Consultation outcome

Revoking vaccination as a condition of deployment across all health and social care: consultation response

Updated 1 March 2022

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This publication is available at https://www.gov.uk/government/consultations/revoking-vaccination-as-a-condition-of-deployment-across-all-health-and-social-care/outcome/revoking-vaccination-as-a-condition-of-deployment-across-all-health-and-social-care-consultation-response

Introduction

Background and objectives

On 31 January 2022, the government announced its intention to revoke the regulations making coronavirus (COVID-19) vaccination a condition of deployment in health and social care, subject to consultation and parliamentary process.

As part of the announcement, the government set out the changes in clinical evidence which made it right to revisit the balance of risks and benefits that had guided government's original decisions to introduce COVID-19 vaccination as a condition of deployment in health and social care. At that time Delta was the dominant variant of COVID-19, compared to Omicron which is intrinsically less severe. With a population that had immune systems that had limited exposure to COVID-19, and with vaccine effectiveness against infection after 2 doses estimated at 65% to 80%, the clinical evidence weighed heavily in favour of introducing the requirement in order to protect patients and the people who receive care and support.

Our overriding concern remains their protection, as well as protecting our valuable health and social care workforce. Our population as a whole is now better protected against hospitalisation from COVID-19 thanks to our world leading vaccine programme and we will build on the existing work to support and encourage vaccine uptake it continues to be a clear professional responsibility of all health and social care staff to be vaccinated. However, combined with the reduced vaccine effectiveness against infection, it is right and responsible to revisit the vaccination as a condition of deployment policy.

Government subsequently held a consultation between 9 and 16 February 2022 to seek views on the government's intention to revoke the vaccination as a condition of deployment policy in health and social care. This document sets out the government's response.

Latest COVID-19 vaccine uptake

Data collected for the NHS shows that over 1.45 million (95%) NHS trust staff have received at least one dose, with 1.4 million (92%) staff having received 2 doses. The percentage of staff receiving a first dose is above 96% in all regions (2 doses above 90%), bar London, which is at 92% for first dose (87%, 2 doses). Over 1.17 million (77%) have received a booster. All data as of 3 February 2022, covering vaccinations up to 30 January 2022 (https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/).

More than 1.3 million social care workers in England have now taken up at least one dose of the vaccination. As of 13 February 2022, 96% of staff in care homes have received a first dose of the vaccine and 95% a second dose. In wider social care settings, while the regulations have not come into force, providers were reporting that 89% of home (domiciliary) care staff and 76% of staff in other settings had received one dose of the vaccine, as of 13 February 2022. There is little regional variation in care home uptake, however there is some variation in domiciliary care staff uptake, which ranges from 85% in London, to 92% in the North East and Yorkshire.

We have all been kept safer by the incredible efforts of the NHS and volunteers who stepped forward to help with the rollout of vaccines. As of 1 February 2022, over 84% of England's population aged 12 and over have received 2 doses of the vaccine (https://coronavirus.data.gov.uk/details/vaccinations?areaType=nation%26areaName=England#card-latest_reported_vaccination_uptake), while 64.6% have received their third dose or booster. This is a fantastic achievement and we are grateful to all those who have played their part.

As of 13 February 2022, 96% of all care home residents have received 2 doses of the vaccine and 88% have received a booster. In the general population, 92% of adults aged 80 and over have received 2 doses of the vaccine and 88% have received their third dose or booster. Of those identified as clinically extremely vulnerable to COVID-19, 94% have received 2 doses of the vaccine and 85% have received their third dose or booster.

Our consultation

The Department of Health and Social Care (DHSC) conducted a public consultation regarding government's intention to revoke the requirements imposed by the Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021 (https://www.legislation.gov.uk/uksi/2021/891/contents/made) and the Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) (No.2) Regulations 2022 (https://www.legislation.gov.uk/uksi/2022/15/made) (collectively referred to as 'the regulations'). These regulations place requirements on health and social care providers relating to the vaccination of workers against coronavirus COVID-19 and, in the case of care homes, individuals entering the care home premises.

We consulted on the revocation from 9 to 16 February 2022 and the full consultation document is available online (https://www.gov.uk/government/consultations/revoking-vaccination-as-a-condition-of-deployment-across-all-health-and-social-care/revoking-vaccination-as-a-condition-of-deployment-across-all-health-and-social-care). This is the formal government response to that consultation.

The consultation posed a series of questions about the government's proposals, which covered the following areas:

- proposed legislative change
- steps to further increase vaccine uptake
- equality impacts

The consultation was available through an online survey hosted on gov.uk from 9 to 16 February 2022, and over 90,000 responses were submitted. A total of 17 responses to the consultation were received outside of the online platform, which were also accepted and analysed. The government is grateful for the responses received from individuals and organisations and values the comments and views submitted.

This document summarises the responses to that consultation and sets out the government's response to the issues raised in each section. In the government response sections, 'we' refers to the UK government.

Stakeholder Engagement

Pre-consultation engagement with a broad range of stakeholders across health and care was undertaken following the Secretary of State's announcement on 31 January. This covered the government's intention to consult on revoking the regulations making vaccination a condition of deployment. To supplement the views provided in the consultation following its publication, DHSC also conducted further engagement with stakeholders during the consultation period. We are grateful to all those who joined the stakeholder engagement meetings for adult social care stakeholders on 14 February and representative organisations of patients and people who receive care or support on 15 February. The topics discussed included:

- the rationale behind the proposal to revoke the requirement
- what else could be done to promote vaccine uptake

- equality issues and workforce impacts as well as views
- issues in relation to vulnerable to COVID-19 or immune-suppressed individuals

We have raised awareness of, and encouraged participation in, the consultation through our DHSC communications channels and through targeted communications delivered directly to health and social care stakeholder organisations.

Methodology

The survey hosted on GOV.UK comprised of closed-ended (quantitative) and open-ended (qualitative) questions. We also received 17 off-platform responses via email.

Descriptive statistics of the quantitative responses were produced, which are used to describe and summarise the characteristics of the consultation responses, not to make inference or prediction, or assess the interaction between variables. For each question, distributions of responses were calculated as percentages of those who provided an answer to that question.

