Occupational health management in the workplace

A guide to the key issues of occupational health provision

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Occupational health management in the workplace – a guide to the key issues of occupational health provision

The effective management of health risks, as well as safety risks, is an essential part of good health and safety management systems. When risk management is integrated into the core business functions, real change and improvement can be seen – not only by preventing physical and mental harm to employees, but by improving business performance.

The first part of this guide aims to provide occupational safety and health (OSH) practitioners and other business professionals with guidance on identifying, controlling and measuring health risks in the workplace.

The second part focuses on the aspects to consider when providing occupational health services. The effectiveness of any health management relies on the competence and capability of those providing it. In the case of occupational health services, there are many crucial elements to be aware of and these are set out in this guide – whether you're providing them in house or contracting them.

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Foreword

So workplace health is on the agenda, after decades as the Cinderella to safety. But what is this rather mysterious, seemingly complex, scientific-clinical, multi-disciplinary area all about? That's a great question and one this guide attempts to begin to answer for occupational safety and health (OSH) practitioners. Whenever anyone tells me their organisation 'does health', I always begin by saying "Great, but what sort of health do you mean?" At that point, more often than not, they look a little puzzled and I go on to explain that the 'health' word has been both confusingly used and regularly misunderstood. Simply put, there are three broad and overlapping spheres of health in the workplace, as the overview on page 2 of this guide explains: managing the health of the worker; managing the health risks created by the workplace; and managing the wellbeing of the workforce. In simple terms, the delivery of these three spheres are led respectively by occupational clinicians, occupational hygienists and occupational health professionals, though with areas of overlap as I've indicated. This guide tries to unpack some of the 'mystery' around these scientific-clinical disciplines and their approaches to the management and control of health risks at work. It is a welcome addition to raising awareness and understanding of workplace health, complementing the many resources available for workplace safety.

The successful management and control of workplace safety risks has been one of the major occupational success stories of the last century (if only people were aware of it). I hope and believe that the successful management and control of workplace health risks can be the major occupational success story of the next century. In view of the huge burden of work-related health morbidity and mortality, it certainly should be.

Steve Perkins
Chief Executive
BOHS

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Overview of health aspects in business

Historically, health in the workplace has had little focus. As a result, ill health caused by work costs individuals, business and public services billions of pounds a year. The hidden costs for the individual who has been made ill by work are incalculable – not being able to play with their children or grandchildren; not being able to walk to the shops; and often a slow and painful death.

But things are changing – health is now on the agenda for business and governments. Business recognises that a healthy workplace is a happy and productive one; governments recognise that business has a leading role in preventing ill health and promoting good health. Individuals are also recognising how important their health is; older workers recognise they need to stay fit and healthy to work; and younger generations expect their employers to actively provide healthy workplaces, not ones that merely protect them from harm.

Health activities in business are often multi-faceted with multi-disciplinary approaches. This can cause confusion and result in the most important aspect – health risk – being overlooked as the trendier and easier 'wellbeing' activities take centre stage.

It is critical, therefore, that OSH practitioners and business leaders make sure that health risks remain at the heart of health management. Figure 1 sets out the hierarchy of health aspects in a business and outlines multi-disciplinary teams that have a role in each.

Occupational disease and illness can be prevented, provided risks are properly eliminated, managed and controlled. This requires a concerted effort by everyone to recognise the hazards to health, evaluate the degree of exposure, and implement effective and reliable control measures.

Figure 1: Aspects of health in business

Why managing health at work is harder than safety

In the case of a safety hazard, any accident that results from it is generally the same; for example, a spillage of oil on a hard floor will probably cause a slip, trip or fall. But when dealing with health hazards, the effect on health is complicated, often not immediate, and individuals exposed to such hazards don't always react in the same way. Managers and OSH practitioners need to be aware of the differences between the 'health' and 'safety' aspects of a risk assessment, and where there is overlap.

Employers need to have a clear understanding of the health risks in their business and how these affect employees, more vulnerable individuals and others (contractors and the public, for instance). By working with suitable professionals to identify the risks, assess them, identify suitable controls, monitor those controls and, where needed, carry out risk assessments for individuals, an organisation will greatly improve its OSH understanding and performance.

Health is not straightforward

Consider smokers or sunbed users – why risk such activities when they increase one's chances of illness, or even death? The answer lies in a person's beliefs, lifestyle, education and attitude to risk, as well as the fact that many smokers and sunbed users usually show no obvious short-term ill effects. Individual characteristics – such as age, genetics, gender, ethnicity, medical history and nurture – influence health outcomes too, which makes the practice of predicting health risks highly complex.

Health is not instant

Many occupational ill-health problems manifest years after the work that caused the problem has finished. Take asbestos, for instance, which kills over 3,000 people in the UK each year,[1] from exposures 10, 20, 30, 40 or more years ago.

To raise awareness of health risks, Park Health, which provided occupational health services during the construction of the Olympic Park in London, described health damage as the 'slow accident' – a reflection of the fact that health problems are slow moving yet their effects can be just as dramatic as accidents.

Health is not logical

The way people react and behave – for example, how they recover after head injuries or experience pain – can be influenced by their personal beliefs and past experiences. Medical professionals recognise this behaviour as the biopsychosocial model, which explains how a person's health is deeply affected by non-medical factors. The importance of each factor depends on its seriousness to the individual compared with the other factors.

To illustrate, two workers in the same job could have their appendix removed on the same day, in the same hospital, but rarely would they both return to full duties at work on the same day.

The biopsychosocial model (BPS)
This model describes the way non-medical matters (biological, psychological and social factors) influence health and recovery. The BPS model is used throughout the field of medicine as an important consideration when dealing with individuals and health beliefs.

[1] Asbestos related disease, **www.hse.gov.uk/statistics/causdis/asbestos.htm**

Understanding health risks in the workplace

Legislation provides protection for workers against health hazards at work, with specific risks having specific legislative requirement– for example, working with lead,[2] noise[3] and toxic substances.[4]

In order to understand health risks in the workplace, it's useful to consider the body's responses to a health hazard.

1 Acute effects (immediate reactions)

- Instantaneous or develop a few seconds to hours after exposure
- Usually easy to identify the source (cause)
- Can follow repeated or prolonged exposure, eg a chef developing contact dermatitis from onions
- With treatment or by preventing further exposure, can recover (or manage)

2 Chronic effects (delayed)

- Occur gradually over a long period (years)
- Produce no obvious signs of ill health at the time of exposure
- Are diagnosed by medical professionals
- Not easily linked to a specific health hazard, exposure or work activity/ workplace
- Often no cure, but treatment may alleviate symptoms, eg cancer or chronic obstructive pulmonary disease

Health issues are an integral part of the risk assessment process. Risk assessments for health issues should be carried out at the earliest stage of a project or operation, reviewed periodically, and revisited if significant changes occur or legislation requires it. Personal health issues must be considered too, eg pregnancy, older/ younger workers, those with a disability, and even those with minor health issues that affect work. This is where personal risk assessments may be required in addition to task or activity assessments.

Do-it-yourself option

The prevention of ill health at work doesn't always require the intervention of specialists. SMEs, OSH practitioners and others will often only need advice on matters to enable them to implement changes, eg ergonomic design; substitution of materials and processes; dust extraction; adjusting equipment and work locations for rehabilitation purposes.

For many businesses, health risks are well known, and the general principles of protection promoted by the HSE or trade bodies can be followed for both safety and health issues. Figure 2 summarises the main health hazards.

To check on commonly occurring health issues in specific business sectors, visit the HSE's website at **www.hse.gov.uk** and search for your industry – for example, caterers' main health issues are contact dermatitis and manual handling. Businesses should prioritise issues for investigation and apply risk assessment processes for analysing and quantifying health risks. Identifying health risks is no different from identifying safety risks, except that the OSH practitioner needs to expand their understanding of health.

Identify new or existing health hazards

Think about all the activities and processes throughout your business.

Are there substances or practices that have health risks? Where do you use chemicals and substances? How do you use them? Do you spray them, paint them, mix them or process them in some other way? Do you know what is in the chemicals or substances? Does the work involve asbestos, lead, compressed air or ionising radiation?

Processes also give rise to health hazards, such as fume from welding or soldering; mist from metalworking; dust from cutting, drilling and sawing stone, wood and other materials; and gases from silage or waste products.

Are there naturally occurring health hazards, eg legionella, zoonoses, biological, spores, radon and sunlight?

