Department of Health & Social Care

Equality Impact Assessment form – Public Sector Equality Duty

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Introduction

The general equality duty that is set out in the Equality Act 2010 requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

The general equality duty does not specify how public authorities should analyse the effect of their existing and new policies and practices on equality, but doing so is an important part of complying with the general equality duty.

Legal advisers need to clear equality impact assessments before they are sent to ministers.

The Secretary of State also has a legal duty relating to reducing health inequalities. If you have any questions about that duty, please contact the Health Inequalities team at healthinequalities@dhsc.gov.uk.

Equality Impact Assessment

Title: Making vaccination a condition of deployment in care homes for working age adults

What are the intended outcomes of this work?

We are pursuing a policy of making the COVID-19 vaccine a condition of deployment of staff in CQC-registered adult care homes. A care home is defined as follows:

> a place where personal care and accommodation are provided together. It can also include qualified nursing to ensure the full needs of the person are met, although this is not mandatory for residential social care.

Uptake of the COVID-19 vaccine is currently optional, as is the uptake of all other vaccines in the UK, but it is strongly encouraged among frontline health and social care staff.

In considering these policy changes, Ministers must comply with the equality legislation, including the public sector equality duty (PSED) under section 149 of the Equality Act 2010, their general duties under the National Health Service Act 2006, which are included in sections 1 to 1G, and the Family Test.

Under the PSED, Ministers must have due regard to the impact of decisions on those people with the protected characteristics, which are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. In particular, they must have due regard to the three limbs of the PSED:

1. Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;

2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

3. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

As part of this Equality Analysis we have considered each of the protected characteristics stated below, to ensure any new policy meets the above requirements.

We are seeking to implement this policy based on evidence that residents in care homes are some of the most vulnerable to COVID-19, and that there is not adequate vaccine uptake among staff in this sector. The SAGE Social Care Working Group has also advised that at least 80% of staff and 90% of residents in a care home should have had a

first vaccination dose to provide a minimum level of protection against outbreaks of COVID-19[1], recognising that current or emergent variants may require even higher levels of coverage and/or new vaccines to sustain levels of protection. The dual 80%/90% threshold provides only a minimum level of protection; higher coverage and both doses would increase that level of protection[1].

The overall figure of 84.1% for staff vaccination uptake masks significant variation at a regional, local and individual care home level. As of 15 June[2], only 64.7% of older adult homes in England are currently meeting the dual threshold as set out by the SAGE Social Care Working Group for the first dose, falling to 44.1% for London. While the SAGE Social Care Working Group advice is specifically about first doses, it should be noted that, for second doses, only 40.5% of homes are reaching this 80/90% level of coverage. Again, London has the lowest coverage, with only 23.0% of care homes reaching the dual threshold for second doses[1].

The rollout of the vaccine was designed to prioritise those most at risk of serious illness and hospitalisation from COVID-19 and the Joint Committee on Vaccination and Immunisation (JCVI) produced a ranking of priority groups to receive this vaccine. This placed residents and staff in care homes serving older adults as the top priority. We have also received further advice from the SAGE Social Care Working Group which identifies a strong case for extending the policy to include care homes with working age adults, given the high levels of vulnerability of residents combined with the high risk of outbreaks occurring in those settings.

Public Health England has published guidance on COVID-19 vaccination for both health and social care workers[3], highlighting that staff members in these workforces are likely to encounter people with COVID-19 during their routine work. The guidance also highlights the need for the health and social care workforce to be protected. In addition, since we launched the consultation, further evidence has emerged of the effect of vaccination on transmission of Covid-19. Research by PHE shows that those who do become infected 3 weeks after receiving one dose of the Pfizer-BioNTech or AstraZeneca vaccine were between 38% and 49% less likely to pass the virus on to their household than those who were unvaccinated.[4]

The aim of the UK's vaccination programme is to save as many lives as possible, while reducing hospitalisations and pressures on the NHS. The SAGE Social Care Working Group has highlighted that people living in care homes have been particularly impacted by the Covid-19 pandemic, due to a combination of a heightened risk of severe outcomes following Covid-19 infection and the risk of outbreaks in these closed settings.

Ensuring and sustaining very high levels of vaccination of people living and working in these settings is an essential public health intervention for a serious vaccine-preventable disease. In terms of the wider public health benefits, as early as 2011, the World Health

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[1] Social Care Working Group consensus statement, March 2021 - GOV.UK (www.gov.uk)
[2] Statistics » Supplementary Information (england.nhs.uk)
[3] COVID-19 vaccination: guide for healthcare workers - GOV.UK (www.gov.uk)
[4] One dose of COVID-19 vaccine can cut household transmission by up to half - GOV.UK (www.gov.uk)

Organisation (WHO) identified vaccine hesitancy as one of its top public health concerns and highlighted the need for government to work with vaccine-hesitant populations to address and overcome their concerns.[5]

Making vaccination a condition of deployment in care homes will help ensure that residents at high risk from Covid-19 either due to their age, underlying health conditions, or disability are better protected against the virus and as well as contributing to delivering these wider public health benefits.

