

Sexual health: an OH issue?

When workers are based away from home in high HIV prevalence areas, the risk of exposure to HIV – as well as other STIs – can become a workplace issue. Where do OH and public health responsibilities overlap?

Where academia meets practice

The different priorities of OH practice and academic research can create a divide between the two communities. Can the relationship be enhanced to improve applied research?

Pre-employment health screening

Part 2 of our exclusive survey of policy and practice in pre-employment health screening looks at health questionnaires, declarations, medical reports and cost-benefit.

Hygiene matters

BOHS chief executive and president-elect discuss the role of occupational hygiene in the post-industrial era.

Meet the practitioner

Dr Bernadette Paver explains the perks and challenges of her role running an OH company on the Falkland Islands.

Expert witness

When are employers deemed to be aware of an employee's disability, and should OH professionals provide a diagnosis of disability?

PLUS:

LEADER ■ NEWS ■ LEGAL NEWS ■ RESEARCH
DIGEST ■ RESEARCH PLUS ■ BRIEFING



[Inside this issue]

FEB/MAR_14

FEATURES ▶ ▶ ▶ LEGAL ▶ ▶ ▶ NEWS ▶ ▶ ▶ RESEARCH ▶ ▶ ▶ EXPERT WITNESS

- 03 LEADER**
Safe in our hands Scrap the Fee for Intervention scheme and let the HSE get on with the job in hand
- 04 NEWS**
 ... first triennial review finds strong case in support of the HSE ... assessing cognitive impairment – a snapshot of OH opinion ... government to extend OH tax exemption ... NHS England withdraws central funding for OH assessment in most cases ... consultation on nurse revalidation ... evidence supports telephone triage ... young people with chronic conditions ... NHS absence guidance ... fit note letter template ... mental health first aid ... zero-hours, zero balance? – findings of a new CIPD study
- 10 LEGAL NEWS**
 ... consent to test blood of dead body – *CM v Executor of the Estate of EJ (deceased) and Her Majesty's Coroner for the Southern District of London* ... how long is too long? – *BS v Dundee City Council*
- 13 MEET THE PRACTITIONER**
Dr Bernadette Paver
 In the first of a new series, Rebecca Ghani asks occupational health physician Dr Bernadette Paver about her work on the Falkland Islands.
- 14 FEATURE**
Collaborative research
 Occupational health nurse Karen Coomer looks at the benefits of, and the barriers to, OH practitioners and academics working together on research projects.
- 18 FEATURE**
Protecting the sexual health of workers
 What is the role of occupational health professionals working in industries based in countries with a high HIV prevalence and little access to primary healthcare? Rebecca Ghani investigates.
- 22 FEATURE**
Hygiene matters
OH [at Work] asks BOHS chief executive Steve Perkins and president-elect Mike Slater how the occupational hygiene profession can best serve industry and forge closer ties with other OH professions in the post-industrial era.
- 24 FEATURE**
Health screening at recruitment
Part 2: health questionnaires, declarations, medical reports and cost-benefit
 John Ballard presents the findings from the 2013 *Occupational Health [at Work]* survey of employers' practice in pre-employment health screening. The second part focuses on the reasons for carrying out health screening at recruitment; GP reports and medical examinations; how much time practitioners spend doing recruitment health screening; and whether or not it is worth the effort.
- 36 EXPERT WITNESS**
Disability: known and unknown knowns
 Our legal expert Diana Kloss looks at the statute and case law relating to when an employer can actually be said to know of an employee's disability, and what role the expert opinion of an OH practitioner plays.
- 38 RESEARCH DIGEST**
 ... surviving cold water immersion ... German doctors and the introduction of the Working Time Directive ... work after heart disease ... divers and PTSD ... football medicals
- 40 RESEARCH PLUS**
 Our compendium of published evidence on occupational health.
- 43 BRIEFING**
 ... your need-to-know guide to this issue



Just three-and-a-half years, the coalition government has delivered a near continuous onslaught on Britain's health and safety system and the work of the Health and Safety Executive (HSE). They have been subjected to three major reviews and repeated calls to rid the country of 'health and safety nonsense'¹. Prime minister David Cameron said he was 'waging war against the excessive health and safety culture that has become an albatross around the neck of British businesses'¹. We've had reviews by Lord Young², in 2010, and Professor Löfstedt³ a year later. Now we have Martin Temple's *Triennial review report*⁴ – one of a series of evaluations of non-departmental public bodies – commissioned to answer the key question: 'Do the functions that the HSE performs remain necessary and if so do they need to be done by the HSE?' These continual examinations are hardly votes of confidence by the government for the 39-year old regulator. And yet, Temple concludes resoundingly that the HSE remains fit for purpose and is almost universally praised by stakeholders (this issue pp.4–5). What is most interesting, though, is his condemnation of a government innovation whereby the HSE charges lawbreakers for being inspected.