Responses to the consultation are not representative of the groups referenced, but only of those who chose to respond to the consultation. Where particular groups are referred to or compared for example, ‘members of the public are most likely to say…’ this refers only to members of the public responding to the consultation and cannot be taken to represent the views of the public more generally. As such, statistical significance testing has not been used to analyse results. Differences between responding groups have been highlighted using judgement.

We have assumed in analysis that respondents submitted responses in good faith which, if given, accurately represent their characteristics and their view. For example, we take at face value those selecting ‘member of health workforce – registered nurse’ are indeed from this group, as verification was not sought.

For ease of reading and consistency with the previous consultations on this issue, unless specified otherwise, we have aggregated positive or negative responses. For example, if 28% were unsupportive and 5% slightly unsupportive, we have written this as ‘33% unsupportive’. These aggregated figures are derived from the frequencies rather than the rounded percentages. In most cases, this would result in the same figure, but may in some cases result in a one or 2 percentage point difference from adding together rounded percentages.

Accompanying data tables have been published alongside the consultation response. These data tables present full breakdowns for each quantitative question in the consultation and provide the data used in the analysis section. We have also published a set of data comparing the demographics of the responses to the consultation to the English population and English workforce demographics. The number of respondents in each of the categories is set out in the accompanying Excel tables.

The consultation included 4 open-ended questions where respondents could provide free text responses. Across these questions, around 4 million words were received in approximately 125,000 free text responses.

A random sample of all respondents’ free text responses for each of the open format questions was taken and reviewed using thematic analysis to code responses into themes. A further sample was then drawn to check themes and ensure adequate coverage. We also took a random sample of those who opposed the proposed revocation, stratified by type of respondent, and ran similar thematic analysis to understand the concerns of this group.

Whilst qualitative analysis is not intended to show exactly how many people held a certain view, we have endeavoured to provide an indication of the weight of opinion in responses, using words such as ‘many’, ‘some’, ‘several’, or ‘a few’.

Government response to the issues raised

Proposed legislative change

Respondents were asked about their preference regarding revocation of the vaccination as a condition of deployment requirements. The consultation responses showed clearly the strength of feeling about the policy, both through the large number of total responses received and the clear preferences indicated.

90% of respondents supported revoking the requirement with 9% opposing this proposal. There was some variation between different groups, with members of the public most likely to support revocation (96%) whereas 30% of managers and 22% of organisations providing health and care services opposed revocation.

It was evident in a limited number of responses from members of the public that their support for revoking vaccination as a condition of deployment was based in wider vaccine hesitancy rather than concerns specific to the impacts of this particular policy. The scientific and clinical evidence is clear that vaccines save lives and remain our very best line of defence against COVID-19 and it is on this basis that government remains clear that everyone should take up their offer of a vaccine, especially those working in health and social care who have a professional responsibility to do so.

Our discussion of the government's proposed approach through engagement with health and social care stakeholders has shown a broad level of support for revocation of vaccination as a condition of deployment. Key themes from stakeholders who supported revocation include:

- widespread dissatisfaction with the timing of communication of the intention to revoke the policy
- recognition of the issues already caused as a result of the implementation of the policy to date and the impact on relations between managers and staff in increasing uptake
- desire for clarity over the timelines for revocation and the need for certainty for staff who are currently not fully vaccinated
- calls for clarity on scope and timeframes for future guidance on infection prevention and control measures in health and social care settings, including the government's announced intention to consult on updating the Code of Practice on the prevention and control of infections (the code applies to all Care Quality Commission (CQC) registered health and social care providers in England and the consultation will look at strengthening its requirements in relation to COVID-19)
- some stakeholders, in particular those representing care homes, raised concerns over the ongoing impact on workforce capacity of vaccination as a condition of deployment remaining in place
- some stakeholders also raised concerns in relation to protection of patients and people who receive care or support who are particularly vulnerable to COVID-19. This is considered further in the 'Consideration of potential impacts' section below

The government is grateful to the large number of people who took the time to provide their views as part of the consultation and has considered these carefully.

Government recognises both the clear importance of engagement and communication with stakeholders as part of policy announcements and the incredible efforts undertaken across the health and care sector as part of the drive to increase vaccination levels. We do not underestimate the effort and engagement that has been taken across employers and their staff and the impact of the proposed change in approach.

However, it is right that government responds to the changing landscape of the pandemic. The latest scientific evidence shows that the Omicron variant, relative to Delta, is intrinsically less severe (https://www.medrxiv.org/content/10.1101/2022.01.12.22269148v1.full.pdf) and that a full primary course of an approved vaccine does not provide the intended longer-term public health protection against the spread of COVID-19 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1050236/technical-briefing-34-14-january-2022.pdf). However, the initial data also shows that a booster increases protection against Omicron infections and protection against hospitalisation is even higher and more durable. The intended benefits of the policy must be balanced against the existing and predicted impacts, including workforce capacity.

In light of this latest scientific evidence and having considered the views received as part of the consultation (see Analysis section below), as well as an analysis of equalities impacts (set out in full in 'Annex A' below), the government will bring forward regulations to revoke vaccination as a condition of deployment.

The regulations will revoke the requirements that CQC registered persons only permit those who are vaccinated against COVID-19, unless otherwise exempt, to be deployed for the provision of a CQC-regulated activity in health and/or social care, and to enter CQC registered care home premises.

We fully recognise the calls for clarity and for quick revocation of the regulations. Regulations revoking vaccination as a condition of deployment will be made following the publication of this consultation response. The regulations will come into force on 15 March in order to provide certainty for employers, their staff, patients and people who receive care or support ahead of 1 April when regulations extending the requirement to health and wider social care were due to come into force.

Increasing vaccine uptake

The importance of vaccination remains clear and receiving a full course of vaccination, in particular a booster dose, is crucial in ensuring the levels of protection that individuals receive against COVID-19. This is particularly the case for those working in health and social care who have a duty to protect those they care for against COVID-19. The efforts of the health and social care sector to encourage staff to receive their COVID-19 vaccinations have been, and continue to be, incredible. While this government is of the view that it is no longer proportionate to require this through statute, we also asked for views on what else can be done to increase vaccine uptake.

