



Guidance to support COVID-19 vaccine uptake in frontline staff

Guidance for HR directors

12 March 2021, Version 2

Changes from version 1 are highlighted in yellow

A) The effectiveness of the COVID-19 vaccine and its immediate implications for staff and patient safety

The efficacy of the COVID-19 vaccine is now well-established. We are seeing real world evidence that the COVID-19 vaccines are highly effective in preventing hospitalisations and reducing adverse outcomes from COVID-19. We must act swiftly to protect our staff and patients, which forms part of our duty of care. As a result, there is a necessity to ensure our staff are protected with the COVID-19 vaccine; this guidance outlines approaches to support universal first dose coverage by 12 March 2021 for all frontline staff.

NHS England and NHS Improvement are collecting data on frontline staff vaccination uptake. It is important that offers for vaccination and **declines** apply to frontline staff only. Local record keeping and data submitted centrally should accurately reflect staff uptake/**declines** in frontline settings.

NHS England and NHS Improvement support shared decision-making but this must be balanced with the immediate safety of colleagues and patients. The Chief People Officer of the NHS has put in place an extensive engagement and educational programme to support informed decision-making on the vaccine. During our engagement it has become apparent that there are a spectrum of issues stopping colleagues taking the vaccine.

There may be concerns amongst staff that must be addressed or reasons why the vaccine cannot be taken e.g. severe allergies. Examples from primary care have shown a 60-70% conversion from initial **decline** to taking the vaccine following a one-to-one conversation.

Self-reporting on COVID-19 vaccination status should be positively encouraged and should form part of a supportive and sensitive one-to-one conversation.

B) FAQs

The following can be used as a guide by trusts to craft answers to frequently asked questions you are receiving. **They are not intended to be published in full.**

One-to-one conversations

Why are you asking employers to do this this now?

We have made good progress in staff vaccine rollout and in moving from vaccine hesitancy to increasing vaccine confidence. The effectiveness, safety profile and reduced transmission rates provided by the vaccine will allow healthcare workers to protect themselves, their colleagues and their patients.

The COVID-19 vaccine is our most potent tool in keeping staff safe. It should be viewed with the same rigour as Personal Protective Equipment (PPE), handwashing and social distancing, but it is not a replacement for these measures.

Should we approach all unvaccinated staff?

Employers should prioritise unvaccinated frontline healthcare workers as outlined in the [Standard Operating Procedure](#) and the [Green Book](#).

Are we being asked to mandate the COVID-19 vaccine?

No. At present, there are no plans to mandate the COVID-19 vaccine.

What is the purpose of the individual conversation?

The vaccines are a key tool in keeping staff safe, and ultimately, we want everyone to be vaccinated. However, for many staff the chance to talk this through with someone privately is crucial to making an informed decision on their terms.

The conversation is supplementary to the efforts many employees are making to ensure staff are regularly receiving culturally competent and up-to-date information on the vaccine.

The conversation should be approached holistically, with empathy and respect. Line managers should have a good awareness of and feel confident in signposting colleagues to local and [national wellbeing support offers](#), employee assistance programmes and services such as occupational health and wellbeing teams, as appropriate.

Does the staff member have to have the conversation with the line manager?

It is **proposed** that the line manager holds these conversations. However, some organisations will already have different mechanisms for these conversations, utilising occupational health or HR expertise, **but also could involve a person of trust such as a clinician, vaccinator, trusted peer or chaplain**, with line managers kept informed that conversations have taken place. HR Directors should exercise discretion on the best approach where something already in place will produce the same outcome.

It is recommended that staff are made aware of a variety of options of how to have these conversations.

How do employers identify unvaccinated staff?

Employers should consult their legal teams to ensure they have taken a legally robust approach based on their local processes. If an employer is already collecting personally identifiable data about vaccination status in a transparent manner where the workforce is aware of this and knew it would be followed up, this is likely to be in keeping with GDPR.

For organisations without a system of identification, line managers are unlikely to have access to data on vaccine uptake amongst direct reports. Therefore, line managers should contact their direct reports to offer them a conversation if they have not been vaccinated – and allow them to self-identify.