Increasing or decreasing the health risk

Is the work environment hot or cold; confined or well ventilated; close to welfare facilities? Is the work done for five minutes or five hours; once a year or every day? Key factors influencing the likelihood and consequence of harm include:

- the time period of exposure
- the level of exposure (dose)
- the mode of exposure, eg contact, inhalation, injection or ingestion
- individual susceptibility and behaviours, eg people who bite their nails or smoke
- the work environment – does the layout make the activity more hazardous, eg incorrect height, poor ventilation or lighting?
- variables such as different work rates, and seasonal variations, eg wind, rain and sunlight.

[2] Control of Lead at Work Regulations 2002, **www.legislation.gov.uk/uksi/2002/2676/made**

[3] Control of Noise at Work Regulations 2005, **www.legislation.gov.uk/uksi/2005/1643/regulation/3/made**

[4] Control of Substances Hazardous to Health Regulations 2002, **www.legislation.gov.uk/uksi/2002/2677/regulation/7/made**

Review all workplace activity and operating procedures, including routine and non-routine (breakdowns, occasional tasks) and emergency activities. It's important to involve workers or workers' representatives, who have experience of doing the job, know the problems and issues, and often come up with the best solutions. Plus, they need to understand what the health risks are.

The checklist in Appendix 8 can help you when identifying health hazards.

Hierarchy of control for health risks

The general principles of the hierarchy of control are used extensively in safety risk assessments. The aim is to eliminate the risk, with personal protective equipment used only as a last resort. The same hierarchy applies to health risks.

- Elimination: do you need to do this part of the process?
- Substitution: use a less hazardous substance or process, eg use water-based paints instead of solvent-based paints.
- Engineering: modify the equipment or process to reduce the risks, eg apply paint using a brush rather than a spray; use local exhaust ventilation; purchase reduced noise/vibration equipment; use enclosures for containment to protect workers, or limit the spread of the noise, fume, dust and so on by compartmentalising processes.
- Administrative procedures: develop safe working practices and in-house standards for control of exposures to protect health. For example:
  - welfare facilities (hand and face-washing facilities) and housekeeping practices to remove contamination from the body and surfaces
  - hoovering rather than sweeping
  - education and training for all who work with health risks so that they can learn how to protect themselves
  - management training programmes for managers and supervisors regarding the identification of health risks
  - health surveillance programmes: these programmes ensure control methods are adequate and that individual workers are not affected by work.
- Personal protective equipment (PPE): this is the last resort in terms of effectiveness. In many cases where workers have suffered ill-health effects, PPE was insufficient in protecting against the risks because it was faulty, contaminated or worn incorrectly.

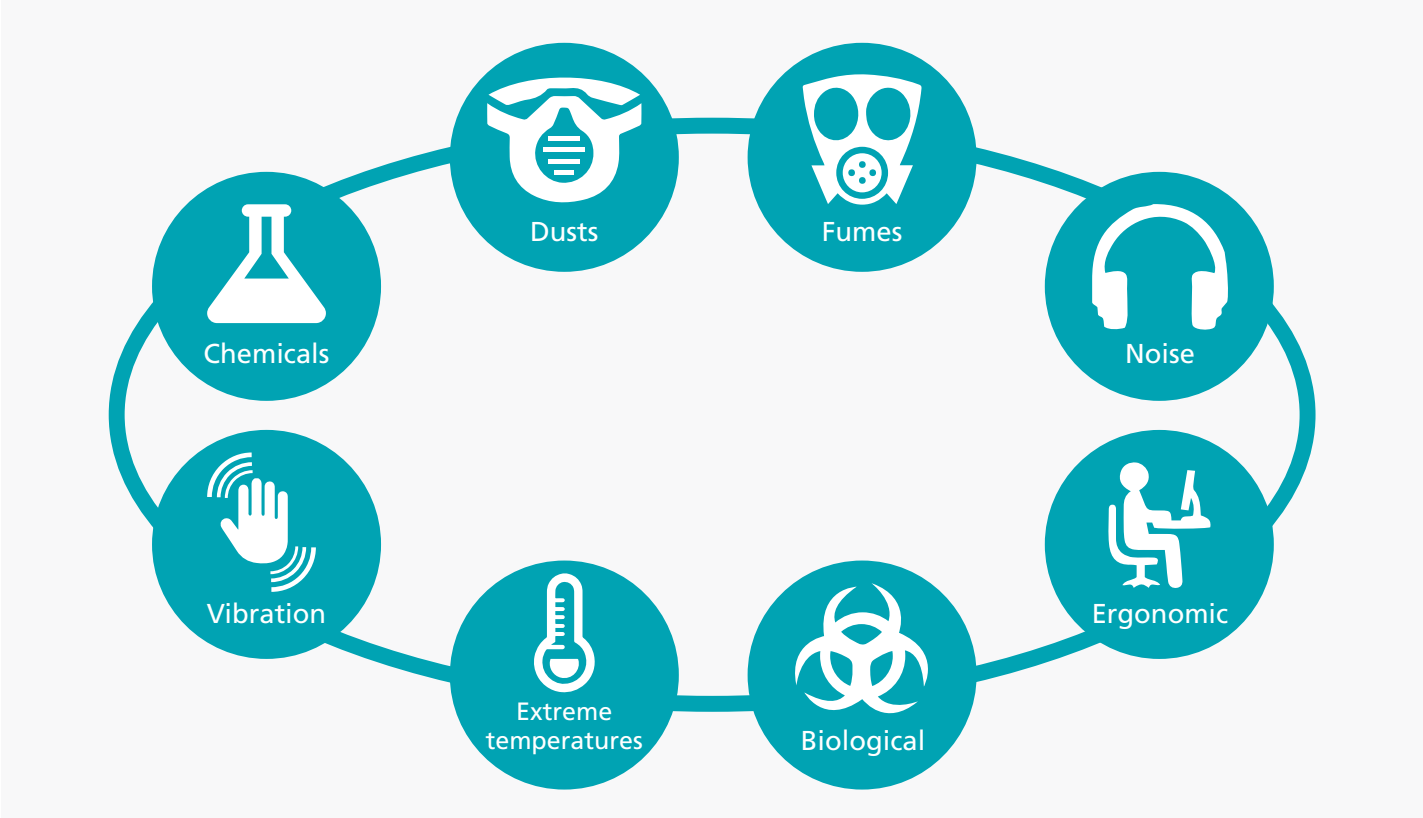


Figure 2: Health risks in the workplace, courtesy of BOHS

Bear in mind that introducing new control and remedial measures can create other hazards; for example, introducing water suppression near electrical equipment, substituting a chemical which may remove a health risk may introduce new risks such as fire or explosion; PPE can stop heat escaping from the body or cause safety spectacles to steam up and reduce vision.

In relation to health, a written record of the risk assessment should also:

- be kept for a period, as required by regulatory bodies such as the HSE
- show how conclusions and decisions were reached, and why health surveillance is or isn't required
- include exposure monitoring by an occupational hygienist, where applicable
- be linked to health records, where applicable
- be linked to the organisation's IT management system for recall dates
- include a date for review, which may be different from the safety review date
- be reviewed early if there are changes in processes, or the health of workers is affected, eg absence levels increase or reports from occupational health service providers show health issues arising.

When to get help

It's important to recognise your own or the business's limitations. In order to manage health risks effectively, you need to fully understand them. It's difficult to be an expert on everything and often specialist equipment or techniques are required – for instance, noise meters and lung function monitors need to be calibrated; samples have to be analysed in a laboratory; complex calculations to develop 'time-weighted' exposures are often required with health risks; and medical data may have to be interpreted.

Of course, the Management of Health and Safety at Work Regulations 1999 (MHSWR) impose a legal duty on employers to appoint a 'competent person or persons' to assist them. You're likely to need two main areas of expertise – technical and medical.

Technical – Occupational hygienists

Occupational hygienists are experts in managing and controlling workplace health risks. They use science and engineering to identify the level of risks, and control them by designing out hazards and applying engineering controls to reduce exposures to a minimum.

Occupational hygienists have the letters CertOH or DipOH, indicating their level of qualification, and AFOH, LFOH, MFOH or FFOH, indicating their grade of membership within the BOHS Faculty of Occupational Hygiene.[5] The highest grade of practising professional hygienists are also authorised to use the title 'Chartered Occupational Hygienist'. Occupational hygiene professionals have varying levels of expertise and subject specialisms, which you need to be aware of. To help you select an appropriate technical service, BOHS provides an online Directory of Occupational Hygiene Services, which is the UK's register of qualified practising professionals.[6]

Typical projects for an occupational hygienist to work on might include:

- conducting a noise survey in a factory to determine the noise levels to which workers are exposed
- measuring and sampling levels of dust in an aggregates plant or quarry – using specialist equipment – to evaluate worker exposure
- effectively managing the handling of chemical products in a factory, to prevent ill-health conditions such as musculoskeletal disorders, asthma and dermatitis.

