INFLUENTIAL

Cheshire and Merseyside
Health and Care Partnership

# Getting under the skin

## The impact of COVID- 19 on Black, Asian and Minority Ethnic communities

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# Introduction

# Context

There is clear evidence that COVID-19 does not affect all population groups equally. The risk of dying is higher for:

People who are aged 80 or older

Males than female

People living in deprived areas; and

Those from ethnic communities

*These inequalities replicate existing inequalities in mortality rates in previous years, except for ethnic groups.*

*The COVID-19 pandemic has also disrupted and changed the access and delivery of NHS and social care services*

# Overall objectives of the project

- To **understand the impact of COVID on different ethnic community groups**
  - Social factors: impact on family, friends and communities
  - Access to health and social care services
  - Individual health behaviours
  - Mental health and wellbeing
  - How might this impact future behaviour
  - The ‘fear factor’
  - Views on the COVID vaccination

- To **gain a better understanding of the cultural, behavioural and religious aspect** that influences health and care

- To **understand how some public health messaging and COVID related messages are perceived** and even acted on by different ethnic communities

- To **gain insight into preferred communication and engagement methods**
  - What are the best advertising and communication channels to use to target different communities?
  - Who are the community ‘influencers’?

# Approach

## Phase one: Desk top research

- Developed a model which included using other data sources to refreshed Census data to give an updated view
- Detailed understanding of ethnic profiles across Cheshire and Merseyside
- An interactive tool which can drill down by postcode level to see exactly where our ethnic communities live and their characteristics and estimated numbers of people in each of the communities

## Phase two: Quantitative research

- Target was to complete a minimum of 500 interviews conducted via online and telephone surveys

## Phase three: Qualitative research

- Views and themes which have emerged from phase to be explored in greater detail via focus groups and in-depth interviews

# Phase 2: Recruitment method

1. Online panel

2. Out reach campaign: community and faith groups

3. Out reach campaign: local organisations

4. PR

5. Social media campaigns

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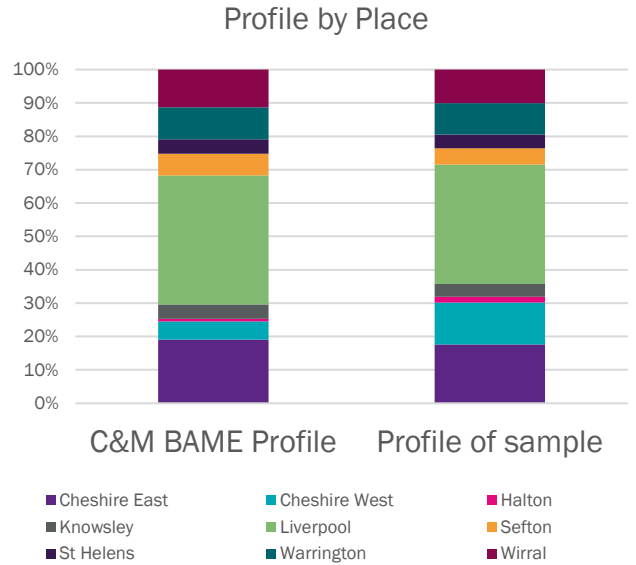
# Phase 2: Survey method

- An online survey was conducted between 7th December 2020 and 24th January 2021.
- To be eligible for interview respondents had to be a member of a ethnic community and resident within one of the Nine Places covered by The Partnership. (A control sample of White British was not conducted.)
- The sample was generated through the following methods:
  - *Online panel* (respondents recruited through a commercial online panel)
  - *Landing page* (respondents directed to a survey landing page through Social Media campaigns, PR activity, community out reach and engagement with local businesses/community groups)
- A pilot survey of 10 respondents was conducted online between 2nd and 3rd December 2020.
- The questionnaire was translation into seven languages, *Simplified Chinese, Traditional Chinese, Farsi, Arabic, Hindi, Urdu and Bengali*. In total, 32 of the 33 translated completes were conducted in Chinese.
- The data were weighted by gender and Place to ensure that the sample was representative on these variables.
- This report only contains the findings from Phase 2 of the project.
- A total of 636 completes was generated, as follows:

| Source of complete | Number of completes |
|---|---|
| Online panel | 309 |
| Landing page | 327 (33 using translated versions) |
| **TOTAL** | **636** |

# Sample achieved: geographical split

| Location | Profile of C&M ethnic community | Profile of sample | Final sample size |
|---|---|---|---|
| Cheshire East | 19.1% | 17.6% | 112 |
| Cheshire West | 5.4% | 12.6% | 80 |
| Halton | 0.8% | 1.7% | 11 |
| Knowsley | 4.3% | 3.8% | 24 |
| Liverpool | 38.7% | 35.8% | 228 |
| Sefton | 6.5% | 4.9% | 31 |
| St Helens | 4.3% | 4.1% | 26 |
| Warrington | 9.6% | 9.4% | 60 |
| Wirral | 11.3% | 10.1% | 64 |
| TOTAL | | | 636 |




The profile of responses broadly reflects the profile by place. Base sizes for Halton, St Helens, Sefton and Knowsley are low and results for these areas should be treated with caution

# Sample achieved: ethnic Group

| | Area profiles | Final sample size | Profile of sample |
|---|---|---|---|
| African Ethnic Origin | 6.1% | 79 | 12.4% |
| Caribbean Ethnic Origin | 0.5% | 22 | 3.5% |
| Any Other Black Background Ethnic Origin | 4.3% | 20 | 3.1% |
| Chinese Ethnic Origin | 3.9% | 78 | 12.3% |
| Bangladeshi Ethnic Origin | 2.2% | 26 | 4.1% |
| Indian Ethnic Origin | 4.8% | 104 | 16.4% |
| Pakistani Ethnic Origin | 2.9% | 30 | 4.7% |
| Any Other Asian Background Ethnic Origin | 7.0% | 37 | 5.8% |
| White And Asian Ethnic Origin | 5.7% | 27 | 4.2% |
| White And Black African Ethnic Origin | 4.0% | 16 | 2.5% |
| White And Black Caribbean Ethnic Origin | 4.1% | 65 | 10.2% |
| Any Other Mixed Background Ethnic Origin | 11.9% | 23 | 3.6% |
| Gypsy/Irish Traveller Ethnic Origin | 2.4% | 10 | 1.6% |
| Irish Ethnic Origin | 1.9% | 23 | 3.6% |
| Any Other White Background Ethnic Origin | 28.0% | 44 | 6.9% |
| Any Other Ethnic Group Ethnic Origin | 10.4% | 32 | 5.0% |

Insight has been gathered from every ethnic group

Base sizes for many specific ethnic groups are low and therefore results for specific ethnic groups should be treated with caution.

# Sample: ethnicity and Place

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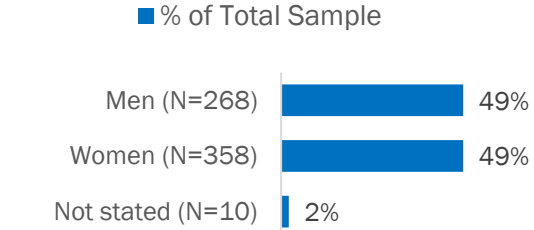
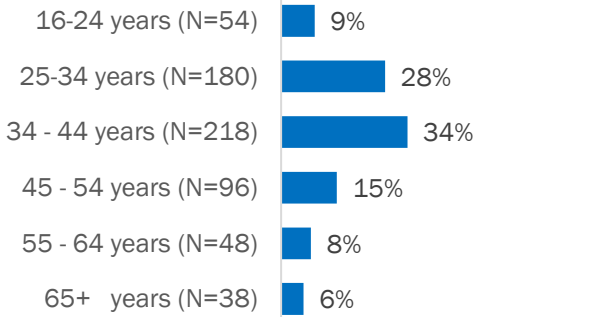
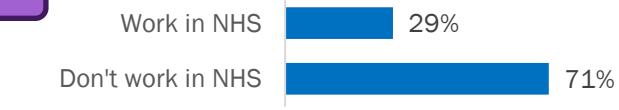
**Sex**



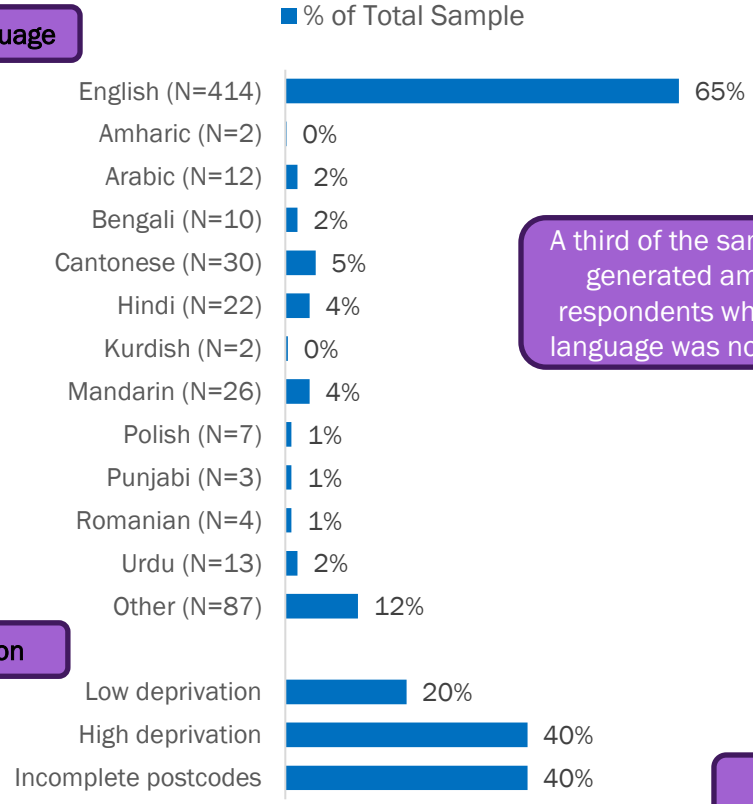

**Age**




**Work in NHS**




**Main language**




A third of the sample was generated amongst respondents whose first language was not English

**Deprivation**




**Weighted profile**

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# Phase 2: Survey Findings

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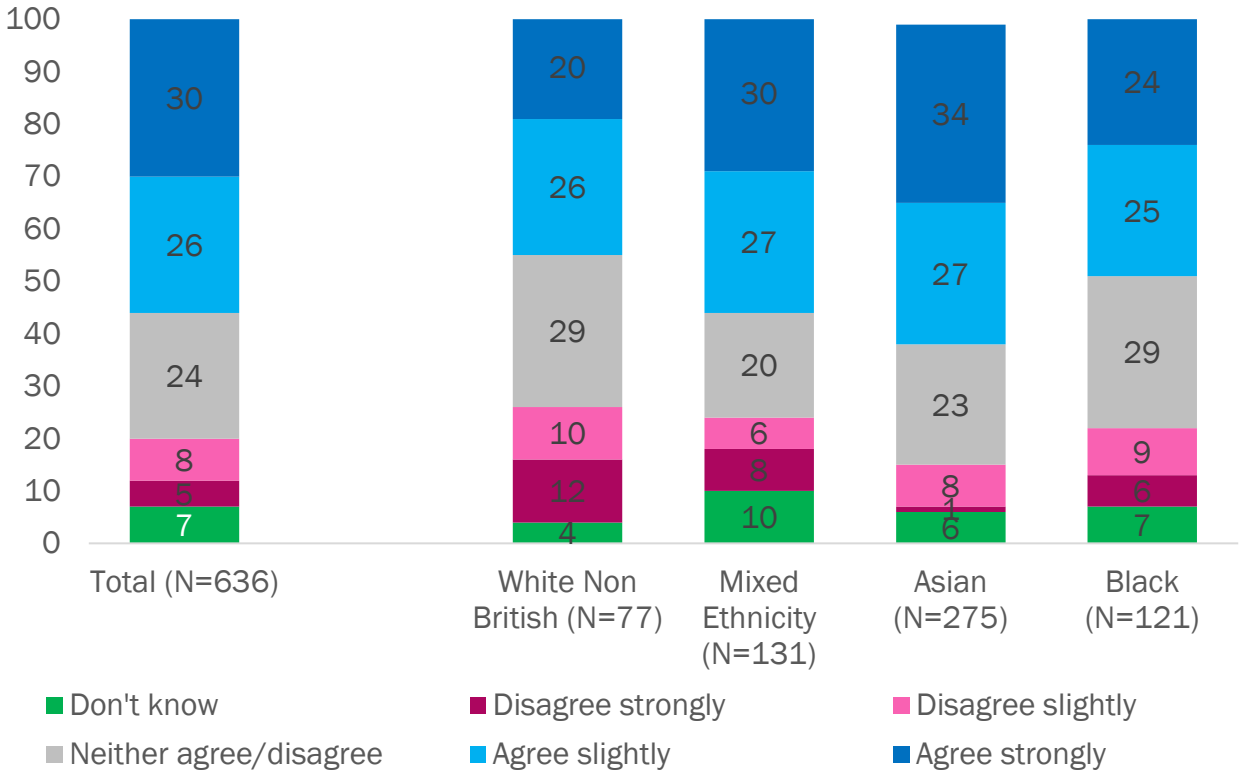
# Vaccine Take Up

# Agreement with “Vaccines are safe”



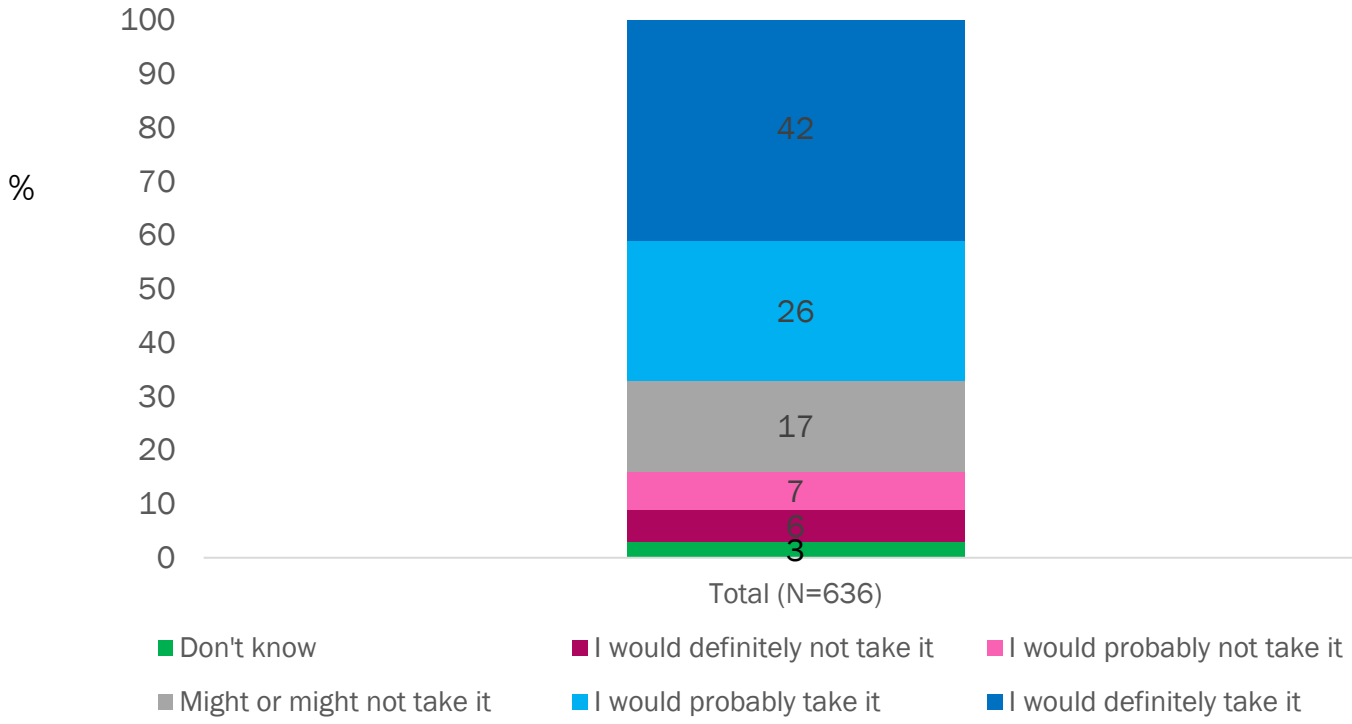

Agreement with this statement was 56%.

This leaves one in eight (13%) who did not think that vaccines are safe and a further quarter (31%) who were undecided or *don't know*. This represents a large number within the population of who have not yet been convinced of the safety of vaccines.

White Non British and Black ethnic groups had the highest levels of disagreement.

The attribute refers to vaccines in general and not specifically to the COVID vaccine.

# Propensity to take vaccine



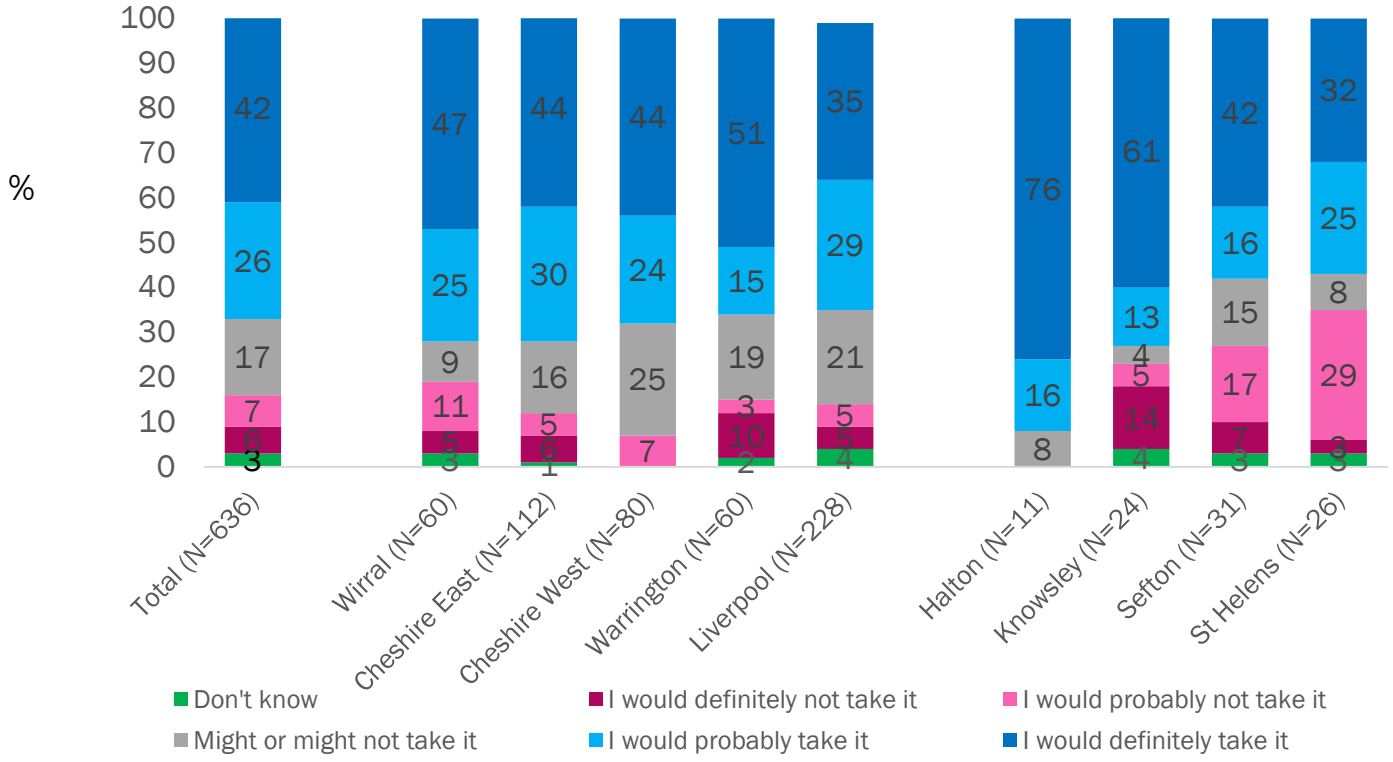

Overall, 68% stated that they would 'definitely' or 'probably' take the vaccine.

But they were significant numbers of the ethnic population who were *hesitant* about (20%) or *rejected* the vaccination (13%).

This suggests that more communication is required to convince vaccine hesitants and vaccine rejecters to take the vaccine.

**Q. Which, if any, of these statements best describes how likely you would be to take this vaccination if it were offered to you?**
Base: all respondents (N=636).

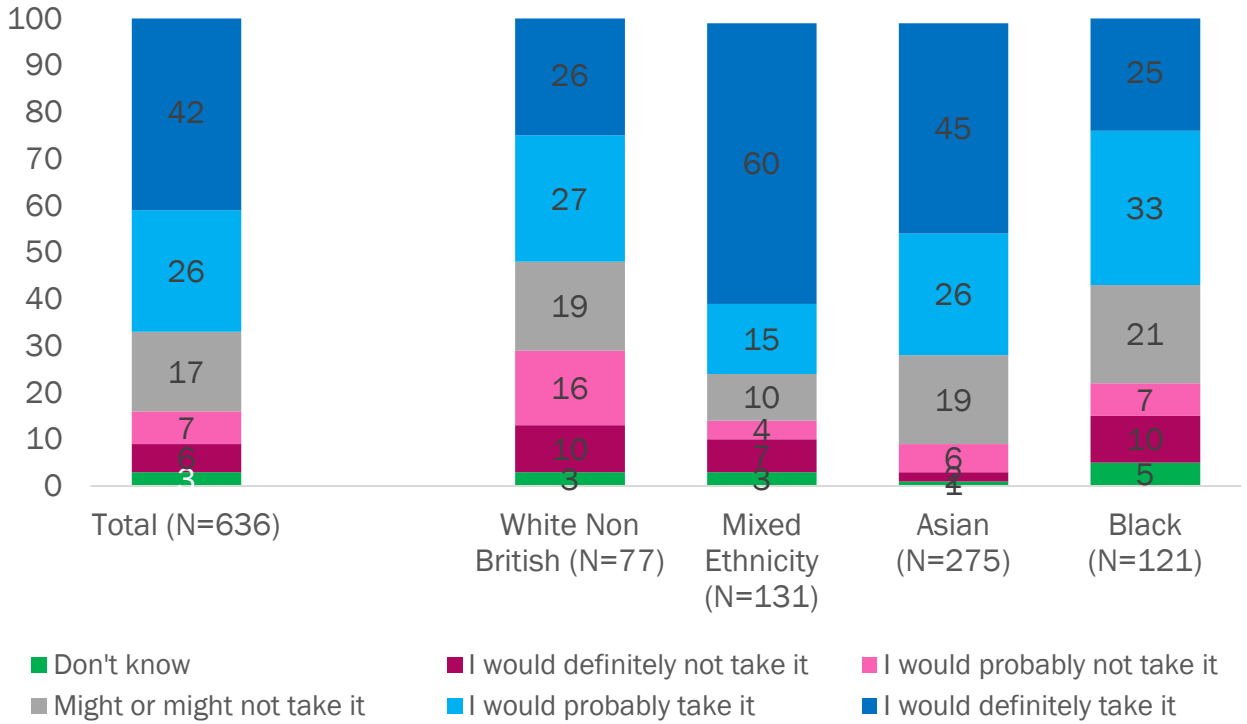
# Propensity to take vaccine by geography




Propensity to take the vaccine was higher in the more affluent local authorities (e.g. Wirral at 72%) and lower in the less affluent (e.g. Liverpool 64%).

**Q. Which, if any, of these statements best describes how likely you would be to take this vaccination if it were offered to you?**
Base: all respondents (N=636).

# Propensity to take vaccine by ethnic group



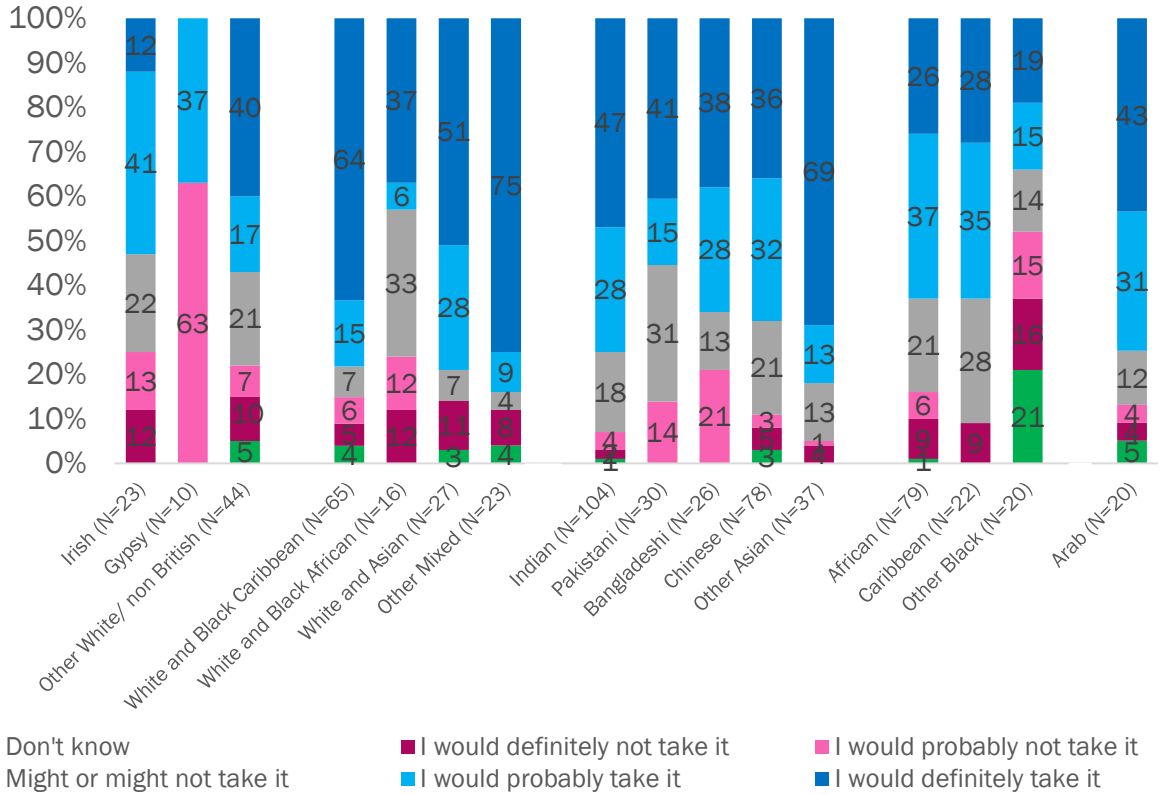

Resistance to taking the vaccine was strongest among White ethnic groups.

Black respondents were the most ambivalent about taking the vaccine.

The views of Mixed ethnicity groups were polarised, with high acceptance, but 11% not wishing to take it

**Q. Which, if any, of these statements best describes how likely you would be to take this vaccination if it were offered to you?**
Base: all respondents (N=636).

# Propensity to take vaccine by ethnic group

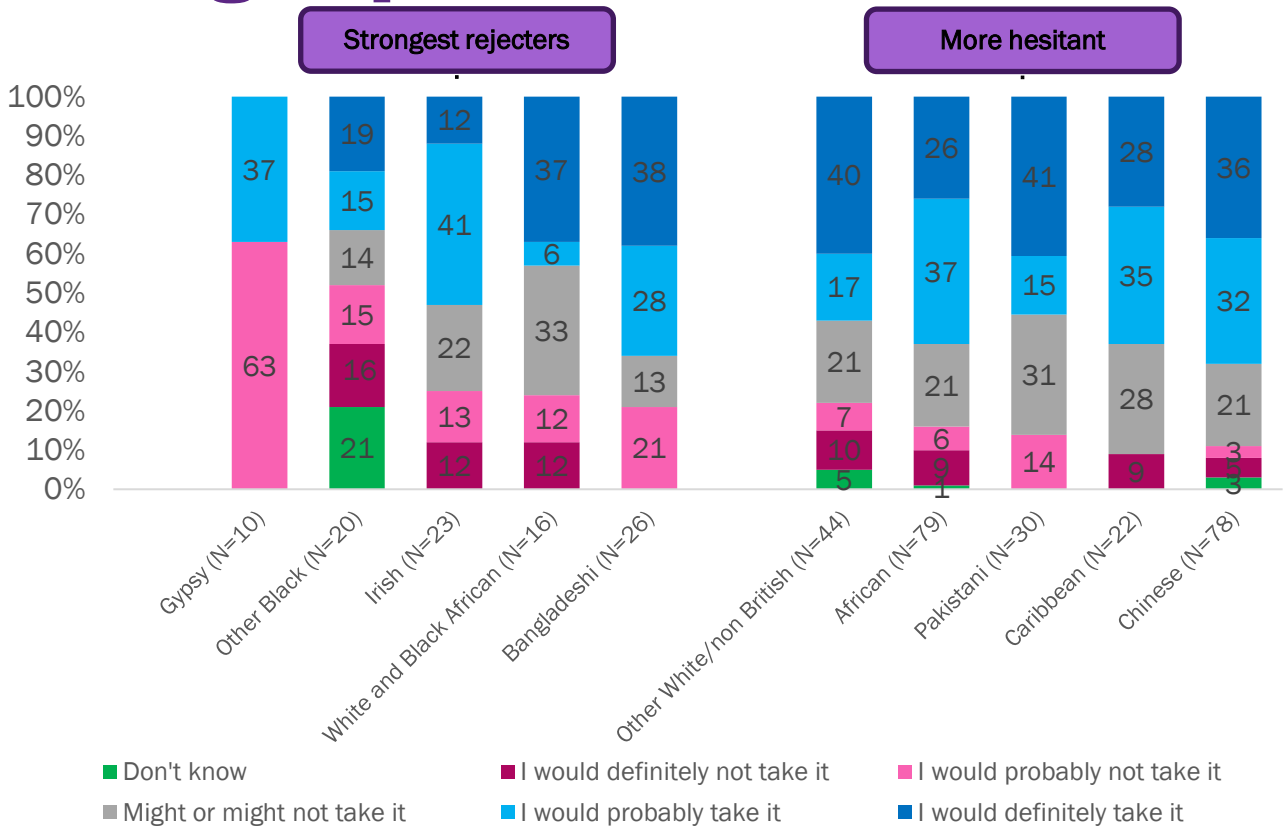



Interpretation by specific ethnic groups must be treated as indicative due to low base sizes.

The highest acceptance of the vaccine was amongst White and Black Caribbean, other mixed ethnicities, other Asian, White and Asian and Indian.

**Q. Which, if any, of these statements best describes how likely you would be to take this vaccination if it were offered to you?**
Base: all respondents (N=636).

# Ethnic groups to focus communications on



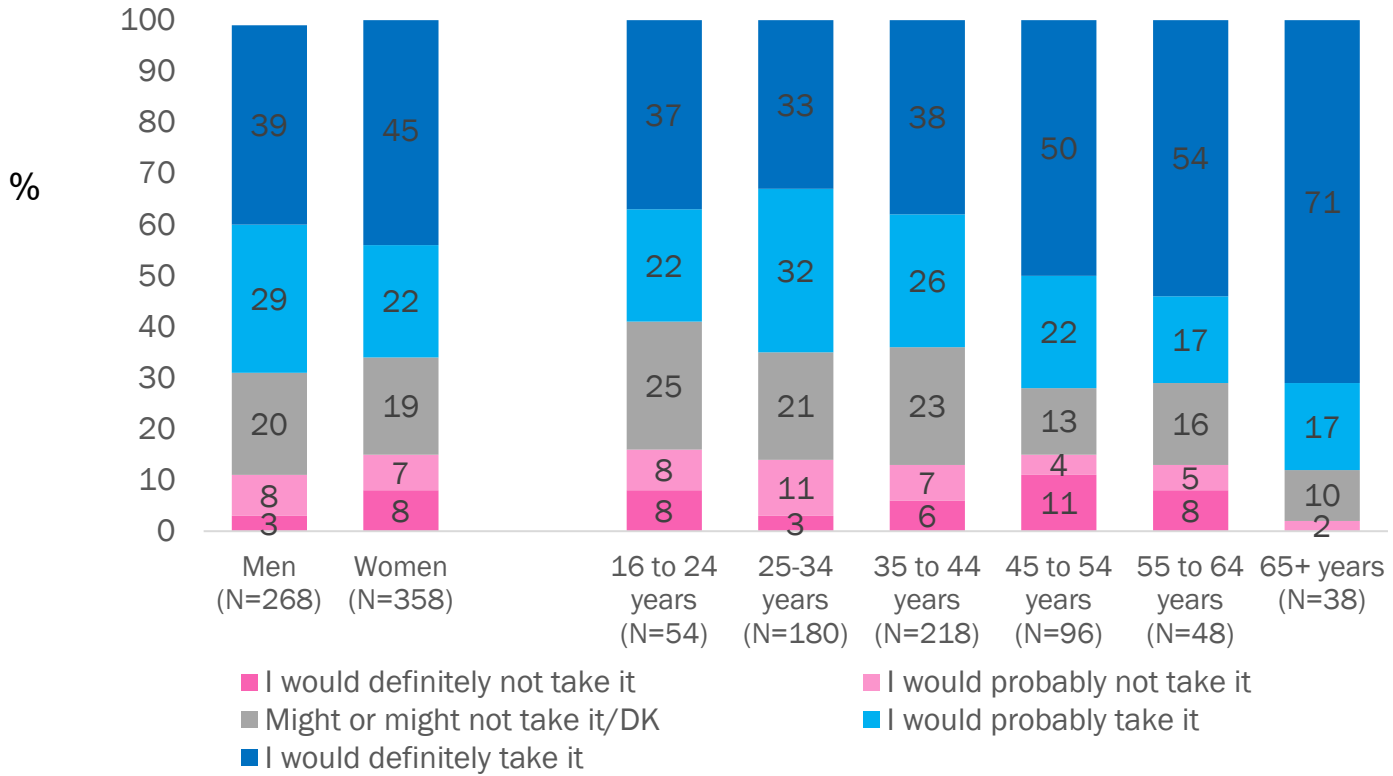

All these groups had the lowest propensity levels (less than 75%) to take the vaccine.

Gypsy, Irish, Bangladeshi, and some Black/mixed groups were the strongest rejecters (over 20% rejection).

Whereas other white (non British), Pakistani, Caribbean, African and Chinese were more hesitant (over 20% Hesitant).

**Q. Which, if any, of these statements best describes how likely you would be to take this vaccination if it were offered to you?**
Base: all respondents (N=636).

# Propensity to take vaccine by age



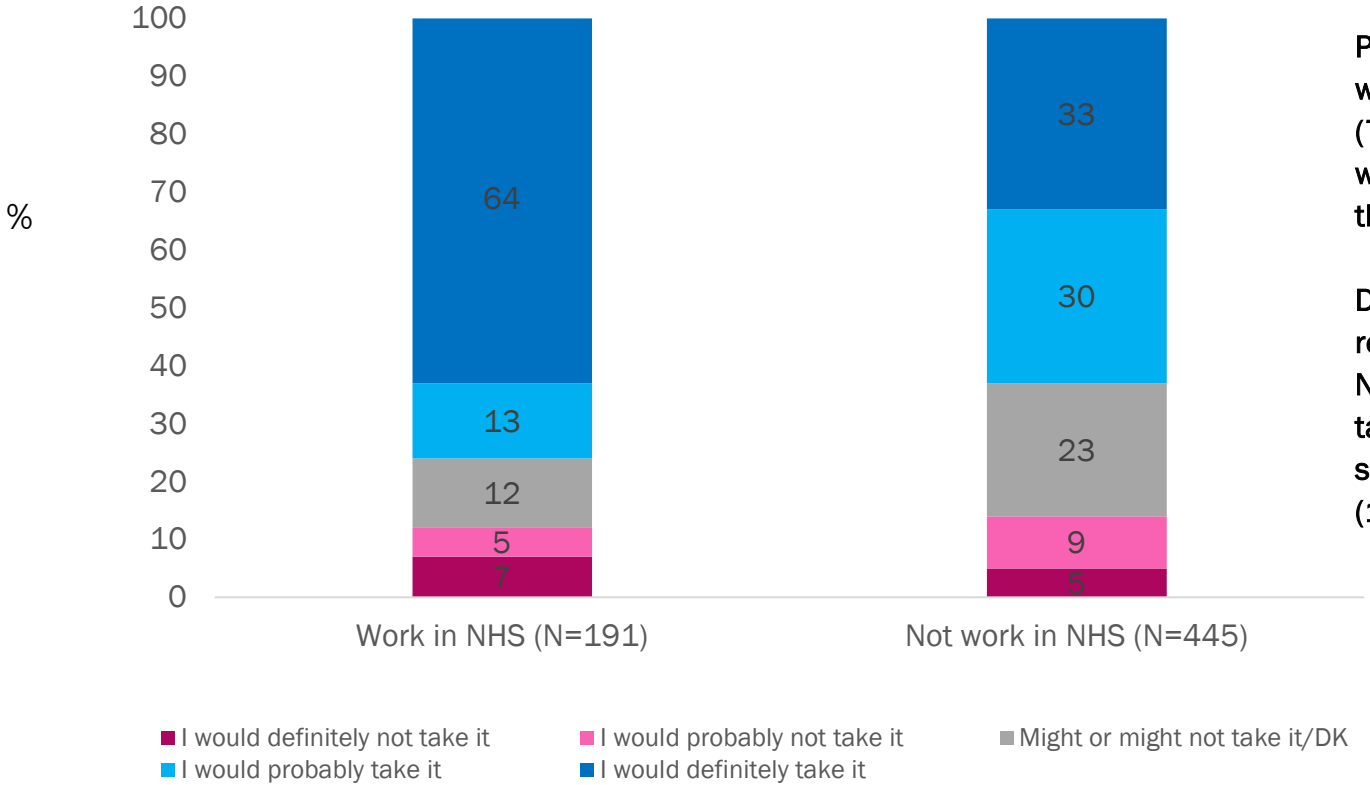

Propensity to take the vaccine increased with age, with thresholds at 45 years and 65 years.

There was less variation by age for *rejection of the vaccine,* with similar levels of rejection up to the age of 65 years.

Women were slightly more polarised than men, with a slightly stronger propensity to *definitely* take the vaccine and also a slightly higher propensity to *reject* it.

**Q. Which, if any, of these statements best describes how likely you would be to take this vaccination if it were offered to you?**
Base: all respondents (N=636).

# Propensity to take vaccine by NHS workers

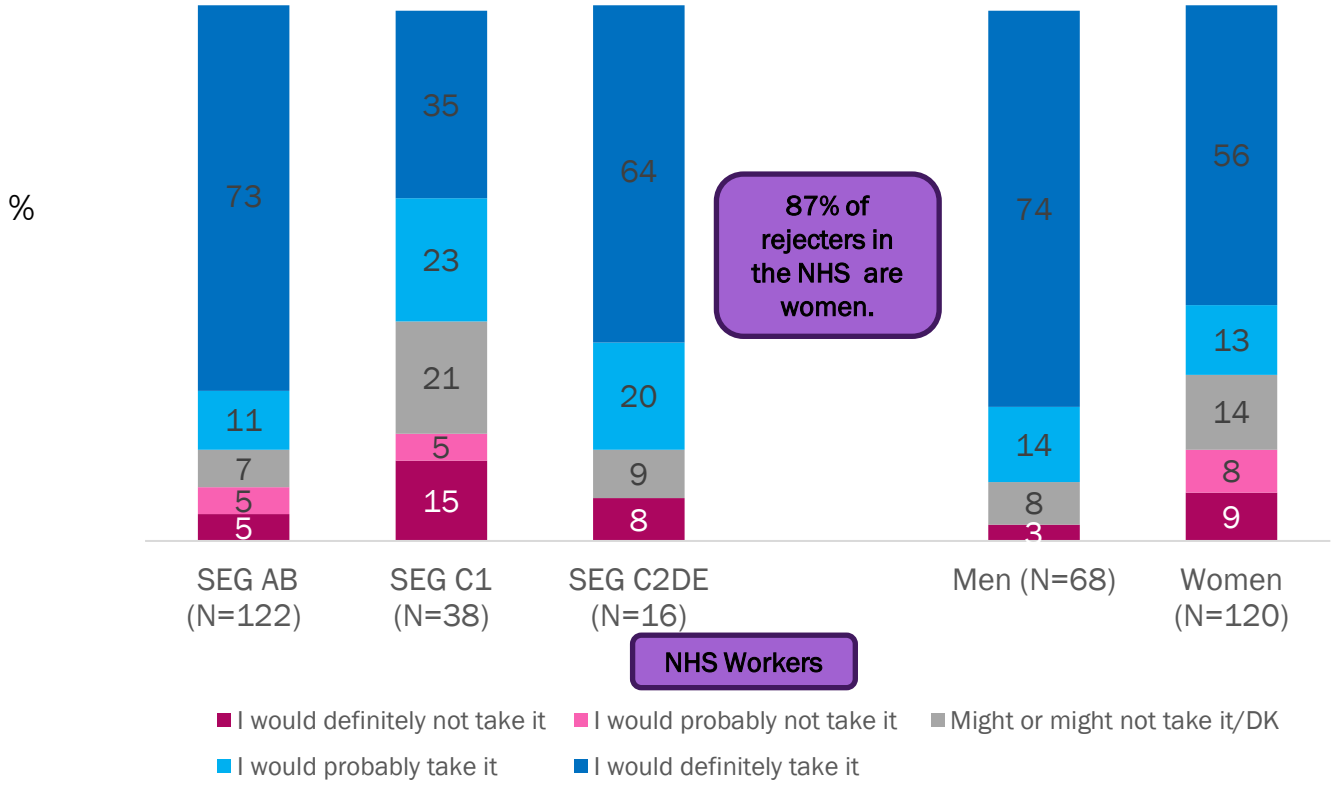



Propensity to take the vaccine was higher amongst NHS workers (77%) – the strength of feeling was particularly strong among this group.

Despite this, there was still some resistance to the vaccine among NHS workers (12% would not take it) and rejection rates were similar to non NHS workers (14%).

**Q. Which, if any, of these statements best describes how likely you would be to take this vaccination if it were offered to you?**
Base: all respondents (N=636).

# Propensity to take vaccine – work in NHS



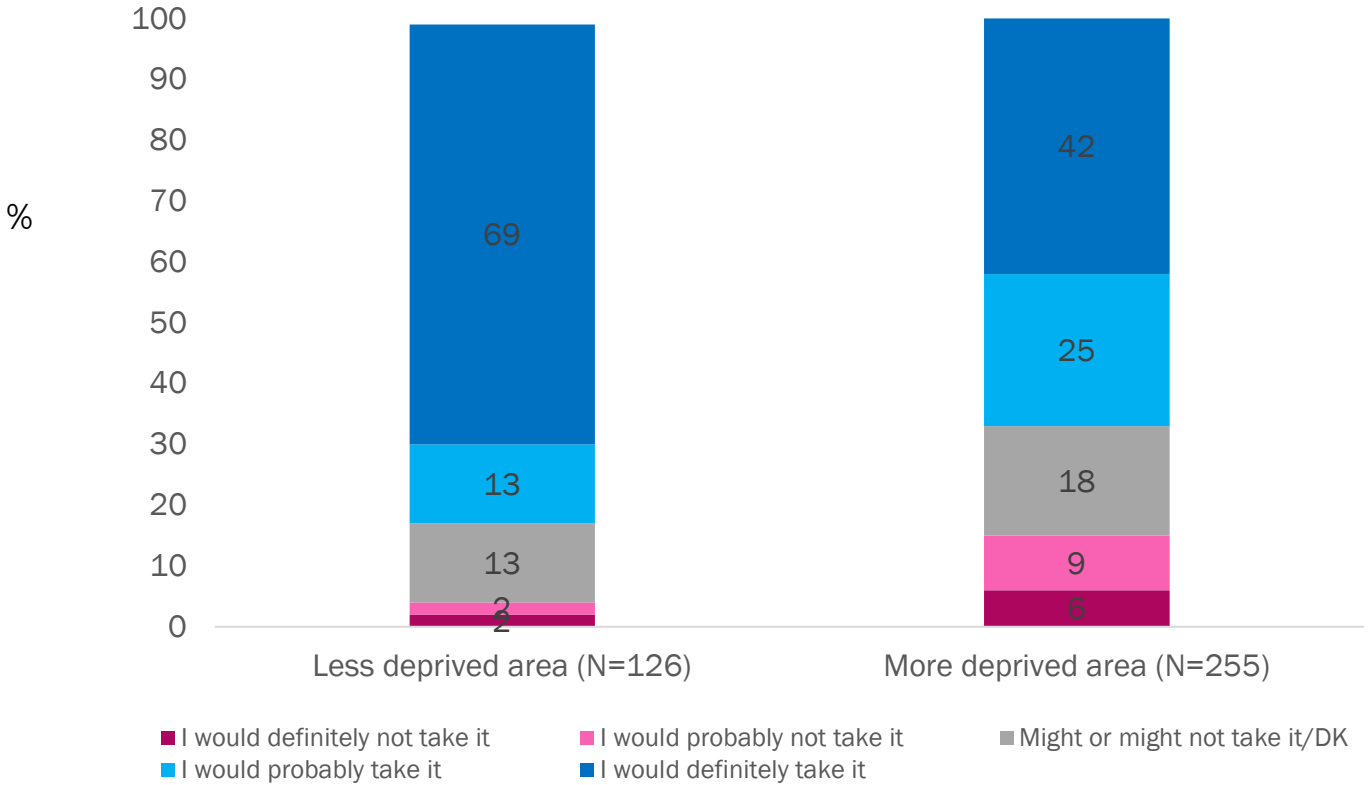

While base sizes are low, non acceptance of the vaccine was higher among C1 NHS workers (e.g. admin) than other workers.

However, even among Socio-economic groups (SEG) AB, one in ten (10%) would not take the vaccine.

Propensity to take the vaccine was much lower among women than men, with 17% rejecting the vaccine. Almost nine out of ten rejecters (87%) were women.

**Q. Which, if any, of these statements best describes how likely you would be to take this vaccination if it were offered to you?**
Base: all respondents who work in the NHS (N=191).

# Propensity to take vaccine by areas of deprivation




Acceptance of the vaccine was markedly lower in more deprived areas, with 42% top box (definitely take it) and 25% 2nd box (probably take it).

Almost one in seven (15%) rejected the vaccine (almost four times higher than less deprived areas).

