

Title: The Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021 Vaccination as a Condition of Deployment in Care Homes IA No: 9570 RPC Reference No: RPC-DHSC-5085(1) Lead department or agency: Department of Health and Social Care	Impact Assessment (IA)
	Date: 20/07/2021
	Stage: Development/Options
	Source of intervention: Domestic
	Type of measure: Secondary legislation
	Contact for enquiries: Martin Teff

Summary: Intervention and Options	RPC Opinion: Fit for Purpose
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Cost of Preferred (or more likely) Option (in 2019 prices)			
Total Net Present Social Value	Business Net Present Value	Net cost to business per year	Business Impact Target Status Qualifying provision
£90.8m	£88.1	£88.1	

What is the problem under consideration? Why is government action or intervention necessary?

Residents in care homes are particularly vulnerable to severe illness and death from COVID-19. In March 2021, the Social Care Working Group of SAGE has advised that a vaccination uptake rate of 80% in staff and 90% in residents in each individual care home setting would be needed to provide a minimum level of protection against outbreaks of COVID-19¹. However, this was before the rise in prevalence of the more transmissible Delta variant. In addition, they recommended this as a minimum advised level and that higher coverage and both doses would increase that level of protection. Sustaining high levels of staff vaccination now and in the future as new people enter the workforce is important to minimise the risk of outbreaks.

Care home staff are already subject to a regular testing regime and clinicians have advised that testing alone is not an effective mitigation. Despite high levels of testing and high compliance with testing in care homes we have still seen over 13,000 deaths of care home residents from COVID-19 in 2021 (as of 23rd July 2021)².

What are the policy objectives of the action or intervention and the intended effects?

SAGE advice has been clear that vaccines are crucial to reduce risk of COVID-19 entering a care home, and in turn reduces the risk of transmission, outbreaks, and deaths. Thus, the requirement to be vaccinated applies to all care home staff and all persons entering a care home registered by the CQC, aside from those who are exempt in the regulations.

The Vivaldi 1 study³ noted that infections in staff are more likely to transmit infections to residents than vice versa.

SAGE have advised that while there may be staff on site who never come into contact with service users, co-worker networks have been shown to be an important factor in transmission. This means unvaccinated individuals entering the home remain a potential source of infection and transmission in the home, regardless of whether they provide close care to service users. Thus, the requirement applies to all those entering the home, with some exemptions as detailed in this document. We have exempted friends and family on the basis of SAGE advice that there is a balance to be struck between the risk of a loved one visiting and transmitting the virus versus the wellbeing benefits to those in a care home.

Making vaccination a condition of deployment in care homes will help ensure that residents at high risk from COVID-19 due to their age, underlying health conditions, or disability are better protected against the virus. The policy will be kept under review on a continuing basis. Since completing this analysis, a further consultation on making vaccination a condition of deployment in the health and wider social care sector has been published.⁴ We will review the responses to the consultation and consider whether it is necessary to extend the policy to other parts of the adult social care and health sectors.

¹ [Social Care Working Group consensus statement, March 2021 - GOV.UK \(www.gov.uk\)](#)

² [Number of deaths in care homes notified to the Care Quality Commission, England - Office for National Statistics \(ons.gov.uk\)](#)

³ [Vivaldi 1: COVID-19 care homes study report - GOV.UK \(www.gov.uk\)](#)

⁴ [Making vaccination a condition of deployment in the health and wider social care sector - GOV.UK \(www.gov.uk\)](#)

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

We have been pursuing non-regulatory options to drive uptake throughout the rollout of the vaccination programme. This approach, which focuses on encouragement and maximising access, will continue alongside our proposed regulations.

In March 2021, the Social Care Working Group of SAGE advised that a vaccination uptake rate of 80% in staff and 90% in residents in each individual care home setting would be needed to provide a minimum level of protection against outbreaks of COVID-19⁵. While the majority of care home workers have been vaccinated, and despite the already existing non-regulatory options to increase uptake, the latest published data (as of 18/07/21) highlighted that only 72% of older adult care homes in England were meeting the SAGE level and this fell to just 64% of care homes in London⁶. Furthermore, the SAGE advice was given before the rise in prevalence of the more transmissible Delta variant. In addition, they recommended this as a minimum advised level and that higher coverage and both doses would increase the level of protection. Thus, it is important that together we now take every step necessary to reduce the risk of spreading the virus to those most at risk from COVID-19 and those who care for them. The regulations have been made in order to sustain high levels of staff vaccination now and in the future as new people enter the workforce.

Will the policy be reviewed? It will be reviewed with a maximum of 12 months between each review point. **If applicable, set review date: N/A**

Is this measure likely to impact on international trade and investment?		No			
Are any of these organisations in scope?	Micro Yes		Small Yes	Medium Yes	Large Yes
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)		N/A	Traded: N/A	Non-traded: N/A	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister: Gillian Keegan



Date:

08/11/2021

⁵ [Social Care Working Group consensus statement, March 2021 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/consultations/social-care-working-group-consensus-statement)

⁶ [Statistics » COVID-19 Vaccinations \(england.nhs.uk\)](https://www.nhs.uk/statistics/covid-19/vaccinations)

Summary: Analysis & Evidence

Policy Option 1

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year 2019	PV Base Year 2021	Time Period Years 1	Net Benefit (Present Value (PV)) (£m)		
			Low: -£149m	High: -£38m	Best Estimate: -£94m

COSTS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
	Low	£38m		
High	£149m	£0	£149m	
Best Estimate	£94m	1	£0	£94m

Description and scale of key monetised costs by 'main affected groups'

This IA monetises the cost to social care providers of recruiting replacements for workers who may not fulfil the requirement of having both doses of the vaccine by the end of the sixteen-week grace period, as stated by the policy. This excludes the 10% of staff who may be expected to leave as part of the usual turnover seen in the sector, over a 16-week period. Due to the high degree of uncertainty around the number of workers who may need to be recruited, the recruitment costs range from £38m to £149m. The best estimate of £94m is a centralised estimate of this range and forecasts that 7% of the workforce may require replacement due to non-fulfilment. The cost uses this 7% (which equates to c.38,000 workers) and assumes a cost of recruitment per worker of £2,500 based on evidence from the sector.

Other key non-monetised costs by 'main affected groups'

The non-monetised costs to business and civil society organisations include:

- Direct, transitional costs to care providers of cover for staff absent due to side effects from having the vaccination, or replacement of staff who suffer complication as a result of it.
- Direct, transitional costs to care providers of management familiarising themselves with the regulation and guidelines on exemptions
- Indirect costs to care providers from temporary increased strain on those working in social care who are already vaccinated, and on workforce capacity
- Indirect costs to businesses as lost earnings or revenue from those who have unvaccinated visiting professionals who can no longer be hired by care providers.

There are also likely to be non-monetised costs to individuals as a result of this policy, which include:

- Indirect cost of restricted job choice for current social care workers who may leave the workforce due to the policy
- Indirect cost of temporary loss of earnings for those leaving the workforce

BENEFITS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
	Low	£0		
High	£0	£0	£0	
Best Estimate	£0		£0	£0

Description and scale of key monetised benefits by ‘main affected groups’	
<p>Though we are not able to monetise any of the benefits, we have conducted some breakeven analysis which is referred to in more detail in the non-monetised benefits section below.</p> <p>This shows that the intervention will have a net positive social impact under the central cost estimate if 1,547 or more additional Quality-Adjusted Life Years are generated.</p>	
Other key non-monetised benefits by ‘main affected groups’	
<p>Reduced risk and anxiety in vaccinated residents and staff in care homes where staff vaccine rates are lower. Reduced likelihood of care home outbreaks and productivity gains from individuals who may have been unable to work due to the virus. Greater protection for care home users, co-workers, and visitors. Reduced rate of transmission in the community by offering greater protection for those not already vaccinated. Lower costs of hospital treatments by maximising protection against the virus for those most</p>	
Key assumptions/sensitivities/risks/Discount rate (%)	N/A
<p>We assume all those who have had one dose of the vaccine will be willing and able to have their second dose, if not already administered. The uncertainty surrounding the direction and magnitude of behaviour change as a result of the policy has justified the method taken to arrive at our centralised best estimate.</p> <p>It is likely that at least some exits will occur during the sixteen-week grace period, representing greater staff turnover rather than a sudden reduction. As providers are already recording and reporting the vaccination status of their staff to DHSC through the Capacity Tracker collection, they should have the time and information needed to prepare for any drop in staffing at the end of the grace period. These impacts occur in the context of a sector which experiences a relatively high annual workforce turnover rate of over 30%, where recruitment forms a regular part of their operations. Therefore, we have reduced the costs by 10% in the counterfactual to reflect the proportion of workers who may have needed replacement due to the policy but may also have left the sector otherwise over the course of a 16-week period.</p> <p>There is limited data to determine the number of workers who would be eligible for exemption. Though unknown, we expect there to be very small numbers of staff who will have medical reasons not to be vaccinated and therefore will be exempt - therefore, we have arrived at an estimate that 1% of the overall workforce may be exempt. This estimate is supported by a Driving Uptake Project survey (part of the Government’s programme of work to encourage vaccine uptake), and though that survey sample is not representative of all care homes, we would expect the share falling within this category to be broadly consistent across all homes.</p>	

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only)
Costs: 91.2	Benefits: 0	Net: 91.2	
			88.1

The only direct cost to business that has been monetised is that of replacing workers who do not meet the condition of deployment by the end of the grace period. Other direct and indirect costs to business feature in the non-monetised costs section. It is worth noting that the costs to business referred to here (and in the whole document) include that of civil society organisations as well, and that care home providers include non-profit organisations.

Using NHS Digital data¹ to calculate the share of older adult care home client weeks in 2018/19 that were provided by local authority in-house providers, it appears that only 2-3% of older adult care homes are local-authority run (a higher proportion of care packages are local-authority funded but the majority of these are commissioned from independent providers). This only reflects the older care settings - whilst we believe the equivalent figure is higher for younger adult care homes and they may be further behind in uptake rates given they were a lower JCVI cohort than older adult care homes, younger adult care homes make up only around 25%² of the total meaning the equivalent figure would have to be significant to alter the average, along with the care homes being smaller in size and so having a less sizeable impact. Therefore, we are using the 3% as the estimate across both settings which we believe to be reasonable. We have then applied this proportion to the calculations above to net off the impact of public providers, reducing the costs from £94m to £91m. It is worth noting that the 2018/19 data referred to represents the latest available data on the share of local authority in-house providers, as the collection of 2019/20 data for the Adult Social Care Activity and Finance Report was affected by the Covid-19 pandemic. The 2020/21 Report is scheduled to be published on 21 October 2021.

Evidence Base

Problem under consideration and rationale for intervention

1. The COVID-19 vaccination programme is the biggest vaccination programme in NHS history. As of 20th July, over 38 million people have had their first COVID-19 vaccine dose in England³. All people living in care homes, staff, health and social care workers, and the clinically extremely vulnerable have been offered a vaccine. These groups account for 99% of deaths from COVID-19, meaning potentially thousands of lives will be saved. This is in addition to all adults having been offered the COVID-19 vaccine, offering further protection of the population against the virus. Analysis carried out by Public Health England suggests that the COVID-19 vaccination programme prevented 13,200 deaths in England⁴. The UK's COVID-19 vaccines have been approved by the MHRA as being safe and effective in reducing the likelihood of COVID-19 infection and preventing severe disease in those who do catch the virus.

