Background Since the emergence of COVID-19, the academic and scientific community has reacted at pace to understand its epidemiology, diagnosis, treatment, prevention and impact. There are concerns that in the panic to get answers to help manage the pandemic, many of the cornerstones of robust methods are being omitted. The aim of this review was to map the nature, scope and quality of evidence syntheses on COVID-19 and to explore the relationship between review quality and the extent of researcher, policy and media interest.
Methods We conducted a systematic review of systematic reviews, rapid reviews, overviews and qualitative evidence syntheses addressing a research question relating to COVID-19. Searches were conducted in PubMed, Epistemonikos COVID-19 evidence, the Cochrane Library of Systematic Reviews, The Cochrane COVID-19 Study Register, EMBASE, CINAHL, Web of Science Core Collection, and the WHO COVID-19 database in June 2020. Abstract and full text screening were undertaken by two independent reviewers. Descriptive information on review type, purpose, population, size, citation and attention metrics were extracted along with whether the review met six key methodological criteria. For reviews meeting all six methodological criteria, additional data were extracted on methods and publication metrics and AMSTAR-2 was used to assess the quality of the reported methods. *Registration*: PROSPERO CRD42020188822
Results Searches returned 2334 unique records. After applying eligibility criteria we included 280 reviews. Less than half reported undertaking critical appraisal and a third had no reproducible search strategy. There was considerable overlap in topics, with discordant findings. Eighty-eight of the 280 reviews met all six methodological criteria. Of these, 3 were rated as of moderate or high quality on AMSTAR-2, with the majority having critical flaws: only a third reported registering a protocol, and less than one in five searched named COVID-19 databases. Review conduct and publication was rapid, with 56 of the 88 systematic review reported as being conducted within three weeks, and half published within three weeks of submission. Despite being of low quality and many lacking robust methods, the reviews received substantial attention across both academic and public platforms, and the attention was not related to the quality of review methods.
Conclusion Methodological flaws limit the validity of systematic reviews and the generalisability of their findings. Yet by being reported as 'systematic reviews', many readers may well regard them as high quality evidence, irrespective of the methods undertaken. To maintain trustworthiness, researchers, peer-reviewers and journal editors need to ensure systematic reviews adhere to guidelines of best practice.

OP32 JOB LOSS AND LOWER HEALTHCARE UTILIZATION DUE TO COVID-19 AMONG OLDER ADULTS ACROSS 27 EUROPEAN COUNTRIES

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Background Older adults are one of the population groups at the highest risk of severe illness from COVID-19. However, little is known about the impact of the pandemic on economic activity and healthcare utilization for reasons unrelated to COVID-19 among older adults. This study aimed to examine the prevalence and predictors of unemployment due to COVID-19 and healthcare utilization during the pandemic in a sample of older adults across 27 European countries. We examined the associations between individual and household demographic characteristics as well as country-level characteristics and the likelihood of the outcomes.
Methods We utilized cross-sectional data from the large multinational Study of Health, Ageing and Retirement in Europe (SHARE) COVID-19 Survey, collected between June and August 2020. All participants (n = 52,061) reported whether they forwent medical treatment and whether their appointment was postponed due to COVID-19. Economically active participants (n = 10,958) reported whether they lost a job due to COVID-19. Three-level hierarchical models were estimated for each outcome to test the effects of individual, household, and country-level characteristics.
Results The mean prevalence of reported job loss, forgone, and postponed medical care were 19%, 12%, and 26%, respectively. Women we more likely to lose their job than men (OR 1.27; 95% CI 1.14–1.41 at mean age) and this effect was larger for older women. Covid-related job loss was also associated with household income (OR per 1,000 EUR was 0.84; 95% CI 0.78–0.90) and lower education (OR comparing primary vs. tertiary education was 1.27; 95% CI 1.14–1.41). Forgone and postponed medical care was associated with older age in men, female sex, and higher education. For example, women were more likely to forgo medical treatment compared to men (OR 1.63; 95% CI 1.54–1.73 at mean age). At the country level, postponed medical care was associated with more stringent governmental anti-COVID measures (OR for inter-quartile range of stringency index was 1.48; 95% CI 1.14–1.93).
Conclusion Job loss and lower healthcare utilization for non-COVID-19 related reasons were prevalent among older adults in the SHARE sample and were associated with several socio-demographic and country characteristics. Job loss appeared to disproportionally affect already economically vulnerable individuals, which may contribute to an exacerbation of social inequalities over time. Additionally, the results highlighted the importance of focusing on maintaining access to healthcare during the lockdown and following up on any missed medical appointments to prevent increased morbidity due to missed screenings and treatment.

OP33 DIGITAL EXCLUSION DURING THE COVID-19 PANDEMIC IN THE ENGLISH LONGITUDINAL STUDY FOR AGEING POPULATION

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Background The NHS long term plan commits to 'digital first primary care' by 2024. Increasing reliance on digital access may disadvantage those who do not use the internet. We aimed to assess changes in internet use in adults over 50 years of age before and during the coronavirus pandemic.
Methods Participants in the English Longitudinal Study for Ageing were asked how often they used the internet or email in Wave 9 (W9) from June 2018 to June 2019 and COVID Wave 1 (CW1) from June to July 2020. Response options

were daily, weekly, monthly, every 3 months or never. Multivariate logistic regression on weighted data was performed to assess variation by sex, age group (50 to state pension age (SPA), SPA to 74, 75 and over), and wealth quintile.