Respondents were asked whether there are other steps (other than those set out in the original consultations on introducing vaccination as a condition of deployment) the government and health and care sector could take to increase vaccine uptake. The consultation responses showed that a majority answered 'no' to this question; respondents who were in favour of revoking the vaccination requirement were much more likely to say this. Respondents who would prefer the vaccination requirement not to be revoked were more split on whether the government and health and care sector could be doing more. Some suggested that further evidence and information on the benefits of vaccination and likelihood of any risks, direct engagement with those who are vaccine hesitant, and removing practical and logistical barriers to accessing the vaccine could all help drive uptake. As part of discussions with stakeholders, the need for employers to rebuild trust through engagement with those who are vaccine-hesitant was also stressed. Respondents also drew specific attention to hesitancy among ethnic minority groups, with the recommendation that a community-led approach to engagement should be taken to drive uptake.

The government will review these recommendations and work with the NHS and social care stakeholders to engage with those who are yet to make the positive choice to be vaccinated. This will build upon the existing programme of work that is being delivered to support and encourage vaccine uptake in the adult social care sector, which includes bespoke communications aimed at stakeholders, providers, and frontline workers themselves. A Vaccine Boosters Taskforce for Social

Care was established in January 2022 to identify further actions to improve vaccine uptake. The Taskforce has since published a paper to support good practice (https://www.skillsforcare.org.uk/resources/documents/News-and-events/News/COVID-19/Good-practice-for-local-booster-vaccination-3-Feb-22.pdf) for driving booster vaccination in England, (aimed at integrated care systems, local authorities and providers).

Both the government and stakeholders are clear that those working in health and social care have a professional responsibility to be vaccinated if they can be. A joint statement from the General Medical Council and Academy of Medical Royal Colleges (https://www.aomrc.org.uk/statements/doctors-vaccination-joint-statement-from-the-gmc-and-academy-of-medical-royal-colleges/) reiterates that doctors have a professional duty to protect patients from risks posed by their health, and to be immunised against common serious communicable diseases, unless contraindicated. The government will continue to work with the professional regulators to review current guidance to registrants on vaccinations, including COVID-19, and to emphasise their professional responsibilities in this area.

The government has set out its intention to consult on the Code of Practice on the prevention and control of infections to strengthen requirements in relation to COVID-19 and bring it in line with updated infection prevention and control (IPC) guidance for registered providers of health and social care. This is not considered as part of this consultation response; updates to the code will be consulted on separately. We will set out the next steps on this as soon as possible.

Consideration of potential impacts

Respondents were asked whether there are particular groups of people, such as those with protected characteristics, who would be particularly negatively affected or would particularly benefit from COVID-19 vaccination not being a condition of deployment in health and social care. They were also asked what actions could be taken to protect those with protected characteristics. The government concludes that although there are potentially impacts on particular groups of people, identified in the analysis below, on balance the decision to revoke is proportionate. A detailed Public Sector Equality Duty (PSED) Assessment is available in Annex A and is factored into the above consideration.

A key theme raised as part of the consultation was the protection of people who are vulnerable to COVID-19 when in health and care settings. During the consultation we heard views from representative organisations of vulnerable to COVID-19 or immune supressed patients or people who receive care or support. The concerns raised included:

- the measures other than vaccination that are in place in health and social care settings to protect patients who are vulnerable to COVID-19 from transmission of COVID-19
- the adequacy of communication to patients and people who receive care and support on the clinical evidence and the rationale for the government's intention to revoke the vaccination as a condition of deployment policy
- whether and how patients and people who receive care and support could decide not to be treated by unvaccinated workers

While the government intends to revoke vaccination of condition of deployment there remain long established IPC measures which in their own right minimise the risk of transmission of COVID-19 and help protect those that are vulnerable to COVID-19 as well as those caring for them. These are actively kept under review to ensure they are proportionate and effective.

National guidance (https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-guidance-for-maintaining-services-within-health-and-care-settings-infection-prevention-and-control-recommendations) issued jointly by DHSC, Public Health Wales (PHW), Public Health Agency (PHA) Northern Ireland, NHS National Services Scotland, UK Health Security Agency

(UKHSA) and NHS England details the IPC principles required to prevent transmission of COVID-19 and other respiratory viruses and minimise disruption to health and care services throughout the winter period 2021 to 2022.

This guidance also details the duties that an organisation must undertake in protecting both its workforce and patients and people who receive care or support. This includes:

- risk assessment(s) to be undertaken for health and care staff who may be at high risk of complications from respiratory infections such as influenza, and severe illness from COVID-19 (for example pregnant and ethnic minority staff)
- patients who are at high risk or extremely high risk of severe outcomes of respiratory infection are protected from COVID-19 and other respiratory infections. This must include consideration of their families and carers accompanying them for treatments/procedures
- screening, triaging and testing for SARS-CoV-2 or other respiratory infections according to local or country-specific testing strategies or frameworks and data

Analysis

The full data used in this section can be found in the accompanying Excel tables.

Over 90,000 responses were received to the consultation. Those identifying as a member of public made up the largest proportion of respondents (55%). Those identifying as a person who delivers health or social care services to patients or people needing care and support were the second largest group responding (26%).

Question 1: which of the following best describes your preference for this requirement?

There were 90,020 responses to this question, which were as follows:

Responses to question 1	**Total**	**Percent**
I feel strongly that the requirement should be revoked	78,527	87%
I would prefer that the requirement is revoked	2,787	3%
I don’t mind either way	366	0%
I would prefer that the requirement is not revoked	1,830	2%
I feel strongly that the requirement should not be revoked	6,271	7%
I don’t know	239	0%

90% of respondents to this question in the consultation supported revoking the requirement for COVID-19 vaccination in health and social care settings, with only 9% expressing opposition to revocation.

Support for revocation differed by type of respondent, but the vast majority of all groups supported revocation. The public overwhelmingly supported revoking the requirement (96%); this was the highest level of support of any respondent type, ahead of patients or friends or family or carers of patients (92%). The largest opposition to revocation was by managers of health or social care services, 30% of whom said the requirement should not be revoked, followed by 22% of organisations providing health or social care services.