¹ <https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2018-19>

² Care directory with filters, June 2021, <https://www.cqc.org.uk/about-us/transparency/using-cqc-data>.

³ <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/07/COVID-19-daily-announced-vaccinations-20-July-2021.xlsx>

⁴ [Vaccine update COVID-19 Special, Issue 322, June 2021 \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/94848/vaccine-update-covid-19-special-issue-322-june-2021.pdf)

2. There is evidence to suggest that the vaccine also reduces the risk of those who catch the virus from infecting other people and thus limiting the spread. The SIREN study provides strong evidence that vaccinating working age adults will substantially reduce asymptomatic and symptomatic SARS-CoV-2 infection and therefore reduce transmission of infection in the population. This study has shown an effectiveness against infection of 72% (95% CI 58-86) 21 days after first dose of Pfizer - this is similar to the effects seen in the AstraZeneca trials. Research by PHE, published on 28 April 2021, showed that those who do become infected 3 weeks after receiving one dose of the Pfizer-BioNTech or AstraZeneca vaccine were between 38% and 49% less likely to pass the virus on to their household contacts than those who were unvaccinated⁵. Vaccine effectiveness might decline over time or be lower against specific variants so it is critical that we do everything we can to protect people who are most at risk of serious illness from COVID-19. Vaccination is key to our route out of this pandemic. We have come a long way but there is still further to go.

Uptake of vaccination in older adult care homes

3. We never again want to return to a position of widespread outbreaks in care homes in which too many people living and working in care homes lost their lives. The Joint Committee on Vaccinations and Immunisation (JCVI) identified people living in older adult care homes and their staff, as the top priority group for vaccine rollout⁶.
4. The independent Scientific Advisory Group for Emergencies (SAGE) Social Care Working Group has highlighted that people living in care homes have been significantly impacted by the COVID-19 pandemic due to a combination of a heightened risk of severe outcomes following COVID-19 infection and the risk of outbreaks in these closed settings. Ensuring very high levels of vaccination of people living and working in these settings is an essential public health intervention for a serious vaccine-preventable disease. Environments with the same group of people who come into close contact with each other numerous times a day will enable faster and more comprehensive transmission of the virus to all occupants (workers and residents) than other more open settings.
5. In March 2021, the Social Care Working Group of SAGE advised that an uptake rate of 80% in staff and 90% in residents in each individual care home setting would be needed to provide a minimum level of protection against outbreaks of COVID-19. This is for a single dose against the then dominating Alpha variant. These rates may be lower after a second dose, but the emergence of the Delta variant and future dominating variants may increase these levels, so estimates of the minimum coverage level can vary. Thus, there is a clear public health rationale protect residents in high-risk settings who are most at risk from COVID-19 and its complications by driving vaccination uptake in care homes, and by ensuring high staff vaccination levels are maintained given regular staff turnover.

⁵ <https://www.gov.uk/government/news/one-dose-of-covid-19-vaccine-can-cut-household-transmission-by-up-to-half>

⁶ [Joint Committee on Vaccination and Immunisation: advice on priority groups for COVID-19 vaccination, 30 December 2020 - GOV.UK \(www.gov.uk\)](#)

6. The success of the rollout of the COVID-19 vaccination to older adult care homes has been possible because of the leadership shown across the NHS, the social care sector, and local government. As of 18 July 2021, 96.1% of eligible residents of older adult care homes have been reported to have received at least one dose of the vaccine. As of 18 July 2021, 87.5% of all eligible staff in older adult care homes have been vaccinated with at least one dose. The total number of eligible residents and staff exclude those who have tested positive for COVID-19 in the last 28 days and cannot be vaccinated as a result. It also includes residents and staff who did not receive the vaccine for valid medical reasons. 92.5% of residents of younger adult care homes have been reported to have been vaccinated with at least one dose as of 18 July 2021 and 83.8% of staff working in independent CQC-registered younger adult care homes⁷.
7. However, there are still a high number of older adult care homes which are not yet achieving the level of protection needed as advised by SAGE to reduce the risk of outbreak. The overall figures for staff vaccination uptake masks significant variation at a regional, local and individual care home level. As of 18 July, only 72.1% of older adult homes in England are currently meeting the dual threshold as set out by the SAGE Social Care Working Group for the first dose, falling to 64% for London⁸. The equivalent figure for the proportion of younger adult care homes in England with at least 80 percent of staff vaccinated and 90 percent of residents vaccinated, as of 20 June is 52%⁹.
8. Therefore, there is a strong case for the requirement to make vaccination or proof of medical exemption a condition of entry to all CQC registered care homes in order to make very high-risk environments as safe from the devastating effects of COVID-19 as possible.

Consultation response

9. The Department of Health and Social Care (DHSC) conducted a public consultation on the requirement for older adult care home providers to deploy only those workers who have received their COVID-19 vaccination in line with government guidance (unless medically exempt). We consulted on the amendment from 14 April to 26 May 2021 and the full consultation document is available online¹⁰.
10. Overall, the consultation showed that, while a majority (57%) of respondents did not support the proposal, the responses from the adult social care sector were mixed, with some groups, for example care home providers, mostly supporting the proposed legislative change while others, such as service users and relatives of service users were mostly opposed.

⁷ <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/07/COVID-19-weekly-announced-vaccinations-22-July-2021.xlsx>

⁸ [Statistics » COVID-19 Vaccinations \(england.nhs.uk\)](#)

⁹ Internal DHSC analysis using vaccination data submitted by providers via Capacity Tracker on the 20 June 2021

¹⁰ <https://www.gov.uk/government/consultations/making-vaccination-a-condition-of-deployment-in-older-adult-care-homes/outcome/making-vaccination-a-condition-of-deployment-in-care-homes-government-response#impact-and-implications>

11. The consultation showed very clearly that the initial scope of including only CQC-registered care homes with at least one resident over the age of 65 would be extremely challenging to implement (a birthday or a death could see a home moved into or out of scope, respectively), that it would not protect all residents who are clinically vulnerable to COVID-19, and that it might give rise to unintended consequences such as the risk of someone turning 65 being moved to avoid a home falling within scope of the policy.
12. Older adults in care homes are at the highest risk of severe outcomes from COVID-19, which is why we consulted on these settings initially. However, several respondents raised concerns that younger adults with a learning disability and autistic adults who live in care homes would be disproportionately affected if they were not included in the policy.
13. Based on this feedback, we extended the scope of the policy to all CQC-registered care homes, in England, which provide accommodation for persons who require nursing or personal care, not just those care homes which have at least one person over the age of 65 living in their home.
14. We also, on the basis of SAGE advice and the consultation response, extended the requirement to include all persons who enter a care home regardless of their role (with exemptions for residents; friends or relatives of residents who are visiting; members of emergency services performing their professional duties; persons providing emergency assistance or urgent maintenance work in the care home; those visiting someone who is dying or providing support to a service user following the death of a friend or relative; and those under the age of 18). The SAGE Social Care Working Group have advised that while there may be staff on site who never come into contact with service users, co-worker networks have been shown to be an important factor in transmission. This means unvaccinated staff remain a potential source of infection and transmission in the home, regardless of whether they provide close care to service users. Further, many consultation respondents opposed limiting the scope to include only paid staff deployed in the care home and volunteers deployed to carry out regulated activities, for reasons of parity with other groups; and for reasons relating to the simplicity of implementation.

What the Government has done to encourage uptake

15. In February 2021, we published the UK COVID-19 Vaccines Delivery Plan¹¹, setting out the significant programme of work underway to drive vaccine uptake, including actions to improve access and address the concerns of those who may be hesitant to receive the vaccine. We are continuing to deliver a targeted programme of work to support vaccine uptake among adult social care staff and care home staff specifically, working with national and local stakeholders, including care home managers.

¹¹ UK COVID-19 vaccines delivery plan - GOV.UK (www.gov.uk)

16. We have been working to make vaccines accessible to people living and working in care homes, and in older adult homes NHS England is running a minimum four-visit schedule to deliver vaccines on site to those most vulnerable to COVID-19. Social Care workers have been prioritised for vaccines since December 2020 and can book a vaccine appointment via the NHS website at any time. Financial support is available via the Infection Control Fund to support social care workers getting to and from appointments, and to cover sick days for staff that experience symptoms following a vaccination.
17. In order to address any questions and concerns among care home workers (and the wider adult social care workforce), we have delivered an extensive communications programme. This includes:
 - Bespoke communications materials (posters, videos, leaflets, and shareable social media assets) shared across our CARE App, weekly newsletter, and Adult Social Care and Department of Health and Social Care social channels.
 - A paid advertising campaign targeting social care workers with digital advertising to build vaccine confidence and encourage booking via the National Booking Service
 - A stakeholder toolkit (Q&As, guidance and communications materials) which is updated weekly
 - Positive messaging using influencers, leaders and care home workers who have already been vaccinated to boost confidence and tackle misinformation.
 - Content in different languages and briefings with different faith groups who have expressed interest in co-creating vaccine content and acting as ambassadors.
 - Webinars for social care workers, including a webinar on 21st May 2021 in which the Minister for Vaccines led a session alongside clinical experts including the Deputy Chief Medical Officer (DCMO), to answer social care workers' questions and concerns about the vaccine.
18. In areas and demographics where uptake has lagged, we have sought to encourage and build confidence in vaccines. In February 2021, we established a Vaccines Hesitancy Task and Finish group, jointly owned by NHSEI and DHSC and bringing together stakeholders from across the social care sector. Outputs included more targeted support to BAME groups, sharing of best practice and increased translated comms products. We continue to work with stakeholders to identify further actions at a local, regional and national level to increase vaccine uptake, including providing directed support with the support of our regional assurance teams to care home managers.
19. Despite these efforts, vaccine uptake amongst care home workers is not consistently at the level we know from SAGE advice is needed to minimise the risk of outbreak. It is imperative that together we now take every step necessary to reduce the risk of spreading the virus to those most at risk from COVID-19 and those who care for them. We must protect people living in care homes, and we must protect the workforce who perform such a vital role. Vaccination is a safe, effective way of preventing the spread of COVID-19. It is right that the Government acts to ensure that those working and assisting in care homes are vaccinated to protect everyone in these settings.

