Department of Health & Social Care

Making vaccination a condition of deployment in health and wider social care settings- Equality Impact Assessment

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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.

Equality Impact Assessment

Title: Making vaccination a condition of deployment in the health and wider social care sector

What are the intended outcomes of this work?

We are pursuing a policy of making the COVID-19 vaccine a condition of deployment for health and care workers who have face-to-face contact with patients and service users, as part of a CQC regulated activity.

Uptake of the COVID-19 vaccine is currently optional but strongly encouraged for healthcare workers. The government has already introduced requirements for registered providers of care home accommodation to secure that anyone entering the care home has been vaccinated unless an exemption applies. In addition, prior to the pandemic, workplace health and safety and occupational health policies were already in place which required the Hepatitis B vaccine for those deployed to undertake exposure prone procedures.

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, marriage and civil partnerships, and sexual orientation. In particular, they must have due regard to the three elements of the PSED and the need to:

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

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

- 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. We are implementing this policy because the evidence shows that people receiving health and care support are some of the most vulnerable to COVID-19, and that the government wants to do all that it can to ensure that as many people in the health and social care sectors as possible are vaccinated to protect services users.

Overall average uptake of vaccination by NHS staff is currently at 92.9% for 1st doses and 89.9% for 2nd doses (data as of 4 November). Whilst these headline figures for uptake are high, they mask significant variations in uptake across organisations and hospital trusts. Uptake rates still vary from 84.2% to 97.1% for first dose (79.5% to 94.8% for both doses) amongst NHS trusts (data published 14 Oct). Among primary care workers, this ranges from 94% in the South West to 76% in the East of England. In adult social care, 83.7% of domiciliary care staff had received one dose of the vaccine and 74.6% have had a full course of a COVID-19 vaccine, which we believe represents the best proxy for Other Settings too for the workforce in scope of the policy.

Studies have reported on vaccine effectiveness against infection with COVID-19. For the Delta variant, the vaccine effectiveness against infection has been estimated at around 65% with the Oxford-AstraZeneca vaccine and 80% with the Pfizer-BioNTech vaccine. Effectiveness against symptomatic disease is even higher, at 65% to 70% for the Oxford-AstraZeneca vaccine, and 80 to 95% with Pfizer-BioNTech[1]. Vaccination reduces the risk of infection, which in turn reduces the risk of transmission. The more staff who are vaccinated against COVID-19, the more likely it will be that vulnerable people in their care are protected; staff themselves will be protected and their colleagues will also be protected.

Beyond preventing infection there may also be the additional benefit of reduced transmission by those individuals who become infected despite vaccination because of reduced duration or level of viral shedding. A household transmission study in England found that where household contacts of COVID-19 Alpha variant cases had been vaccinated with a single dose, they had approximately 35 to 50% reduced risk of becoming a confirmed case themselves.[2]

Throughout the pandemic the aim of the UK's vaccination programme has been to save as many lives as possible, while reducing hospitalisations and pressures on the NHS. This is why the rollout of the vaccines 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 the vaccines. This placed the elderly and clinically vulnerable as a top priority. We know the elderly and vulnerable are more likely to use health and care services, so ensuring workers in these settings are vaccinated is a priority, to help protect the vulnerable.

Additionally, the Scientific Advisory Group for Emergencies (SAGE) has previously advised there is a strong scientific case for parity of approaches with respect to vaccination offer and support between NHS inpatient settings and care homes, given the similarly close and overlapping networks between residents or patients and workers of all kinds in both. Public Health England has also previously published guidance[3] on COVID-19 vaccination for both health and social care workers, 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.