Members of the health and care workforce were highly likely to support revocation (84%). The most supportive workforce groups (with at least 100 consultation responses) were community care workers (90%), dental practitioners (90%), homecare workers (90%), nursing associates (91%), other regulated health or social care professionals (91%), and unpaid carers (90%). The workforces most likely to oppose revocation (with at least 100 consultation responses) were ancillary or administrative staff (24%), healthcare scientists (21%), medical practitioners (27%), pharmacists (30%), radiographers (22%), and volunteers (24%).

There was overwhelming support for revocation across all demographic groups. The groups most likely to support revocation were 35 to 44 year olds (93%), Black or African or Caribbean or Black British (94%), Males (93%), and those in the West Midlands (94%) and South West (93%). The demographic groups (with at least 100 responses) most likely to oppose revocation were Asian and Asian British (15%) and Hindu respondents (20%).

Question 2: thinking about yourself, your colleagues, your staff or care providers who are hesitant to get vaccinated, do you believe there are other steps (other than those set out in the original consultation) the government and the health and social care sector could take to increase vaccine uptake?

There were 90,020 responses to this question, which were as follows:

Responses to question 2	**Total**	**Percent**
Yes	14,950	17%
No	63,389	70%
I don’t know	11,681	13%

The majority of respondents thought there were no other steps that the government and health and social care sectors could take to increase vaccine uptake (70%).

Respondents who selected ‘Yes’ or ‘I don’t know’ were asked what specific actions the government and the health and social care sector should be taking to further increase vaccine uptake. Many respondents suggested or implied that no further actions should be taken. Comments often referred to personal autonomy and freedom of choice in relation to vaccination.

A number of respondents told us that actions could include enhancing awareness, engagement and education about the vaccine. Some respondents said that there should be engagement with people who are hesitant about the vaccine by discussing their concerns with them.

Further evidence and information on the benefits and risks of the vaccine was mentioned by a number of respondents as actions the government and the health and social care sector should be taking to further increase vaccine uptake. Some respondents said that providing further data and

evidence, as well as open discussion about vaccine risks, would enhance transparency and help individuals make an informed choice.

Some respondents mentioned that further practical or logistical support could be provided to enable further vaccine uptake. Suggestions included more vaccination sites and vaccination sites having longer opening hours to make it more compatible for shift workers to access the vaccine.

Question 3: are there particular groups of people, such as those with protected characteristics, who would be particularly negatively affected by a COVID-19 vaccination not being a condition of deployment in healthcare and social care?

There were 90,020 responses to this question, which were as follows:

Responses to question 3	Total	Percent
Yes	12,654	14%
No	60,101	67%
I don't know	17,265	19%

Two-thirds (67%) of respondents said there were not any particular groups that would be particularly negatively affected by the revocation.

Respondents who selected 'Yes' or 'I don't know' were provided with a free text box to provide details about which particular groups might be negatively impacted by revoking the COVID-19 vaccination being a condition of deployment. There were some data quality concerns about the responses to this question. Responses suggest that a large number of respondents misinterpreted the question and that these respondents mistook the question to refer to negative effects of the original requirement rather than of the revocation. Despite these concerns, some clear groups were identified in the responses to this question, often by those who feel strongly or would prefer that the requirement is not revoked.

People who are vulnerable to COVID-19, for example people who are immunocompromised, people who have disabilities, and people with underlying health conditions, were identified as potentially being negatively affected by the revocation. This group was mentioned by many respondents who feel that the requirement should not be revoked. Both patients and health and social care staff who are vulnerable to COVID-19 were specifically mentioned by some respondents as being negatively affected by the revocation. These respondents tended to highlight vulnerability to COVID-19 in a more general way rather than specific references to nosocomial infection.

A number of respondents mentioned older people and ethnic minorities who have been more vulnerable to COVID-19 as groups who may be negatively affected by the requirement being revoked. As above, these respondents usually made general reference to COVID-19 vulnerability than to specific health and social care settings.

Some respondents mentioned those who are pregnant as a group which could be negatively affected. People who are unable to receive the vaccine themselves were identified by some respondents as a group who may be negatively impacted by the revocation. Although this was often left unstated, some respondents suggested this was because those who cannot be vaccinated are at danger if vaccination levels of those around them are lower.

A few respondents mentioned health and social care staff who have previously been vaccinated due to the requirement, who may not have otherwise chosen to get vaccinated, as a group which could be negatively impacted. These responses tended to suggest that this group was disadvantaged because they have already decided to be vaccinated, anticipating the vaccination as a condition of deployment requirement that this proposal is now seeking to remove. They are disadvantaged since they did not wish to originally get the vaccine and would not have done so had it not been for the requirement.

Question 4: are there particular groups of people, such as those with protected characteristics, who would particularly benefit from a COVID-19 vaccination not being a condition of deployment in healthcare and social care?

There were 90,020 responses to this question, which were as follows:

Responses to Q4	**Total**	**Percent**
Yes	43,247	48%
No	27,645	31%
I don't know	19,128	21%

Responses to this question were more mixed, but nearly half (48%) of respondents thought there were particular groups who would particularly benefit from the revocation.

Respondents who selected 'Yes' or 'I don't know' were provided with a free text box to provide details about which particular groups might benefit from revocation of COVID-19 vaccination being a condition of deployment. There were some data quality concerns about the responses to this question. Responses suggest that some respondents misinterpreted the question and mistook it to refer to positive effects of the original requirement rather than of revocation. Despite these concerns, some clear groups were identified in the responses to this question.

Patients were a common group identified in responses as benefiting from the requirement being revoked. Comments related to preventing health and social care staff leaving and consequently further staff shortages impacting staffing levels and hence care for patients and people with care and support needs, which could be a result of vaccination being a condition of deployment.

Another group identified by a number of respondents was health and social care staff. It was suggested that the revocation would prevent staff losing their current jobs if they choose to remain unvaccinated. Some respondents mentioned that revocation would improve morale amongst staff. It was also mentioned that more people may be inclined to join the health and social care workforce if the requirement was revoked.

