22 October 2021

RCGP response to Department for Health and Social Care consultation on making vaccination a condition of deployment in the health and wider social care sector

1. Which of the following best describes your opinion of the requirement: Those deployed to undertake direct treatment or personal care as part of a CQC regulated activity in a healthcare or social care setting (including in someone's home) must have a COVID-19 and flu vaccination?

- **COVID-19 vaccination in healthcare**
  Not supportive
- **COVID-19 vaccination in social care**
  Not supportive
- **Flu vaccination in healthcare**
  Not supportive
- **Flu vaccination in social care**
  Not supportive

2. Which of the following best describes your opinion of the requirement: Those under the age of 18, undertaking direct treatment or personal care as part of a CQC regulated activity (in a healthcare or social care setting, including in someone's home), must have a COVID-19 and flu vaccination?

- **COVID-19 vaccination in healthcare**
  Not supportive
- **COVID-19 vaccination in social care**
  Not supportive
- **Flu vaccination in healthcare**
  Not supportive
- **Flu vaccination in social care**
  Not supportive

Please provide further details to support your answers

The RCGP welcomes the opportunity to respond to this DHSC Consultation on making vaccination a condition of deployment in the health and wider social care sector.

The Royal College of General Practitioners (RCGP) is the largest membership organisation in the UK solely for GPs. Founded in 1952, it has over 54,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. The RCGP is an independent professional body with expertise in patient-centred generalist clinical care.

Vaccinations are a vital tool in preventing the spread of viruses and reducing the risk of serious illness or death. Additionally, high levels of vaccination among clinicians can help reduce vaccine hesitancy among patients. The RCGP urges both clinicians and patients be vaccinated against both COVID-19 and flu (except where medically exempt), to protect both themselves and others from these diseases.

However, the RCGP does not support mandating staff vaccination against COVID-19 or flu as a condition of deployment in health and social care settings (for either adults or those under 18 years old). Mandates such as the one proposed here, effectively force individuals to choose between vaccination and their livelihood. Perceptions of coercion will have the effect of undermining both individual autonomy over healthcare choices, and wider trust in vaccines. The RCGP believes that, in the long term it is more effective and sustainable to boost vaccine uptake through education to enable informed choice.

Individual risk assessments based on personal health needs and circumstances are critical for ensuring vaccine safety. Similarly personalised conversations covering risks, benefits and uncertainties have proven to be very effective in countering vaccine hesitancy.

Experience with vaccination programmes

In 2020/21, 79.3% of staff in general practice in England received the flu vaccine, including 83.1% of GPs, 84.8% of practice nurses, and 79.0% of other clinical and support staff.[i] These rates represent a significant increase on vaccination rates for 2019-20, indicating that it is possible to improve uptake year-on-year without introducing a mandate. Similarly, as of 31 August 2021, 87.3% of health care workers in primary care in England had received at least one dose of a COVID-19 vaccination.[ii] Given these high rates of vaccine take up amongst healthcare workers across the country, it is highly questionable whether a mandate is needed at all. There is significant regional variation within these rates, ranging from 75.8% in the East of England to 94.0% in the South West. This suggests that there is potential to boost uptake in areas with lower vaccination rates, without relying on a mandate, by instead learning from what has worked well in other areas.

Implementing a mandate of this kind would also break with precedent. Although the COVID-19 pandemic has been ongoing for over 18 months, there has been no move to mandate that all clinical staff be vaccinated against either COVID-19 or flu before this point. Similarly, no mandate for flu vaccination was implemented during previous challenging times for the

healthcare system such as the 2009 H1N1 pandemic. The GMC's Good Medical Practice notes that doctors "should be immunised against common serious communicable diseases".[iii] However, this is not a legal requirement, and recommendations around Hepatitis B vaccination in the Green Book fall to individual employers to enforce.[iv] Implementing a mandate for flu or COVID-19 vaccination would inevitably raise questions as to whether such a policy ought to be applied to other common, communicable diseases for which effective vaccines are available.

Workforce implications

Perhaps most concerningly, at a time when general practice is already working under intense pressure, implementing a mandate could have significant workforce implications. Between September 2015 and August 2021, the number of fully qualified, full time equivalent GPs in England has fallen by 1,380, even as England's population has grown.[v] As a result, the number of patients per fully qualified FTE GP has increased from 1,935 to 2,178, and the pandemic has only added to these pressures, with GPs and their teams delivering the COVID-19 vaccination programme and supporting patients awaiting specialist assessment or treatment, alongside their routine work providing acute and long-term care to patients.

