Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report

An international review: Policies relating to healthcare personnel who do not avail of COVID-19 vaccination

Submitted to NPHET: 8 April 2021

Updated on: 20 April 2021

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory authority established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

HIQA's mandate to date extends across a wide range of public, private and voluntary sector services. Reporting to the Minister for Health and engaging with the Minister for Children, Equality, Disability, Integration and Youth, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.
- **Regulating social care services** — The Chief Inspector within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.
- **Regulating health services** — Regulating medical exposure to ionising radiation.
- **Monitoring services** — Monitoring the safety and quality of health services and children's social services, and investigating as necessary serious concerns about the health and welfare of people who use these services.
- **Health technology assessment** — Evaluating the clinical and cost-effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.
- **Health information** — Advising on the efficient and secure collection and sharing of health information, setting standards, evaluating information resources and publishing information on the delivery and performance of Ireland's health and social care services.
- **National Care Experience Programme** — Carrying out national service-user experience surveys across a range of health services, in conjunction with the Department of Health and the HSE.

Version History

Version number	Date	Details
V1.0	14 April 2021	
V2.0	20 April 2021	Incorporating the HSE's discontinuation (from 12 April 2021) of a stipulation that nursing and other healthcare students who are eligible for COVID-19 vaccination, but who have declined vaccination, should not be assigned to clinical placements in HSE facilities.

An international review: Policies relating to healthcare personnel who do not avail of COVID-19 vaccination

Key points

- Vaccination of healthcare personnel against COVID-19 is viewed as critical in ensuring the health and safety of this essential workforce, preventing patients from contracting SARS-CoV-2, and protecting vital healthcare capacity.
- A rapid review was conducted to identify relevant policy and guidance documents relating to frontline staff in the healthcare sector who do not avail of COVID-19 vaccination (either due to refusal or potential contra-indications). This review relates to policies and guidelines regarding healthcare personnel (including both healthcare workers and frontline health administrative staff).
- Websites from the following three broad categories were searched for relevant information:
    - public health agencies and governmental health departments (from 18 countries and two international health agencies)
    - professional bodies (from five countries)
    - occupational health agencies (five organisations).
- Two policy or guidance documents from the UK were identified relating to healthcare personnel who do not avail of COVID-19 vaccination. These were documents by the:
    - NHS England providing guidance on supporting COVID-19 vaccine uptake in frontline staff
    - UK Royal College of Nursing (RCN) providing information on COVID-19 vaccinations for its membership of nurses, midwives, health care assistants and nursing students.
- Both documents recommend that:
    - COVID-19 vaccination should be strongly encouraged among healthcare personnel
    - staff should be facilitated to make the decision to be vaccinated in a supportive environment with the right information, encouragement and clear explanation of the benefit and value of the vaccine.
- Additional points raised within the documents were that:

  - one-to-one conversations should be held between line managers and unvaccinated healthcare personnel, in a respectful manner, with the aim of encouraging vaccine uptake. Evidence from primary care suggests that one-to-one conversations may result in a 60-70% conversion from initial decline to subsequent uptake of the vaccine
  - data should be collected on vaccine uptake and refusal among frontline staff
  - organisations should make it as easy as possible for staff to get vaccinated.

- Both documents highlight the duty of employers to undertake a risk assessment that will consider the risk an unvaccinated worker presents to staff and patients, and steps that can be taken to mitigate these risks. These steps may include:
  - considering redeployment to a lower risk area
  - a continued requirement for COVID-19 testing and the wearing of personal protective equipment (PPE)
  - ensuring effective ventilation
  - ensuring that employees are aware of infection prevention and control standards and have undertaken appropriate training.

- The RCN policy document highlights important legal and ethical issues regarding the management of employees who do not avail of COVID-19 vaccinations. It is important that policies do not discriminate against those who cannot have the vaccine due to a medical or other reason (such as pregnancy or religious grounds). However, any potential risk to the health and safety of staff and patients must be mitigated.
- Mandatory vaccination is typically grounded in considerations about the harm, or risk of harm, that non-vaccination presents to other people. Although there is precedence for mandatory vaccination of healthcare personnel, to date only Italy has introduced mandatory COVID-19 vaccinations for all healthcare workers at a national level. There are well established mandates in some jurisdictions for certain vaccinations, such as certain childhood immunisations. In Ireland, mandatory vaccination is in place for healthcare workers if proof of immunity cannot be provided against certain pathogens not including SARS-CoV-2.