Further economic rationale

20. The COVID-19 vaccination programme is effectively reducing the number of COVID-19 infections by controlling the spread of the virus and preventing severe illness in those who do catch the virus. The pandemic has demonstrated that those living in care homes as well as health and social care workers are among the groups most clinically vulnerable to the threat of the virus. Keeping adults social care staff and users safe is therefore a priority.
21. The vaccine decreases the likelihood of a vaccinated individual falling ill to the virus but there are greater societal benefits that are also created. Vaccinated people help to reduce the transmission of the virus in the community as they help to reduce the spread to those people who have not yet been vaccinated. As noted, recent research by PHE¹² shows that those who do become infected 3 weeks after receiving one dose of the Pfizer-BioNTech or AstraZeneca vaccine were between 38% and 49% less likely to pass the virus on to their household contacts than those who were unvaccinated.
22. As universal health care ensures that the financial costs of ill health are borne by the taxpayer, reducing the likelihood of an individual catching COVID-19 and falling ill benefits society as a whole. A COVID-19 vaccine, like most vaccinations, also has benefits that go beyond the benefits felt by the vaccinated individual. This third-party, societal benefit is known as a positive externality. By vaccinating the social care workforce, additional benefits to society include a reduction in the rate of transmission by the workforce among the remainder of the workforce, care home residents and the wider community. In addition, the vaccine will reduce the likelihood of social care workers falling ill as a result of COVID-19 and needing to isolate or be absent from work. This has an economic benefit to the individual and/or employer, as well as to any close contacts who may need to self-isolate, depending on the Government measures to control COVID-19. Reducing the spread of the virus will have further positive impacts by reducing hospital admissions and the consequential cost of dealing with hospital treatments. This will allow other illnesses to be addressed and for life saving treatments to progress, producing further benefits to society as a whole. When considering the COVID-19 vaccine's contribution to enabling society to exit COVID-19 restrictions, this shows that, taken together, the deployment of COVID-19 vaccines has a very considerable economic benefit to wider society, to which every dose administered is a contributing part.
23. An individual chooses whether to have the COVID-19 vaccine based only on their individual costs and benefits. When a positive externality is present, market failure arises as the social benefits are greater than the private benefits. The social benefits are not considered in the individual's decision, at the margin. Making a vaccination a condition of deployment among care home staff is an attempt to overcome the market failure that is occurring by increasing the number of people in society who will have the vaccine, which will help to realise the benefits of additional protection.

¹² One dose of COVID-19 vaccine can cut household transmission by up to half - GOV.UK (www.gov.uk)

24. Even with government provision of the COVID-19 vaccine, alongside ongoing, increasing attempts to inform people about the benefits of the vaccine, uptake is still not at a socially optimal level. Having vaccine uptake at a level that is below the socially optimal level, poses a great deal of risk, in settings like care homes, where the threat of infection and severe illness is high. The aim of the policy is therefore to increase vaccine uptake level to a socially optimal point, within care home settings, to protect residents in high-risk settings who are most vulnerable to severe illness and death as a result of contacting the virus.

Rationale and evidence to justify the level of analysis used in the IA (proportionality approach)

25. Due to the high degree of uncertainty around how the affected workforce may react to this policy, we identify two estimates for the proportion of the workforce who may not have fulfilled the requirements by the end of the sixteen-week grace-period to arrive at a central estimate. We have jointly used Capacity Tracker outturn data to forecast, and an estimate of vaccine hesitancy amongst the care workforce, to provide two potential estimates for the number of staff who will not have fulfilled their condition of deployment by the end of the grace-period. The former, whilst based on a projection of outturn data on vaccination rates, does not factor in behaviour change and so represents a more pessimistic estimate, whilst the latter may more closely account for it, given that it uses a range of survey data that estimates the proportion of the workforce who may choose to remain unvaccinated. This includes the reported hesitancy of people; where hesitancy is defined as those who have been offered the vaccine but declined the offer, are very or fairly unlikely to have the vaccine if offered; are neither likely nor unlikely to have the vaccine if offered; don't know; or preferred not to say and so represents a more optimistic estimate. Using both of these estimates as guidelines, we have then taken the midpoint in order to reach a proportion of the workforce who may not have fulfilled their condition of deployment and therefore could be subject to being replaced. It is this number of staff being replaced, using a 7% rate of non-fulfilment, that we have modelled the monetised costs of this policy on. These estimates consider various sources to justify why we feel this represents a sensible approach and is set out in more detail in the cost and benefits section below. Breakeven analysis has been applied as current constraints mean that it is difficult to isolate the impact that vaccinating the adult social care workforce is having on the intended outcomes of protecting staff and residents in care homes and saving lives as a result. This is because other measures (including vaccinating care home residents, social distancing measures and vaccinating people in the community among others) are also contributing towards the same outcomes.
26. We have also considered a range of other non-monetised costs and benefits, which although have not been possible to quantify, could represent a sizeable impact. These are discussed in more detail in their relevant sections below.

Description of options considered

27. The SAGE Social Care Working Group has advised that at least 80% of staff and 90% of residents in a care home should have had a first vaccination dose to provide a minimum level of protection against outbreaks of COVID-19, recognising that current or emergent variants may require even higher levels of coverage and/or new vaccines to sustain levels of protection. The dual 80%/90% threshold provides only a minimum level of protection; higher coverage and both doses would increase that level of protection.
28. The rollout of the COVID-19 vaccination to older adult care homes has been impressive thanks to leadership across the NHS, the social care sector, and local government. As of 18 July, 2021¹³:
- 96.1% of all eligible residents living in older adult care homes in England have received at least their first vaccination.
 - 87.5% of eligible staff in older adult care homes had received their first vaccination.
 - 83.8% of total staff in independent CQC-Registered Younger Adult Care Homes were reported to have been vaccinated with at least their first dose of the vaccine.
 - 92.5% of all eligible people living in independent CQC-Registered Younger Adult Care Homes in England have received at least their first vaccination.
29. However, there are still a high number of older adult care homes which are not yet achieving the level of protection needed as advised by SAGE to reduce the risk of outbreak. While 87.5% of older adult social care staff and 83.8% of Independent CQC-Registered Younger Adult Care Home staff have been vaccinated with at least one dose, this masks significant variation at a regional, local and individual care home level. As of 18 July, only 72.1% of older adult homes in England are currently meeting the dual threshold as set out by the SAGE Social Care Working Group for the first dose, falling to 64% for London¹⁴. The equivalent figure for the proportion of younger adult care homes in England with at least 80 percent of staff vaccinated and 90 percent of residents vaccinated, as of 20 June is 52%¹⁵.
30. Therefore, there was a case for introducing a new requirement in order to make very high-risk environments as safe from the devastating effects of COVID-19 as possible.
31. Since the start of the pandemic we have continually expanded testing capacity to care homes to help identify positive cases, break the chain of transmission and protect the most vulnerable. In light of the new variant and the current lockdown, we have expanded testing to include twice weekly rapid turnaround staff LFD tests to identify and isolate more positive cases in addition to the current weekly PCR test. Despite high levels of testing and high compliance with testing in care homes we have still seen over 13,000 deaths of care home residents from COVID-19 in 2021 (as of 23rd July 2021)¹⁶. Thus, clinicians have advised that testing is not a complete mitigation.

¹³ <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/07/COVID-19-weekly-announced-vaccinations-22-July-2021.xlsx>

¹⁴ [Statistics » COVID-19 Vaccinations \(england.nhs.uk\)](#)

¹⁵ Internal DHSC analysis using vaccination data submitted by providers via Capacity Tracker on the 20 June 2021

¹⁶ [Number of deaths in care homes notified to the Care Quality Commission, England - Office for National Statistics \(ons.gov.uk\)](#)

32. As of Sunday 11 July 2021, 296,512 residents in care homes serving any older adults (65+) have been vaccinated with the first dose (96% of total residents). Some residents in these homes are not currently eligible to receive the vaccine due to having tested Covid positive in the last 28 days. We have ruled out mandating vaccination for care home residents because vaccination coverage is already extremely high. In addition, any requirement for residents would pose stark ethical dilemmas (for instance, what action would be taken against those who chose not to comply).
33. Since the beginning of the vaccination rollout in December 2020, we have worked closely with stakeholders and across government to encourage and build confidence in vaccines and their delivery.
34. On 13 February 2021, we published the UK COVID-19 Vaccines Delivery Plan¹⁷, setting out the significant programme of work underway to drive vaccine uptake, including actions to improve access and to address the concerns of those who may be hesitant to receive the vaccine.
35. We are also delivering a targeted programme of work to support vaccine uptake among adult social care staff and care home staff specifically, working with national and local stakeholders, including care home managers, via a number of projects and initiatives focussed on increasing vaccines uptake among social care workers in care homes showing lower staff vaccination rates, and working with local systems across London to understand what more can be done to tackle hesitancy among the sector, and in particular the London social care workforce. All of this is supplemented by work locally, by employers, local authorities, public health teams and others.
36. There is precedent for making vaccinations a condition of work for health care workers in the UK, for instance Hepatitis B – though the approach on this is different. The Hepatitis B vaccine is recommended for healthcare workers who may have direct contact with patients' blood or blood-stained body fluids. Both routine and recommended vaccination requirements are checked as part of the occupational health assessment when an individual starts a new job. Healthcare workers for whom Hepatitis B vaccination is contra-indicated, who decline vaccination or who are non-responders to vaccine are restricted from performing certain procedures unless shown to be non-infectious. Hepatitis B is not a universal vaccine programme for adults and has only recently been introduced into the childhood programme. Providing hepatitis B is therefore an employer's responsibility under health and safety legislation. In reality most clinicians will have been vaccinated against Hepatitis B since they started training.
37. Globally, making COVID-19 vaccinations a condition of deployment for care home staff in legislation have been discussed by the Governments of Denmark, France, and Italy¹⁸.
- 38.

¹⁷ [UK COVID-19 vaccines delivery plan - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/94222/uk-covid-19-vaccines-delivery-plan)

¹⁸ [National discussions on mandatory vaccination for long-term care staff in 24 countries. LTCcovid international overviews of long-term care policies and practices in relation to Covid-19 \(No. 1, May 2021\) – Resources to support community and institutional Long-Term Care responses to COVID-19](#)

Policy objective

39. In order to protect all care home residents who are clinically vulnerable to COVID-19, the Government has made regulations to require all CQC-regulated service providers of nursing and personal care, in care homes in England, to only deploy workers and volunteers who can demonstrate evidence of having had a complete course of an authorised COVID-19 vaccine (or evidence that they are exempt from vaccination). From November 11, the requirement will apply to anyone deployed to a care home, such as healthcare workers, tradespeople, hairdressers, and beauticians, and CQC inspectors. The requirement also extends to businesses providing ancillary services to care home such as cleaning and maintenance services; however, for most care homes, these services are undertaken in-house by employees. The requirement will only apply indoors and will exclude residents; friends or relatives of residents who are visiting; members of emergency services performing their professional duties; persons providing emergency assistance or urgent maintenance work in the care home; those visiting someone who is dying or providing support to a service user following the death of a friend or relative; and those under the age of 18. Individuals will be able to use the existing NHS COVID Pass service to show their vaccination status. This can be accessed via the NHS app, the website or by requesting a letter online or via 119.
40. The policy includes all CQC-registered care homes, in England, which provide accommodation for persons who require nursing or personal care, not just those care homes which have at least one person over the age of 65 living in their home.
41. After the 16-week grace period, individuals will be able to show they are exempt from the requirement if they have an allergy or condition that the Green Book lists (COVID-19: the green book, chapter 14a) as a reason not to administer a vaccine. We intend to publish further guidance to describe, in more detail, the scope and process for granting exemptions, which will continue to be informed by the Green Book.
42. There are many other settings across adult social care and health, where people most at risk from COVID-19 are being cared for in high risk, closed settings. We will be launching a consultation shortly on extending to wider health and adult social care. The Secretary of State will carry out a review of these regulations, set out the conclusions of the review in a report, and publish the report. These reviews will happen at a maximum interval of 12 months. The report in particular must set out the objectives intended to be achieved by this policy, assess the extent to which those objectives are achieved, and assess whether those objectives remain appropriate and, if so, the extent to which they could be achieved with a system that imposes less regulation.