People with religious, cultural or other personal views which dissuaded them from being vaccinated for COVID-19 were identified by a number of respondents as benefiting from revocation, since they would otherwise be disproportionately affected by any job losses as a result of vaccination as condition of deployment (since they have lower vaccination rates).

Question 5: what actions can the government and the health and social care sectors take to protect those with protected characteristics or the groups you've identified, if a COVID-19 vaccination is not a condition of deployment?

A number of respondents mentioned infection control and personal protective equipment (PPE) measures as actions which the government and the health and social care sectors could take if COVID-19 vaccination is not a condition of deployment. Some respondents referred to regular testing and staying home if positive for COVID-19.

Some respondents said that the government and the health and social care sectors could provide public health advice to improve general health and immune systems, such as taking certain vitamin supplements, exercise, and maintaining a healthy diet.

Many respondents identified that they would like to see reduced government action and COVID-19 measures more generally. Many respondents reflected that they would like more individual responsibility and choices in how they respond to COVID-19.

Annex A: public sector equality duty – impact assessment

Introduction

In reaching the decisions as set out in the government response to the consultation, Ministers must comply with equality legislation, including the PSED under section 149 of the Equality Act 2010 and the Family Test. Under the PSED, Ministers must have due regard to the impact of decisions on people with protected characteristics, which are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. The Equality Act 2010 also applies to marriage and civil partnership but only in respect of the requirement to have due regard to the need to eliminate discrimination, rather than being included under the PSED.

Ministers must have due regard to the 3 elements of the PSED which underline 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
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it

Workforce

Those working or deployed in health and social care settings are likely to have been affected by the vaccination as a condition of deployment requirements. The equality impact assessments undertaken as part of previous consultations on introducing the requirements set out that the effects could be significant as a result of a greater prevalence of vaccine hesitancy in some groups making up the workforce. This could lead to the redeployment or dismissal of staff who work in health and social care settings who are not exempt and choose not to be vaccinated. It could also result in these workers feeling pressured to have vaccinations when they would not otherwise have done so.

The impact assessment for the vaccination as a condition of deployment requirements for care homes[footnote 1] estimated that around 37,000 additional staff might leave the care home workforce as a result of implementation of the policy. The size of the care home workforce has reduced by far less than estimated since the regulations were introduced. The care home workforce fell by 19,300 between 20 July and 29 December 2021, although this also reflects the effect of new staff joining the sector over the same time period and staff leaving for other reasons.

For health and wider social care settings where the regulations have not yet come into force, the government made a statement[footnote 2] with the announcement of the intention to revoke this legislation, subject to consultation and parliamentary process, advising employers that they do not serve notice of termination to employees in connection with the regulations. Therefore, revoking these vaccination requirements is likely to have a beneficial effect on workforce numbers.

Patients and people receiving care and support

Patients in health settings and people with care and support needs in adult social care settings are particularly vulnerable to severe illness and death from COVID-19. Some of those receiving care and support or healthcare services remain at the highest risk of getting seriously ill, despite being vaccinated. People who are immunosuppressed, or have specific other conditions, for instance Down syndrome, have a reduced ability to fight infections and other diseases, including COVID-19, and are deemed to be at higher risk. The Green Book (chapter 14a Table 3)[footnote 3] includes a list of clinical risk groups. In the fourth quarter of 2021, the most common pre-existing conditions in deaths involving COVID-19 included diabetes, dementia and Alzheimer's, heart diseases, obesity, and lower respiratory diseases. Some individuals at higher risk as a result of these pre-existing conditions may also have protected characteristics as discussed further in the analysis section below.

However, strong infection prevention and control measures, including PPE, remain in place for health and care settings. Engagement with stakeholders in health and social care is also ongoing, in order to reinforce the importance of vaccination and to increase uptake as set out in the Increasing vaccine uptake section in the government response above. Therefore, on balance and taking account of the latest clinical evidence, which shows Omicron is a less severe variant, we believe we can continue to appropriately support the management of COVID-19 and protect people who are vulnerable to COVID-19 through means other than vaccination as a condition of deployment.

When the original impact assessments for vaccination as a condition of deployment were published, they recognised the impacts, both short and long-term, that the policy might have on the workforce. They flagged the policy could result in members of the workforce leaving the health and social care sectors in the short-term, and highlighted the knock-on risk of disruption that this might cause to health and care services. In turn, this disruption could have resulted in a worsening of the health and care services provided to patients and those receiving care and support, and a negative impact on their day to day lives. In this respect, by revoking the regulations now we are reducing the risk to those who access healthcare and social care.

As part of this equality impact assessment, we have considered each of the protected characteristics stated below.

Analysis of impacts

Our PSED analysis indicates that revoking the regulations making COVID-19 vaccination a condition of deployment in CQC-regulated health and social care settings, including care homes, would impact certain groups. Analysis is based on consultation responses, health and social care workforce data and wider demographic statistics. While the workforce data available represents most (but not all) of the staff groups impacted by revocation of the vaccination requirements, 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. This analysis considers the impact on the workforce, patients and people who receive care or support in all health and social care settings, including care homes and domiciliary care.

The following societal benefits may arise for different groups as a result of revocation of the COVID-19 vaccination as a condition of deployment requirements:

- reduction in numbers of those leaving the workforce due to vaccination requirements, which would reduce service disruption, leading to better care for patients
- greater likelihood of retaining a more diverse workforce as the regulations being revoked could have a disproportionate impact on women and minority ethnic groups; people in both groups may now be more likely to remain in employment due to the removal of the requirements

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

Health and social care workforce

4% of the NHS workforce have a disability (although 10% do not disclose their disability status), [footnote 4] which is below the population average reported as 22% of the population in the Family Resources Survey 2019 to 2020.[footnote 5] The adult social care workforce estimate shows a lower prevalence of disability among workers, at 2%,[footnote 6] although this estimate is likely to be under-reported due to being reported by the employer, and likely due to the use of a different definition of disabled. Some respondents to the consultation highlighted the benefits of the original policy on members of workforce who have a disability, and who therefore might be better protected by vaccination as a condition of deployment. To further reduce the impact of revoking vaccination as a condition of deployment on this group, mitigations to reduce the risk of COVID-19 transmission, including IPC measures such as continued free PPE, remain in place across health and social care settings.