We conducted a public consultation regarding amending the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 from 14 April to 26 May 2021. Over 13,500 responses were submitted and the full consultation document and government response are available online.[6]

Who will be affected?

Staff in CQC-registered care homes:

Staff working in care homes would be affected by any requirement to have the COVID-19 vaccination. The nature of the impact would vary according to the protected characteristic under consideration. There would be a particular impact on staff who had already turned down the vaccine or who were hesitant to accept it. If people working in care homes are not vaccinated and do not have an exemption, they will no longer be able to be deployed there. If an employer is unable to redeploy the person outside the care home then this might lead to the person being dismissed. People might therefore feel pressured into accepting the vaccine or prefer to leave the workforce instead.

The policy would also apply to everyone working in a care home providing accommodation for persons who require the regulated activity of nursing or personal care. The condition applies regardless of role, with the exception of those with medical exemptions, care home residents, visiting family or friends, those attending an emergency or to undertake urgent maintenance work, and children or young people under the age of 18.

We will also provide exemptions for individuals where vaccination is not clinically appropriate (e.g. a pre-existing diagnosis of anaphylaxis). Guidance will give more detail about exemptions, which will reflect the Green Book on Immunisation against infectious (COVID-19: the green book, chapter 14a) and clinical advice from the Joint Committee on Vaccination and Immunisation (JCVI). The guidance will also set out suitable grace periods after a temporary exemption has expired.

[5] Microsoft Word - Oct 3 WORKING GROUP on vaccine hesitancy_final.docx (who.int)
[6] Making vaccination a condition of deployment in older adult care homes - GOV.UK (www.gov.uk)

Those being cared for in care homes:

The Scientific Advisory Group for Emergencies (SAGE) Social Care Working Group highlighted the particularly high impacts of the COVID-19 pandemic on people living in care homes. Closed environments, such as care homes, in which the same group of people come into close contact with each other many times a day, enable faster and more efficient transmission of the virus to all occupants (workers and residents) than more open settings. In addition, those being cared for in care homes are among the most vulnerable to the effects of COVID-19 infection and subsequent hospitalisation.

PHE have been monitoring the link between vaccination and transmission via their surveillance systems and by following up individual cases to monitor the effectiveness of the vaccine in protecting against a range of outcomes including infection and onward transmission, symptomatic disease, hospitalisation and mortality. Research by PHE shows that those who become infected 3 weeks after receiving one dose of the Pfizer-BioNTech or AstraZeneca vaccine were 38 - 49% less likely to pass the virus on to their household contacts than those who were unvaccinated. [7]

The SIREN study has also shown that the Pfizer vaccine has 72% effectiveness against infection 21 days after the first dose, similar to the effects seen in the AstraZeneca trials.

For all the above reasons, ensuring that as many of the people living and working in these settings are vaccinated is an essential public health intervention for a serious vaccine-preventable disease such as COVID-19.

The Social Care Working Group of SAGE has advised that a minimum uptake of 80% among staff and 90% among residents in each individual care home setting is needed to provide a minimum level of protection against outbreaks of COVID-19. This is for a single dose against the current dominant variant. These coverage rates required to provide a minimum level of protection against outbreaks may be lower after a second dose, but the emergence of new variants may increase these levels, so estimates of the minimum coverage level can vary.

Overall, this policy is likely to have a positive impact on care home residents by causing more staff being vaccinated and therefore reducing the risk of transmitting COVID-19. If we did not implement this policy, staff vaccination rates might not reach the minimum acceptable safe levels set out by SAGE, so maintaining unacceptable levels of COVID-19 transmission risk to care home residents.

This analysis considers whether the policy will have significant impacts on people with certain protected characteristics and how significant this may be, as well as outlining actions that will be taken to mitigate adverse impacts.

[7] One dose of COVID-19 vaccine can cut household transmission by up to half - GOV.UK (www.gov.uk)

Evidence

The Equality Act 2010

The DHSC Social Care Bill

The state of the adult social care sector and workforce in England, Skills for Care 2020

DHSC analysis. This includes data analysis from DHSC Adult Social Care Data Team, data modelling carried out to assess impact of the policy on social care workforce and safe staffing levels, and modelled estimates of the demographic make-up of the ASC workforce.

The DHSC Vaccines Team commissioned work from the Behavioural Insight Team and the Cabinet Office Fieldwork Team to gain insight and inform the development of this policy.