The Fee for Intervention scheme (FFI) was introduced in October 2012 by the *Health and Safety (Fees) Regulations 2012* to enable the HSE to recover its costs for carrying out inspections and enforcement in cases where the 'duty holder' (usually the employer) has broken the law. The HSE would generate income – £2.7 million was invoiced in the first six months of the scheme⁵ – and the costs would be a disincentive not to break the law, the government argued. But the problem identified by Temple is that FFI damages the HSE's reputation for independence, with enforcement activity perceived as being driven by the need to fill the gap created by budget cuts. There is a suspicion, says Temple, 'that inspectors' decisions about where and who to inspect, and what to do once there, will be based on the potential for raising income, rather than an analysis of the risk'. He found no indication that inspectors' behaviour had actually changed but did find 'clear evidence that FFI is having a negative impact on previously constructive relationships between HSE inspectors and those they inspect'. He described the link between funding the HSE and 'fines' (ie the fees) as damaging the 'positive relationship between HSE and business, which has previously been the basis of improved health and safety performance'. Unless the link can be broken, FFI should be phased out, he said.

Temple recognises the importance of the HSE working with business to promote rather than destroy Britain's health and safety culture. The HSE – and its local authority enforcement colleagues – will never have enough resources to regularly inspect every workplace. Thus, while enforcement remains a crucial weapon the HSE cannot afford to alienate those employers, often in higher risk sectors, that rely on its advice to improve compliance. The FFI has damaged a reputation and partnerships built over the past four decades. The government should take heed of Temple's recommendation on FFI and, to put it bluntly, get off the HSE's back.

Scrap the Fee for Intervention scheme and let the HSE get on with the job in hand.

Notes

¹ Cameron D. *Health and safety laws are holding back business*. *Evening Standard* 2012; 5 January. ohaw.co/1drGwqQ

² Lord Young. *Common sense, common safety*. London: The Cabinet Office, 2010. ohaw.co/1fWjyQ

³ Löfstedt RE. *Reclaiming health and safety for all: an independent review of health and safety legislation*. CM8219. London: TSO, 2011. ohaw.co/1f3JAOZ

⁴ *Triennial review report: an independent review of the function, form and governance of the Health and Safety Executive (HSE)*. London: DWP, 2014. ohaw.co/1eBvtOi

⁵ HSE Board. *Minutes of meeting 26 June 2013*. ohaw.co/1hIHrse

John Ballard, editor

Send letters to:
editorial@atwork
partnership.co.uk

STRONG CASE FOR THE HSE

Paul Suff

The first triennial review¹ of the HSE has concluded that there remains a very strong case for the five functions set out in the *Health and Safety at Work etc Act 1974* (HSW Act) to continue to be delivered by an 'arms-length body', and that the HSE remains the right delivery vehicle. The review makes several recommendations to improve how the HSE operates, however, including the possible removal of the 'fees for intervention' (FFI) scheme. It also finds that the HSE needs to do more to tackle work-related ill health and ensure health is not seen as the poor relation to safety.

The HSW Act requires the HSE to: set standards and make regulations; enforce the law; conduct research; provide guidance and advice; and advise the government. 'None of the evidence presented to me suggested that these functions were no longer required,' says EEF chair Martin Temple, who led the review.

The review, which was launched by the DWP in April 2013, considered the functions of the HSE against the three Cabinet Office tests of

technical capability, political impartiality and independence to assess whether the existing regulator is the right delivery mechanism. Temple also considered alternative delivery models. He found near universal support for the HSE, which he says is a reflection of the impartiality and independence it maintains in its regulatory and other work, in addition to the professionalism and technical competence of its staff.

The review reports, however, that the FFI scheme, which makes companies that break health and safety laws liable for the regulator's related costs, has damaged the HSE's reputation for acting impartially and independently, and thereby its integrity as a regulator. Stakeholder concerns focus on the following:

- ▶ that FFI is a penalty or fine regime, but without any of the usual safeguards for such statutory schemes
- ▶ that the introduction of FFI is linked to the need for HSE to fill the gap in its budget created by the reduction in government funding, creating the impression that HSE has an income target to achieve.

According to Temple, these

concerns would not arise if British health and safety law was 'black and white rather than goal-setting', meaning that there is an element of judgment in how it is interpreted. As a result, there is a risk that inspector decisions will be, or be seen to be, skewed by the need to raise income, says Temple. 'Unless the link between "fines" and funding can be removed or the benefits can be shown to outweigh the detrimental effects, and it is not possible to minimise those effects, FFI should be phased out,' he concludes.

The review also makes a number of recommendations for how the HSE could be more effective and efficient in the delivery of its functions, particularly given its declining budget. 'The funding from [the] government has decreased over the last 10 years and it is unrealistic to expect in financially constrained times that HSE's budget will be returned to levels at an equivalent value to those it had previously,' it warns. It recommends the development and publication of performance indicators for the HSE's work on producing guidance and enforcement activities. He also wants the regulator to continue to

FROM THE VAULTS = LANDMARK CASES IN OCCUPATIONAL HEALTH BY SPIKE GERRELL.



reduce the time it takes to complete its investigations, aiming for 95% of non-fatal accident investigations to be completed within 12 months of the accident.

Temple reports that he received many comments that the HSE had not allocated sufficient efforts to 'health' as opposed to 'safety', though most stakeholders acknowledge that taking effective action on work-related ill health can be challenging.