Line managers should not be encouraged to interrogate data systems for this information, as this may breach GDPR. It is important for them to have the required information available to make their workplaces as safe as possible due to the threat posed by COVID-19 infection in high-risk healthcare settings.

[Data notification guidance](#), updated on 10 February 2021, does not change this advice as employers are still required to comply with relevant and appropriate data protection standards and to ensure within reason that they operate within statutory and regulatory boundaries.

Employees cannot be compelled to discuss their vaccine status but should be encouraged and offered alternative routes for a conversation if necessary.

If a staff member **declines** to disclose their vaccine status or following a sensitive one-to-one conversation, supported by occupational health colleagues, decides to **decline** the vaccine, a conversation on job adjustments will need to be conducted to move them into a less exposure prone setting. These conversations may require input from local trade union representatives.

How should we provide data to NHS England and NHS Improvement?

We recognise that employers already face heavy data burden on reporting during the pandemic and will not be required to provide an additional dataset on the completion of 1:1 conversations.

Which staff (if any) are exempt from having the vaccine?

We recognise that not all staff will be eligible to take the vaccine (e.g. medical contraindications) and therefore universal coverage may not be achieved. The underlying and guiding principle is to ensure the vaccine is taken by everyone that is able to and that we have done everything possible to protect our staff.

Staff that have had COVID-19 infection should wait for 28 days after a positive test or their symptoms started, before receiving a vaccine dose. Organisations should proactively follow up with staff unable to take the vaccine for this reason after the 28-day period has passed.

Can shielded staff come back once vaccinated?

This remains under review, and subject to medical advice. At this stage, these staff should continue to shield. A combination of both jobs and/or lower rates of COVID-19 could reduce the risk to an appropriate level whereby shielding staff are invited to come back with relevant and adequate safety measures in addition to the vaccine. We will continue to monitor the evidence.

What action should organisations take to keep staff safe, who have not been vaccinated?

The safety of all staff is paramount. All staff should have a risk assessment that is purposeful, supportive and specifically designed to review physical and psychological risk factors to an individual, as well as their personal circumstances.

The vaccine will reduce the risk of COVID-19 to staff, and risk assessments should be reviewed for staff who have been vaccinated. For staff who decline the vaccine, employers should consider how best to ensure those staff members are safe at work. This could include (not exhaustive) ensuring measures such as:

- The appropriate PPE is in place and being used to ensure protection
- That fit testing has been undertaken on the FFP3 mask being used by the member of staff
- That employees are aware of infection control standards and have undertaken appropriate training
- That employees have an up to date risk assessment in place to identify their individual risks, taking into account latest government and professional body advice.

In addition to the above, if the risk to the member of staff, their colleagues or patients is still very significant, they could be moved into a less exposure prone setting as an option. These sensitive conversations may require input from local trade union representatives and HR

Are these conversations in addition to risk assessments?

The risk assessment process has been in place since Wave 1 to allow line managers to assess risk profiles of staff members and facilitate discussion around workplace risk. Self-reporting of vaccination status should routinely form part of this process, as well as a conversation on the protective effects of the COVID-19 vaccine. However, where this is not possible, the conversation should be held as a standalone.

General information

What vaccine for COVID-19 is currently available?

Both the Pfizer/BioNTech and Oxford/AstraZeneca COVID-19 vaccines are now available. Both vaccines have been shown to be safe and offer high levels of protection, and have been given regulatory approval by the MHRA.

The Government has in principle secured access to seven different vaccine candidates, across four different vaccine types, totalling over 357 million doses. This includes:

- 40 million doses of the BioNTech/Pfizer vaccine
- 100 million doses of the Oxford/AstraZeneca vaccine.
- 17 million doses of the Moderna vaccine, which has been approved by the MHRA but is not expected to be delivered to the NHS until Spring.
- 60 million doses of the Novavax vaccine, which has reported positive results from clinical trials but has not yet been approved by the MHRA.

Is the NHS confident the vaccines are safe?

Yes. The NHS will not offer any COVID-19 vaccinations to the public until independent experts have signed off that it is safe to do so.