Medical – Appointed doctors

Under certain regulations, employers have a duty to ensure workers are placed under 'statutory medical surveillance' by an 'appointed doctor'. This is special type of health surveillance required under certain regulations (such as for work with asbestos or ionising radiation). Appointed doctors must be approved by the HSE.

Medical – Occupational health doctors and nurses

Occupational health doctors and nurses can provide:

- health surveillance services
- pre-placement and fit-for-role/ functional assessments (see next section)
- sickness absence and rehabilitation management
- broader support in wellbeing initiatives.

Medical – Occupational health technicians

Occupational health technicians are trained and qualified in specific areas, such as spirometry or audiology. If they're engaged in health surveillance, they should provide competent advice to the employer. There's also a category of 'technicians', who are trained to deliver more general health checks, sometimes called 'health MOTs' or 'lifestyle checks'. These cover things such as blood pressure, body mass index (BMI) and lifestyle questions, and are often part of health promotion activities under a wellbeing initiative.

[5] Certificate of Operational Competence in Occupational Hygiene, Diploma of Professional Competence in Occupational Hygiene; Associate, Licentiate, Member and Fellow of the BOHS Faculty of Occupational Hygiene

[6] www.bohs.org/find-expertise/find-an-occupational-hygienist

When to assess individual health

When your business has assessed the health risks that employees may be exposed to, it's important to consider at what stage the 'individual' should be assessed. There are generally four points at which this occurs:

1 Pre-placement health checks before starting a job
2 Health/medical surveillance – checking for signs of work-related ill health
3 Fit for role – checking if a worker is fit for a job
4 Individual health changes, absence and rehabilitation management

1 Pre-placement health screening

Under UK employment law, it's illegal to use medical tests or questions as a means of stopping candidates from getting a job. Health enquiries should follow an offer of employment. Many are confused about when to ask capability questions because if, say, a crane operator can't stand heights, the interviewer and candidate need to explore this from a practical point of view. Guidance is available from the Equality and Human Rights Commission's website (**www.equalityhumanrights.com/private-and-public-sector-guidance/employing-people/recruitment**), which sets out exactly what you can and can't discuss in job interviews.

There's a belief among some people that the occupational health professional decides whether a person can or can't do a job by ruling if applicants are fit or unfit for work. Pre-placement health screening isn't done to exclude workers but acts like a risk assessment for an individual, ensuring the job fits the individual with reasonable adjustments, if required. The overwhelming majority of applicants will be fully fit for a job and many of those who aren't will only need some minor adjustments, eg spectacles or blood pressure medication.

By law, those in high-risk occupations – such as flight crew and train drivers – require specific medicals prior to starting work and throughout their careers, and some work requires careful monitoring of staff, eg workers who handle asbestos or lead.

In low-risk work (administration, call centre staff), pre-placement screening can be as simple as signing a health declaration, which a suitably trained person checks and decides if any adjustments are required.

The types of question to ask during pre-placement screening can be found in Table 1.

Pre-placement health screening is for:

- establishing baseline health records (useful for measuring health when starting a new job and before exposure to potential health risks)
- identifying reasonable adjustments to the work or the working environment
- explaining specific health risks and requirements for each job
- complying with OSH procedures, eg demonstrating how to insert ear plugs; reporting health problems caused by work
- a change of work role – from a warehouse operator to a forklift truck driver, for instance – for which the health requirements may be different, eg vision, hearing
- exposing new starters to the OSH culture of a business
- assessing specific groups of workers for extra precautions, eg pregnant workers, young workers and workers with asthma.

1	Do you need any special adaptations or aids to assist you at work, whether or not you have a disability?	Yes	No
2	Are you having, or waiting for, treatment or investigations of any kind at present?	Yes	No
3	Do you have, or have you ever had, any health problems that have been caused or made worse by your work?	Yes	No
If the applicant answers 'yes' to any of the above, do not enquire into the reasons but make an appointment for them to see the occupational health doctor or nurse to have a full discussion			
Signature:		Date:	

Table 1: Simple, non-confidential health questionnaire

Meaningful pre-placement health assessment depends on the initial OSH risk assessment setting out the requirements of the job, mitigation of health risks (where possible), and identifying areas of high risk. With this information, pre-placement health assessment can begin.

The process of pre-placement health screening is set out in Flowchart 1.

2 Health surveillance

For certain health issues, regular programmes of health or medical surveillance[7] and monitoring can be used (and may be legally required) to check individuals for evidence of harm. These tests can involve:

- blood tests – for example, for evidence of lead exposure
- visual checks of skin, for evidence of dermatitis
- hearing tests, for evidence of hearing damage
- lung function testing, for evidence of asthma or lung damage
- other specific health checks, as set out in guidance papers and expert opinion.

Health surveillance programmes assess individuals to ensure control methods are working effectively. Any negative changes to a worker's health should prompt a full incident investigation to understand the immediate, underlying and root causes, so that action can be taken to make sure that no further detriment to health takes place – for the individual or others.

More frequent health checks may be required if health risks can't be eliminated or fully controlled. The HSE has a health surveillance decision-making map at **www.hse.gov.uk/health-surveillance/requirement/decision-making-map.htm**.

For technical information on setting up health surveillance programmes and to obtain schedules for testing, visit the HSE website, **www.hse.gov.uk/health-surveillance**.

3 Fit for role

This process is closely linked to the pre-placement health assessment, but fit-for-role health checks happen periodically throughout working life and may be required to comply with legislation – eg Class 2 drivers – or as part of company policy – eg medicals for working at height. Workers who operate at height or in confined spaces, or in cold or extreme heat, need a higher level of physical fitness/capability to complete the job, or to escape in response to emergencies. Also, the fit-for-role option can be used when workers have a health problem that is likely to affect their safety or performance, or after an incident you suspect is due to health issues, eg fatigue or drug/alcohol misuse.

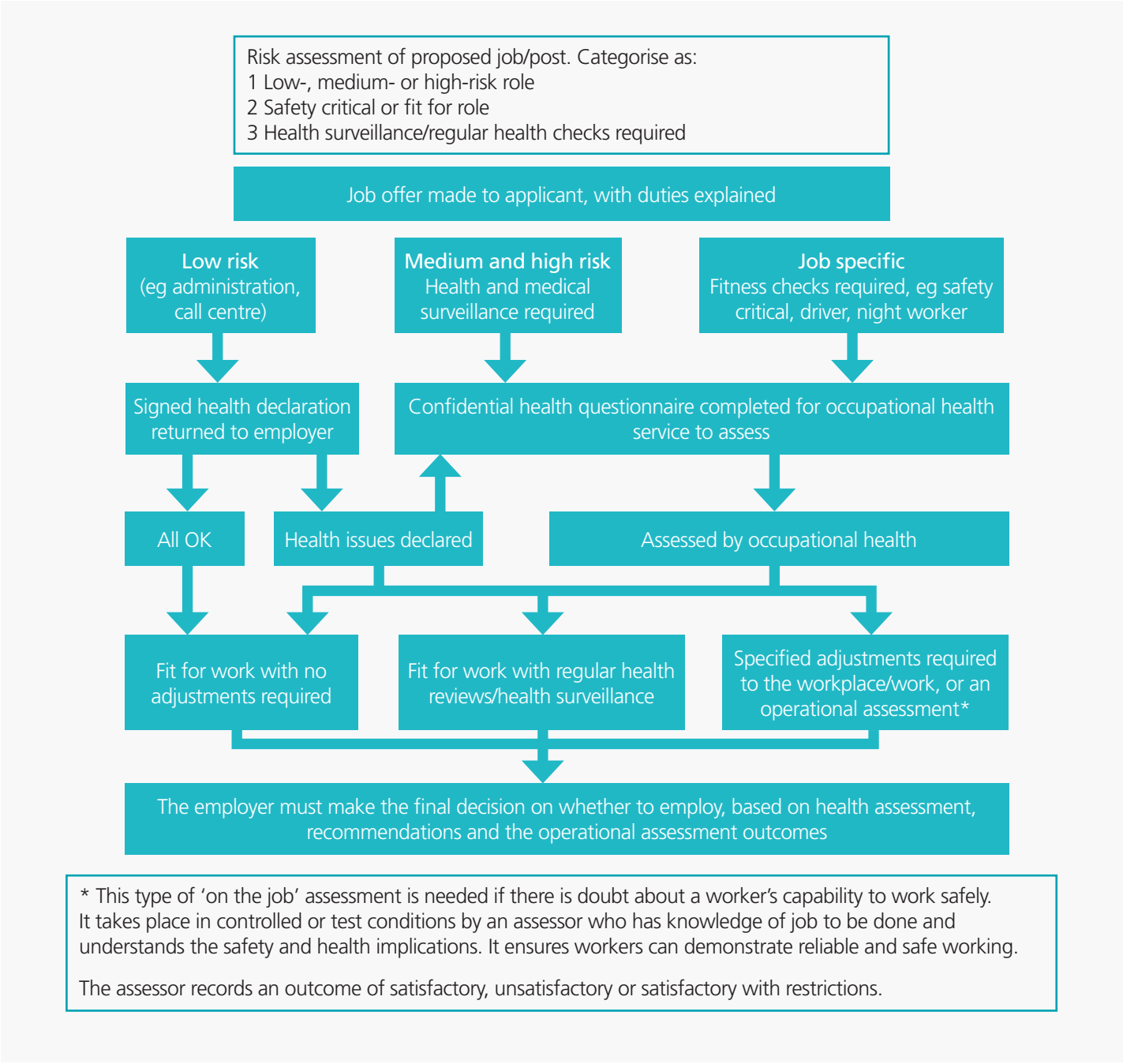
Make sure that workers are aware of testing procedures and standards before applying these rules; otherwise, accusations of unfair treatment may follow.