Ensuring and sustaining very high levels of vaccination of people working in these settings is an essential public health intervention to reduce the risk faced by the elderly and vulnerable from COVID-19. In terms of the wider public health benefits, as early as 2011,

[1] UK Health Security Agency, COVID-19 vaccine surveillance report, Week 44
[2] Harris RJ, Hall JA, Zaidi A, Andrews NJ, Dunbar JK, Dabrera G. 'Impact of vaccination on household transmission of SARS-COV-2 in England.' Public Health England 2021
[3] Public Health England, COVID-19 vaccination: guide for healthcare workers, December 2020

the World Health 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.[4]

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

We conducted a public consultation from 9 September to 22 October 2021 regarding amending the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Over 34,900 responses were submitted, and the full consultation document and government response are available online.

Who will be affected?

Workers who have face-to-face contact with patients and who are deployed, as part of a CQC regulated activity

Staff working in health and wider social care settings will be affected by a requirement that a registered provider may only deploy people who have been vaccinated against COVID-19 into a role with patient contact. There will be a particular impact on staff who have already turned down the vaccine or who are hesitant to accept it. If people working in these settings are not vaccinated and do not have an exemption, they will no longer be able to be deployed in roles where they have face-to-face patient contact. If an employer is unable to redeploy the person to an alternative, non-patient facing role then this might lead to the person being dismissed. People who continue to feel unable to have the vaccine might therefore leave the workforce instead.

We will provide for exemptions where individuals have supplied evidence that vaccination is not clinically appropriate for them. 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).

Patients being cared for / treated in health and wider social care settings:

Overall, this policy is likely to have a positive impact on staff and service users in health and care settings by causing more staff to be vaccinated and therefore reducing the risk of them transmitting COVID-19. If we did not implement this policy, staff vaccination rates might still be variable across providers and local areas.

[4] Microsoft Word - Oct 3 WORKING GROUP on vaccine hesitancy_final.docx (who.int)

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.

Analysis of impacts

Our Public Sector Equality Duty (PSED) analysis indicates that making COVID-19 vaccination a condition of deployment in health and social care could impact certain groups. Analysis is based on NHS workforce and General Practice workforce data published by NHS Digital. While the workforce data available represents most (but not all) of the impacted staff groups, there is no evidence to suggest that the composition of the workforce referenced below, differs significantly to the composition of the complete list of impacted staff groups. Given the policy will also apply to providers of social care who were not captured by the requirements relating to care homes, this analysis also considers the impact on staff who work in those settings (including domiciliary care workers).

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

- A higher level of vaccination amongst health and care staff in order to protect health and wider social care users and staff;
- Reduced likelihood of COVID-19 infections being acquired in health and wider social care settings, providing greater safety for service users;
- Reduced staff absences in the health and social care workforces over winter due to staff sickness from COVID-19 infection, leading to better care for patients;
- Reduced rate of COVID-19 transmission in the community, in turn putting less pressure on health care services.

1. Disability – attitudinal, physical, and social barriers for both visible and hidden disability

Healthcare workforce

Disabled staff make up around 4% of the NHS workforce (although 10% do not disclose their disability status[5]). There would be an exemption so that service providers could continue to deploy unvaccinated staff with disabilities who were advised not to be vaccinated for clinical reasons. Proof of exemptions will be straightforward to acquire for those who qualify, meaning no one who is disabled and clinically recommended not to be vaccinated will be disadvantaged by this policy. The exemption route will be open to job applicants, including those with disabilities. This policy would have a positive impact on exempt staff with disabilities if a greater number of their colleagues were vaccinated and therefore provided them with some protection. Some disabled staff may have faced access issues which may have resulted in them being less likely to have had the vaccines prior to this policy being implemented. Access issues could include lack of information in an accessible format or difficulty in travelling to vaccination centres. If disabled staff faced access issues and are not clinically exempt from vaccination, then this policy may disadvantage them. The requirements will be implemented with a 12-week grace period for people to get both doses of the vaccine. This may help those who previously had difficulty accessing vaccination, for instance due to accessibility issues, and provide them with the opportunity to become eligible for deployment.