Factors influencing COVID-19 vaccine uptake among minority ethnic groups

COVID-19 vaccine hesitancy in the UK: The Oxford coronavirus explanations, attitudes and narratives survey (Oceans) II

The Greenbook chapter 14a, 2021

Office for National Statistics

Predictors of COVID-19 vaccine hesitancy in the UK, Household Longitudinal Study

State of Vaccine Confidence in the EU and the UK 2020, European Commission

New poll finds BAME groups less likely to want COVID vaccine, Royal Society for Public Health 2020

Factors influencing COVID-19 vaccine uptake among minority ethnic groups, SAGE 2020

https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00432-3/fulltext

Analysis of impacts:

Several societal benefits may arise to different groups as a result of making vaccination a condition of employment, including:

1. More equitable level of vaccination status of care home staff in order to protect care home residents and the wider community

2. Reduced likelihood of care home outbreaks, providing greater safety for care home users

3. Reduced cost of hospital treatments for both residents and workers

4. Reduced rate of transmission in the community

Disability - attitudinal, physical and social barriers for both visible and hidden disability

We have identified that this policy is likely to have a significant positive impact on staff and residents with disabilities.

According to Skills for care report[8] based on the Labour Force Survey (LFS), 18% of the population of England is disabled. LFS states that 22% of workers in social care occupations are disabled according to the Disability Discrimination Act 1995 (DDA) definition. But Skills for Care data (ASC-WDS) which are employer reported show 2% disability amongst workers as it only captures the LFS equivalent of 'work-limiting disability'. Although we lack data on the proportion of staff whose disability prevents them from receiving the COVID-19 vaccine, this policy would have a positive impact on them if a greater number of their colleagues were vaccinated and therefore provided them with some protection.

21% of care home residents with care commissioned by the LA are working age adults with a disability. A similar positive impact would accrue to disabled residents of care homes, including working age adults.

Staff with disabilities who are clinically advised against vaccination would be exempt from this policy. However, some disabled staff may have clinical concerns regarding the vaccine that could make them less willing to be vaccinated or prevent them from having the vaccine, including allergies to ingredients in the vaccines or to other unidentified substances. This could lead to them being advised against vaccination with a specific vaccine or against vaccination entirely. Immunocompromised staff may be reluctant to accept the vaccine due to concerns they will not have a significant immune response or concerns around live vaccines in general.

Some disabled staff may face access issues meaning they are less likely to have had the vaccine prior to this policy being implemented. This could include lack of information in an accessible format or practical barriers such as difficulty in travelling to appointments at

[8] Workforce estimates (skillsforcare.org.uk)

vaccination centres. Issues with access to vaccine information have been mitigated by ensuring all guidance and information is readily available in a variety of formats such as easy read, large print and braille, as well as being accessible via screen readers. Transport barriers have been mitigated by providing transport to vaccine centres and arranging for staff to be vaccinated at work. However, it is possible that staff with disabilities may still have found it difficult to access their vaccination.

Issues surrounding access to vaccine information have been mitigated by ensuring all guidance and information is readily available in a variety of formats such as easy read, large print and braille, as well as being accessible via screen readers. Barriers to accessing transport have been mitigated by providing transport to vaccine centres and ensuring that all staff can be vaccinated at work.

This policy would not advance equality between staff who have a disability and those who do not. It could work against workforce cohesion and good relations between staff, with negative impacts on the wellbeing of disabled staff if tensions arise between vaccine-exempt staff and those who are not exempt.

Conversely the policy could force staff to disclose their disabilities to management, with the risk of less favourable treatment by their employer or colleagues. A potential mitigation would be to allow staff to provide their employer with proof of medical exemption, without revealing the reason for it. We will ensure this is considered as part of developing the process for staff to provide evidence of exemption. A further mitigation would be for staff with allergies to ingredients in some, but not all, of the COVID-19 vaccines to be able to choose which COVID-19 vaccination they receive to ensure it is as safe as possible for them.

Sex - men and women

We have identified that this policy is likely to have a significant impact on women.

There are many more women than men in the social care workforce. The adult social care workforce in 2019/20 comprised 82% female and 18% male workers.[9] As a result, more women will be impacted than men by a policy requiring COVID-19 vaccination in care homes.

There is also some evidence that women have higher rates of vaccine hesitancy than men, and they may also face more barriers to accessing the vaccine. According to the Office of National Statistics, in 2019, two thirds (62%) of ‘sandwich-carers’ were women, (those who care for both sick, disabled or older relatives and dependent children).This may

[9] The state of the adult social care sector and workforce in England (skillsforcare.org.uk)

impact an individual's ability to travel and receive a vaccine, particularly given recent disruption in schooling, nurseries and childcare services.

The impact of a vaccine as a condition of deploying staff to work in a care home could lead to women being disproportionately at risk of facing enforcement action at work and potentially losing their jobs.

Access issues are being mitigated by ensuring staff can receive their vaccine during work hours, either on-site or with transport provision to a vaccination centre, as well as by re-opening the National Booking Service to allow staff to select convenient appointments. Staff can also book vaccinations through the National Booking Service at a time and a place which is convenient to them. Vaccine hesitancy is being tackled by investigating the causes of vaccine hesitancy among women working in social care and addressing these through targeted communications.

It should be noted that, although women are more likely to admit to vaccine hesitancy, they are also more likely to have been vaccinated. NHS England data on vaccination uptake as of 10 June shows that in every age group and in every region of England, more women than men had received both doses of the vaccine.[10] Although we do not have data by sex and age for care home staff, it is likely that these trends translate to the social care workforce. Given that vaccination rates are likely to be higher among men than women, vaccination as a condition of deployment might disproportionately boost vaccine uptake amongst men.

