenage students at local schools can often be effective community liaisons for hard-to-reach communities as they comfortably span their ethnic community and wider communities such as that of the school.

Somali community

Anecdotal reports were given of challenges with the Somali community, particularly adults currently residing at a local refugee centre who regularly engaged in organised football training and matches in a nearby park (the use of vests and cones suggested the activities were not spontaneous). The Community Wardens had broken up such training on a number of occasions and expressed some resentment that there was no apparent follow-up from the Council to prevent further transgressions.

However, whilst such activity breaks lockdown regulations, it is also worth considering that it is probably low-risk. The activity took place outdoors and appeared to be between people who were residing together and so did not involve any additional community mixing. While

[25] Bell, S., Saliba, V., Ramsay, M. and Mounier-Jack, S., 2020. What have we learnt from measles outbreaks in 3 English cities? A qualitative exploration of factors influencing vaccination uptake in Romanian and Roma Romanian communities. *BMC public health*, *20*(1), pp.1-10.

[26] Condon, L., Bedford, H., Ireland, L., Kerr, S., Mytton, J., Richardson, Z. and Jackson, C., 2019. Engaging gypsy, roma, and traveller communities in research: maximizing opportunities and overcoming challenges. *Qualitative health research*, *29*(9), pp.1324-1333.

[27] http://www.euprimarycare.org/sites/default/files/efpc2017198_-_sala_braga_-_parallel_sessions_round_1_day_1-_09h45_-_10h30_-_engaging_gypsy_roma_and_traveller2.pdf

annoying to others who are being more compliant with regulations, it may not be a likely cause of community spread.

It was suggested that discussion with the refugee centre staff could, however, stress that such activity drives resentment towards the Somali community and that refraining from it may help improve acceptance and cohesion with the wider Slough community.

It was also clear that the Community Wardens have a good rapport with the Slough communities they patrol – including the Roma community – and their instructions were generally followed, even if begrudgingly, when people were asked to move on or refrain from certain behaviour. It was recommended that this rapport be built on to help build trust with some of the hard-to-reach groups, possibly transitioning some of the Wardens into Community Liaison Officers or Community Health Workers if patrols were scaled down once lockdown restrictions eased.

CONCLUSIONS AND RECOMMENDATIONS

1. Instigate an ongoing social listening campaign There is no ongoing, systematic programme to quickly pick up and address circulating concerns and to provide the information necessary to prevent misunderstandings taking hold. Such a programme should be prioritised with support from local comms teams, media or Community Champions, to provide a one-stop platform and point of contact for reporting concerns and formulating reassuring answers.

2. Address vaccine hesitancy in Muslim communities during Ramadan with targeted posters in shops already displaying Halal products posters, community centres and Mosques. Engage local faith leaders to support a campaign on local radio, newspaper and social media. Provide access to vaccine services outside fasting hours, ideally at a faith-based centre with clerics on hand to help provide confidence. PHE will print posters for free when design and wording has been confirmed.

3. Address access issues to vaccination and testing for 'under the radar groups' Available data and community champions point to significant numbers of people who would take the vaccine (and tests) if they could do so anonymously. Reaching this group could be key to reducing the last mile of infections. Community champions confirmed that when asked, these individuals said they would take the vaccine (and in fact, actively wanted to do so) under such conditions. Community champions could help identify people and link them with community health workers for vaccination in the home or in local community spaces, including pubs.

4. Make vaccination more convenient for 'can't be bothered' groups People who don't feel threatened by COVID-19 may not go out of their way to seek out the vaccine but may be willing to have one if it was made more convenient and taking it is incentivised. Positioning mobile vaccination stations in popular city centre locations and in bars and pubs, similar to the Israeli model, may reach younger and less interested demographics.