The MHRA, the official UK regulator, have said that both of these vaccines have good safety profiles and offer a high level of protection, and we have full confidence in their expert judgement and processes.

As with any medicine, vaccines are highly regulated products.

There are checks at every stage in the development and manufacturing process, and continued monitoring once it has been authorised and is being used in the wider population.

Why are healthcare workers among the first groups to receive the vaccine?

The Joint Committee of Vaccination and Immunisations (JCVI) have put patient-facing health and social care staff into a priority group because of their heightened risk of exposure to the virus. Healthcare workers are not the top priority though, and with limited vaccine available up to now, employers have been asked to offer the vaccine to the most at-risk healthcare

workers first. With many more doses now expected over the coming weeks, employers will be widening this out and protecting staff as soon as possible.

The NHS is experienced in vaccinating hundreds of thousands of staff quickly and safely – we do it every year for the flu vaccine – and all local NHS employers will be responsible for ensuring that 100% of eligible staff have the opportunity to take it up over the coming weeks and months.

How will healthcare workers get the vaccine?

The NHS will offer vaccinations using different models. For healthcare workers, most will get vaccinated either at their own work or a local hospital.

Should people who have already had COVID, or who are suffering from ‘Long Covid’, get vaccinated?

Yes, if they are in a priority group identified by JCVI. The MHRA have looked at this and decided that getting vaccinated is just as important for those who have already had COVID-19 as it is for those who haven’t, including those who have mild residual symptoms. Where people are suffering significant ongoing complications from COVID they should discuss whether or not to have a vaccine now with a clinician.

Do I need to leave a space between having the flu vaccine and having the COVID vaccine?

It is not essential to leave time between the flu and COVID vaccine, but it is recommended that there should be a gap of a week.

We would always encourage anyone who is eligible but not yet taken up their flu jab to do so as soon as possible.

Can people pick what vaccine they want?

No. Any vaccines that the NHS will provide will have been approved because they pass the MHRA’s tests on safety and efficacy, so people should be assured that whatever vaccine they get, it is worth their while.

If a household has a priority group member, such as an NHS frontline worker or vulnerable person, will everyone living in that household be vaccinated together?

These decisions are for the JCVI. Their current prioritisation plan does not include household members of NHS staff or clinically vulnerable people automatically – although in some cases family members may be eligible in their own right.

Are there any groups that shouldn’t have the vaccine?

People with history of a severe allergy to the ingredients of the vaccines should not be vaccinated. Clinicians will discuss this with people before vaccinating them.

Can I have the vaccine during Ramadan/does the vaccine invalidate fasting?

The British Islamic Medical Association have issued specific advice urging Muslims observing Ramadan not to delay getting the vaccine, drawing on analysis from Islamic scholars which says that injections for non-nutritional purposes do not invalidate the fast.

How were vaccines developed so quickly?

Medicines including vaccines are highly regulated – and that is no different for the approved COVID-19 vaccines. The enablers below made this ground-breaking medical advancement possible, allowing the vaccines to be developed relatively quickly compared to other medicines:

1. The different phases of the clinical trial were delivered to overlap instead of run sequentially, which sped up the clinical process.
2. There was a rolling assessment of data packages as soon as they were available, so experts at the MHRA could review as the trial was being delivered, ask questions along the way and request extra information as needed – as opposed to getting all the information at the end of a trial.
3. Clinical trials managed to recruit people very quickly, as a global effort meant thousands of people were willing to volunteer.

Is it mandatory, and what happens if staff don't want the jab?

The JCVI has advised all frontline healthcare workers are prioritised for the vaccine. The definition of frontline healthcare workers is outlined in the [Standard Operating Procedure](#) and the [Green Book](#).

NHS England and NHS Improvement are collecting data on frontline staff vaccination uptake. It is important that offers for vaccination and **declines** apply to frontline staff only. Local record keeping and data submitted centrally should accurately reflect staff uptake/**declines** in frontline settings.

We need to balance engagement with immediate safety of staff.

At present, there are no plans to mandate the COVID-19 vaccine.