- Ethical commentaries highlight the risk of a breakdown in trust between staff and their institutions if mandatory vaccination is implemented. They identify that the trust of healthcare personnel in healthcare systems should be strengthened by addressing concerns, including factors that have put them at risk of infection throughout the COVID-19 pandemic, before mandating vaccination.
- The information summarised from policy and guidance documents included in this international review is correct as of 1 April 2021, but may be subject to change.

Background

The Health Information and Quality Authority (HIQA) has developed a series of evidence syntheses to inform advice from HIQA to the National Public Health Emergency Team (NPHET). The advice takes into account expert interpretation of the evidence by HIQA's COVID-19 Expert Advisory Group.

This review relates to policies and guidelines regarding healthcare personnel (including both healthcare workers and frontline health administrative staff) who do not avail of COVID-19 vaccination (due to vaccine refusal or potential contraindication to the vaccine). The US Centers for Disease Control and Prevention (CDC) define healthcare personnel as follows: all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. Healthcare personnel include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).[(1)]

The following policy question was outlined by NPHET:

> "What policies, mitigation actions or initiatives have been implemented internationally relating to healthcare workers who do not avail of COVID-19 vaccination that could be considered by the Irish Health Service?"

The following research question (RQ) was formulated to inform this policy question:

> "What international policies and guidelines exist relating to healthcare personnel who do not avail of COVID-19 vaccination?"

Methods

A search was conducted to identify relevant policy and guidance documents relating to frontline staff in the healthcare sector (that is, healthcare personnel) who do not avail of COVID-19 vaccination. A standardised protocol was employed (www.hiqa.ie).

The following three broad categories were searched:

i. public health agencies and governmental health departments (from 18 countries and two international health agencies)
ii. professional bodies (from five countries)
iii. occupational health agencies (five organisations).

The selection of sources was based on their applicability to the Irish context, in terms of geography, healthcare system similarity or guidance to date. The full list of sources are provided in the protocol.

The information summarised from policy and guidance documents included in this international review is correct as of 1 April 2021, but may be subject to change.

Results

All public health agencies, professional bodies and occupational health agencies reviewed emphasised the importance of vaccination and strongly encouraged all healthcare personnel to avail of COVID-19 vaccination. Two guidance or policy documents were identified that specifically outline procedures for dealing with healthcare personnel that do not avail of COVID-19 vaccination,[2, 3] either due to refusal or contra-indication to vaccine components (Appendix 1). Both of these documents originated in the United Kingdom (UK).

One of the included documents, developed by NHS England, provides guidance on supporting COVID-19 vaccine uptake in frontline staff.[3] This guidance document is targeted at human resources (HR) directors. This guidance document recommends that HR collect data on vaccine uptake and declination in frontline settings. Caution is urged with regards to the method for identifying unvaccinated staff, with particular attention on data protection and confidentiality issues. It is acknowledged that employees cannot be compelled to disclose their vaccine status, but should be encouraged to do so. It is also recommended that one-to-one conversations should be held between line managers (or suitable alternatives such as a clinician or a trusted peer) and unvaccinated healthcare personnel with the aim of encouraging vaccine uptake. These conversations should be approached holistically, with empathy and respect. The NHS England guidance document states that examples from primary care have shown a 60-70% conversion from initial decline to taking the vaccine following a one-to-one conversation.

The NHS England guidance document recognises that not all staff will be eligible for vaccination due to medical contraindication or other reasons, and therefore universal coverage may not be achieved.[3] The underlying and guiding principle is to ensure the vaccine is taken by everyone that is able to and that everything possible is done to protect staff and patients. It is recommended that all staff (regardless of vaccine status) 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. For staff who decline the vaccine, employers should consider how best to ensure those staff members are safe at work. This could include the following measures:

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

In addition to the above, the guidance identifies that if the risk to the member of staff, their colleagues or patients is still very significant, an option would be to move them into a less exposure prone setting. These sensitive conversations may require input from local trade union representatives and human resources (HR).

The second document was developed by the Royal College of Nursing (RCN) in the UK, and provides information on COVID-19 vaccinations for its membership of nurses, midwives, health care assistants and nursing students.[(2)] As both a professional body and a trade union, the RCN presents a different perspective to vaccination than that of the NHS (the publicly funded healthcare system). The RCN strongly recommends all members have the vaccine as soon as they are able to do so, but acknowledges that some members may decide not to be vaccinated for a variety of reasons. The RCN does not support staff being mandated to have the vaccine, but recognises that there may be consequences for those who choose not to be vaccinated due to health and safety risks this may present in the workplace. Staff need to be able to make this decision to be vaccinated in a supportive environment with the right information, encouragement and clear explanation of the benefit and value of the vaccine. It is important that all organisations make it easy for their staff to get vaccinated.