Patients and those receiving care and support

The Office for National Statistics (ONS) estimates of COVID-19 related deaths by disability status study showed that disabled people made up 6 in 10 (59.5%) of all deaths involving COVID-19 in England for the period up until 20 November 2020 (30,296 of 50,888 deaths), while disabled people comprised only 17.2% of the population included within the study.[footnote 7] This suggests that disabled people may have a significantly increased likelihood of death involving COVID-19 compared to the population as a whole, and may therefore be disproportionately impacted by revocation of the vaccination requirement.

The same study showed that people with a learning disability made up 6 in 100 (5.8%) of all deaths involving COVID-19 for the period of January to 20 November 2020 (2,955 of 50,888 deaths). For comparison, people with a learning disability made up 1.2% of the study population, therefore suggesting that people with a learning disability have also been disproportionately impacted by the COVID-19 pandemic. Data also suggests that living in a care home or other communal establishments was a major factor in the increased exposure of people with learning disabilities to COVID-19.[footnote 8] Many respondents to the consultation highlighted the benefits of the vaccination as a condition of deployment policy to these people; revoking the vaccination requirements may therefore disproportionately impact individuals with learning disabilities compared to those who do not have a learning disability. The latest scientific evidence about the reduced severity, and thus risk, of the dominant Omicron variant, coupled with continued use of IPC measures such as PPE in health and social care settings will however help to mitigate the remaining risks posed by revoking the requirements.

Sex – men and women

Health and social care workforce:

Women make up approximately 64% of the NHS workforce[footnote 9] and 82% of the adult social care workforce.[footnote 10] Therefore, more women will be impacted by revocation of vaccination as a condition of deployment compared to men. As previously set out in the impact assessment on introducing vaccination as a condition of deployment in health and wider social care settings, the vaccination requirement could lead to individuals leaving the sector; this would predominantly have impacted women. Women may also face more barriers to accessing vaccines for example as a result of being more likely to have caring responsibilities, impacting their ability to travel to a vaccination centre. This may particularly have been the case during the early stages of the pandemic, given the disruption to schools, nurseries, and childcare services. 87% of women responding to the consultation felt strongly that the COVID-19 vaccination requirements should be revoked, with some respondents highlighting that hesitancy around the potential impact of vaccination on future pregnancy played a role in their decision not to be vaccinated. Therefore, the impact of revoking the COVID-19 vaccination requirements in the health and social care sectors may lead to more women being able to remain in the workforce.

Patients and those receiving care and support:

In England, there are more women than men, and this difference increases with age; the latest ONS estimates indicate that 52.2% of the English population aged 70 are women.[footnote 11] By age 80, women make up 54.8% of that age group, and 67.5% of those aged 90 or over are women. In 2020 to 2021, 9 in 1,000 18 to 64-year-olds received long-term health and social care support during the year, while 53 in 1,000 clients aged 65 and over received this type of support. 57.4% of clients receiving long-term social care on 31 March 2021 were women, but when looking at specific social care settings on the same date, 61.3% of those in a residential home and 62.7% of those supported in a nursing home were women. Due to this, a greater number of women than men will be impacted by revocation of the vaccination as a condition of deployment policy. However, this should be seen in the light of the latest scientific evidence regarding the reduced severity of Omicron, coupled with vaccination uptake in the general population and the range of IPC measures in place across health and social care.

Sexual orientation – heterosexual, homosexual or bisexual

Health and social care workforce:

Around 72% of the NHS workforce are heterosexual, 1% bisexual and 2% gay or lesbian.[footnote 12] These proportions generally stay consistent across individual staff groups (except amongst ambulance and ambulance support staff, where gay, lesbian and bisexual (LGB) proportions are considerably higher). We do not have data on the sexual orientation of the adult social care workforce. There is also no data on the prevalence of vaccine hesitancy by sexual orientation. However, 1 in 7 LGB people (14%) say that they have avoided medical treatment for fear of discrimination on the grounds of sexual orientation[footnote 13] and this could also apply to receiving vaccination. Therefore, the same benefits afforded by other groups in terms of reduced anxiety around employment retention as a result of revocation of the vaccination requirements (as outlined previously in this analysis) may well also apply to LGB staff.

Patients and those receiving care and support:

Given that individuals receiving healthcare or social care and support are not required to disclose their sexual orientation to healthcare or social care professionals, it remains a challenge to determine the full impact of the revocation of the vaccination requirement on this group. However, regardless of

sexual orientation, all patients and those receiving care and support in health and social care settings will benefit from existing mitigations already in place to reduce the risk of COVID-19 transmission such as IPC measures.

Race – ethnic groups, nationalities

Health and social care workforce:

Minority ethnic groups account for over 20% of the NHS workforce.[footnote 14] Workforce data from Skills for Care also shows a diverse range of ethnicities across the care sector. One in 5 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 or African and Black or Caribbean staff comprise 12% of the adult social care workforce.[footnote 15] Evidence suggests that minority ethnic groups may be more hesitant about vaccinations more generally, for example seasonal flu and pneumococcal vaccines.[footnote 16]

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 ONS (May and June 2021) indicates that Black or Black British adults had the highest rates of vaccine hesitancy (21%) compared with White adults (4%).[footnote 17] While we recognise the increased excess mortality risk from COVID-19 in Black and South Asian groups, revocation of the vaccination requirement will afford them with a greater opportunity to consider the benefits and importance of vaccination whilst continuing to work in the health and social care sectors. In addition, continued infection prevention control measures in place in health and social care settings, combined with the latest scientific evidence about the reduced severity of the dominant Omicron variant, will help to mitigate against any negative impacts of revocation.