Qualitative analysis of the responses DHSC received to the consultation shows that many respondents suggested that people who are classed as vulnerable / immunocompromised / disabled / who have underlying health conditions would be a particular group that would be positively impacted by the requirement. This is likely as they will face a reduced risk of COVID-19 infection, from which they face high risk of complications, when using health and care services.

Social care workforce

According to Skills for Care report[6] 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 Equality Act 2010 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,

[5] Factors influencing COVID-19 vaccine uptake among minority ethnic groups
[6] Workforce estimates (skillsforcare.org.uk)

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.

2. Sex – men and women

Healthcare workforce

Women make up over 75% and 80% of the NHS and General Practice workforce respectively[7,8]. As a result, more women will be impacted compared to men by a policy requiring COVID-19 vaccination as a condition of deployment. Although there is some historical evidence to suggest that women have higher rates of vaccine hesitancy than men, May-June 2021 data from the Office of National Statistics (ONS) showed that COVID-19 vaccine hesitancy is equal for men and women (at 4%)[9]. Women may also face more barriers to accessing vaccines (e.g. more caring responsibilities which may impact on their ability to travel to a vaccine centre). 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. If the policy results in health and care workers leaving their jobs, this will impact more women as they make up a such a significant portion of the workforce. The requirements will be implemented with a 12-week grace period for people to get both doses of the vaccine. This may help those who previously had difficulty accessing vaccination, for instance due to childcare responsibilities, and provide them with the opportunity to become eligible for deployment.

Social care workforce

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[10]. As a result, more women will be impacted than men by a policy requiring COVID-19 vaccination to be deployed in health and wider social care settings. 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

[7] NHS Workforce Statistics - December 2020 (Including selected provisional statistics for January 2021)
[8] General Practice Workforce, England - Bulletin Tables, September 2015 - March 2021
[9] Coronavirus and vaccine hesitancy, Great Britain: 26 May to 20 June 2021
[10] The state of the adult social care sector and workforce in England (skillsforcare.org.uk)

or older relatives and dependent children).This may 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 policy requiring a vaccine as a condition of deploying staff to work in the adult social care sector could lead to more women being at risk of facing enforcement action at work and potentially losing their jobs.

3. Sexual orientation - heterosexual, homosexual or bisexual

Healthcare workforce

Around 70% of NHS workforce are heterosexual, 1% bisexual and 2% homosexual[11]. (18% of staff do not disclose their sexuality). These proportions generally stay consistent across individual staff groups (except amongst ambulance/ambulance support staff where homosexual/bisexual proportions are considerably higher). There is 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[12]. These figures suggest this policy may have an impact on LGBT staff as they may be less likely to already be vaccinated. Given that individuals are not required to disclose their sexual orientation to healthcare professionals, it will be a challenge to determine the full impact of this policy for these groups, if implemented. Service users with this protected characteristic will derive the same benefits as others using health and social care services through being less likely to be infected from COVID-19 from a member of staff.

Social care workforce

There is no evidence available on the demographics of the adult social care workforce regarding sexual orientation. There is also no data on the prevalence of vaccine hesitancy by sexual orientation. If the figures quoted in the previous paragraph 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 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.

[11] NHS Workforce Statistics - December 2020 (Including selected provisional statistics for January 2021)
[12] LGBT in Britain - Health (stonewall.org.uk)