The RCN highlights the duty of the employer to undertake a risk assessment that will consider both the risk the unvaccinated worker presents, and the steps that can be taken to mitigate these risks. These steps may include:

- considering redeployment to a lower risk area
- a continued requirement for COVID-19 testing and the wearing of PPE

- ensuring effective ventilation.

Additionally, the RCN highlights the fact that "smaller independent employers may not have the capacity to implement measures that larger employers can offer. The ongoing provision of PPE and testing for staff who refuse the vaccine will add additional financial outlays for the employer which they may argue are not considered a reasonable adjustment in the long-term."

The current legal and ethical uncertainties due to refusal to get vaccinated is outlined in the RCN policy document. The RCN states that "if your employer believes your reason for refusing the vaccine is unreasonable, this could result in disciplinary action on the basis you have failed to follow a reasonable management instruction. This will depend on the vaccination policy in place at your workplace and whether vaccination is a necessity to do your job." However, the RCN state that there may be a justifiable discrimination complaint against such a measure in accordance with the UK Equality Act 2010, if the reason for declining vaccination is because of a protected characteristic such as pregnancy, disability or age. Additionally, the RCN recommends that "if you intend to refuse a vaccine on medical grounds you may require a GP report to support this." With regards to adherence to the Nursing and Midwifery Council (NMC) code of conduct, the RCN states that unvaccinated staff have a professional responsibility to work with their employer to mitigate any risks they present to themselves or others.

On 31 March 2021, the Italian Government announced that all healthcare workers, including pharmacists, are required to undergo COVID-19 vaccination. Those who refuse could be suspended without pay for the rest of the year.[(4)] No evidence of national COVID-19 vaccination mandates for healthcare personnel were identified in any of the other jurisdictions included in this review. This finding is supported by a report published by the European Centre for Disease Prevention and Control (ECDC) on 29 March 2021, which reported that at the time of survey conduct (22 March 2021) none of the 24 European countries who responded to this question, reported having mandatory vaccination in place for the general population or for any particular target group.[(5)] However, the situation is fluid and may change quickly.

In Ireland, third level institutions were instructed on 26 March 2021 not to assign clinical placements to students who refuse vaccination. In a letter sent by the Chief Clinical Officer to third level institutions, the HSE COVID-19 Vaccination Working Group recommended that "students that are eligible for vaccination, that have been offered vaccination and decline vaccination should not be assigned to clinical placements in HSE facilities".[(6)] Institutions were asked to apply this instruction with effect from 1 April 2021. This instruction referred to unpaid clinical experience for healthcare students whose presence is not specifically required to sustain service

delivery; students who constitute part of the workforce (for example 4th year nursing students) were noted to be in the same category as other healthcare workers, so the instruction did not apply to them. This instruction did not apply to the rare instances of a specific and documented medical contraindication to vaccination; for these students it was emphasised that "an individual risk assessment should be performed by the higher education institute to determine if a suitable placement can be designed that minimizes risk to patients and to the student". The instruction was subsequently superseded by advice from the Chief Clinical Officer on 12 April 2021 that clinical placements for all healthcare students (those who have and have not received/taken a vaccine) could continue in HSE facilities subject to students continuing compliance with public health recommendations and infection prevention and control practice.[7]

Discussion

This international review identified two guidance or policy documents relating to measures or procedures to address healthcare personnel who do not avail of COVID-19 vaccination. Both documents were developed in the UK and both emphasise that COVID-19 vaccination should be strongly encouraged among healthcare personnel. The importance of providing a supportive environment for healthcare personnel to make an informed decision is emphasised along with the importance of conducting a thorough risk assessment. While vaccination is not currently mandatory, both documents acknowledge that there may be consequences for those who choose not be vaccinated depending on the health and safety risks this may present in the workplace.

At the time of writing, with the exception of Italy, COVID-19 vaccination was not found to be mandatory at a population-level for healthcare workers in any jurisdiction reviewed in this report, nor was there evidence of any plans to introduce vaccine mandates. In Ireland, COVID-19 vaccination has not been mandated for healthcare personnel. A stipulation by the HSE that healthcare clinical placements should not be offered to healthcare students who were eligible for, offered and declined COVID-19 vaccination, has been rescinded.