Patients and those receiving care and support:

In the 2011 Census, people from Asian ethnic groups made up the second largest percentage of the population (at 7.5%), followed by Black ethnic groups (at 3.3%), Mixed/Multiple ethnic groups (at 2.2%) and Other ethnic groups (at 1.0%). There is evidence of higher levels of vaccine hesitancy in ethnic minority groups, for example, surveys of the wider population conducted by the ONS,[footnote 18] and a paper prepared by the ethnicity sub-group of the Scientific Advisory Group for Emergencies (SAGE) state that in general for new vaccines (post-2013), adults in minority ethnic groups were less likely to have received the vaccine compared to those in white ethnic groups (by 10-20 percentage points).[footnote 19]

The ONS has found that measures of disadvantage, occupation, living arrangements and pre-existing health conditions accounted for a large proportion of the excess COVID-19 mortality risk in most ethnic minority groups; however, most Black and South Asian groups remained at higher risk than White British people in the first wave of the pandemic.[footnote 20] Due to the lower vaccine take-up and higher excess mortality risk from COVID-19, some adults from minority ethnic groups who are patients or who receive care and support may be disadvantaged by vaccination as a condition of deployment being revoked. The consultation responses and stakeholder sessions highlighted the need for further action that could be undertaken by government and the health and social care sectors to promote vaccine take-up in this group, as set out in the ‘Increasing vaccine uptake’ section of the government response. As referenced in the above sections, ongoing infection prevention and control measures in health and social care settings will help to mitigate any negative impacts of revocation on these groups.

Age

Health and social care workforce:

Only 5.5% of the NHS workforce are aged under 25, while 25% of NHS staff are aged 25 to 34[footnote 21] with the average age of a healthcare worker being 42 years old.[footnote 22] Skills for Care data[footnote 23] indicates that the average age of an adult social care worker is 44 years, with 26% of workers being over 55 years old, compared to 21% of workers in the wider economically active population. We estimate that around 15% of the adult social care workforce is made up of women under 30.

One in 12 (8%) adults aged 16 to 29 years reported vaccine hesitancy; this was the highest of all age groups.[footnote 24] Younger women are also reported to have higher levels of vaccine hesitancy, specifically related to fertility concerns (consideration of pregnancy as a protected characteristic is covered below). A benefit for this group is therefore being able to maintain employment due to revocation of vaccination as a condition of deployment. Revocation however may have a negative impact on levels of vaccine take up of these groups, although, given the older average age profile across the health and social care staff, the impact on overall workforce is likely to be proportionate.

2.44% of the NHS workforce are aged over 65.[footnote 25] The benefits of receiving vaccination for those in the over 65 group has been widely circulated through both employers and wider public health messaging. Reducing the risk of severe disease and therefore reducing hospitalisation, remains the rationale for receiving vaccination. The impact of revoking vaccination as a condition of deployment for this group allows more time for consideration and engagement in public health messaging surrounding vaccination. Further to this, revocation allows for retention of health and social care workers throughout a wide range of age groups.

Patients and those receiving care and support:

Approximately 4 in 5 (79%) of older adult care home residents receiving local authority commissioned care are aged 65 or over. We note that in the week ending 13 February 2022, hospital admissions and deaths with COVID-19 were highest among older people.[footnote 26] Revoking the vaccination requirement could therefore have a negative impact on residents in care homes for older adults, as well as on older staff, due to the increased risk posed by contact with unvaccinated individuals. However, this risk is reduced due to the dominant Omicron variant causing less severe illness, and further mitigated through the high level of vaccination in the population and workforce, as well as the current IPC measures and access to antivirals.

Gender reassignment (including transgender and transsexual people)

Health and social care workforce:

There is also no evidence that this group experiences higher levels of vaccine hesitancy. However, there are reports[footnote 27] that persons with this protected characteristic face some issues when accessing health and social care, including fear of discrimination and experiences of healthcare staff in particular lacking understanding of specific trans health needs. 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. The revocation of vaccination as a condition of deployment reduces the impact of exclusion of transgender people from the workforce based on the incidence of limited medical engagement.

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

Health and social care workforce:

There are high levels of vaccine hesitancy in adherents to certain religions and beliefs, according to surveys of members of the health and social care workforce conducted by the ONS.[footnote 28] Based on the data available and consultation responses received, revocation is therefore likely to benefit them in terms of removing anxiety over retaining employment, although we do not have data on the overall proportion of health and social care workers who subscribe specific religions and beliefs.

Patients and those receiving care and support:

We do not have data on the overall proportion of patients and those receiving care and support who subscribe to specific religions and beliefs. However, based on the consultation responses received, revocation of the COVID-19 vaccination requirements is likely to enable greater retention in the workforce and therefore help ensure the continuity of care for all patients and those receiving care and support – including those with different religions and beliefs. A potential negative impact of the removal of the COVID-19 vaccination requirements is an increased likelihood of patients and those receiving care and support being in contact with unvaccinated staff. However, ongoing engagement with staff to encourage vaccine uptake, current IPC measures used in health and social care settings, and the reduced severity of the Omicron variant now dominant in the UK will all help mitigate this risk.

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

Health and social care workforce:

As the health and social care workforce is predominantly female, the incidence of pregnancy and maternity among the workforce is higher than the general population. Many women would have previously been advised in early 2021 that while the available data did not indicate any safety concern or harm to pregnancy, there was insufficient evidence to recommend routine use of COVID-19 vaccines during pregnancy. In April 2021, the Joint Committee on Vaccination and Immunisation (JCVI) updated their advice on COVID-19 vaccination during pregnancy to state that pregnant women should be offered the COVID-19 vaccine at the same time as people of the same age or risk group;[footnote 29] other vaccinations, such as the inactive seasonal flu vaccine are also recommended during pregnancy. In December 2021, based on increased safety data and accompanying analysis, the JCVI announced that pregnant women are now considered a ‘vulnerable to COVID-19’ group within the COVID-19 vaccination programme, emphasising the urgency of them receiving COVID-19 vaccination and booster doses.[footnote 30]

Vaccination is also encouraged during breastfeeding; the JCVI has recommended that the vaccines can be received whilst breastfeeding, and that there is currently no evidence to suggest that the COVID-19 virus can be transmitted through breast milk. The Royal College of Obstetricians and Gynaecologists also advise that there is no plausible mechanism by which any vaccine ingredient could pass through breast milk.[footnote 31] The latest evidence is constantly reviewed by the World Health Organisation and regulatory bodies around the world.