In contrast, acceptance of the vaccine was extremely high in less deprived areas (82%) and rejection extremely low (4%).

**Q. Which, if any, of these statements best describes how likely you would be to take this vaccination if it were offered to you?**
Base: all respondents (N=636).

# Vaccination Take Up

## Key highlights

- While vaccine acceptance is high there are large minorities who are hesitant or who reject the vaccine.
- There is evidence  that there is more resistance among certain communities (e.g. Gypsy and Irish).
- Propensity to take the vaccine increases with age, with thresholds at 45 years and 65 years.  However, rejection is broadly constant by age (until 65+ year, when it declines).
- Greater concern about the side effects among women has generated slightly higher levels of rejection among women.
- Propensity to take the vaccine is much higher among NHS staff, but there is still a small minority of rejecters (12%) – this is largely driven by female NHS workers and clerical (SEG C1) workers.
- Propensity to take the vaccine is significantly lower in more economically deprived areas.

Vaccination Take Up KEY POINTS

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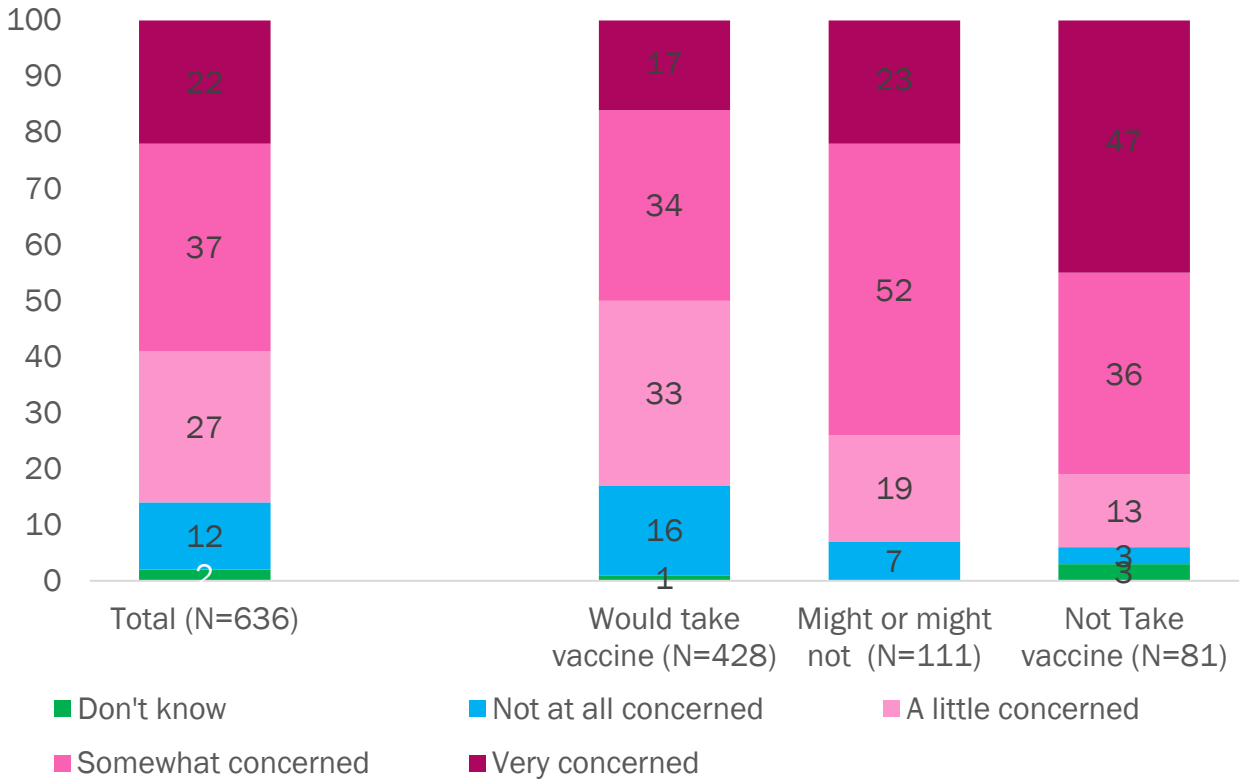
# Barriers to taking vaccine

# Concern about side effects



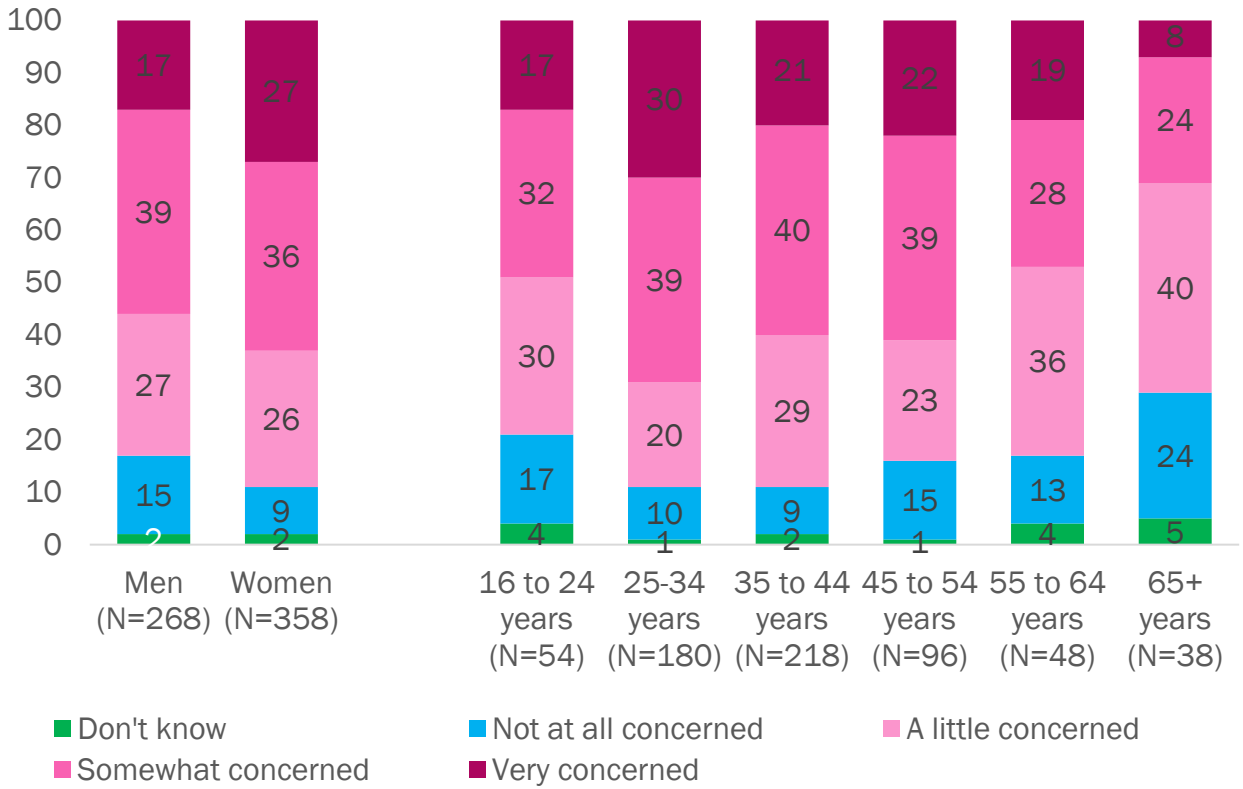

Concerns about the side effects were extremely high among vaccine rejecters.

Concerns were also relatively high amongst hesitants, but this was mostly an increase in those stating *somewhat concerned* rather than top box score (although this did increase as well).

This suggests that reassurances about side effects could help convince rejecters somewhat to take the vaccine.

**Q. Which, if any, of these statements best describes how unconcerned or concerned you are about potential side effects or safety of the vaccine?**
Base: all respondents (N=636).

# Concern about side effects of vaccine

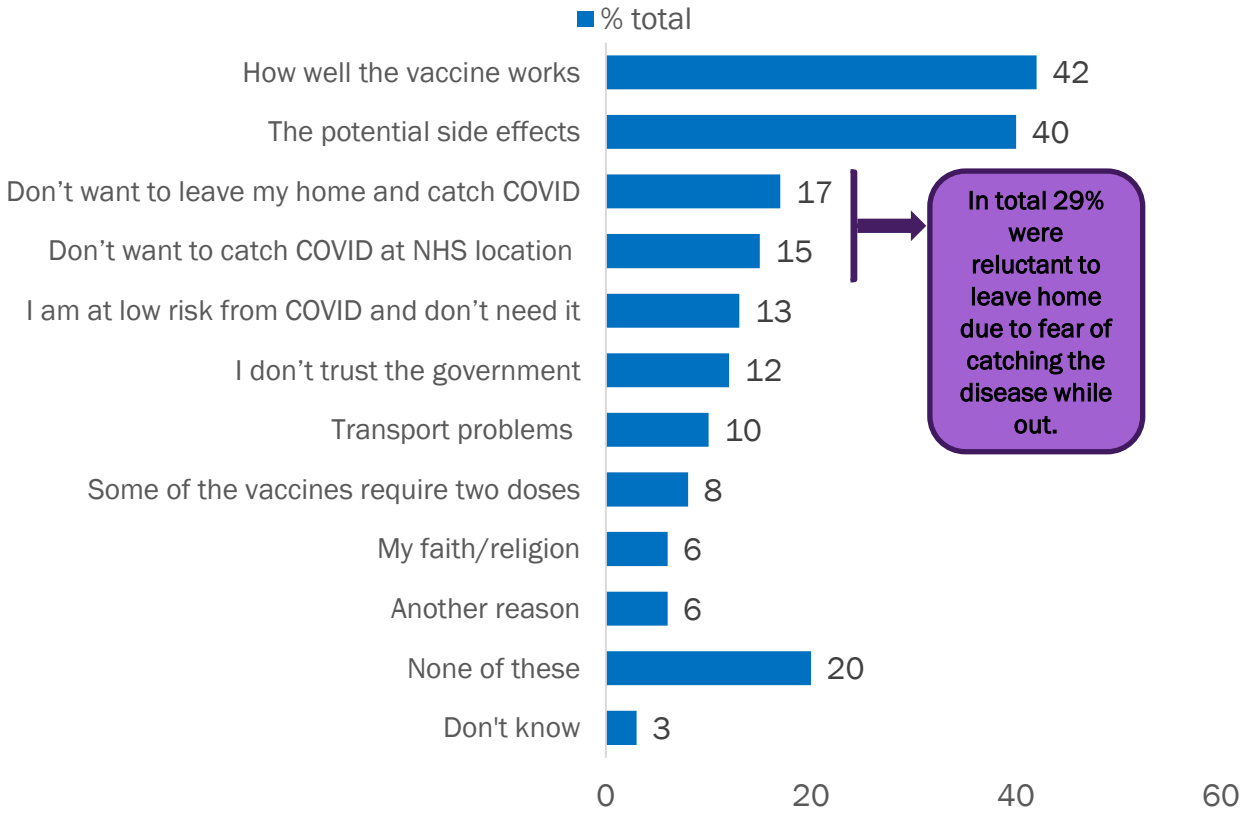



Concern about the side effects declined with age – it is possible that older respondents are making different trade offs between the benefits of the vaccine and concerns about its side effects than younger respondents.

Concerns about the vaccine were higher among women and this could be a driver behind slightly higher rejection amongst this group.

**Q. Which, if any, of these statements best describes how unconcerned or concerned you are about potential side effects or safety of the vaccine?**
Base: all respondents (N=636).

# Barriers to taking vaccine



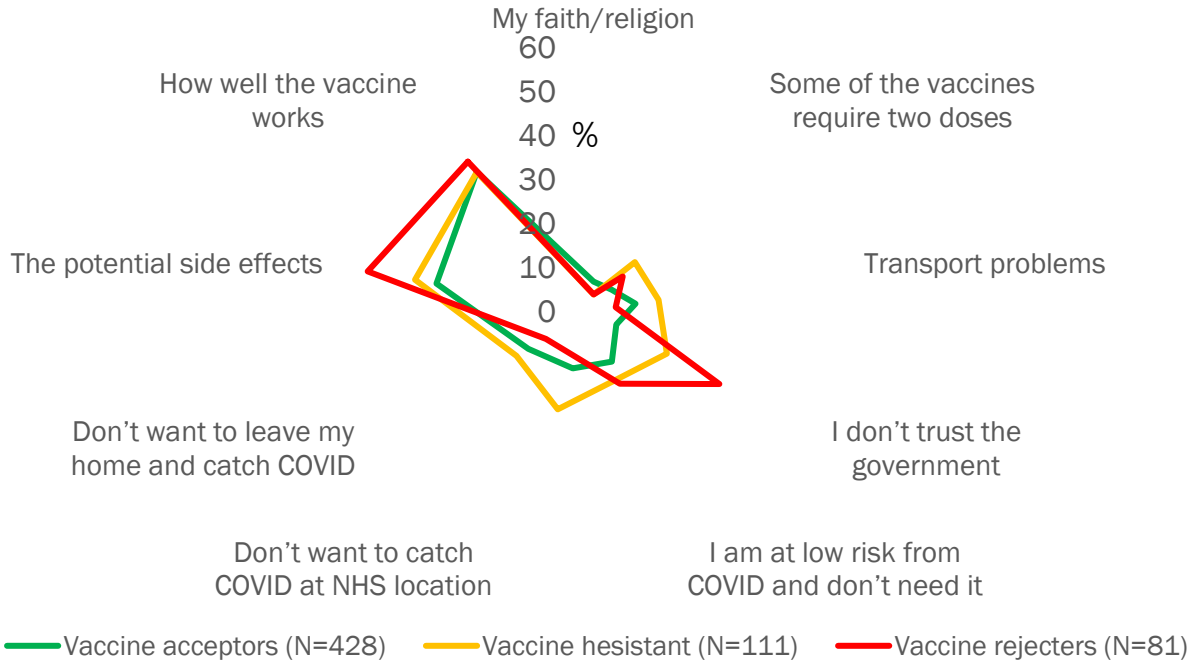

**Q. Which, if any, of the following might influence your decision to take the COVID vaccine?**
Base: all respondents (N=636).

*How well the vaccine works* and *potential side effects* were the biggest concerns about the vaccine.

However, a *lack of trust in the government* (12%) and *fear of catching the disease when receiving the vaccine* were also relatively high (29% in total).

Concerns about religion or faith (6%) were relatively low.

# Barriers to taking vaccine – vaccine hesitancy



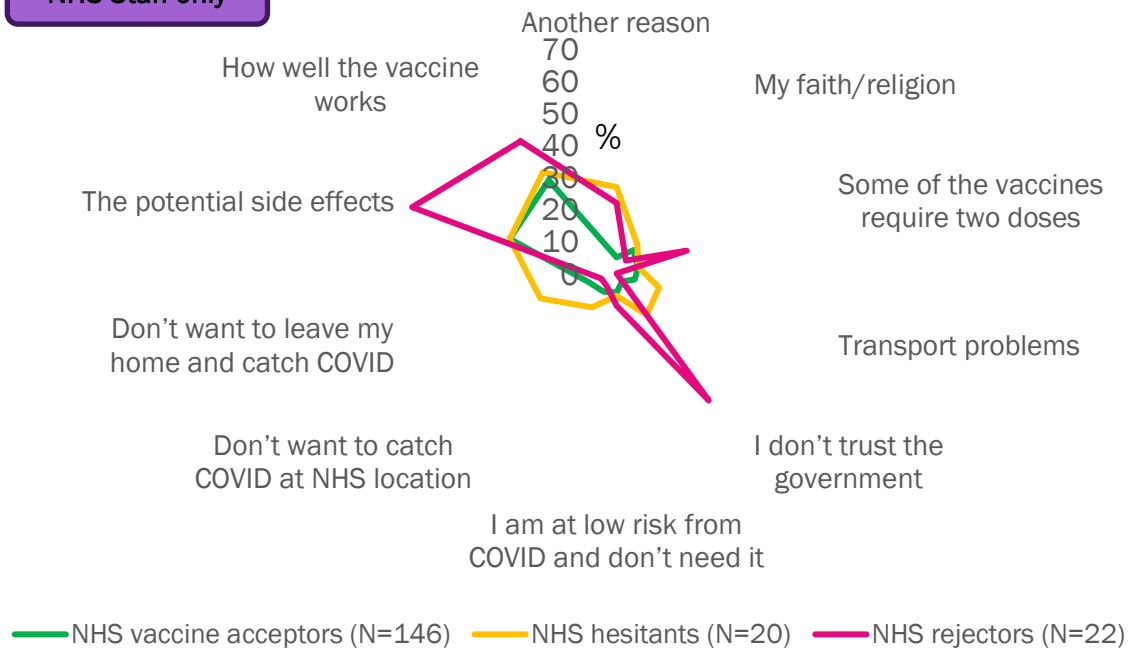

Among rejecters of the vaccine, *side effects* were the biggest barrier. However, *a lack of trust in the government* and *efficacy* concerns were also high.

Among *vaccine hesitants*, some more additional functional barriers emerged, such as, *transport problems or fear of catching COVID while getting the test*. In total 42% of hesitants were reluctant to leave home in fear of catching the disease.

**Q. Which, if any, of the following might influence your decision to take the COVID vaccine?**
Base: all respondents in sub-group.

# Barriers to taking vaccine – NHS staff

NHS Staff only

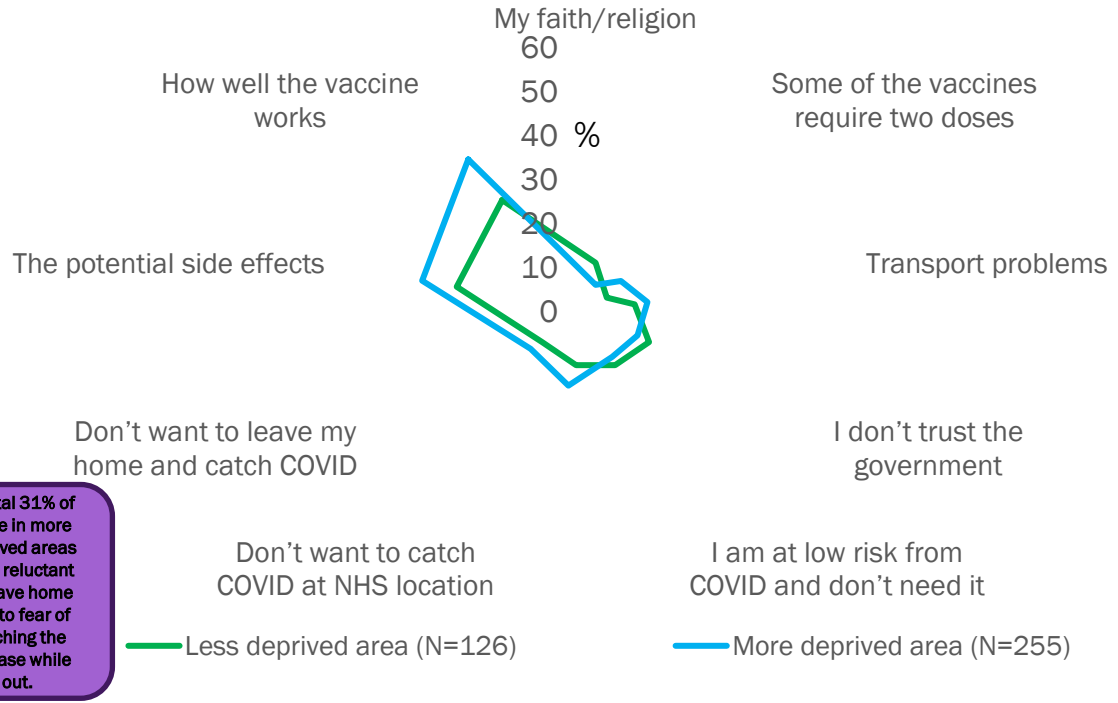



While base sizes are low, NHS rejecters of the vaccine were much more likely to cite *efficacy* and the potential *side effects* of the vaccine as barriers.

They were also much more likely to state a *lack of trust in the government* as a barrier.

**Q. Which, if any, of the following might influence your decision to take the COVID vaccine?**
Base: all respondents in sub-group.

# Barriers to taking vaccine - deprivation



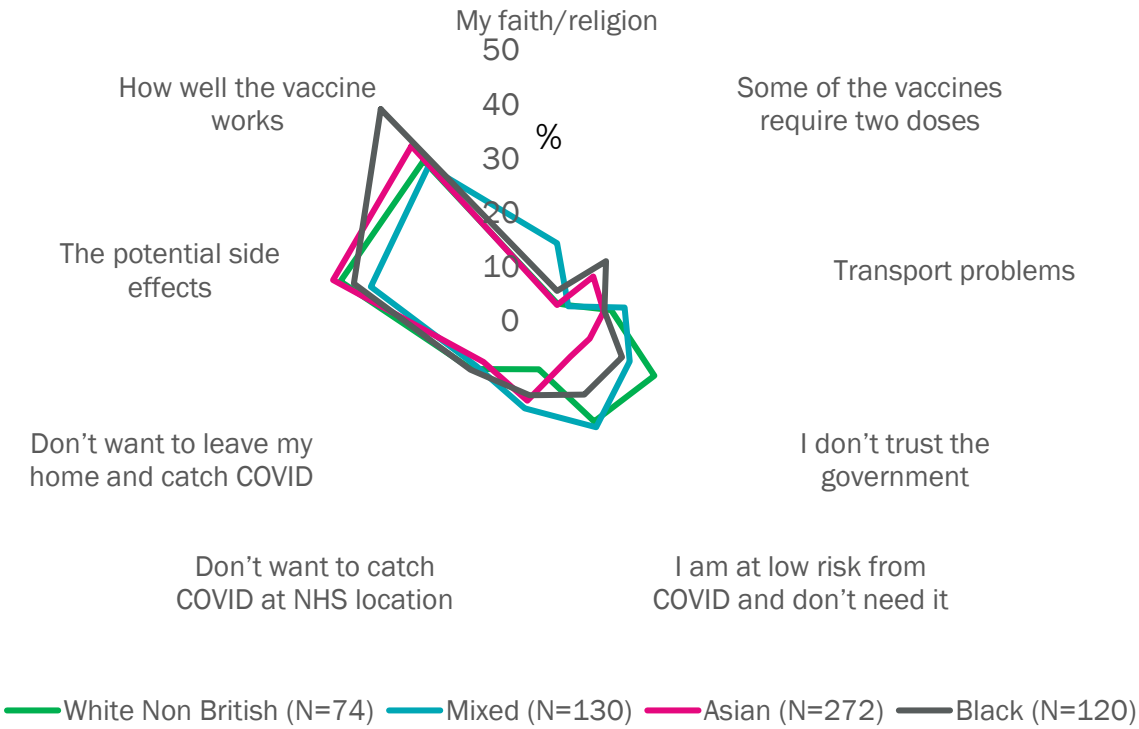

In total 31% of those in more deprived areas were reluctant to leave home due to fear of catching the disease while out.

**Q. Which, if any, of the following might influence your decision to take the COVID vaccine?**
Base: all respondents in sub-group.

In more deprived areas, the *efficacy* of the vaccine and the potential *side effects* were greater barriers than in less deprived areas.

Overall, more deprived areas had a greater number of barriers facing them; almost a third (31%) expressed some concern about *leaving home and catching COVID* (25% for less deprived areas).

# Barriers to taking vaccine – ethnic group




Barriers to taking the vaccine were broadly similar across all ethnic segments.

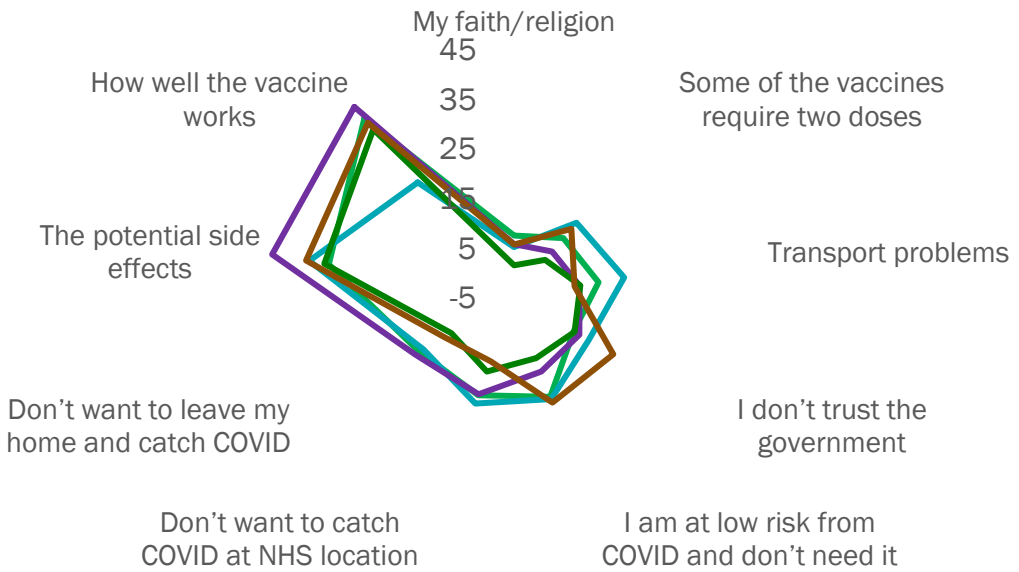
Among Black communities the barrier *'how well the vaccine works'* was greater than other communities.

Those from White Non British communities were more likely to '*not trust the government*'.

Those in mixed ethnicity groups were more likely to cite *faith/religion* as a barrier (14%)

**Q. Which, if any, of the following might influence your decision to take the COVID vaccine?**
Base: all respondents in sub-group.

# Barriers to taking vaccine - Place




**Q. Which, if any, of the following might influence your decision to take the COVID vaccine?**
Base: all respondents in sub-group.

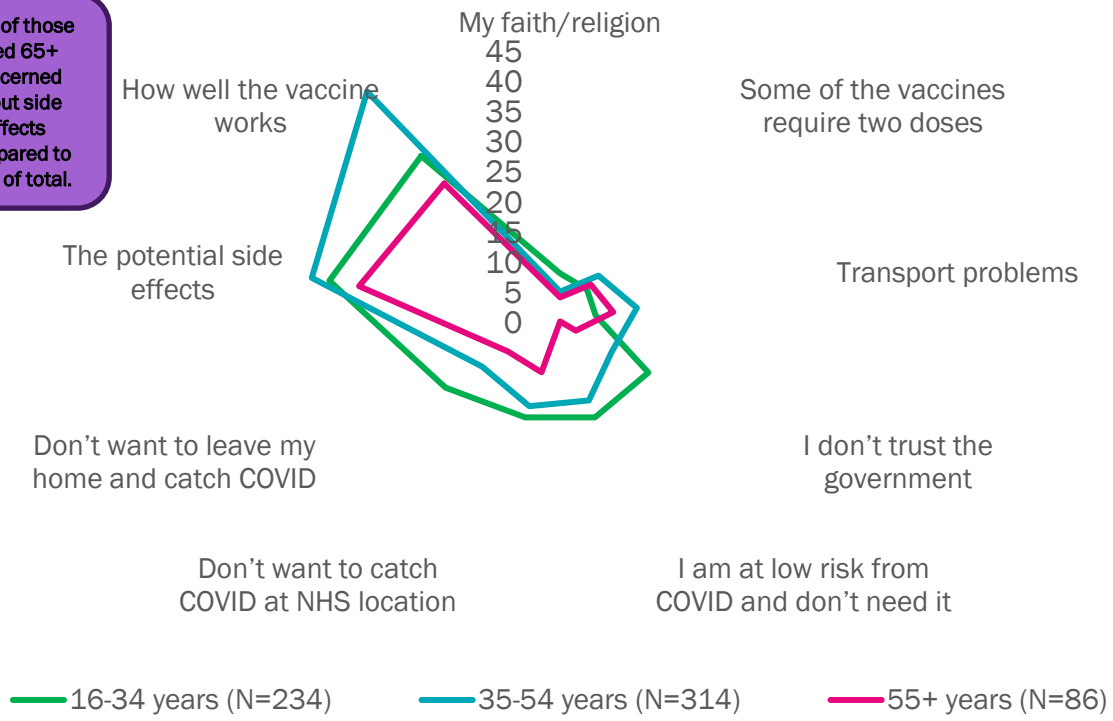
*Potential side effects* were a bigger barrier in Liverpool than other LAs. (This was a relatively low barrier in Cheshire West).

Liverpool also scored higher on *how well the vaccine works*.

While relatively low, *transport issues* were nevertheless higher in both Cheshire Places.

# Barriers to taking vaccine - Age

21% of those aged 65+ concerned about side effects compared to 40% of total.

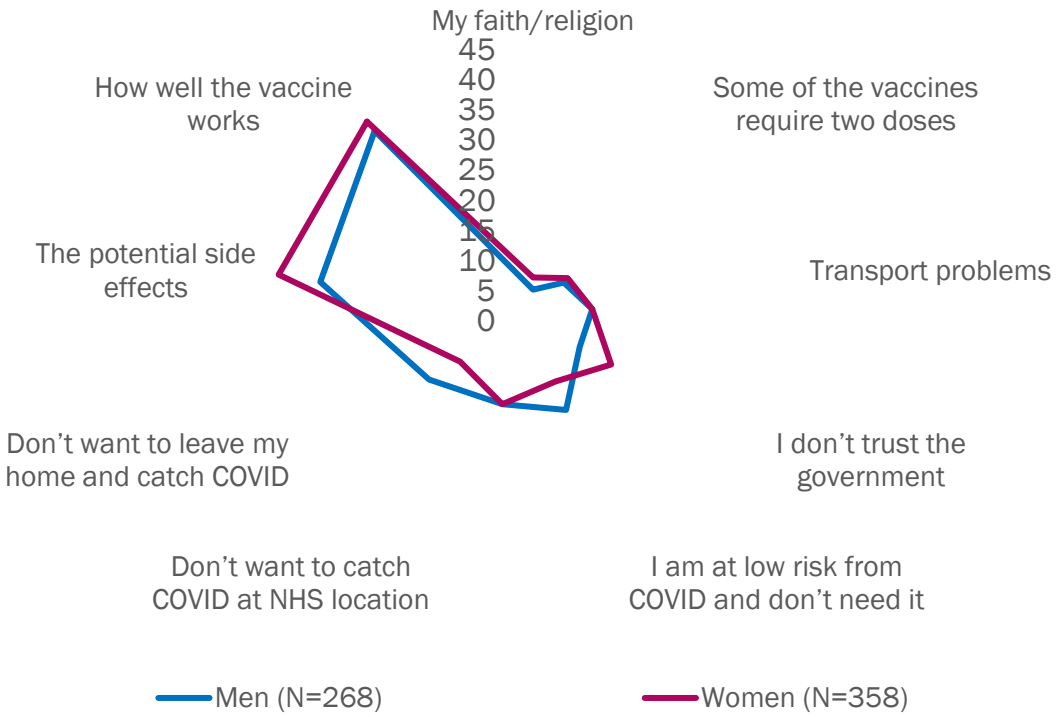



Q. Which, if any, of the following might influence your decision to take the COVID vaccine?
Base: all respondents in sub-group.

Older respondents reported fewer barriers to taking the vaccine. They were less likely to be concerned about the *potential side effects* and much less likely to say that they are at *low risk from COVID*. This suggests that their risk/benefit calculation was different to younger participants.

Younger respondents were much more likely to state that they *don't trust the government*.

# Barriers to taking vaccine - Sex




Barriers to the vaccine by sex were broadly similar.

However, women had greater concerns about *the side effects* than men.

In addition, women were slightly more likely *not to trust the government*.

**Q. Which, if any, of the following might influence your decision to take the COVID vaccine?**
Base: all respondents in sub-group.

# Reasons for not taking vaccine (verbatims)

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<u>Rushed</u>

Based on published information immunity provided by the vaccine is less than natural immunity. Given the speed of producing this vaccine and the still many unknowns about Covid-19 in addition to the published. *(Liverpool, Chinese, aged 35-44 years)*

I feel the vaccine has been rushed (*Cheshire West, Bangladeshi, aged 35-44 years)*

It's been rushed. I don't know what it contains. I'm not convinced of the safety of it or it's efficiency. I don't know of the long term side effects. *(Liverpool, other Mixed Ethnic Group, aged 35-44 years)*

Because I have seen people that got COVID 19 and recovered without having the vaccine, and people dying after having the vaccine.  Two the vaccine was done without passing through the stages of trial*. (Warrington, African, aged 55-64 years)*

Q. Why do you say..... would probably/would definitely not take vaccine?

# Reasons for not taking vaccine (verbatims)

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Lack of information

Because it hasn't been tested and there is zero information about potential negative consequences. *(Sefton, African, 45-54 years)*

I am a Pharmacist, therefore from a professional point of view would need to see further evidence of efficacy with limited side effects before I had it personally. Yet, as it has been approved by the MHRA I would professionally recommend the vaccine to patients who are higher risk, with co-morbidities etc. *(Liverpool, Indian, aged 18-24 years)*

Pregnancy

I was offered a Pfizer vaccine. In my country on young woman died after this vaccine, but mostly I am scare to loose a chance to have a baby (or something would happen to him). I am 29 and never had one, planning to get pregnant in nearly future. Overall I am not trust vaccine which was made that fast and not sure how it can affect me by the time. *(Warrington, Other White Non British, 25-34 years)*

As planning to get pregnant. *(Warrington, Black and White African, aged 25-34 years)*

Q. Why do you say..... would probably/would definitely not take vaccine?

# Reasons for not taking vaccine (verbatims)

Cheshire and Merseyside
Health and Care Partnership

<u>Don't need it</u>

Is not a deadly virus, it' just a flu. People die because they are not treated for the diseases they have [cancer, diabetes, … ,appendicitis, heart attack and stroke] You have a fever, stay home? Maybe it's not COVID . *(Warrington, Other White non British, 35-44 years)*

<u>Side effects</u>

Unaware of long term effects as has not been developed for a long period of time. Developed quickly and therefore unsure if there are any unknown side effects, also feel I am low risk of catching it. *(Wirral, White and Asian, 25-34 years)*

Unsure of the long term outcome, it is still early days and is being rolled out to the older generation who may respond completely differently to the younger generation therefore how can this be trialled correctly if it is only being given to the older group. *(Wirral, Bangladeshi, 25-34 years)*

I am following guidelines. I have several medicine allergies. I'm also under 40 and I've already had it. Also a senior colleague I respect greatly has had vaccine and was violently sick and had numbness and swelling. *(Wirral, African, 35-44 years)*

Q. Why do you say..... would probably/would definitely not take vaccine?

# Reasons for not taking vaccine (verbatims)

Cheshire and Merseyside
Health and Care Partnership

Immunity

I have had the COVID-19 disease already as I have tested positive during the first wave of the pandemic. Luckily, I have developed an antibody in my immune system that has aided me to full recovery. I have strong belief that my antibody is actively protecting me, therefore, I would not take the COVID-19 vaccine. *(Cheshire East, Other Asian, aged 35-44 years)*

Because I would rather wait till my natural immunity runs out (*Wirral, African, aged 35-44 years)*

.

Q. Why do you say..... would probably/would definitely not take vaccine?

# Vaccine Barriers

## Key highlights

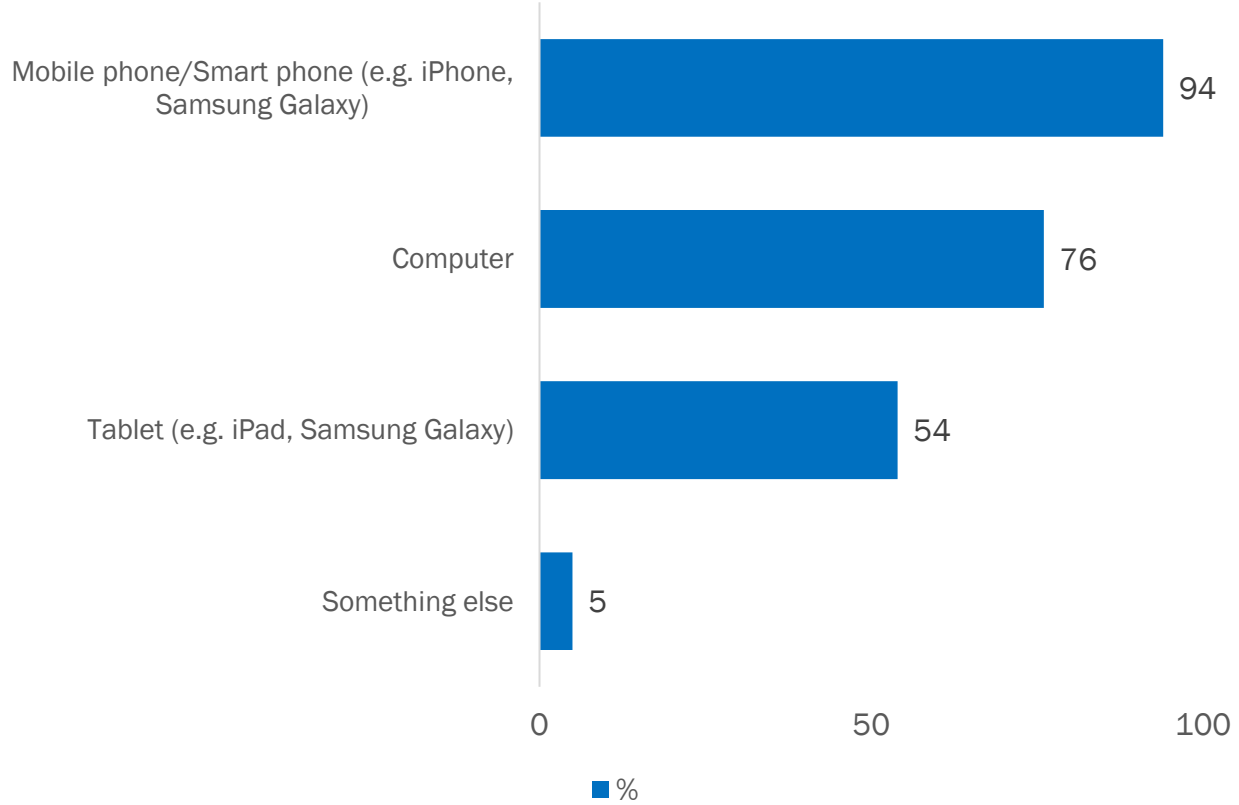
- Concerns about the side effects of the vaccine are wide spread, with 86% of respondents having some concern (22% *very concerned*).
- Concern about the side effects is a key driver of vaccine rejection.
- In addition to *side effects*, concerns about the *vaccine efficacy* is the main barrier to taking the vaccine.
- While side effects and efficacy are the principal barriers, some secondary barriers also emerged. Concern about *leaving the house and catching COVID* is a relatively common concern and this is more prevalent among *vaccine hesitants*. Transport barriers are also a more common concern among *hesitants*.
- One in eight (12%) cite a *lack of trust in the government* as a barrier and this was more common among White Non British and the young (16-34 years).

Barriers to taking vaccines KEY POINTS

Cheshire and Merseyside
Health and Care Partnership

# Communication

# Devices Available to Access the Internet

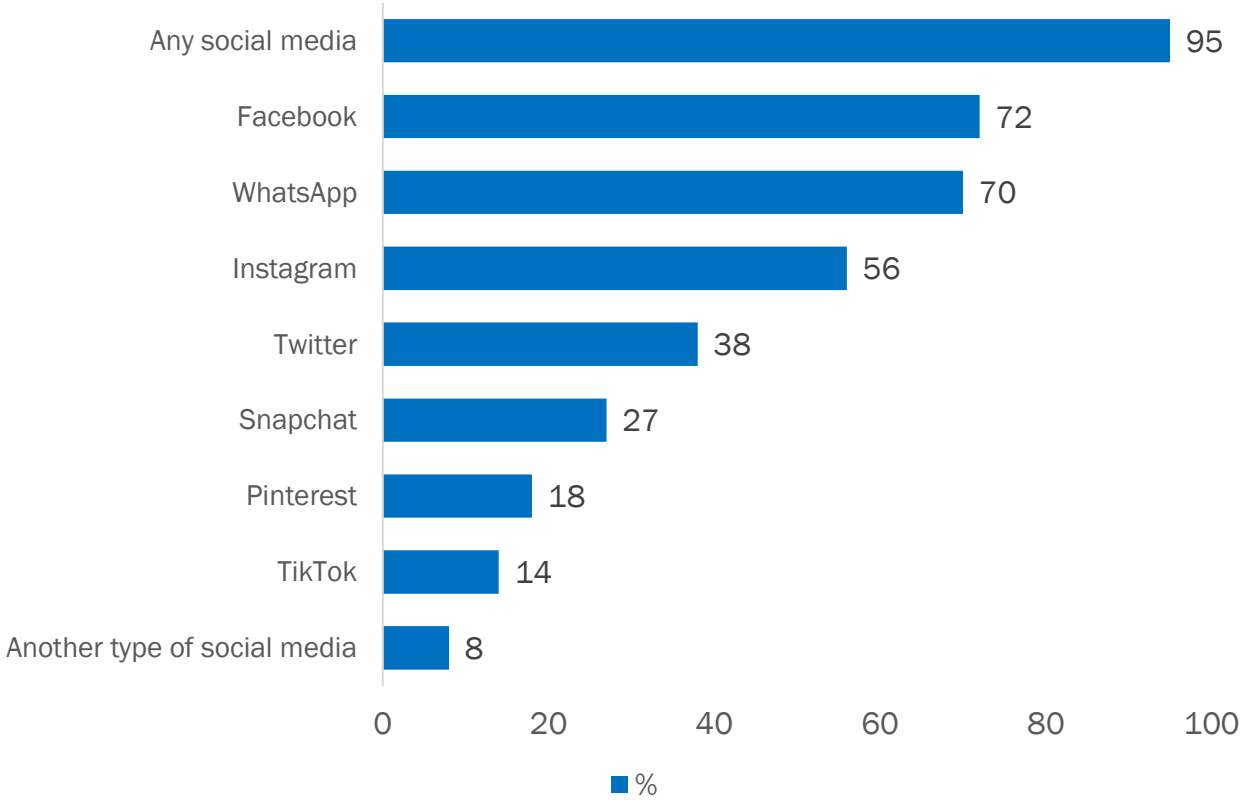



Given that the survey was conducted online it is to be expected that ownership of devices that connect to the internet was high.

Only one in 20 (6%) did not own a phone that connects to the internet and three out of four (76%) owned a computer.

**Q. And do you have a device that allows you to access the internet, such as, a smart phone, computer or tablet?**
Base: all respondents (N=636).

# Social Media Used



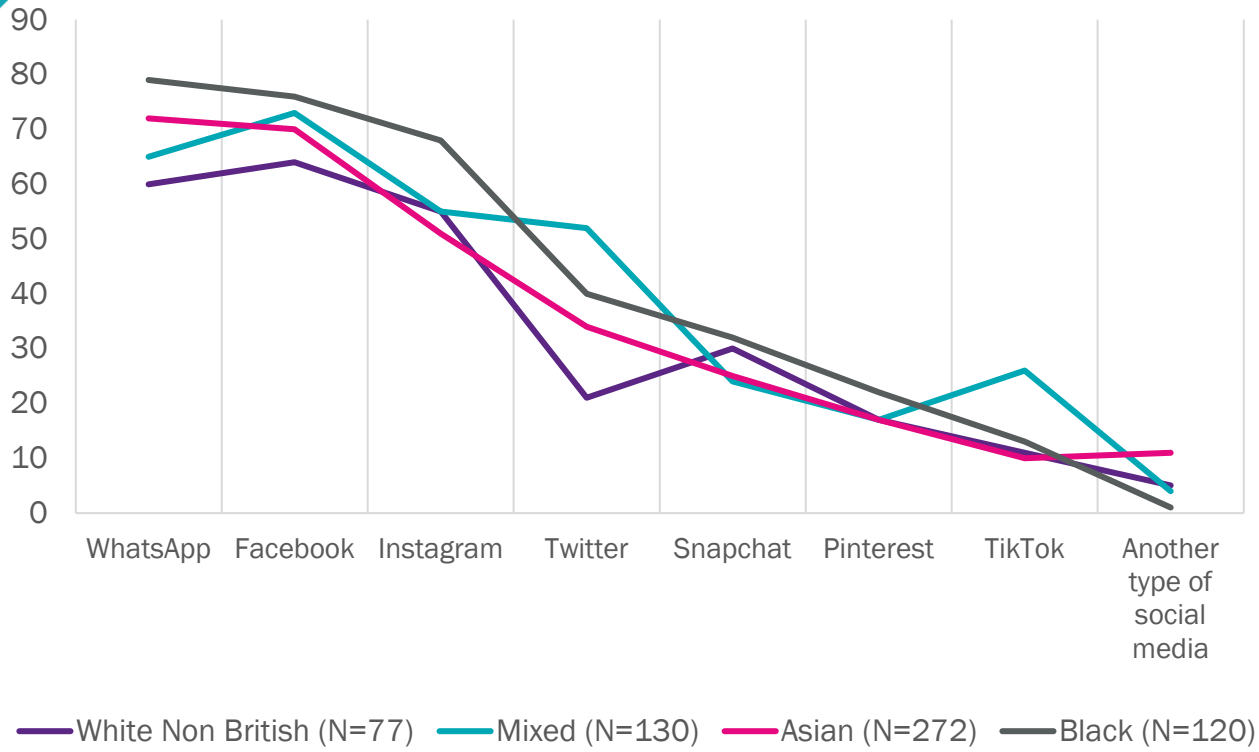

**Q Which, if any, of the following types of social media do you currently have accounts with?**
Base: all respondents (N=636).

Use of social media was extensive, with 19 out of 20 (95%) respondents having a social media account.

*Facebook* (72%) and *Whatsapp (70%)* were the most common social media sites.

*Instagram* was also a relatively common platform, but only just over third (38%) had a *Twitter* account.