While it is hard to say exactly what impact a mandate might have on the general practice workforce, existing evidence provides cause for concern. Following the implementation of a vaccine mandate for healthcare staff in Greece, vaccination rates did increase, but some 6% of hospital staff were suspended as they refused vaccination, and it may well have been possible to boost vaccination rates without such an intervention.[vi] A survey of RCGP members conducted ahead of this consultation[vii] suggests that a COVID-19 vaccination mandate for healthcare workers would have the effect of 6% of GPs ceasing clinical work. This may be for numerous reasons including medical exemption from vaccination and ethical objection to such a mandate as well as vaccine refusal. Similarly, the Government's own impact assessment of mandatory vaccination for staff in social care settings suggested that between 12% and 3% of staff would refuse vaccination, with a central estimate of 7%.[viii]

A 7% decrease in the general practice workforce would mean, in real terms, that the number of fully qualified, full-time equivalent GPs would fall from 28,023 to 26,061, and the number of patients per fully qualified FTE GP would increase from 2,178 to 2,341.[ix] Such a dramatic decline in GP numbers could catastrophically undermine the ability of general practice to deliver the care patients need and rightly expect. Indeed, this loss of workforce could well result in greater harm to patients than that caused by exposure to small numbers of unvaccinated staff.

In the RCGP's member survey 60% of respondents across the UK thought making flu or COVID-19 vaccination mandatory would make clinical staff a little or a lot more likely to be vaccinated while 15% thought it would make them a lot or a little less likely. A further 18% and 20% thought there would be no change for flu or COVID-19 uptake respectively. Given a lack of clear evidence that a mandate would increase vaccination rates amongst healthcare worker and the fact that, as noted above, it is clearly possible to achieve high rates of vaccination without such mandates, the risk of jeopardising already sparce workforce numbers does not seem to be one worth taking. This is particularly true in areas with already very high vaccine

uptake, such as the South West where as noted 94% of healthcare workers in primary care have received the COVID-19 vaccine. Assuming a 6 or 7% rate of workforce attrition, a mandate may serve to reduce workforce numbers in such areas without seeing any increase in vaccination rates.

Regional variation in vaccination rates also highlights the inappropriate nature of national guidance on this issue. It would be more productive to allow local health systems to set their own targets and policies based on their local knowledge and context.

Employment relationships
While it may be argued that if a mandate were to be introduced those who refuse a vaccine could be redeployed and retained in the workforce, in the context of general practice this is not a meaningful distinction. GPs have inherently public facing roles and while providing remote consultations may be an alternative for non-vaccinated staff, this could unfairly increase the face to face requirement for other staff or result in reduced numbers of face to face appointments. Furthermore, other members of the general practice team such as nurses are less able to work remotely and for these roles, redeployment would be especially challenging.

In addition to employment and redeployment challenges, the implementation of any mandate would create difficulties in terms of employment relationships. General practice lacks the HR support that is available within NHS Trusts for example, meaning responsibility for seeking proof of vaccination status and discussing options with staff would take up valuable time for already overworked GP partners and practice managers. In this way a vaccine mandate could have a negative effect on access to general practice.

3. Are there particular groups of people, such as those with protected characteristics, who would particularly benefit from COVID-19 vaccination and flu vaccination being a condition of deployment in healthcare and social care? *
Not sure

Patients who are particularly vulnerable to COVID-19 and flu could be positively impacted by all those deployed in healthcare and social care being vaccinated as this may reduce their risk of contracting these illnesses. However, as outlined above any resulting reduction in workforce numbers or time taken up by bureaucracy, could serve to counteract this benefit and may particularly disadvantage vulnerable patients who, in addition to being at risk of COVID-19 and flu, are likely to have higher healthcare needs.

4. Are there particular groups of people, such as those with protected characteristics, who would be particularly negatively affected by COVID-19 and flu vaccination being a condition of deployment in healthcare and social care?
Yes

Given the varied levels of vaccine uptake within different parts of the population, health and social care workers from groups with lower-than-average vaccination levels would be

particularly negatively affected by these proposals. COVID-19 and flu vaccination being a condition of deployment would disproportionately jeopardise the livelihoods of staff from these groups.

Vaccine hesitancy remains higher amongst pregnant women than the population as a whole while vaccination rates vary by ethnicity with lower-than-average uptake amongst black people in particular, and black Caribbean groups especially.

The RCGP's member survey, showed that a mandate would be likely to affect particularly negatively those identifying as black/African/Caribbean/black British. The proportion who thought a mandate for COVID-19 and flu would make clinical staff more likely to be vaccinated fell from 60% overall to 44% and 39% respectively for black respondents. Similarly, for both COVID-19 and flu, the proportion who thought a mandate would make clinical staff less likely to be vaccinated rose from 15% overall to 37% for black respondents. Those identifying as Black/African/Caribbean/Black British were also significantly more likely to suggest that mandatory vaccination would lead to staff ceasing clinical work, with 10% and 12% of black respondents indicating this from flu and COVID-19 respectively, compared to 6% overall.

Those from mixed or multiple ethnic groups and Asian or Asian British backgrounds were also more likely than white or white British respondents – but less likely than black respondents – to believe that a vaccine mandate would result in workforce attrition

In addition to the inequity implications of this for staff, variation in the deployment of healthcare staff of different ethnicities could compound the potential impacts of a vaccine mandate. Within general practice, BAME doctors have been shown to work disproportionately in smaller practices and in more deprived areas[x]. As a result, any reduction in workforce numbers resulting from mandatory vaccination would be likely to serve to increase health inequalities and limit access to general practice for those most in need.