There is precedence for mandatory vaccination of healthcare personnel.[8] Beyond COVID-19 vaccination, there is a large body of literature on the justification for the use of mandatory vaccination for other infectious pathogens.[9] Mandatory vaccination is typically justified on the grounds of preventing harm to others.[10] However, valid reasons for refusal, including contraindications due to a medical condition or known hypersensitivity to vaccine components do still apply. Population-level mandatory vaccination policies for non COVID-19 illnesses are in place in a number of different countries, for example, childhood immunisations (including

pertussis, measles-mumps-rubella [MMR], varicella, Haemophilus influenzae type b [Hib], diphtheria, tetanus, hepatitis B and polio) in Australia,[11] Italy[12] and some US states.[13] Any non-voluntary element to vaccine consent can fall under the umbrella of 'mandatory vaccination'. These elements include any penalty or cost for unjustified refusal. In Australia, the "No Jab, No Pay" and "No Jab, No Play" schemes are in place which withhold child benefits and kindergarten childcare benefits, respectively for parents of children and young people under 20 years of age who are not fully immunised or on a recognised catch-up schedule.[14] In Italy, fines were introduced for unvaccinated children who attend school.[12] In the US, individual state regulations mandate that children cannot attend school if they are not vaccinated.[13] In Ireland, healthcare workers (both clinical and non-clinical) are required to demonstrate evidence of immunity against a range of pathogens, including Hepatitis A (following a risk assessment), Hepatitis B, measles, mumps, rubella, pertussis and varicella.[15] Influenza vaccination is not mandatory, however healthcare workers must be offered seasonal influenza vaccination annually. In the US, increasingly healthcare workers are mandated to be vaccinated for seasonal influenza.[13]

The European Court of Human Rights (ECHR) has recently ruled that compulsory vaccinations would not contravene human rights law (8 April 2021).[16] The ruling came following the evaluation of a complaint brought to the ECHR by Czech citizens regarding mandatory childhood vaccinations that are in place in Czechia. The court ruled that the Czech health policy was not in violation of Article 8 on the right to respect for private life in accordance with the European Convention on Human Rights. In its judgement, the ECHR stated that compulsory vaccination may be "necessary in a democratic society". The judgment stated that "in all decisions concerning children, their best interests must be of paramount importance. With regard to immunisation, the objective has to be that every child is protected against serious diseases, through vaccination or by virtue of herd immunity." The ECHR found that the Czech health policy was consistent with the best interests of the children who were its focus. While the ruling did not deal directly with COVID-19 vaccinations, the judgement may be applicable to future policy decisions regarding mandatory vaccination in the context of the COVID-19 pandemic.

A recent commentary in BMJ Global Health highlighted the ethical issues in mandatory COVID-19 vaccination of healthcare personnel.[17] In this commentary, it was acknowledged that while mandating COVID-19 vaccination would maximise vaccine uptake, there is a risk of a breakdown in trust between staff and their institutions. The review highlights two key ethical arguments for mandating COVID-19 vaccination of HCWs: appealing to their duties to 'do no harm' and to care for patients. However, the fulfilment of these duties requires a safe working environment. Of utmost importance is the strengthening of healthcare personnels'

trust in healthcare systems by addressing their concerns, including the institutional factors that have put them at risk of infection throughout the COVID-19 pandemic, before considering a COVID-19 vaccine mandate.

There are also important legal aspects, with respect to health and safety and discrimination claims, that need to be considered when developing a policy on COVID-19 vaccination in the workplace. The Chartered Institute of Personnel and Development (CIPD) which is a professional association for HR management in the UK has developed guidance for employers regarding COVID-19 vaccination.[18] While mandating vaccination may be justified as a means of maintaining staff health and safety in the workplace, the CIPD advises that these policies should not discriminate against those who cannot have the vaccine due to a medical or other reason (such as pregnancy or religious grounds). They advise that employers should strongly encourage and enable employees to get vaccinated once they become entitled to it. As part of any risk assessment, employers should consider reasonable alternatives, or additions to, COVID-19 vaccination, such as continued working from home, social distancing, use of PPE, and redeployment.