# Social Media Used



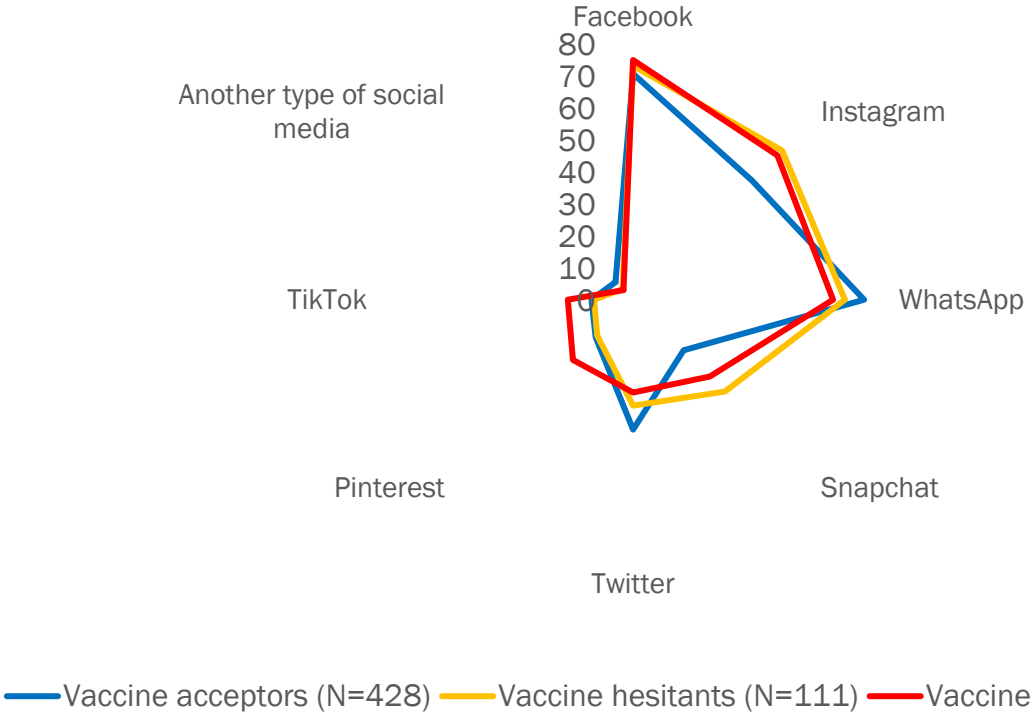

There was some variation by ethnic group in terms of which social media platforms they had accounts with.

Mixed ethnic groups were the most likely to have *Twitter* and *TikTok* accounts. (White Non British were the least likely to use Twitter.)

Black respondents used *Instagram* more than other ethnic groups.

**Q. Which, if any, of the following types of social media do you currently have accounts with?**
Base: all respondents (N=636).

# Social Media Used



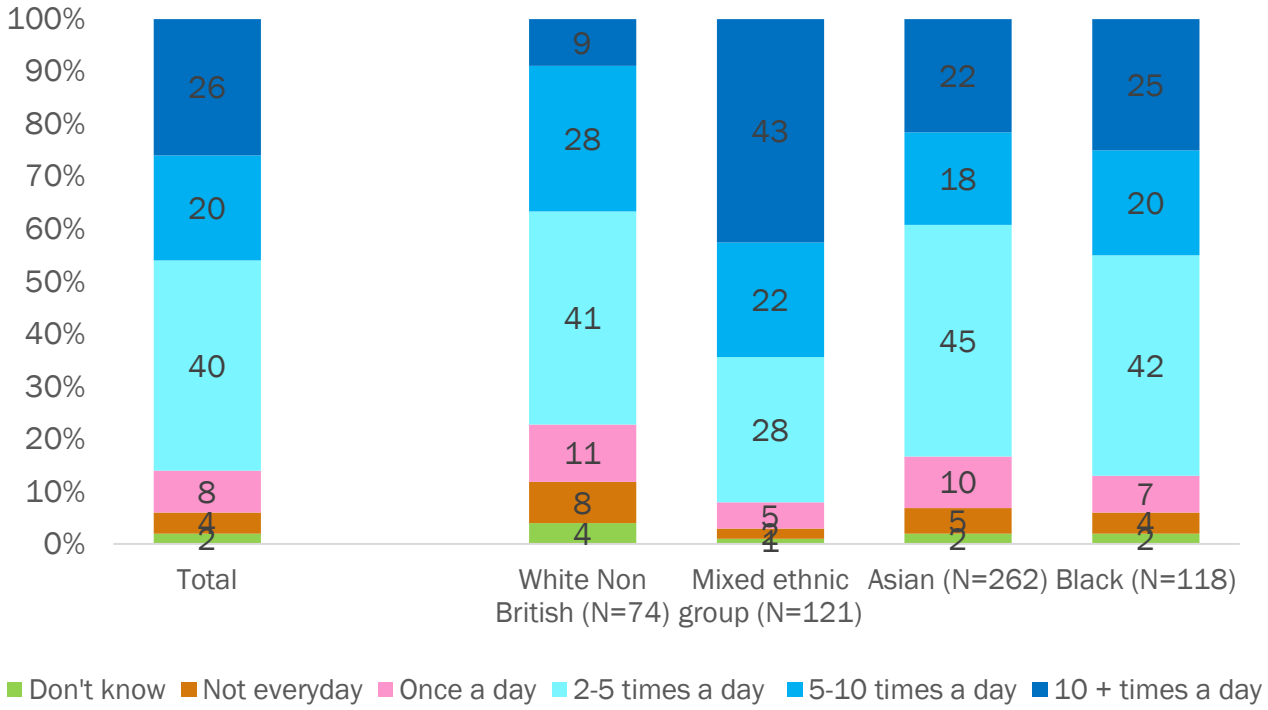

Use of social media by vaccine acceptance was broadly similar.

However, both *rejecters* of the vaccine and *hesitants* were less likely to use Twitter than those who would take the vaccine.

The opposite was true of Instagram where the *rejecters* and *hesitants* were more likely to use this platform than *acceptors*.

**Q. Which, if any, of the following types of social media do you currently have accounts with?**
Base: all respondents (N=636).

# Times access Social Media a day

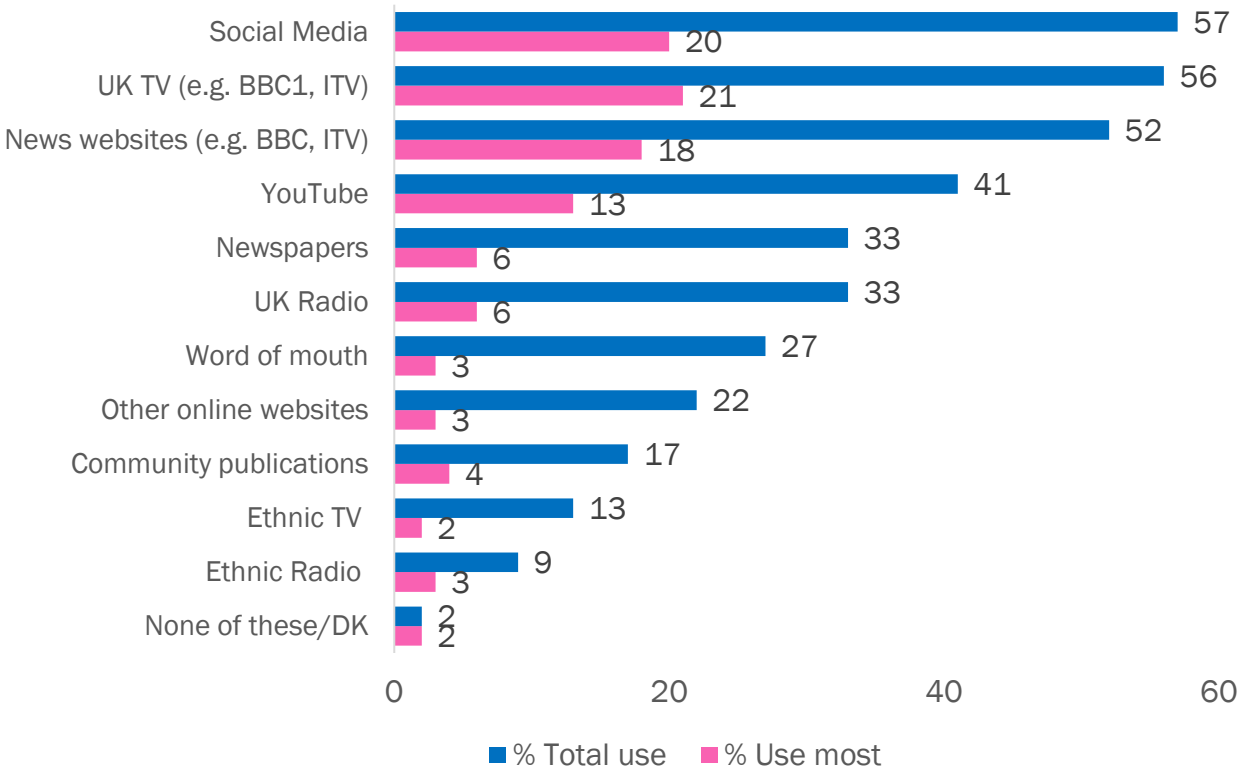



**Q And how many times a day do you look at or use social media?**
Base: all respondents (N=636).

The vast majority of all ethnic groups accessed social media *at least once a day*, with a quarter of all respondents accessing social media 10 or more times a day.

Mixed ethnic groups were the most prolific users of social media, with over four out of ten (43%) looking/using social media 10 times a day.

# Media used to find out about world




A wide range of different types of media channels were used by the sample to find out about the world in general.

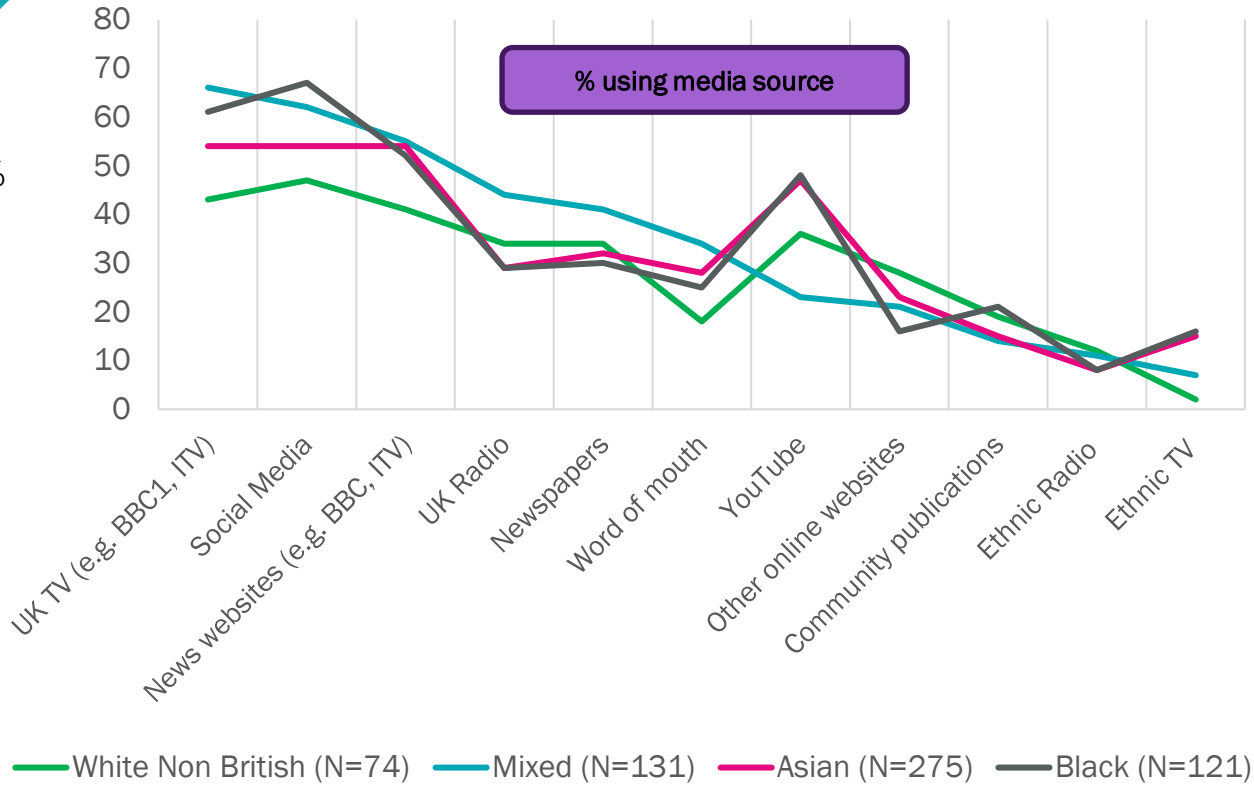
However, no one media source dominated and the picture is fragmented, with traditional media no longer in a position of dominance.

The top four media channels were: *social media*, *UK TV*, *News Websites* and *YouTube*.

Newspapers and UK Radio were also commonly used.

**Q. Which, if any, of the following sources of information do you currently use to find out about what is happening in the world in general?**
Base: all respondents (N=636).

# Media sources used




There was some variation by ethnic group in terms of general use of media to find out about the world.

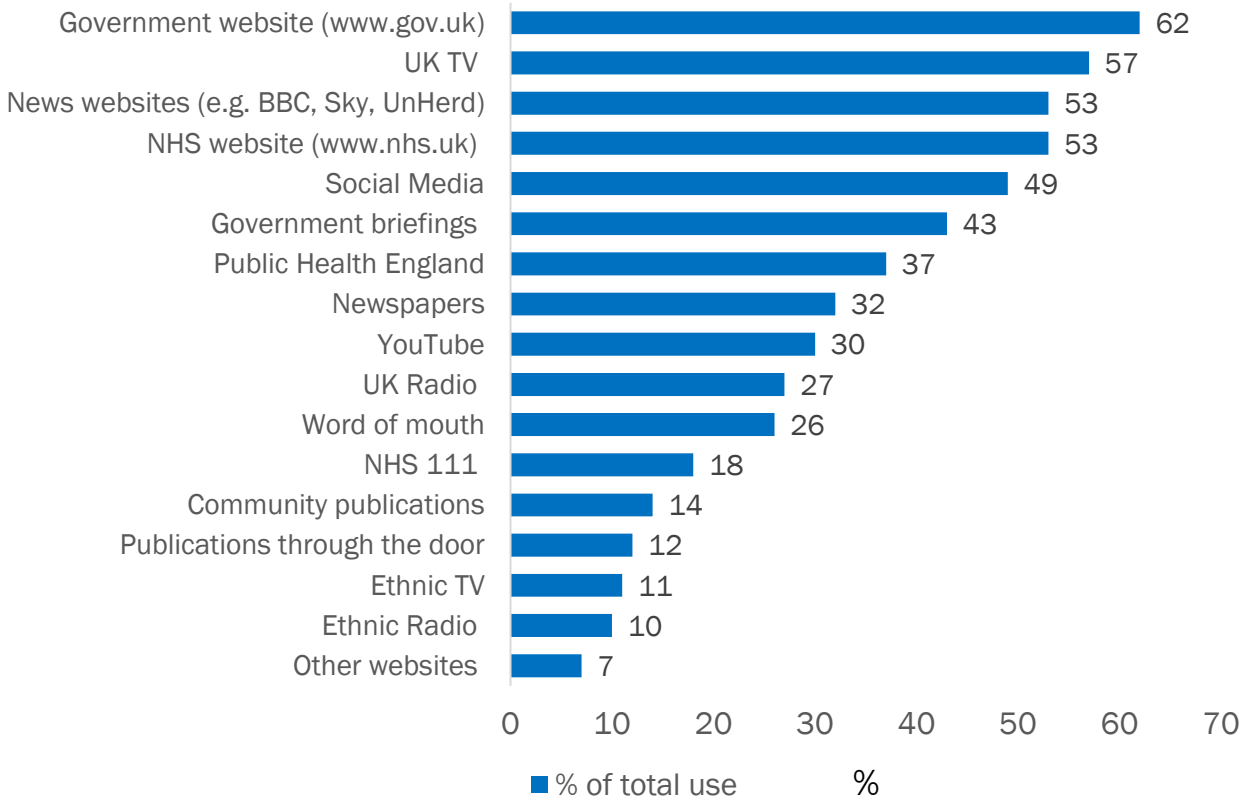
Broadly speaking those in mixed ethnicities were slightly higher users of media than other ethnicities.

*White non British* used many of the principal media sources less than other groups (e.g. *UKTV* and *news websites*).

Black ethnic groups were slightly heavier consumers of *social media* and *YouTube*).

**Q. Which, if any, of the following sources of information do you currently use to find out about what is happening in the world in general?**
Base: all respondents (N=636).

# Media used to find out about COVID-19



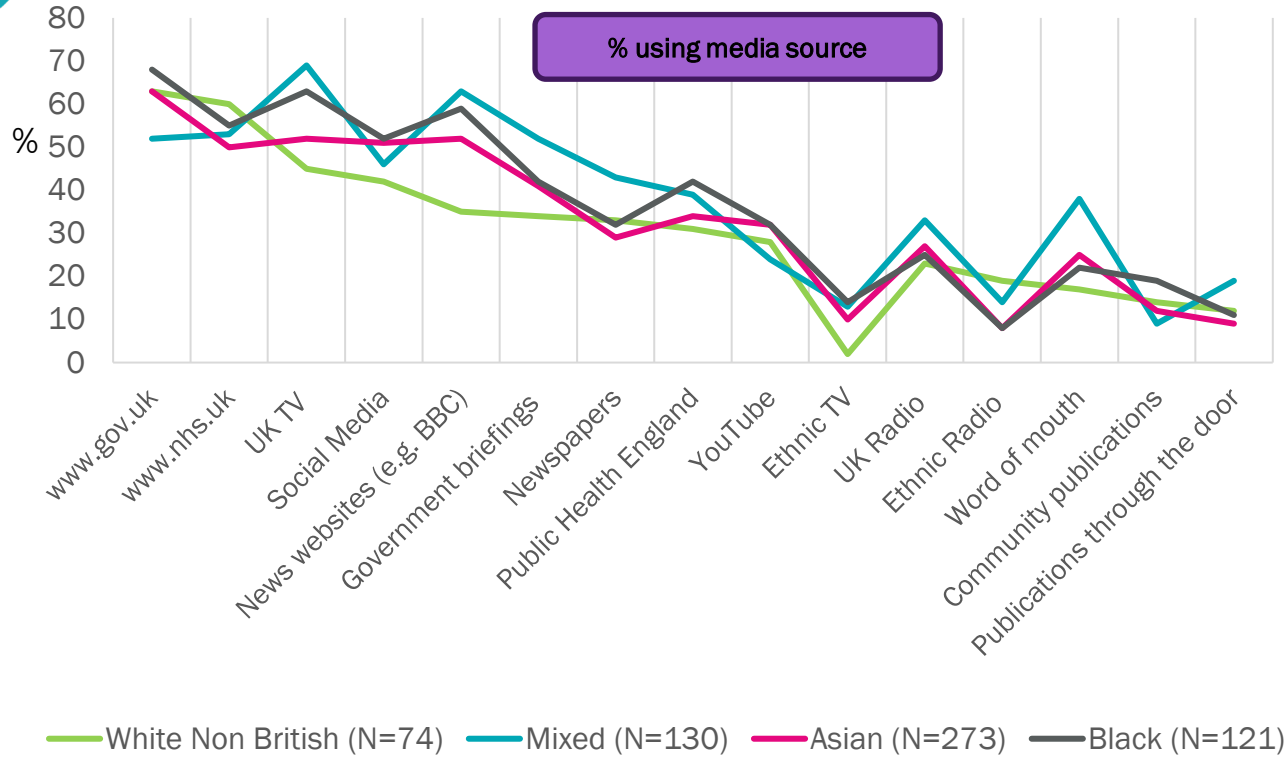

Official websites were used extensively by the sample to find out about COVID, both www.gov.uk (62%) and www.nhs.uk (53%) were rated in the top four sources of information.

In addition to this 43% used *government briefings* as a source.

*UK TV* (57%) and *News Websites* (53%) were also widely used.

**Q. Which, if any, of these sources have you used to find out information about issues relating to COVID-19?**
Base: all respondents (N=636).

# Media used to find out about COVID-19



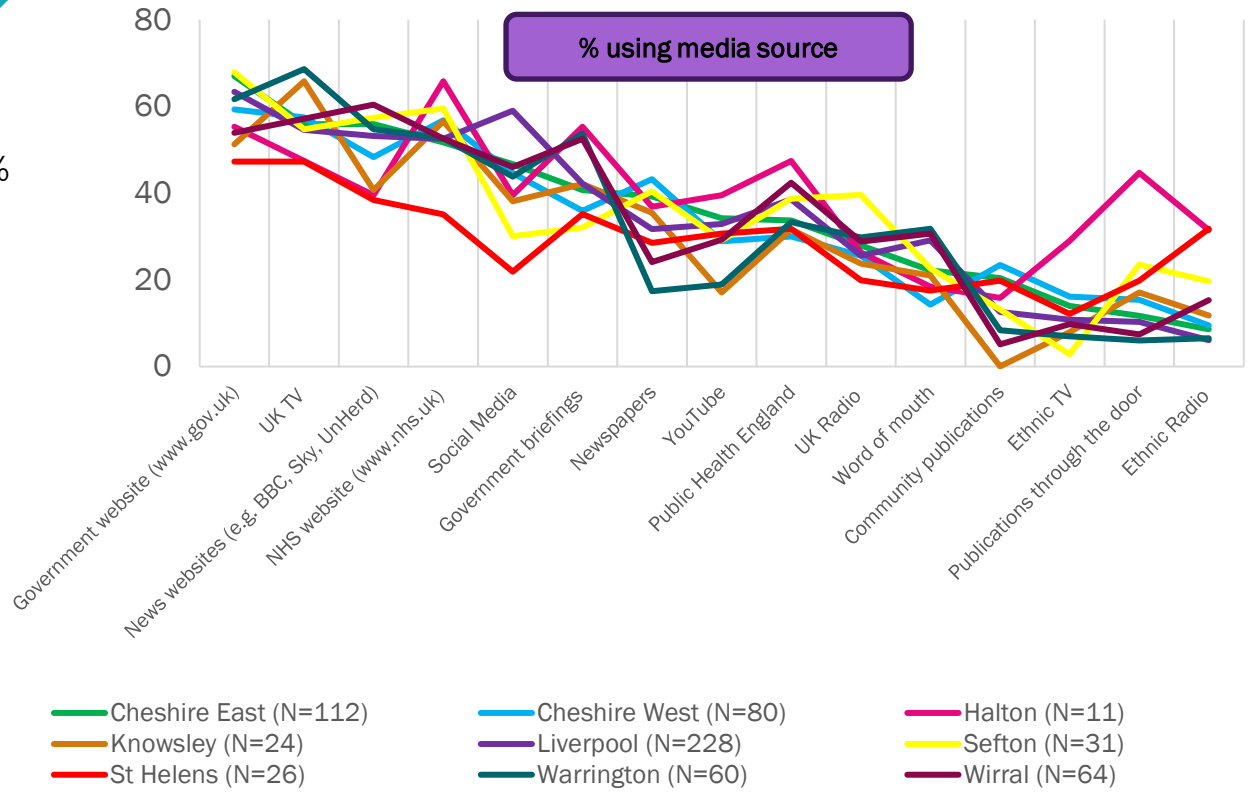

There was some variation by ethnic group in terms of media sources used to find out about COVID-19.

On balance, White Non British respondents used fewer media sources and were particularly less likely to use *UK TV*.

Mixed race respondents used the widest selection of sources in general (but less than other ethnic groups for *www.gov.uk*)

**Q. Which, if any, of these sources have you used to find out information about issues relating to COVID-19?**
Base: all respondents (N=636).

# Media used to find out about COVID



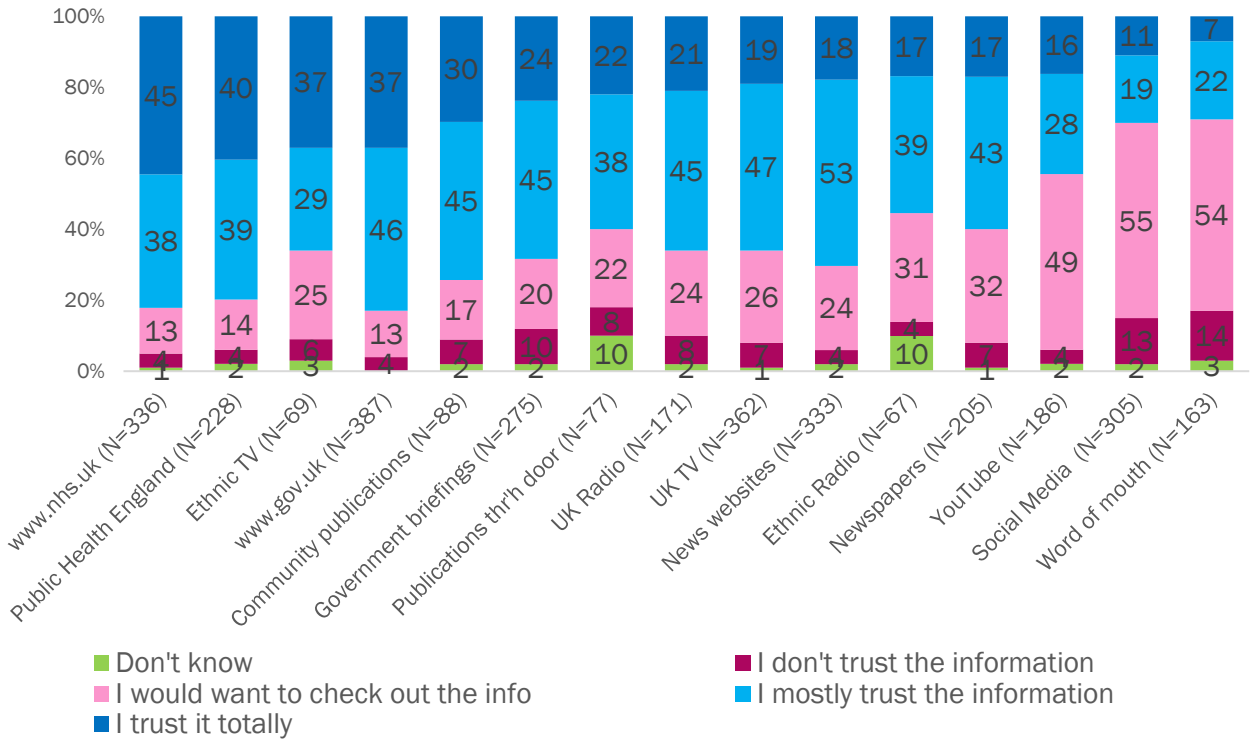

There was more variation than might be expected in terms of media consumption by Place. (This variation could be driven somewhat by low base sizes.)

Halton, St Helens and Knowsley score low on *news websites* and *other online websites*. Overall, St Helens was consistently low on a wide range of communication channels (although relatively high on ethnic Radio).

Liverpool was highest on *social media*, while Wirral was relatively high on *ethnic TV*, *news websites* and *word of mouth*.

**Q. Which, if any, of these sources have you used to find out information about issues relating to COVID-19?**
Base: all respondents (N=636).

# Trust in media about COVID-19

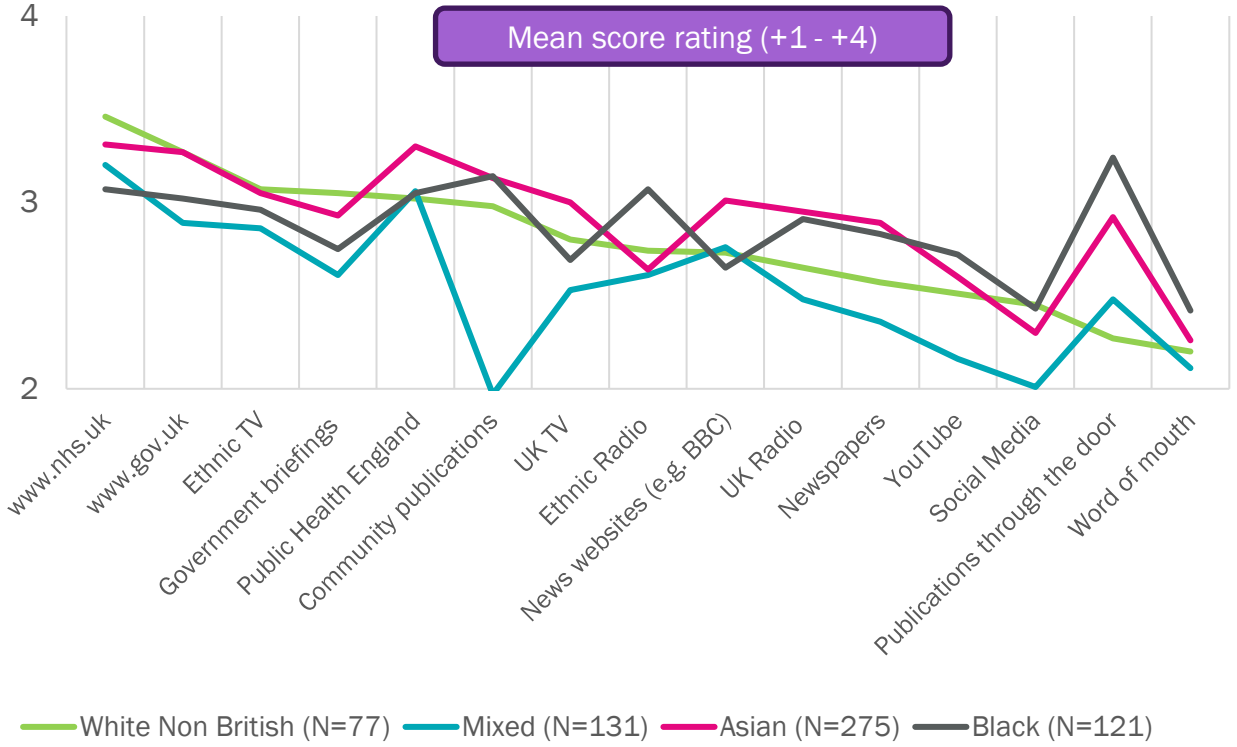



Information from official health authorities were generally trusted the most, with www.nhs.uk rated highest and Public Health England also scoring highly.

It is interesting that among those who use them, *Ethnic TV* and *Community Publications* received high trust ratings.

**Q. Which, if any, of these statements best describes how much you trust or distrust the information that you receive about COVID-19 from each of the sources of information that you use?** Base: all respondents who use media

# Trust in media sources: for COVID




There was variation in the amount each ethnic groups trusted media sources.

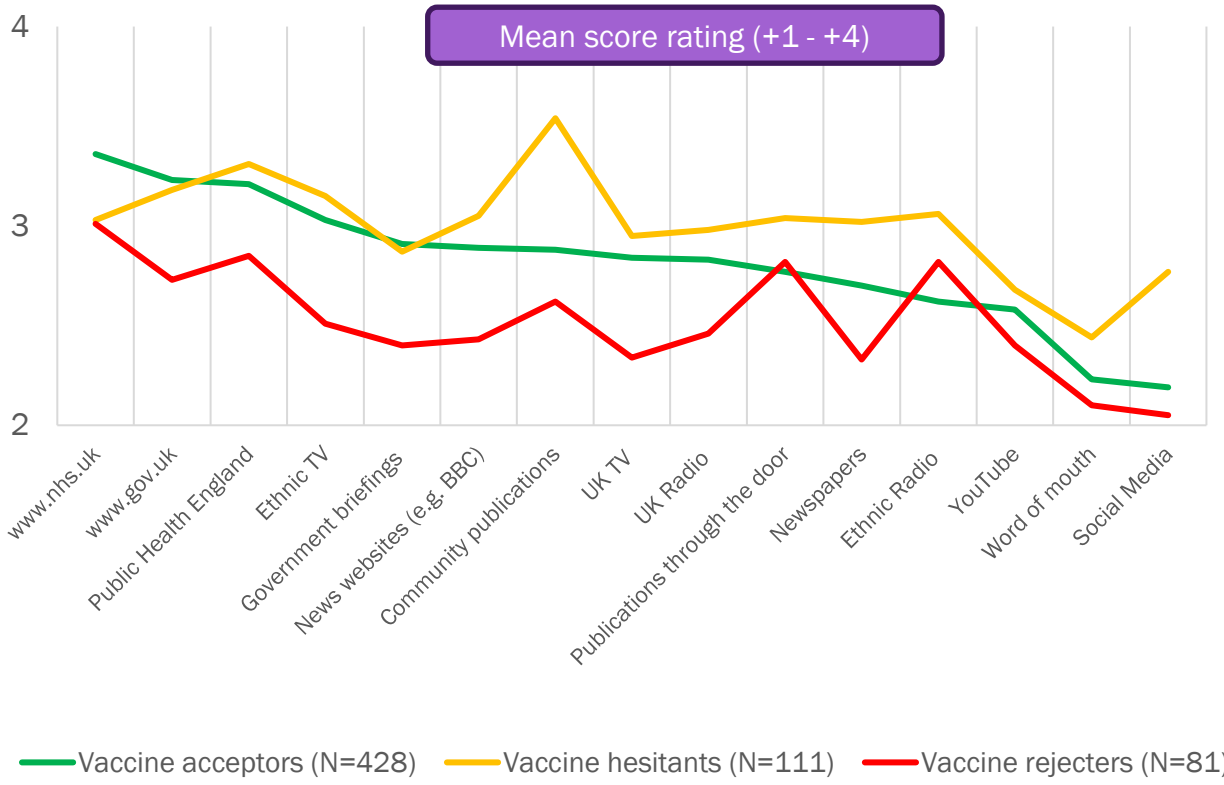
Asian respondents trusted *UK TV* more than other ethnic groups.

Asian and Black communities were also more likely to trust *newspapers*, *community publications* and *publications through the door* than other communities.

Mixed ethnic groups had generally lower trust ratings of media channels.

**Q. Which, if any, of these statements best describes how much you trust or distrust the information that you receive about COVID-19 from each of the sources of information that you use?**
Base: all respondents in sub-group who receive information from source.

# Trust in media sources: for COVID



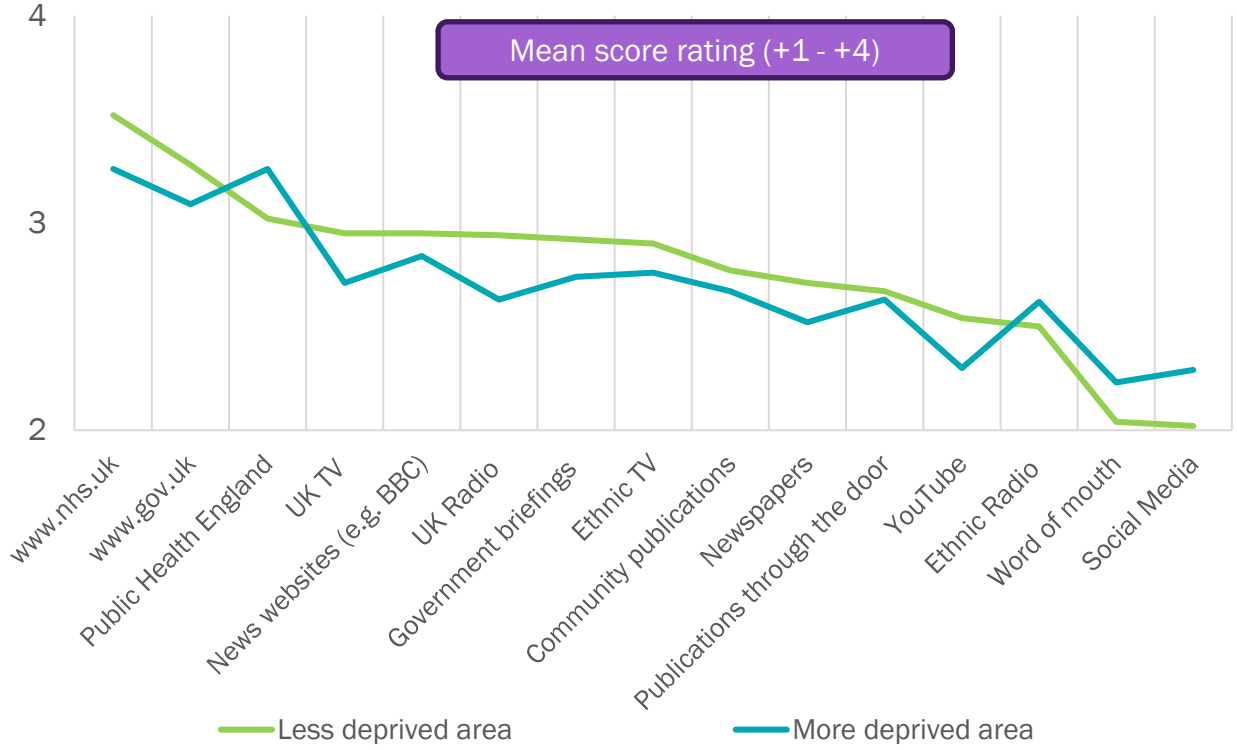

Vaccine *rejecters* displayed much lower trust ratings than either vaccine *acceptors* or vaccine *hesitants*.

The *hesitants* generally had higher trust ratings suggesting that it is not a lack of trust in the information that is driving their ambivalence towards taking the vaccine.

*Hesitants* had much more trust in *social media* than *acceptors* or *rejecters.*

**Q. Which, if any, of these statements best describes how much you trust or distrust the information that you receive about COVID-19 from each of the sources of information that you use?**
Base: all respondents in sub-group who receive information.

# Trust in media sources: for COVID



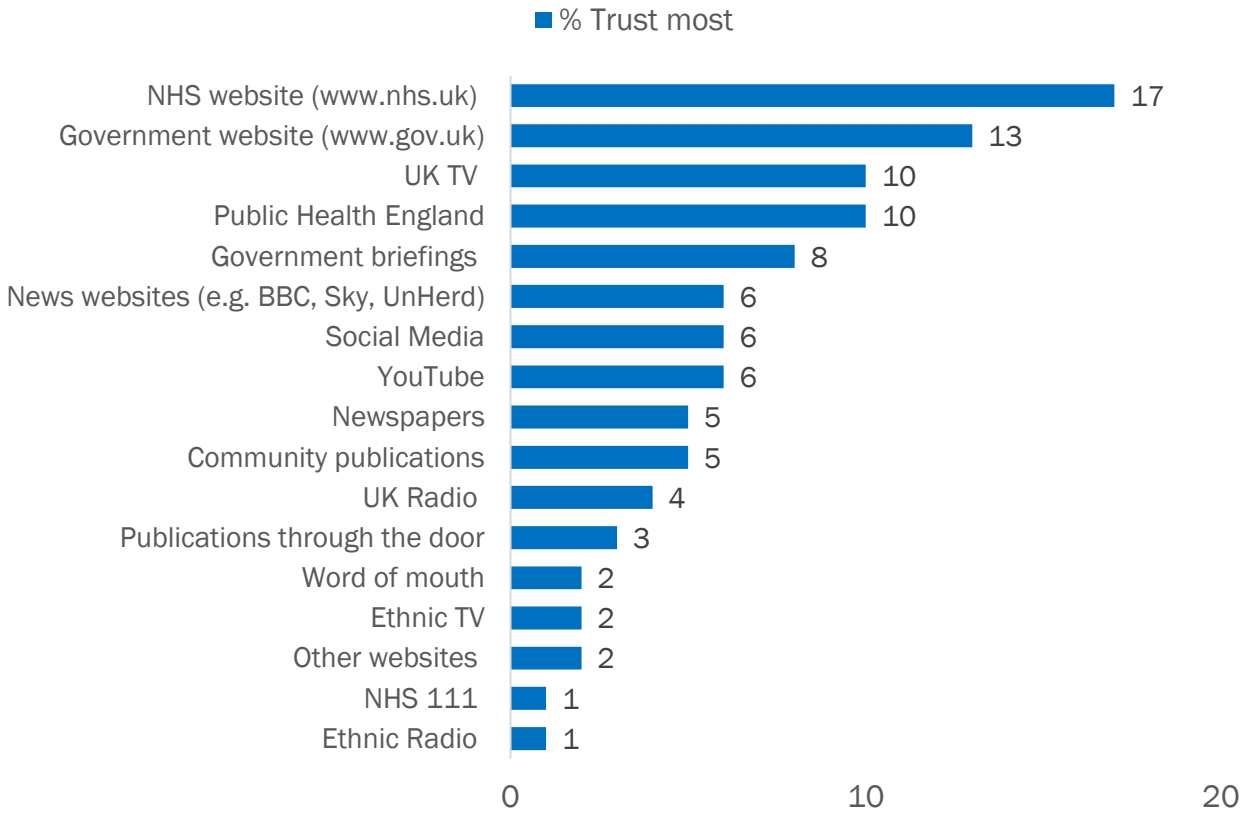

Those in higher deprivation areas had lower levels of trust in media sources about COVID, with mean score generally lower than those of lower deprivation areas.

The only exceptions were *social media* and *Public Health England* (and *ethnic radio,* slightly).

This suggests that it will be more difficult to get people in areas of higher deprivation to accept and trust messages about the vaccine.

**Q. Which, if any, of these statements best describes how much you trust or distrust the information that you receive about COVID-19 from each of the sources of information that you use?**
Base: all respondents in sub-group who receive information.

# Media trust most about COVID-19




**Q. Which, if any, of the following sources of information would you say you trust the most?**
Base: all respondents (N=636).

There was no single source of information that completely dominated the *most trust* measure.

However, official websites were sources of information that were more likely to be *trusted most* by respondents.

www.nhs.uk ranked 1st and www.gov.uk ranked 2nd. Almost a third (30%) trusted one of these sources *most*.

Public Health England (4th) and Government briefings (5th) were also ranked highly.

# Usage versus Trust Charts

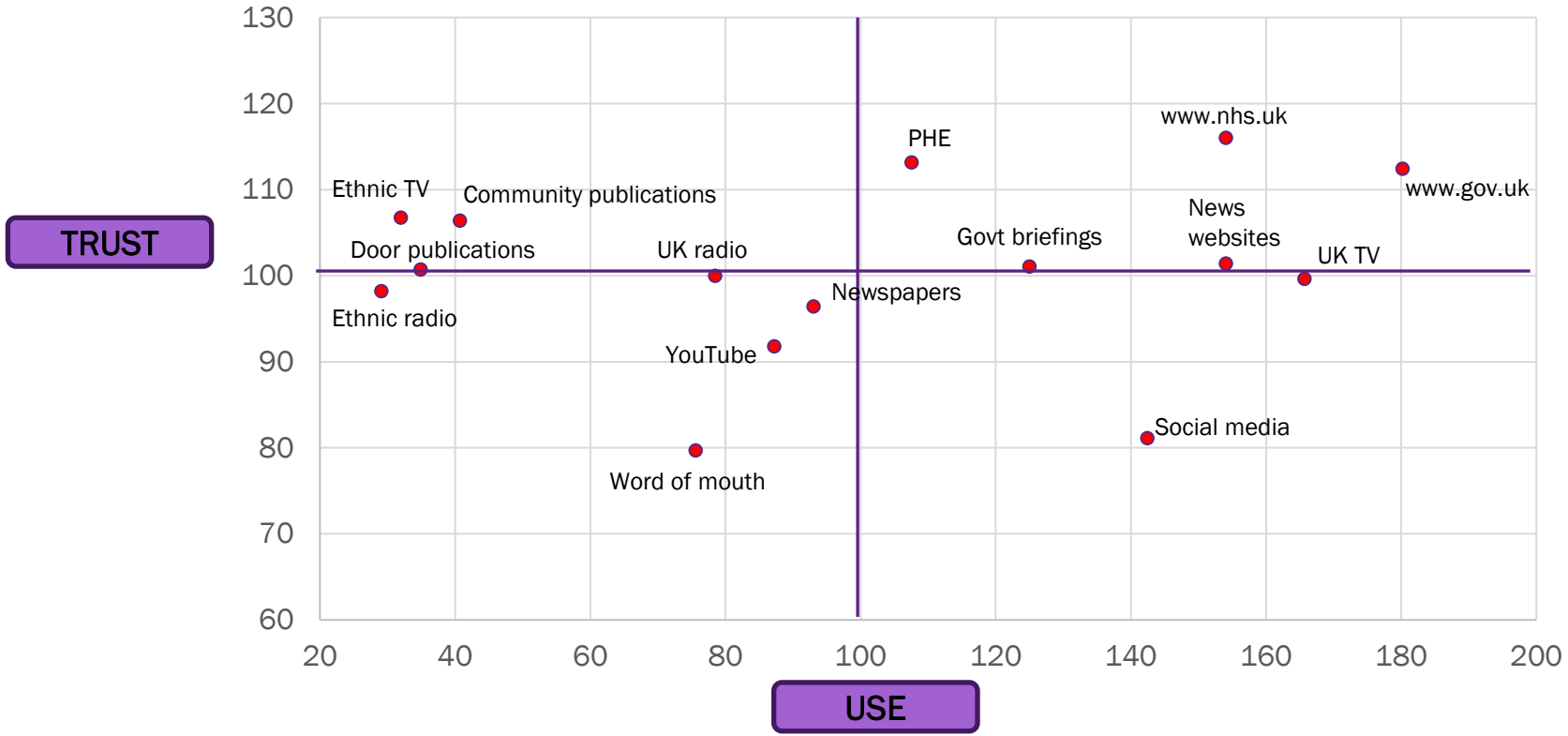
- The following Charts plot usage of media channels against trust in media channels.

- For both usage and trust, the results have been indexed against the total sample (which represents an index of 100).