International Medical Graduates, newly arriving in the UK may also be disadvantaged by vaccination being a condition of deployment as they may not universally have had access to a recognised, or indeed any, vaccine. Assuming continued vaccine availability, this would however be a short-term issue as graduates would be likely to be able to access a recognised vaccine once registered in the UK.

5. Do you think a vaccination requirement policy could cause any conflict with other statutory requirements that healthcare or social care providers must meet? (please give details)*
Yes

As outlined above, a vaccination requirement policy could lead to increased workload in the form of bureaucracy as well as reduced workforce numbers. Given the already immense pressures in general practice, this could result in difficulties meeting other statutory requirements.

6 What could the government do to encourage those working in unregulated roles to have the COVID-19 and flu vaccine?
The RCGP is supportive of all those who are eligible receiving both the COVID-19 and flu vaccine, regardless of their role. In addition to healthcare and social care workers, there are many roles within healthcare settings who may come into contact with patients including reception staff, care navigators, porters and cleaners. However, the RCGP does not believe it would be appropriate for any vaccination requirements that were introduced to be extended beyond those providing direct care. Any such extension would be likely to further jeopardise livelihoods and potentially be discriminatory. In all cases, education and open conversations is likely to be the more effective means of increasing vaccine uptake.

7. We would welcome any comments you may have relating to Annex B - proposed addition to the code of practice – criterion 10.
As outlined, the RCGP is concerned about the workload implications of these proposals. The requirement in Annex B for the registered provider to collect evidence of vaccination, to complete risk assessments for those not vaccinated, and to record and review vaccination status, will be particularly detrimental in general practice where separate HR support is minimal. These requirements would therefore l take up critical clinical and practice management time.

8. We welcome any further comments you may have relating to this consultation
For the reasons outlined in this response, the RCGP does not believe mandatory vaccination is the most effective route to increasing vaccine take-up amongst clinical staff. We are particularly concerned about the unintended negative consequences of such a mandate in terms of workforce numbers and workload as well as the disproportionate impact on certain groups in society and the risk of increasing health inequalities.

Although 60% of respondents to the RCGP's member survey thought mandatory vaccination might increase vaccination rates, when asked about various possible steps that could be taken to boost vaccine take-up, only 37% rated a mandate as one of the most effective options. Several other steps were considered significantly more likely to be effective, including vaccination programmes in the workplace (supported by 62% of respondents), more education and information on the benefits of vaccination (59%), open conversations amongst colleagues about vaccinations (56.4%) and targeted campaigns to counter social media disinformation about vaccination (49%). Learnings from areas with particularly high vaccine take-up among staff (e.g. the South West) may also be helpful in boosting vaccine uptake in areas with lower coverage.

The RCGP would urge the Department to reject the idea of making vaccination a condition of deployment in health care and instead to consider such alternatives.

[i] *Flu uptake report: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/996100/Seasonal_influenza_vaccine_uptake_HCWs_2020-21_FINAL_v2.pdf*

[ii] COVID-19 monthly announced vaccinations 09 September 2021: https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-vaccinations/

[iii] https://www.gmc-uk.org/-/media/documents/good-medical-practice---english-20200128_pdf-51527435.pdf

[iv] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/147882/Green-Book-Chapter-12.pdf

[v] RCGP Analysis of NHS Digital GP Workforce Data. 2015 data includes estimated data for the workforce for practice not returning data (now archived). 2021 data does not include these estimates, so has been uplifted to account for the small number of practices not returning data.

[vi] EKathimerini.com, "Almost 7,000 unvaccinated healthcare workers remain suspended, says minister", (2 September 2019). https://www.ekathimerini.com/news/1167358/almost-7-000-unvaccinated-healthcare-workers-remain-suspended-says-minister/.

While data on the current primary care workforce in Greece is not available, the number of hospital staff in Greece stood at 102,130 in 2019. OECD, *Health Care Resources: Hospital employment* (https://stats.oecd.org/Index.aspx?ThemeTreeId=9#)

[vii] RCGP Mandatory COVID-19 and Flu Vaccination survey, conducted October 2021, 1779 responses received.

[viii] Department for Health and Social Care, *Statement of impact – The Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021*. https://www.gov.uk/government/consultations/making-vaccination-a-condition-of-deployment-in-older-adult-care-homes/outcome/statement-of-impact-the-health-and-social-care-act-2008-regulated-activities-amendment-coronavirus-regulations-2021#central-estimate

[ix] RCGP Analysis of NHS Digital GP Workforce Data. 2021 data does not include estimates of the GP workforce for the small number of practices not returning data, so has been uplifted to account for this.

[x] https://www.gmc-uk.org/-/media/documents/fair-to-refer-report_pdf-79011677.pdf