4 Individual health changes, absence and rehabilitation

Changes to individual health – because of pregnancy or a diagnosis of epilepsy, for instance – may require individual assessments. Certain other groups may also require additional consideration, such as young people, older workers or those with disabilities. More information on this topic can be found in the IOSH OH toolkit at **www.iosh.co.uk/ohtoolkit** and on the HSE website at **www.hse.gov.uk/vulnerable-workers**.

Recording and monitoring attendance levels may be the first indicator of a work-related health issue. Interviewing those returning to work as part of an attendance management programme provides an opportunity to discuss OSH issues, investigate where the absence is work-related, and make adjustments to the workplace, if required. Absence management and rehabilitation are covered in detail in our guide 'A healthy return', **www.iosh.co.uk/healthyreturn**.

[7] Medical surveillance requires an occupational health doctor as opposed to a nurse – see **www.hse.gov.uk/health-surveillance**



Flowchart 1: Pre-placement health assessment

Monitoring the impact on health using leading and lagging indicators

For many years, the safety industry has used leading (before an event) and lagging (after an event) indicators to measure performance. In the case of occupational ill health, leading indicators are difficult to identify and even more difficult to measure, because of vast differences in personal characteristics and the length of time between exposure and outcomes (which, in some cases, stretch to decades). Lagging indicators, meanwhile, have helped identify many occupational diseases, such as cancers and disability, but by this time it's too late to change the outcome. Health outcomes are the result of numerous causes and lifestyle choices, so if using leading or lagging indicators to improve health performance, it's important to choose the right measures for the workforce and industry in question.

Any measurement of OSH performance should evolve throughout the life of the business.

There is no single set of leading or lagging indicators to use, as indicators in one organisation may not transfer to another organisation, even if they are both in the same sector. To be effective, indicators for both 'health' and 'safety' must be an integral part of the overall business objectives, strategy and decision-making processes for delivering expected performance.

Figure 3 provides an overview of health performance indicators. Examples include:

- pre-employment health screening and fit-for-role assessments
- on-time maintenance of equipment that minimises dust and fume levels, eg seals and filters, as well as on-time maintenance of extraction and dust-suppression equipment
- auditing occupational hygiene risk controls, observing workers' behaviour (with respect to dust, fumes and so on) and carrying out surveys of workers' opinions
- carrying out management 'tours' to assess occupational hygiene
- absence data, including the cause and length of absence, departmental differences, work-related health issues
- results of exit interviews
- diseases reportable under RIDDOR
- failures in health surveillance programmes
- ill health that contributes to accidents
- qualitative surveys and questionnaires, eg worker satisfactory surveys, body mapping
- observation tours and audits
- interviews
- non-attendance at health-check appointments
- metrics from occupational health services, eg numbers seen, reasons for referrals, counselling statistics with analysis of causes
- training courses attended against plan
- qualifications in identified training programmes
- turnover of staff.

Often, data have to be collected and analysed over several years to measure the overall effectiveness of the health management programme, although immediate short-term data provide valuable insights and should not be ignored.

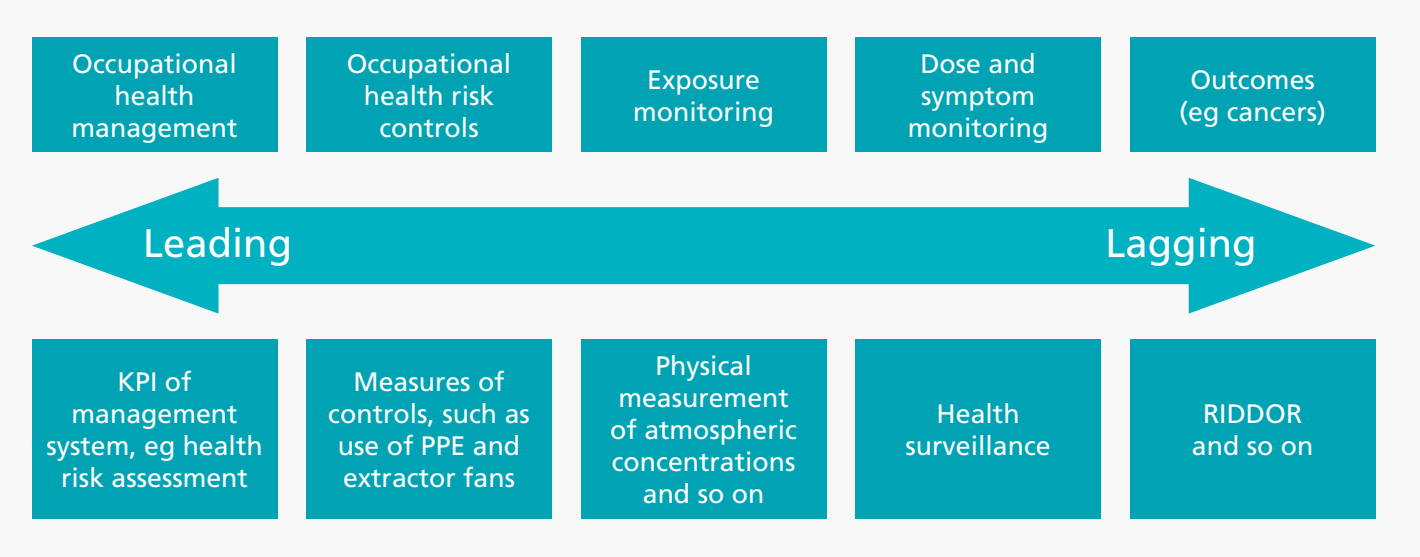


Figure 3: Conceptual spectrum of leading to lagging indicators – Adapted from www.hse.gov.uk/research/rrpdf/rr734.pdf

Choosing an occupational health service

Choosing the right kind of occupational health service relies on an organisation understanding its health risks and conveying this to the provider. It's also important to understand and specify what other services may be required, either as part of the contract or on an *ad hoc* basis. For this reason, a multi-disciplinary procurement team should be in place, consisting of human resources (for confidentiality and employment law issues), OSH practitioners familiar with health hazards and risks, and employee representatives.

Competence

The importance of competence in this area is key to providing effective and efficient services. The Faculty of Occupational Medicine provides a cautionary warning on the importance of having the right qualifications for the role. It advises: 'While all practising doctors have to be on the General Medical Council (GMC) register, being on the register, by itself, gives no guide to their specialist skills and competencies. Many doctors who offer their services as experts will not have had any specialist training in occupational medicine. More often than not, they will have only very limited knowledge of the workplace and health issues associated with the workplace.'[8]

Doctors and nurses practising occupational health medicine should have further, specific training in occupational health. It's also important to find someone with experience in your industry, or a related industry. But even where this is the case, there will inevitably be differences in levels of expertise. So, if you're considering engaging the services of an occupational health professional, you need to be aware of them.[6]

It's the employer's responsibility to check the competency of all employees and contractors, and it's no different for health professionals. Search facilities are freely available on each profession's website; you'll need the first name, family name, and personal identification number to check the qualifications of both doctors and nurses.