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

Minority ethnic groups account for over 20% of the NHS workforce and over 15% for the General Practice workforce.[13,14] Evidence suggests that minority ethnic groups may be more hesitant about vaccinations more generally e.g. seasonal flu and pneumococcal vaccines. Population-based analysis of previous routine vaccination uptake shows consistent reduced vaccination uptake in Black African and Black Caribbean groups (50%) compared to White Groups (70%)[15]. For South Asian groups, people of Pakistani origin have significantly lower uptake of vaccines. For more recent vaccinations (post 2013), there is lower vaccination uptake across all ethnic minority populations (10-20% lower than white populations). Regarding the COVID-19 vaccine specifically, analysis from November 2020 showed that vaccine hesitancy was highest in Black or Black British Groups (with 72% indicating they were unlikely/very unlikely to be vaccinated). Pakistani and Bangladeshi groups were the second most hesitant ethnic group. Although vaccine hesitancy is significantly reducing, more recent analysis by the Office for National Statistics (May/June 2021) indicate that Black or Black British adults had the highest rates of vaccine hesitancy (18%) compared with White adults (4%)[16]. A higher proportion of staff from ethnic minority groups could, if the policy is implemented and they still do not take up the offer of vaccination , be unable to satisfy their employers that they can be deployed in accordance with the requirements of the regulations. This ultimately could result in those members of staff losing their jobs.

Factors influencing vaccine hesitancy in minority ethnic groups pre-date COVID-19 and include[15]:

- Lower trust and confidence in vaccine effectiveness and safety.
- Lower perception of risk;
- Inconvenience and access barriers (e.g. location of vaccine appointment, relative cost, time/distance to get to vaccine appointment).
- Context and socio-demographic variation (e.g. ethnicity intersects with other factors such as socio-economic status, education levels etc.)

Factors influencing vaccine hesitancy must not be trivialised. The Government has taken a multi-channel approach to encouraging vaccine uptake in ethnic minorities. Initiatives have included (but not limited to) i) working with specialist agencies to hold a series of roundtables for ethnic minority healthcare professionals, religious and community leaders to act as ambassadors within their communities[17] ii) the development of editorial content

[13] NHS Workforce Statistics - December 2020 (Including selected provisional statistics for January 2021)
[14] General Practice Workforce, England - Bulletin Tables, September 2015 - March 2021
[15] Factors influencing COVID-19 vaccine uptake among minority ethnic groups
[16] Coronavirus and vaccine hesitancy, Great Britain: 26 May to 20 June 2021
[17] Second quarterly report on progress to address COVID-19 health inequalities

packages with trusted voices among ethnic minority healthcare professionals and celebrities, who feature in media opportunities and digital content.[18] 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.

Current evidence suggests that individuals from minority ethnic groups are at increased risk of mortality from COVID-19[19],[20]. Persons of Black African and Black Caribbean descent appear to be at greatest increased risk. In England, it is likely that health inequalities known to affect minority ethnic groups, may be increasing the risk of transmission and the risk of mortality from COVID-19. Therefore, making COVID -19 vaccination a condition of deployment is likely to have a particular beneficial effect on the outcomes of COVID-19 infection in some staff from these ethnic groups.

It is also notable that when we breakdown responses to the consultation by ethnicity (table 1), Black/African/Caribbean/Black British responders show the lowest level of supportive/slightly supportive of all ethnic groups at 11%. This corroborates the analysis set out above. Additionally, it is Asian/Asian British responders that have shown the highest level of support of all ethnic groups at 33%.

Table 1: Support for mandatory COVID-19 vaccination by ethnicity

	White	**Black/ African/ Caribbean/ Black British**	**Asian/Asian British**	**Mixed/ multiple ethnic groups**	**Another ethnic group**
Supportive	28%	8%	33%	17%	14%
Slightly supportive	3%	3%	3%	1%	1%
Neither supportive or unsupportive	5%	11%	7%	6%	5%
Slightly unsupportive	2%	4%	4%	1%	2%
Not supportive	62%	72%	52%	74%	77%
I don't know	1%	2%	1%	1%	1%

[18] Third quarterly report on progress to address COVID-19 health inequalities
[19] The Greenbook chapter 14a, 2021
[20] Beyond the data: Understanding the impact of COVID-19 on BAME groups

Additionally, qualitative analysis of the responses DHSC received to the consultation shows that many respondents suggested that people of ethnic minorities would be a particular group that would be negatively impacted by the requirement. Responders suggested this is likely as these groups may have higher levels of mistrust in vaccination than the wider population and, therefore, higher risk of redeployment or dismissal if unvaccinated.