5. Provide support and information on support for groups with no welfare safety net to enable them to isolate when necessary Gig and grey economy workers with no recourse to sick pay,

precarious living conditions and insecure jobs cannot isolate should they test positive and so do not undergo testing, particularly where this would require working housemates as well as themselves to isolate. Anonymous testing would enable them to be aware of a positive status and thus take additional precautions even if they continue to work, which may help prevent spread to colleague and customers. Anonymous testing could be doubled-up with in-home hygiene information and clear signposting to support groups, including food banks and financial support, to enable isolation.

6. Continue with education and information provision to Community Champions to enable them to cascade information out to their communities. Strengthen the OneSlough platform as a portal for reassuring and in-depth information, perhaps with a regular blogspot (Dr Jim O'Donnell was mentioned as a local trusted voice) that can address specific concerns and answer specific questions. If possible, enable academic library access for CVS group or council public health office so that the latest evidence and understanding regarding COVID-19 can be quickly accessed; more educated members of the group can help to explain academic papers to the rest of the group.

7. Provide consistent, free COVID-19 safety messaging posters to local shops and food outlets who feel aggrieved at being expected to pay for and source their own. Make compliance as easy as possible.

8. Consider taking testing to challenging 'hot spots' where low-levels of mask compliance and social distancing are known to be persisting. Consider instigating mobile testing of staff and temporary closures for outlets where staff test positive. This may help to drive compliance with mask-wearing among staff and customers in an effort to avoid closure.

9. Identify community liaison officers for disengaged communities The Roma and Somali communities were singled out as hard-to-reach and flaunting some restrictions. Attempts should be made to reach out to these communities and attempts made to work with trusted insiders to encourage compliance and reduce behaviours seen as challenging by the wider community. Stress the damage these behaviours are doing to community cohesion as an incentive to improve compliance.

10. Accept that some conditions specific to the local context make Slough more vulnerable to infection than other areas High numbers of multi-generational, multi-occupancy households, furloughed workers, precarious jobs and housing all put Slough residents at heightened risk of infection. These are systematic challenges that COVID-19 highlighted and which need to be considered long-term. In the short-term, demonising Slough residents as 'uncaring', 'non-compliant' or 'stupid' does not help. There are deep-seated reasons why some residents are struggling to access vaccination, prefer not to be tested, and are hesitant to trust the authorities to be doing the right thing. Showing understanding and empathy to their situations will help to build trust and convince them that you are (trying to be) on their side and willing to work with them to improve the situation long-term, not just for the sake of stopping the spread of COVID-19.

ADDITIONAL RESOURCES

Posters and leaflets to download that could be use immediately following the consultation:

Public Health England

https://coronavirusresources.phe.gov.uk

National Health Service

https://www.england.nhs.uk/coronavirus/primary-care/other-resources/posters/

US Centers for Disease Control

https://www.cdc.gov/coronavirus/2019-ncov/communication/graphics-buttons.html

https://www.cdc.gov/csels/dls/locs/2020/cdc_offers_new_covid-19_specimen_collection_infographics.html

https://www.cdc.gov/coronavirus/2019-ncov/communication/print-resources.html?Sort=Date%3A%3Adesc

ECDC infographics

https://www.ecdc.europa.eu/en/health-communication/communication-tools/infographics

World Health Organization

https://www.who.int/health-topics/coronavirus#tab=tab_1

https://www.who.int/health-cluster/news-and-events/news/COVID19-Resources/en/

For use on public transport

https://covid19communicationnetwork.org/featured-resource/social-and-behavior-change-collection/

FACT-CHECKING/MYTH-BUSTERS/GENERAL INFO

Full Fact

https://fullfact.org

AFP Fact Check

https://factcheck.afp.com/busting-coronavirus-myths

Africa Check

https://africacheck.org/fact-checks/blog/fighting-covid-19-infodemic-five-strategies-african-fact-checkers

Reddit r/coronavirus FAQ wiki

https://www.reddit.com/r/Coronavirus/wiki/faq/

Science Media Centre

https://www.sciencemediacentre.org

Dr Lambert's Blog

https://www.sciencemediacentre.org

ANNEX I: SLOUGH VACCINE CONCERNS (SURVEYMONKEY ONLINE SURVEY)