To check nurses' registrations and qualifications, go to the Nursing and Midwifery Council website, **www.nmc.org.uk/registration/search-the-register** and look for Registered Specialist Comm Public Health Nurse – OH.

Occupational medicine doctors (physicians) have the letters DOccMed,[9] AFOM, MFOM or FFOM after their name and an entry on the specialist register. To check doctors' registrations, go to the General Medical Council website, **www.gmc-uk.org/ doctors/register/LRMP.asp**.

As discussed earlier, some doctors need to be appointed by the HSE, or other regulator (such as the UK's Civil Aviation Authority for aeromedical examiners). Details of these appointments can be found on the regulators' websites.

The Employment Medical Advisory Service – part of the HSE – offers information on the availability of local occupational health services. You can find your local EMAS office at **www.hse.gov.uk/ contact/maps**.

Finally, the Safe Effective Quality Occupational Health Service (SEQOHS) accreditation scheme is a quality certification for medical occupational health services, supported and advocated by central government. The scheme is managed by the Royal College of Physicians of London on behalf of the Faculty of Occupational Medicine. SEQOHS is available in Ireland and is endorsed by the Faculty of Occupational Medicine, Royal College of Physicians of Ireland. The names of SEQOHS-accredited medical services are available at **www.seqohs.org**.

Fit for Work

Fit for Work is a service that supports people in work with health conditions and helps with sickness absence.

Fit for Work offers:

- free, expert and impartial work-related health advice
- referral to an occupational health professional for employees who have been, or could be, absent from work for four weeks or more.

For more information, visit the Fit for Work website at **http://fitforwork.org**.

[8] Faculty of Occupational Medicine. *An employer's guide to engaging an occupational health physician*, **www.fom.ac.uk/wp-content/uploads/empopguid.pdf**

[9] Diploma in Occupational Medicine, Associate of the Faculty of Occupational Medicine, Member of the Faculty of Occupational Medicine and Fellow of the Faculty of Occupational Medicine

Models of occupational health delivery

While NHS services can provide a number of occupational health services such as Fit for Work (see box below), these services don't cover health surveillance, fit-for-role assessments, or specific occupational medicals such as those required in aviation and rail. Therefore, businesses have three main options for the provision of these occupational health services:

- in-house
- direct appointment
- competitive tender.

As with all decisions on whether to provide the services in-house or 'contract out', there are pros and cons.

The service delivery model your business decides on will be driven by a number of business-specific factors. This section aims to highlight some of the specific issues to consider for occupational health services.

Scope of work

Clearly, you'll need to specify the services you want. There will usually be core services, such as:

- health surveillance, and absence and rehabilitation management
- *ad hoc* services, for instance ergonomic assessments and specialist medical reports.

There will also be a range of additional services, depending on your business requirements. These might include:

- drugs and alcohol testing
- vaccination services
- broader health promotion activities as part of a wellbeing programme.

You'll need to specify how many people will require these services (or estimates for aspects such as absence management); frequency; and locations where you have multiple sites. Also, if you have remote or shift workers, consider how they will access the service.

On-site or off-site provision

Consideration will need to be given to where the activities will physically take place. If your occupational health service provider has offices or locations close to your work premises, your employees can travel to them.

If the provider doesn't have offices or locations nearby, or you decide to bring the service in-house, you'll need to consider some specific issues. These are set out in Table 2.

Doctor-led, nurse-led, face-to-face or telephone-based

While specific health surveillance requirements may require a doctor, and most health surveillance activities will need to be done face-to-face (eg lung function, hearing and so on), other occupational health services may be delivered by doctors or nurses. These are principally absence management and rehabilitation services. Additionally, these services can be delivered by telephone or face-to-face.

Nurse-led, telephone-based services are common and generally better value on a per case basis. However, these services will be supported by doctors and all cases will be 'triaged'. Medically complex cases will be reviewed by a doctor, at an additional cost. So, although a nurse-led model may seem good value for money, if you have a lot of complex or high-profile cases (where employment tribunals are likely, for instance), a doctor-led model can actually save you money – as you 'save' the initial nurse review fee.

Other factors to consider are sector-specific medical requirements, such as in aviation or rail, which can (generally) only be given by specific doctors. Speed of access will also be a consideration. Telephone appointments can be arranged much more quickly than face-to-face appointments and location is not an issue if your appointment is by telephone.

Finding suitably qualified occupational health doctors with specific industry experience can be a real challenge, so face-to-face appointments can involve a long wait or significant travel – both of which may have a negative impact on the individual and business needs.

All of these factors will need to be taken into account when considering service delivery models. It's a good idea to speak to other businesses in your industry to see which models they use and assess the pros and cons; and, of course, you should seek recommendations and references for suppliers.

Key elements in a contract

Organisations employing or contracting occupational health services need to include a number of key elements in the contract to protect the employer, contractor and, especially, the employee.

Occupational health contracts can be very complex, with many factors to consider. It's essential that every element is agreed on and clearly written into the contract. The more specific the contract at the outset, the more effectively the delivery will be for all concerned.

The main aspects of a contract are set out in Appendix 1. The section that follows discusses some of these aspects in more depth.

Service level agreements and key performance indicators

Service level agreements (SLAs) set out the expectations and the deliverables of a service, agreed early on in negotiations between the purchaser and provider.

When appointing an occupational health service, it's important to agree both the SLA and key performance indicators (KPIs). Measuring performance is an important part of any supplier contract, but it's especially important for health issues. Non-delivery of the terms of service against the contract KPIs puts the organisation and workers at risk.

When considering SLAs, be explicit on what the implications of failing to meet the SLAs mean. In practice, a standard 'breach of contract' clause may have limited weight as changing occupational health suppliers can be time-consuming and complex.

Therefore, discuss including 'fees at risk' or other penalties with your procurement and legal team when drawing up the specification before going out to tender.

For an example of a service level agreement, visit the NHS England website at **www.england.nhs.uk/2012/11/05/temp-sla**.

The site	Can all employees who will need occupational health services actually be able to get to the site? If you have a multi-site business, or remote or shift workers, consider how they will access the service
Confidentiality	Sound-proof rooms; lockable storage for files
Clinical waste	Body fluids; dressings; vaccination equipment; sharps
Hand-washing facilities	Hot and cold running water (can use alcohol gels)
Disabled access	Compliance with the Equality Act; also, consider those with temporary reduced mobility, eg on crutches
Toilet facilities	Checks for diabetes; drug and alcohol testing (whilst testing is going on, the facilities can't be used by others; when testing for drugs and alcohol, the toilet and basin need to be in separate areas); people with disabilities
Position of medical room	Discreet entrance and waiting area away from main workplace/factory; quiet room required for hearing tests; parking
Chaperones/trade union reps	Can be requested by employees
Risk assessment of staff and premises	Risk assessments of new hazards introduced; emergency buttons; oxygen; fire; alarms; smokers; security; welfare facilities
Electrical access	Number of sockets required for clinical equipment
IT access/Wi-Fi	Appointment systems; records management; report writing and upload
Files and storage	Fire risk; equipment; access
Reception	Waiting area; leaflets; notices; confidentiality
Equipment – desk, medical equipment and disposables	Telephone; photocopier; fridge for vaccines; storage space; maintenance; calibration of medical equipment
Examination rooms	Couch; chairs; medical equipment, eg blood pressure monitor; privacy screens; hands-free phones for telephone appointments
Home or external visits	Manual handling of equipment; lone working
Administrative assistance	Confidentiality agreements

Table 2: Issues to consider if delivering services on site

Data protection and sharing information

There have been many situations where organisations have lost personal data because of oversights in data security, compromising the health and safety, and personal data security, of individuals.

In the UK, rules on data collection need to be followed in order to comply with the Data Protection Act (**www.gov.uk/data-protection/the-data-protection-act**). Many other countries have their own equivalent statutes. The principles of data collection and processing would apply, for example, when workers complete a questionnaire about their health or have a consultation with an occupational health professional.

The Act's rules about 'sensitive data' – a category that includes individuals' health information – do not prevent the processing of sensitive information but limit the circumstances in which it can occur. Therefore, if employers collect and hold information on their workers' health, it's important that the reasons why they are doing so are made clear and how the action is justified.

If you use an external supplier for services and change supplier, records have to be transferred from the old supplier to the new one. This is a complex process, as you have to inform your workers and give them the option of saying 'no'; as confidential records, they have to be transferred securely – which is not as easy as it may sound, even when the records are electronic; and the supplier you're leaving may have little impetus to process this in a timely manner. It's a good idea, therefore, to consider these issues during the early stage of a contract.