Impacts on the protected characteristic of pregnancy and maternity will be covered in the pregnancy and maternity section of this assessment.

Sexual orientation - heterosexual, homosexual or bisexual

There is no evidence available on the demographics of the adult social care workforce regarding sexual orientation.

There are no data on the prevalence of vaccine hesitancy by sexual orientation. However, one in seven LGBT people (14%) say that they have avoided treatment for fear of discrimination on the grounds of sexual orientation. Further, one in five (19%) of LGBT people have not disclosed their sexual orientation to any healthcare professional when seeking health care. If these figures are also true for LGBT care staff, this policy may have an impact on them as they may be less likely to already be vaccinated, or may face

[10] Statistics » COVID-19 Vaccinations (england.nhs.uk)

additional access barriers to vaccination. Given that individuals are not required to disclose their sexual orientation to healthcare professionals, it remains a challenge to determine the full impact of the policy.

Race - ethnic groups, nationalities, Gypsy, Roma, Travellers, language barriers

We have identified that this policy is likely to have a significant impact on ethnic minorities

Workforce data from Skills for Care shows a diverse range of ethnicities across the care sector. One in five members of the social care workforce are Black, Asian or from another ethnic minority, a higher proportion than in the overall population of England, in which 1 in 7 (14%) are Black, Asian or another ethnic minority. In particular, Black/African and Black/ Caribbean staff comprise 12% of the adult social care workforce, compared to 3% of the overall population.

The evidence suggests that vaccine hesitancy is highest among Black people, people of Pakistani and Bangladeshi heritage, and non-UK/Irish White ethnic groups. A variety of reasons have been suggested as part of the consultation that the government undertook, including lack of trust in the safety and efficacy of vaccines and a wider lack of trust in authority.

A higher proportion of staff from ethnic minority groups could therefore face action from their employers or lose their jobs for refusing to take the vaccine.

Vaccine hesitancy among people in ethnic minority groups is being addressed through targeted communications, partnership working with community leaders and sharing the personal stories of social care workers from ethnic minority groups who have been vaccinated.

A relatively high proportion of social care workers do not have English as their first language. Hence, they could have difficulty interpreting information and guidance about the COVID-19 vaccine. To mitigate this risk, advice and other communications have been issued on a variety of platforms including TV, radio and social media in 13 languages including Bengali, Chinese, Filipino, Gujarati, Hindi, Mirpuri, Punjabi and Urdu. Print and online material, including interviews and practical advice have appeared in over 600 national, regional, local and specialist titles including media for Black, Asian, Bangladeshi, Bengali, Gujarati and Pakistani communities.

The relatively high level of vaccine hesitancy among non-UK/Irish White ethnic groups could arise from negative opinions about vaccines in other European countries. Countries highlighted as having particularly low trust in vaccines include Hungary, Malta, Cyprus,

Romania, Slovakia, Slovenia. EU nationals from these and other countries with low levels of trust in vaccines could be more likely to decline a COVID-19 vaccine and therefore be significantly impacted by this requirement. Information about the COVID-19 vaccine has been translated into 40 languages, to mitigate impacts that individuals without English as a first language may face when considering whether to be vaccinated. Public consultation documents about the policy were made available in Albanian, Arabic, Bengali, Chinese, Farsi, French, Gujarati, Hindi, Kurdish, Nepali, Polish, Punjabi, Romanian, Somali, Spanish, Tagalog, Turkish, Ukrainian and Urdu, to ensure that individuals who do not speak English as their first language to provide their views on the proposed changes. These translations were published later than the consultation document, which may have had a negative impact on the ability of some individuals to respond to the consultation. The final equalities assessment of this document takes into account all responses received, including those submitted after the publication of translations.

There are ongoing challenges faced by the Gypsy, Roma and Traveller communities in accessing healthcare. This could lead to difficulties in accessing the vaccine if not provided through their employer. Gypsy, Roma and Traveller people may also have lower levels of trust in health professionals and lower levels of health literacy. No data is available relating to levels of Gypsy, Roma and Traveller people employed in care homes or their specific attitudes towards the vaccine. Ensuring culturally and linguistically appropriate materials about the COVID-19 vaccine are available to social care settings could provide reassurance to these staff and help mitigate the impact.

Some of the impacts of COVID-19 vaccination as a condition of deployment could be mitigated by ensuring culturally and linguistically appropriate materials about the COVID-19 vaccine are available in social care settings. Targeted communications and working in partnership with community leaders and sharing personal stories of social care workers from ethnic minority groups receiving the vaccination are also helping to build trust and drive vaccine uptake.

However, there is a risk that issues such as lack of trust could be exacerbated by this policy. There is likely to be a significant effect on this cohort regardless of mitigations carried out, with regards to Public Sector Equalities Duties 1, 2 and 3:

1. Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;

2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

3. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Age - age ranges, old and young

We have identified that this policy is likely to have a significant impact based on age.