Summary and preferred option with description of implementation plan

43. We are implementing this policy through an amendment to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are inserting the requirement into regulation 12 of those Regulations (which deals with safe care and treatment) as a supplement to regulation 12(2)(h), which requires that, as part of providing safe care and treatment, providers must assess the risk of, and prevent, detect and control the spread of, infections, including those that are healthcare associated. We are also amending the Code of Practice on Infection Prevention and Control and its associated guidance, which is issued by the Secretary of State under section 21 of the Health and Social Care Act 2008 and to which providers must have regard when complying with their obligations under regulation 12 of the Regulations.
44. Due to the importance of this issue, we have acted to change the law quickly. Regulations were made on 22 July 2021 and come into force on 11 November 2021. It is our current intention for individuals deployed in CQC registered care homes to be required to keep their COVID-19 vaccination status up to date but the regulations we are making do not currently cover this due to lack of certainty about requirements for boosters. This policy will be kept under review.

CQC registered care homes

45. The regulations apply to any care home which is CQC registered in England. This is estimated to be approximately 15,000 care homes.
46. We have received advice from the SAGE Social Care Working Group which has identified care homes for adults with a severe disability at any age, as well as care homes for older adults, as being high-risk settings for outbreaks of COVID-19; and where maintaining high levels of staff vaccination could prevent severe disease and transmission. Therefore, there is a strong clinical rationale for implementing the policy in all residential care homes, in the first instance, since they are all closed settings.
47. We conducted a public consultation which began on 14 April and ended on 26th May 2021. 14,357 responses were completed in total. We gathered a wide range of perspectives from across the care home sector about whether this should be introduced and how it would be put into practice. The Government's response to the public consultation was published on the 15 June.
48. Regarding policy scope, the consultation showed very clearly that including only CQC-registered care homes with at least one resident over the age of 65 adult would be extremely challenging to implement (a birthday or a death could see a home moved into or out of scope, respectively), that it would not protect all residents who are clinically vulnerable to COVID-19, and that it might give rise to unintended consequences (for instance, the risk of someone turning 65 being moved to avoid a home falling within scope of the policy).

Persons requiring vaccination

49. The Government has brought forward regulations to require all CQC-regulated service providers of nursing and personal care, in care homes in England, to allow entry to the premises only to those who can demonstrate evidence of having had a complete course of an authorised COVID-19 vaccine (or evidence that they are exempt from vaccination). This will ensure that vaccination coverage protects individual workers and people living in care homes and protects against the risk of outbreaks in the care home. This in line with advice from the SAGE Social Care Working Group.
50. As stated above, the requirement includes all persons who enter a care home, as outlined earlier, with certain exceptions applying. The policy does not extend this policy to friends and family members who visit people living in care homes or who are designated as essential care givers. Public Health England have advised that members of this group should be encouraged to get vaccinated; but if they cannot or will not, it would be unjustifiably detrimental to residents to deprive them of contact with, and care from, their loved ones. In these cases, other Infection Prevention and Control mitigations should be used.

Exemptions

51. We have carefully considered the different options to strike a balance between the range of views submitted in response to the consultation on what is a complex issue. Permitting limited exemptions will help to ensure that the requirement does not exclude, or impose a disproportionate burden on, certain individuals. It is also important to ensure that the scope of exemptions does not undermine the public health benefits of the policy or create a system that can be used by individuals to circumvent the requirement.
52. In addition to the groups that are not included in the requirement (as outlined in paragraph 36) the Regulations exempt anyone who for clinical reasons should not be vaccinated with any authorised vaccine. This will include anyone for whom a clinician recommends vaccine deferral or that vaccination is not appropriate (for instance, a pre-existing diagnosis of anaphylaxis). Guidance will give more detail about exemptions, which will reflect the guidance on 'Immunisation against infectious disease: the Green Book' (COVID-19: the green book, chapter 14a) and clinical advice from the Joint Committee on Vaccination and Immunisation (JCVI). The guidance will also set out suitable grace periods after a temporary exemption has expired.
53. Since completing the analysis for this IA, we have extended the scope of medical exemptions to include those vaccinated outside of the UK. Additionally, time-limited exemptions will also be available for those with short-term medical conditions, which is an option that some pregnant women may choose to take. We anticipate that may raise the number of people who fall within the scope for an exemption.
54. For those who are exempt, who will be able to be deployed in the care home, we will work with stakeholders to produce guidance on steps that should be taken to mitigate the risk of COVID-19 transmission to residents.

55. We have considered exemptions for those who hold, and refuse the vaccine due to, religious beliefs and opted not to provide this exemption. Such an exemption would be difficult to implement/prove and would likely significantly reduce the impact of the policy in achieving its aims of increasing levels of protection for both residents and staff. It may also cause tension between those who have been exempted, and other staff who have received the vaccine, as a condition of deployment. We are mitigating opposition to the vaccine by ensuring that information regarding the ingredients of the vaccines is readily available to staff in care homes, as well as amplifying the voices of trusted community leaders and religious figures who can assuage concerns. We are also ensuring safety or efficacy concerns about the COVID-19 vaccination are addressed through access to information, through projects such as the Community Champions scheme so that communities can look to trusted local leaders to answer questions about the vaccine and work locally with the NHS and public health teams.
56. The Muslim Council of Britain has shared information from the British Islamic Medical Association recommending that Muslims can take the Oxford/AstraZeneca vaccine¹⁹. The Vatican has also announced that Catholics may use vaccines derived from foetal cell lines where alternatives are not available²⁰.
57. Noting the concerns raised about rare blood clots as a side effect of vaccinations, we will ensure people under the age of 40 will be offered an alternative to the Oxford/AstraZeneca vaccine, in line with the Green Book on Immunisation against infectious diseases ([COVID-19: the green book, chapter 14a](#)) and clinical advice from JCVI.
58. We have considered the concerns raised about pregnancy. We have been assured by clinicians that vaccines are safe for the majority of pregnant women, however we recognise that in some circumstances, vaccination may not be appropriate during pregnancy and we will consider that in our guidance to clinicians regarding granting exemptions.

Implementation

59. Care home managers are ultimately responsible for the safety of people living in their care. Under the change to regulations, from November 11, it will be their responsibility to check evidence that workers deployed in the home are vaccinated, or medically exempt from vaccination. This means that workers will need to provide evidence to the manager that they have been vaccinated.
60. The Government has considered what would be an appropriate grace period for new and existing care home workers before they are required to be vaccinated, and we have included a 16-week grace period from when the regulations come into force.

¹⁹ [Latest COVID19 Advice for British Muslims - Muslim Council of Britain \(MCB\)](#)

²⁰ [Covid: Vatican says coronavirus vaccines 'morally acceptable' - BBC News](#)

61. It is our expectation that care home managers would already keep a record of vaccinations as part of their staff employment or occupational health records and will continue to do so.

The role of the Care Quality Commission

62. This requirement will form part of the Fundamental Standards (set out in The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) imposed on care home providers and would be monitored, and enforced in appropriate cases, by the Care Quality Commission (CQC). It would apply to any care home that provides nursing or personal care. Reported vaccination rates would form part of a suite of information CQC considers when determining which settings to inspect.
63. At time of registration and when inspected, care home managers would have to provide evidence that their workers are up to date with vaccination of an MHRA-approved COVID-19 vaccine or are medically exempt.
64. In case of non-compliance with the legislation, CQC would take a risk-based and proportionate approach to enforcement, looking at all the evidence identified and whether the public interest test is met, in line with its enforcement policy. CQC has civil enforcement powers and in the most serious of cases, criminal enforcement against the provider or registered manager may be appropriate.
65. Civil enforcement options available to CQC include issuing: a warning notice, issuing a notice of proposal/decision to impose, vary or remove registration conditions, issuing a notice of proposal/decision to suspend or cancel registration, making an application to court for immediate cancellation of registration where there is serious risk to a person's life, health or well-being and issuing an urgent notice of decision to suspend or vary conditions of registration where there is risk of harm to a person.
66. Regulation 12 imposes a requirement on providers and registered managers to provide safe care and treatment. This includes a requirement for the provider and registered manager to assess the risk of, and prevent, detect and control "the spread of, infections, including those that are health care associated". This is supplemented by the Secretary of State's IPC Code issued under s.21 of the Health and Social Care Act 2008. Where a breach of regulation 12 results in avoidable harm or a significant risk of avoidable harm to a service user, the provider or registered manager may be guilty of a criminal offence, and the CQC will look at whether to take criminal enforcement action. The maximum fixed penalty notice is £2,000 or £4,000, in respect of an offence committed by a registered manager or provider respectively. This Impact Assessment assumes full compliance with the new regulations, so no additional costs associated with enforcement action are estimated.
67. We have amended regulations through secondary legislation with arrangements coming into effect sixteen weeks after the regulations were made to allow care home workers flexibility to get fully vaccinated. The regulations will be reviewed yearly to ensure they are still relevant and appropriate with the latest scientific advice.

Monetised and non-monetised costs and benefits of each option (including administrative burden)

68. This section presents the economic assessment of the preferred option, split out into costs and benefits. Firstly, on the costs side, we have quantified the direct cost of replacing workers who may not have fulfilled the conditions of deployment by the end of the stated sixteen-week grace-period. For the benefits side, making the vaccine a condition of deployment will deliver a higher level of protection for care users, cost savings from reduced hospitalisations and avoided lost productivity caused by COVID-19 related absences, among others. However, we have not been able to accurately quantify the impact of vaccinating the workforce given the difficulty in isolating the effect that vaccinating the workforce is having on the intended outcomes of reducing COVID-19 cases and deaths from other factors including care user vaccination and infection control measures. Therefore, we have applied a breakeven analysis to demonstrate the total number of additional QALYs generated by the policy as a result of Covid-19 harms avoided through vaccinations, for the intervention to likely have a net positive social impact under the central cost estimate. This benefit is likely to occur as vaccinating additional care home staff against Covid-19 reduces the risk of infection and harm to staff, care users and people in the wider community. The non-monetised cost and benefits are then also considered. It should be noted however that the benefits stated in the breakeven analysis together with those non-monetised are likely to accrue over a prolonged period of time (likely several years), compared to the costs which will likely occur over a significantly smaller time frame (likely one year).

Monetised costs

69. As there is a high degree of uncertainty on the reactive response of the affected workforce to the introduction of the policy, we have used two estimates available to us to calculate a midpoint for the potential proportion of the workforce that may not have fulfilled the requirements as set out by the policy change, by the end of the grace period.

