Impact Statement: The Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) (No. 2) Regulations 2021

The following impact statement sets out the analysis which has been conducted on the vaccination as a condition of deployment policy for health and wider social care, covering estimates of the potential size of the workforce who may not have met the requirement by the end of the grace period, the potential scale of exemptions, and assumptions made around the cost of replacing workers.

This will form the basis of a more detailed impact assessment which will be submitted to the Regulatory Policy Committee (RPC) for their scrutiny and published in due course.

Problem and justification for action

1. All adults in the UK have been offered the COVID-19 vaccine but vaccine hesitancy remains a real concern and is more prevalent within certain groups of our society. In health and social care providers, communications and engagement work have been carried out to maximise uptake but despite this, coverage is not universal. As of 14 October, 92.4% of NHS workers had received at least one dose of the vaccine, while 89% were fully vaccinated[1]. As of 24 October, 83.4% of domiciliary care staff had received at least one dose of the vaccine and 74.1% have received a second dose.[2]

2. Having both doses of the COVID-19 vaccination as a condition of deployment in care homes was previously analysed and the legislation is due to come in to force from 11 November 2021[3]. Extending this policy to health settings, domiciliary care and other adult social care settings reduces the risk of infection of those deployed, which in turn reduces the risk of transmission to patients and care users, members of the wider community, and the risk of serious illness and death to workers themselves. Additionally, this will reduce anxiety for current and prospective health patients and care users.

Policy objective

3. Making COVID-19 vaccination a condition of deployment in health and adult social care settings (domiciliary care and other CQC-regulated settings) is intended to:

    - **drive up vaccination levels in health and care workers** as a means of protecting all those who use health and care services, a large number of whom are vulnerable, as well as the wider community
    - **protect staff themselves by increasing vaccination rates**. This will also help reduce COVID-19 related sickness absences for these workers

Policy option

4. The policy options considered are outlined below.

5. **Option 1** is a 'Business as Usual' (BAU) option, which continues to rely on non-statutory measures to drive COVID-19 vaccination uptake.

6. **Option 2** will, in addition, put in place regulations that will require a registered provider of a CQC-regulated health, domiciliary care or other adult social care services, may only deploy

[1] https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/
[2] https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/
[3] COVID-19 vaccination of people working or volunteering in care homes (easy read) - GOV.UK (www.gov.uk)

those who have direct contact with patients or services users, if they have been vaccinated against COVID-19, unless medically exempt.

Who will be impacted by the policy?

7. The regulations will apply to all health and adult social care staff who have face-to-face contact with patients and who are directly involved in patient care, as well as ancillary staff such as porters or receptionists who may have social contact with patients but are not directly involved in their care.

8. The requirement to be vaccinated will apply to all those that are deployed to undertake a CQC-regulated activity either in the public (NHS) or independent sector. It will sit alongside the previously announced care home regulations which come into force on 11 November 2021.

Impacts of the policy

9. There is significant uncertainty around the change in staff's willingness to be vaccinated as a result of this policy's introduction. The table below provides mid-point estimates, based on a range of scenarios for different levels of vaccine uptake.

Table 1: Potential impacts of the policy

	Total Health	*NHS only*	*Independent health sector only*	Social care	**Total**
Number of staff in the sector	1,813,000	*1,485,000*	*327,000*	503,000	**2,316,000**
Number vaccinated if no intervention (counterfactual)	1,680,000	*1,375,000*	*306,000*	428,000	**2,107,000**
Total number exempt from vaccination	36,000	*30,000*	*6,000*	10,000	**46,000**
Number to be vaccinated under the policy	27,000	*22,000*	*5,000*	27,000	**54,000**
% to be vaccinated due the policy	1.5%	*1.5%*	*1.5%*	5.4%	**2.3%**
Number remaining unvaccinated (and not exempt)	88,000	*73,000*	*15,000*	38,000	**126,000**
% to remain unvaccinated (and not exempt)	4.9%	*4.9%*	*4.6%*	7.6%	**5.4%**

10. The policy is likely to have a greater impact in domiciliary care and other care settings where uptake rates are lower compared to healthcare settings.