- The figures that have been used for each are as follows:
  - Usage: the percentage of that sub-group that use the media source
  - Trust: mean score ratings of Trust (using a four point scale)

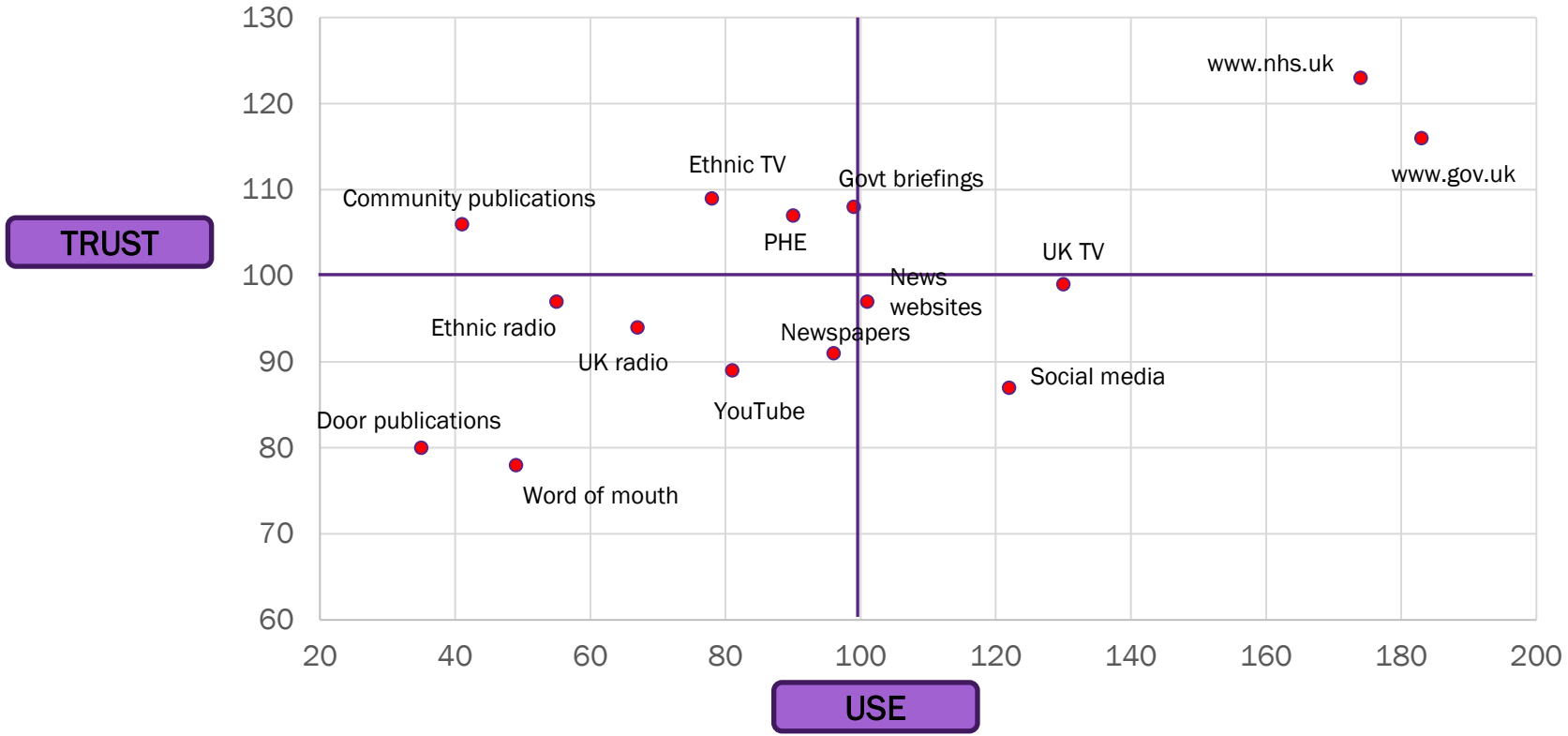
- Each chart is divided into four quadrants:
  - Top right: media sources with above average usage and above average trust
  - Bottom right: media sources with above average usage and below average trust
  - Top left: media sources with below average usage and above average trust
  - Bottom left: media sources with below average usage and below average trust

# Usage versus trust of media: Total



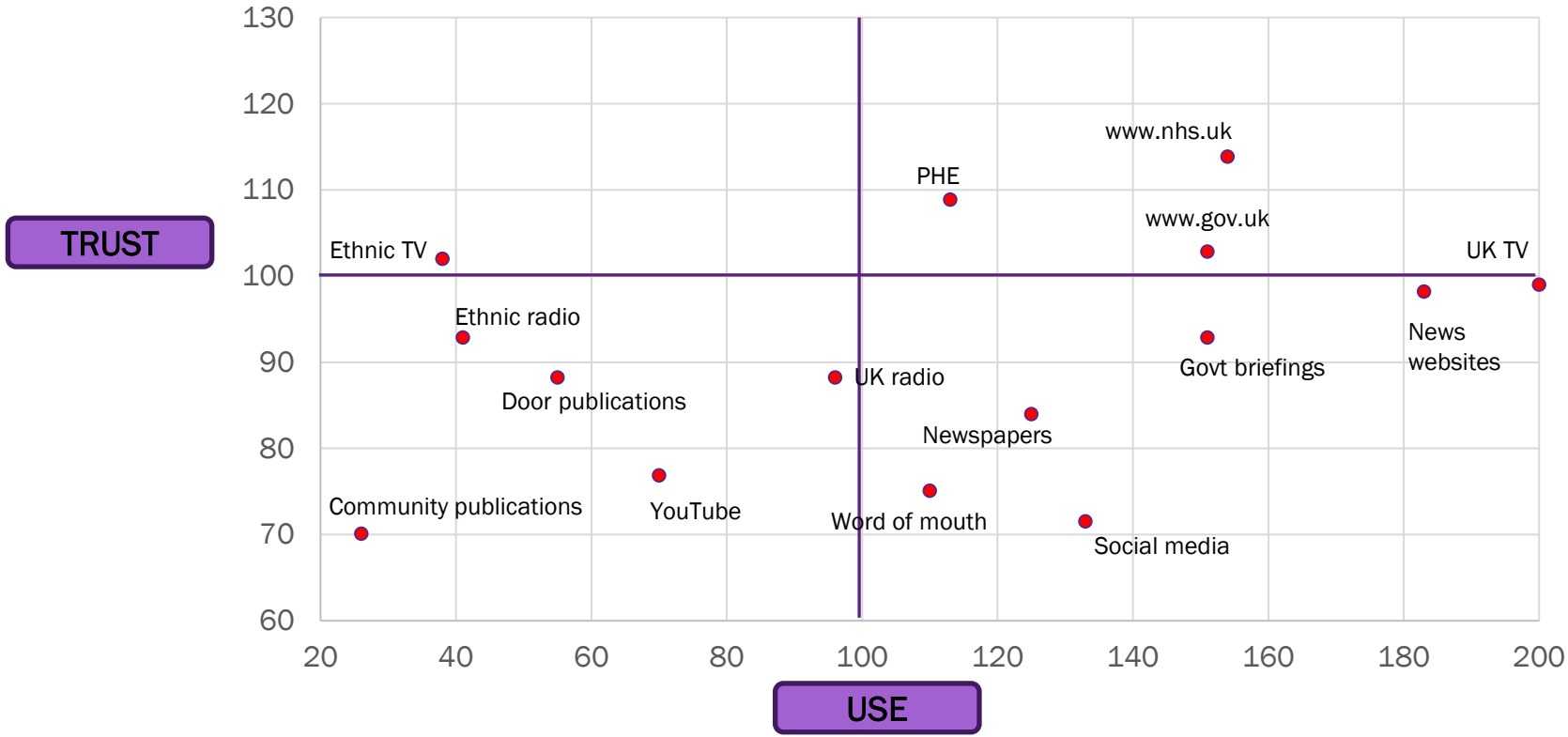

**Q. Which, if any, of these sources have you used to find out information about issues relating to COVID-19? /**
Base: all respondents (N=636).

# Usage versus trust of media: White Non British ethnicity



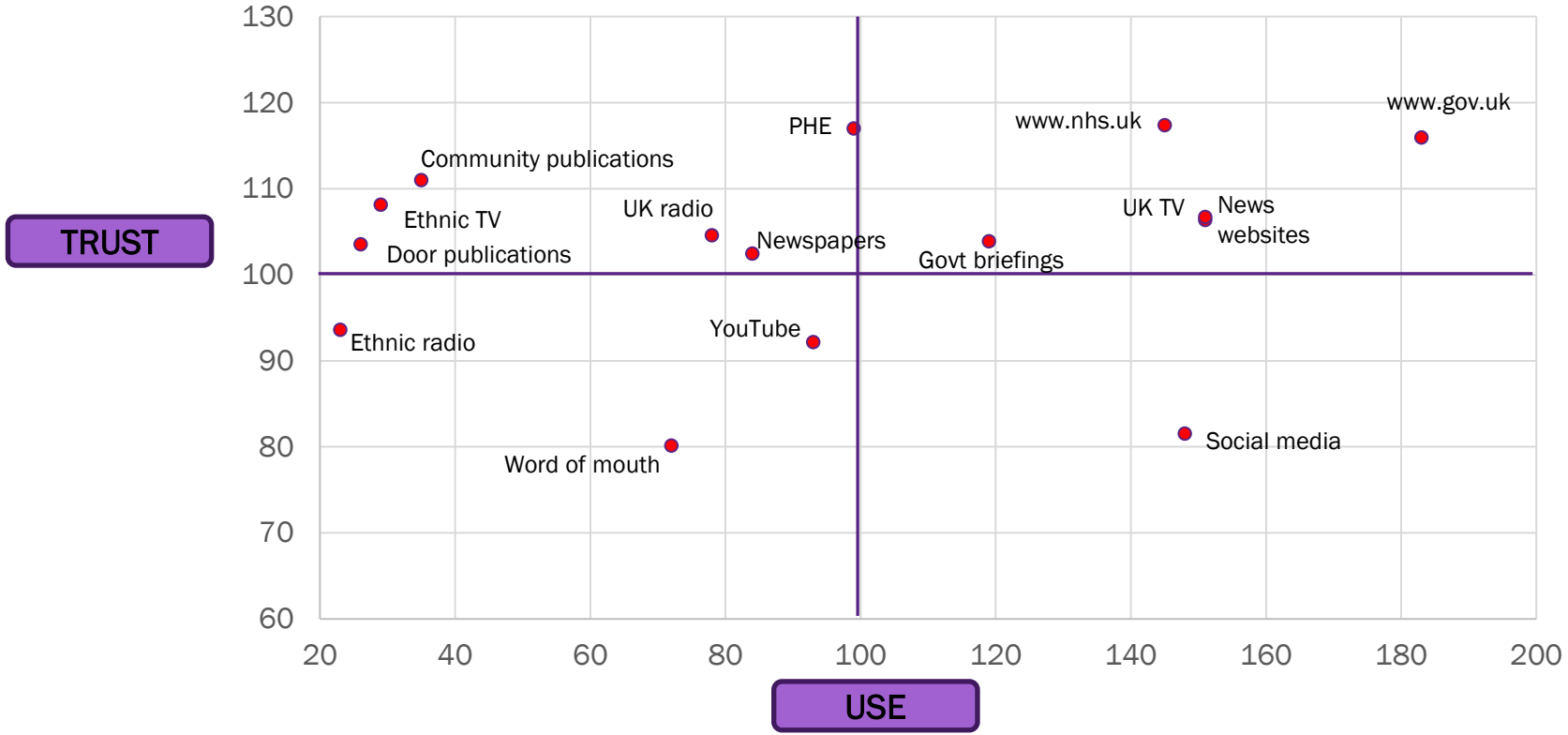

**Q. Which, if any, of these sources have you used to find out information about issues relating to COVID-19? /**
Base: all respondents (N=636).

# Usage versus trust of media: Mixed ethnicity



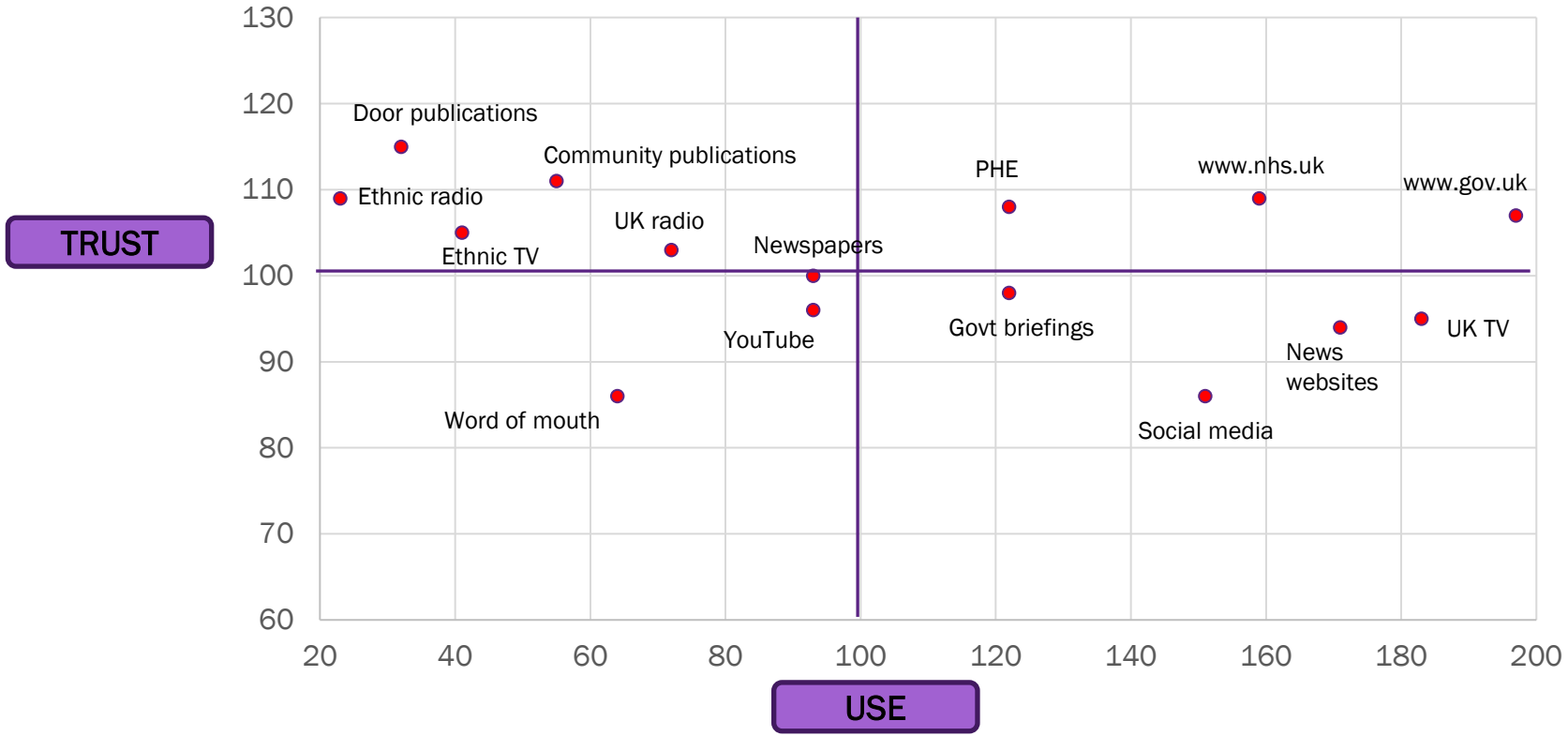

**Q. Which, if any, of these sources have you used to find out information about issues relating to COVID-19? /**
Base: all respondents (N=636).

# Usage versus trust of media: Asian ethnicity



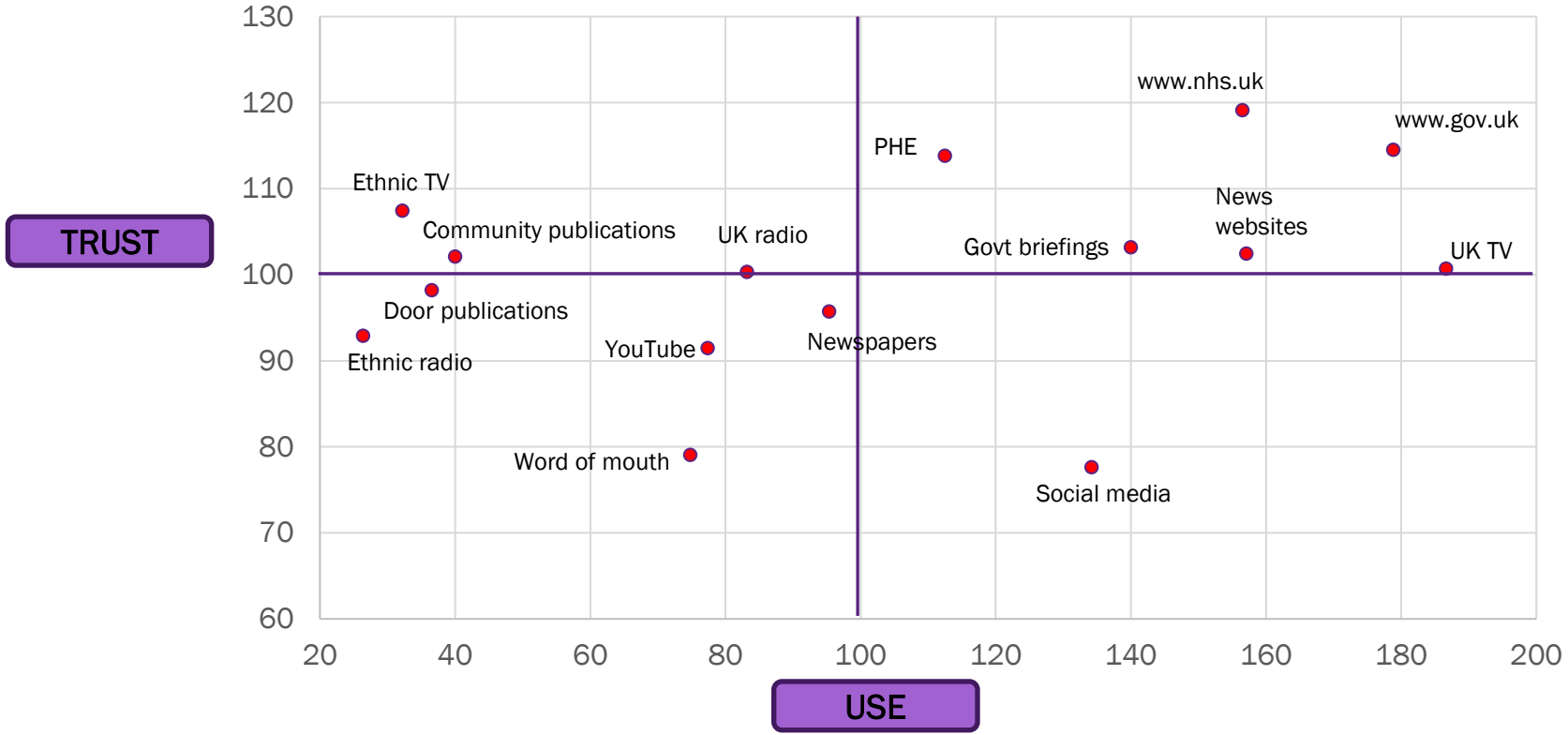

**Q. Which, if any, of these sources have you used to find out information about issues relating to COVID-19? /**
Base: all respondents (N=636).

# Usage versus trust of media: Black ethnicity



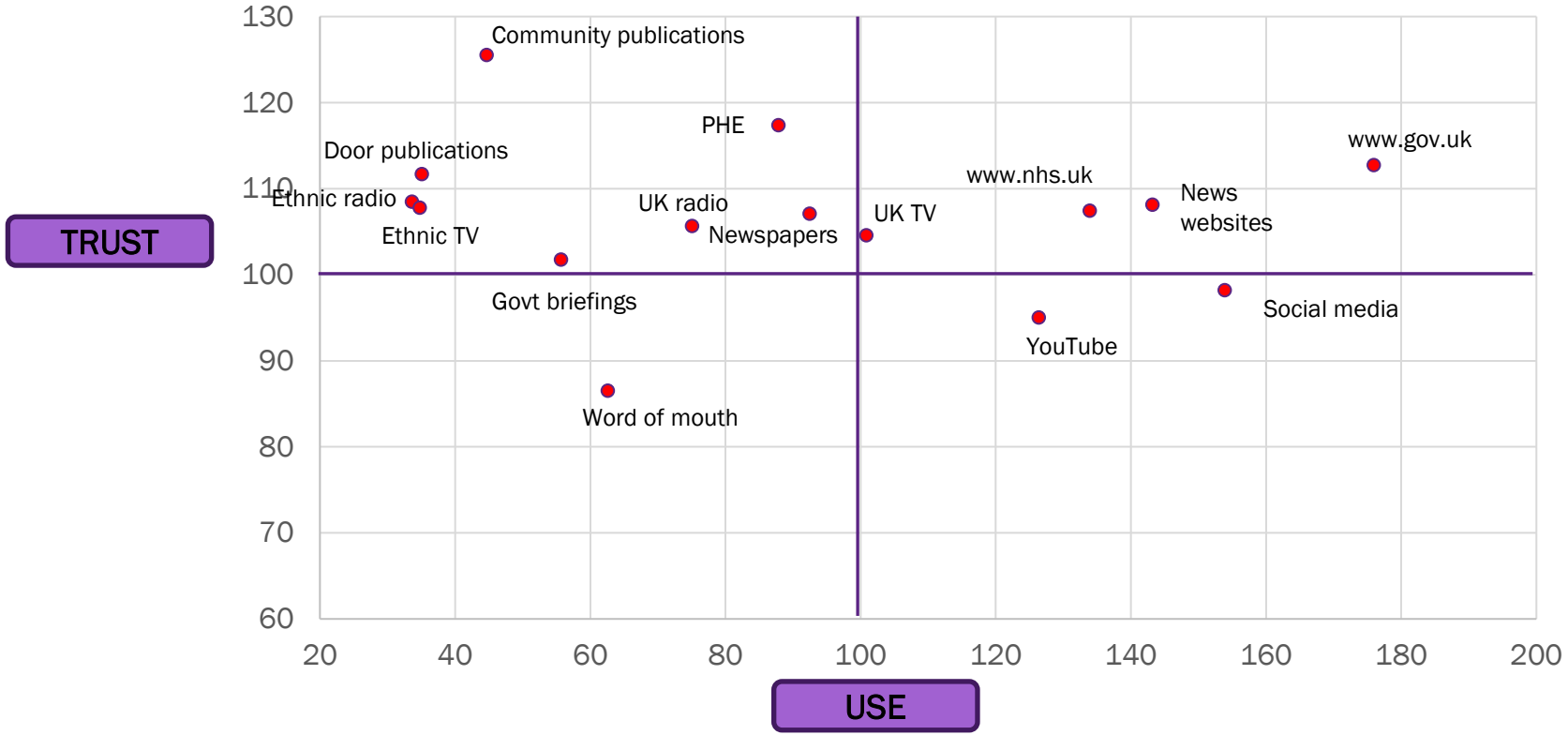

**Q. Which, if any, of these sources have you used to find out information about issues relating to COVID-19? /**
Base: all respondents (N=636).

# Usage versus trust of media: vaccine acceptors



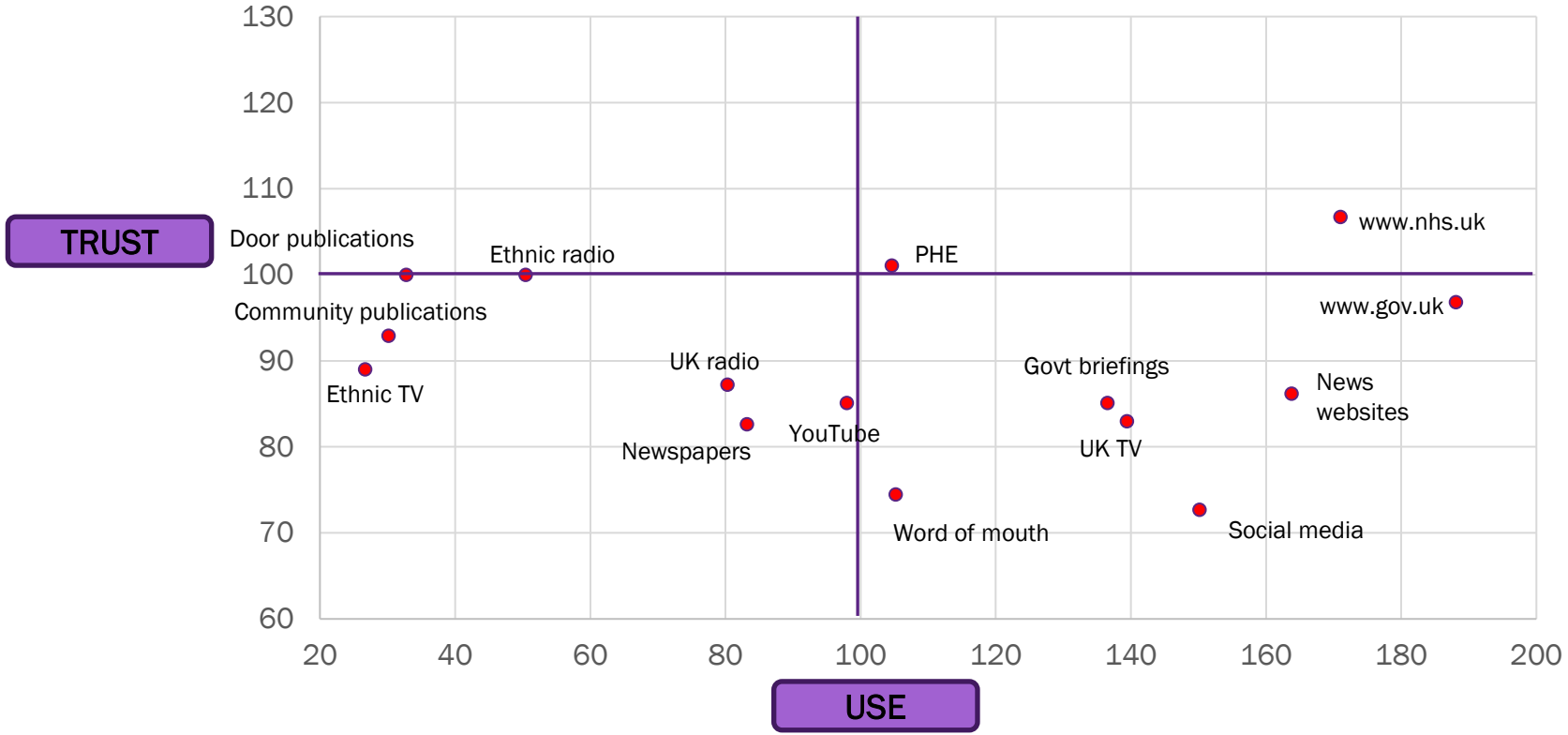

**Q. Which, if any, of these sources have you used to find out information about issues relating to COVID-19? /**
Base: all respondents (N=636).

# Usage versus trust of media: vaccine hesitants



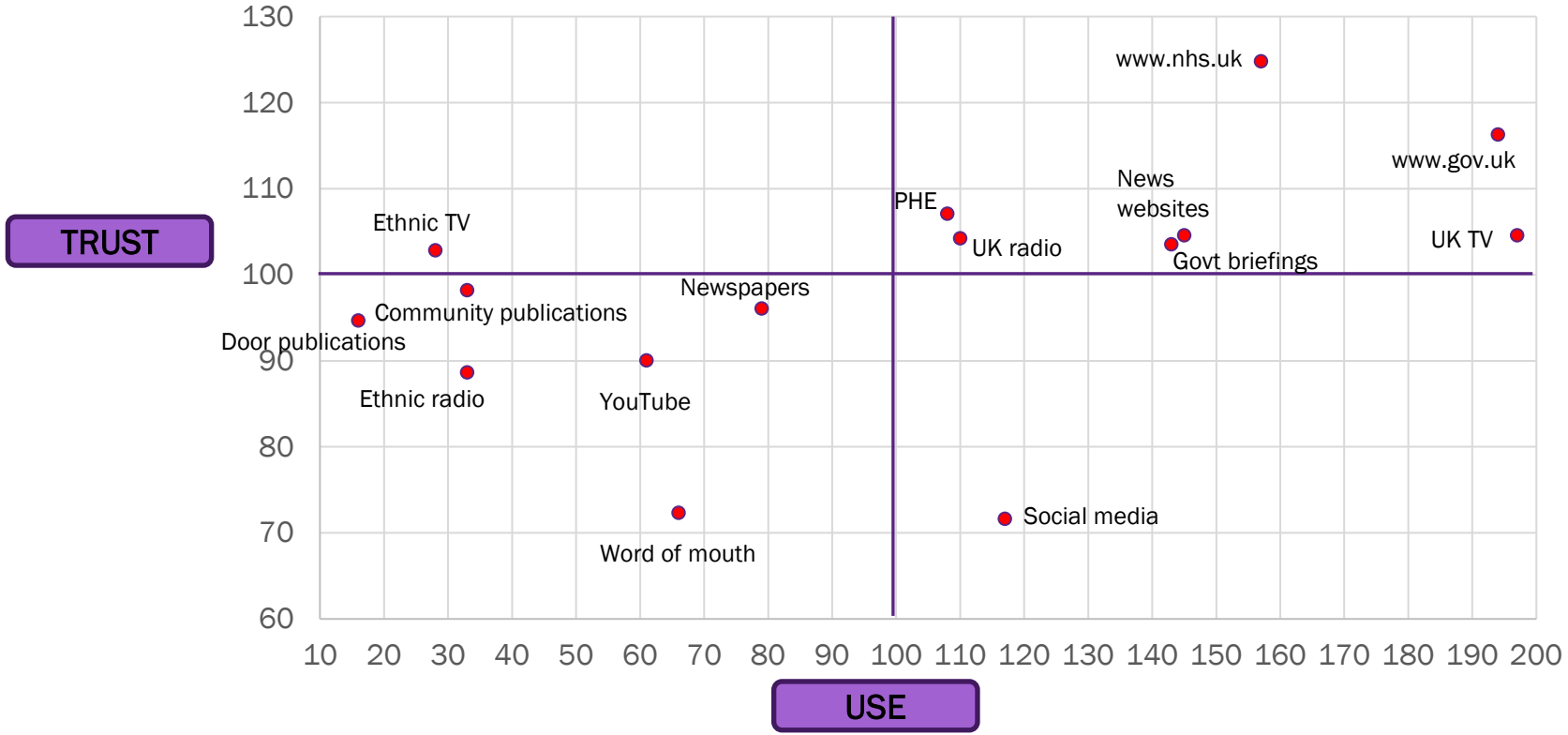

**Q. Which, if any, of these sources have you used to find out information about issues relating to COVID-19? /**
Base: all respondents (N=636).

# Usage versus trust of media: vaccine rejecters



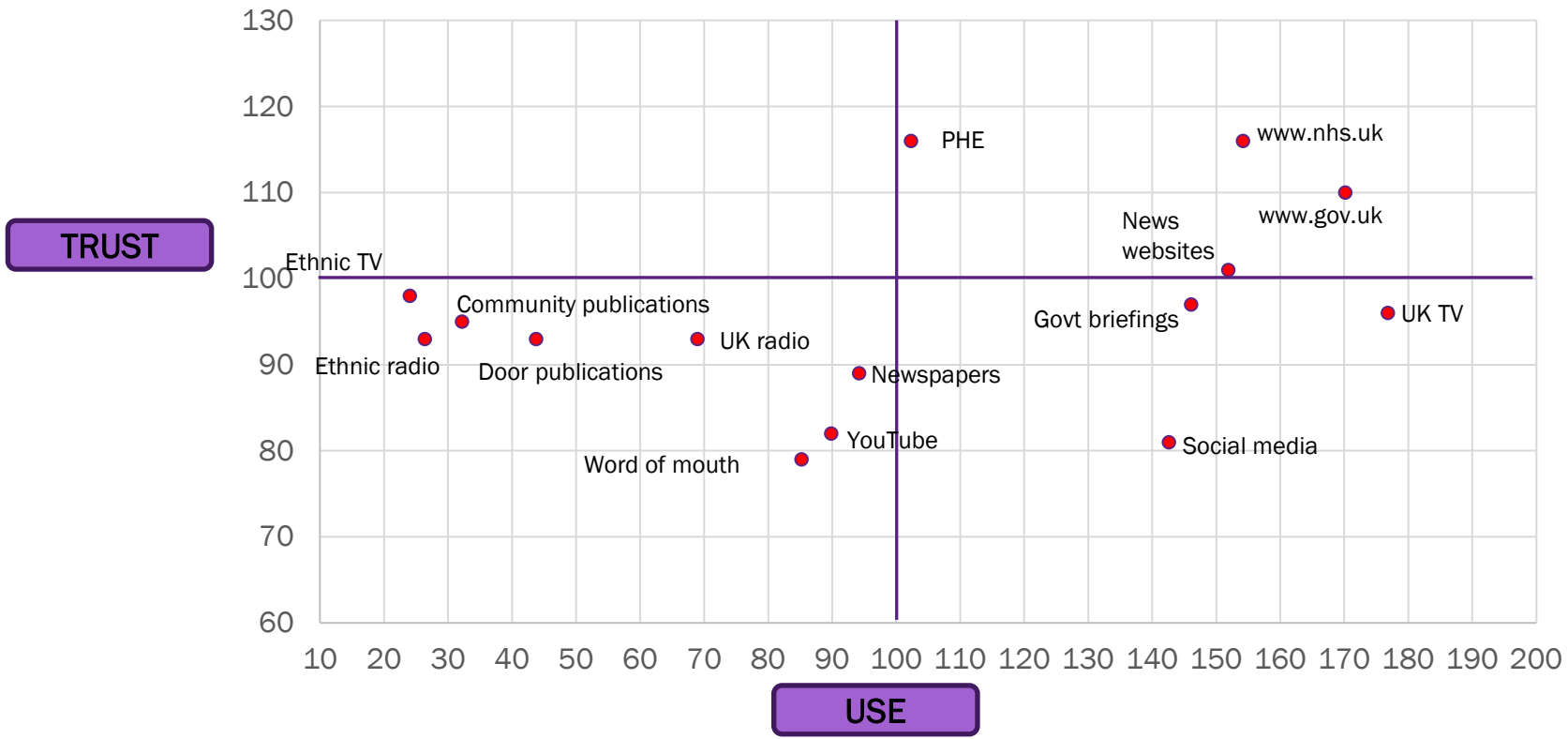

**Q. Which, if any, of these sources have you used to find out information about issues relating to COVID-19? /**
Base: all respondents (N=636).

# Usage versus trust of media: less deprived area




**Q. Which, if any, of these sources have you used to find out information about issues relating to COVID-19? /**
Base: all respondents (N=636).

# Usage versus trust of media: more deprived area




**Q. Which, if any, of these sources have you used to find out information about issues relating to COVID-19? /**
Base: all respondents (N=636).

# Communications

## Key highlights

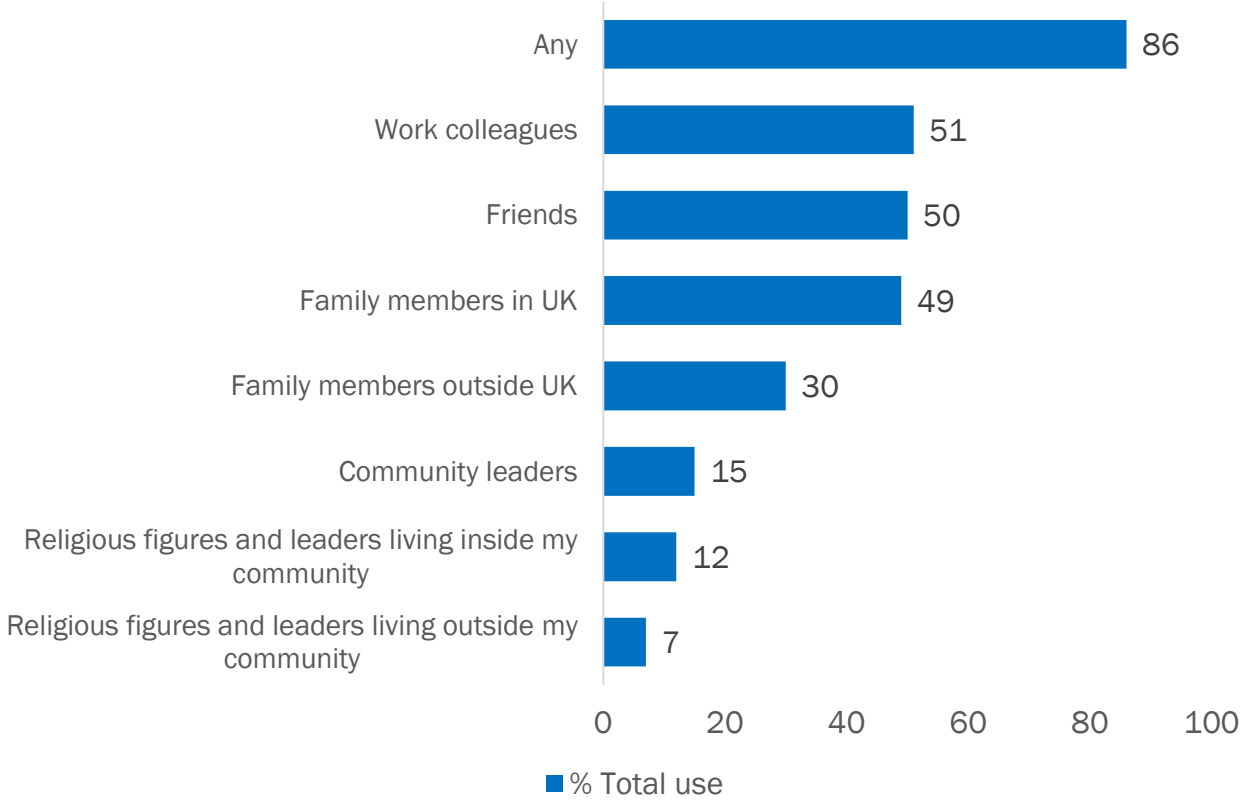
- Use of social media was widespread, although there was some variation by ethnic group with *mixed ethnic groups* being the most frequent users.
- The communications picture is fragmented and a wide range of different media channels being used to find out about COVID.
- Official channels of information were used extensively to find out about COVID (www.gov.uk and www.nhs.uk) , with UK TV (e.g. BBC and Sky) and News websites also widely used.
- www.gov.uk and www.nhs.uk were the most trusted sources of information.
- Trust in media channels varied by ethnic group with mixed ethnic groups having lower levels of trust than other groups.
- Overall White Non British used fewer media channels to find out about COVID.

Communications
KEY POINTS

Cheshire and Merseyside
Health and Care Partnership

# Community sources of information

# Community information sources used




Community based sources of information about COVID were used extensively to find out about COVID.

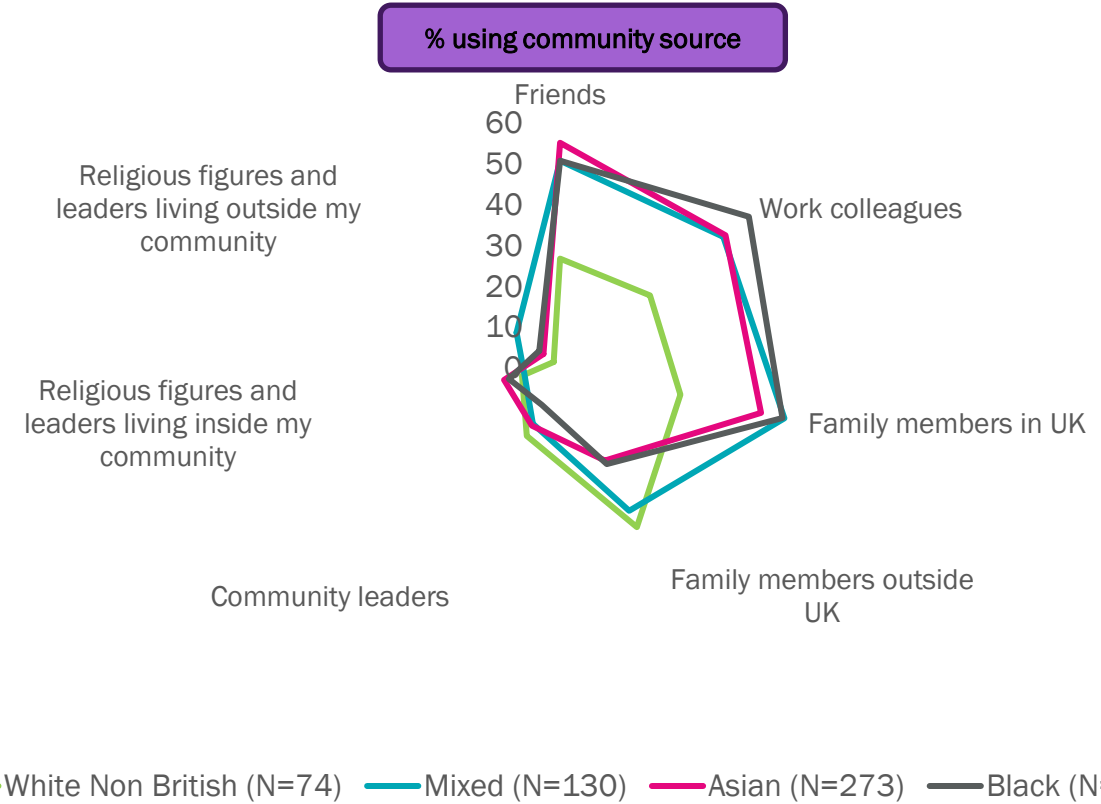
Work colleagues (51%) and friends (50%) were the most widely used community sources, but family members (in UK) also (49%).

Almost a third (30%) also used family members from outside UK.

Religious leaders and community leaders were less commonly used.

**Q. Below are some other potential sources of information that you may have about COVID-19. Which of these do you use to find out information about issues relating to COVID-19?** Base: all respondents (N=636).

# White Non British have fewer community networks



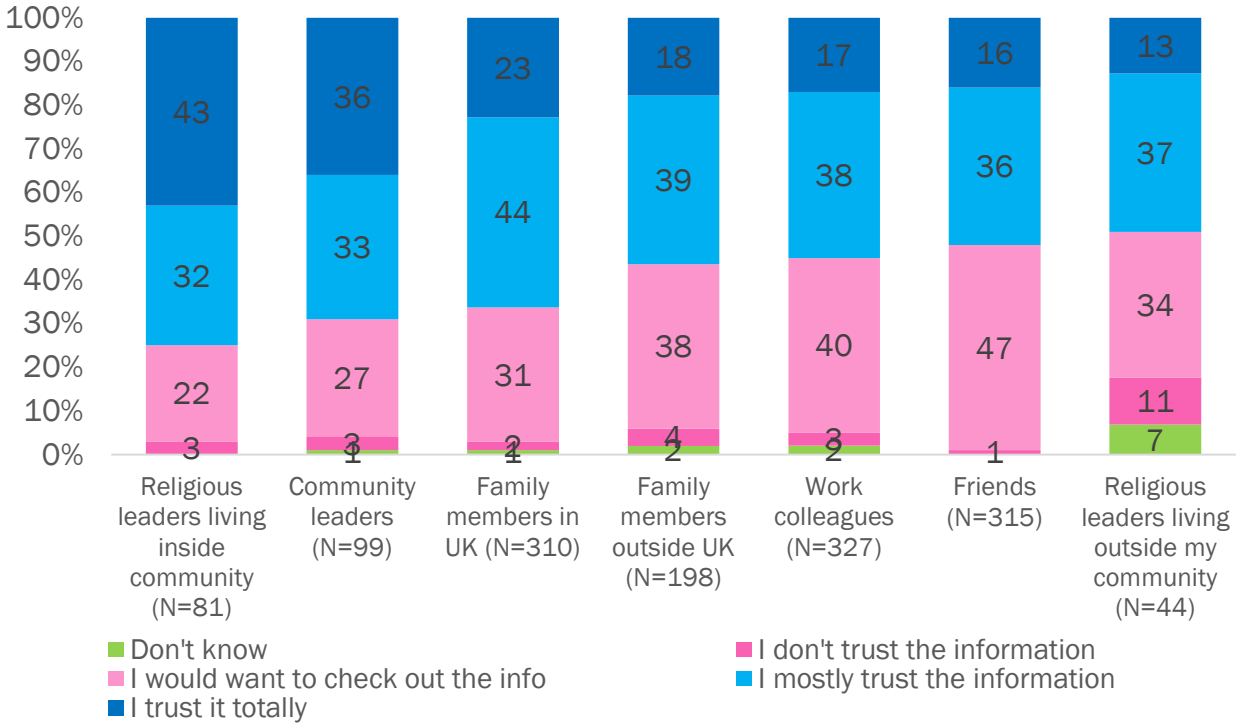

White Non British had fewer community networks and were much less likely to use *family in the UK, friends* and *work colleagues*, but more likely to use *family outside of the UK*.

The profile of use of community sources of information is similar among Black, Asian and Mixed ethnic groups.

However, mixed ethnic communities were also likely to use *family from outside the UK* as a source.

**Q. Below are some other potential sources of information that you may have about COVID-19.**
**Which of these do you use to find out information about issues relating to COVID-19?** Base: all respondents (N=636).

# Trust in Community Sources



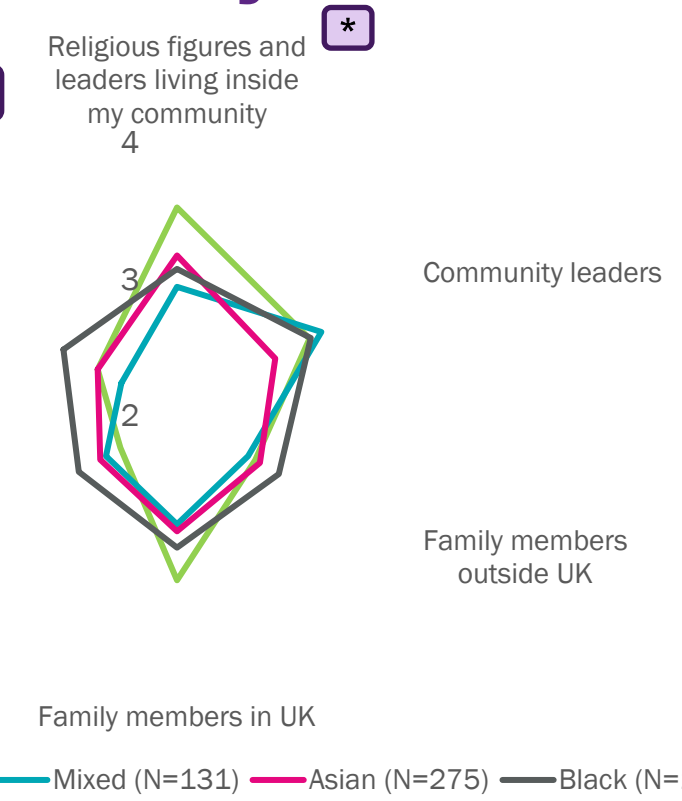

**Q. For each please tell us how much you trust or distrust this type of information?**
Base: all respondents (N=636).

Leaders within the community (either *religious leaders* or *general community* leaders) were trusted the most. (Religious leaders outside of the community were not trusted much less.)

The closeness of relationships helps determine trust, with *UK family members in the UK* trusted more then those *outside UK*, then *work colleagues* and *friends*.