He notes that since March 2013 the HSE has sought to reinvigorate its approach to tackling work-related ill health and ensure it is not seen as the poor relation to safety issues. Examples include working to promote and encourage new and innovative ideas for activity, particularly around occupational cancer and respiratory disease, and refreshing existing projects to tackle work-related diseases and to examine whether the HSE has the right technical support in this area.

The review says the HSE should continue to seek new and innovative ideas for interventions that maximise its impact on the continuing high levels of work-related ill health. It highlights the success of the 'Hidden killer' asbestos campaign aimed at tradespeople, which combined traditional media to promote messages and online guidance.

Prospect, the main union at HSE, welcomed the findings, particularly that the functions should continue to be delivered by a non-departmental public body, allowing the HSE to retain its independence. It also agreed that the FFI scheme posed a significant risk to the HSE and how stakeholders view the regulator.

'FFI was rushed in to fill gaps in HSE's budget caused by government cuts. Prospect warned that the proposals would be perceived as a business burden and risked damaging the regulatory balance. We have been proved right,'

commented deputy general secretary Garry Graham.

1 Triennial review report: an independent review of the function, form and governance of the Health and Safety Executive (HSE). London: DWP, 2014, ohaw.co/1eBvtOi

COGNITIVE IMPAIRMENT

In November's e-newsletter, we asked OH professionals: 'If you, or a manager, suspected an older worker had developed a cognitive impairment, would you be confident in dealing with this?'

One third (33%) of respondents said no, while almost two-thirds (65%) said yes (2% were unsure). Some practitioners commented that they would be confident, 'up to a point'.

The issue was covered at the At Work Partnership's two-day autumn conference, Workplace Health 2013. Dr Ola Junaid, clinical director at Nottingham Healthcare NHS Trust's Mental Health Services for Older People, said that OH professionals are well placed to do initial testing, and that screening tests are straightforward and quick to do. He pointed delegates to the Alzheimer's Society toolkit, *Helping you to assess cognition: a practical toolkit for clinicians*¹.

1 ohaw.co/1gYiITu

OH TAX EXEMPTION

The government is to widen its previously announced tax exemption for treatments recommended by the forthcoming Health and Work Service. Following consultation, the government says it will extend the exemption to 'medical treatments recommended by employer-arranged occupational health services'. Tax exemption will be capped at £500 per employee.

The measure was announced in the chancellor's Autumn Statement¹ (para. 2.49) and will be introduced through the *Finance Bill 2014*.

1 ohaw.co/1dm5Vso

CENTRAL FUNDING WITHDRAWN

NHS England has confirmed that occupational health assessments for primary care staff should be funded directly by their employers, and not via a central fund. It says that workplace assessments, return to work, capacity and capability issues are all the responsibility of the employer.

Central funding will still be available to those who are on the national performers' list, and who have declared a health issue at or before the point of application to the list.

NURSE REVALIDATION

The Nursing and Midwifery Council (NMC) has launched the first of a two-part consultation on revalidation¹. Part one will run until July this year and will consider how the NMC's proposed model of revalidation can be implemented in a variety of employment settings and practice areas.

Nurses and midwives will be required to revalidate every three years and will be responsible for their own revalidation. Failure to revalidate will mean they will be removed from the register. All nurses and midwives will have to gather evidence of continuing professional development, in accordance with the new NMC code, standards and guidance, which will be published in December 2014. Revalidation is due to start in December 2015.

1 ohaw.co/19Z45wH

TELEPHONE TRIAGE

Rebecca Ghani

There is strong evidence that telephone-based assessments can help facilitate a timely return to work for people with common health problems, a government review into telephonic assessment methods has found. The review, *Telephonic support to facilitate return to work: what works, how and when?*, was commissioned following the government's proposal for the Health and Work Service (HWS), which will provide health and work advice to GPs, employees and employers. The service is set to launch in autumn 2014.

The review provides an evidence base for the use of telephonic methods in four key areas where telephone-based support may be used: assessment and triage; case management; information and advice; and return to work. As well as academic literature, researchers used evidence from professional practice and grey literature sources, and also looked at evidence around implementation issues including safety, acceptability, timing, cost-benefit and required skills.

If well designed and implemented, telephone-based services compare favourably with face-to-face methods, the review finds. It emphasises that this approach works with common cases including musculoskeletal and mental health problems and that it is not intended to be a replacement for standard clinical care. The review states: 'Telephonic contact has a dual role: to identify clients' needs and then signpost them to the right intervention at the right time.' For more complex cases, it suggests that there should be a combination of telephone and face-to-face contact.

There is a heavy emphasis on effective staffing of the service. Positive work outcomes will only be achieved, says the report, if staffed by skilled professionals with appropriate training and support.

The review reiterates that telephonic services should not be used in place of clinical examination and diagnoses, and this relies on professionals having good skills and training, and understanding the limits of telephonic methods. It states that this should mitigate any safety concerns around overlooking serious medical conditions.

It also states that it is critical that work is seen as a health outcome and that 'work participation is the principal focus for the service' – although it notes that clinical outcomes should also be included.