11. In health 1.813 million staff will be subject to the new regulations across both NHS and independent health care providers. Of these, 1.68 million are already vaccinated, Under the central scenario, 27,000 are vaccinated following the introduction of this policy, 36,000 are exempt and 88,000 will remain unvaccinated.

12. Similarly for domiciliary and other social care settings, 503,000 staff will be subject to the new regulations, and 428,000 are expected to be vaccinated in the counterfactual without intervention, 27,000 further staff are expected to be vaccinated as a result of this policy, 10,000 are exempt, and 38,000 will not be able to be deployed. Given high historic levels of turnover in the social care sector, we would expect around 3,000 of this last group to have left the sector even in the absence of the policy, suggesting the additional reduction in the available workforce in these care settings would be 35,000. It is this adjusted estimate of 35,000 workers that is used for the purposes of the cost calculations.

13. The central estimate for the number of workers in both health and social care settings who will get vaccinated in response to the policy is 54,000 (ranging from 4,000 and 103,000 in the low and high estimates respectively).

14. It has not been possible to monetise all of costs and benefits potentially resulting from this policy and as such any conclusion on value for money will need to consider the unmonetised costs and benefits as well as breakeven analysis.

15. The monetised benefits are:

- **direct health benefits to the individual health and care worker –** using Quality Assured Life Years (QALYs) saved due to averted infections and fatalities to health and care workforce
- **averted sickness absences –** monetised by valuing the work of individuals in terms of their wages (which is lost during their sickness absence period)
- **reduced hospitalisation costs –** due to serious infections that are averted

16. The monetised health benefits from a reduction in COVID-19 infections and mortality in health and care settings is £6.9 million. There are also potential savings to health and care providers from reduced COVID-19 related sickness absences of £4.3million and savings from averted hospitalisations are £196,000.

17. The unmonetised benefits include:

- **health benefits** (reduced COVID-19 infections and deaths) to patients and care service users from additional vaccinations in the workforce
- **benefits to society (health, wellbeing and economic)** from higher vaccination uptake levels as a whole and better control of COVID-19
- **greater reassurance (public confidence)** to patients and care users

18. At present there is a lack of academic modelling to directly quantify the societal impacts specifically from vaccinating the health and care workforce cohort. However, in aggregate the economic impacts of the pandemic have been vast globally and domestically, with large increases to the unemployment rate, and government borrowing in the UK continuing to rise to the highest cash deficit on record. Additionally, estimates from the OBR suggest the UK experienced a sharp economic contraction of around 22.6% of GDP during the first wave in April 2020. Approximately £250 billion was spent in the financial year 2020/21 to support businesses and households in dealing with COVID-19.

19. While wider economic and societal impacts are not built into the monetised costs and benefits of vaccine deployment, they are expected to yield large benefits.

20. The monetised cost of this policy is the **recruitment costs to health and adult 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 12-week grace period.

21. This was monetised by estimating the costs of recruiting a worker into health and social care settings. For health, the recruitment costs reflect costs faced by the NHS in the administration, interview process, and induction of a Band 5 nurse, as representative of typical NHS workforce. The figure estimated £2,100 (midpoint of £1,600 and £2,600) includes administration costs (£380), interview costs (£620) and costs of induction (£1,100).

22. For social care, a unit cost of £2,500 for each role which needs to be filled by a new recruit This is the midpoint of the total average cost of recruitment estimated by Skills for Care[4] (£3,642) and the same cost excluding the estimated value of lost productivity (£1,313). There is greater uncertainty in the source regarding the productivity component, which is harder to measure robustly and is based on a very high-level assessment by care providers, and we therefore include only 50% of Skill for Care's estimate of this component in social care own assumptions.

23. The modelled cost of replacing unvaccinated workers is £270 million in our central estimate (with a range from £162 million to £379 million). This is a sum of our central estimates for health and care settings; £185 million (ranging from £129 million to £240 million) for healthcare workers and £86 million (ranging from £32 million to £139 million) for adult social care workers.