# Trust in community sources: Ethnic group

Mean score rating +1 to +4




*Low base size

Base size for religious leaders outside community was too low to chart

Members of Black ethnic groups tended to have higher trust ratings for community sources of information (*work colleagues*, *friends*, *family members outside of the UK*).

White non British had higher trust in *family members in the UK* and *community religious leaders* (albeit this is based on a low base size).

As with other trust measures, mixed ethnicities had generally lower levels of trust.

**Q. Which, if any, of these statements best describes how much you trust or distrust the information that you receive about COVID-19 from each of the sources of information that you use?**
Base: all respondents in sub-group who receive information from source.

# Community Sources of Information

## Key highlights

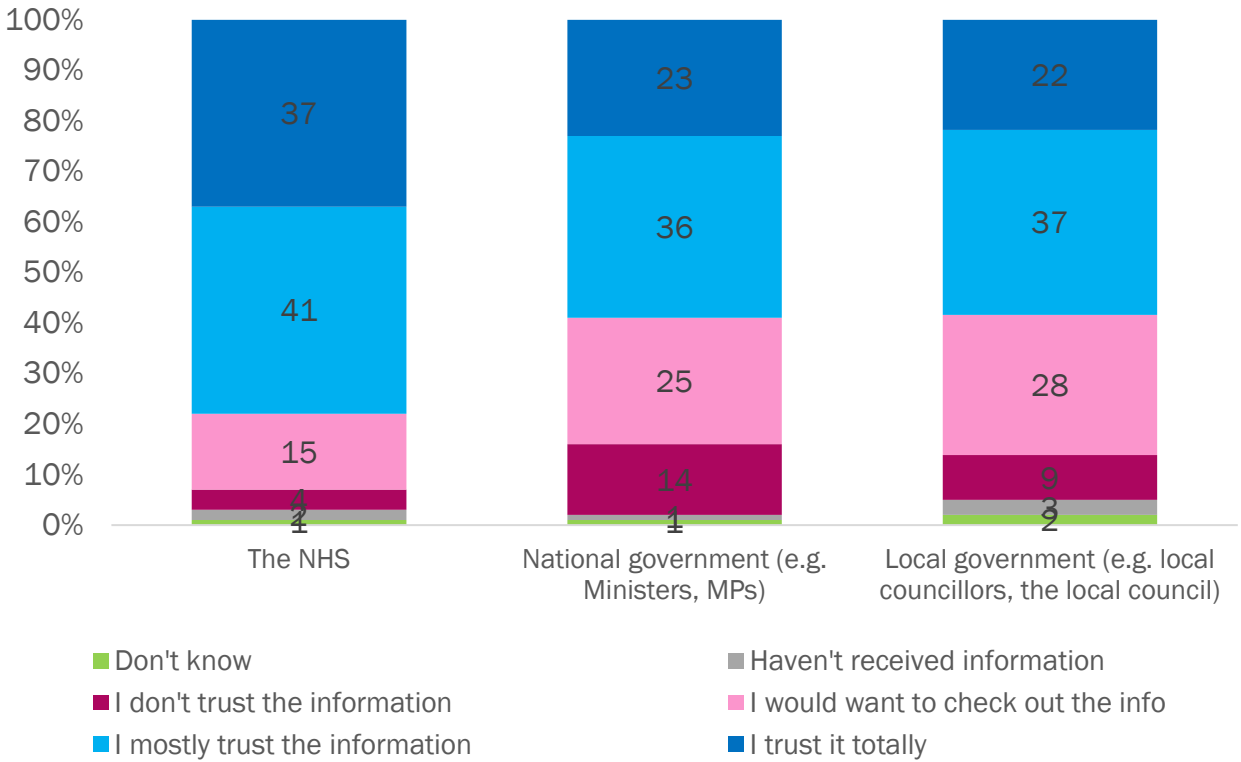
- Community sources of information about COVID were widely used, with work colleagues, friends and family members in the UK used by approximately half of respondents.
- Despite these sources of information being widely used, the information obtained by these sources were not generally taken at face value and the vast majority of respondents did not totally trust the information. Notwithstanding this, levels of trust for some community sources was good (e.g. family members in both the UK and outside the UK).
- Community leaders and religious leaders were not widely used as sources of information, but where they were used they were highly trusted.

Community Sources of Information KEY POINTS

Cheshire and Merseyside
Health and Care Partnership

# The government

# Trust in official sources about COVID-19



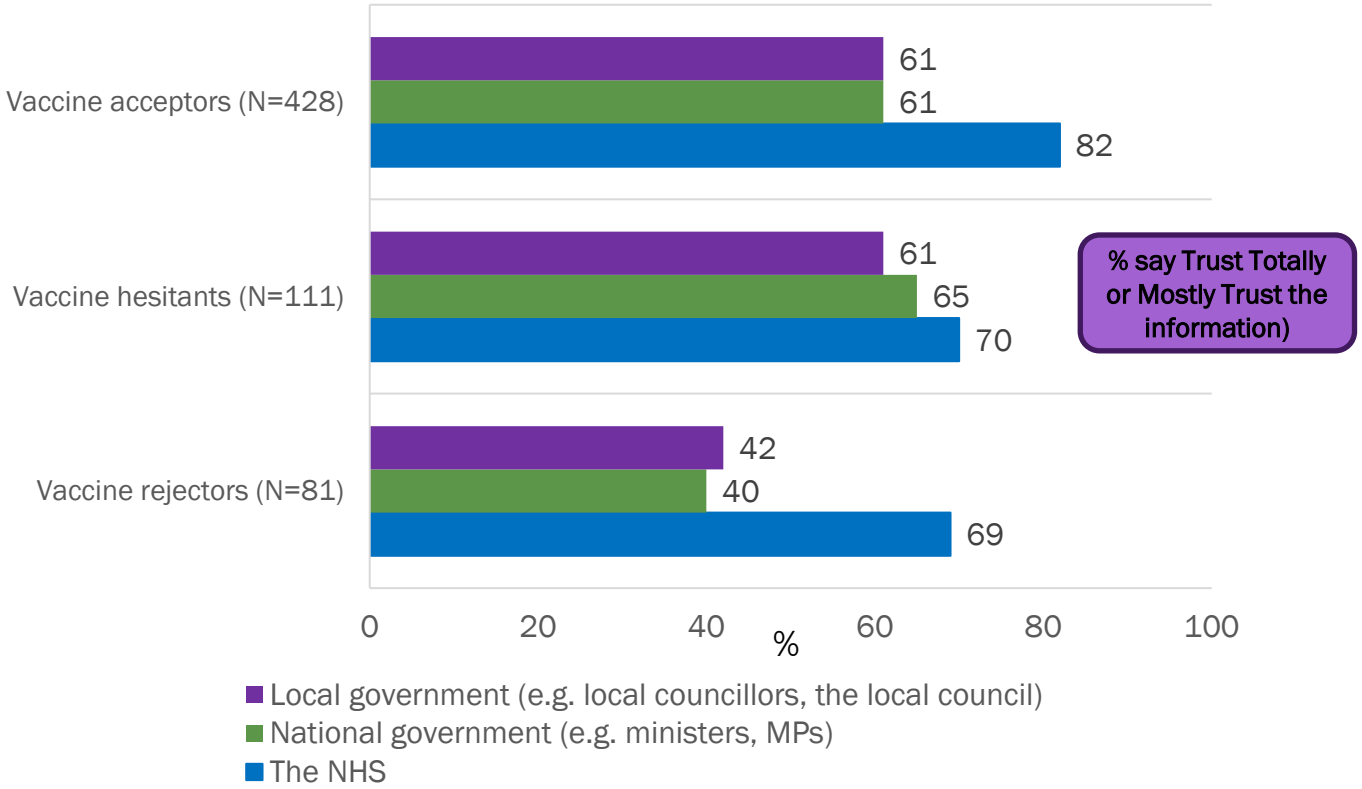

In terms of official sources, trust in information from the *NHS* far exceeds that from either *national* or *local government*.

One in 7 people (14%) do not trust the information received from national government and a further quarter (25%) did not take it at face value and would want to check it.

These data suggest that NHS branded information is more likely to be trusted than information from government.

**Q. Below are sources of official information about COVID-19.**
**For each please tell us how much you trust or distrust information from each of these sources?** Base: all respondents (N=636).

# High trust of NHS among vaccine rejecters

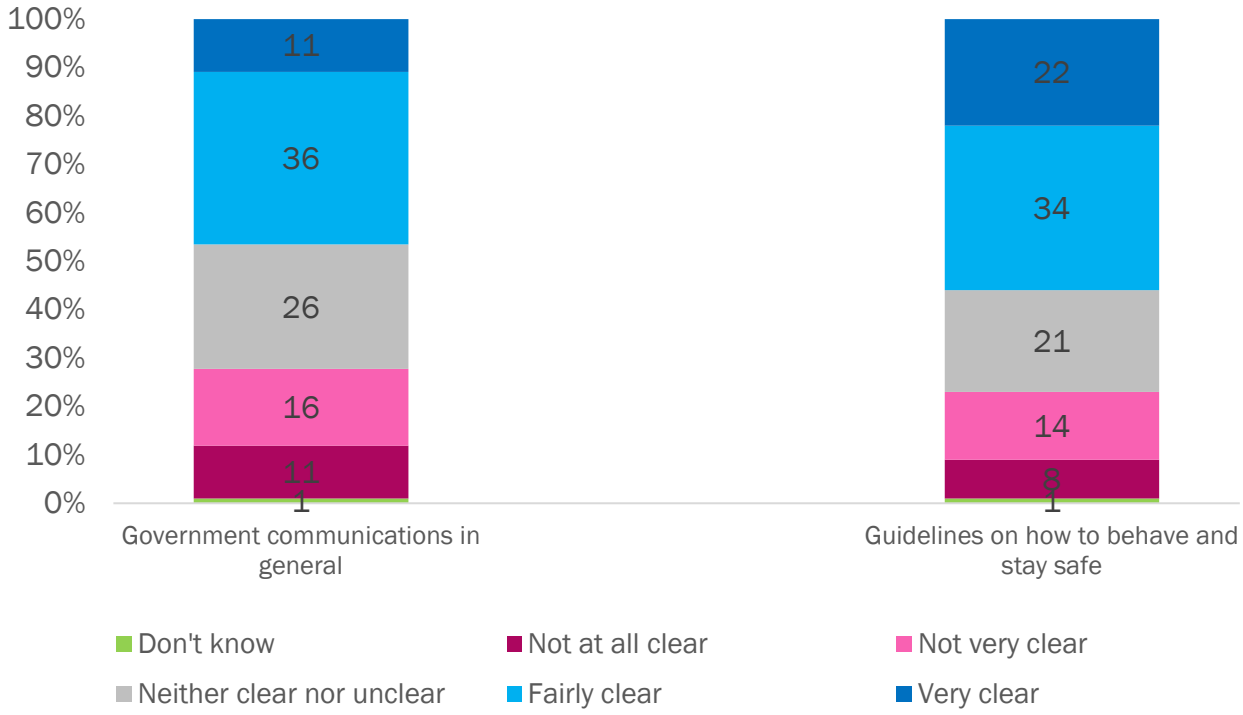



Vaccine rejectors had much lower levels of trust in government sources of information (*local* or *national*), with fewer than half either *totally* or *mostly* trusting the information

However, rejectors still had high trust in the NHS and therefore messages from the NHS are the most likely to cut through to this audience.

**Q. Below are sources of official information about COVID-19. For each please tell us how much you trust or distrust information from each of these sources?**
Base: all respondents (N=636).

# Clarity of Government messages



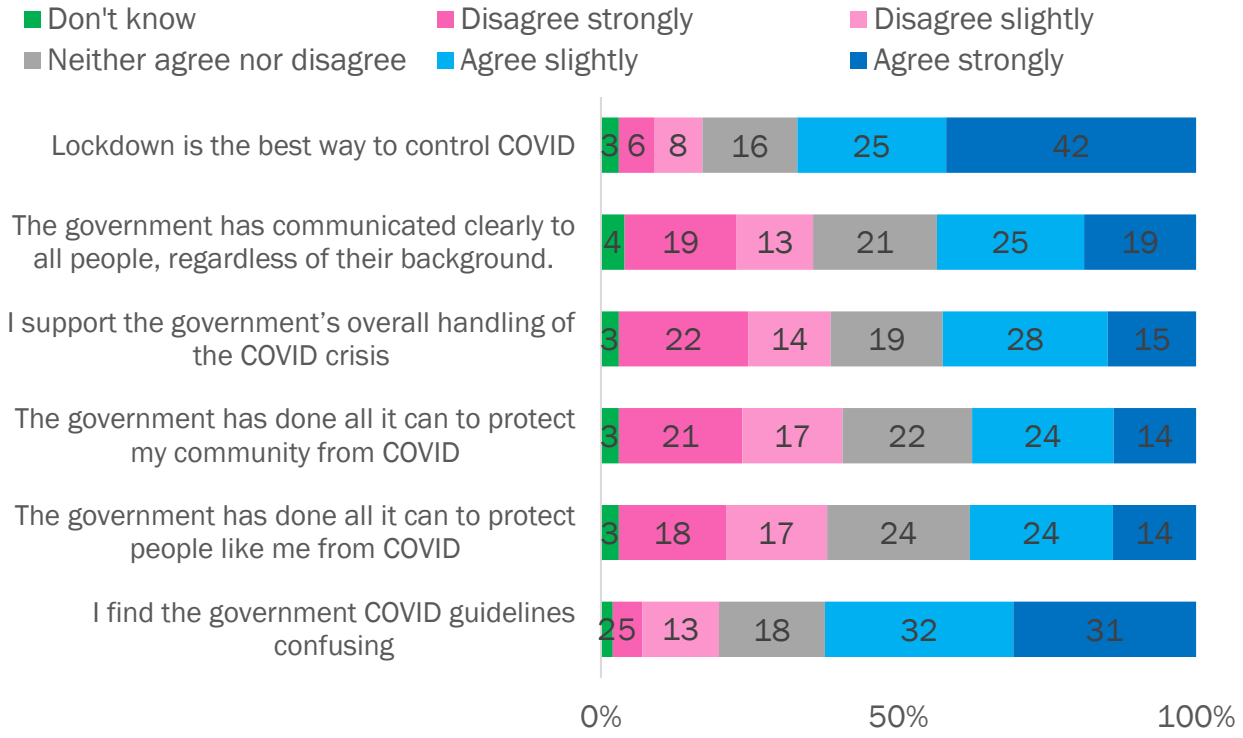

There was a large group of respondents who *did not think* that government communications have been clear.

More than half (53%) did not think that *general communications* have been clear.

Communications *about guidelines* were slightly clearer, but almost half (44%) still thought that they have not been clear.

**Q. Thinking about government communications about COVID-19 in general/government guidelines to stay safe, which of these statements best describes how clear or unclear have they been?** Base: all respondents (N=636).

# Attributes: Government response




There was widespread support for lockdown being the best way to control COVID.

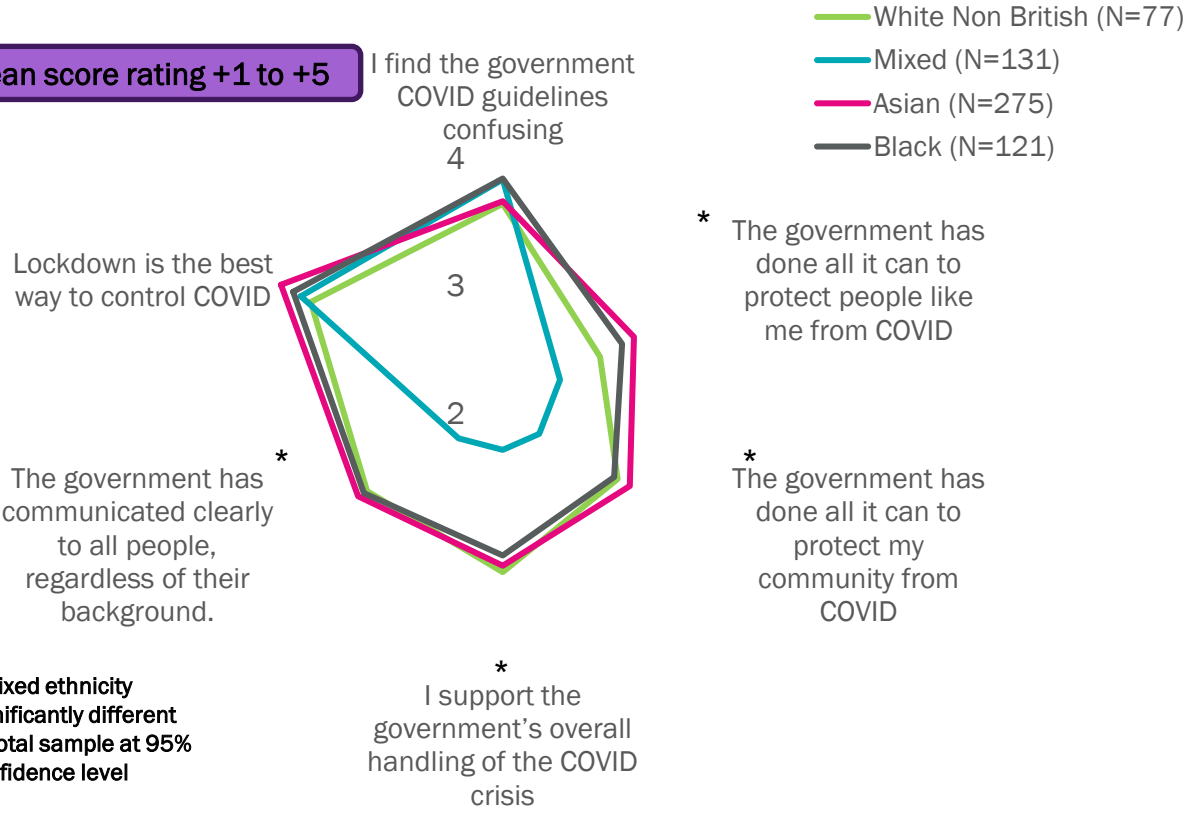
On many attributes, opinion of the government response was polarised, with high levels of agreement and high levels of disagreement across most attributes. For example, over a third disagreed that *the government has done all it can to protect my community from COVID*.

There was high agreement that the *government COVID guidelines have been confusing* (63% agree).

**Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?**
Base: all respondents (N=636).

# Attributes: Government response

Mean score rating +1 to +5




Mixed ethnic groups were significantly more critical of the government response than other ethnic groups.

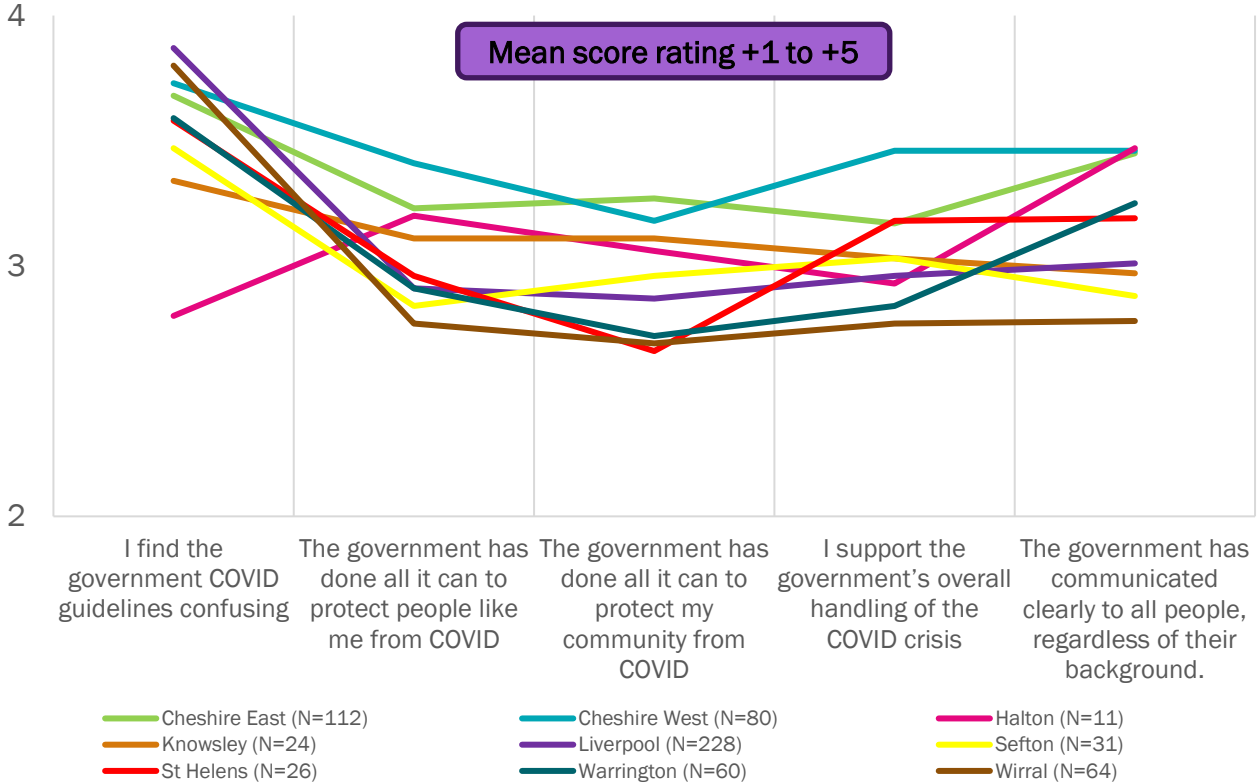
Levels of agreement were markedly lower for: *the government has done all it can to protect people like me* and *my community from COVID*.

This community was also much less likely to *support the government's overall handling of the COVID crisis*.

*** Mixed ethnicity significantly different to total sample at 95% confidence level**

**Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?**
Base: all respondents (N=636).

# Attributes: Government response



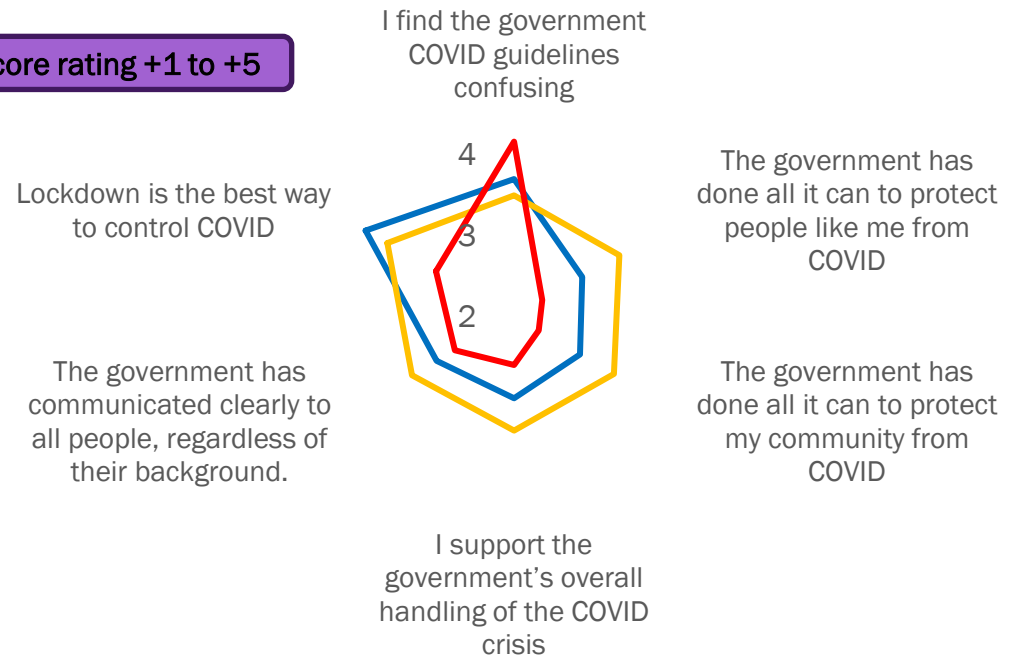

Broadly speaking, respondents from Cheshire West and Cheshire East were the most supportive of the government response.

Respondents in Wirral were the most critical of the government response, with respondents in Liverpool also relatively critical.

Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?
Base: all respondents (N=636).

# Attributes: Government response

Mean score rating +1 to +5



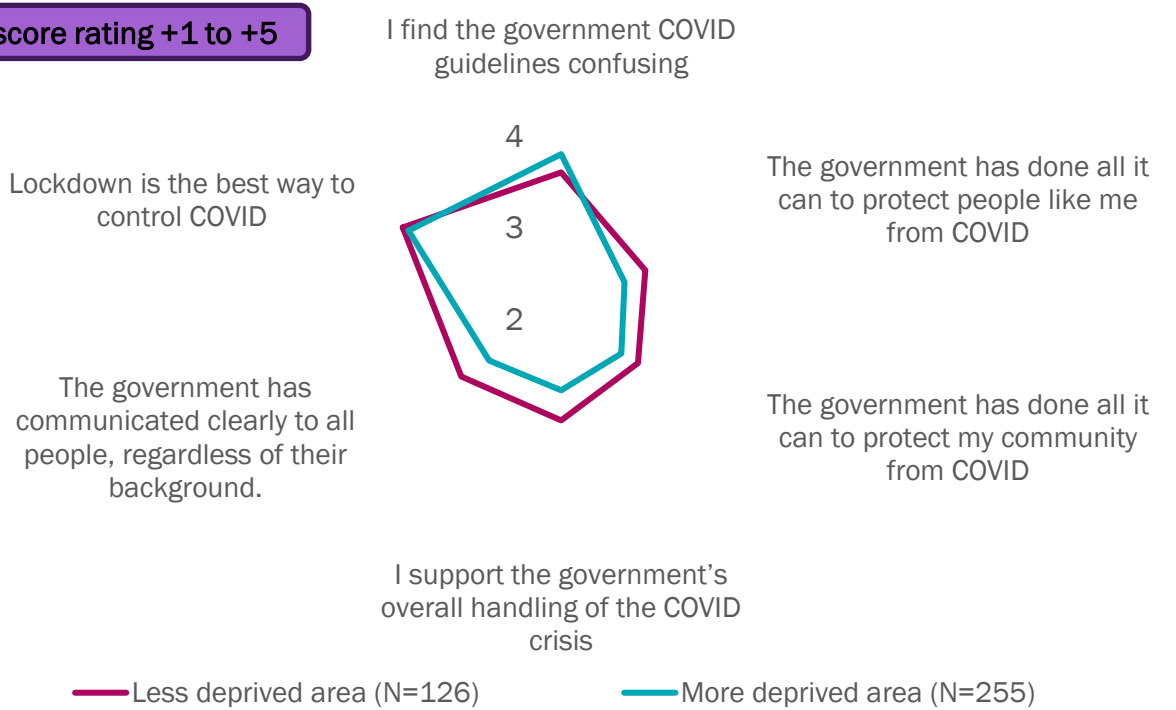

Vaccine rejecters were highly critical of the government response and lockdown being the *best way to control COVID*.

Vaccine hesitants were the most supportive of the government. While opinion of the government is likely a driver of vaccine rejection, it is less of a driver behind hesitancy towards the vaccine.

**Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?**
Base: all respondents (N=636).

# Attributes: Government response

**Mean score rating +1 to +5**




Those from more deprived areas were more negative about the government response than those from less deprived areas.

They were just as likely to agree that *lockdown is the best way to control COVID*, but were more critical of the government's handling of the crisis and how much they had done to protect them and their community.

**Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?**
Base: all respondents (N=636).

# Community Sources of Information

## Key highlights

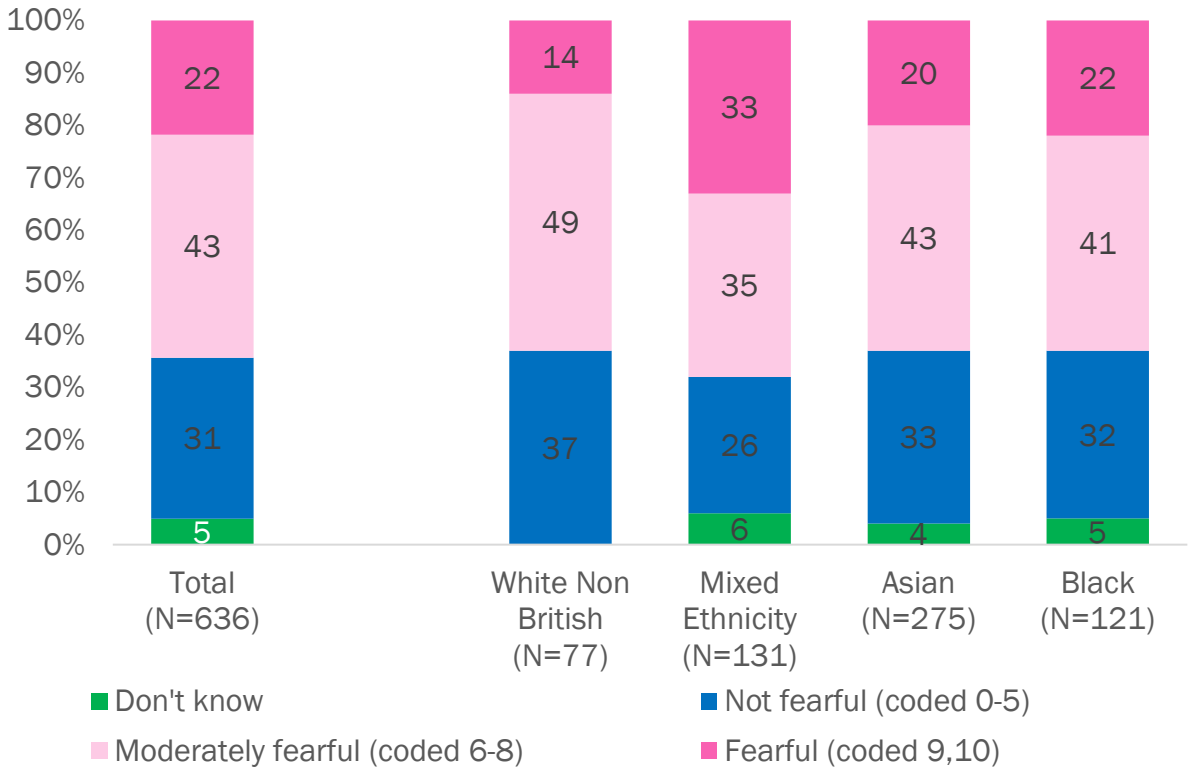
- The NHS was much more trusted than either the national government or local government (this was particularly true for *vaccine rejecters,* who had relatively high trust in the NHS).
- There was some criticism of government communications, with less than half (47%) rating it as being clear. Clarity on *guidelines on how to behave* was better, with over half (56%) rating it as clear.
- While there was widespread agreement that *Lockdown was the best way to control COVID*, attitudes to the government response to COVID were highly polarised, with high levels of agreement and high levels of disagreement across most attributes.
- Mixed ethnicities were the most critical group of the government response and levels of disagreement were markedly higher for: *the government has done all it can to protect people like me* and *my community from COVID*.

Community Sources of Information KEY POINTS

Cheshire and Merseyside
Health and Care Partnership

# Experience of COVID

# Fear of COVID

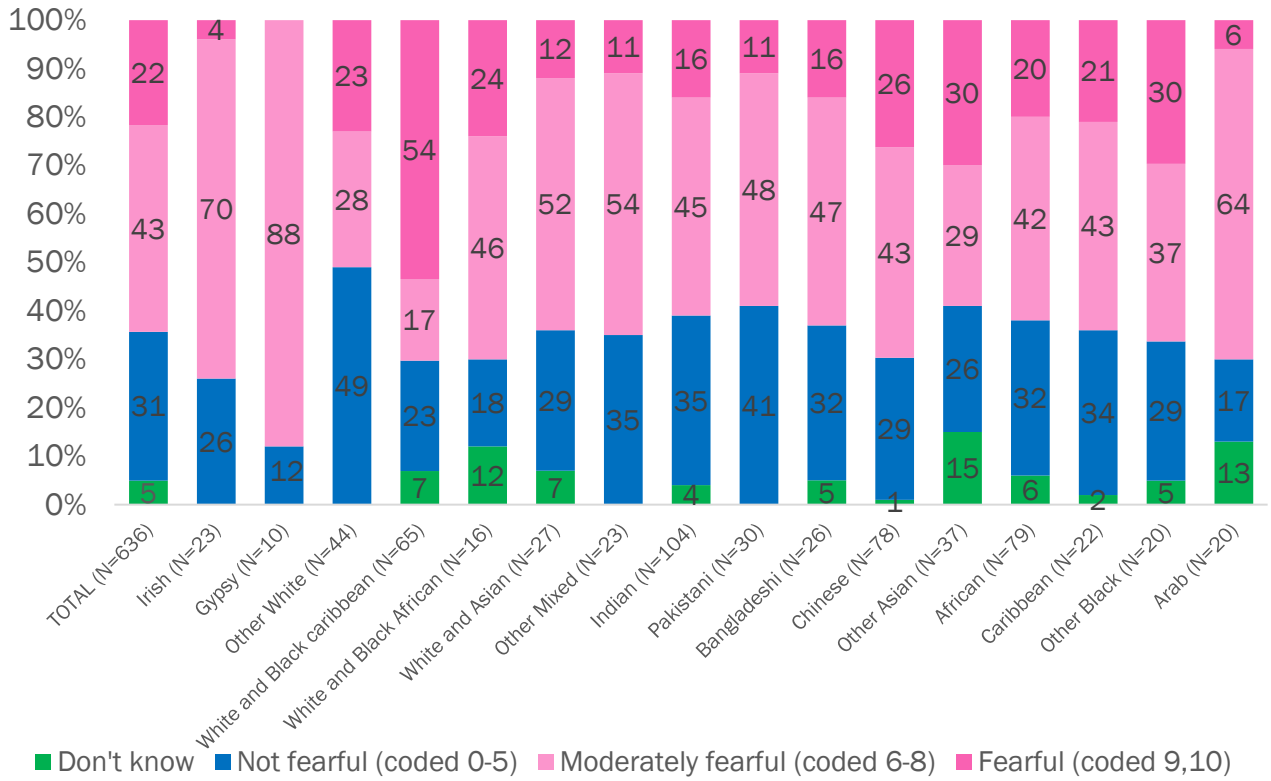



A relatively large minority of the ethnic community had a high level of fear of the disease, with just over a fifth (22%) being *extremely fearful* of catching the disease (a score of 9 or 10 out of 11).

The mixed ethnicity community was the most fearful of the disease with a third (33%) providing a score of 9 or 10.

**Q Where 0 is not at all fearful and 10 is extremely fearful. How fearful are you about catching the disease?**
Base: all respondents (N=636).

# Fear of COVID

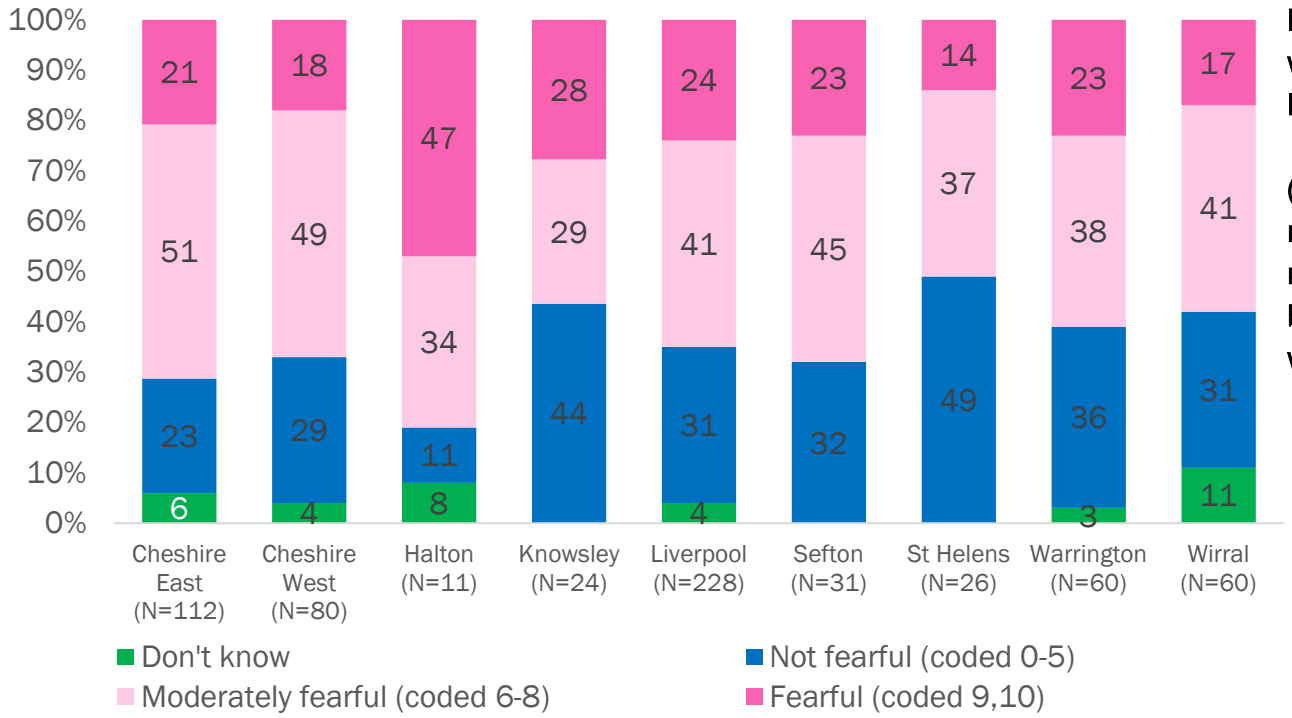



Interpretation by specific ethnic groups must be treated as indicative due to low base sizes.

However, the *Mixed White and Black Caribbean* community was the most fearful of catching the disease, with over half (54%) giving a score of 9 or 10.

**Q Where 0 is not at all fearful and 10 is extremely fearful. How fearful are you about catching the disease?**
Base: all respondents (N=636).

# Fear of COVID

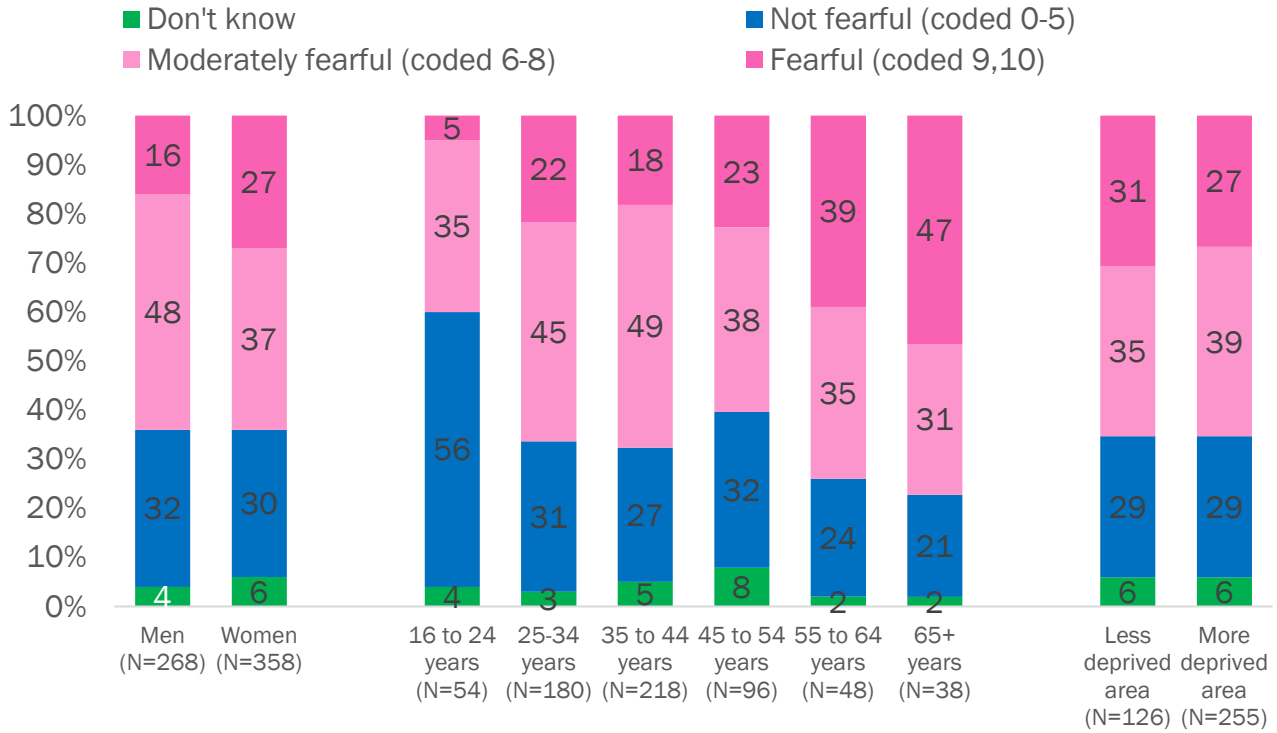



Fear of catching the disease was broadly similar across all Places within the Partnership.

(The high level of fear recorded in Halton was measured on an extremely low base and should be treated with caution.)

**Q Where 0 is not at all fearful and 10 is extremely fearful. How fearful are you about catching the disease?**
Base: all respondents (N=636).

# Fear of COVID



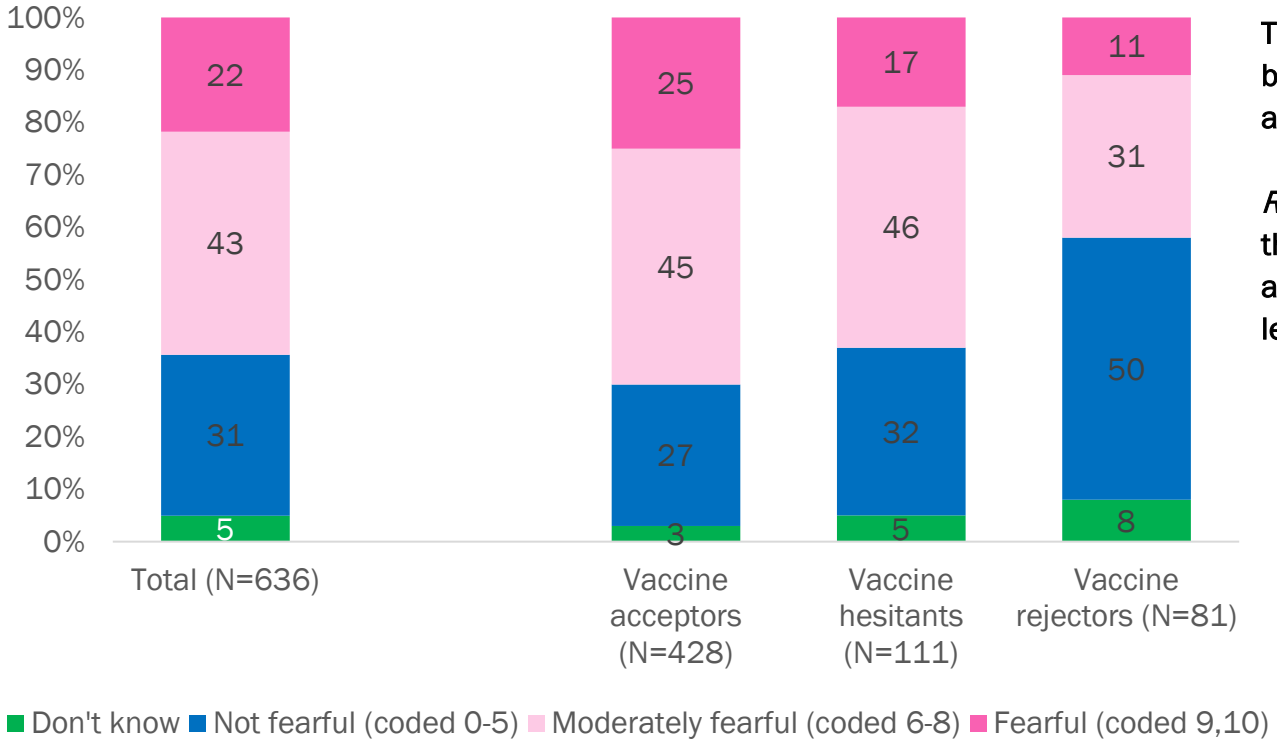

Women were more fearful of catching the disease than men (this despite men having a higher risk factor of serious illness).

Fear increases by age, with the age of 55 years being a threshold for increased fear.

There was no relationship between fear and social deprivation.

Q Where 0 is not at all fearful and 10 is extremely fearful. How fearful are you about catching the disease?
Base: all respondents (N=636).

# Fear of COVID

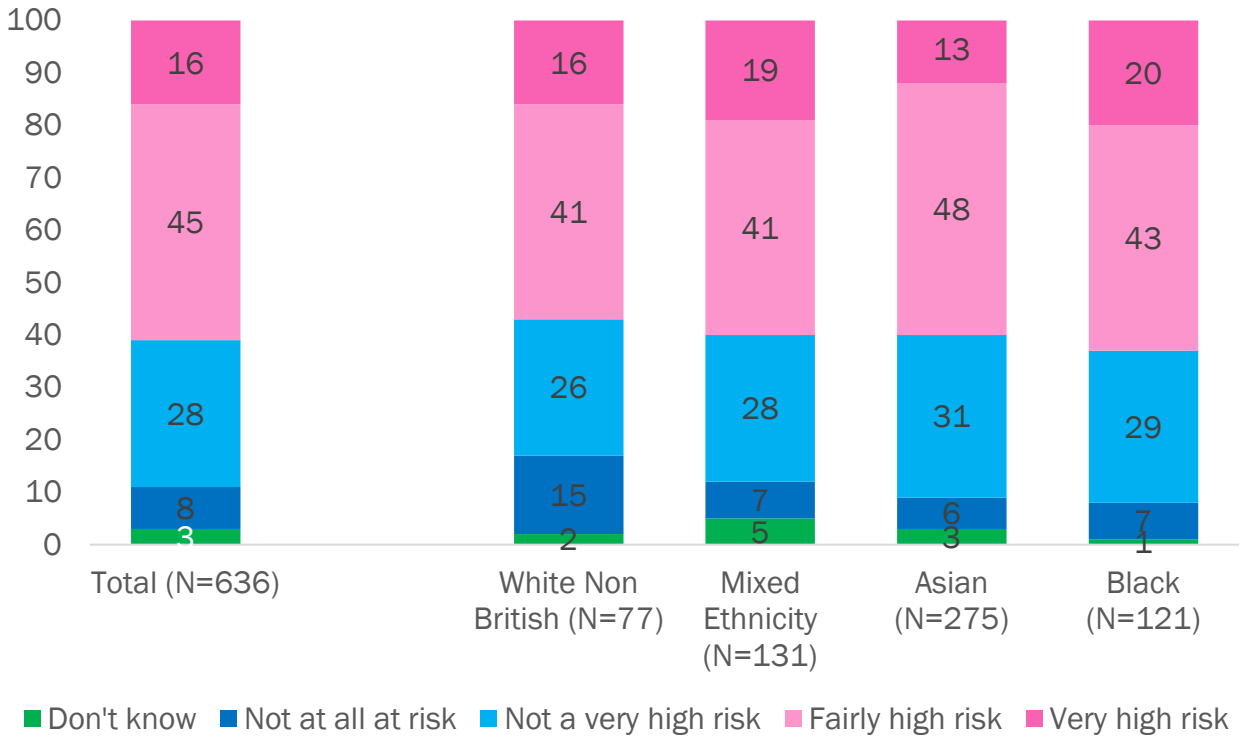



There was a relationship between fear of the disease and vaccine acceptance.