In terms of assessing the clinical and participation needs of people with common health problems by telephone, the evidence for its use in musculoskeletal cases is described as 'robust', while in relation to mental health problems it is 'adequate'. The review finds robust evidence – for both musculoskeletal and mental health problems – that telephonic services work well for triage in terms of allocating people with common health problems to appropriate occupational and clinical management pathways. It also notes that interview 'schedules' will need to be tailored to the health condition.

The review finds robust evidence that case management via the telephone can: support people with common health problems through care pathways; monitor progress; and facilitate return to work. It can also help to manage costs by reducing delays and speeding up referral times. There is also the advantage of ease of access, and efficiency, 'due to telephonic case managers being able to carry higher caseloads'.

There is only adequate evidence to support 'telephonic interventions' – including providing relevant information and advice. It finds that although telephone advice is generally incorporated into a multifaceted intervention package, it is also capable of having a positive effect in isolation. In everyday

practice telephone advice is likely to be augmented by written information, says the review. It also finds adequate evidence that self-management of common health problems can be encouraged and enhanced via telephone contact.

Telephonic approaches are found to be effective in supporting return to work for both musculoskeletal and mental health problems. With early contact, 'a sizeable proportion of cases can be managed successfully without healthcare input by promoting and supporting self-management,' the report finds.

Moving onto implementation, the review finds that there is acceptable evidence that 'telephonic approaches have been demonstrated to be safe when well designed and delivered by well-trained staff.' It acknowledges that while it is impossible to avoid malpractice events, such as incorrect assessment following poor communication, as with other forms of healthcare, training is key to mitigating this risk. To ensure client safety, the review recommends that telephonic assessors have a system which ensures serious musculoskeletal conditions and signs of serious psychological disorders are identified and managed, including highlighting the potential for self-harm and harm to others.

Overall, the review finds that telephonic approaches can work for assessment and triage, as well as case management and return to work. It says the service can facilitate a timely return to work, and can be cost-effective. It warns that this relies on good coordination of the key players – client, employer, in-house OH services and GP – and on services that are well designed and implemented, and staffed by professionals with appropriate skills, training and support.

1 Telephonic support to facilitate return to work: what works, how, and when? London, DWP 2013. ohaw.co/teQrMEY

YOUNG PEOPLE WITH CHRONIC CONDITIONS

Paul Suff

The Work Foundation has published a new study looking at the obstacles faced by young people with long-term, chronic or fluctuating conditions as they seek to make the transition from education to employment¹. It found that the physical symptoms of chronic conditions were a barrier to seeking work, as young people were still learning how best to cope with and manage their condition.

The researchers polled 247 young individuals living with long-term conditions, and the findings highlight the negative impact that sufferers believe their condition has had on their job opportunities and careers. The survey reveals that more than half (57%) of respondents believe their career progression has been negatively impacted by their condition.

The research found that one of the major barriers to young people with chronic conditions successfully entering work was the fluctuating nature of both the physical and psychological symptoms of their condition. Survey respondents explained that their chronic condition could be unpredictable, and their employment had to be sufficiently flexible to accommodate these fluctuations. Also, delays in receiving a correct medical diagnosis and appropriate treatment have implications for young people successfully entering the workforce, as it takes them longer to learn how to live and cope with their condition.

The survey findings also reveal that the majority of respondents who were in work had managers who were supportive of their condition when they disclosed it, and many also provided workplace adjustments. However, just under half of the respondents had not

discussed workplace adjustments with their employer, suggesting, say the authors, that there is still progress to be made in terms of how employers support young people with chronic conditions. Many of those polled report an expectation of discrimination and stigma when applying for jobs.

The study makes several recommendations, including a requirement for the government to raise awareness of, and enforce, existing disability employment legislation. It also recommends that the forthcoming Health and Work Service should be prepared to help young people with chronic conditions.

Employers need to do more to support young people with chronic conditions at work, says the report. Among the recommendations is the need for employers to address the stigma and discrimination both at the recruitment stage and in relation to employees disclosing their health conditions. Training should be provided to managers and employees in organisations to raise awareness of the impact that chronic conditions can have on an individual, and how they can be managed in the workplace, says the report. It also says that employers need to be supportive in identifying and establishing appropriate workplace adjustments.

In her foreword to the report, Dame Carol Black notes that providing young people living with chronic illness with access to healthcare, rehabilitation support and vocational guidance is vital if they are to successfully move into the world of work. 'My hope is that this report will add to the now overwhelming evidence that timely, work-focused interventions by clinicians, other health professionals, career advisors, teachers and employers can mean that good quality jobs and fulfilling working lives are within the grasp

of all young people living with chronic illness,' she writes.

¹ Bevan S, Zheltoukhova K et al. *Life and employment opportunities of young people with chronic conditions*. London: The Work Foundation, 2013. ohaw.co/1dsmaDW

MALINGERING

'Do managers/HR expect you to tell them if an absent employee is malingering?' This was the question posed in our December tea-breaker poll. Over half of respondents (56%) said 'yes', just over a third (35%) said 'no', with the remaining 9% choosing 'other'. Comments included: 'They should realise that nothing happens without a reason – learn from it!'; 'They would like to but know better'; 'Only the bad ones – besides which malingering is not a diagnosis'; and 'Yes, but I won't voice that opinion.'