The CIPD recommends that employers should consider vaccine refusal cases individually.[18] For employees with a genuine medical reason that prevents vaccination, the CIPD recommends that employers take other steps with regards to health and safety, for example reinforcing their COVID-19 secure working environment, facilitating remote working where possible, or considering a different role. In some cases, medical advice may need to be taken with the employee's consent. Regarding those who may be hesitant to take the vaccine (due to pregnancy, religious grounds or other reasons), the CIPD recommends that employers listen to any concerns employees have around vaccination with empathy and understanding. Managers also need to be briefed on the organisation's vaccination policy, possible questions and concerns they could face from employees about the vaccine, and how to deal with them and refer to HR if necessary. Within employment law, failure to obey a "reasonable instruction" has been used by employers to justify disciplinary processes and dismissals.[19] Whether an instruction by an employer to have a COVID-19 vaccine is viewed as a "reasonable instruction", has not yet been tested in the tribunals and courts, as noted by the CIPD at time of guidance development (15 Feb 2021). Hence, significant legal uncertainties remain regarding disciplinary processes for employees who do not avail of COVID-19 vaccinations.

The Advisory, Conciliation and Arbitration Service (ACAS), a public sector body in the UK which works to improve workplace relationships, has issued guidance on dealing with COVID-19 vaccine refusal.[20] ACAS recommends that, in the case of a worker who does not wish to be vaccinated, it is important that the employer listens to the

worker's concerns, including potential contraindication. Employers should be sensitive towards personal situations, avoid discrimination and maintain confidentiality. If an employer feels it is important for staff to be vaccinated, they should talk together with staff or the organisation's recognised trade union to discuss what steps to take.

In addition to the health risk posed by unvaccinated healthcare personnel to themselves and to others, there may be other consequences of low COVID-19 vaccination uptake rate in certain settings. For example, recent Irish guidance regarding visits to long-term residential care facilities (LTRCFs) recommend that twice weekly visits for residents be permitted only if there are high levels (>80%) of COVID-19 vaccination among both residents and staff in the LTRCF.[21]

An evidence summary on factors influencing, and measures to improve, influenza vaccination uptake was published by HIQA on 16 December 2020.[22] This evidence summary identified four overarching themes that affected individual's uptake of vaccination, namely perceived risks and or benefits, knowledge, social influences and patient-specific factors. Of the wide range of interventions identified, mandatory vaccination was the most effective single intervention (risk ratio 1.71; 95% confidence interval 1.70 to 1.72; six before and after studies, N=105,538 participants). However, as discussed, there are legal and ethical implications associated with mandated vaccination.

A strength of this international review was the comprehensive nature of the search which reviewed websites from a broad range of public health agencies, governmental health departments, professional bodies and occupational health agencies. This comprehensiveness enables a useful overview of how other countries are dealing with this complex issue. A limitation of this review was that few relevant policy and guidance documents were retrieved. Searching websites can be particularly challenging when there is limited search functionality,[23] and hence there is a possibility that some relevant documents were missed. Additionally, it is possible that vaccine mandates are in place at a local or employer level, and any relevant information would not necessarily be captured by the current search strategy. Furthermore, due to the quickly evolving nature of the pandemic, there is a possibility that very recently published information could have been missed.

Conclusions

Two policy or guidance documents from the UK were identified relating to healthcare personnel who do not avail of COVID-19 vaccination (either due to refusal or potential contra-indications). Both documents recommended providing a supportive environment to employees to enable vaccination. They also recommend the use of

thorough risk assessments and outline steps that could be adopted to mitigate risk. Thus far, only Italy has introduced mandatory COVID-19 vaccinations for all healthcare workers at a national level. While mandatory vaccination has been introduced at a population-level, or specifically at a local level for healthcare personnel, for other infectious pathogens, it is noted that any mandate for COVID-19 vaccination must be balanced by the risk of deteriorating staff morale and trust in the healthcare system. Significant legal and ethical uncertainties remain in this complex area, which may evolve as the majority of the population become vaccinated.

The information summarised from policy and guidance documents included in this international review is correct as of 1 April 2021, but may be subject to change.

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Appendix 1 Data extraction table

Source	Description of context Description of HCW roles	Policy recommendations
Organisation NHS England **Guidance title** Guidance to support COVID-19 vaccine uptake in frontline staff **URL** https://www.england.nhs.uk/coronavirus/publication/guidance-to-support-covid-19-vaccine-uptake-in-frontline-staff/ **Date published/updated** Published 5 March 2021 Last updated 12 March 2021	Guidance for HR directors regarding NHS 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. ▪ Employers should prioritise unvaccinated frontline healthcare workers for a one-to-one conversation regarding the safety and efficacy of 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. ▪ 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. ▪ Employers should consult their legal teams to ensure they have taken a legally robust approach to identifying unvaccinated staff, 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. ▪ 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. ▪ 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.