Results 5,142 core participants responded to both W9 and CW1. Of these, 553 (10.75%; 95% confidence interval (CI) 9.71 to 11.89) reported never using the internet in W9 and 733 (14.26%; 13.05 to 15.57) in CW1. Of those aged 75 and older, 320 (30.64%; 26.87 to 34.87) were 'never users' in W9 and 419 (40.03%; 35.51 to 45.03) in CW1. Univariate analysis found that the odds of reporting 'never use' were higher for women than men (W9 odds ratio (OR) 1.39; (CI) 1.11 to 1.73, CW1 1.35; 1.11 to 1.66), older age groups (W9 4.21; 3.36 to 5.27, CW1 4.24; 3.50 to 5.14), and less wealthy quintiles (W9 1.18; 1.10 to 1.26, CW1 1.19; 1.11 to 1.27). Multivariate analysis found that age was the most important predictor of never using the internet. The odds for older age groups were 4.73; 3.81 to 5.89 (W9) and 4.93; 4.09 to 5.93 (CW1). The differences between women and men, and between wealth quintiles, were no longer statistically significant.

Conclusion The proportion of participants reporting that they never used the internet increased slightly during the pandemic and included 4 in every 10 of those aged 75 and older. A limitation is that W9 data were collected using a paper survey delivered by an interviewer, and CW1 were administered over the phone or internet. Overall, there is a substantial risk that a 'digital first primary care' policy will create barriers for those aged over 75 years. It will be important to maintain alternative access routes to avoid increasing barriers to health care access and subsequent inequalities in the care provided to older people in England.

OP34 ETHNIC AND EDUCATIONAL INEQUALITIES IN COVID-19 VACCINE HESITANCY: CROSS-SECTIONAL ANALYSIS OF THE UK HOUSEHOLD LONGITUDINAL STUDY

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Background Vaccination is crucial to address the COVID-19 pandemic but inequalities in uptake may exacerbate existing health inequalities. We investigate the UK prevalence of COVID-19 vaccine hesitancy, identify which population subgroups are more likely to be vaccine hesitant, and report stated reasons for hesitancy.

Methods Nationally representative survey data from 12,035 participants were collected from 24th November to 1st December 2020 for wave 6 of the UK Household Longitudinal Study ('Understanding Society') COVID-19 web survey. Participants self-reported ethnicity, highest educational attainment, gender, age, how likely they would be to have a vaccine if offered and their main reason for hesitancy. Weighted cross-sectional analysis assessed the prevalence of vaccine hesitancy and logistic regression models estimated independent associations.

Results Overall vaccine hesitancy was low (18% unlikely/very unlikely). Vaccine hesitancy was higher in women (21.0% vs 14.7% in men), in younger age groups (26.5% in 16–24 year olds vs 4.5% in 75+) and in those with lower education levels (18.6% no qualifications vs 13.2% degree qualified). Vaccine hesitancy was high in Black (71.8%) and Pakistani/Bangladeshi (42.3%) ethnic groups. Odds ratios for vaccine hesitancy after adjustment for age and gender were 13.42 (95% CI:6.86, 26.24) in Black, 2.54 (95% CI:1.19, 5.44) in Pakistani/Bangladeshi groups, and 1.76 (95% CI:1.10, 2.82) for Other White (including Eastern European) ethnic groups (compared to White British/Irish). Vaccine hesitancy was not higher in all minority ethnic groups; for example, ORs were 1.11 (95% CI:0.64, 1.95) for Indian ethnicity and 0.67 (95% CI:0.24, 1.87) for Other Asian (including Chinese) ethnicity. Lower education was also related to vaccine hesitancy (no qualifications versus degree OR 3.54; 95% CI:2.06, 6.09) but ethnic differences largely remained when education was included in the model. For those who were vaccine hesitant the most common stated reason for hesitancy was concerns over unknown future effects (42.7%). However, when compared to the White British/Irish group, Black participants were more likely to state they 'Don't trust vaccines' (29.2% vs 5.7%) and the Pakistani/Bangladeshi ethnic group more frequently cited worries about side-effects (35.4% vs 8.6%).

Conclusion Vaccine hesitancy is strongly associated with education and ethnicity, with marked ethnic heterogeneity. Black and Pakistani/Bangladeshi participants reported considerably greater vaccine hesitancy than White British/Irish ethnicity, but some minority ethnic groups did not. Educational inequalities did not account for ethnic differences. Vaccine programmes need to understand reasons for vaccine hesitancy within specific population sub-groups and take urgent action to improve uptake.

OP35 RACE, ETHNICITY AND COVID-19 VACCINATION: A QUALITATIVE STUDY OF UK HEALTHCARE STAFF

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Background COVID-19-related inequities experienced by racial and ethnic minority groups including healthcare professionals mirror wider health inequities, which risk being perpetuated by lower uptake of vaccination. We aim to better understand lower uptake among racial and ethnic minority staff groups to inform initiatives to enhance uptake.

Methods Twenty-five semi-structured interviews were conducted (October 2020-January 2021) with UK-based healthcare staff. Data were inductively and thematically analysed.

Results Vaccine decision-making processes were underpinned by an overarching theme, 'weighing up risks of harm against potential benefits to self and others'. Sub-themes included 'fear of harm', 'moral/ethical objections', 'potential benefits to self and others', 'information and misinformation', and 'institutional or workplace pressure'. We identified ways in which these were weighted more heavily towards vaccine hesitancy