*Rejecters* of the vaccine had the least fear of COVID, with acceptors having a the highest level of fear.

**Q Where 0 is not at all fearful and 10 is extremely fearful. How fearful are you about catching the disease?**
Base: all respondents (N=636).

# Perceived risk to impact of COVID-19

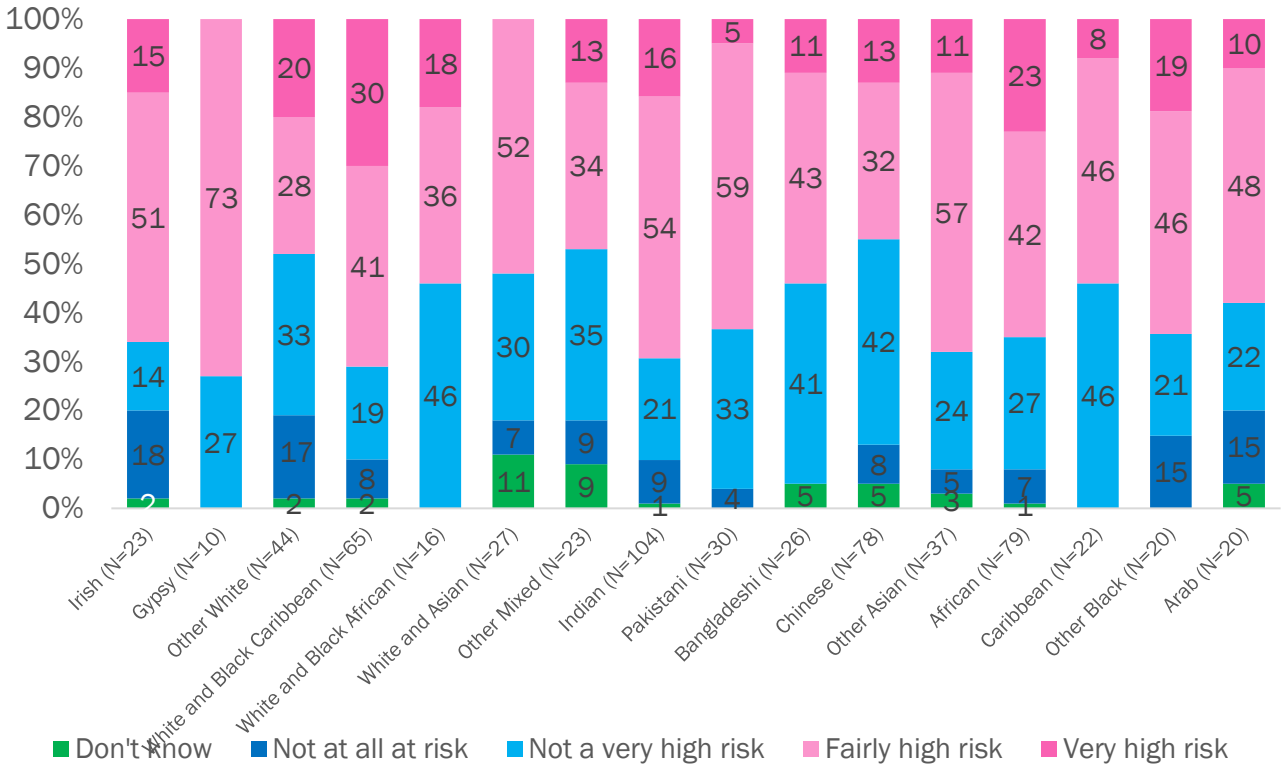



The majority of the sample felt that they were at either a *fairly high* (45%) or *very high* risk (16%) of the impact of COVID.

There was only minor variation by broad ethnic groups, although top box score was slightly lower amongst Asian groups.

**Q. Which of the following statements best describes how at risk you think you personally are to the impact of COVID-19?**
Base: all respondents (N=636).

# Perceived risk to impact of COVID-19



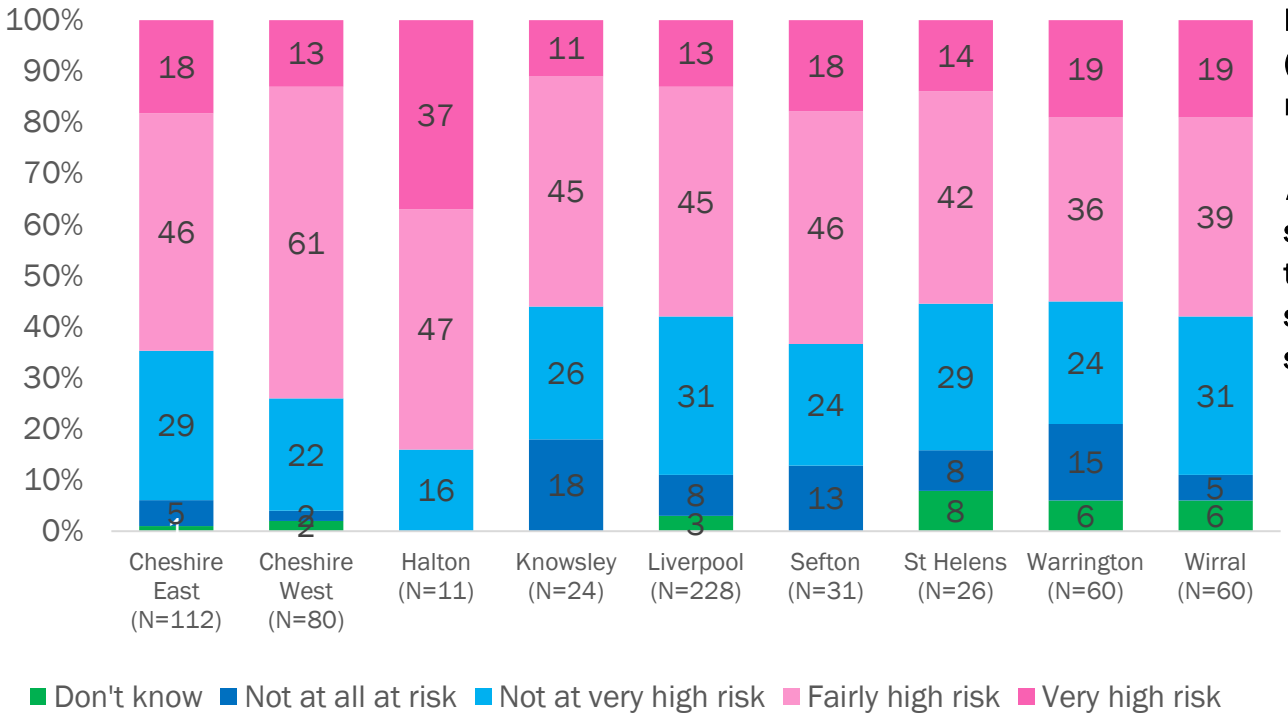

Interpretation by specific ethnic groups must be treated as indicative due to low base sizes.

Top two box scores were highest, amongst: *White and Back Caribbean, Gypsy* and *Indian*. (*White and Black Caribbean* respondents were also the most fearful of the disease.)

The *Chinese* community felt less at risk than other groups.

**Q. Which of the following statements best describes how at risk you think you personally are to the impact of COVID-19?**
Base: all respondents (N=636).

# Perceived risk to impact of COVID-19

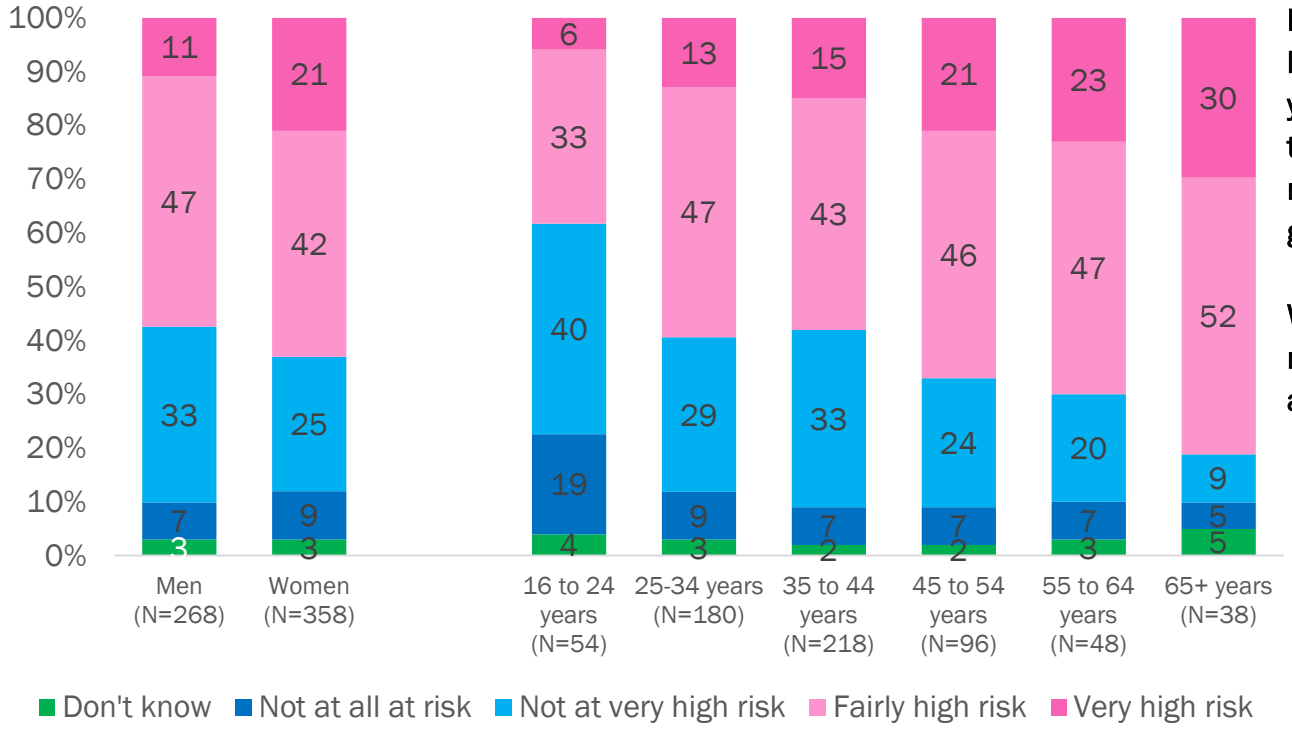



Respondents in both *Cheshire* (*East* and *West*) Places felt the most at risk to COVID.

*Halton* and *Sefton* also had slightly higher risk perceptions than average, but low base sizes means that these data should be treated cautiously.

**Q. Which of the following statements best describes how at risk you think you personally are to the impact of COVID-19?**
Base: all respondents (N=636).

# Perceived risk to impact of COVID-19

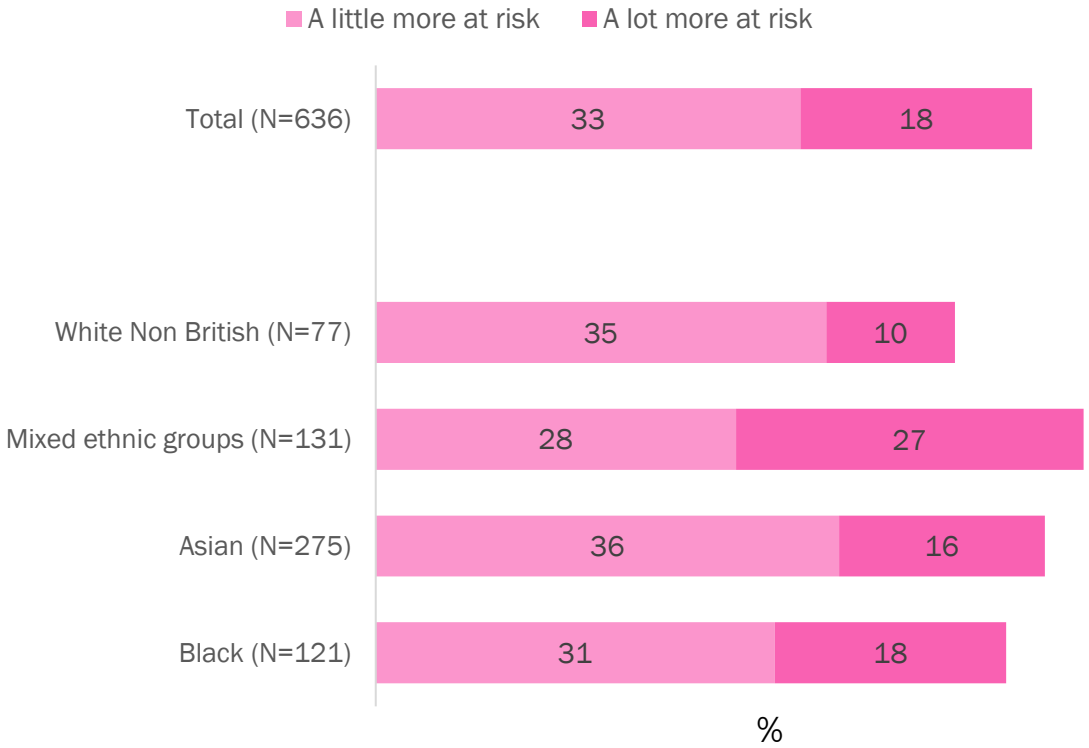



Perceived risk increases linearly with age, with the 65+ year old group perceiving themselves to be markedly more at risk than other age groups.

Women felt more at risk than men, with a top box score almost double that of men.

**Q. Which of the following statements best describes how at risk you think you personally are to the impact of COVID-19?**
Base: all respondents (N=636).

# Relative risk of COVID compared to others

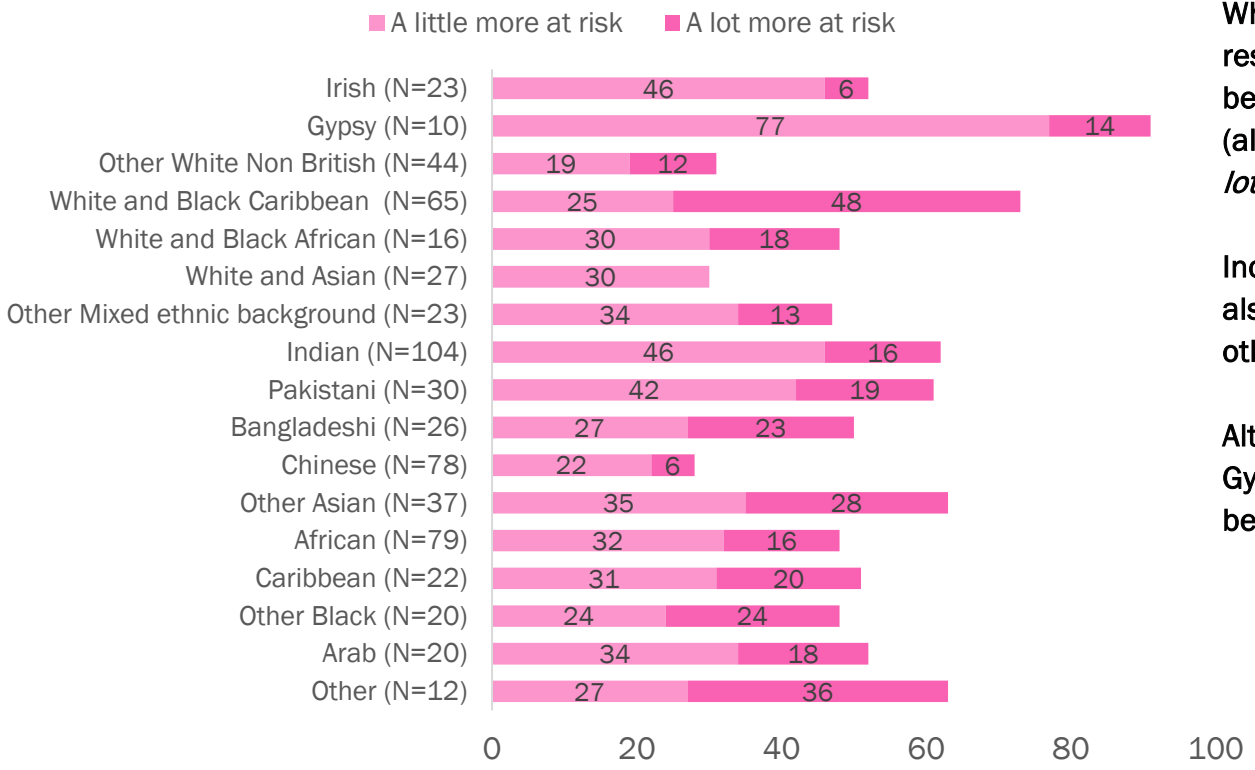



Overall half (51%) of those in ethnic communities thought that they were more at risk of COVID than most other people.

Those in mixed ethnic groups felt that they have a higher risk, with over a quarter (27%) perceiving themselves to be *a lot more* at risk than others.

**Q. Do you consider yourself to be more at risk to the impact of COVID-19 than most other people?**
Base: all respondents (N=636).

# Relative risk of COVID compared to others



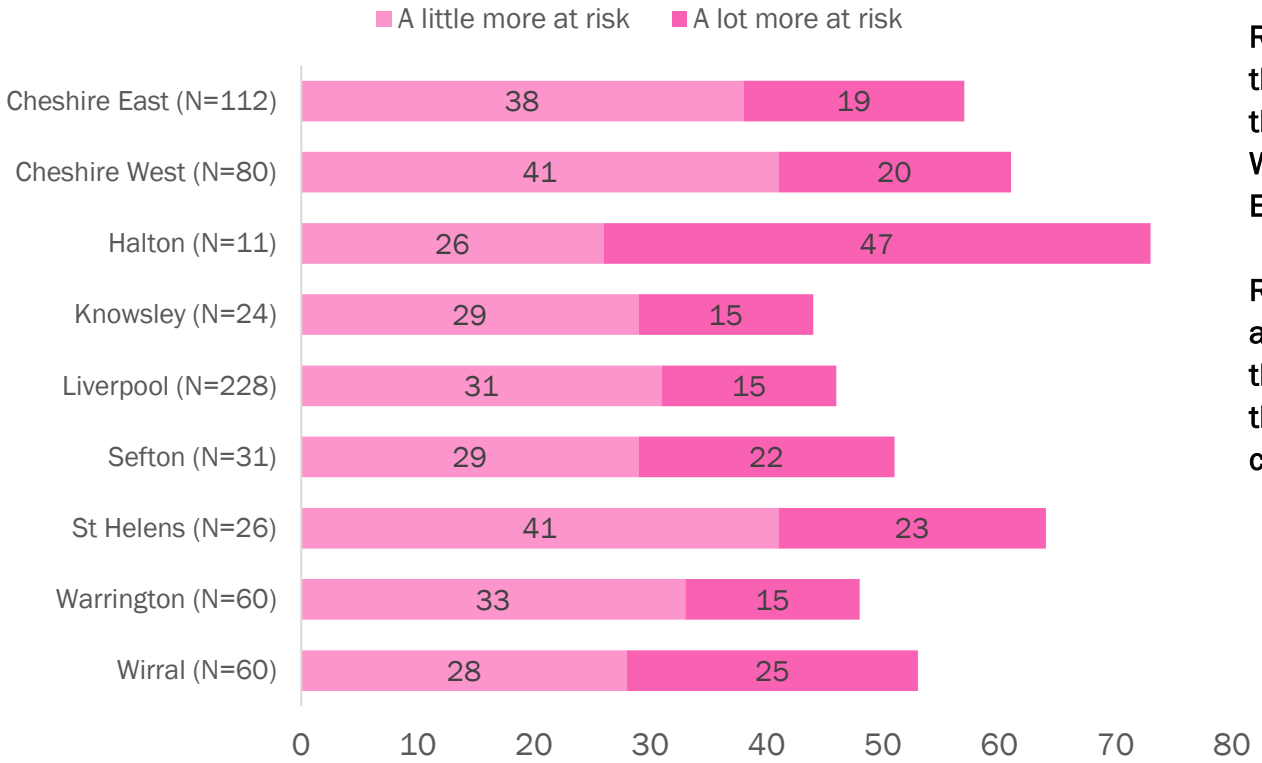

White and Black Caribbean respondents perceived themselves to be at a higher risk than other groups (almost half thought that they were *a lot more at risk* than other groups).

Indian and Pakistani respondents also felt themselves at more risk than others.

Although on a very low base size, Gypsy respondents feel themselves to be at the highest risk of all groups.

**Q. Do you consider yourself to be more at risk to the impact of COVID-19 than most other people?**
Base: all respondents (N=636)

# Relative risk of COVID compared to others

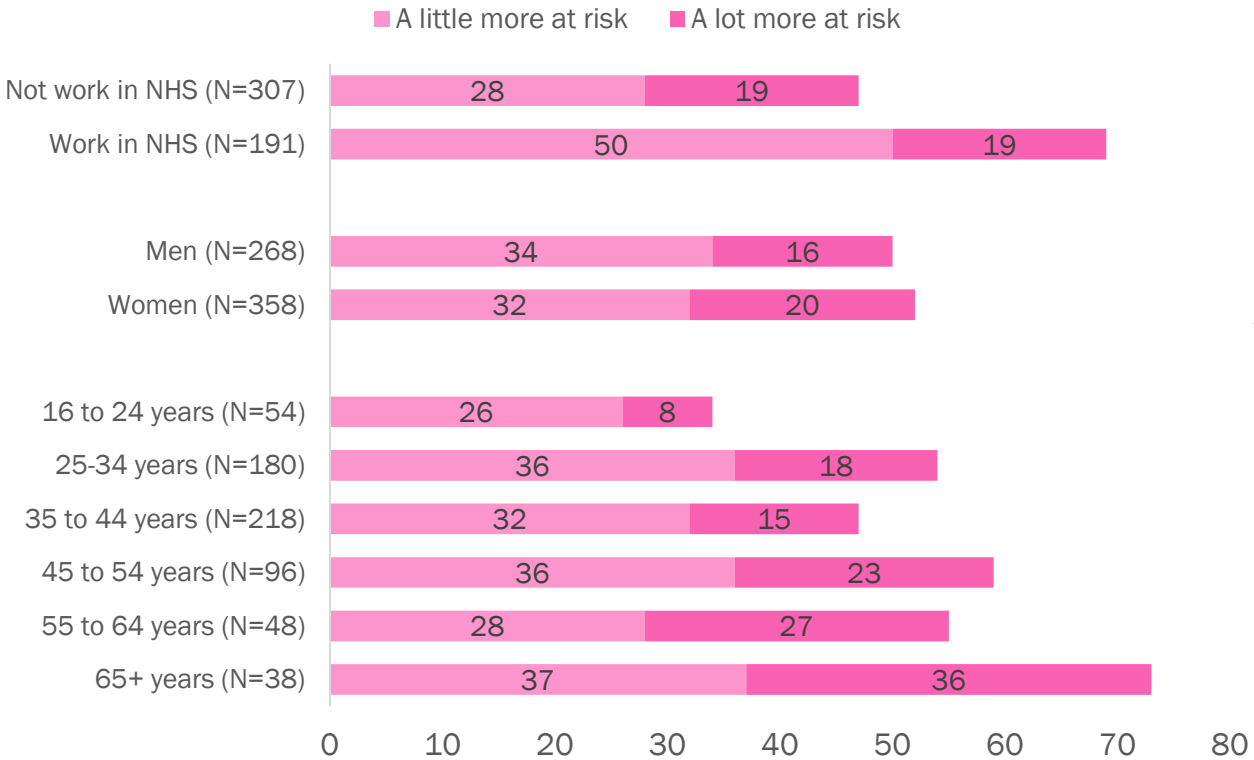



Respondents in Cheshire perceived themselves to be at slightly higher risk than those in other Places (Cheshire West, 61% more at risk; Cheshire East, 57%).

Respondents in Halton and St Helens also felt that they were more at a risk than others, but low base sizes means that these data should be treated cautiously.

**Q. Do you consider yourself to be more at risk to the impact of COVID-19 than most other people?**
Base: all respondents (N=636)

# Relative risk of COVID compared to others



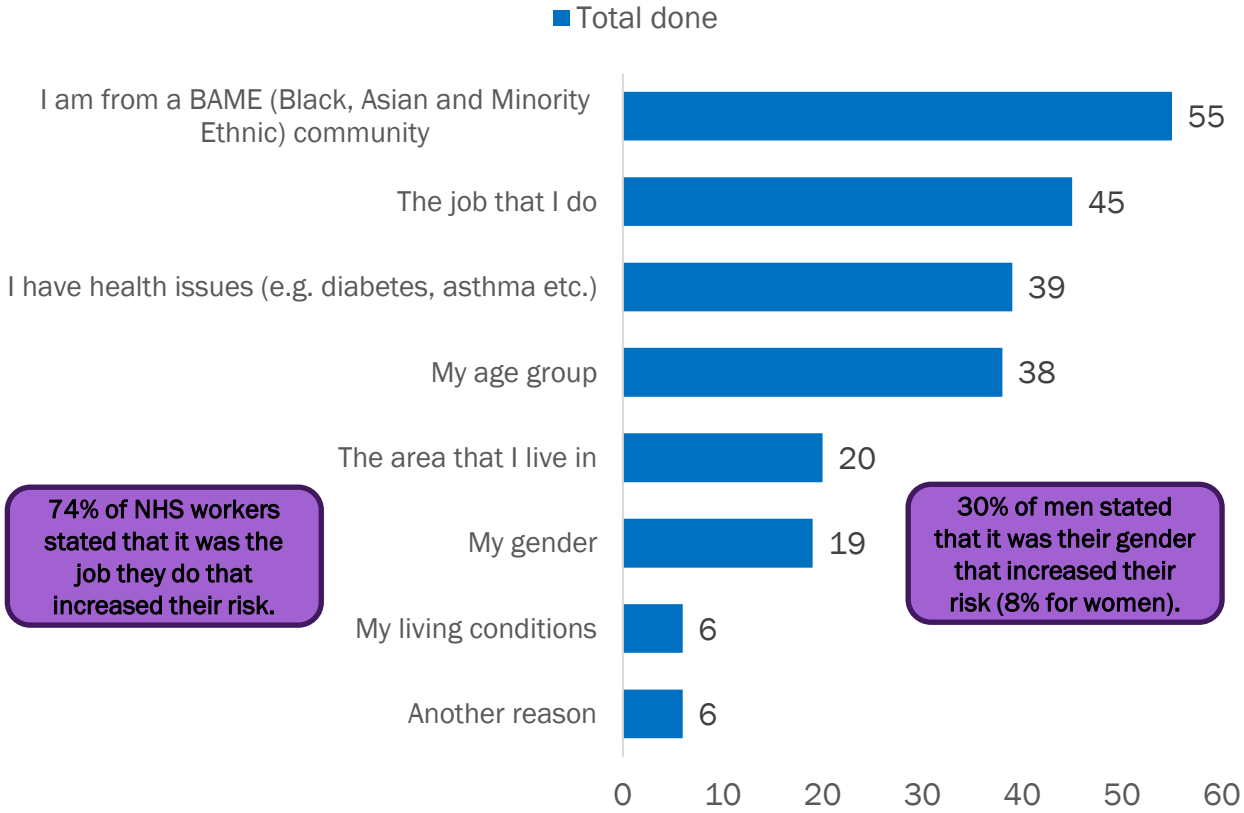

Perceptions of relative risk are broadly similar between the ages of 25 years and 64 years.

Perceptions of risk then increased sharply at 65 or more years.

Younger respondents felt at the least risk. However, a third (34%) of the ethnic population aged 16-24 years still felt that they were more at risk than *most other people*.

**Q. Do you consider yourself to be more at risk to the impact of COVID-19 than most other people?**
Base: all respondents (N=636).

# Reasons why more at risk than others




74% of NHS workers stated that it was the job they do that increased their risk.

30% of men stated that it was their gender that increased their risk (8% for women).

**Q. Please indicate which, if any, of these reasons describe why you feel that you are more at risk?**
Base: all respondents feel that they are more at risk from COVID-19 (N=333).

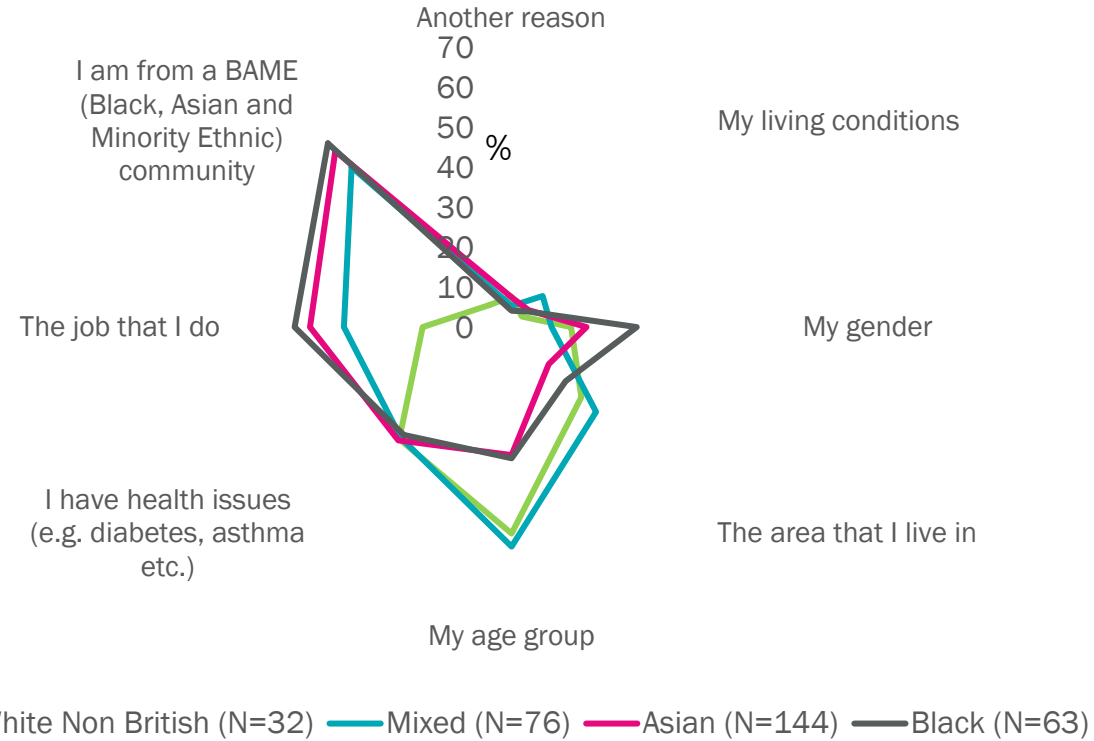
Perceptions of greater risk were driven by a wide range of different factors and not just membership of a ethnic group.

Notwithstanding this, the biggest perceived risk factor was membership of a ethnic group.

However, other factors, such as, *job*, *other health issues* and *age group* were commonly mentioned as a reason for perceptions of increased risk.

Men were more likely to see gender as a risk factor than women.

# Reasons for higher risk



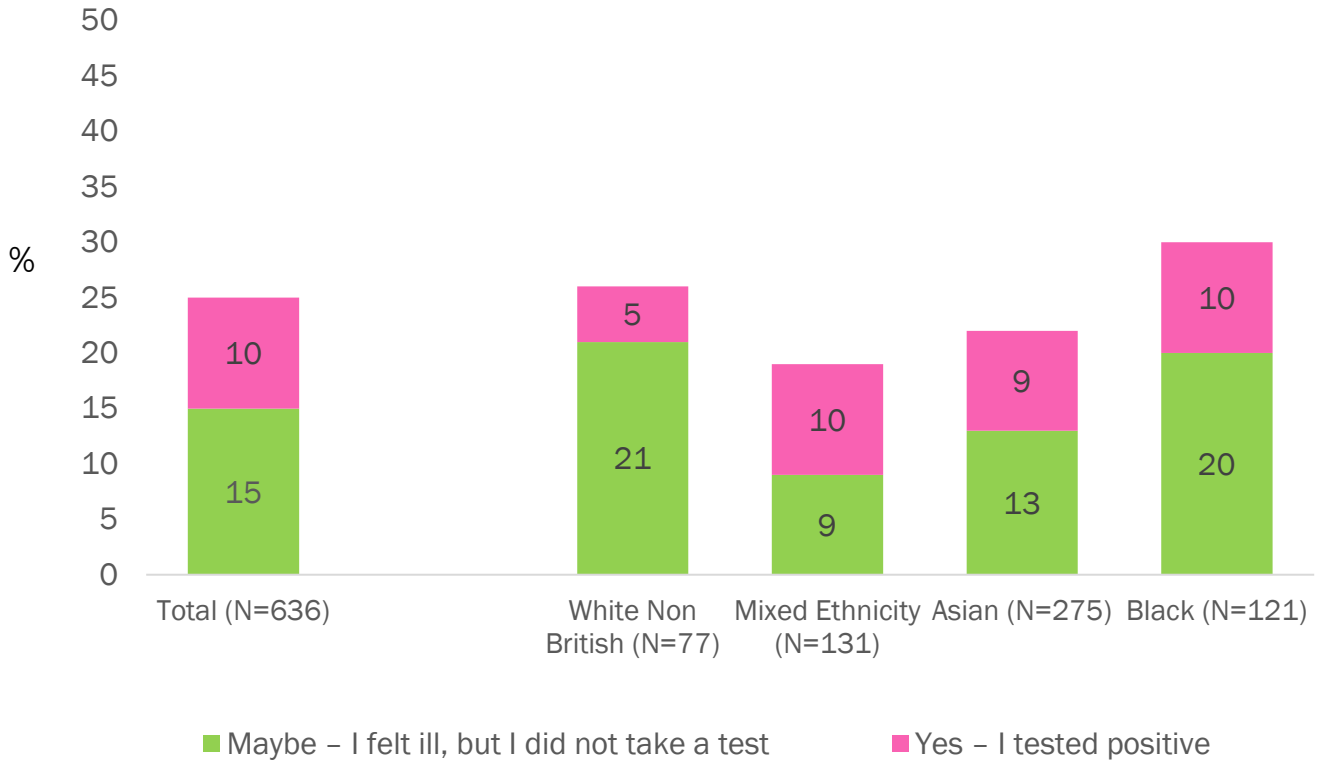

Being part of a ethnic community was the biggest perceived risk factor for COVID.

However, *White Non British* respondents were much less likely to state that being a member of a ethnic group was a driver of their increased risk (as many don't perceive themselves to be part of ethnic.). For this group, *health issues*, *age* and *where they live* were bigger risk factors.

Black and Asian respondents were the most likely to mention both their *membership of a ethnic group* and *the job that they do* as reasons for their increased risk.

**Q. Please indicate which, if any, of these reasons describe why you feel that you are more at risk?**
Base: all respondents feel that they are more at risk from COVID-19 (N=333).

# Whether had COVID-19



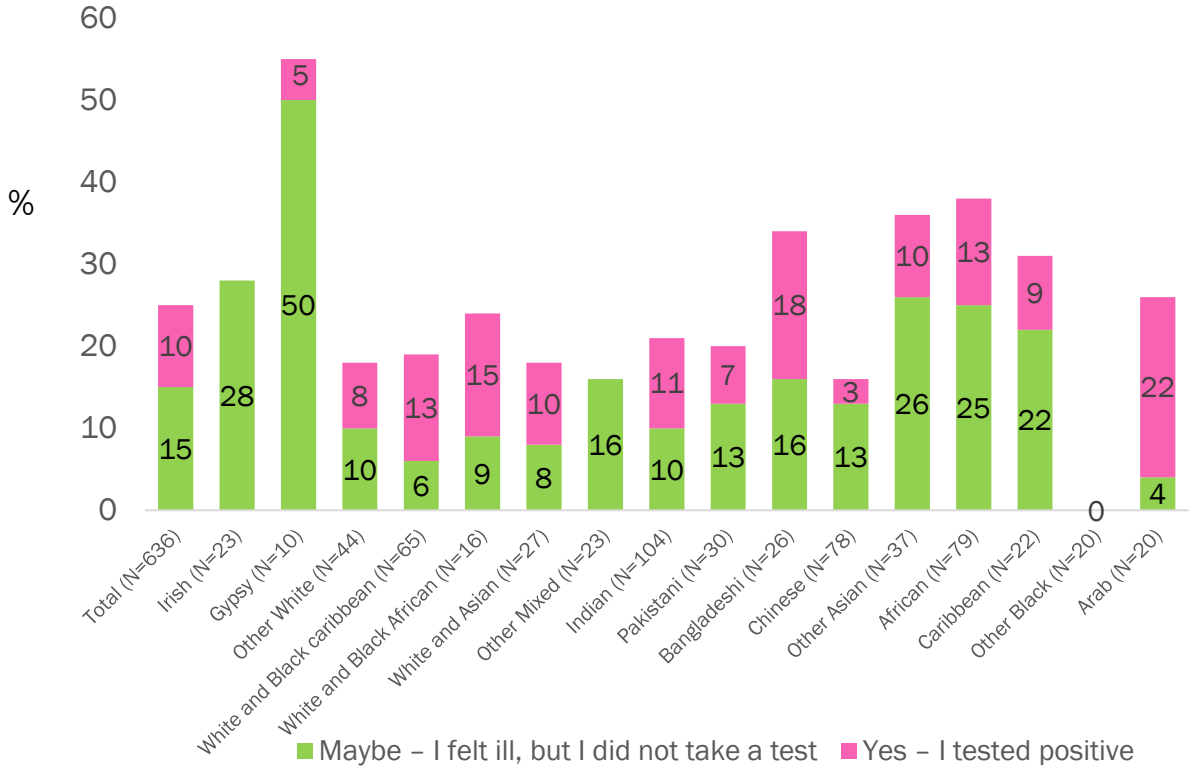

In total, a quarter of the sample thought that they had had COVID. However, 15% thought they *have had it but didn't take a test*.

Those in Black ethnic groups were more likely to think that they have had COVID.

A fifth of those in White Non British and Black ethnic groups claimed that they may have had COVID, but had not taken a test. This could mean that these groups are less likely to seek a test than other groups.

**Q. Have you had COVID-19?**
Base: all respondents in sub-group.

# Whether had COVID-19



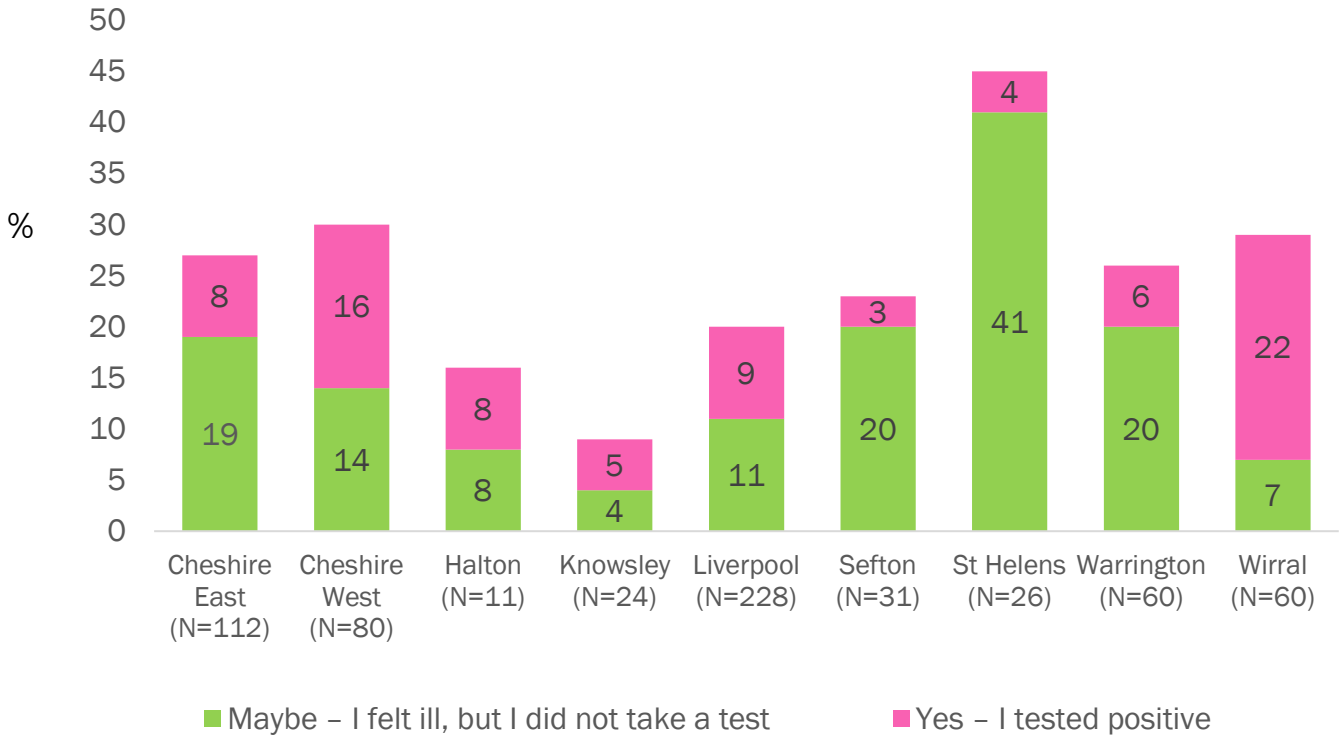

The data suggest that a lot of people thought that they had COVID without it being confirmed by a test (15%).

Irish, Gypsy, African, Caribbean, Bangladeshi and other Asian respondents had the high claimed levels of illness from COVID without a test.

This could suggest that there are barriers to taking a COVID test.

**Q. Have you had COVID-19? ?**
Base: all respondents in sub-group.

# Whether had COVID-19

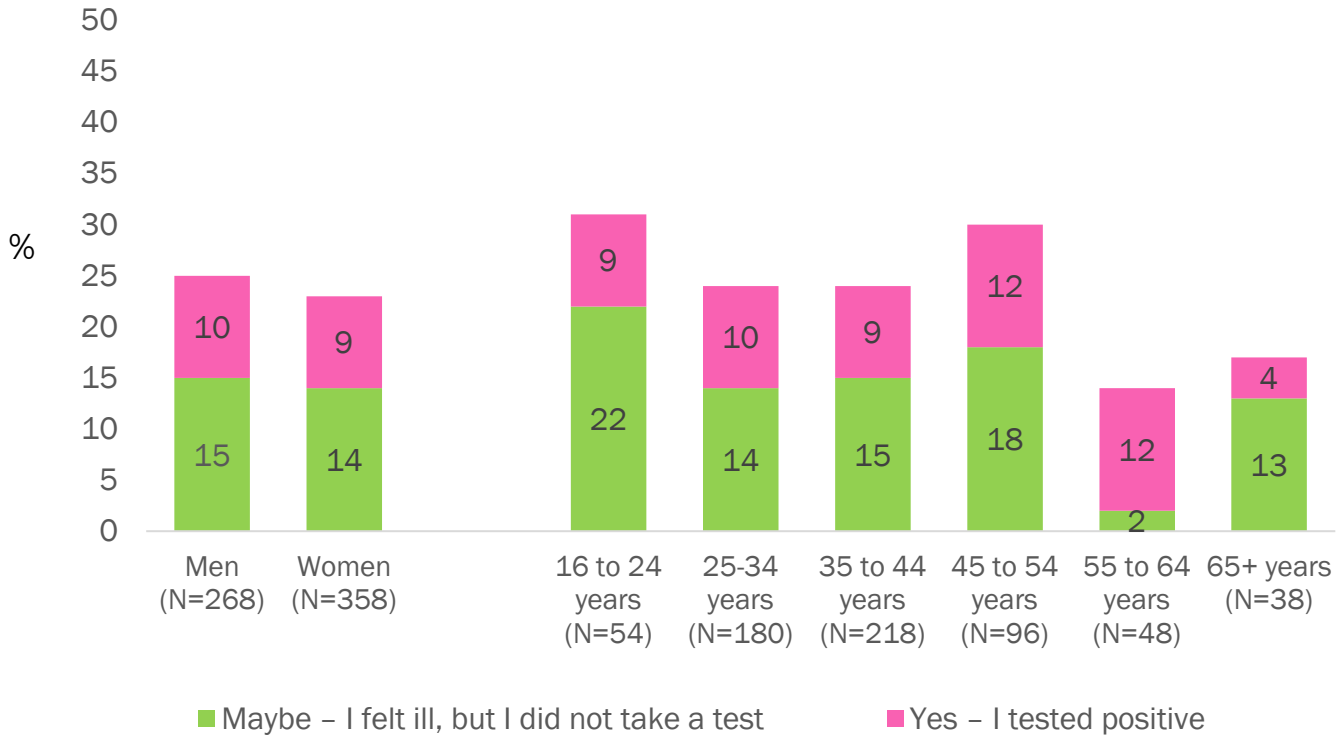



While base sizes are low in some areas there is a lot of variation by area in terms of who has had COVID-19.

A high proportion of those in Wirral (over a fifth) claimed to have been tested positive for COVID (this could be due to more NHS workers in the Wirral sample).