One practitioner wrote: 'Managers do ask about malingering and often give their opinion about this. However, I report on facts and base my opinion on this. A report would require very careful wording if I suspect malingering. I would only comment on facts with employee consent.'

London, 2013. ohaw.co/1eQrMEY



NHS ABSENCE GUIDANCE

NHS Employers has published revised guidelines¹ on the prevention and management of sickness absence. The guidelines, which have been developed by the NHS Staff Council's Health, Safety and Wellbeing Partnership Group, outline the key principles that health service organisations should follow to prevent and manage sickness absence.

¹ ohaw.co/L742nj

FIT NOTE LETTER TEMPLATE

Rebecca Ghani

To help make more effective use of the fit note, manufacturers' organisation EEF will develop a letter template for employers to send to GPs, describing the adaptations and modifications that could facilitate an earlier return to work for employees. The measure was announced at the first sickness absence summit on the fit note and long-term sickness absence.

The aims of the summit in December 2013 – attended by 24 organisations including the British Medical Association, the Royal College of GPs, the Department for Work and Pensions, and EEF – were to share solutions to help reduce the length of long-term sickness absence, and to agree on the best way for all stakeholders to use the fit note effectively.

The summit was organised following EEF's annual sickness absence survey of its members, which found that the average duration of long-term sickness absence has increased over the past five years, and that an increasing number of employers do not believe that the fit note is facilitating an earlier return to work for employees.

Professor Sayeed Khan, chief medical adviser for EEF said: 'It is important to make the fit note

work better for employees who want to make an earlier return to work. EEF is committed to improving the dialogue between the medical professional and employer. To help this we will develop a template which employees can give to their GP describing the adaptations and modifications their employer can make to facilitate earlier return to work.'

The letter template will be available at no cost to employers, and will provide a framework outlining possible modifications that could help an employee return to work. It will complement the DWP's existing fit note guidance¹ and will be available from mid-April.

¹ ohaw.co/L3DAKN

MENTAL HEALTH FIRST AID

A guide to help line managers deal with employees' mental health issues has been reissued by Mental Health First Aid England¹. It provides advice to employers and line managers about improving support to employees with mental health problems and a framework for creating a healthier environment in the workplace. Topics include: managing an employee experiencing mental ill health; recognising when clinical help is needed; reasonable adjustments; returning to work; and employment legislation.

¹ ohaw.co/KlhjTc

ZERO-HOURS ZERO BALANCE?

Rebecca Ghani

There are approximately one million people (3.1% of the UK workforce) employed on zero-hours

contracts, according to the Chartered Institute of Personnel and Development (CIPD). Its report, *Zero-hours contracts: myth and reality*¹, also found that those on zero-hours contracts were as satisfied with their job as the average UK employee, and more happy with their work-life balance than other workers. But others claim that the uncertainty over income and lack of control over hours and when they will be at work puts zero-hours workers at greater risk to their mental health.

Zero-hours contracts are currently under scrutiny from various bodies, ranging from workers' unions and an inquiry by the Scottish Affairs Committee² into the practice in Scotland, to a consultation by the Department for Business, Innovation and Skills (BIS), focusing on concerns about exclusivity, transparency, uncertainty of earnings, and balance of power in the employment relationship³. The BIS consultation, which ends on 13 March, states that although zero-hours contracts have been used responsibly in some sectors for many years, there are cases when they are used incorrectly and individuals are exploited.

*The Workplace Employment Relations Survey*⁴, commissioned by the government, found that 8% of employers had some staff on zero-hours contracts in 2011, compared with just 4% in 2004. It also found that: 19% of the hotel and restaurant sector use zero-hours contracts, up from 4% in 2004; the health sector had the second highest proportion at 13%, up from 7% in 2004; and the education sector had 10% in 2011, compared with 1% in 2004.

Commenting on the government's consultation, Neil Carberry, CBI director of employment and skills, defended the arrangement. 'Zero-hours contracts offer a choice to those

who want flexibility in the hours they work – such as students, parents and carers – and provide a stepping-stone into the jobs market for those most vulnerable to long-term unemployment,' he said.

Unite the union disagrees about the impact of zero-hours contracts on workers. Speaking to *Occupational Health [at Work]*, Susan Murray, Unite national health and safety adviser, said: 'With the high level of insecurity comes the risk of bullying, harassment and stress which are likely to affect workers' health and safety.'

Murray cited a survey commissioned by Unite – based on 5,000 respondents – which found that 76% of people on zero-hours contracts feel anxious about being on a zero-hours contract. It also found that: 72% would not be on a zero-hours contract if they had a choice; 58% had spoken out about their contract; 50% had asked their employer for a regular formal contract with set hours; and 46% who had spoken out have experienced bullying or harassment as a result.

Regarding OH services, Murray said: 'Unite expects all employers to provide high quality occupational health services for all their employees.'

We asked fast-food company McDonald's, which employs 90% of its staff on zero-hours contracts, about OH provision. A spokesperson said: 'There is no difference in access. Occupational health is provided on a case-by-case basis to those who require it.' The company also confirmed it provides night-work health assessments to all workers, regardless of contract type, and that all pregnant employees are given a pregnancy risk assessment. Regarding uncertainty about hours, McDonald's said that, at the latest, employees are given notice of their weekly schedule on the preceding Thursday.