Age is the dominant risk factor for serious illness and death as a result of COVID-19, as reflected in the JCVI's vaccine rollout prioritisation. Approximately four in five (79%) of residents receiving LA-commissioned care are aged 65 or over. This policy could therefore be expected to have a positive impact on residents in care homes for older adults, as well as on older staff, through the increased protection from COVID-19 due to increased staff vaccination.

Levels of vaccine hesitancy in the general population are higher among younger people, possibly because they feel themselves at lower risk of death or adverse outcomes from COVID-19. One in 6 (17%) adults aged 16-29 years reported vaccine hesitancy; this was the highest of all age groups. Younger women are also reported to have higher levels of vaccine hesitancy, specifically related to fertility concerns.

Skills for Care data suggest that the average age of an ASC worker is 44 years - 9% are aged under 25; 65% aged 25-54; and 27% are over 55 years old[11]. We estimate that around 15% of the ASC workforce is made up of women under 30. This group may be particularly vaccine hesitant and thus could be significantly affected by this policy.

The recent JCVI guidance advised that under-40s with no underlying conditions should be offered an alternative to the Oxford/AstraZeneca vaccine where available. The risks associated with the Oxford/AstraZeneca vaccine for under 40s may increase vaccine hesitancy, particularly among young women, though the guidance to offer an alternative may mitigate this risk. The UK's independent regulator, the MHRA, and the JCVI having both said that the benefits of the vaccine far outweigh the risks for the vast majority of adults. The government will follow the updated advice, which sets out that, as a precaution, it is preferable for people under the age of 40 with no underlying health conditions to be offered an alternative vaccine where possible once they are eligible.

There is a significant programme of work underway to tackle vaccine hesitancy in the wider population, as set out in the uptake plan we published on 13 February. DHSC and NHS England and Improvement have developed communications tailored to social care audiences whom stakeholders have told us are hesitant about getting the vaccine, including people from Black, Asian, and Minority Ethnic communities and women of childbearing age. These groups make up a significant proportion of the care home workforce.

[11] The state of the adult social care sector and workforce in England (skillsforcare.org.uk)

To encourage voluntary vaccine uptake in younger people, and therefore reduce negative impacts, communications to care homes have been targeted to address specific concerns of staff. They have highlighted the potential benefits of receiving the vaccine to colleagues, service-users and patients, as well as to one's own family. These communications have included videos from care home workers, blogs sharing best practice for encouraging staff uptake, stories of staff who have overcome their own hesitancy, and first-person video diaries of staff getting vaccinated.

Gender reassignment (including transgender) - transgender and transsexual people

We do not have data on the number of transgender or gender non-conforming people in the social care workforce. There is also no evidence that this group experiences higher levels of vaccine hesitancy. However, there is some evidence that people with this protected characteristic are more likely to have negative interactions with healthcare staff and are less likely to seek testing or treatment for COVID-19 for this reason. As a result, they may not be registered with a GP, or may be less likely to respond to a GP letter inviting them to have the vaccine.

As a result they are at greater risk of employer action to implement the policy and at increased risk of losing their jobs due to not being vaccinated.

Access barriers to the vaccine are being mitigated by ensuring vaccination is repeatedly offered through the workplace. In addition, communications should accurately address the gender identity of the recipient, using the correct titles and names, and gender-neutral language where appropriate (i.e. "dear recipient" as opposed to "dear Sir/Madam"). Communications to the workforce from the Department of Health and Social Care tend to address recipients as 'Colleague' which is a gender-neutral term of address. If these mitigations are being carried out, there is unlikely to be a higher impact on people with this characteristic than those without. Although, due to the lack of data available, it remains a challenge to determine the full impact of the policy.

Religion or belief - people with different religions, beliefs or no belief

We have identified that this policy is likely to have a significant impact based on religion or belief

A number of people may be opposed to vaccination in principle due to their beliefs, either religious or nonreligious. These beliefs could encompass concerns about safety,

scepticism about vaccine efficacy, germ theory, lack of trust in conventional medicine, a belief that immunity acquired through disease is superior to vaccine-acquired immunity, belief in conspiracy theories or other factors.

Some religious groups, such as Muslims, Jews and Hindus, or people whose dietary practice is vegan or vegetarian could also refuse vaccination due to the reported presence of animal products, or by-products, or alcohol in COVID-19 vaccines. Concerns around the use of foetal cell cultures to manufacture the vaccine have also been noted.

We have no data on the numbers in the social care workforce who follow these religions or hold beliefs that may make them reluctant to take the COVID-19 vaccination.

People who hold these beliefs may therefore be likely to feel compelled to have a vaccine they do not want, or to lose their jobs, as a result of this policy. Staff may also face a situation in which they have to reveal their religion or beliefs to employers against their will, potentially exposing themselves to stigma or harassment from employers and colleagues who do not hold the same beliefs.

The Muslim Council of Britain has shared information from the British Islamic Medical Association recommending that Muslims can take the Oxford/AstraZeneca vaccine[12]. The Vatican has also announced that Catholics may use vaccines derived from foetal cell lines where alternatives are not available[13].