**Q. Have you had COVID-19?**
Base: all respondents in sub-group.

# Whether had COVID-19



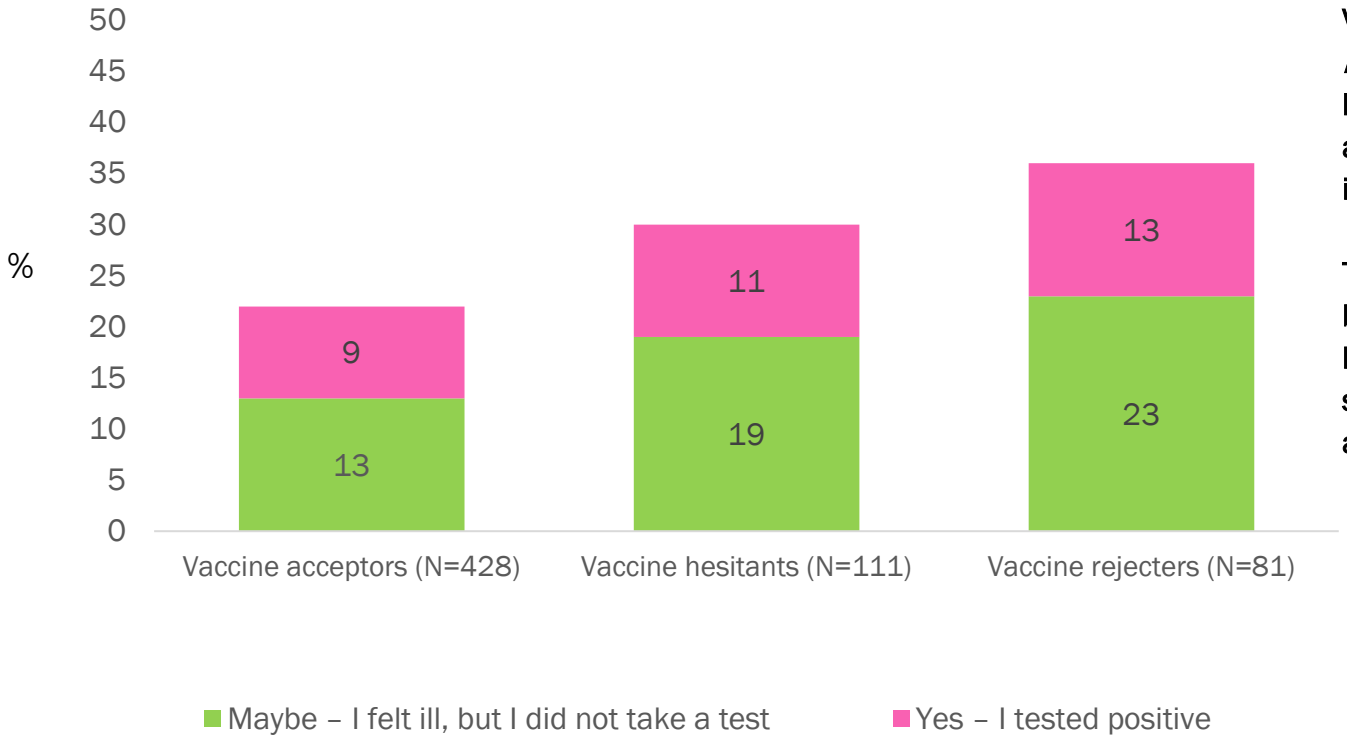

Q. Have you had COVID-19?
Base: all respondents in sub-group.

Up until age 55 years, there were only marginal differences in terms of who has had a positive test by age.

Younger respondents (16-24 years) were most likely to think that they had had the disease without being tested. (It is possible that this age group is less likely to take a test even if feeling ill.)

In contrast, the 55-64 year old age group was much less likely to feel that they had had COVID without having the test – this could suggest that this age group is most likely to get tested when feeling ill.

# Whether had COVID-19

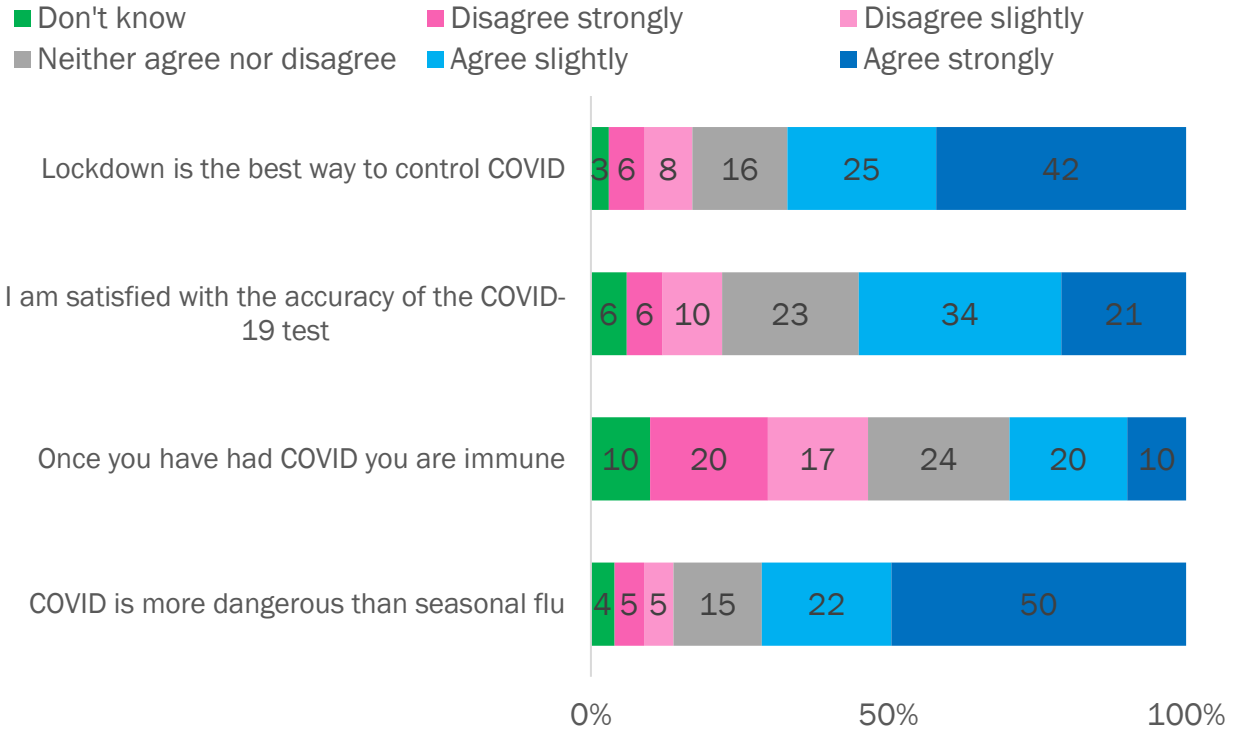



Vaccine *hesitants* and vaccine *rejecters* were much more likely to think that they had already had the disease (even if they hadn't been tested).

This could be a potential driver behind their rejection or hesitancy of the vaccine as some already think that they are immune.

**Q. Have you had COVID-19?**
Base: all respondents in sub-group.

# Attributes: COVID




There was strong agreement that *COVID is more dangerous than seasonal flu*.

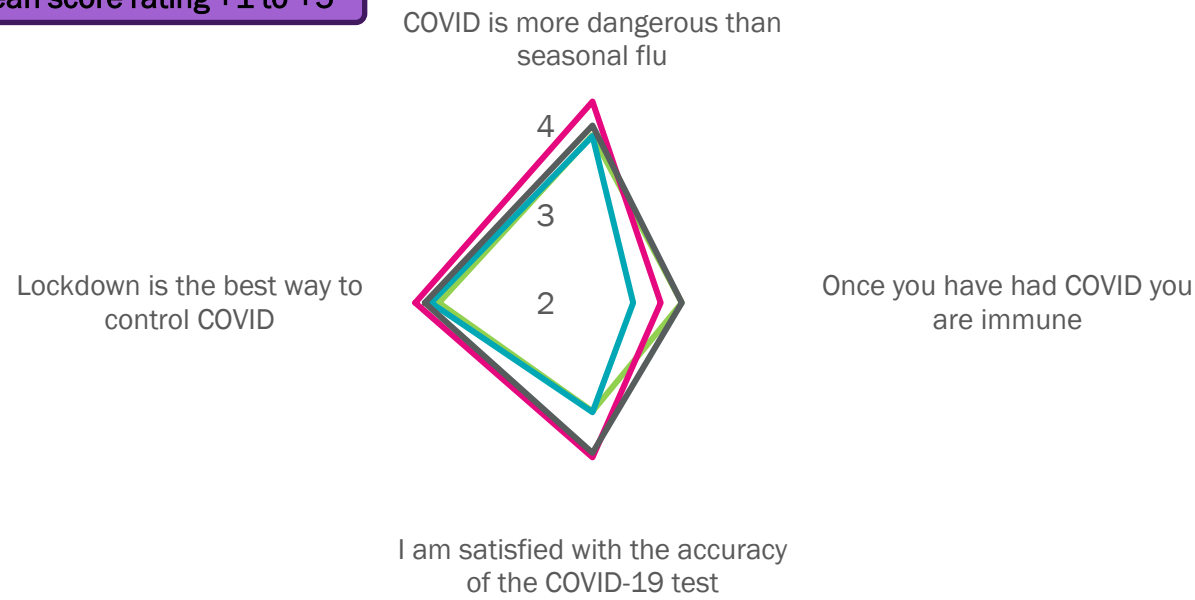
Most were satisfied with the *accuracy of the COVID test*, although one in six (16%) were not.

Opinion was polarised on *immunity once had COVID*: a third (30%) thought that you were and just over a third (37%) thought that you were not.

**Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?**
Base: all respondents (N=636).

# Attributes: COVID

Mean score rating +1 to +5

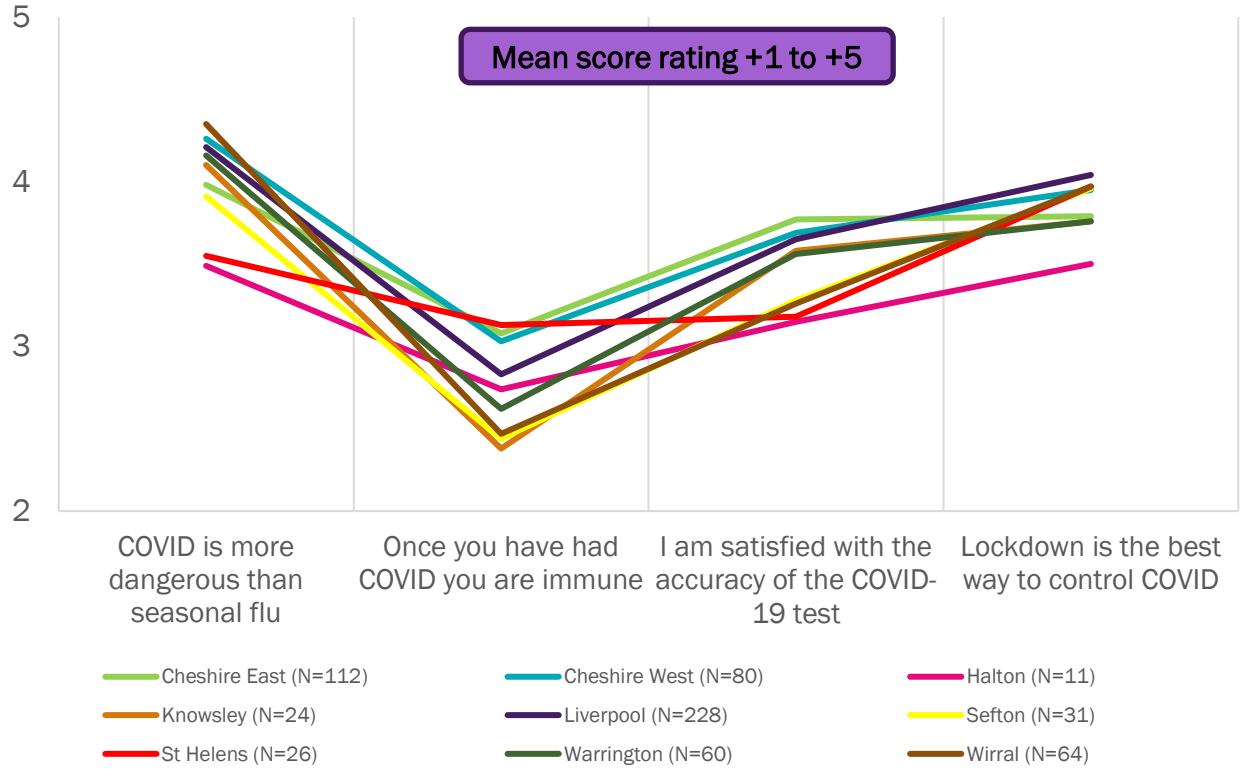



Mixed ethnic group and White Non British were the least satisfied with the *accuracy of the COVID test*.

Mixed ethnic groups were also less likely to think that *once you have had COVID you are immune.*

**Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?**
Base: all respondents (N=636).

# Attributes: COVID



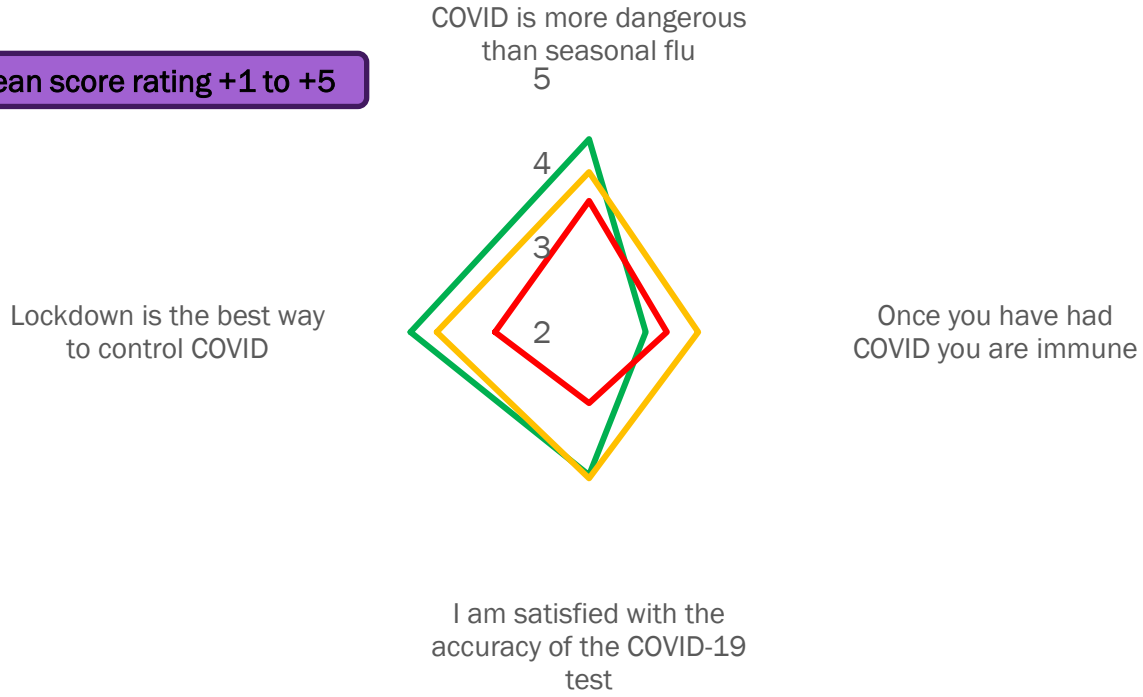

Respondents in St Helens and Halton were the least likely to think that *COVID is more dangerous than seasonal flu* (albeit on low base sizes).

St Helens and Halton respondents were least likely to be satisfied with the *accuracy of the COVID test.*

**Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?**
Base: all respondents (N=636).

# Attributes: COVID

Mean score rating +1 to +5



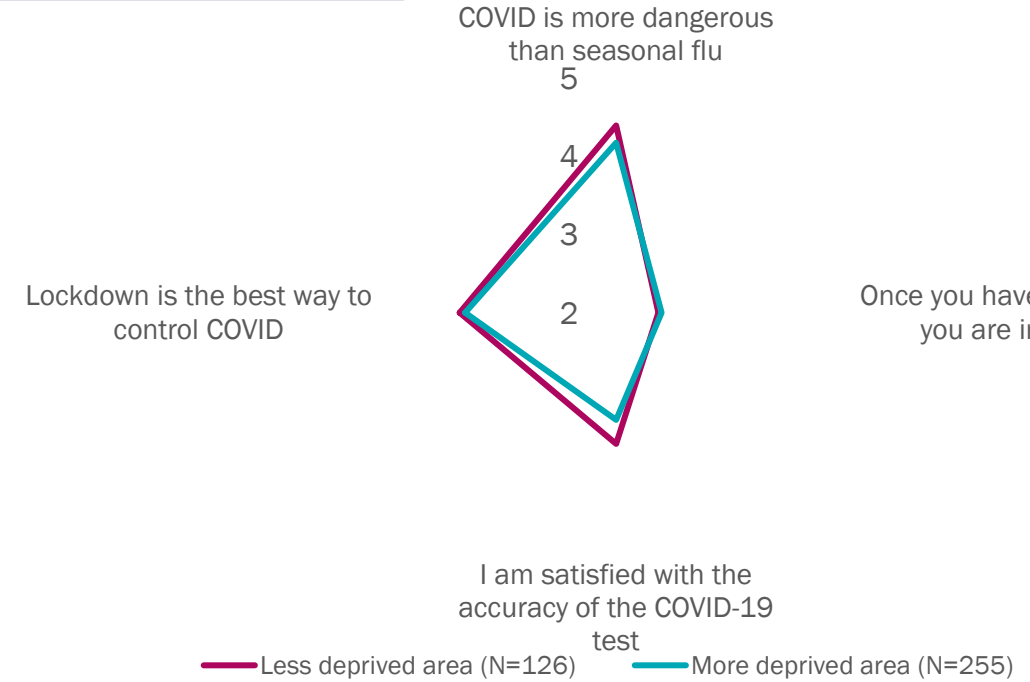

*Vaccine hesitants* were more likely than *rejecters* and *acceptors* to agree that *once you have had COVID you are immune*.

From a previous chart, 30% of *hesitants* thought that they had already had the disease. It is therefore possible that perception of immunity is one of the drivers behind their hesitation towards receiving the vaccine.

**Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?**
Base: all respondents (N=636).

# Attributes: COVID

Mean score rating +1 to +5




Opinions about COVID were broadly similar by areas of deprivation.

However, those from higher deprivation areas were slightly less likely to agree that they were *satisfied with the accuracy of the COVID test*. This group were also slightly less likely to be compliant on getting a COVID test and these attitudes may be related.

**Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?**
Base: all respondents (N=636).

# Experience of COVID

## Key highlights

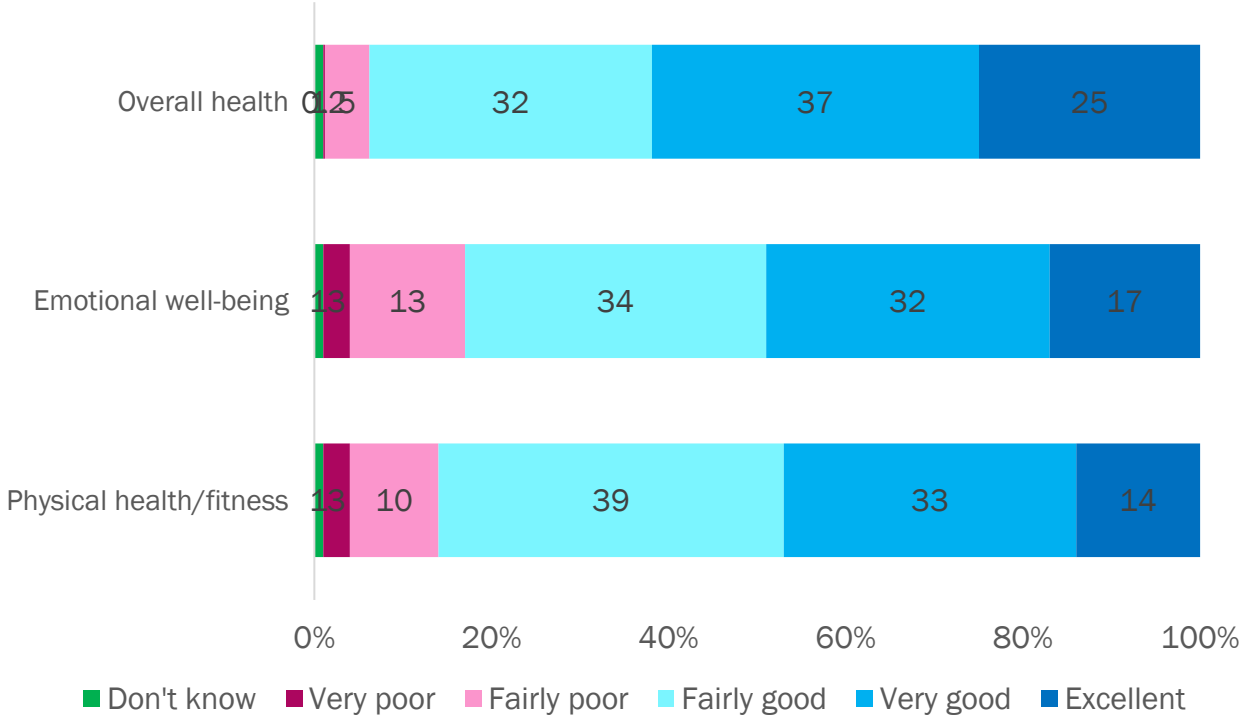
- There was a relatively high fear of the disease, with over a fifth being extremely fearful. Fear increased with age, with almost half of all those age 65 years or more being extremely fearful.
- Over half thought that they were more at risk than most other people and being a member of a BAMR group was perceived to be the biggest risk factor..
- A large proportion (30%) agreed that *once you have had COVID you are immune*. This opinion could impact take up of the vaccine as vaccine *hesitants* were particularly likely to agree with this statement.
- One in ten (10%) of the sample had suffered from COVID and had it confirmed by a test. A further 15% thought that they might have had it, but didn't get tested; this suggests that there could be barriers to getting tested. This also suggests that there could be a large number of people who think that they have immunity.

Experience of COVID KEY POINTS

Cheshire and Merseyside
Health and Care Partnership

# Impact of COVID on access to health

# Rating of aspects of overall health



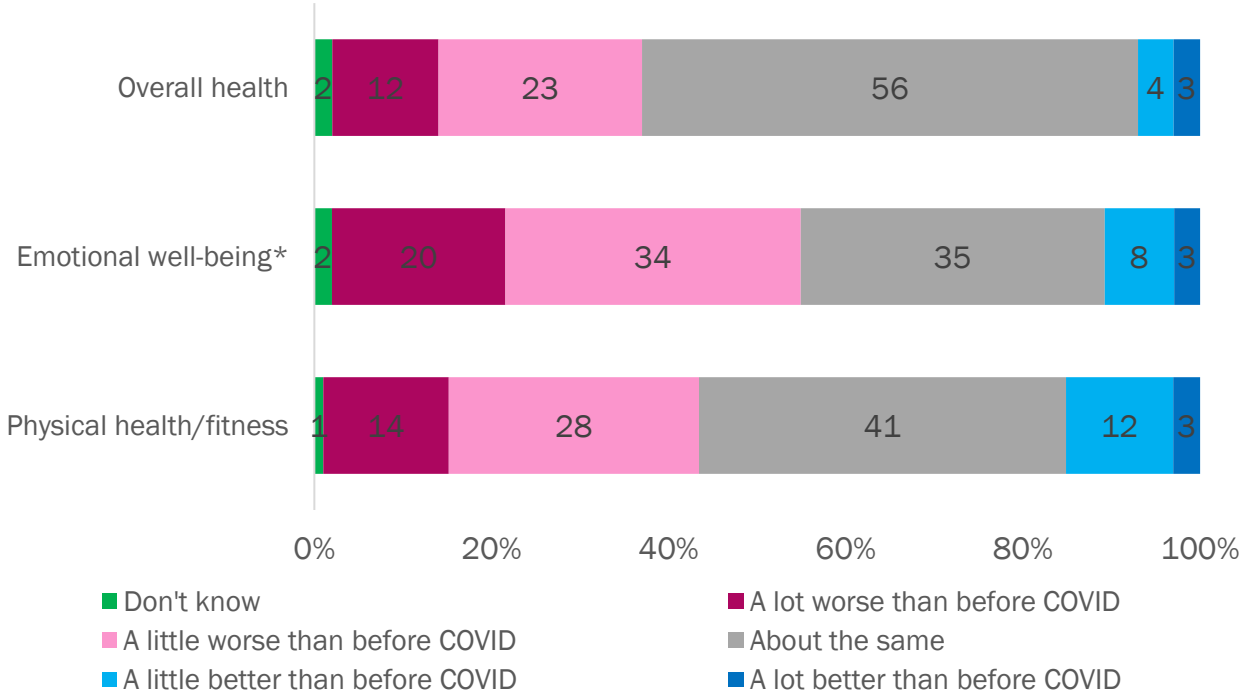

Overall health was reasonably good, with almost two thirds providing a top two box score and very few rated their overall health as *poor (very or fairly poor)*.

However, one in six (16%) rated their *mental health* as being poor, this suggests that a large number of people in the total ethnic population are currently suffering from poor mental health.

We do not have comparable data on this question taken before COVID so we do not have a benchmark to compare these results against.

**Q. Which of these statements best describes the following aspects of your health at the moment?**
Base: all respondents (N=636).

# Impact of COVID on overall health




Compared to before COVID, all aspects of health have declined markedly for a large proportion of respondents.

Over half (54%) have seen a deterioration in their *emotional well-being*, with a fifth (20%) stating that it a *lot worse than before COVID*. This could have a major impact on family and community resilience going forward.

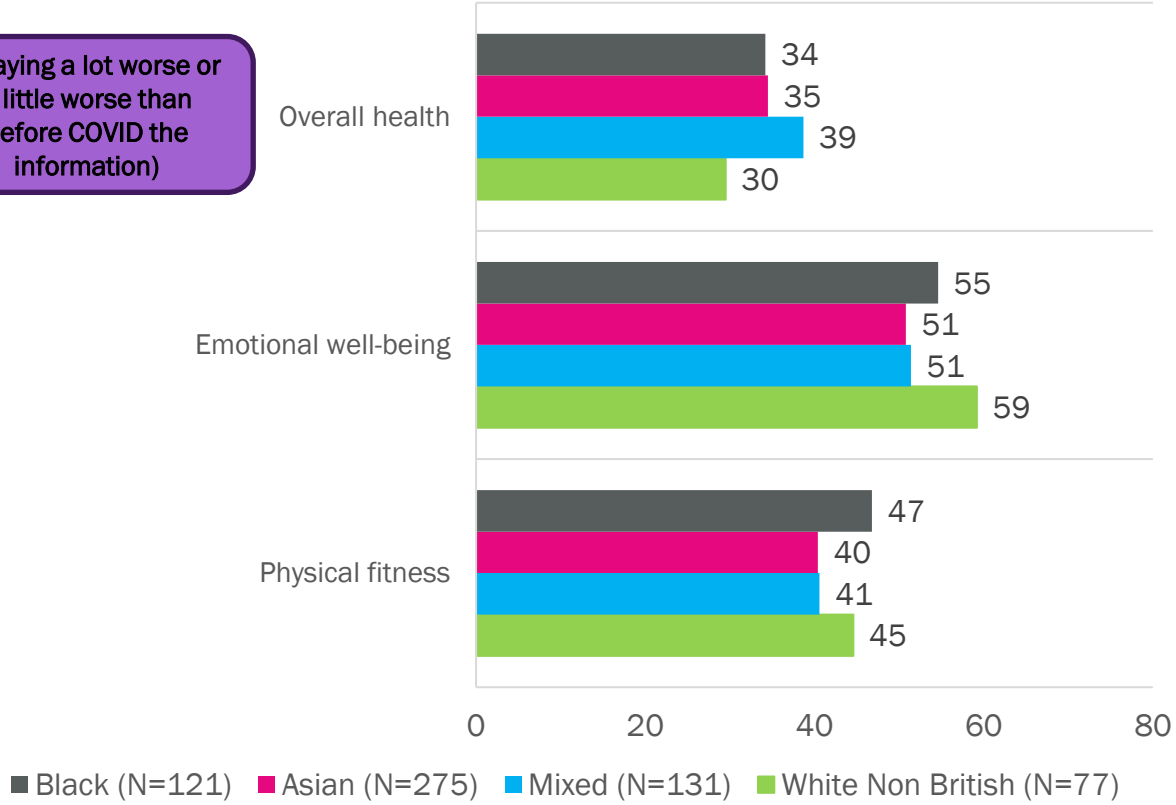
Four in ten (42%) have experienced a decline in *physical fitness* and a third (35%) a decline in *overall health*.

**Q. Which of the following statements best describes how you feel about the following aspects of your health now compared to before COVID?**
Base: all respondents (N=636).

*The term *emotional well-being* was used as it was felt it had less stigma than *mental health.*

# Impact of COVID on overall health

% saying a lot worse or a little worse than before COVID the information)



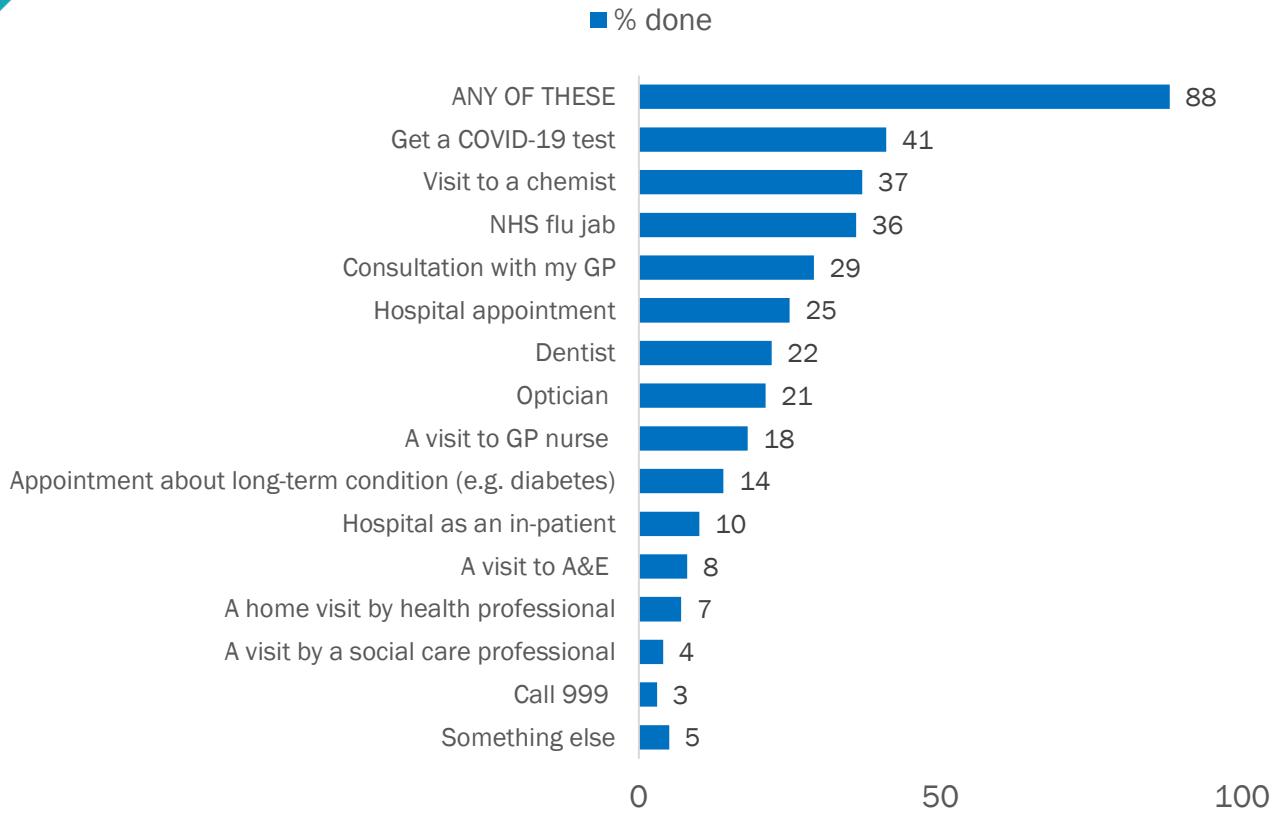

The health of all broad ethnic groups have been similarly affected.

There have been similar declines in overall aspects of health observed for all ethnic communities.

*The term *emotional well-being* was used as it was felt it had less stigma than *mental health.*

Q. Which of the following statements best describes how you feel about the following aspects of your health now compared to before COVID?
Base: all respondents (N=636).

# Health actions done in last 6 months



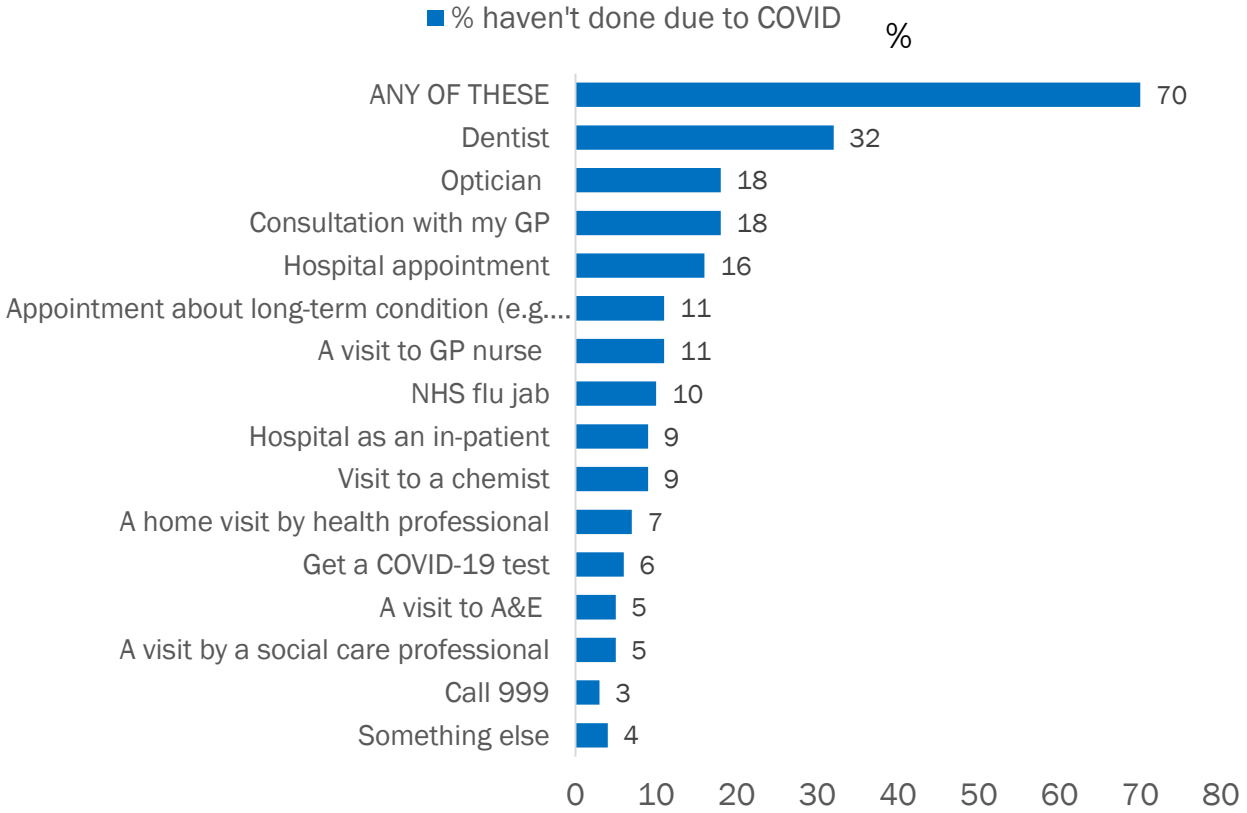

**Q. Which, if any, of these have you done in the past 6 months?**
Base: all respondents (N=636).

Nearly nine out of ten (88%) had completed some health action in the last six months.

Four out of ten (41%) had claimed to have had a *COVID test* and a third (36%) had received a *flu jab*.

Just under a third (29%) had had a consultation with a GP.

# Health actions needed but not done



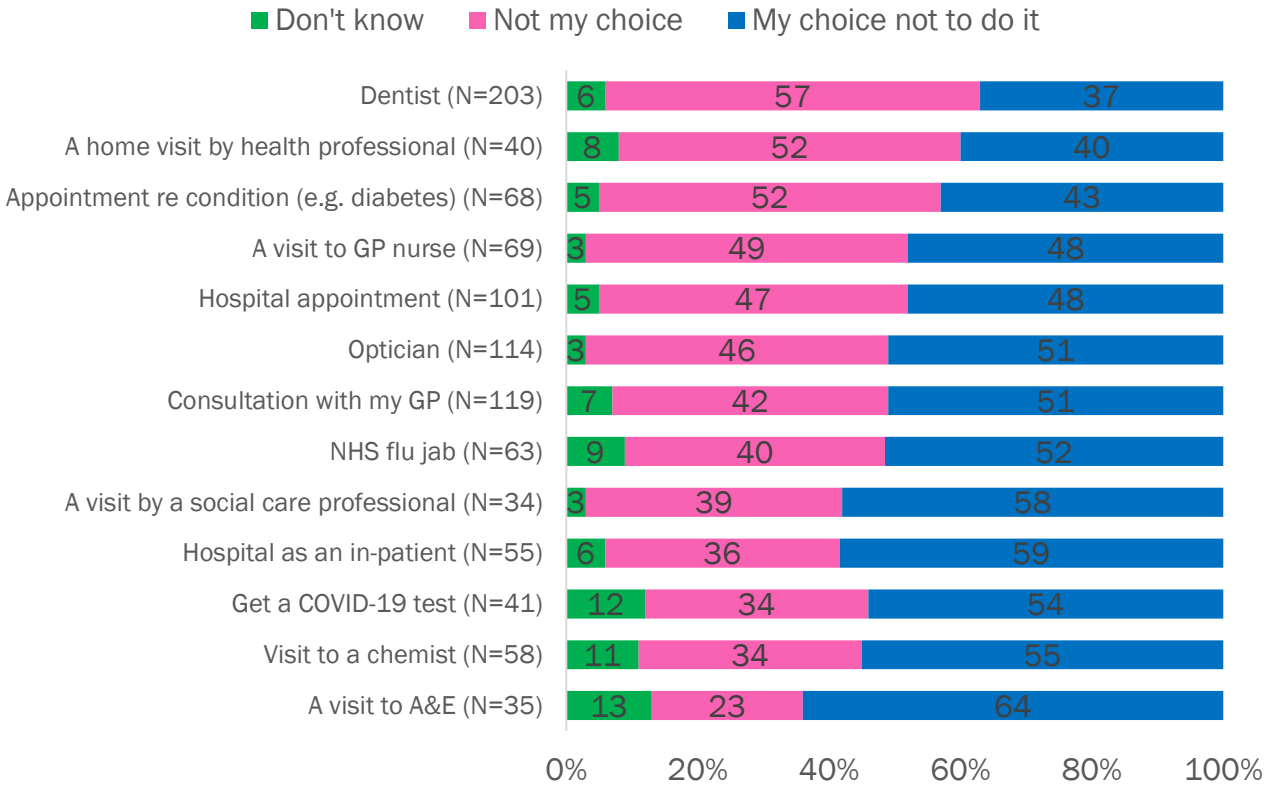

**Q. Which, if any, of these have you needed to do in the past 6 months, but for whatever reason didn't do because of COVID-19?**
Base: all respondents (N=636).

However, COVID has had a major impact on access to health care among the ethnic community.

Two thirds (70%) had needed but not done *any health action* as a result of COVID.

The impact has been particularly strong on *dentists visits* (32%) as well as *opticians* (18%), *GPs* (18%) and *hospital appointments* (16%).

# Health actions not done – driver of decision



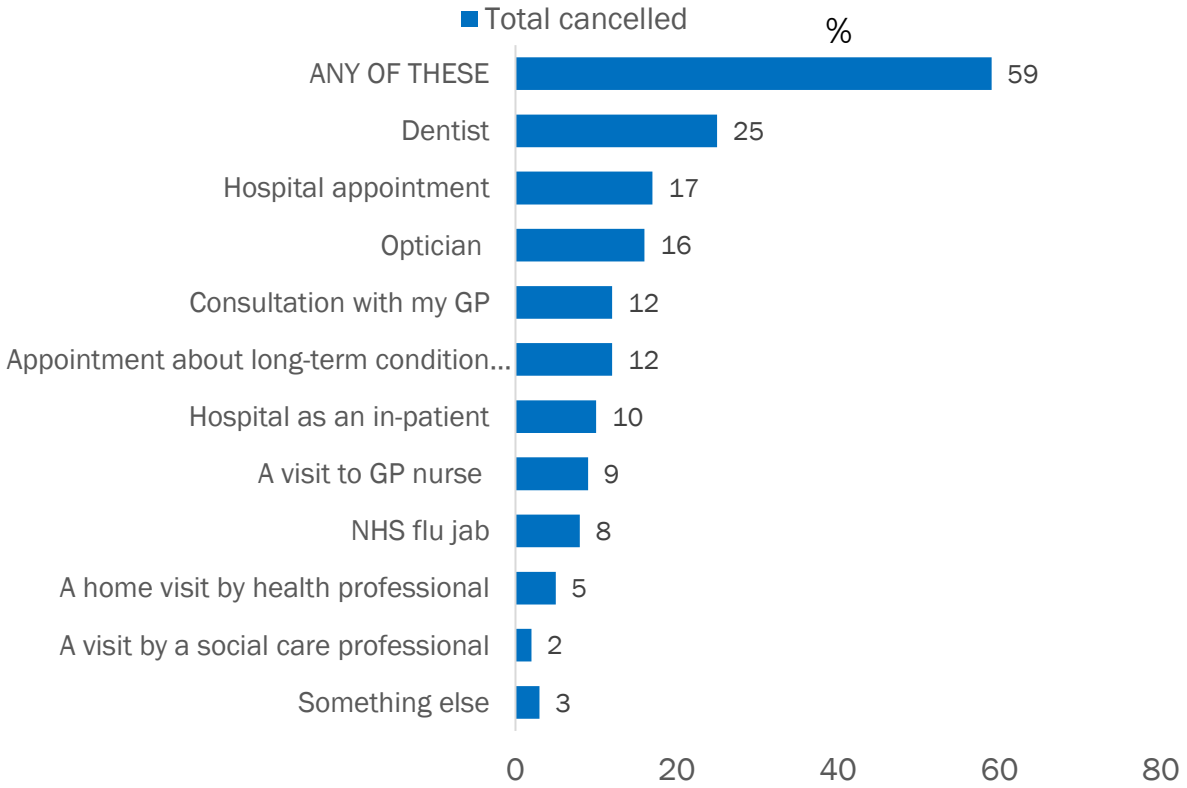

**Q. For each of the things that you didn't do, please tell us whether it was your choice NOT to do it?**
Base: all respondents (N=636).

Many of the health actions not done were the choice of the individual rather than the NHS. This strongly suggests that many people are altering their behaviour as a result of COVID.

For example, half (52%) of those who did not *get a flu jab* or *visit their GP* (51%) as a result of COVID, chose not to do it themselves.

The fact that 54% of those who did not get a COVID test chose not to get one suggests that there are barriers to getting a test among some.

# Health actions cancelled due to COVID-19



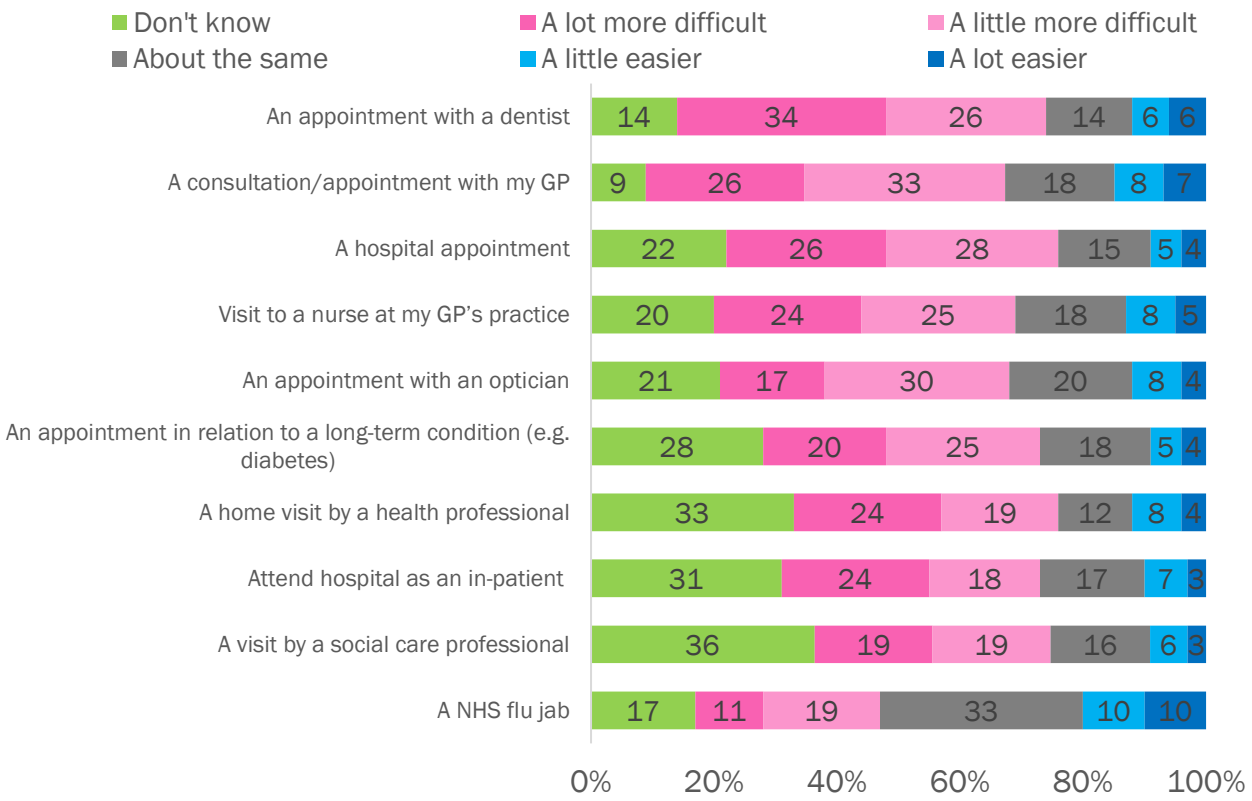

Three out of five (59%) of the ethnic community had a health action cancelled as a result of COVID.