Upper Estimate

70. The more pessimistic of the two estimates is such since we are assuming there is no behavioural change by workers due to the policy. In addition, assuming that the vaccine uptake rate for care home staff continues at the current trend (of increasing but at a slowing rate) we find that in the week commencing the 12th September (eight weeks into the sixteen week grace period, where the cut-off point may be to allow for a sufficient eight week gap between doses of the vaccine), up to 13% of the affected workforce across England may not have fulfilled the requirement of having received both doses of the vaccine and so may require replacing. This estimate uses the number of staff from both Older Adult Care Homes and Younger Adult Care Homes who have received their first dose of the vaccine, as reported weekly by care providers on the Capacity Tracker Tool – a regular mechanism for providers to provide requested information to DHSC to aid the design of sector support and which serves as the basis for relevant NHS and DHSC statistical publications. This uptake is then projected forwards in time using a logarithmic

trendline-of-best-fit²¹. We think that this is appropriate given that such a trendline is often used when change begins quickly before slowing gradually and approaching a limit, which is a similar pattern to that we have observed in vaccine uptake among care home workers.

71. Using weekly data from 14th March to 4th July to project England-level uptake of the first vaccination eight weeks into a grace period starting in the week commencing 18th July (so as to allow a further eight weeks for a second dose within the grace period, per current guidance), our projection suggests that c.87% of the workforce would have had both doses and therefore c.13% of the workforce will not have met the requirement by the end of the grace period, without factoring in exemptions which are covered below in the document. We have used the data on the number of workers who have had their first dose (rather than those with both doses) as it provides a more robust forward projection given that a longer time series is available (as it leads second dose uptake by around eight weeks), as well as enabling additional sensitivity analysis on our projections described below. As a result, since we require the estimate of those who have had both doses by the end of the grace period, and current guidance states that eight weeks is required between doses, we use a cut-off date of eight weeks into the grace period to measure the number of staff who have had their first dose (covering both those who have already had their first dose and allowing eight weeks for those who haven't had either to get their first dose) – this then assumes that all those with the first dose will then receive their second dose eight weeks on from this date, per the current guidance.

Medical Exemptions

72. There is limited data to determine the number of workers who would qualify for exemption in line with Ministerial decisions on exemption eligibility, and this uncertainty extends to the number of workers who may need to be replaced. Though unknown, we expect there to be very small numbers of staff who will have medical reasons not to be vaccinated and therefore will be exempt. Only a small proportion of staff will have relevant allergies to a specific vaccine ingredient, for example, as these are very rare in the overall population. Similarly, only small proportion of pregnant staff are likely to experience the kind of complications which would mean that vaccination is not advised, and exemption is to be determined on a clinical, case-by-case basis. Taking these factors together, we have arrived at an estimate that 1% of the overall workforce may be exempt. This estimate is supported by a Driving Uptake Project survey (also detailed below), and though that survey sample is not representative of all care homes, we would expect the share falling within this category to be broadly consistent across all homes. Applying this figure to our projection above, we estimate that at most 12% of the workforce might no longer be deployable as a result of the policy.

²¹ Please note that the data is based on data which is **self-reported** by care homes, via Capacity Tracker and that **response rates might affect vaccination rates**. First dose vaccines have been reported by 99% of care homes.

Sensitivity analysis – potential impact of government efforts to improve uptake

73. Care homes in London have recently seen an uptick in the number of staff coming forward, due at least in part to additional measures put in place by Integrated Care Systems and other local partners to address low vaccination rates. Additional measures first introduced in London have since been shared as good practice across other regions. This policy effect cannot be fully captured in an England-level projection estimated over a longer time period. We have therefore conducted a sensitivity analysis which assumes that the recent progress in London can be replicated in other regions as good practice is implemented. By applying the rate of “acceleration” seen in London from the 1st June to 6th July (in the latest Capacity Tracker data received by DHSC) to each other region’s own rate of uptake for the following six weeks, we can arrive at an alternative projection over the same timeframe. Using this approach, we find that, having aggregated the regions to national level, by the end of the grace period up to 92% of the England workforce in care homes would be vaccinated and so 8% unvaccinated. Applying our estimate of medical exemptions within the workforce, we estimate that under this scenario, 7% of the workforce might no longer be deployable as a result of the policy.

Lower Estimate

74. Our second estimate uses a range of survey data to estimate the proportion of the workforce who may choose to remain unvaccinated. Using ONS survey data on the proportion of the entire adult population of Great Britain who indicate vaccine hesitancy²² broken down by key demographics and adjusting those figures to match the demographics of the adult social care workforce (principally age and gender) through a weighted average, we estimate that 5% of the care home workforce could be vaccine hesitant. While the ONS data on vaccine hesitancy is reported at Great Britain level and is broken down by age and gender, we have used Skills for Care’s workforce estimates on gender, age and the total number of all job roles within the adult social care workforce to adjust the figures reported by the ONS to match the workforce demographics. We think that this is a sensible approach to calculate the potential vaccine hesitancy in the workforce. Vaccine hesitancy as measured in this survey has been declining over time, as more people have been offered and chosen to accept a vaccine. A significant share of those who are “vaccine hesitant” and aged under 30 told the ONS that they have not made up their minds or prefer not to say – in part because many in this cohort have been offered access to the vaccine more recently than others. If these positive trends were to continue for this cohort, then the proportion of the care home workforce who might choose to remain unvaccinated is estimated to be 4%, and if it were to continue across all cohorts (though less likely given there is limited evidence that this trend would be sustained) then this estimate will be 2%, falling to 3% and 1% respectively once exemptions have been

²² Coronavirus and vaccine hesitancy, Great Britain - Office for National Statistics (ons.gov.uk). The ONS define “vaccine hesitancy” as the proportion of respondents who: have been offered a vaccine but declined the offer; are very or fairly unlikely to have the vaccine if offered; are neither likely nor unlikely to have the vaccine if offered; don’t know; or preferred not to say.

accounted for. This projection of vaccine hesitancy illustrates an optimistic scenario for uptake, assuming both that attitudes to vaccination change in younger cohort and that care home employees in particular are willing to accept the costs of accessing a vaccine e.g. the time taken. The mandate strengthens employees' incentives to be vaccinated by increasing the costs of not doing so. This is likely to be more effective than non-legislative approaches to improving vaccine uptake on their own.

75. The impact of the policy on staff vaccination uptake could vary between care homes. The Driving Uptake Project (part of the Government's programme of work to encourage vaccine uptake) surveyed the managers of care homes who were reporting that only 25%-50% of staff had had the first dose of the vaccine. On average, this found that 8% of all staff in such homes were considered unlikely to ever accept the vaccine. Whilst this survey deliberately focused on care homes with low vaccination rates, and so is not representative of the wider care home workforce²³, it provides information on the potential effect of the policy in the most-impacted individual care homes.
76. Moreover, analysis using 2011 Census and Skills for Care demographical data to estimate the proportion of the workforce who may be pregnant at any one point (one of the primary reasons given for hesitancy by respondents to the ONS and a further NHSEI survey of care home managers), found this to be around 4%. Since many of those who are currently pregnant will choose to take up the vaccine, an estimate of 2 - 3% is again plausible. Taking this survey evidence together, there are a range of estimates for those who may decide not to take up the vaccine. Whilst the Driving Uptake survey provides a useful upper estimate at care-home level, the ONS data (of the projected hesitancy rate with a sustained downward trend in those under 30) provides a more reasonable estimate for the likely vaccine hesitancy amongst the workforce. We therefore conclude that the most reasonable lower estimate would be 3%, having accounted for those who are medically exempt from the regulation.

Central Estimate

77. Given that the sector sees an annual workforce turnover rate of over 30%²⁴, it is assumed that over a 16-week period, usual turnover could be as high as 10%. The costs for the upper, lower and central estimates are therefore each reduced by 10% to account for the staff who may have left, even without the policy.
78. Based on estimates of between 12% and 3% (reducing to 11% and 3% respectively after accounting for the above) as detailed above, we judge that a midpoint of 7% represents

²³ Alongside this caveat, it is worth noting that: a sizeable proportion (23%) of staff reported as unvaccinated in the care homes undertaking the survey were missing from the call agent team data, so it is not known if managers estimated them as likely or unlikely to take the vaccine; the survey was undertaken before the government had announced its intention to introduce legislation to require vaccinations as a condition of deployment, but the consultation had launched before this.

²⁴ ASC-WDS 19/20 - <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/Workforce-estimates.aspx>

our best possible single estimate. This midpoint is also broadly in line with the sensitivity analysis resulting from government efforts to improve uptake.

79. Using approximately 560,000 as the total number of staff in CQC-registered care homes, as per Capacity Tracker data as of 6th July 2021, and assuming that approximately 7% of those may not have fulfilled the requirements by the end of the grace period (using the midpoint of the two estimates when having accounted for exemptions), this equates to around 42,000 workers, with the equivalent figures for the upper and lower estimates being 67,000 and 17,000 workers. Assuming that 10% of each of those estimates are made up of those who would have left as part of the usual turnover, the equivalent figures that are used to estimate the cost of recruiting workers as a result of the policy for the central, upper and lower estimates are 37,000, 60,000 and 15,000 workers respectively.

Cost implications for care home providers

80. Since the condition of deployment will require all staff working in a CQC-Registered care home to be vaccinated, the cost of recruitment is used to quantify the possible cost of replacing all non-vaccinated workers with vaccinated ones, as a result of the policy. The cost used is £2500, per worker, as derived from the stated costs of recruitment by a small adult social care provider (using the midpoint between the training & recruitment costs only, and include the training & recruitment costs plus the lost productivity from using new workers) ²⁵. The costs from this source are based on a single small adult social care provider, that employs 20 full time equivalent care workers so is used with caution.
81. The total calculated cost of recruitment from this source combines the individual costs of covering exiting staff through agency workers, preparing a job description and the application process, advertisement and promotions, shortlisting, conducting interviews, doing checks and contracting, completing induction and training, having initial supervision support and the lower productivity caused by a reduced capacity.
82. The derived cost of £2500 that is used as the basis to estimate the cost of recruiting new workers, falls in the middle of the total cost of recruitment as calculated by the source at £3,642 and the total cost when excluding the cost of lost productivity at £1,313. We have assumed that the cost of recruiting a new worker will fall in the middle of this range, because of the uncertainty surrounding the estimate of lost productivity for new staff. We have therefore only included 50% of this component in the value we use.
83. Playing through this figure for replacing a worker by the number of workers who will not have a vaccine (and are not exempt) then estimates the cost of the policy at £94m. This stated cost of the policy may represent a conservative estimate since the cost of recruitment per worker does not consider any potential efficiency savings that may be incurred through the process of providers recruiting a reasonable number of workers as a result of the policy change. This is explained in more detail below.