We are mitigating opposition to the vaccine by ensuring that information regarding the ingredients of the vaccines is readily available to staff in care homes, as well as amplifying the voices of trusted community leaders and religious figures who can assuage concerns. We are also ensuring safety or efficacy concerns about the COVID-19 vaccination are addressed through access to information, through projects such as the Community Champions scheme so that communities can look to trusted local leaders to answer questions about the vaccine and work locally with the NHS and public health teams.

Other options to mitigate adverse impact on people with religious or ethical objections to the vaccine could include allowing a choice between vaccines to address concerns about their manufacture, although this would need be assessed as a proportional response.

[12] Latest COVID19 Advice for British Muslims - Muslim Council of Britain (MCB)
[13] Note on the morality of using some anti-Covid-19 vaccines (21 December 2020) (vatican.va)

Pregnancy and maternity - working arrangements, part time working, infant caring responsibilities

We have identified that this policy is likely to have a significant impact on pregnancy and maternity

As already mentioned, the social care workforce is predominantly female. Hence the incidence of pregnancy and maternity among the workforce is higher than among the population at large. Women are also more likely to be responsible for childcare than men, which could impact an individual's ability to travel and receive a vaccine, particularly during the pandemic, and given the disruption to schools, nurseries and childcare services. Women with children are also more likely to work part-time, with 3 in 10 mothers stating they have reduced working hours due to childcare[14].

The high proportion of women of child-bearing age among the social care workforce, and the related pregnancy, maternity and childcare responsibilities could mean that this group is significantly impacted by a move to make vaccination a condition of work. Hence, they are more likely to face enforcement action by their employer if they do not consent to vaccination. There is a serious risk of discrimination against those who do not wish to take the vaccine due to pregnancy or maternity issues, such as breastfeeding.

Advice on vaccination during pregnancy was updated recently, on 16 April 2021, to say that pregnant people should be offered the vaccine at the same time as people of the same age or risk group. Previously, routine vaccination during pregnancy was not advised. The advice recommends that those who are breastfeeding are informed about the lack of data on the safety of the vaccine while breastfeeding[15].

Given this, pregnant and breastfeeding employees working in social care may be less likely to have already been vaccinated against COVID-19. A requirement to have the vaccine would be likely to cause significant anxiety in pregnant and breastfeeding staff.

The Joint Committee on Vaccination and Immunisation (JCVI) has advised that pregnant women should be offered the COVID-19 vaccine at the same time as the rest of the population, based on their age and clinical risk group. There have been no specific safety concerns identified with any brand of COVID-19 vaccines in relation to pregnancy. Real-world data from the United States show that around 90,000 pregnant women have been vaccinated, mainly with mRNA vaccines including Pfizer-BioNTech and Moderna, without

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14 https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/familiesandthelabourmarketengland/2019

15 Updated advice on COVID-19 vaccination in pregnancy and women who are breastfeeding (rcm.org.uk)

any safety concerns being raised. Based on this data, the JCVI advises that it is preferable for pregnant women in the UK to be offered the Pfizer-BioNTech or Moderna vaccines where available.

The regulations will apply to all staff working in a CQC-regulated care home for people requiring nursing or personal care in England, including those who are pregnant, unless they have a medical reason not to be vaccinated. Further details will be outlined in guidance, which we will provide in due course. Guidance will consider how this can be implemented in practice and, as with other exemptions, we will work through how the exemptions process can ensure women can inform their employer that they are exempt without disclosing the reason for it.

We have been assured by clinicians that vaccines are safe for the majority of pregnant women, however we recognise that in some circumstances, vaccination may not be appropriate during pregnancy and we will consider that in our guidance regarding granting exemptions.

It is likely that the policy could negatively impact women who are trying to conceive, or planning to do so in the future. Although there is no evidence that the vaccine affects fertility, it has been noted as a significant area of concern for some women, and may mean that some women feel pressured into having the vaccine, or else lose their jobs. All the vaccines are subject to rigorous testing before they can be given to the public. There is no evidence to suggest the vaccines can cause problems with fertility. The British Fertility Society (BFS) and Association of Reproductive and Clinical Scientists (ARCS) say there is absolutely no evidence, and no theoretical reason, that any of the vaccines can affect the fertility of women or men.

Barriers to access are being mitigated by ensuring employees can receive their vaccine during work hours and to either have it on-site or be provided with transport to a vaccination centre. Follow-up visits from mobile vaccine teams to capture staff who were not originally present are also being carried out for care homes. Social care workers can also book vaccinations through the National Booking Service at a time and a place which is convenient to them.

Marriage and civil partnership - married couples, civil partnerships

There is no current evidence that making COVID-19 vaccination a condition of work will have a greater or lesser impact depending on marital and partnership status.

Families Test

A policy of making the COVID19 vaccination a condition of work is unlikely to have a significant impact on the formation of families.