24. There are also additional costs that have not been monetised, and will add to the pressures faced by providers, leading to potentially lower quality of care:

- **potential disruption** to health and care services from needing to replace unvaccinated workers
- **productivity losses** if new, relatively inexperienced staff are recruited to replace staff who leave
- **productivity losses** from staff absences arising from side effects and potentially lower morale of staff if they feel forced into having vaccination
- **familiarisation costs** to the health and care providers to become aware of the regulation and its guidelines
- **administrative costs** to health and care providers who have to deal with complications arising from the regulation, including the redeployment of workers
- **costs of vaccinations** – which are to a large extent sunk costs given already purchased so already accounted for in terms of administrative capacity

VFM summary

25. The table below outlines the total monetised costs, benefits and net present value (NPV) of Option 2.

Table 2: Summary of the central estimates for Option 2

	Total monetised cost	Total monetised benefits	Monetised Net Present Value
Health providers	£185,000,000	£4,600,000	-£180,000,000
Domiciliary and other care settings	£86,000,000	£6,800,000	-£79,000,000
Total	**£270,000,000**	**£11,400,000**	**-£259,000,000**

26. As discussed above, this does not include important non-monetised costs and benefits, which it is important to factor into decision-making The health benefits through reduced infections and deaths to health and care users, as well as to the wider community, from the workforce being vaccinated, are likely to be large but there is a lack of data to value this in

the VFM assessment. As an illustration, using a societal value of a QALY of £60,000, an additional 4,500 QALYs delivered through these or other routes would result in the policy breaking even.

Workforce risks

27. While it is uncertain how many and when workers may choose to leave their jobs rather than have a vaccination, our central estimates are of around 88,000 (73,000 workers in NHS, 15,000 in independent health sector) and 35,000 workers in domiciliary care and other care services having not fulfilled the conditions of deployment by the end of the grace period, with a range of between 62,000 to 115,000 in health in the low and high scenario ranges. This suggest the impact on workforce levels and health and care services could be significant.

28. Any reduction in the numbers of health and social care staff may lead to reduced or delayed services. The health system is currently stretched with an elective waiting list of 5.72 million and high levels of vacancies. Some staff shortfalls may be covered by temporary staff, but the effective capacity in the temporary labour market is unknown.

29. If a proportion of staff decides to leave the NHS, this would put pressure on NHS services. This is likely to be more acute in clinical staff groups where there are existing staff shortages and lags in labour supply caused by education and training requirements, but all services are likely to be impacted. Leaver rates in the NHS are around a third those in social care so there are likely to be far fewer staff lost due to natural turnover. In addition, a larger proportion of exits may be expected to occur at the end of the grace period given this is what has been reported in relation to the implementation of vaccination as a condition of deployment in care homes and because the same approach is being take in terms of providing a grace period.

30. In social care, it is likely that some exits will occur during the twelve-week grace period, It is likely that a large proportion of these may occur at the end of the grace period, as we saw with those leaving care homes. In the context of a sector which experiences a relatively high annual workforce turnover rate of over 34% (of which a third are sector exits), and where recruitment forms a regular part of their operations (our cost estimates account for those who would have left the sector anyway), this presents a significant workforce capacity risk. Moreover, this is in a sector that is already facing serious recruitment challenges owing to high competition for labour as the economy re-opens, with competing sectors such as retail, logistics and hospitality offering higher wages and better conditions, as well as high levels of vacancies (now higher than pre-pandemic). Industry sources suggest that recruitment is “more, or much more” challenging than in April 2021.

31. Whilst we have recently announced £162.5 million workforce recruitment and retention fund to support the sector this winter, we envisage that sizeable portion of the fund will be spent by Local Authorities and providers on retaining the existing workforce and/or paying the existing workforce to supply additional hours. As we cannot quantify the maximum working capacity of the current workforce, however, we cannot be confident that the system – even with additional funding – will be able to absorb the loss of capacity resulting from the implementation of this policy, without further intervention.

Implementation/enforcement

32. A registered person (that is the service provider or registered manager) must not deploy a person as part of a regulated activity unless that person is fully vaccinated against COVID-19, in accordance with the requirements of the regulations, unless they are medically exempt.

33. It would be the CQC's role to monitor and take enforcement action in appropriate cases. At time of registration and when inspected, the registered person would have to provide evidence that those deployed to undertake the regulated activity have been vaccinated.