Consent

Occupational health services have to follow professional rules relating to medical confidentiality.

In order to release personal health information, the worker needs to consent to the process. Consent in the workplace covers seven key points:

1. Consent from the individual concerned should be obtained before entering their health data into any type of recording system, eg an electronic database of medical records.
2. Consent should be obtained from an individual before they undergo health checks.
3. Medical services must inform the worker about the purpose and nature of any examination or interview, including the likely consequences of a report being written about them.
4. Written consent must be obtained before releasing medical or personal information – such as on legal proceedings or insurance claims – to a third party.
5. Research requires written consent from each worker.
6. When requesting a medical report from the GP or specialist, the Access to Medical Reports Act applies, which sets out certain rights of workers (see Appendices 2, 3 and 4). This can take weeks.
7. Different levels of consent also apply in relation to releasing management reports to the employer. A worker can consent to the report being released without seeing it first; to it being sent at the same time they receive the report; or they can ask to see the report first. In the latter case, they have a set period of time to review it and can request factual amendments before it's finally released to the employer.

Line managers often get frustrated with the fact that it can take weeks to get a report back from the occupational health provider. They often don't realise that it is due to the legally required consent process.

It's important, therefore, to educate managers and workers on this aspect of occupational health to ensure that expectations are managed and frustrations are minimised.

Record-keeping

Good quality record-keeping is the foundation of occupational health services. Confidential and readily retrievable storage systems, which can hold data obtained over several years of working with a hazard, are crucial.

Workers' medical files can be either electronic or paper-based, but both systems must be secure and available to workers so that they can check that information in their files is factually correct.

For many hazardous substances used in industry, the UK has developed specific legislation. In the cases of asbestos, lead and other hazardous substances, employers must retain non-clinically confidential health records (see Appendix 6: Health record template) for 40 years – and 50 years in the case of ionising radiation.

There is no rule regarding the retention of other medical records, but most expert guidance suggests keeping records for eight to 10 years.

Intelligent customer capability and responsibility

Finally, where a service relates to health (or safety), it's a good idea to consider 'intelligent customer capability'. This can be defined as 'The capability of the organisation to have a clear understanding and knowledge of the product or service being supplied.'[6]

In simple terms, your business needs to understand the hazards and risks it creates, and demonstrate that it is effectively controlling them. Where services are contracted-out, your business has to show that it is actively managing the contract and satisfying itself that the hazards and risks are still being effectively controlled. The quality and effectiveness of the service will rely on the capability of your business to identify, describe, explain, monitor and review it. If the input from your business and managers is poor, then the output will also be poor and, ultimately, your workers won't be protected.

Contracting-out doesn't absolve the business of its responsibility to manage health risks, or make a decision on whether someone is fit to work or covered by the Equality Act. While the occupational health service may advise and make recommendations, the business should demonstrate that it is responsible and make the final decision. Blindly following the advice of occupational health doesn't show intelligent customer capability and, ultimately, won't hold up in court, as shown in Gallop v Newport City Council [2013] EWCA Civ 1583, which found that a responsible employer has to make their own judgment as to whether or not a worker has a disability.

Appendices

Appendix 1: Issues to consider when contracting for OH services, and points to confirm and include in the final contract

Account manager	Will an account manager be appointed and what charge will there be? You should ensure that you have their contact details and those of a deputy (eg when they are on leave), plus an escalation contact if there are contractual issues (see also 'Complaints procedure')
Advice availability	What advice will be available and how much will it cost? Some providers operate a separate helpline with a set annual charge; others offer advice through OH staff, but may charge per 15 minutes
Attendance at individual case conferences	Complex cases may require meetings between OH, HR/line managers and the individual. Will this be included in the contract, or offered *ad hoc*? What will be the charge for each of these options?
Attendance at OSH or other internal meetings	Would you want the OH provider to attend meetings? If so, who should attend and what will be the cost? Should they attend every meeting, or just once a year?
Bonuses and penalties	This should cover performance bonuses, as well as penalties (fees at risk) associated with not meeting SLAs
Business terms of reference	When will invoices be submitted and what supporting information will they come with? Spreadsheets showing different services can be useful, as you can look at costs per service, for instance. What are the payment terms, eg 30 days?
Charges	It's important to look very closely at charges. The more services you have the more complex it can become. With individual case management (related to sickness absence), the charges come in many different forms, which can make budgeting difficult. Some OH providers may charge 'per contact' and 'contact type', eg one charge for telephone, another for a face-to-face appointment. Others may charge 'by case' – this could be one telephone call from a nurse, one report and one follow-up call. Other services may have an annual charge or 'per use' fees. What is included in these charges, eg reports, administration? What other charges are there, eg travel, supply of equipment, out-of-hours service, obtaining GP or specialist reports?
Clinical waste	If you have services on-site, who is responsible for disposal arrangements, including safety measures?
Communication	What are the communication routes? Normally, routine progress updates would go to a line manager, while emergency situations, such as an individual being found unfit for work, would go to HR or OSH. Will the communication be by email or phone? This should include agreeing set timeframes for responding to queries as part of SLAs
Complaints procedure	What is the complaints procedure – for your business, but also for individuals?
Consent (see page 14)	Who is responsible for gaining consent and at what stage? How will communication on consent requirements and implications be delivered?
Contract reviews	When will these be held and will there be a cost, or will they be included in an annual service charge?
Disability/limited mobility access	Do you have suitable arrangements for parking, lifts and access routes? Are other arrangements required?
Equipment (if services provided at business premises)	Will the OH service provide the equipment? Will they arrange for it to be delivered to site and who will cover the cost? How will it be maintained?

Holiday/sickness cover	How will arrangements be managed and communicated? If your business is 24/7, 365 days a year, what impact will this have? Note that many OH providers only operate during normal working hours
Implementation plan and timeframe	Who will manage the plan and over what period? What information will you need to supply to set up the account and in what format? Generally, site addresses, organisational structures, the names, roles and contact details of line managers and HR staff are required, and often in a specific format so that they can be uploaded to the supplier's system. What training/information/communication is included? Is something separate required for employees/trade union representatives? Will the implementation be phased (across sites or departments) or in single 'roll-out'?
Litigation claims	What are the arrangements for storing and retrieving records? How will they be retrieved in the case of litigation/employment tribunal cases? What are the timeframes? Is there an administration charge?
Management information reports	This refers to anonymous statistical and trend data based on service usage, eg how many people have been referred. You should agree in what format you want the information and how often. This should also include arrangements for quality assurance and customer satisfaction surveys to establish if service delivery meets contractual requirements and delivery against SLAs
Non-attendance at appointments	Will non-attendees be charged? Will there be a re-booking fee?
Notice on termination	What is the notice period? Remember to include a clause on timely and professional transfer of records to the new supplier
Occupational health records	Where are they held and in what format? What will happen to records if the business closes? How will records be transferred, if required?
Occupational health training	Will there be induction training for managers and HR? Will it be free of charge during implementation? What are the costs of other training?
Policies and procedures	Who will produce policies and procedures, including management referral processes for capability, rehabilitation and health surveillance (specific to your business), plus a policy on dealing with drugs and alcohol misuse? (see also 'Complaints procedure')
Service level agreements (SLAs)	You should develop SLAs for all key services. They should cover aspects such as how and when initial acknowledgement of referral is made; waiting times for appointments; when the report will be written and sent; and how quickly communication on other issues will be made
Special arrangements	Are different arrangements required for night workers/other shift workers, or for services such as drug and alcohol testing?
Templates and questionnaires	The OH service provider would normally provide these, but do they need revising/adapting to suit your business? Will there be a cost if they need to be tailored to your business? How long will it take? Are they online or paper-based? Most are now online, but this may not work for your organisation – paper-based can be more expensive and time-consuming
Wellbeing and other programmes	If wellbeing or other programmes are to be included in the contract, you should define the programme and your expectations, and include return-on-investment measurements and opportunities for feedback

Appendices

Appendix 2: Template letter to treating doctor

Occupational health and wellbeing
Type your address

Type GP contact address
Type date
Private and confidential

Dear Dr *Type GP/specialist name*
Surname/Family name *Type name*
DOB *Type date of birth*

Forename *Type name*
Address *Add address*

I am writing to you in my capacity as Occupational [Adviser or Physician] to *Company name*.

Mr/Mrs/Miss/Ms *type name* is currently employed as a *type job role and hours worked*. He/she has been referred to me in relation to *outline the nature of the problem*.

This has resulted in *outline the nature of the problem*.