It is possible that the policy could have an impact on an individuals' childcare or other caring responsibilities. If individuals were unable to access the vaccine during workhours, alternative child-care and other caring responsibilities would need to be arranged. To mitigate this, all attempts are being made to make vaccinations accessible through the workplace or at a convenient time for the individual.

It is unlikely that making the vaccine a condition of work would have an impact on families before, during and after couple separation or impact those families most at risk of deterioration of relationship quality and breakdown.

Engagement and involvement

To supplement the views provided in the consultation, DHSC conducted extensive engagement with stakeholders. Three meetings convened by Department of Health and Social Care took place between 28 April and 17 May 2021. The topics discussed included: the rationale behind the policy proposal, proposed scope of the regulations, equality issues, workforce impacts and impacts on providing a safe service.

The Minister of State for Social Care met with stakeholders with lived experience on Thursday 13 May to discuss the proposal. This included representative groups of care users (e.g. Think Local Act Personal), ambassadors with lived experience of care, and representatives of unpaid carers (e.g. Carers UK). The session was used as a listening exercise to hear what the challenges might be, from a resident's perspective, and explore the potential impact of the policy on resident safety and resident-carer relationships.

DHSC representatives met with a patient group on Monday 24 May to hear more from the perspectives of patients, residents, their families and their carers.

We have raised awareness of, and encouraged participation in, the consultation through our DHSC communications channels and through targeted communications delivered directly to all registered care homes, social care agencies, and membership bodies.

We have also analysed a sample of organisational responses in detail, the qualitative summary of which is included in the analysis sections of the Government response to the consultation.

Summary of Analysis

The effects of this policy could be significant, as it could lead to dismissal of, or penalisation of, staff who work in care homes who refuse to or cannot be vaccinated or could lead to such workers feeling pressured to consent to vaccination. There would be a positive impact on residents living in CQC registered care homes providing nursing or personal care, as more staff would be vaccinated, providing them greater levels of protection against COVID-19.

In the case of disability, and pregnancy and maternity, the impacts are centred on access and medical exemptions to the vaccine. For disabled people, access barriers could be mitigated by ensuring information is readily available in accessible formats and travel to get vaccinated is arranged. Offering the vaccine through multiple routes could also support people with childcare responsibilities to access the vaccine. An exemption will also apply to those who have a medical reason not to be vaccinated.

It is also worth considering that, for people with disabilities, pregnancy or maternity, vaccination as a condition of deployment for colleagues may have a significant benefit for them, through mechanisms such as potential reducing the transmission of COVID-19 within the workplace.

Women and young people may be significantly affected by this policy due to higher levels of vaccine hesitancy and, in the case of women, potentially higher barriers to accessing the vaccine and higher representation in the workforce. This impact could be mitigated somewhat by increased communications regarding concerns and lowering barriers to access. Given the aims of the policy, it does not seem to have an unreasonable impact on these groups.

Ethnic minority staff and adherents to certain religions and beliefs are likely to be significantly impacted by this policy. This is because there appears to be more significant levels of vaccine hesitancy in these groups, meaning more people would be affected by making the COVID-19 vaccine a condition of work. Without exemptions relating to religious or belief-based refusal of the COVID-19 vaccine, mitigating this impact entirely will not be possible. It is key therefore to carry out work relating to culturally, religiously and linguistically suitable and effective communications to improve voluntary vaccine uptake.

Work is continuing to examine how significantly the COVID-19 vaccine affects transmission of the virus, including by Public Health England. There is good evidence emerging to support the theory that receiving a vaccine reduces the risk of people transmitting the virus. Research by PHE[16] shows that those who do become infected 3

[16] One dose of COVID-19 vaccine can cut household transmission by up to half - GOV.UK (www.gov.uk)

weeks after receiving one dose of the Pfizer-BioNTech or AstraZeneca vaccine were between 38% and 49% less likely to pass the virus on to their household contacts than those who were unvaccinated.

There is ongoing work to understand why certain sections of the social care workforce express vaccine hesitancy, as well as how vaccine uptake amongst the workforce can be accelerated. In February 2021, we published the UK COVID-19 Vaccine Uptake Plan, setting out the significant programme of work underway to drive vaccine uptake, including actions to improve access and to address the concerns of those who may be vaccine-hesitant. We have been working to make vaccines accessible to social care workers and have delivered an extensive communications programme aimed at addressing their concerns. We have also been continually working with stakeholders to identify further actions at a local, regional and national level to increase vaccine uptake, such as for example, through the Vaccine Hesitancy Task and Finish group established in February 2021, jointly owned by NHSEI and DHSC and bringing together stakeholders from across the social care sector. We have also held a number of roundtable sessions focusing on care homes and agency workers. This programme of work could alleviate some of the impacts of this policy by increasing the number of staff in care homes serving older adults who are voluntarily vaccinated.

Health Inequalities

In exercising functions in relation to the health service, the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service.