²⁵ [Calculating the cost of recruitment \(skillsforcare.org.uk\)](https://skillsforcare.org.uk)

84. It is worth noting that the above central cost estimate of £94m is highly sensitive to the proportion of the workforce who do not fulfil the condition of deployment by the end of the grace period, of which there exists a high degree of uncertainty. As mentioned above, the figure of 7% for the central scenario is based on the midpoint of two potential estimates for what this potential proportion could be (3% and 12%, net of exemptions) which sets out the proposed range of this uncertainty. If this proportion were to be 3%, the costs of the policy would decrease (from the central estimate) to £38m, whilst if the proportion were to be 12% then the costs would increase to £149m.
85. The cost of the policy will vary across providers, based on an array of factors including the role and therefore pay of the workers needing to be replaced and the total number of workers being replaced. If providers replace a large number of workers, they may have the potential to reduce the cost of recruitment, per worker, by employing recruitment strategies that offer savings for recruiting a large number of workers at one time. Additionally, it is sensible to assume that the stated cost per worker is likely to vary significantly, based on each providers ability to realise savings during the recruitment process. These savings may occur through several ways, including (but not limited to) training a large number of staff at one time or mass advertising. These savings may reduce the cost of recruitment per worker. Therefore, the stated cost of £2500 which is used to calculate the total cost of replacing staff may be seen as a conservative estimate. This saving is not adjusted for in the monetised cost as it is likely that on average, the differences in the ability to do this may balance out across providers.
86. In order to capture this uncertainty around the cost of recruitment, we have conducted a further a sensitivity test on the central estimate. Using the upper estimate of the cost of recruitment from Skills for Care of £3600 per worker, which is consistent with estimates from a representative body within the sector, and applying it to the central estimate for the number of workers who may be unvaccinated, estimates that the cost would increase to £137m.

Uncertainties with the cost estimation

87. It is important to note that there are a number of uncertainties with some of the assumptions underpinning the analysis.
88. We have used a range of estimates, one with a simplifying assumption that no behaviour change will take place and the other looking at vaccine hesitancy, both as a basis for developing a midpoint cost of the policy for the workforce who may not have fulfilled the requirements, since there is mixed evidence to suggest whether behaviour change will have a positive (reduce the cost) or negative (increase the cost) effect on the vaccine uptake rate. We might expect the policy to act as a signal to workers who previously would not have been vaccinated, in order to protect their job, and for their employers to support them to do this (to reduce their re-employment costs at minimum) – evidence does suggest this has occurred in similar instances. However, the international evidence is limited and the circumstances of the countries in which the vaccine is a condition of employment are not necessarily relatable to England (e.g. at our current uptake rate,

other laws on vaccine as a condition of employment in the country at the time, etc.). Moreover, various evidence sources suggest there are multiple factors which drive lower levels of uptake, including some such as access which will be relatively unaffected by the policy, and other evidence that it could go further and reduce the vaccine uptake rate than its current projections. As such, this estimate represents a central scenario for what could occur.

89. There could however be the possibility of negative behaviour change resulting from the policy. For example, a German experiment found that compulsory vaccination increased anger among individuals with existing negative vaccination attitudes and led to a decrease in uptake by 39%²⁶. Moreover, recent public consultation²⁷ found that the biggest concern among respondents was that staff might refuse the vaccine and resign, with four in five (81%) of respondents citing this and three in four (75%) raised a similar concern, that staff might resign in protest. Though this evidence does highlight that there could be a negative impact when factoring in behaviour change, given we are not able to quantify the level to which it may change due to the lack of consensus and difficulty in applying international evidence to our analysis due to uncertainty over accuracy and representation, we have not been able to include this in our approach to quantifying the costs. As such, the additional positive change which we cannot measure is implicitly being traded off against the possibility of there being a negative behaviour change resulting from the introduction of the policy, of which there is some.
90. The figure used as the total number of staff working in CQC registered care homes and therefore in scope for this policy may be an underestimation. This total number is the sum of staff employed by care homes serving any older people and staff employed by CQC registered younger adult care homes. The total sum is based on responses from 99% and 98% of providers respectively.
91. We have not included the cost of deploying the vaccine since the cost of acquiring and administering the vaccine is already factored into the government budget for national rollout. Vaccine purchases have already been made therefore vaccinating this group of the population does not represent an additional cost over the initial cost of vaccinating the population.
92. The estimate of the proportion of workers who qualify for exemption and so will not need to be replaced contains some uncertainty. Exemptions will apply for individuals below the age of 18, for those who are taking part in clinical trials, and for those who are deemed clinically exempt on the basis of the Green Book and JCVI guidance or by a clinician. We have estimated this is up to 1% but this is uncertain given the lack of data available on the numbers of people that meet a clinical exemption listed in the Green Book.

²⁶ Betsch C, Bohm R. (2016). "Detrimental effects of introducing partial compulsory vaccination: experimental evidence". *European journal of public health* (1101-1262), 26 (3), p. 378.

²⁷ <https://www.gov.uk/government/consultations/making-vaccination-a-condition-of-deployment-in-older-adult-care-homes/outcome/making-vaccination-a-condition-of-deployment-in-care-homes-government-response>

93. To estimate the cost of recruiting replacement workers who may leave as a result of the policy, we have assumed that 10% of those workers identified as those who may not fulfil the requirements of the policy, may have left even without the policy. Therefore, we have excluded those 10% of workers as the cost of recruiting them would form a regular part of providers operations and therefore costs and not part of the cost of policy.

Non monetised costs

94. There are several non-monetised costs that may arise to different groups as a result of making the vaccination a condition of deployment, some of which fall to business and civil society organisations, and some which fall to individuals. The non-monetised costs to business and civil society organisations include:

- Direct, transitional costs to care providers of cover for staff absent due to side effects from having the vaccination, or replacement of staff who suffer complication as a result of it.
- Direct, transitional costs to care providers of management familiarising themselves with the regulation and guidelines on exemptions
- Indirect costs to care providers from temporary increased strain on those working in social care who are already vaccinated, and on workforce capacity
- Indirect costs to businesses as lost earnings or revenue from those who have unvaccinated visiting professionals who can no longer be hired by care providers.

95. A direct cost to care providers may emerge if some of the additional workers who are vaccinated as a result of the policy experience side effects severe enough to result in absence from work. Around one in eight people who have received one dose of the Pfizer COVID-19 vaccine have experienced at least one systemic effect within seven days of their job compared with roughly one in three who received the AstraZeneca vaccine. The additional cost of dealing with absences due to side effects of those vaccinated as a result of the policy would be the cost of covering staff shifts using overtime or agency staff at a premium over and above what would usually be paid to existing staff. We have not included this as part of the monetised costs given that we do not know how often side effects are severe enough to result in absence from work, the duration of such absences, or – given the reported range in incidence of side effects between the Pfizer COVID-19 and AstraZeneca vaccines - the proportion of workers vaccinated as a result of the policy who will receive each type of vaccine. We do not know the incidence of these side effects for the social care workforce vaccinated as result of the policy. However, assuming a third of these workers (so as to represent the most conservative estimate) were to be absent from work for an (illustrative) five days, and a premium for staff cover of 20% of the average wage, this could be estimated at an illustrative cost of roughly £600,000.

96. There will also likely be a direct cost to care providers for the time management need to familiarise themselves with the regulation and guidelines around exemptions. We

consider that the time required by each provider to familiarise themselves will be small, as providers have been required to monitor and report the vaccination status of staff deployed in their care homes to DHSC via the Capacity Tracker collection for some time and are therefore familiar with considering this issue. The regulation has been consulted on in its current form (1,422 responses were received from care home providers) and DHSC will engage with providers and their representative bodies to explain the implications of the regulation during the sixteen-week grace period between introduction and enforcement. The care home market is also partially concentrated, and familiarisation costs may be lower within hierarchical businesses: the CQC register includes c. 15,000 locations providing residential social care but only c. 6,000 unique provider organisations delivering such services. Managerial pay in the independent sector workforce i.e. those not employed directly by local authorities was approximately £16 per hour in 2019/20, implying a cost per organisation of familiarisation in the order of £40 (assuming an illustrative 2 hours per organisation to consider exemptions and alter existing guidance to staff), suggesting total familiarisation costs would very likely be less than £600,000. Given the very significant uncertainties already expressed in the range of monetised direct costs to business estimated above, we have not explicitly including an impact of the magnitude in our quantification of potential costs.

97. The policy may also place a short-term strain on the members of the workforce who are already vaccinated as a consequence of potentially needing to pick up extra work due to temporarily reduced capacity. This is likely to vary substantially across regions, given that the current vaccine uptake differs a lot across local authorities. Providers in the London region currently have the lowest vaccine uptake and are therefore most at risk of suffering from temporarily increased strain on the already vaccinated workforce, as a higher number of replacement workers would be required. The size of this impact is likely to be impacted by the number of replacement workers necessary and the speed at which replacement workers are recruited. Any strain will however only exist in the short term before replacement workers are recruited, and the sector typically recruits c.10% of its workforce from other sectors over the course of each year. A fully vaccinated workforce should also reduce the likelihood of this increased, unexpected strain occurring in the future, offsetting expected future costs as a benefit of the policy. Additionally, since we do not assume that staff requiring vaccinations do so during working hours, those being vaccinated as part of the policy should not cause any significant loss of productivity, other than those mentioned below. Care users are also likely to be consequentially impacted by the changes, because of the loss of familiar staff and the short-term strain on the remaining workforce.
98. Providers may also suffer – and potentially be at operational risk – if there are labour market shortages resulting from workers leaving the sector. Whilst there has been a 15.1% reduction in total care homes from September 2010 to June 2021 and the provider market tolerates provider failures, there is still the risk that given the difficulty that the adult social care sector has in attracting workers (due to relatively low pay when compared with similar jobs in the NHS for example) this policy could face represent a risk to providers in replacing workers. Most commentators point to significant uncertainty over the future path of the wider labour market, and to conflating effects in potential indicators

and data – driven by more significant macroeconomic factors including changes to payroll taxes and means-tested benefits, the maturation of the Coronavirus Job Retention Scheme, the reopening of sectors of the economy such as hospitality and longer-term changes such as changes to migration rules – leading to us not being able to assess the impact of the labour market conditions on workforce capacity in detail. The risk to providers and the provision of care is mitigated by the duty of LAs to manage local markets to care and care workers, oversight by the CQC, and support put in place by DHSC and Skills for Care to support providers in recruiting and/or retaining additional workers. . Given that both occupancy rates and local labour market conditions would differ in each region, we can make a judgement that it is likely the impact of this would be felt differently in each region.

99. There is a statutory scheme under which in the rare event that a person is severely disabled as a result of vaccination, they may be eligible to make a claim under the Vaccine Damage Payments Act (VDPS), established in 1979. Successful applicants receive a one-off tax-free lump sum of £120,000. VDPS is not a compensation scheme as it does not preclude individual from perusing litigation. However, proving causation often proves to be difficult in these types of cases. The Government has agreed to provide an indemnity as part of the contract between the Government and COVID-19 vaccine manufacturers, and the Government continues to update Parliament on liabilities related to the deployment of COVID-19 vaccines. We have not estimated quantified costs here as a result of the policy due to the difficulty in estimating the number of claims that may be made, and the difficulty of estimate the number of vaccinations that may have taken place in absence of the policy.
100. As the policy change also impacts visiting professionals who enter a care home who are not part of the social care workforce, businesses who have unvaccinated staff will likely suffer a cost. These businesses may need to reallocate staff to deal with this change or may suffer from lost business as care home providers are forced to select from competing businesses who have vaccinated staff. As some businesses may lose revenue from lost work in care homes if their staff are unvaccinated, other businesses with vaccinated staff will benefit from increased work and therefore revenue. This is likely to result in a zero to small net cost to businesses. An additional new cost that is likely to be incurred by businesses and providers is the cost associated with showing that staff are vaccinated. There may be a cost associated with implementing and maintaining a system to verify vaccine status among visiting professionals. This cost is likely to reflect the necessary staff time dedicated to this.
101. There is likely to be some cost associated with verifying the clinical evidence required for exemptions though the given that the scope of exemptions is narrow we expect any associated costs to be very small.
102. There are also likely to be non-monetised costs to individuals as a result of this policy, which include:

- Indirect cost of restricted job choice for current social care workers who may leave the workforce due to the policy
- Indirect cost of temporary loss of earnings for those leaving the workforce

103. By making vaccination a condition of employment, some workers who refuse to have the vaccine for whatever reason, may choose to leave the social care workforce. This restricts the choice that an individual has over their place of work which may lead to temporarily reduced job satisfaction. Workers who do not fulfil the requirements and therefore leave the workforce as a result, may also suffer from a temporary loss of earnings. While those choosing to leave the workforce will suffer from a loss of income, those finding employment will gain income - therefore we do not expect to see a net loss of income among any societal groups. Moreover, since there are a record number of vacancies in the labour market²⁸, it is likely that it will be easier than it was previously to find another job and so any loss of income would be minimal.

Benefits

104. Several non-monetised benefits may arise to different groups as a result of making the vaccination a condition of deployment, including:

- More equitable level of care provided to care users
- Reduced likelihood of care home outbreaks, providing greater safety for care home users and a reduction in lost productivity from staff absences
- Reduced cost of hospital treatments for both residents and workers
- Reduced rate of transmission in the community
- Staff moving to related health and social care settings and not leaving the sector altogether

105. As the current vaccine uptake among care home staff is highly unequal across local authorities, the resulting risk posed to care home users and the wider community is also highly unequal. Due to the low level of vaccine uptake among particular local authorities, the unequal level of risk may translate into an unequal level of outbreaks, staff absences and potentially restricting visitor rights across care users. All of which may largely impact the quality of care provided to users. The policy will help to reduce this unequal level of risk across care home users by reducing the threat of the spread of the virus by workers. The risk of outbreaks is higher among care homes where fewer of the workforce are vaccinated because workers are less protected. Although the onward protection provided to other members of the workforce from additional members of staff becoming vaccinated is not quantified, this will have positive impacts on limiting the transmission of the virus and reducing lost productivity caused by staff absences.

106. Reducing the risk of future outbreaks also reduces the likelihood that care home users will suffer from restricted visitor rights, which will contribute towards maintaining a higher

²⁸ <https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/unemployment/datasets/vacanciesbyindustryvacs02>

quality of care for users. The number of deaths involving COVID-19 in care home residents from the week of the 2 January 2021 to 14 May 2021, in England, has totalled 10,068, as stated by the Office for National Statistics (ONS).

107. Therefore, by offering a high level of protection for both users and other workers by vaccinating the workforce, there will be a benefit from reduced hospital admissions and treatments.
108. At the height of the pandemic, care users and workers were among the most clinically vulnerable groups in society and represented a large proportion of hospital admissions and treatments. Although we have not monetised this, there is likely to be a large cost saving to the NHS from avoided hospitalisations.
109. During the height of the pandemic, other urgent medical procedures were cancelled or postponed to allow the NHS to deal with the significant pressures faced by COVID hospitalisations. This demonstrates the opportunity cost of hospitalisations and the value of reducing them. Through vaccinating more of the population and increasing the onward protection in the community, other treatments can continue as those most clinically vulnerable gain further protection from the virus.
110. Increasing the number of people who are vaccinated will further help to reduce the level of transmission of the virus across the community. By vaccinating the entire workforce, this contributes towards the increasing number of people who are vaccinated, helping to protect those not yet vaccinated from catching the virus. Increasing the protection of the wider community is a necessary step towards giving people the confidence to continue to return to life as usual.
111. It is a possibility that given the policy does not apply across all adult social care settings, workers who will need to be replaced may not leave the sector altogether but move to another related setting within health and social care. Though there is little evidence to support this claim or point to a particular proportion of those who would be replaced that would consider this, it is a reasonable assumption to make. As such, and if so, this will act as a benefit through providing a saving to future training and recruitment through retention, and through maintaining expertise and skilled staff within it.
112. Though we are not able to monetise these benefits, we have conducted breakeven analysis to estimate the necessary number of additional QALYs generated by the policy as a result of Covid-19 harms avoided through vaccinations for the policy to have a net positive social impact under the central cost estimate – this is set out below.

Breakeven Analysis

113. As mentioned above, we are using breakeven analysis rather than attempting to quantify the benefits of this policy, given the difficulty in isolating the effect that vaccinating the workforce is having on the intended outcomes of reducing COVID-19 cases and deaths.

Other factors – such as resident vaccination and infection control measures – are occurring simultaneously and contributing towards the same overall effects.

Additional Quality-Adjusted Life Years

114. Quality-Adjusted Life Years (QALYs) are a concept commonly used in health economics and in particular by the National Institute for Health and Care Excellence to value the outcome of different health interventions. The approach takes account of not only the increase in life expectancy a policy or treatment is expected to generate but the quality of that life and any improvements made. Based on willingness-to-pay research, the social value of one QALY – one additional year of life, experiencing the highest possible quality of life – has been established at £60,000.
115. Vaccinating additional care home staff against Covid-19 reduces the risk of infection and harm to the staff directly affected, but also reduces the chance that they will pass Covid-19 onto either the vulnerable people they care for or their own friends, family and communities.
116. On this basis, if the total number of additional QALYs generated by the policy, as a consequence of Covid-19 harms avoided through vaccinations, is greater than 1547 then the intervention is very likely to have a net positive social impact under our central scenario for costs.
117. To put this figure in context for residents in care homes, the average life expectancy of a care home resident receiving nursing care is approximately one year and three months²⁹ (but for those in care homes not receiving nursing care, this figure is longer – and many care users will live in a home for significantly longer than this average). The average Social Care-Related Quality of Life (SCRQoL) Score of 19.1 out of a potential 24, as reported by all respondents who answered eight adult social care specific questions in England can be used as a proxy for the quality of life of an average care user.
118. For those in the wider community, whom care home staff may interact with in their day-to-day lives or whom could be affected by wider onward transmission of Covid-19, the benefits of avoiding long Covid or death are potentially even greater, even though the risk to the average individual may be substantially lower.
119. A breakeven analysis based on QALYs does not account for the wider social and economic benefits of preventing infection and harm, such as cost savings to the NHS, lost productivity for workers who are infected or obliged to self-isolate, or the marginal impact on the need for further infection control measures.

²⁹ Forder, J and Fernandez, J-L (2011) Length of stay in care homes, Report commissioned by Bupa Care Services, PSSRU Discussion Paper 2769, Canterbury: PSSRU. This research found that half of care home residents (using 11,565 residents in total across 305 care homes) had died after 462 days in the home. This sample only considers people over the age of 65 and therefore may be an underestimate for the average life expectancy of all care users impacted.

120. It is also important to recognise that although there are other plausible ways of valuing changes to the risk of a statistically prevented fatality including statistical life-years (SLYs) and disability-adjusted life-years (DALYs), using QALYs is the most applicable in a social care setting.

Direct costs and benefits to business calculations

121. Providers are likely to experience a short-term cost (i.e. accruing in the first year) of dealing with replacement of workers (short-term cover alongside recruitment and training costs), if 7% of workers do not choose to get vaccinated as a result of the policy and are not eligible for an exemption— this is the full cost of £94m estimated within this impact assessment and is therefore subject to a one-year appraisal period. As stated in the Business Impact section earlier though, we have estimated that there are around 3% of public providers in the market, and so netting this off provides an estimate for the direct cost to providers at £91m. In the long run however, having a fully vaccinated workforce reduces the likelihood of a high number of absent days, which would benefit the provider as it reduces the need and therefore cost of finding replacement work.
122. As mentioned in the non-monetised cost section above, businesses are likely to experience a change in business from care home providers, depending on the proportion of their workforce that are vaccinated. Although there may not be a net cost to businesses as a result of this, there is likely to be a small cost to providers in the form of the time spent by staff to verify the vaccine status of visiting professionals entering the care home.
123. Whilst there has been a 15.1% reduction in total care homes from September 2010 to June 2021 and the provider market tolerates provider failures, there is still the risk that given the difficulty that the adult social care sector has in attracting workers (due to relatively low pay when compared with similar jobs in the NHS for example) this policy could face risks in replacing workers.

Risks and assumptions

124. Making vaccination a condition of deployment in a care home is likely to have a significant impact on staffing in the short- to medium-term, with those who do not fulfil the requirements needing to be replaced by providers who can no longer deploy them. Whilst a midpoint estimate of 42,000 workers of not fulfilling their condition of deployment could present a risk given existing staff capacity issues in the sector, given it is likely that any exits will occur throughout the sixteen-week grace period and not all at once, this should represent increased turnover rather than a sudden reduction. It should be recognised that some of this will be part of the usual turnover within the workforce. The sector experiences a relatively high annual workforce turnover rate of over 30%³⁰, where recruitment forms a regular part of their operations. Applying this proportion to the 16-week grace period, it may be reasonable to expect that as much as 10% of the workforce could leave during this period, for a reason that is independent of the policy. Therefore, in the counterfactual, some of these 42,000 (c.4,000) would have left their current

³⁰ ASC-WDS 19/20 - <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/Workforce-estimates.aspx>

employment in any case over the course of a 16-week period. Given this, we assume that c.38,000 workers may leave as a result of the policy alone. It is worth noting that the extent of the challenge posed by increased turnover will also depend on the local labour market conditions. Some of these risks could be somewhat mitigated at the local level through levers which are set out below.

125. Whilst we are assuming that a potentially large number of replacement workers may be necessary to help address the vacancies that may arise as a result of the policy, there are plausible reasons to suggest why we think this may be possible. These include the approaching end of the furlough scheme, introduced to help deal with the pandemic, which may result in a possible sudden increase in the size of the adult social care (ASC) workforce entrant pool, helped further by the limited level of requirements necessary for those entering the sector. The policy may also incentivise some people to enter this labour market, given their increased level of protection against the spread of the virus at the workplace relative to other labour markets.
126. Whilst we cannot predict the profile for those who will leave the workforce during the grace period, and envisage that it will be spread throughout, if it were a sudden reduction it would likely put a larger number of care homes at risk of breaching safe staffing levels, leading to a reduction in capacity, and, in the worst cases, service closures. Based on a simplified model and a reasonable worst-case scenario about the proportion of the workforce who may not fulfil the requirements of the policy, we might expect a sudden loss of workforce breaching safe staffing levels and care homes reporting significant risks. This is likely to have a greater impact in urban areas, such as London, where current uptake has been lower.
127. The estimates for the proportion of the workforce who may not have fulfilled their condition of employment by the end of the grace period is at England-level. This means that the differences will likely differ between regions with the risks higher in those areas with lower vaccine uptake rates. However, there may be local levers in place to manage this risk. For example, we can expect Local Authorities to proactively manage these risks given their knowledge of local provider and labour markets and the ongoing work taking place regarding vaccine uptake. We can expect them to have contingency plans in place to deal with workforce shortages and provider failures as set out in the Care Act³¹. The DSHC regional team will be ensuring this is the case over the next few weeks. Examples of actions that can be taken are redeploying staff from their own or other services or relocating residents in the event of service closures.
128. Whilst the requirements apply to all care home staff and all professional persons entering a care home, we have only considered care home staff for the basis of our modelling. This is in response to a lack of vaccination data on all other persons entering a care home.