For workers from outside the UK, we will set out specific requirements for those vaccinated aboard, including where necessary, a top-up dose with a UK authorised vaccine, consistent with UKHSA's advice on vaccination doses and mixed vaccines. This will limit the risk that non-UK workers will be disadvantaged by this requirement.

Social care workforce

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. Black/African and Black/Caribbean staff comprise 12% of the adult social care workforce, compared to 3% of the overall population.

Vaccine hesitancy among people in ethnic minority groups is being addressed through a number of means outlined in the healthcare impact section these include but are not limited to, 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.

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.

5. Age - age ranges, old and young

Healthcare workforce

Within the NHS workforce, the proportion of those aged between 25-34, 35-44 and 45-54 is approximately 25% for each age bracket. Around 6% of staff are aged below 25, and 2% are aged 65 or over[21]. Ambulance and support staff tend to have a higher representation of younger people, whereas older people are more represented in roles within NHS infrastructure support. If implemented, this policy is likely to have a positive impact on older staff, given that increased age is a risk factor for poorer outcomes of infection. Recent ONS data show that levels of COVID-19 vaccine hesitancy in the general population are higher in younger people – 9% in those 18-21 years, and 10% in those aged 22-25 compared with 4% in the general population[22]. This may possibly be because they feel themselves to be at lower risk of death or adverse outcomes from infection. Throughout the time the Government has consulted on this policy it has worked to encourage uptake in younger people, the Government will continue to highlight the potential benefits of vaccination to one's colleagues, patients and families in addition to personal benefits.

It is also possible that as younger people have been eligible for vaccination for a shorter amount of time, this may have impacted their ability to access vaccination, potentially resulting in them being significantly impacted by this requirement. This risk will be abated as the requirements will be implemented with a 12-week grace period for people to get both doses of the vaccine. This may help those who previously had difficulty accessing vaccination and provide them with the opportunity to become eligible for deployment.

Qualitative analysis of the responses DHSC received to the consultation shows that many respondents suggested that elderly people would be a particular group that would be positively impacted by the requirement. This is likely as they will face a reduced risk of COVID-19 infection, from which they face high risk of complications, when using health and care services.

Social care workforce

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[23]. We estimate that

[21] NHS Workforce Statistics - December 2020 (Including selected provisional statistics for January 2021)
[22] Coronavirus and vaccine hesitancy, Great Britain: 26 May to 20 June 2021
[23] The state of the adult social care sector and workforce in England (skillsforcare.org.uk)

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.

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. Whilst these mitigations are all in reference to care homes specifically, we will seek to extend them where appropriate to the wider adult social care sector.

6. 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 healthcare workforce. There is also no evidence that this group experiences higher levels of vaccine hesitancy. However, there are reports that persons with this protected characteristic face some issues when accessing healthcare, including fear of discrimination and experiences of healthcare staff lacking understanding of specific trans health needs[24]. Factors such as these can deter transgender people from accessing medical treatment. As a result, they may be less likely to be registered with a GP, or less likely to respond to communication inviting them to have the vaccine.

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. Therefore, they may be 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

[24] Trans health. Trans inclusion.

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.

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

Healthcare workforce

Christianity is the most widespread religious belief in the NHS Workforce (at 43%), followed by atheism (12%). However, the majority of other beliefs and none, are also represented. Recent ONS data indicate that COVID-19 vaccine hesitancy was higher for adults identifying Muslim (15%) or 'other' (11%) as their religion, when compared with adults who identify as Christian (3%)[25]. There was no statistically significant difference when compared with any of the remaining religious groups.

A number of people may be opposed to vaccination in principle due to their beliefs, either religious or nonreligious. These beliefs may encompass safety concerns, 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. If this policy is implemented, people who hold these beliefs may be likely to feel compelled to have a vaccine they do not want, or, by refusing to have the vaccinations, unable to satisfy their employers that they can be deployed in accordance with the requirements of the regulations. This ultimately could result in those members of staff being dismissed.