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. They lead to poorer outcomes, shorter, unhealthier lives and additional burdens on the NHS. We have explored how a policy making the COVID-19 a condition of work for staff working in care homes for older people could impact on existing inequalities in relation to socioeconomic status and deprivation, geographical locations and inclusion health and vulnerable groups. It is important to note there is interaction between an individuals' protected characteristics and factors that can compound health inequalities.

Socioeconomic Groups and Deprivation

People who live in deprived areas have higher rates of COVID-19 diagnosis and death than those living in less deprived areas. The mortality rates from COVID-19 in the most deprived areas were more than double the least deprived areas, for both males and

females. Poor outcomes from COVID-19 infection in deprived areas remain, even after adjusting for age, sex, region and ethnicity.

Given that the social care workforce is geographically dispersed across the country, it is reasonable to assume that at least some of the workforce live in deprived areas. This policy could therefore have a positive impact on staff who live in deprived areas, where COVID-19 prevalence and mortality are highest, as it would give them greater protection against the virus.

Conversely, adults living in the most deprived areas of England were more likely to report vaccine hesitancy (16%) than adults in the least deprived areas (7%).

Working age adults (aged 16 to 64 years) who reported annual gross income of £10,000 or less were nearly three times as likely to report vaccine hesitancy (14%) than those whose annual income was £40,000 or £50,000+ (both 5%). Conversely, adults living in the most deprived areas of England were more likely to report vaccine hesitancy (16%) than adults in the least deprived areas (7%). Working age adults (aged 16- to 64 years) who reported an annual gross income of was up to £10,000 a year or less were nearly three times as more likely to report vaccine hesitancy (14%) than those whose annual income was £40,000 or up to £50,000+ (both 5%).

Given that social care workers receive a median hourly rate of £8.50, and 58% of staff earn less than the current National Living Wage of £8.91, they may be more likely to be vaccine-hesitant. Hence this policy is likely to have an increased impact upon them as they would require a vaccination in order to avoid actions from their employer.

Geography

Mortality rates from COVID-19 were high in urban areas such as London. Data from the Office for National Statistics (ONS) shows that, in the first wave of the pandemic between 1 March and 17 April 2020, London local authorities had the highest COVID-19 mortality rates in England, allowing for the age distribution of the population.

Urban areas also have higher levels of vaccine hesitancy. In London, 13% of adults reported vaccine hesitancy. Vaccine hesitancy was much lower outside London e.g. 8% in the South East and 9% in the East of England and the East Midlands.

Studies show that people living in urban areas have increased odds of testing positive for COVID-19 relative to people living in rural areas. Within local authorities in England, higher population density, increased deprivation and a more ethnically diverse population have also been associated with higher mortality from COVID-19.

The highest age-standardised mortality rates involving COVID-19 in wave one of the pandemic (for the period March to July 2020) were in major urban areas. The lowest rates were all found in sparse settings, rural hamlets and isolated dwellings in a sparse setting. Those living in rural settings may, however, face barriers such as lack of transport, less choice regarding setting or available vaccine although we don't currently have evidence to support this.

Ethnicity interacts with geographical location and deprivation, and ethnic minority groups are more likely to live in urban, overcrowded, and more deprived communities. Ethnicity in the social care workforce varies by region, with London having the most diverse workforce (66% BAME) and the North East the least diverse workforce (3%). As outlined in the 'Race' section of the PSED above, people from BAME background are at higher risk of adverse impacts from COVID.

This policy could protect those living in areas with highest levels of mortality, specifically urban areas. However higher levels of vaccine hesitancy may mean social care staff feel pressured to accept the vaccine when they don't want to or elect to leave the workforce as an alternative to taking the vaccine.

In areas and among groups where uptake is low, we have actively sought to encourage and build confidence in vaccines. In February 2021, we established a Vaccines Hesitancy Task and Finish group, jointly owned by NHSEI and DHSC and bringing together stakeholders from across the social care sector. Outputs included more targeted support to BAME groups, sharing of best practice and increased translated comms products. We continue to work with stakeholders to identify further actions at a local, regional and national level to increase vaccine uptake, including providing directed support with the support of our regional assurance teams to care home managers.

We are also delivering a targeted programme of work to support vaccine uptake among adult social care staff and care home staff specifically, working with national and local stakeholders, including care home managers, via a number of projects and initiatives focussed on increasing vaccines uptake among SCWs in care homes showing lower staff vaccination rates, and working with local systems across London to understand what more can be done to tackle hesitancy among the sector, and in particular the London SCW workforce. All of this is supplemented by work locally, by employers, local authorities, public health teams and others.

Inclusion Health and Vulnerable Groups

Socially excluded populations, including populations such as homeless people, Gypsy, Roma, and Traveller communities, people in contact with the justice system, migrants and sex workers, tend to have the poorest health outcomes, putting them at the extreme end of the gradient of health inequalities. This is a consequence of being exposed to multiple, overlapping risk factors, such as facing barriers in access to services, stigma and

discrimination. It is unlikely that a policy of making the vaccine a condition of deployment will have positive or negative impact on vulnerable groups listed above as they would only constitute a very small proportion of people working in care homes.

Insert name of Directorate/Division/Branch

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