Sports retailer SportsDirect also employs many staff on zero-hours contracts but would not comment when asked about its provision of OH services across its workforce.

Legal rights

The term zero-hours contract, although widely used, does not have a specific meaning in law, and as such, is open to mixed interpretation. The CIPD, in its report, *Zero-hours contracts: understanding the law*⁵, offers its own definition of the contract type: 'An agreement between two parties that one may be asked to perform work for the other but there is no set minimum number of hours. The contract will provide what pay the individual will get if he or she does work and will deal with the circumstances in which work may be offered (and, possibly, turned down).'

The report notes that all workers are entitled to the right to health and safety in the workplace. However, the entitlement to benefits and protections depends on whether an individual is defined as a 'worker' or an 'employee' – rather than whether a zero-hours contract is being used. For example, an employee is entitled to: the right not to be unfairly dismissed (after two years' service); statutory redundancy pay (after two years' service); and statutory maternity, paternity, adoption leave and pay, says the report. However, a worker who is not an employee does not have these benefits. In terms of statutory sick pay (SSP), the HMRC states that 'part-time, casual and temporary employees can also get SSP as long as they meet the qualifying conditions.'⁶

Regardless of rights and benefits, could being on a zero-hours contract itself create health issues? Mark Beatson, chief economist at the CIPD says: 'Undoubtedly, some people will find the uncertainty over future hours implicit in a zero-hours contract a

source of worry if it is their only source of income and they have significant and regular financial commitments such as rent or mortgage payments to meet and/or dependents to look after.

'For them, the stress is likely to be magnified if hours offered vary greatly from week to week and if work tends to be offered at very short notice. However, other people may view the same working arrangements very differently. The ability to vary hours from week to week – and to turn work down – will be seen by some as a plus, putting them in control of their working arrangements.'

Beatson adds that because of these differences in opinion, employers should 'avoid making blanket assumptions about the impact of zero-hours contracts' and should mitigate any adverse impact through sensible management as outlined in CIPD guidance. He says this should include 'transparency about the arrangements and how they will work in practice, sensible forward planning and periodic reviews of how they are working.'

¹ Chartered Institute of Personnel and Development. *Zero-hours contracts: myth and reality*. London, 2013. ohaw.co/KlIkfP

² Parliament. *Scottish Affairs Committee launches new inquiry into zero-hours contracts*. London, 2013. ohaw.co/1kBuS6J

³ Department for Business, Innovation and Skills. *Consultation: zero-hours employment contracts*. London, 2013. ohaw.co/1d5LOlv

⁴ UK government. *The 2011 Workplace Employment Relations Study (WERS)*. London, 2013. ohaw.co/1gJhpE5

⁵ Chartered Institute of Personnel and Development. *Zero-hours contracts: understanding the law*. London, 2013. ohaw.co/1m44tg4

⁶ HM Revenue and Customs. *Statutory Sick Pay: an overview*. ohaw.co/19tQyWB [accessed 13 January 2013]



CONSENT TO TEST BLOOD OF DEAD BODY

John Ballard

The High Court has ruled that it was lawful for samples to be taken from a dead body in order that a medical practitioner who had administered first aid could have the deceased's blood tested for bloodborne disease, when only a fairly distant relative was available to provide appropriate consent¹. Under the *Human Tissue Act 2004* (HTA) it is unlawful to take, store or use tissue or blood from a deceased person without them having consented in advance of their death or without the consent of a person with a sufficiently close 'qualifying relationship' with the deceased.

CM is a medical practitioner and while off duty saw a woman, EJ, lying motionless on the pavement. It was obvious that EJ was seriously injured and CM attempted emergency first aid. This was unsuccessful and EJ died at the scene.

On returning home about an hour later, CM noticed that she had various abrasions on her hand. She commenced a course of post-exposure prophylactic (PEP) antiviral medication to reduce the risk of HIV infection, but sought early permission for EJ's blood to be tested by the coroner. This would enable her to determine if she was at risk of a bloodborne infection and whether she should continue with the PEP.

EJ was a foreign national, with only one relative, OP, in the UK. OP consented to the blood sample being taken but CM was concerned about the legality of taking the sample, particularly as OP was not the next of kin – he was a cousin of EJ's mother – and applied to the High Court for the matter to be settled.

The collection, removal,

storage or use of human tissue without consent is an offence under the HTA, and, according to the accompanying Code of Practice², this includes tissue or blood removed, stored or used for the purpose of 'obtaining scientific or medical information, which may be relevant to a person including a future person' (para 72(iv)).

The Code (in para 84) also states: 'If there is no one available in a qualifying relationship to make a decision on consent (and consent had not been indicated by the deceased person or nominated representative), it is not lawful to proceed with removal, storage or use of the deceased person's body or tissue for scheduled purposes.' Coroners do not have power to consent to samples being taken 'for the benefit of a third party'.

High Court judge Stephen Cobb held that in the circumstances, it was not reasonably practicable to seek the consent of EJ's parents – they were in fact unaware of her death at the time of the hearing – but that in the absence of any closer relatives, OP did fall within the definition of a 'qualifying relationship'.