I would therefore be most grateful if you would provide me with a medical report on Mr/Mrs/Miss/Ms *type name*, in particular, addressing the following areas:

1 current state of health, including physical and mental capability
2 the history of the conditions detailed above and their prognosis
3 investigations and treatment to date (please provide copies of specialist reports, if possible)
4 proposed treatment and investigations
5 a likely return-to-work date (only use if employee is currently off sick).

Our role is to support employees and help them return to work or improve performance if affected by a health condition. We act as experts to our management and make recommendations, based on your reports and our knowledge of the workplace. We will consider restrictions or adjustments as part of the support we can offer to your patient. We may also have to form an opinion on their ability to offer regular and effective service in the future, based on your information and the job role. I have attached a job description for your information.

In this case we have suggested *insert information* and would welcome your thoughts on this.

Please find enclosed a completed consent form. You will see that Mr/Mrs/Ms/Miss *type name* has/has not expressed a wish to see the report before it is sent to me.

Company name generally pays a standard fee of £80 on receipt of a report concerning the above areas; this would be open to negotiation if you require more. Please send your report to the address above with a separate invoice so that payment is prompt.

We hope to help your employee return to work/improve performance at the right time and in the right manner, and this relies on the report we are requesting.

Many thanks for your help with this matter. Please do not hesitate to contact me on the above number if you require more information.

Yours sincerely

Type name
Type designation/job title
Enclosures (2)

Appendix 3: Template consent form to write to GP/specialist

Occupational health and wellbeing
Type your address

Access to Medical Reports Act – Consent form

Surname/Family name

Forename

Address

Date of birth

Contact details

Please complete this form to give the occupational health and wellbeing service access to medical information from your GP and specialist. You should read the declaration and sign it to give your consent. The completed form should be sent or given back to occupational health. You should read your rights on the back of this form and keep a copy for future reference.

1 Do you agree that occupational health and wellbeing can write to your GP or specialist for information?

Yes No

2 Under the terms of the Access to Medical Reports Act 1988, do you wish to have access to any information about your medical condition *before* it is supplied to occupational health and wellbeing?

Yes No

Please give the name and address of your GP
Dr _____
_____
_____
_____

Please give the name and address of your hospital specialist
_____
_____
_____
_____

Signature

Date

Appendix 4: Employee rights and flowchart of GP report

This company is concerned with your health and wellbeing and how poor health or disability can affect your performance and attendance. To that end, the occupational health and wellbeing service would like to request more information from your own doctor or specialist. The information will be received by medical personnel, who will advise management on how best to support you in the workplace.

Medical information is considered sensitive, as defined under the Data Protection Act, and is protected. The only exception to this rule will be if the OH professional considers that it is necessary to breach medical confidentiality, in line with guidance provided by the General Medical Council and the Nursing and Midwifery Council.

When we request a medical report for more clinical advice, you have legal rights, as set out below:

1 You can give your consent without asking to see the doctor's report before it is sent to occupational health and wellbeing, and the doctor will send the report directly to us.

2 You can give your consent, but ask to see any report before it is sent to occupational health and wellbeing, in which case you will have 21 days, after we have requested a report, to contact your doctor to make arrangements to see the report.

If you fail to contact the doctor within 21 days, they will be entitled to send the report direct to occupational health and wellbeing. If you contact your doctor and ask to see the report, you must give the doctor written consent before they can release it to us.

You may ask your doctor to change the report if you think it is factually wrong. If your doctor refuses, you can insist on adding your own comment to the report before it is sent to us.

You can change your mind about whether you want to see the report. In such a case, you will have the opportunity to see the report and ask the doctor to change the report, add your comments before it is sent to us, or withhold your consent for its release.

3 Whether you indicate that you wish to see the report before it is sent, you have the right to ask your doctor to let you see a copy, provided that you ask within six months of the report having been supplied to us.

Your doctor is entitled to withhold some or all of the information contained in the report if:

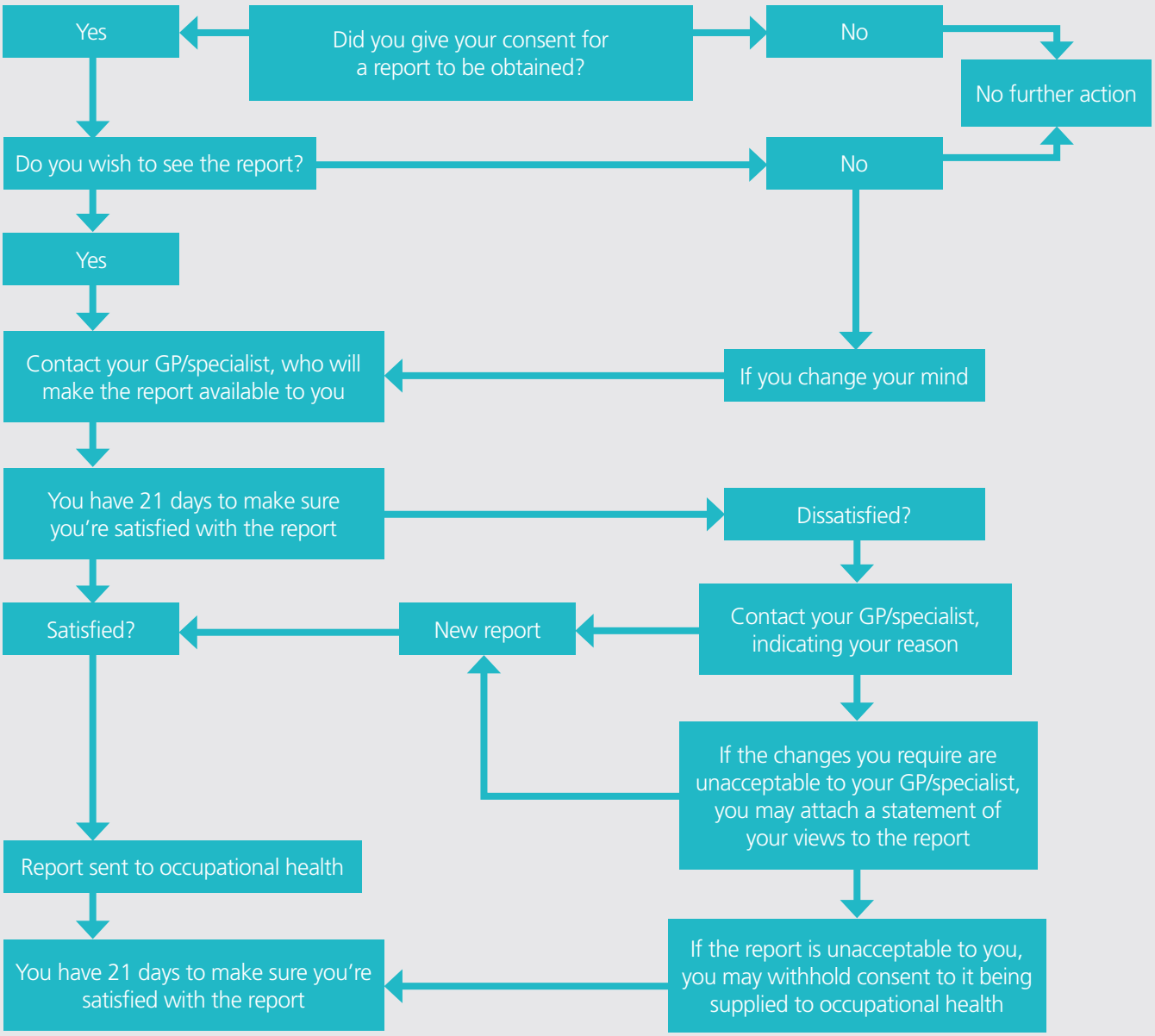
a) they feel that it may be harmful to you
b) it would indicate their intentions in respect of you

or

c) it would reveal the identity of another person without their consent, other than a health professional in relation to your care.

4 You can refuse to allow us to write to your GP and/or specialist but, if you do, please bear in mind that we may be unable to confirm your suitability or fitness for employment or support you with your health needs. Decisions will have to be made without this information being available.