A quarter (25%) had a *dental appointment* cancelled.

Cancelled *hospital appointments* were relatively common (17%) and one in eight had a visit to their GP (12%) cancelled.

**Q. Which, if any, of these have you had cancelled because of COVID-19?**
Base: all respondents (N=636).

# Perceived difficulty of accessing healthcare




Access to health services was perceived to have become more difficult during COVID.

Across all potential services, many more rated services as being *more difficult* to access because of COVID than *more easy*.

*Dentists* (60% more difficult) and *GP services* (59%) were perceived to have become *the most difficult to access*.

These data suggest that the message that *the NHS is open for business* has not been completely absorbed.

**Q. Compared to before COVID how easy or difficult do you think it is for you to access the following types of healthcare. It doesn't matter if you have needed this type of healthcare, it is your opinion we are interested in?** Base: all respondents (N=636).

# Impact of COVID on access to healthcare

## Key highlights

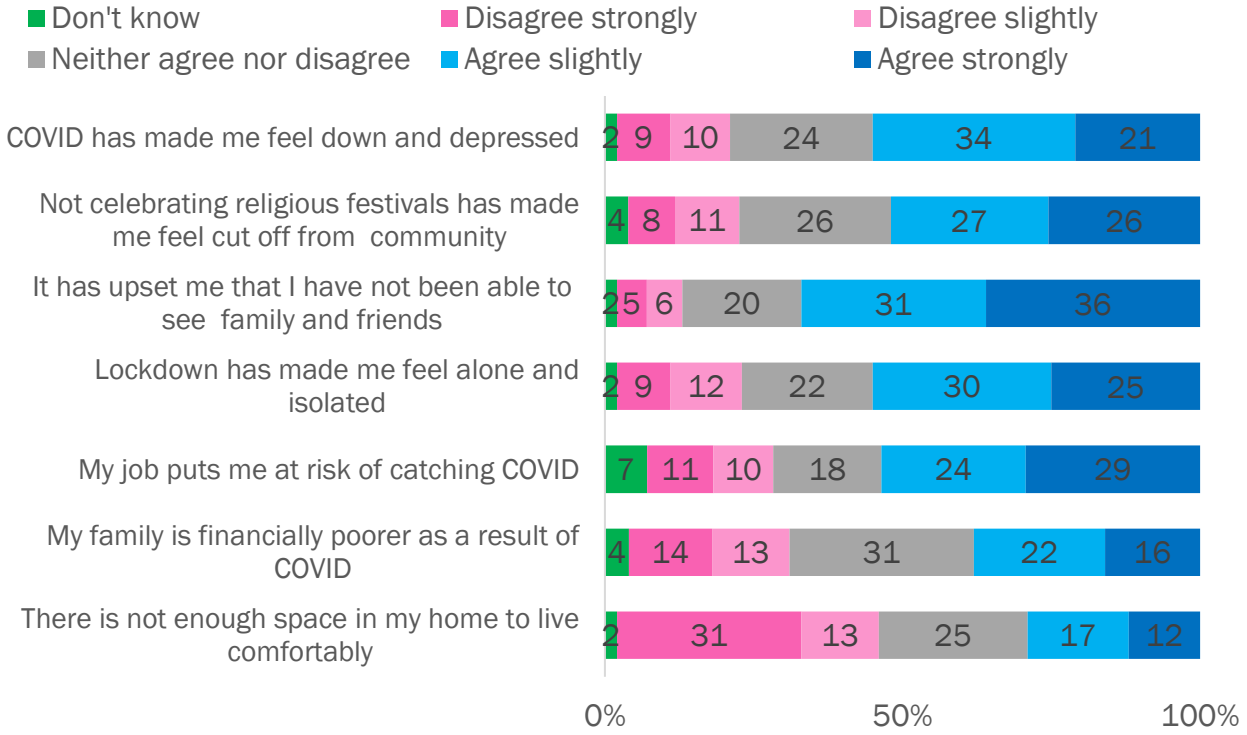
- All aspects of health have declined markedly during COVID, with declines strongest on emotional well-being (54% stated that their emotional well-being was worse than before COVID).
- Access to health services have declined, with many services not accessed and appointments cancelled.
- The impact of COVID has been strongest on visits to the dentist, opticians, GPs and hospital appointments.
- Many respondents made the choice themselves not to access healthcare services, suggesting that healthcare behaviours have changed in response to COVID.
- Many have not absorbed the message that the 'NHS has remained open' during COVID and there was a strong perception that it is more difficult to access health services than before COVID.

Impact of COVID on access to healthcare KEY POINTS

Cheshire and Merseyside
Health and Care Partnership

# Impact of COVID on personal life

# Attributes: personal attitudes




COVID has had a major impact across a range of different personal attributes.

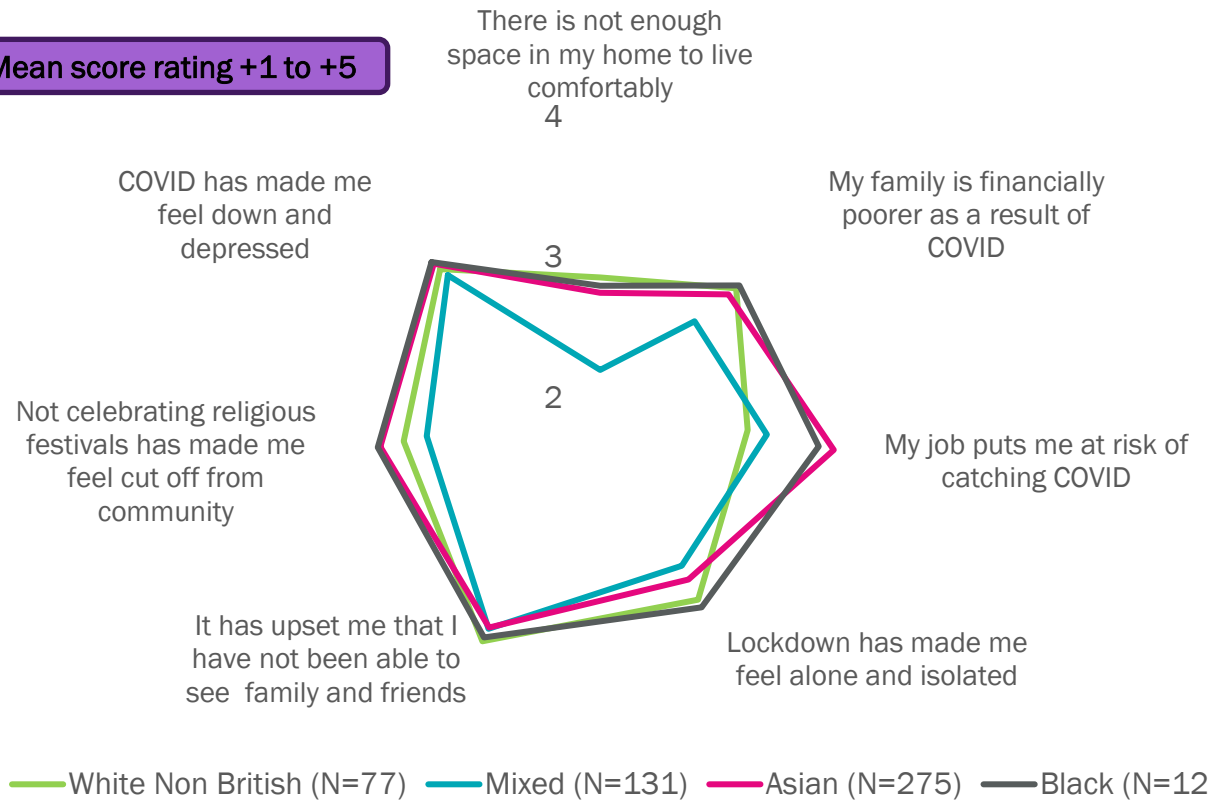
Over half agreed that they felt *down and depressed* (55%) and *alone and isolated* (55%). In addition, two thirds (67%) were *upset at not being able to see family/friends*.

Over a third (38%) were *financially worse off* as a result of COVID.

**Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?**
Base: all respondents (N=636).

# Attributes: personal attitudes

Mean score rating +1 to +5



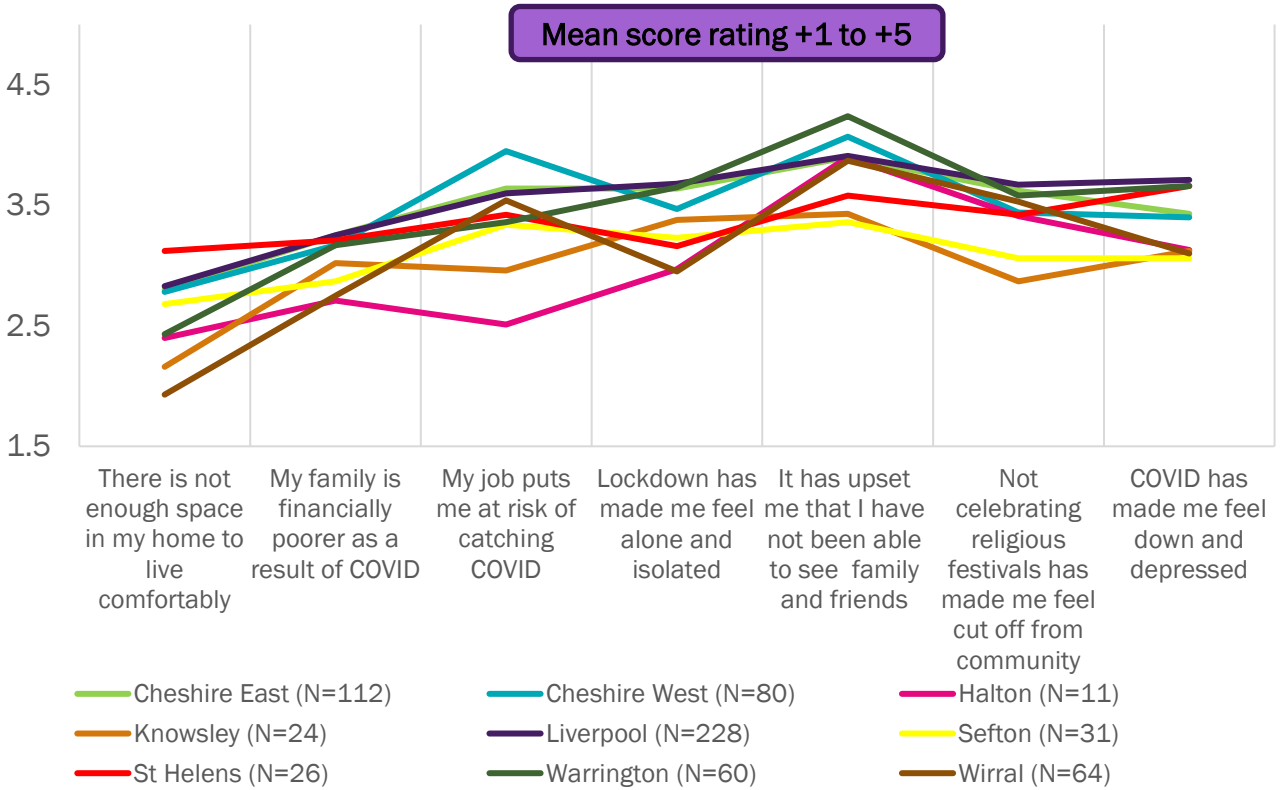

**Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?**
Base: all respondents (N=636).

The negative effects of COVID have been felt by all communities.

There was little variation between ethnic groups on the attributes *COVID has made me feel down and depressed* and *it has upset me that I have not been able to see family and friends*.

Black and Asian respondents were more likely to think that their *job puts them at risk of COVID*.

# Attributes: personal attitudes



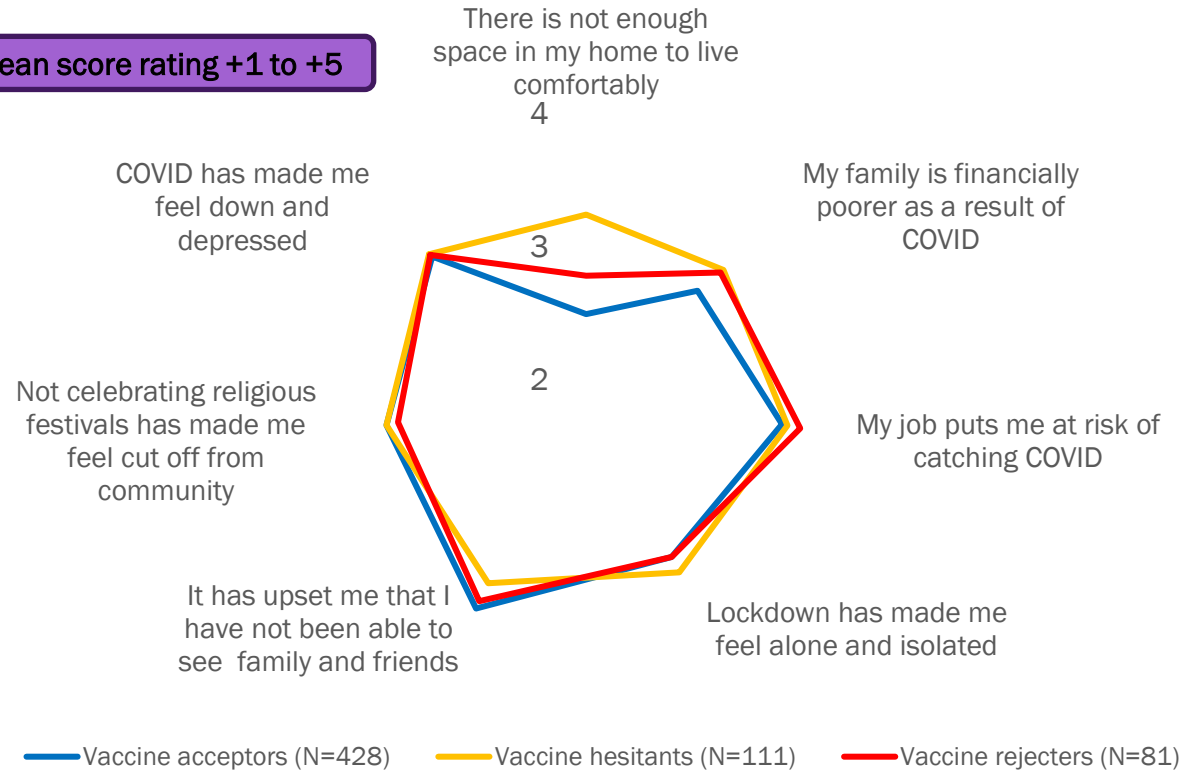

On personal attributes, the impact of COVID has been particularly felt in Liverpool.

Respondents in Liverpool scored highest (albeit slightly) on *COVID has made me feel down and depressed*, *Lockdown has made me feel alone and isolated* and *my family is poorer as a result of COVID*.

**Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?**
Base: all respondents (N=636).

# Attributes: personal attitudes

Mean score rating +1 to +5



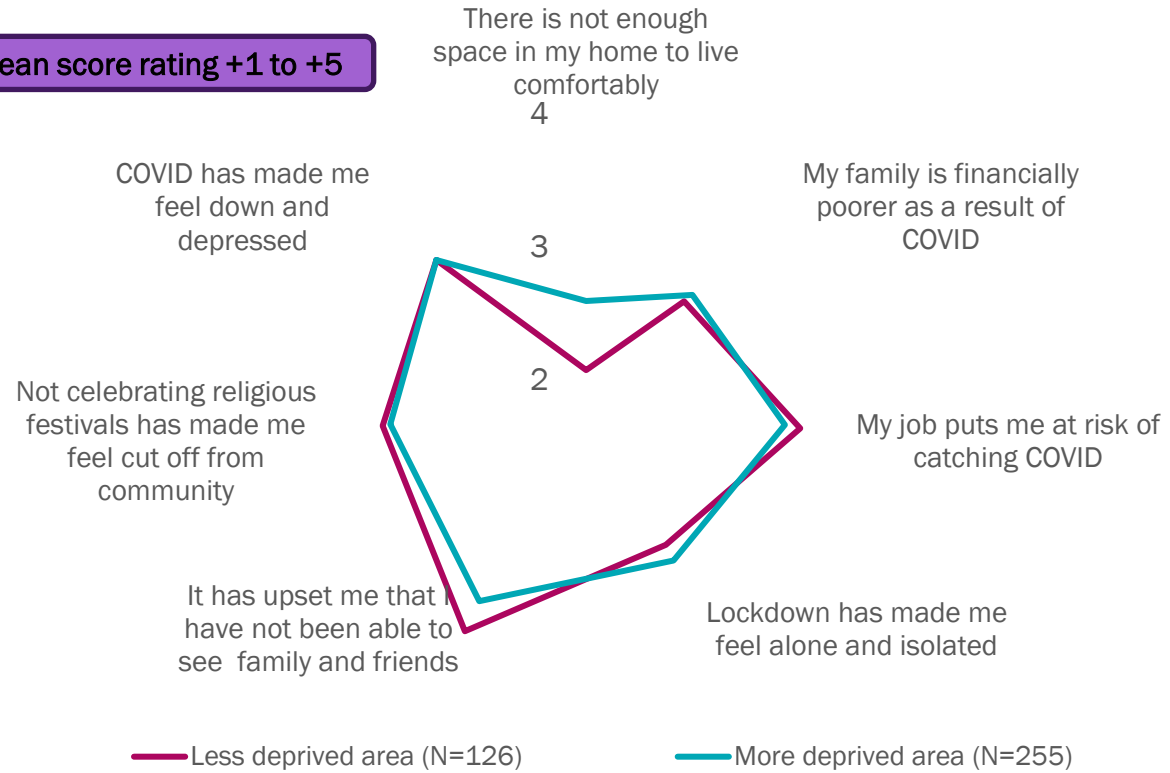

On most personal attributes, vaccine *rejecters* and vaccine *hesitants* felt the same as vaccine *acceptors*.

These attributes are therefore not a driver of vaccine take up.

**Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?**
Base: all respondents (N=636).

# Attributes: personal attitudes

Mean score rating +1 to +5




Those from higher and lower deprivation areas held broadly similar opinions on personal attributes.

However, those from higher deprivation areas were much more likely to agree that *there is not enough space in my home to live comfortably.*

**Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?**
Base: all respondents (N=636).

# Impact of COVID on personal life

## Key highlights

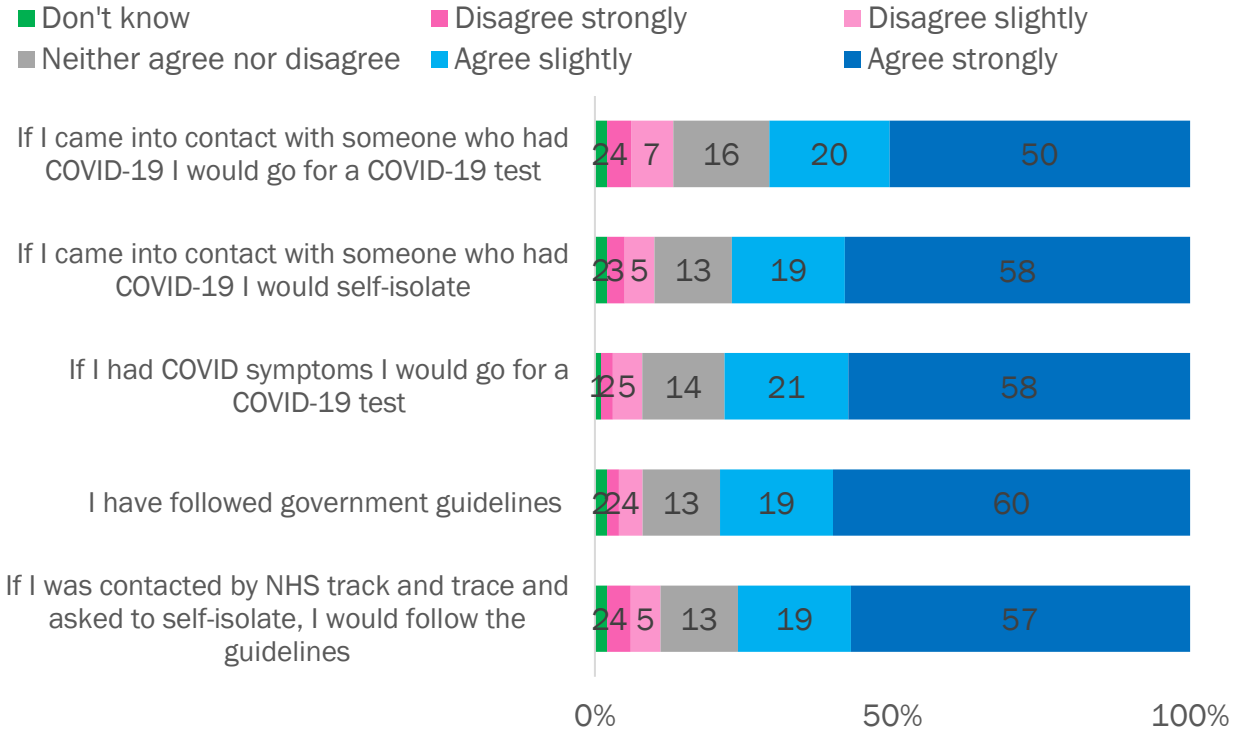
- COVID has had a significant impact on the personal lives of ethnic communities.
- Feelings of isolation were widespread, with over half agreeing that *Lockdown had made them feel alone and isolated* as well as *down and depressed*; in addition two thirds felt *upset that they have not been able to see family and friends*.
- This negative impact was observed in all ethnic communities

Impact of COVID on personal life KEY POINTS

Cheshire and Merseyside
Health and Care Partnership

# Guidelines and compliance

# Attributes: Compliance



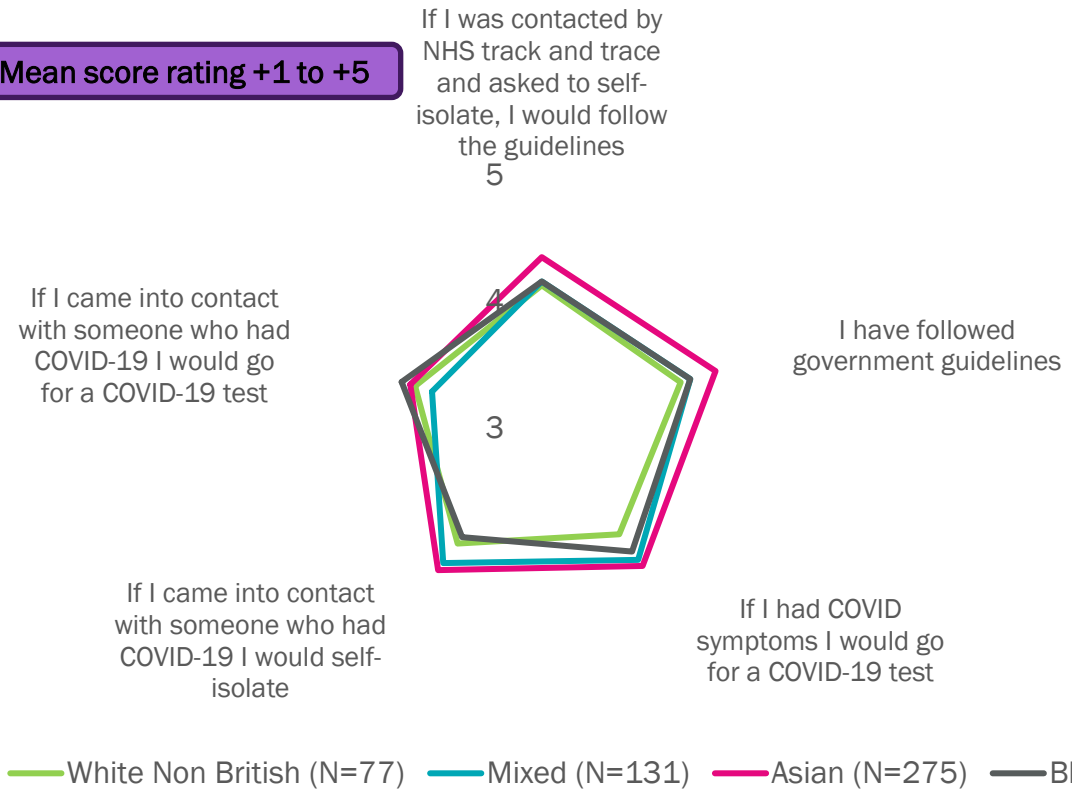

Compliance was extremely high across the total sample with high agreement that respondents were following guidelines.

Disagreement was also very low. However, even with very low levels of disagreement when translated to absolute numbers of people this still represents a large number of people not following guidelines.

**Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?**
Base: all respondents (N=636).

# Attributes: Compliance

**Mean score rating +1 to +5**

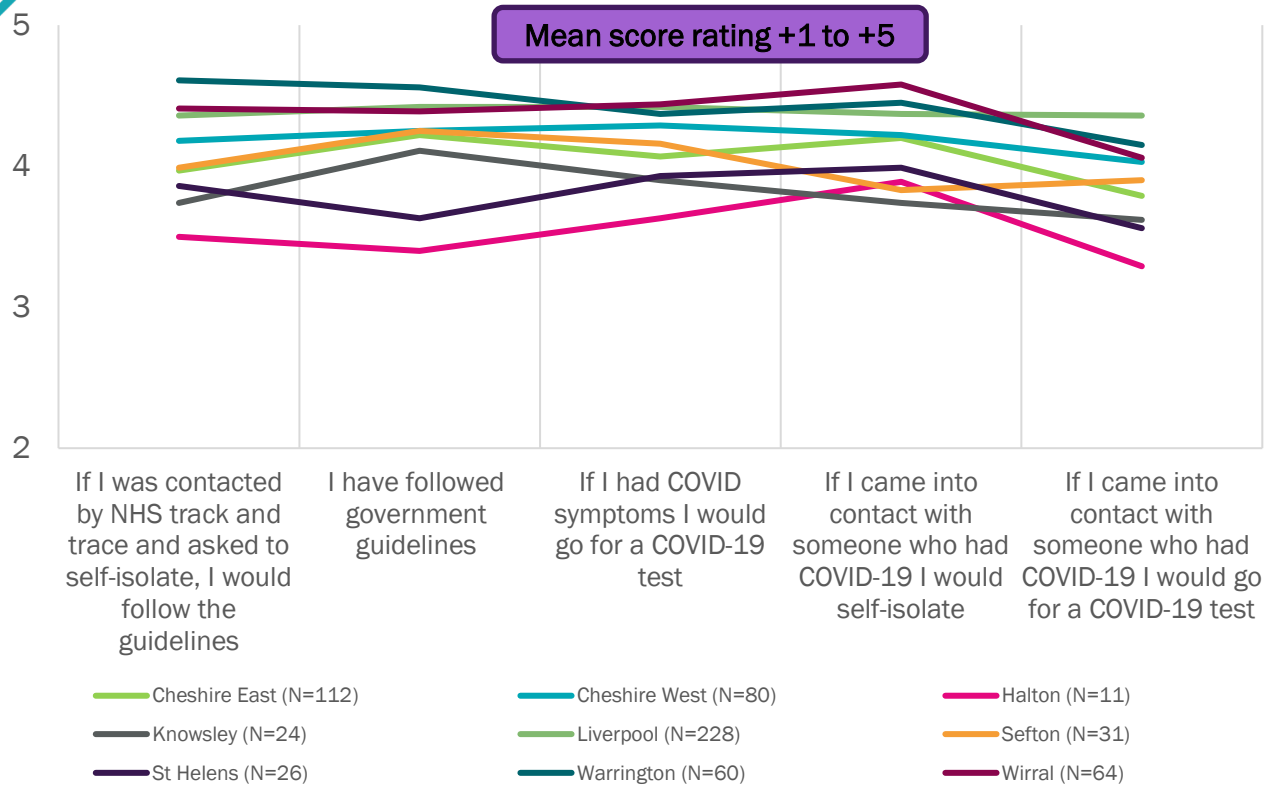



Compliance was good across all ethnic groups.

However, mean scores were generally highest among the Asian ethnic group.

**Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?**
Base: all respondents (N=636).

# Attributes: Compliance



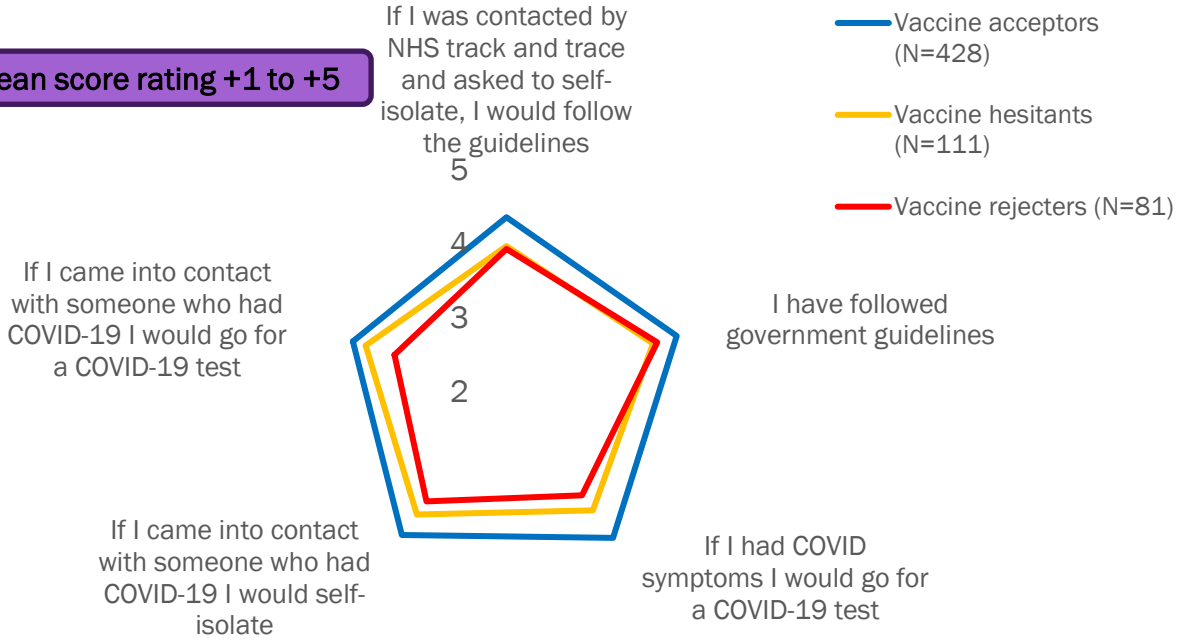

Although on low base sizes, respondents in Halton, Knowsley and St Helens were the least compliant.

Compliance was particularly good in Liverpool, Wirral and Warrington.

Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?
Base: all respondents (N=636).

# Attributes: Compliance

Mean score rating +1 to +5



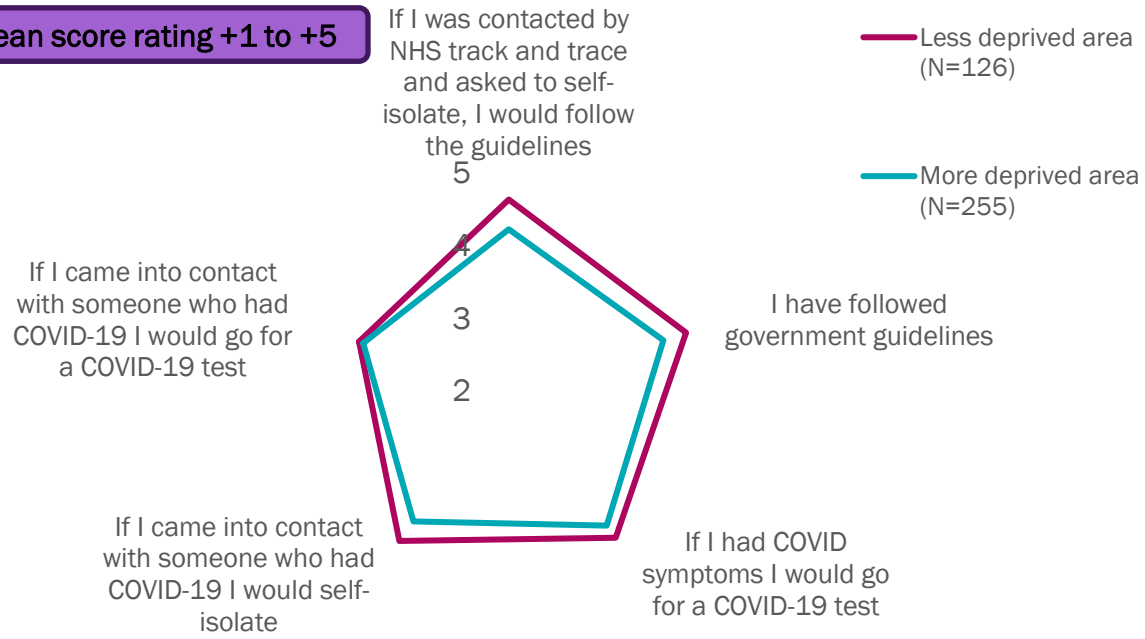

Compliance was the highest among vaccine *acceptors*.

Compliance was lowest among *rejecters* and also relatively low among *hestitants*. However, it should be noted that compliance was still good amongst these groups.

**Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?**
Base: all respondents (N=636).

# Attributes: Compliance

Mean score rating +1 to +5




Compliance was generally lower among those from higher deprivation areas.

They were slightly less likely to agree that they had followed guidelines. In addition, the gaps between the two groups were relatively high on attributes relating to *self-isolation*. It is possible that the impact of self isolation for respondents in higher deprivation areas could be more damaging economically.

**Q. Below are some things that other people have said about themselves and COVID-19. For each please tell us whether you agree or disagree with the statement?**
Base: all respondents (N=636).

# Guidelines and Compliance

## Key highlights

- Compliance with government guidelines has been good amongst the ethnic community, with high agreement that they had followed government guidelines overall.
- There was also high agreement on specific aspects of the guidelines regarding testing and self isolation.
- Compliance was good across all ethnic groups, but slightly higher among Asian communities.
- Those living in areas of higher deprivation were slightly less likely to agree with statements relating to self isolation and it is possible that the economic impact of self isolation amongst these communities may have an negative impact on compliance.

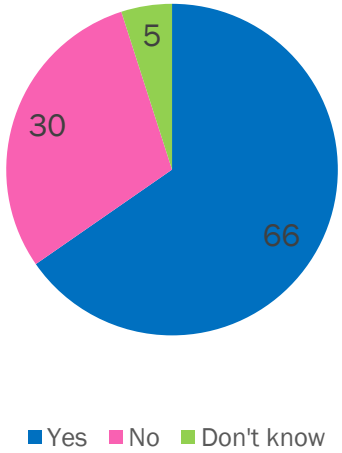
Guidelines and compliance KEY POINTS

Cheshire and Merseyside
Health and Care Partnership

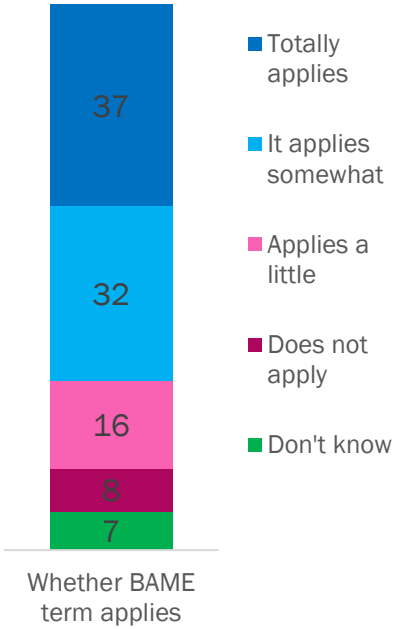
# Opinion of BAME term

# Opinion of BAME Terms

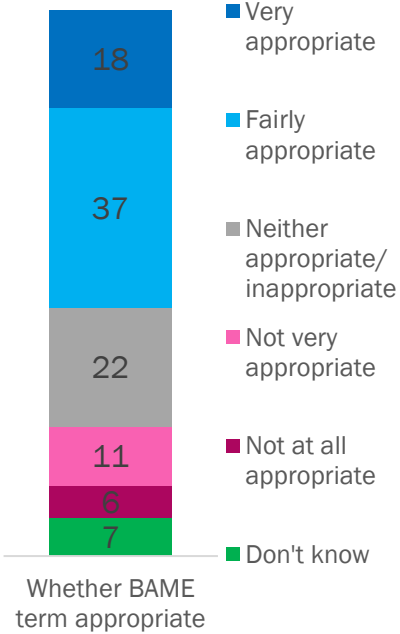
**Heard of BAME term**




**Whether BAME term applies**




**Whether BAME term appropriate**




Awareness of the term BAME was not universal, with a third (35%) of the sample not being aware of the term BAME.

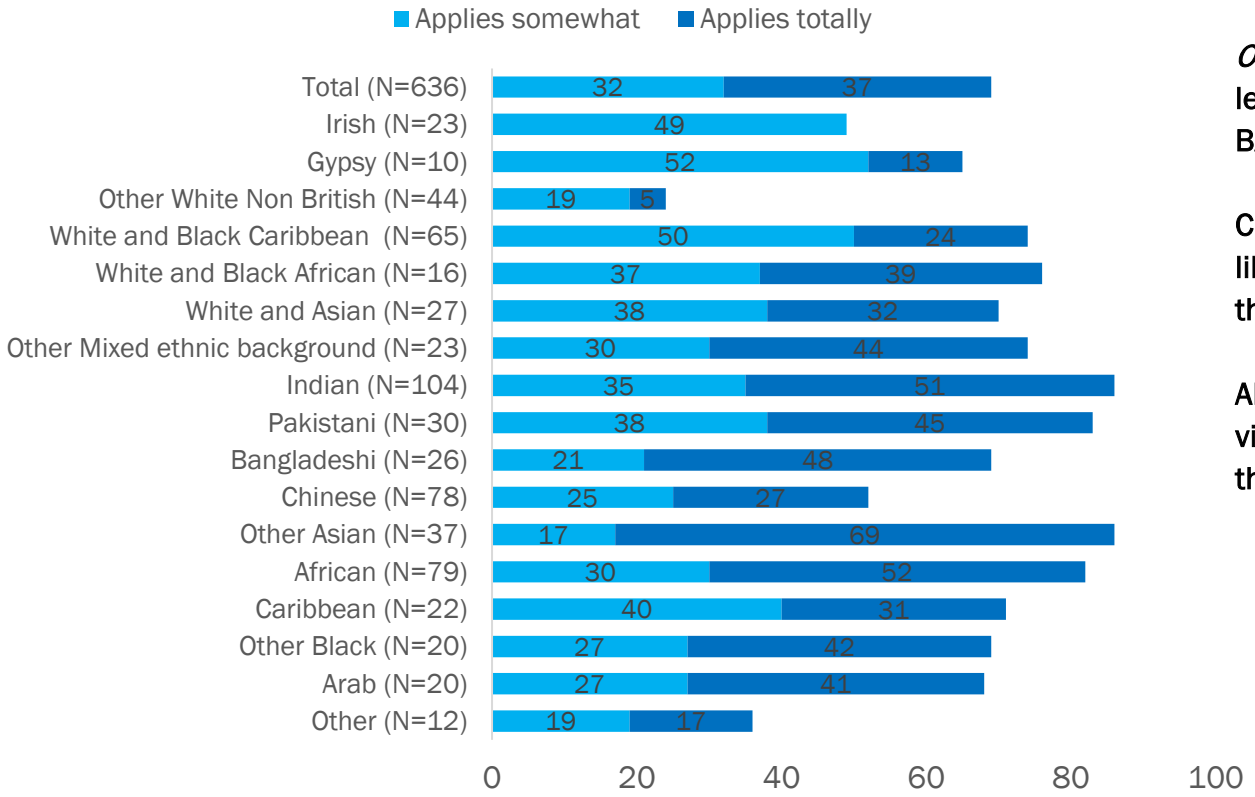
Most thought that the term applied to them at least *a little* and only 8% thought that the term did not apply to them at all.

However, only just over a third thought that it applied totally.

Opinion was muted on how *appropriate* the term was, with only just over half (55% stating that it was an appropriate term.

**Q. Before today, had you heard of the term? Which, if any, of these statements best describes your opinion of how much the term BAME applies to you personally? Which of these statements best describes your opinion of the term BAME?** Base: all respondents (N=636)

# Whether term BAME applies



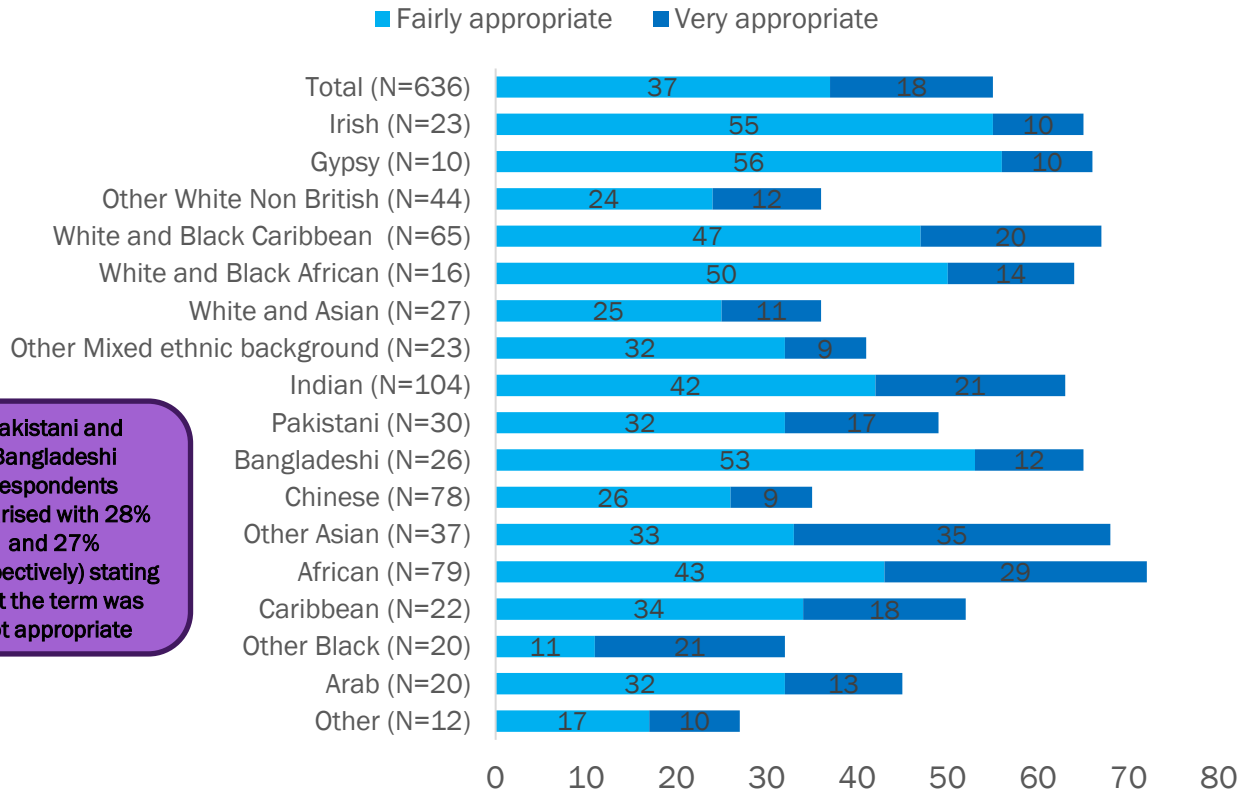

*Other White Non British* were the least likely to think that the term BAME applied to them.

Chinese respondents were also less likely to think that the term applied to them.

All other groups had broadly similar views on whether the term applied to them.

**Q. Which, if any, of these statements best describes your opinion of how much the term BAME applies to you personally?**
Base: all respondents (N=636).

# Variation by ethnic group to how appropriate the term is




**Pakistani and Bangladeshi respondents polarised with 28% and 27% (respectively) stating that the term was not appropriate**

There was some variation by ethnic group on how appropriate the term BAME is.

*African, White and Black Caribbean and other Asian* were most likely to think of the term as being appropriate.

*Other White Non British, White and Asian, Chinese* and *other Black* were least likely to think that it was an appropriate term.

**Q. Which of these statements best describes your opinion of the term BAME?**
Base: all respondents (N=636).

# Some arising themes about BAME term

Cheshire and Merseyside Health and Care Partnership

## Don't lump us all together

*I don't think any term should be used. I believe that a single catch-all term for such a variety of ethnic groups ignores the nuances of those ethnic groups and fails to treat people individuals.*

*It's used to pigeon hole people. This is dangerous when people don't see themselves as part of that group. The opposite can also be true.*

*Refer to each ethnic group in their own merit. You cannot simply lump together everyone who isn't White under one category*

*Reductionist, we all have very different experiences but always get lumped together*

*Race and culture are intersectional and one broad term does not represent the vast majority of people in the community from a diverse background. It would be better to use a persons own preference on how they identify. It at times feels as though it is identifying anyone 'non-white' as 'other' by using BAME. Whereas, we are not 'other' we are inclusive to the community.*

## Term 'Ethnic Minorities' preferred to BAME

*Ethnic minorities as a phrase is suitable enough. "BAME" just leaves the door open for more "minorities" to be added the list, which just complicates things. "LGBTQ+" makes sense as each letter/symbol represents an identity. BAME in comparison is a clunky acronym ("minority ethnic" doesn't make sense!) and was only developed to that there can be a short and snappy term to refer to a very diverse population.*

*Just 'ethnic minorities' as this would not limit people to be Asian and black. This would include Europeans for example*

# The term BAME

## Key highlights

- Awareness of the term BAME was not universal, with a third not having heard the term BAME before.
- Most thought that the term applied to them to some degree, but only just over a third thought that it applied to them totally.
- There was not a strong perception that the term was appropriate. While just over a half thought that it was an appropriate term, only 18% thought that it was *very appropriate*.
- In contrast, 17% did not think it an appropriate term and a further 29% gave a midpoint response (or didn't know).
- White Non British and Chinese were the least likely to think that the term applied to them.
- Other White Non British, White and Asian, Chinese and other Black were least likely to think that it was an appropriate term.

Opinions about the term BAME KEY POINTS

INFLUENTIAL

Cheshire and Merseyside
Health and Care Partnership

# Thank You

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