Cobb granted permission for the sample to be taken and tested for bloodborne disease, and for CM to be informed of the results. He took account of the importance of 'respecting the integrity of the deceased's body prior to burial or cremation' but noted the particular circumstances that had led to the request for a blood sample. 'CM's request only arises in this case because she undertook an act of great humanity in attempting to save EJ's life,' he said.

'I am conscious that if this testing were not to be undertaken, CM would live for

the foreseeable future in a state of profoundly anxious uncertainty as to whether she had contracted a serious, life-threatening illness. This would doubtless affect not only her personal wellbeing, but also her ability to treat other patients in the context of her highly skilled profession. I also bear in mind that CM herself is suffering the harmful side effects of the antiretroviral medication,' said Cobb.

Subsequent tests revealed that EJ was not carrying a bloodborne disease and CM was able to stop taking the PEP drugs.

¹ *CM v Executor of the Estate of EJ (deceased) and Her Majesty's Coroner for the Southern District of London*. [2013] EWHC 1680. ohaw.co/1dFWRZY

² *Human Tissue Authority Code of Practice 1: consent*. London: HTA, 2009. ohaw.co/KR4G7J

HOW LONG IS TOO LONG?

John Ballard

An appeal court in Scotland, the Court of Session (CoS), has held in *BS v Dundee City Council*¹ that an employment tribunal did not address correctly four key issues when deciding how long a reasonable employer would wait before dismissing an employee absent on long-term sick leave. The adequacy of OH advice was a key feature of the case.

BS had been employed by Dundee CC for 35 years. His GP signed him off work on 9 September 2008, initially for 'nervous debility' and later depression and anxiety. He remained off work until his dismissal on 23 September 2009.

BS had been interviewed by police on 9 September 2008 – and later charged – in connection with a serious allegation by a woman with whom he had

recently ended an affair. This led to problems with his marriage and eventual separation, and was the trigger for his ill health. The charge was formally dropped in May 2009 after a police investigation.

BS was referred to the occupational health service, OHSAS, in January 2009 – and several times after – and told the OH adviser about the charge. He did not reveal this to the woman responsible for managing his absence, administration team leader Wilma Hutchinson, but did tell her that he was temporarily separated from his wife and was receiving support from his GP.

In June 2009, Hutchinson wrote to BS expressing her opinion that the reports from OHSAS were of little value as an indication of his progress – according to the judgment ‘they were all in similar terms with almost no change in content from one assessment to the next’ – and said that she was going to request that he be seen by a doctor rather than a nurse. Her concerns were not conveyed to OHSAS and, on 8 July, BS was again assessed by an OH nurse.

Meanwhile, the council received information that BS may have been charged with a criminal offence and a meeting was set up in July to investigate this, in accordance with the disciplinary policy. It was attended by BS and his union representative, Hutchinson, an HR officer and a manager. The employment tribunal found that the meeting was not handled sensitively and that BS had felt humiliated by it. It also found that while BS’s GP had noted that his demeanour and outlook had improved dramatically once the charges had been dropped, the July meeting had set back his recovery.

A further meeting was held in August to discuss the latest OH report and BS’s return to work (RTW). BS said he was still not able to come back as he was on anti-depressants and sleeping tablets. The council gave him a RTW date of 14 September and said that failure to meet this could lead to dismissal. There would be a pre-return assessment by OHSAS. On 7 September, the OH nurse advised that BS remained unfit for work but arranged for him to be seen by an occupational physician.

The physician, Dr Jon Spencer, reported on 14 September that BS’s health was improving and that while he was not yet fit for work he was not permanently incapacitated. He would expect BS to come back to work within one to three months and would be happy for him to return ‘when his GP issues a final certificate’. He also recommended a phased RTW.

BS did not return on 14 September and informed the council that he had been signed off for a further four weeks, until 12 October. Hutchinson invited BS to a meeting on 23 September that would consider terminating his employment. At that meeting BS stated he was doing everything possible to facilitate his RTW, but that he was not feeling any better, and was no further forward than at the previous meeting.

Hutchinson was under the impression that Spencer’s RTW estimate of one to three months was conditional on BS being issued with a final medical certificate from his GP. There had been no ‘final’ certificate and Hutchinson concluded that he was unlikely to return either in the ‘short term’ or ‘foreseeable future’. She decided to dismiss him. She also concluded, in light of Spencer’s findings, that BS was

not eligible for ill-health retirement as this would have required him to be permanently incapacitated.

BS’s internal appeal hearing, on 28 October, was unsuccessful so he brought a claim for unfair dismissal.

Tribunal decision

The employment tribunal noted that the reason for dismissal was ill health, which affected BS’s ability to do his work, and capability was a potentially fair reason for dismissal under section 98(2) of the *Employment Rights Act 1996*. But was it reasonable to dismiss him?

The tribunal was critical of the OH nurse’s reports, which it observed ‘could best be described as perfunctory’. Each had said the same thing and none had properly addressed the ‘critical question’ of when a RTW might be expected. Most simply stated that he was not fit for work and that he would be absent for another eight weeks, or possibly less.