The Muslim Council of Britain has shared information from the British Islamic Medical Association recommending that Muslims can take the Oxford/AstraZeneca vaccine[26]. The Vatican has also announced that Catholics may use vaccines derived from foetal cell lines where alternatives are not available[27]. As previously mentioned, the Government has taken (and will continue to take) steps to ensure religious groups are engaged.

Looking at the responses received through the consultation exercise, table 2 breaks them down by religion. It is notable that those of Hindu and Jewish faith show the highest level of support for the policy, whilst Muslim and Buddhist responders are the most opposed to the policy. This corroborates the analysis conducted above, and it is possible that those of Muslim and Buddhist faith are more inclined to be opposed to vaccination for faith-based

[25] Coronavirus and vaccine hesitancy, Great Britain: 26 May to 20 June 2021
[26] Latest COVID19 Advice for British Muslims - Muslim Council of Britain (MCB)
[27] Note on the morality of using some anti-Covid-19 vaccines (21 December 2020) (vatican.va)

reasons. As such these groups may be more likely to face negative impacts from the implementation of this policy.

Table 2: Support for mandatory COVID-19 vaccination by religion

	No religion	Christian	Muslim	Buddhist	Hindu	Jewish	Sikh	Other
Supportive	27	28	18	13	47	46	24	10
Slightly supportive	3	3	4	2	2	3	5	2
Neither supportive or unsupportive	5	6	8	6	5	4	10	6
Slightly unsupportive	2	2	4	2	3	1	9	1
Not supportive	62	61	66	76	41	46	52	79
I don't know	1	1	1	0	2	1	0	1

Additionally, qualitative analysis of the responses DHSC received to the consultation shows that many respondents suggested that those with religious views and those with cultural / ethical views which may not be compatible with getting the vaccine would be a particular group that would be negatively impacted by the requirement. This is likely as they will face an increased risk of redeployment or dismissal if they refuse vaccination. We have considered exemptions for those who refuse the vaccine due to religious beliefs and have opted not to provide this exemption. This type of exemption would be difficult to implement or prove and would likely significantly reduce the impact of the policy in achieving its aims of increasing levels of protection for both the workforce and patients. It may also cause tension between those who have been exempted and other staff who have been required to be vaccinated as a condition of deployment.

Social care workforce

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. 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. Employers will be encouraged (through guidance) to consider redeployment as an alternative to dismissal wherever a worker is unable/chooses not to get vaccinated. And as above we have considered exemptions for those who refuse the vaccine due to religious beliefs and have opted not to provide this exemption. This type of exemption would be difficult to implement or prove and would likely significantly reduce the impact of the policy in achieving its aims of increasing levels of protection for both the workforce and patients. It may also cause tension between those who have been exempted and other staff who have been required to be vaccinated as a condition of deployment.

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

As the healthcare workforce is predominantly female, the incidence of pregnancy and maternity among the workforce is higher than the general population. As mentioned previously, in April 2021, JCVI updated their advice on vaccination during pregnancy to state that pregnant persons should be offered the COVID-19 vaccine at the same time as people of the same age or risk group[28]. Previously, routine vaccination during pregnancy was not advised. While vaccination is encouraged during breastfeeding - (there are no known risks associated with COVID-19 vaccinations and breastfeeding) - the Royal College of Midwives has advised women to be aware of the lack of safety data for these vaccines in breastfeeding[29]. As a result, pregnant and breastfeeding healthcare staff may be less likely to have already been vaccinated against COVID-19. There is a risk that a requirement to have the vaccine could cause anxiety in pregnant and breastfeeding staff. The JCVI will continue to closely monitor the evidence on COVID-19 vaccination in pregnancy and post-partum and will update its advice as required.