However, as mentioned above, based on the limited evidence available in the early stages of the pandemic, many women were previously advised against receiving a COVID-19 vaccine while pregnant or breastfeeding. We recognise that as a result, pregnant and breastfeeding healthcare staff may have been less likely to have been vaccinated against COVID-19. There was a risk that a requirement to have the vaccine could cause anxiety surrounding employment and wellbeing in pregnant and breastfeeding staff who may have chosen to not get vaccinated. While the original vaccination as a condition of deployment policy did allow for medical exemptions, which included pregnancy as a time-limited exemption, some women noted that they did not feel comfortable continuing to work within the health and social care sectors if they had to satisfy the requirement by the time their exemption ended. This cause of concern could be resolved though revocation, and as such, pregnant and breastfeeding women may be positively impacted by revocation. We note that

COVID-19 vaccines offer pregnant women the best protection against COVID-19 disease which can be serious in later pregnancy for some women. We also note that the JCVI continues to closely monitor the evidence on COVID-19 vaccination in pregnancy and post-partum and will update its advice as required.

Patients and those receiving care and support:

As stated above, we recognise that many pregnant or breastfeeding women have previously been reluctant to get vaccinated against COVID-19 due to the advice that was formerly available (see above). Revocation may have a potential negative impact on pregnant women as they are clinically more vulnerable to COVID-19. To further reduce the impact of revoking vaccination as a condition of deployment on this group, mitigations to reduce the risk of COVID-19 transmission, including IPC measures such as continued free PPE, remain in place.

Marriage and civil partnership, married couples, civil partnerships

There is no current evidence that revoking COVID-19 vaccination as a condition of deployment requirements will have a greater or lesser impact depending on the marital and partnership status of either the health and social care workforce, or patients and those receiving care and support.

The family test

Revoking COVID-19 vaccination as a condition of deployment is unlikely to have a significant impact on the formation of families. It is unlikely that revoking these COVID-19 vaccine requirements would have an impact on families before, during, or after couple separation or impact those families most at risk of deterioration of relationship quality and breakdown.

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 it. In the section below we will however also consider health inequalities in the adult social care sector.

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 revoking the COVID-19 vaccination as a condition of deployment 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 individuals' protected characteristics and factors that can compound health inequalities.

Geography and socioeconomic status

Healthcare:

Data has shown that across the population, there has been regional variation in vaccination uptake, and this is mirrored in the NHS workforce, with 91% of staff in the North West Commissioning Region compared to 83% in the South West Commissioning Region and 88% in London having received one dose of COVID-19 vaccine by 31 December 2021.[footnote 32] The breakdown of ethnicity of healthcare workers by region may also have an impact on vaccination levels amongst this group. London was the most ethnically diverse area of England in the 2011 Census where 40.2% identified with either the Asian, Black, Mixed or Other ethnic group,[footnote 33] while 77.9% of NHS workers are Caucasian, 10.7% Asian, 6.5% Black and 4.5% identified with the Mixed or Other ethnic groups. Data

referenced earlier suggests that vaccine hesitancy is less prevalent in the white workforce (see above). However, within the Asian, Black and other ethnicities statistics indicate a stronger degree of vaccine hesitancy (see above), although further socioeconomic factors also cause regional variation in vaccination levels.[footnote 34] By revoking vaccination as a condition of deployment, we will remove the risk of increased workforce exit in regions with lower levels of vaccine uptake and higher levels of vaccine hesitancy.

Social care:

As with NHS workers, the breakdown of location and ethnicity of social care workers may have had an impact on vaccine uptake. According to ONS estimates, London is the region with the largest estimated proportion of non-UK-born (37%) and non-British (21%) population. Analysis of vaccine hesitancy shows that Londoners remained the most vaccine hesitant among the regions and countries of Great Britain, although the East Midlands also has high level of hesitancy, with one in 3 (34%) Black or Black British adults reporting vaccine hesitancy.[footnote 35]

In the North and the South West of the country however, over 90% of the workforce are white,[footnote 36] and levels of vaccine uptake are above the national average. Among home (domiciliary) care workers for instance, the range of uptake levels for 2 doses of a COVID-19 vaccine is lowest in London at 75.9%, and highest in the North East and Yorkshire at 87.9%. By revoking vaccination as a condition of deployment, we will remove the risk of increased workforce exit from social care workers in regions with lower levels of vaccine uptake and higher levels of vaccine hesitancy such as London.

Inclusion of socially excluded groups

Socially excluded populations, including populations such as homeless people, Gypsy, Roma, and Traveller communities[footnote 37], people in contact with the justice system, migrants and those involved with prostitution or sex work,[footnote 38] tend to have the poorest health outcomes, putting them at the extreme end of the gradient of health inequalities. This is a consequence of them being exposed to multiple, overlapping risk factors, such as facing barriers in access to services, stigma and discrimination. It is possible that rates of vaccine uptake are particularly low among these groups. This would mean that revocation of the vaccine as a condition of deployment requirements will have particular impacts on this group. It will remove the risk of workers from these groups leaving the workforce as a result of vaccination as a condition of deployment. For patients and people within these groups with care and support needs, continued IPC measures in place in health and social care settings, combined with the latest scientific evidence about the reduced severity of the dominant Omicron variant, will help to mitigate against any negative impacts of revocation.

Summary of analysis

The above analysis shows that, for people with protected characteristics, the revocation of the requirement for vaccination as a condition for deployment brings potential positive and negative impacts. The analysis shows that some groups of the health and social care workforce who have protected characteristics are more vaccine hesitant than the general population. The removal of the requirements therefore provides them with assurance of retention of employment, benefitting both them and the people they care for due to reduced service disruption and greater continuity of care.

A negative impact of the removal of the requirements is that vaccine uptake might be lower amongst members of the workforce with protected characteristics. However, the potential negative impact should be considered in the wider context of decreased severity of the dominant Omicron variant, ongoing mitigation against COVID-19 transmission through existing IPC measures, and continued engagement with those who are vaccine hesitant.

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