Turning to Spencer’s report, the tribunal found that no reasonable employer would have dismissed BS only nine days after an occupational physician reported that he would return within one to three months. It held that Hutchinson had no medical evidence to support her belief that BS was unlikely to return to work in the ‘short term’ or the ‘foreseeable future’. In fact, her conclusion that, by the dismissal meeting on 23 September, he was no further forward was inconsistent with Spencer’s opinion that his health was improving. And if she really did think that the issuing of a ‘final’ sick note was relevant to Spencer’s RTW prediction then she could have asked OHSAS to clarify with the GP whether or not the certificate running to 12

October was in fact the final one.

The tribunal said that no reasonable employer would dismiss an employee with 35 years' service 'without first clarifying the true medical position'. It also noted that the council was a large employer, with 8,000 staff; temporary workers were available to take on the work at no extra cost to the employer; and that BS was no longer being paid, having exhausted his sick pay. The employer should have waited, at the very least, until it had ascertained via OHSAS when the GP expected to issue a final certificate. The dismissal was unfair.

Dundee CC took the case to the Employment Appeal Tribunal (EAT), which overturned the tribunal's decision and ordered that the case be remitted to a fresh tribunal. BS appealed to the CoS.

Appeal judgment

The CoS noted three important themes from two previous cases – *Spencer v Paragon Wallpapers Ltd*², and *Daubney v East Lindsey District Council*³. It said:

(1) 'Where an employee has been absent from work for some time owing to sickness, it is essential to consider the question of whether the employer can be expected to wait longer.'

(2) 'There is a need to consult the employee and take his views into account. We would emphasise, however, that this is a factor that can operate both for and against dismissal. If the employee states that he is anxious to return to work as soon as he can and hopes that he will be able to do so in the near future, that operates in his favour; if, on the other hand he states that he is no better and does not know when he can return to work, that is a

significant factor operating against him.'

(3) 'There is a need to take steps to discover the employee's medical condition and his likely prognosis, but this merely requires the obtaining of proper medical advice; it does not require the employer to pursue detailed medical examination; all that the employer requires to do is to ensure that the correct question is asked and answered.'

The CoS found that the tribunal had not properly addressed the balancing exercise required when deciding the first issue – whether or not the employer should have waited longer before dismissing. It did find that temporary staff were available, that BS was no longer being paid, and that Dundee CC was a large organisation and better able to absorb costs than a small one, but these observations did not go far enough to answer the question. 'Against all of these considerations, however, it would be necessary to set the unsatisfactory situation of having an employee on very lengthy sick leave,' the CoS observed.

On the second issue, the council had consulted repeatedly with BS and he had been made well aware before the September meeting that his employment was under threat. Importantly, BS's own evidence did not suggest that an imminent RTW was likely – he said he was no better and no closer to returning. The tribunal, however, had largely ignored BS's views and instead placed emphasis on Spencer's report – ie that a return was likely within three months. The tribunal should in fact have balanced the opinion of the occupational physician against that of the employee.

On the third issue, the CoS said that the tribunal had placed too much emphasis on the need

to obtain further medical evidence. The employer already had a report from Spencer, continuing sick notes from the GP, and the views of the employee himself. 'Against that background, it is difficult to see how further medical advice could clarify matters,' it said. The question remained: would a reasonable employer, armed with this information, have concluded that the employee was unlikely to return in the foreseeable future?

The CoS then addressed a fourth issue: the relevance of BS's 35 years' service. Length of service is relevant in misconduct cases – a long unblemished record is often a mitigating factor. The situation is less clear-cut in ill-health dismissals, said the CoS.

'In an appropriate case, however, it may show that the employee in question is a good and willing worker with a good attendance record, someone who would do his utmost to get back to work as soon as he could,' it said. 'The critical question in every case is whether the length of the employee's service, and the manner in which he worked during that period, yields inferences that indicate that the employee is likely to return to work as soon as he can.'

The tribunal had not addressed that question and merely treated length of service as 'automatically relevant', the CoS found.

The CoS held that the judgment of the tribunal 'was lacking' in respect of the four key issues. The case would be remitted to the original tribunal to consider these issues.

¹ *BS v Dundee City Council*. [2013] CSIH 91. ohaw.co/1df4aLJ

² [1976] IRLR 373.

³ [1977] IRLR 181.



Meet the practitioner

Dr Bernadette Paver

OH on the Falkland Islands



How would you sum up your role? With the help of a secretary and an advanced nurse practitioner I am running the first independent OH company in the Islands, providing a range of services to the public and private sectors which includes ENG1 [Seafarer medical certificate] medicals, offshore medicals, vaccination clinics, health surveillance programmes, case management and company medicals.

Why/how did you get into OH initially? During the 19 years that I worked here as a general practitioner I dealt with a number of people suffering from burnout and work-related stress. I became interested in occupational medicine, did the Society of Occupational Medicine two-week course in 2010 and then was asked to take on the running of the Falkland Islands Government OH service.

How did you get your current role? I ran the government OH service for 18 months and then decided to set up separately as the government was keen to privatise the service.

What is a typical case in your practice? Company medicals – usually fairly straightforward, but I have to bear in mind what can safely be accommodated here – with a moderate number of stress-related management referrals.

What geographical area do you cover? