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COVID-19 OPERATIONS COMMITTEE 21(62)

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Government response to the consultation on making vaccination a condition of deployment for those working in care home AND Intention to launch a consultation: vaccines as a condition of deployment in extended social and health care settings for Covid and flu vaccination

PAPER BY THE SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE

PAPER 1: Government response to the consultation on making vaccination a condition of deployment for those working in care home

Purpose

1. COVID-O met on 17 March 2021 and agreed to DHSC's proposals to consult on making vaccination a condition of deployment for those working in residential care homes, with residents over the age of 65, by amending secondary legislation [*the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].* The consultation was launched on 14 April and closed on 26 May, following a short extension.
2. Subject to COVID O agreement, we intend to publish the Consultation response on 16th June, subject to No.10 agreement to a grid slot, lay regulations on 21st June, make the regulations before summer recess and then have a 16-week grace period before the regulations come into force in late October.

The Committee is now asked to agree to publish the Government response to the consultation; and to the proposed next steps.

Context

3. There is a clear public health rationale for driving vaccination uptake in care homes. This is based upon minimising transmission of COVID-19 and protecting residents in high-risk settings who are most vulnerable to severe illness and death as a result of contracting the virus.

4. There are 17 new and 56 ongoing resident-only outbreaks in the last 14-days but 49 new and 164 ongoing outbreaks in the last 14 days when you include staff. While there is currently some indication that this is due to lower vaccination rates amongst staff the evidence is inconclusive.

5. The social care working group of SAGE has advised that 80% of staff and 90% of residents in a care home need 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. As of 9 June, only 64% of older adult homes in England are currently meeting this dual threshold for the first dose, and the proportion is worst in London with only 44% reaching the dual threshold. And – while the SAGE working group advice is specifically about first doses – it should be noted that, for second doses, only 39% of homes are reaching this 80/90% level of coverage, with London the region with furthest to travel, on 21% of care homes reaching the dual threshold. There is a specific risk associated with interactions between unvaccinated staff and vulnerable patients. The vaccines currently appear to have a significant impact on reducing hospitalisations and deaths to date and so driving uptake remains a key Government objective. Indeed, in the face of rising cases of the Delta variant, there have been very small numbers of outbreaks in care homes.

6. The consultation set out our proposal to amend regulations to require care home providers, whose homes have at least one resident over the age of 65, to deploy only those workers who have received their COVID-19 vaccination (or have a legitimate medical exemption from vaccination). There were over 14,000 responses to the consultation.

7. While a majority of respondents did not support the proposal, the responses from the adult social care sector were mixed, with some groups (e.g. some care home providers) supporting the proposed legislative change while others (e.g. members of the Adult Social Care workforce) were opposed.

8. We are now preparing to:
   - publish a government response on 16th June; and
   - lay regulations on 21st June, with a view to these being debated, approved and signed before summer recess.

Government response to the consultation

Scope

9. The consultation showed very clearly that the proposal to include only CQC-registered care homes with at least one older (65+) adult would be extremely challenging to implement (a 65th birthday or a death could see a home moved into or out of scope, for example); that stakeholders and respondents highlighted the need to protect working age residents who are clinically vulnerable to COVID-19 eg people with learning disabilities; and might give rise to unintended consequences (e.g. risk of someone turning 65 being moved to avoid a home falling within scope of the policy).

10. Similarly, respondents were not in favour of the 'baseline' approach which would include only paid staff deployed in the care home and volunteers deployed to carry out regulated activities. There was significant support for broadening the scope of the policy to include all those coming into close contact with residents

or all those entering care homes in any capacity. There was also some support for broadening the policy to all health and social care staff, in any setting.

11. The proposed government response therefore extends the scope in two ways:

- to include **all CQC-registered care homes,** in England, providing accommodation for persons who require nursing or personal care, not just care homes which have at least one resident over the age of 65. This brings care homes for younger adults into scope.
- to include **all persons who enter a care home**, regardless of their role (excluding residents of the care home; friends and family visiting residents; essential care givers (usually family members); those entering to assist with an emergency; and those under 18). It would include health professionals, hairdressers and CQC inspectors. A postman or delivery driver who is leaving packages at the door **would not** be subject to the condition. Further consideration is being given as to whether tradespeople (eg plumbers or electricians) would be in scope.

12. We intend to make clear in draft regulations that, subject to the exceptions outlined above, and subject to relevant medical exemptions, any person who enters a care home must provide evidence that satisfies the service provider that they have been vaccinated with the complete course of an authorised vaccine.

13. We have prepared a Public Sector Equality Duty Assessment for the policy which we intend to publish alongside the consultation response. We have also prepared an Impact Assessment which will be published as soon as it has been cleared by the Regulatory Policy Committee.

Scope of exemptions and proof of vaccination

14. The majority of respondents agreed with our proposal to grant exemptions on medical grounds. There were also calls for exemptions for visiting emergency services and for women of childbearing age, who were trying to get pregnant, or were pregnant or breast feeding. There was a call for ensuring that the system for demonstrating vaccination status or exemption from vaccination would be as simple and clear as possible.

15. Permitting limited exemptions will help to ensure that the requirement does not exclude, or impose a disproportionate burden on, certain individuals, but a careful balance and controlled solution is required so as not to undermine the public health benefits of the policy, or to create a system that can be used by individuals to circumvent the requirement. This is particularly finely balanced for those who are pregnant, where a blanket exemption could undermine the wider public health messaging that vaccinations are safe in pregnancy, unless a person is clinically exempt. The final position on this exemption will be the subject of further advice to SoS. [redacted]

[redacted]

16. Those who are exempt will be able to be deployed in the care home but we will advise in guidance that they be deployed in non-resident-facing roles wherever possible. This is a mitigation, although would not completely eliminate the risk due to staff inevitably coming into contact with each other in closed care home settings.

17. Service providers would be responsible for checking evidence provided by persons entering the care home, which demonstrates that the person has been vaccinated or is exempt from vaccinations. The regulations will enable care home providers to process this information, in accordance with the Data Protection Act 2018. Detailed guidance will be provided to care homes to help navigate this process.

18. In line with the Green Book on Immunisation against infectious disease (COVID-19: the green book, chapter 14a) the current criteria for health exemptions under this policy include:

- those taking part in Covid19 vaccine clinical trials; and
- exceptional circumstances for individuals, where a clinician recommends vaccine deferral or that vaccination is not appropriate (e.g. a pre-existing diagnosis of anaphylaxis).

19. We also intend to have a blanket exemption for under-18s. We are considering the specific issues for pregnant women (including early stages of pregnancy, miscarriage, abortion).

20. We are working closely with the DHSC COVID-status certification review team and colleagues in NHSX. We intend to adopt the use of the NHS app (and an equivalent web-based and non-digital route) so that people can provide evidence of vaccination status or medical exemption. The process and functionality required for the policy is **similar** to that required for certification. However the scope of our exemptions will be **different** because testing is not a relevant alternative to vaccination. Our use of the NHS app for vaccination status and exemptions is being pursued independently of the certification process and has been approved by the NHSX Delivery Board.

Enforcement

21. CQC has been involved in development of this policy throughout and has advised that it plans to use its enforcement powers to act where a provider does not comply with its requirements. This will depend on the specific circumstances of the individual case, including CQC's assessment of the impact on quality of care and people's safety, and is based on proportionality. CQC may decide it is not appropriate to act based on a single issue if a mitigating rationale can be provided.

Risks

Workforce risks

22. There are concerns from stakeholders and respondents to the consultation about the impact of this policy on a workforce where there are high rates of staff turnover, low wages and competition from other sectors, particularly as hospitality, retail and leisure open up again. This should, though, be balanced against other potential shifts in the labour market, particularly as the furlough scheme ends. Some respondents flagged the risk of care home closures in some areas, particularly among Local Authorities that currently have lower uptake rates. Some respondents to the consultation asked what financial support would be made available to providers. Concerns were also raised about the impact of the policy on those with protected characteristics, such as pregnant people and people from particular ethnic minority backgrounds, where vaccine hesitancy has been higher.

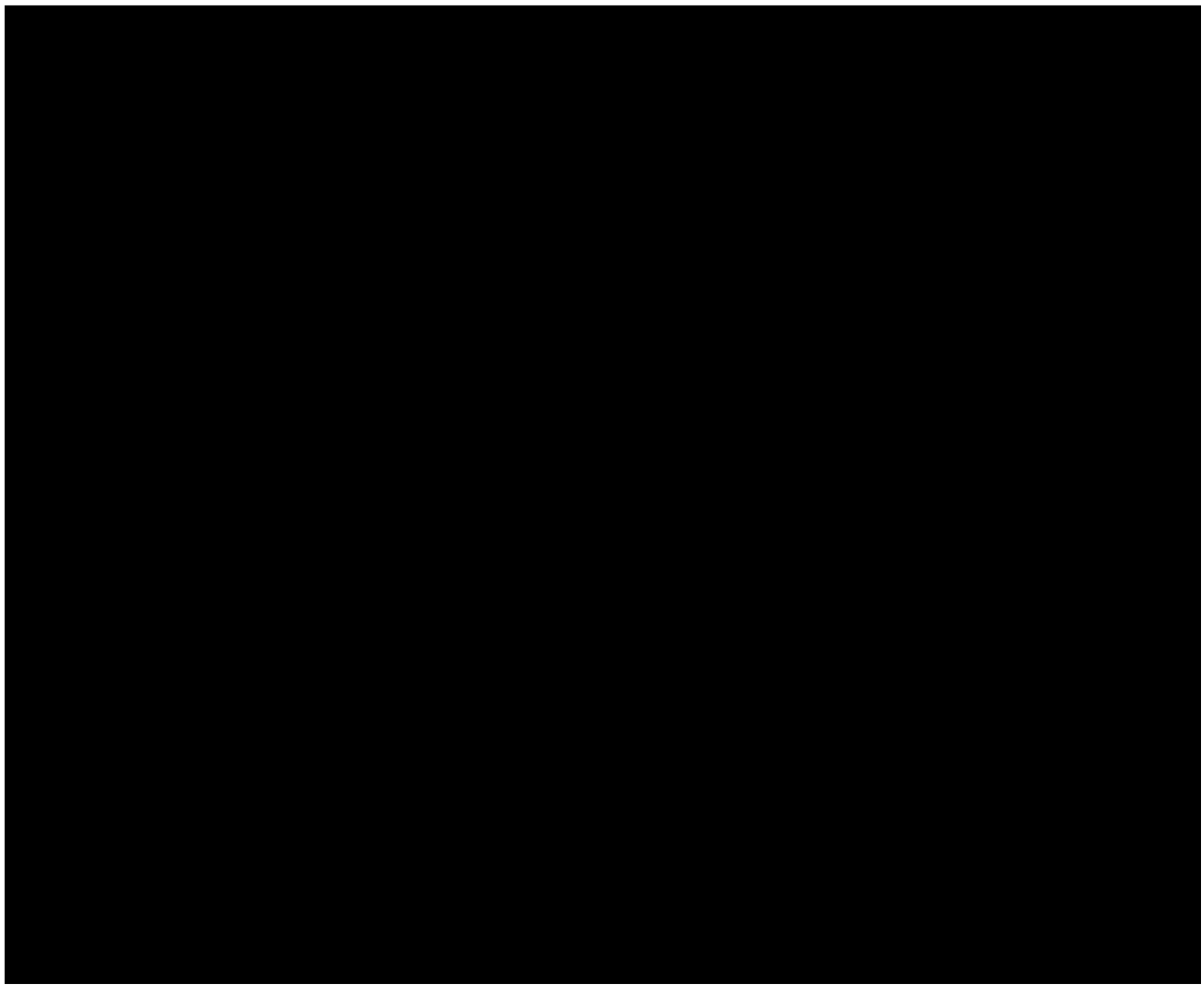
23. Based on the available survey evidence from staff who have stated that they would refuse a vaccine, in our judgement approximately 3% to 7% of the social care workforce might leave their jobs if COVID-19 vaccination becomes a condition of deployment, although the impact will vary between employers and some managers report far greater levels of refusal amongst staff. The available evidence from staff pre-dates some negative press coverage of vaccination risks and some efforts to improve information and outreach. This 3% to 7% is not however an assessment of the total number of staff who could be affected by the policy as proposed. It is **not** based on vaccine uptake. We anticipate the impact of staff leaving would be felt as increased turnover over a period as opposed to sudden reductions in workforce numbers. Applying the policy more broadly, i.e. across the wider health and social care sectors, would mitigate the risk of staff moving to another similar role in a different part of the health/care sector, but not necessarily the risk of them leaving the sector as a whole.

24. To mitigate the risk of a "cliff-edge" effect, we intend to introduce a grace period of 16 weeks between the legislation being passed and the policy being enforced. This would enable a worker to receive both vaccination doses, given the majority of those covered should now be getting both doses within 8 weeks. There may be some, for example among visiting professionals, who are unable to get both doses within this period (as they will be reached in age cohorts), but we expect that care homes could make alternative arrangements in such instances. 16 weeks would also allow an employer more time to fill staff shortages, and thus ensuring continuity of care. [redacted]

25. To further mitigate the workforce impacts, we are working with Skills for Care to ensure Local Authorities and providers have access to guidance, best practice and other resources to support workforce capacity planning and resilience. In addition, DHSC Regional Assurance teams will be working with those LAs most likely to experience workforce risks to ensure they are contingency planning and accessing additional support. The teams will also be promoting joining working across a region to assist with targeted recruitment.

26. We are not proposing financial support for Local Authorities or providers to help mitigate workforce risks at the moment, but will continue to monitor key workforce metrics to understand whether significant workforce capacity issues are emerging and whether funding to mitigate these may be necessary.

27. We are now refining our methods for quantifying and monitoring workforce risk to more accurately reflecting the operational risk to individual LA's ability to meet their obligations. We intend to revise our benchmark for risk to account for both the percentage and number of workers who remain unvaccinated in each service. We are proposing to compile a weekly report to reflect the weekly updates to vaccination figures. This will be combined with additional workforce metrics and operational knowledge of each LA area to produce a more comprehensive view of risk, resilience and capacity, especially for CQC-registered care homes.



Are you content to proceed with publishing the Government response to the consultation on 16th June, subject to agreeing a grid slot with No.10, and laying the regulations on 21st June?

PAPER 2: Intention to launch a consultation: vaccines as a condition of deployment in extended social and health care settings for Covid and flu vaccination

Summary: This paper sits alongside the paper on the outcome of the recent consultation on making vaccination a condition of deployment in care homes. The aim is for the government response to this consultation to be published on 16 June and alongside regulations (pending agreement from No10 on grid slot). The below paper sets out the options for announcing our intention to consult on 16 June to align with the government's consultation response, followed by a six-week consultation to be launched this summer. If it is agreed to proceed with this policy post consultation the **preferred approach is through regulations** as this provides the best opportunity for the policy to deliver in winter 2021/22. This would seek to mitigate risks of staff illness and capacity concerns over the more pressured winter period.

1. This paper seeks agreement to announce the government's intention to consult this summer on the possibility of making both Covid and flu vaccination a condition of deployment in health and wider social care settings. The intention is that this would be an open consultation, with no preferred option, reflecting that vaccine uptake among eligible NHS staff (for first and second doses) is high but that we need to consider how best to protect vulnerable patients, as well as health and social care staff themselves. If approved, the full consultation document will be circulated at a later date for clearance.

2. There is a common-sense case for ensuring that all healthcare workers, and a broader set of adult social care workers who are working with vulnerable patients, have both flu and covid vaccinations for the protection of patients and colleagues. As we move out of the emergency response back to "normal life" public perception of the importance of Covid-19 vaccination may decrease from its current highpoint and we may see reduced vaccine uptake in the future. The aim is to sustain the progress made during the pandemic so that uptake of both flu and covid vaccination becomes the norm in future. Announcing our intention to consult will also reinforce the message to the sector that vaccination is the expectation.

3. Current Covid vaccination uptake rates (first dose) in Trusts are on average at least 88% across England and 81% in London but these include non-frontline staff who would not have been prioritised for vaccination. For frontline staff, we estimate the take-up to be nearer 100% across England and over 90% in London. However, we lack both trust level data and estimates of frontline coverage rates from NHSE/I.

4. The Covid uptake rate for people working in care homes for older adults is 84% first dose and 69% second dose. Covid uptake is marginally lower in other social care settings.

5. In the recent consultation, social care stakeholders have expressed a strong feeling that if the rationale is to protect those most vulnerable to COVID-19, then this policy should be extended to other services in which similarly

vulnerable people receive care. Others have argued that this should extend across all of health and social care sectors both for simplicity and for parity between health and social care staff (across NHS, domiciliary care etc.).

6. For flu, the clinical rationale is similar to that of Covid - care givers transmitting infection to vulnerable cared for people who may suffer serious consequences including death. Outbreaks of flu in care settings are common most winters. People infected with both flu and Covid-19 are more than twice as likely to die as someone with Covid-19 alone. We are seeking further clinical advice from SAGE regarding the risk of flu and evidence of transmission.

7. While flu vaccination uptake has improved over recent years, in 20/21 only 76% of frontline healthcare workers were vaccinated and about 32% of adult social care workers. [redacted] This approach is supported by the initial input from DCMO, indicating he would prefer Covid-19 and flu vaccination to be pursued separately to minimise the chance of Covid-19 being derailed by a flu proposal.

[redacted]

9. JCVI considers frontline health and social care workers who provide care to vulnerable people a high priority for vaccination. Protecting them protects the health and social care sector. CMO has previously flagged that there are risks to vaccination, as for every medicine, and that we should consider it likely that there will be very rare but very serious side effects.

10. For the NHS workforce we want to use consultation to test extending to both flu and covid vaccines, as well as the workforce that should be in scope. Further scientific advice is needed to inform the policy development [redacted]

11. To extend beyond care homes in ASC **we recommend** focusing on regulated homecare agencies; residential recovery services for drugs and alcohol; Shared Lives services; and registered extra care and supported living services. We would also recommend consulting on the inclusion of hospices. We **do not recommend** seeking to extend the scope into the unregulated sector; further details are set out in Annex A.

Extending the scope of this policy

12. Trade Unions, especially RCN, BMA and UNISON are opposed to making the vaccine a condition of deployment. The key NHS trades unions staff members have been consistent, unanimous and vocal in their opposition to mandating

both flu and Covid-19 vaccinations for NHS staff. NHS Employers, whilst significantly less vociferous, broadly support a policy of "encouragement rather than compulsion" and are reluctant to have the task of enforcement placed on employers.

13. The SAGE Social Care working group has suggested there is a case for parity of approaches to vaccination offer and support between health care inpatient settings and care homes, given the similarly close and overlapping networks between residents/patients and workers of all kinds in both. We are seeking further clinical advice on healthcare settings from SAGE and JCVI to help inform the consultation.

14. The intention is to implement the policy in a way that maximises parity across ASC and health care; this includes the use of COVID-status certification.

15. There will be areas of divergence between ASC and healthcare for which we will engage stakeholders to help produce a workable set of exemptions that will be informed by clinical judgement.

16. Initially our thinking is that the consultation would focus on primary care, secondary care and dentistry. However, we intend to seek views on which settings should be in or out of scope. We will also seek views on which staff within those settings may be covered – as there are arguments for and against aligning with ASC on this point.

Optimal legal route for delivering the policy

17. As with the approach proposed for care homes, if Ministers chose to pursue the policy via secondary legislation, we would recommend amending the 'Health and Social Care Act 2008 (Regulated Activities) Regulations 2014' and the associated 'Code of Practice on the Effective Prevention and Control of Infection by Health Service Providers 2015' and related guidance. These regulations and guidance apply to CQC registered settings e.g. hospitals, primary services, and dental services – community pharmacy services and Opticians would be out of scope. We have flagged with CQC that we may need them to support implementation across the NHS as well as adult social care. This is the **preferred approach** as it provides the best opportunity for the policy to deliver in winter 2021/22. Following the regulations coming into force there will need to be a grace period to allow staff to receive a full course of doses of an approved COVID-19 vaccination and potentially to allow time for the flu vaccinations to be administered.

[redacted]

22. Alongside legislation, we will seek to make changes within the Green Book. NHS employers refer to the Green Book published by PHE for guidance on immunisation for certain roles and will make any offers of employment conditional on the new member of staff having the necessary recommended vaccinations.

23. Our aim is to announce our intention to consult on 16th June, subject to No.10 agreement to a grid slot, at the same time as making public the results of the recent ASC consultation. We will launch the consultation by the end of June 2021 for six weeks.

Do you agree to that we should consult on making vaccines a condition of deployment in further social care and health care settings?

Do you agree that we should consult on making flu vaccination, as well as Covid-19, a condition of deployment in care homes, further social care and health care settings?

Finance

24. HMT have at present confirmed £1.65bn to continue the rollout of the Covid-19 Vaccine Programme in 2021/22. A further bid of £2.3bn is with HMT currently to ensure that there is funding to cover both doses for the entire adult population with an aim of achieving this by the end of August 2021.

25. Further funding is required for the 2021/22 flu programme to meet Ministerial uptake ambitions and we are currently in discussions with HMT about overall programme funding. To note, even if we secure funding flu vaccine supply may not meet total demand to meet Ministerial ambitions this season.

26. Given much of the policy detail is yet to be formulated we cannot yet set out the potential financial impact of the overall policy. Different mechanisms to implement the policy will have different financial implications and will need to be considered as part of decisions on the most suitable policy approach.

Stakeholder Engagement

27. We will need to ensure that the consultation document puts the strongest possible evidence forward to manage stakeholder arguments in way that supports proceeding while minimising handling risks.

28. We will also need to carefully consider engagement with specific stakeholder groups representing staff, employers and patients across the full healthcare spectrum e.g. prison healthcare, school nurses etc.

29. Given the uptake issues amongst BAME staff in the NHS, any introduction of mandation will need to be handled very carefully in that context.

30. An impact assessment will be produced to aid both the development of the policy and engagement with stakeholders.

Communications

31. If launched we will promote the consultation across our digital channels including NHS channels, our ASC Update newsletter, our DHSC social media channels, and social care blog, to encourage people across the health and social care sectors to respond. We will also issue a letter directly to all social care providers, care agencies, appropriate professional groups, NHS Employers, NHS Processionals, the royal colleges, LGA, ADASS and NHS stakeholders, informing them about the launch of the consultation and encouraging responses.

Annex A - **Widening the scope of vaccination as a condition of deployment in Adult Social Care**

1. Following the consultation on vaccination as a condition of deployment in older adult care homes, we are now considering a further consultation on extending this to the wider Adult Social Care (ASC) sector and including the 'flu vaccine.

2. The ASC sector comprises a wide range of services, of which a subset are regulated. We propose focussing on regulated services, in line with the approach taken towards care homes (where all CQC regulated care homes are within scope). This paper details the further types of regulated services in ASC and highlights the key risks associated with vaccines as a condition of deployment in each of the sub-sectors.

CQC regulated	**Unregulated**
Homecare (domiciliary care) Extra Care Supported Living Shared Lives	Personal assistants Accommodation Some homecare Daycare and community respite services

3. The key risk associated with extending to the wider sector of CQC regulated settings is the **separation between care and accommodation** where, unlike in care homes, care recipients own their own homes and so care providers cannot assert any control over who can enter or who care recipients can meet. In addition, the accommodation is often not owned or managed by the CQC regulated care provider and therefore even if they were able to assert control over visitors, they would have little knowledge and limited resource to monitor individuals entering the premises.

4. Therefore, **recipients of care would still come into contact with a significant number of individuals who are not registered care staff**, including housing staff, other professionals (e.g. hairdressers), and social visitors. This in turn reduces the impact of vaccines as a condition of deployment in reducing transmission in these settings.

5. In addition, the **unregulated** sector also includes those providing personal care; personal assistants provide a similar service to homecare workers but are **employed directly by the person receiving care** rather than by an agency. If we did seek to make vaccines a condition of deployment here, as the onus would be on the employer i.e. the care recipient, to check and **any enforcement would be taken against the care recipient**. Therefore, we do not recommend that this requirement should be extended to personal assistants.

6. Other headline risks identified at this stage include:

- Many extra care and supported living settings work with domiciliary care agencies to provide care to their residents, meaning that they are not registered at all and may not be known by LAs. Therefore if all staff in a registered service were required to have a vaccine (over and above only care

staff), there is a risk of a **disjointed picture across the sector with limited ability to enforce any requirements**.

- A study by PHE in 2020[1] concluded that the **levels of prevalence of Covid-19 in the homecare sector were similar to the general public** and, in addition to the disparate nature of the sector, the risk of outbreaks is much lower than for those living in care homes.
- **Workforce implications may be greater in the homecare sector** as these workers are generally even lower paid than those in care homes, on zero-hours contracts and working multiple jobs.
- Given the disparate nature of the sector and services such as extra care and supported living only having a subset of the services they provide being regulated, there is insufficient data on the take up of vaccines in the wider sector. Currently, the Capacity Tracker reports data on registered domiciliary care providers and all those in the JCVI's priority cohort 2[2], however the latter is self-reported by LAs at an aggregate level, and the quality of data vastly varies from LA to LA. Obtaining a breakdown of this data would place a significant resource burden on LAs.

Conclusion

7. **The most sensible options for extending the policy to the ASC beyond care homes would be to focus on people working in:**

- Regulated homecare agencies;
- Residential recovery services for drug and alcohol;
- Extra care and supported living who are providing the type of **personal care that is registered**;
- Registered Shared Lives services;
- **Hospices.**

We would not recommend seeking to extend the scope into the unregulated sector. As part of the consultation we would want to focus questions on the best way to implement the policy in these settings.

[1] https://www.gov.uk/government/publications/covid-19-prevalence-survey-domiciliary-care-staff-in-england
[2] Day Care; non-registered Domiciliary Care; non-registered Community Care; Children's Social Care; LA employed - Children; LA employed - Adults; PA's