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. 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 negatively impacted by a move to make vaccination a condition of deployment if this results in more women being unable to or unwilling to access COVID-19 vaccination.

[28] JCVI issues new advice on COVID-19 vaccination for pregnant women
[29] UPDATED ADVICE ON COVID-19 VACCINATION IN PREGNANCY AND WOMEN WHO ARE BREASTFEEDING

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. There are already arrangements in place for demonstrating COVID-19 status with short-term exemptions available for those with short-term medical conditions and as an option that some pregnant women may choose to take. For pregnant women the exemption expires 16 weeks post-partum. This will allow them to become fully vaccinated after birth. We will set this out these arrangements in the guidance on exemptions. This will reduce the extent of the impact of this policy on pregnant women.

9. Marriage and civil partnership - married couples, civil partnerships

There is no current evidence that making COVID-19 vaccination a condition of deployment 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

Alongside the over 39,400 consultation responses that DHSC received and analysed through this exercise, the department also carried out roundtable meetings with a range of stakeholders, direct engagement with Unions through the Social Partnership Forum, and direct engagement with care providers through a regular care forum.

Feedback and evidence from these events have been fed into the consultation and informed the consultation response, and the overall policy. The topics discussed at the events included the rationale behind the policy proposal, the proposed scope of the regulations, workforce impacts and wider implementation issues.

We have raised awareness of, and encouraged participation in, the consultation through our DHSC communications channels and through targeted communications delivered directly to NHS trusts through targeted bulletins, as well as by cascading the consultation through local Healthwatch organisations. 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 the redeployment or dismissal of staff who work in health and social care settings who refuse to be vaccinated. It could also result in these workers feeling pressured to have vaccinations when they would not have otherwise.

There would be a positive impact on services users in healthcare settings and care homes. These are predominantly vulnerable individuals who may face a higher risk from COVID-19 infection than the wider population. This policy will mean that more staff would be vaccinated, providing them greater levels of protection against COVID-19 infection.

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. These risks will also be reduced by the 12-week grace period before the requirements come into force, which will provide the opportunity to get both doses of a vaccine for those who have not yet had the opportunity to get vaccinated. 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 or pregnancy, 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.

Young people may be significantly affected by this policy due to higher levels of vaccine hesitancy, as may women due to 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. It will also be mitigated by the 12-week grace period to allow for full vaccination before the restrictions come into force.

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 higher levels of

vaccine hesitancy in these groups, meaning more people would be impacted by making the COVID-19 vaccine a condition of deployment. 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.

The analysis conducted here is based on evidence gathered through the consultation process, as well as historical data and evidence from the COVID-19 pandemic so far. As set out, there are multiple groups with protected characteristics who may be disadvantaged by this policy, either through redeployment or dismissal. However, this must be balanced against the public health benefits of maximising vaccine uptake in the health and care workforces, and the benefits this will bring, specifically to elderly and vulnerable people who face a high risk of serious complications from COVID-19.

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 deployment for workers in health and wider social care settings 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 health and 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.

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%).

For workers in NHS trusts and Clinical Commissioning Groups in England, the mean annual basic pay per full time equivalent (FTE) was £33,920 in the 12-month period up to the end of June 2021. This is greater than the ONS published average earnings of £29,952 in June 2021. This suggests NHS workers may be less likely than the wider population to be vaccine hesitant due to socioeconomic factors.

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. 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 both health and social care, the government has worked extensively with key stakeholders and arm's length bodies to encourage uptake, and build confidence in vaccines, especially in areas and among groups where uptake is low. The NHS has listened directly to the questions and concerns of its workforce, and targeted communication in a supportive manner to ensure every can make an informed decision regarding vaccine uptake.

This has included using trusted messengers to deliver information, ensuring all staff have a supportive conversation regarding vaccination with their line manager, and other bespoke solutions such as buddying trusts with varying uptake to ensure adoption of best practices.

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 health and care settings.

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