		▪ Whether shielded staff who are vaccinated can return to work remains under review, and subject to medical advice. At this stage, these staff should continue to shield. A combination of both jabs 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. ▪ 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: o The appropriate PPE is in place and being used to ensure protection o That fit testing has been undertaken on the FFP3 mask being used by the member of staff o That employees are aware of infection control standards and have undertaken appropriate training o 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 conversations may require input from local trade union representatives and HR. ▪ 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.
Organisation	Nurses, midwives, health care assistants and	▪ Staff need to be able to make the decision to be vaccinated, in a supportive environment with the right information, encouragement and clear explanation of the benefit and value of

RCN, UK **Guidance title** COVID-19 and vaccination FAQs **URL** https://www.rcn.org.uk/get-help/rcn-advice/covid-19-and-vaccination **Date published/updated** Last updated 1 April 2021	nursing students who are members of the RCN	the vaccine. It is imperative that all organisations make it easy for their staff to get vaccinated. This collaborative approach works well and improves vaccine uptake. ▪ If your employer believes your reason for refusing the vaccination is unreasonable, this could result in disciplinary action on the basis you have failed to follow a reasonable management instruction. This will depend on the vaccination policy in place at your workplace and whether vaccination is a necessity to do your job. ▪ Having the vaccine should not mean that your period of shielding comes to an end. It is still unknown if COVID-19 vaccination will stop people from catching or passing on the SARS-CoV-2 virus. It is really important that everyone who has had the vaccine still follows the guidelines on social distancing, testing, shielding and self isolation where necessary. This applies to the workplace and at home. ▪ If you do not wish to have the vaccine because of a protected characteristic for example: pregnancy, age, religious belief or disability, and your employer persists with disciplinary action, you may have a discrimination complaint in accordance with the Equality Act 2010. Arising from such a claim, your employer would need to show that they had made reasonable adjustments. Your employer may try to defend their actions on the basis that they had good reason for the decision, and it is proportionate. This is known as "objective justification". Other medical issues may give rise to a recommendation that you do not receive a vaccine. Your GP may make such a recommendation, or national guidance may be in place. ▪ If you intend to refuse a vaccine on medical grounds you may require a GP report to support this. ▪ Your employer will need to undertake a risk assessment that will consider both the risk you present and steps that can be taken to mitigate these risks. These steps may include: o considering redeployment to a lower risk area o a continued requirement for COVID-19 testing and the wearing of PPE o having effective ventilation. ▪ It is important to recognise that smaller independent employers may not have the capacity to implement measures that larger employers can offer. The ongoing provision of PPE and testing for staff who refuse the vaccine will add additional financial outlays for the employer which they may argue are not considered a reasonable adjustment in the long-term.

		▪ Under the NMC code all registered nurses midwives and nursing associates have a professional responsibility to preserve safety and to take all reasonable precautions necessary to avoid any potential health risks to themselves or others. Whilst receiving the vaccine will not be mandatory, you must work with your employer to mitigate any risks if you have not been vaccinated. ▪ It is difficult to predict what not availaling of COVID-19 vaccination might mean as the pandemic enters new stages, but it could include redeployment to areas with less vulnerable patients, regular testing and continuing to protect yourself with ongoing use of PPE even when other staff are not required to make use of those precautions. ▪ Under regulation 7 of the COSHH 2002, employers are required to assess the risk to staff of occupational exposure to hazardous substances (including biological agents and pathogens) and take measures to control and reduce the risk of exposure. ▪ Under regulation 3 of the COSHH Regulations employers have a duty to risk assess and put in place control measures to extend to those who may be affected by the work carried out by the employer, this includes taking all reasonable steps to ensure agency and bank staff are protected, vaccinated and provided with PPE. ▪ In their guidance to the COSHH regulations, the UK HSE (Health and Safety Executive) point out that immunisation should be seen only as a useful supplement to reinforce physical and procedural control measures, not as the sole protective measure. ▪ The HSE advise that employees may not wish to take up the offer of immunisation, or they may not respond to a vaccine and will, therefore, not be immune. If so, employers should consider the effectiveness of the other controls and consider whether any additional controls should be implemented to allow them to work safely. In practice this will mean the continued provision of respiratory and other protective equipment, effective ventilation and, where the risk of harm remains high, or potentially redeployment.

Key – HSE – Health and Safety Executive; NMC – Nursing and Midwifery Council; RCN - Royal College of Nursing; UK – United Kingdom; COSHH - Control of Substances Hazardous to Health Regulations.

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