1. Have you heard any vaccine concerns? If so, what?

2. Have these come from a particular community or group?

3. What do you think is the reason for these concerns?

4. What do you think are the main reasons people are not getting vaccinated?

5. If you were previously vaccine hesitant yourself, what changed your mind?

6. Why do you think some people may be reluctant to get a coronavirus test?

7. What do you think might make it easier for them?

8. Why do you think cases are higher in Slough than surrounding areas?

Done

ANNEX II: SURVEY QUESTIONNAIRE ON ACCESS TO TESTING AND TEST SITE

I am a Research Fellow at Royal Holloway University of London, helping Slough Borough Council to understand key challenges people in the borough are facing, particularly around testing and vaccination. Please answer the questions below in as much or as little detail as you feel is appropriate. You will remain completely anonymous. If you have further questions, you are welcome to contact me: jennifer.cole@rhul.ac.uk

1. How easy has it been for you to come for a COVID test?

2. Why do you think you need to be tested?

3. If you think you've been exposed, please explain how you think the exposure happened.

4. Have you been following UK Government guidelines on face coverings, hand sanitiser and social distance?

5. If you answered "no" to Question 4, why has this been difficult?

6. Do you think everyone who thinks they might be showing symptoms comes for a test?

7. If you answered "no" to Question 6, why do you this this is?

8. What do you think might make it easier for people to come for a test?

ANNEX III: RAMADAN VACCINE CONFIDENCE POSTERS

Public Health England

NHS

عيد مبارك لكم ولعائلاتكم!

Blessed Eid to you and your family!

COVID-19 vaccination

COVID-19 vaccines are acceptable for Muslims*

YOU CAN HAVE THE VACCINE DURING RAMADAN

Keep your family safe! Remember...

wash your hands

wear a mask

keep 2m apart

... and have your COVID-19 vaccination!

*As agreed by most Islamic scholars (British Islamic Medical Association)

Public Health England

NHS

COVID-19 vaccines

are acceptable for Muslims*

COVID-19 immunisation
Protect yourself.

Public Health England

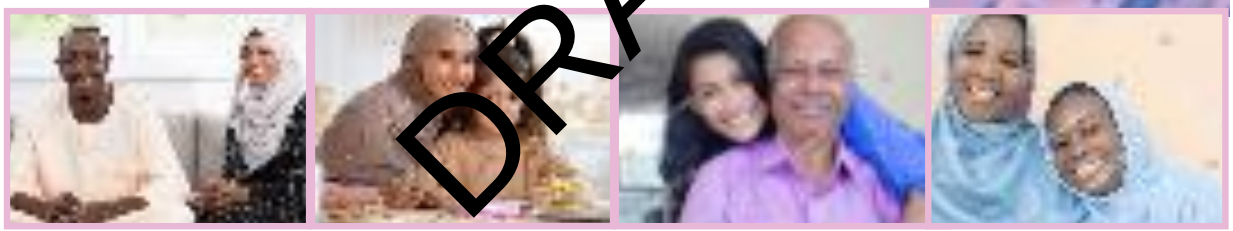
HAPPY Eid Mubarak

NHS

COVID- 19 vaccination

COVID-19 vaccines are acceptable for Muslims*

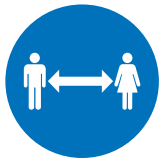
YOU CAN HAVE THE VACCINE DURING RAMADAN



Keep your family safe! Remember…

wash your hands

wear a mask



keep 2m apart

… and have your COVID-19 vaccination!

* As agreed by most Islamic scholars (British Islamic Medical Association)

Further information on Jennifer Cole's role at Royal Holloway is available here: https://pure.royalholloway.ac.uk/portal/en/persons/jennifer-cole(bfb50003-0f58-451a-a46b-5273796a2aa4).html