Appendices



You have the right to:

1. Withhold your consent for a report to be sent to occupational health from your GP/specialist
2. See any report before it is supplied and, for a period of six months, after it has been supplied. This right is subject to you making arrangements with your GP/specialist to see the report within 21 days of receiving notification from occupational health
3. Ask your GP/specialist to amend any part of the report you consider to be misleading or inaccurate before it's supplied to occupational health
4. Attach a statement of your own views if the GP/specialist is unwilling to amend the report
5. Withhold consent for a report to be supplied to occupational health

Note: If you withhold consent, your employer can make a judgment on your fitness for work based on the information they have

Flowchart 2: Consent for GP report

Appendix 5: Health reportable diseases under RIDDOR

These apply where, in relation to a person at work, the responsible person receives a diagnosis of:

1. carpal tunnel syndrome, where the person's work involves regular use of percussive or vibrating tools
2. cramp in the hand or forearm, where the person's work involves prolonged periods of repetitive movement of the fingers, hand or arm
3. occupational dermatitis, where the person's work involves significant or regular exposure to a known skin sensitiser or irritant
4. hand–arm vibration syndrome, where the person's work involves regular use of percussive or vibrating tools, or the holding of materials that are subject to percussive processes, or processes causing vibration
5. occupational asthma, where the person's work involves significant or regular exposure to a known respiratory sensitiser
6. tendonitis or tenosynovitis in the hand or forearm, where the person's work is physically demanding and involves frequent, repetitive movements.

For more information on RIDDOR and disease reporting, go to **www.hse.gov.uk/riddor**.

Exposure to carcinogens, mutagens and biological agents

You are also obliged to report when, in relation to a person at work, the responsible person receives a diagnosis of:

1. any cancer attributed to an occupational exposure to a known human carcinogen or mutagen (including ionising radiation) – visit **www.hse.gov.uk/cancer** for more information on occupational cancers
2. any disease attributed to an occupational exposure to a biological agent – visit **www.hse.gov.uk/biosafety/infection.htm** for more information on biological agents.

Appendix 6: Health record template

Name		Address	
National Insurance no.		Date of starting employment	
Manager's name		Department	
Role 1			
Role 2			
Role 3			
Health risk exposures		Dates of exposures	
Date/type of health surveillance	Outcome	Date recall due	Adjustments advised

Appendices

Appendix 7: UK legislation for occupational health protection

There is no specific legal requirement stating that employers must provide occupational health medical services, but the following legislation is relevant to workplace health.

The Health and Safety at Work etc. Act 1974 (HSWA)

Sections 2 and 3 place duties on employers to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all their employees and those affected by their undertaking. Relevant regulations made under the HSWA include:

The Management of Health and Safety at Work Regulations

- Regulation 6 requires every employer to ensure that their employees are provided with such health surveillance as is appropriate, having regard to the risks to their safety and health identified by the risk assessment, ie the risk assessment required by Regulation 3
- Regulation 7 requires every employer to appoint one or more competent people to help carry out the measures needed to comply with the requirements and prohibitions imposed on under the relevant statutory provisions.

The Control of Substances Hazardous to Health Regulations (COSHH)

- Regulation 11 requires that where it is appropriate for the protection of the health of employees who are, or are liable to be, exposed to a substance hazardous to health, the employer should ensure that such employees are under suitable health surveillance. This regulation goes on to specify the circumstances in which health surveillance is appropriate and when health surveillance has to include medical surveillance under the supervision of an (HSE) employment medical adviser or an appointed (by the HSE) doctor.

Other

- Regulations containing medical surveillance requirements include the Control of Lead at Work Regulations, the Ionising Radiations Regulations, and the Control of Asbestos Regulations.
- A number of regulations cover fitness for work in specific sectors, including the Diving Operations at Work Regulations, the Transport and Works Act, and the Railways (Safety Critical Work) Regulations.
- The Equality Act makes it unlawful to discriminate against people with disabilities.
- The Safety Representatives and Safety Committees Regulations and the Health and Safety (Consultation with Employees) Regulations require employers to consult with their workers on OSH matters.
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations – see Appendix 5.
- The Health and Safety (First Aid) Regulations and Offshore Installations and Pipeline Works (First Aid) Regulations.

Appendix 8: Health hazards checklist

Geographical location (usually covered as part of the risk assessment process)	
	Temperature and climate (eg extreme heat or cold) and wide temperature variations
	Altitude, eg low pressure of oxygen
	Humidity and air quality
	Daylight (extremes of dark or light)
	Transport
	Communication infrastructure
	Location in relation to available health services and facilities (distance and access)
	Ability to access, and standard of, healthcare facilities
	Competence of first aid/medical staff in relevant health issue
	Safety and security, eg access to emergency services and breakdown recovery, especially in remote locations
Physical (usually covered as part of the risk assessment process)	
	Noise
	Motion, eg sea sickness
	Vibration, eg hand–arm, whole body – use equipment with tags fitted that show noise and vibration levels and potential exposure
	Pressure, eg vessels, diving
	Ionising and non-ionising radiation
	Thermal work environment, eg foundries, food freezers
	Display screen equipment
	Ergonomics – associated with mismatches between the task and capability, including man–machine interfaces, manual handling, repetitive movements
	Equipment may pose a risk to health, especially if the design is poor, used incorrectly, or malfunctions. Consider the following:
	- the condition of equipment
	- the age of equipment (newer equipment has less wear and tear, and better design)
	- maintenance programmes and calibrations
	- specific health hazards linked to the equipment, eg noise, vibration, radiation, heat, cold, and exhaust emissions
	- training and method of use
	- future purchases of equipment to reduce noise levels – see, for example, the Buy Quiet campaign at **www.hse.gov.uk/noise/buy-quiet/about.htm**
	Sharp objects
	Transport during work
	Ambient light levels

In most cases, measuring physical hazards requires expert or technical assistance, eg for vibration, dust levels. Consider whether the results of measurements are within legal, published or industry-accepted limits.

Chemicals and hazardous substances (usually covered in COSHH assessments)	
	Poisons that accumulate in the body, eg heavy metals, lead
	Irritants that cause a local effect, such as to skin, eyes or lungs
	Sensitisers that cause skin and respiratory reactions, such as rash or asthma
	Acids and alkalis/caustic agents
	Carcinogens, mutagens, reprotoxins
	Pesticides
	Characteristics of the causal agent (what is the size of the molecule and how far will it travel in the lung?)

Appendices

Look at safety data sheets (SDSs) closely for health information and hazard data sheets' health risk phrases – see **www.hse.gov.uk/coshh**.

Bear in mind that many health effects can happen days, months or years after the original exposure. Review the most current information available – from SDSs, industry trade groups, governmental OSH bodies, and published occupational exposure limits – and incorporate these into the OSH risk assessment. If you're in any doubt about the contents or the meaning of the SDS, contact the supplier for more information.

Biological (usually covered in COSHH risk assessments)	
	Wildlife (animals including pets and guard dogs, reptiles, insects, plants)
	Endemic/epidemic diseases (due to viruses, bacteria, fungi, parasites)
	Occupational diseases (due to viruses, bacteria, fungi, parasites)
	Contaminated food and drink (hepatitis A)
	Poor hygiene (catering, accommodation, toilet facilities, waste disposal)

See, also, the HSE publication, *Infection at work: controlling the risks* (**www.hse.gov.uk/pubns/infection.pdf**), for advice and guidance on pathogens and control measures.

Psychosocial (usually covered in stress risk assessments[10])	
	Overcrowding and lack of privacy
	Communication problems (business and family contacts for those working away from home for long periods)
	Discrimination
	RIsks of violence, bullying and harassment
	Culture, local laws, religion, and language, eg comprehension and comfort level
	Job design, eg control, content, workload, understanding of role
	Job organisation, eg shift patterns, sleep deprivation, fatigue, jet lag
	Organisational change
	Organisational relationships and support, including isolations (degree of access to social support)
	Leisure and recreation opportunities
	Substance misuse/dependence, alcohol use and addiction, and smoking
	Beliefs and culture of an organisation
Individual characteristics (usually assessed by health professionals)	
	Health status – in the case of psychological hazards, social and personal pressures may affect an individual's ability to cope with workplace stress (physical and mental)
	Beliefs/motivators
	Demographics, eg age, sex, gender
	Learning ability, eg dyslexia, reading ability, understanding
	Prescriptions and over-the-counter medications that affect response rates and alertness
	Personality, eg assertiveness, attitude to risk
	Physical condition, eg obesity, fitness
	Hobbies/lifestyle – damage from work hazards increases if workers have hobbies or habits that match work hazards; for example, going to discos, listening to loud music or rifle shooting may significantly increase risks of noise-induced hearing loss, or smokers' risk of vibration white finger

The examples cited above are not exhaustive. The hazard identification process will determine the health hazard profile for specific activities and whether more information is required for individual workers (rather than the group).

[10] For more information, see the Stress management standards at **www.hse.gov.uk/stress/standards**

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