³¹ [Care Act factsheets - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/collections/care-act-factsheets)

129. The Adult Social Care – Workforce Data Set, 2019-20 states that 79% of the ASC workforce are white whilst 21% are BAME³². This compares to the equivalent respective levels of 86% and 14% for England³³. Therefore, there are likely to be disproportionate impacts on the BAME cohort as they are further represented in the ASC workforce relative to the England population, as set out in the Public Sector Equalities Duty³⁴. Similarly, as 82% of the ASC workforce are female compared to 51% for England, there will also be disproportionate impacts on females. Therefore, any impacts (including those set out in both the costs and benefits section above, monetised and non-monetised) will result in a disproportionate impact on both of these cohorts (both negatively and positively). One example of the potential larger negative impacts on the BAME cohort comes from a paper prepared by the ethnicity sub-group of the Scientific Advisory Group for Emergencies (SAGE)³⁵ which states that for new vaccines (post-2013), adults in minority ethnic groups were less likely to have received the vaccine compared to those in White groups (by 10-20%). Given this, there may be the chance of a higher, disproportionate risk to the BAME cohort (relative to other ethnicities) of the potential negative impacts such as being made to leave the workforce if not fulfilling the condition of deployment by the end of the grace period.³⁶
130. Any reduction in the nursing workforce would likely have a more significant impact, as there is less scope to rapidly restore capacity. Given that nurses are required for some roles, the probability of service closures would also be greater.
131. Recent capacity strategies have included £120m in funding to local authorities to provide tailored support such as area staff banks. This funding ran from January-March and initial indications show that it had some success in providing additional capacity during that time.

Potential costs of legal cases against DHSC and providers

132. Costs of a legal challenge to this policy would be extremely difficult to assess in such a hypothetical situation, as the challenge could come from a range of different angles, taking issue with different points and require different remedies.
133. The different variables involved may depend on the numbers of staff involved and the costs incurred by providers in defending any Employee Tribunals. Legal costs would also

³² BAME is calculated here as all non-white ethnic groups (Mixed/Multiple ethnic groups, Asian/Asian British, Black/African/Caribbean/Black British, Other), excluding those that were classed as 'Unknown/Not Given'. The aggregation is used since a breakdown given by ethnicity group does not aggregate to the ASC workforce total and would not capture all workers.

³³ Calculated by aggregating the four ethnic groups identified as BAME in the above footnote – totals may differ due to rounding errors.

³⁴https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/994476/Vaccination_as_a_condition_of_deployment_in_care_homes_-_public_sector_equality_duty_impact_assessment.pdf

³⁵https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/952716/s0979-factors-influencing-vaccine-uptake-minority-ethnic-groups.pdf

³⁶https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/952716/s0979-factors-influencing-vaccine-uptake-minority-ethnic-groups.pdf

depend on whether DHSC defended against the challenge and for how long. They would also depend on how the challenge is formulated.

134. Where legal claims are pursued, for example, in any Employment Tribunal, care homes will incur legal costs in defending those claims which they are unlikely to be able to recover even if they successfully defend the claim. If they lose then they may also be liable to pay compensation to the worker. This could result in significant additional hidden costs for the sector that have not been included in the £104m estimate. However, as stated these costs are extremely difficult to quantify at present as it is not known how many of the workers may resort to legal recourse.

Key Assumptions

135. The total number of people working in a CQC-Registered care home and therefore impacted by this policy, is informed by the latest figures informed by providers inputting vaccination data into capacity tracker. As the total sum is based on responses, as of 6th July 2021, which represents 99% of older care home providers and 98% of CQC registered younger adult care homes, the total figure is a slight underestimation.
136. As mentioned in the above cost section, the cost of recruitment used as the basis of the quantified cost is based on a single small adult social care provider. Given this, we have applied the cost figure as stated by the source with caution however, as there is a lack of alternative options for a sensible recruitment cost, we think that this cost estimate is suitable proxy.
137. To project vaccine uptake forward to depict future uptake we employed a logarithmic trendline-of-best-fit. We think that this is appropriate given that such a trendline is often used when the rate of change increases quickly then levels out, which is a similar pattern to what we have observed in the vaccine uptake among care home workers.
138. Given there is evidence to suggest that the policy could result in some workers having the vaccine who otherwise would not have, as well as some workers refusing to have the vaccine due to the change, the more pessimistic of the two estimates (from which we obtain a midpoint) applies a simplifying assumption of no behaviour change. Whilst theory suggests that making a vaccine a condition of deployment will elicit a positive behavioural change, and evidence of vaccine hesitancy rates forming the optimistic of the two estimates exists, there is also the potential for there to be a negative impact resulting from behaviour change. However, since we have been unable to obtain information that could quantitatively provide an equivalent rate for our estimations, we have not been able to capture this risk in the monetised analysis.
139. Redundancy payment costs have not been considered as part of this analysis because in the event an individual who is not vaccinated or exempt cannot be redeployed (and providing the employer continues to need the same number of employees to carry out the work in question) this will not amount to a redundancy situation. The reason for termination of employment will be dismissal, not redundancy, and dismissed employees will not be entitled to a redundancy payment.

Impact on small and micro businesses

140. Some care providers will be small or micro businesses or civil society organisations, and these proposals will apply to their staff. The burden of verifying that staff are vaccinated and some recruitment costs for replacing staff may be disproportionate, as not all costs will vary with business size. Given that small and micro providers account for a significant proportion of all providers in England, and to ensure that all care users are equally protected, it would not be possible to exempt smaller enterprises. Defining small and micro providers as having fewer than 50 employees and using a ratio of 1.5 employees per bed³⁷, small and micro care providers can be defined as those having fewer than 33 beds in total. We define a provider using the provider ID field in the CQC care directory, and count brands as a single provider even if they have multiple provider IDs. There are 3,785 such care home providers out of 6,485 in England, although they only represent 68,737 beds out of an England total of 458,955. However, some will not in fact be small and micro providers if they have a higher staffing ratio than 5 or if they have activity in other markets. It should be noted that the smaller providers are disproportionately likely to serve younger adults, where self-funder numbers are substantially lower, so will be less affected by the intervention. These numbers therefore represent an upper bound of the number of small and micro businesses affected by the intervention.
141. We are working with Skills for Care to ensure that resources such as guidance and best practice are available to support all providers and local authorities with capacity and workforce planning, recruitment, and well-being. We anticipate that smaller providers will make greater use of these resources due to the potential disproportionate impact on them.
142. Skills for Care has developed a dedicated one stop webpage that brings together a range of support, information, and resources together to support social care employers to continue to recruit and retain their staff in a challenging environment. This includes case examples where employers have successfully encouraged their staff to take up the vaccine ahead of this policy being implemented. These will help share good practice from across the sector. [COVID-19 vaccination \(skillsforcare.org.uk\)](https://www.skillsforcare.org.uk/covid-19-vaccination)
143. Skills for Care can also provide local and national workforce support to local authorities and employers.
144. We will also work with local authorities to ensure they are contingency planning and accessing additional support, as well as promoting joint working across a region to assist with targeted recruitment. In addition, we have put in place a range of measures to help providers recruit and retain staff. This includes relaunching our National Recruitment Campaign to highlight the opportunities of working in adult social care, free and fast-track DBS and barred list checks for covid-19 related recruitment to speed up the onboarding

³⁷ Skills for care report 680,000 residential staff. Table 6, <https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/Size-of-the-adult-social-care-sector/Size-and-Structure-2020.pdf>. CQC data for April 2021 show 458,955 registered care home beds, see the care directory with filters at <https://www.cqc.org.uk/about-us/transparency/using-cqc-data>.

process, and work with DWP to provide resources and training to Job Centre Work Coaches to enable them to effectively promote adult social care careers to jobseekers.

145. We recently announced an investment of at least £500m across three years to deliver new qualifications, progression pathways and wellbeing & mental health support. We will introduce further reforms to improve recruitment and support for our social care workforce, with further detail set out in the upcoming White Paper.

Wider impacts

In line with Better Regulation Guidance, we have considered the following issues as part of this appraisal:

Trade impacts

We do not anticipate that the proposals are likely to impact trade or investment.

Legislation

The proposals are aligned with the Human Rights Act and should not infringe on any right included in the Act. The proposals do not impinge on civil liberties as they do not compel anyone to be vaccinated against their will but do establish an explicit duty of care for those working and volunteering in care homes. The proposals should not contravene the Data Protection Act or Freedom of Information Act.

Competition test

We expect businesses who have a higher proportion of visiting professional workers that are vaccinated to have increased business compared to competitors who have a smaller proportion of their workforce vaccinated.

Rural issues

We do not expect impacts on rural areas in particular. The policy will be reviewed if significant obstacles would prevent eligible workers from accessing vaccination in a timely and accessible way for example due to vaccine supply issues or changes in national clinical guidance. This would mean for example, that if supply issues mean it is impossible for a member of staff to access a vaccination within a reasonable travelling distance, the requirement will disapply to that individual until the supply issue is resolved.

Equality – Public Sector Equality Duty

Please refer to the Equalities Impact Assessment³⁸.

Health and safety

Overall, the expansion of the system will not have any impact on the health and safety measures, but signal that the Government has confidence in the current system.

Regional perspectives

The devolved administrations have been kept informed of the policy development, however the scope of the policy is England only. Devolved consent for these regulations is not required.

³⁸https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/994476/Vaccination_as_a_condition_of_deployment_in_care_homes_-_public_sector_equality_duty_impact_assessment.pdf

A summary of the potential trade implications of measure

There are no impacts on international trade. All services affected are domestic and based in England.

Monitoring and Evaluation

We will work closely with the adult social care sector and key stakeholders to monitor the impacts of this policy. This will include monitoring live data such as vaccine uptake rates and employee numbers using the Capacity Tracker collection and monthly data on workforce size, absence and vacancy rates from Skills for Care's ASC workforce data system, as well as surveys of the sentiment and experience of other stakeholders in terms of retention, recruitment and indicators of strain. Data on staff and resident positive tests for COVID-19, and the outcomes for residents, can also be monitored. We recognise the importance of obtaining qualitative intelligence direct from stakeholders and will utilise our regional assurance teams to gather feedback from providers and local authorities. However, it may not be possible to form direct causal links to the policy given broader factors impacting the sector workforce and the incidence and impact of COVID-19. This monitoring will form a significant part of the monitoring and evaluation plan for the proposals.

We will keep this policy under review. As set out in the statutory instrument, The Secretary of State will carry out a review of the regulations, set out the conclusions of the review in a report, and publish the report. These reviews will happen at a maximum interval of 12 months. The review will incorporate an evaluation of the regulations.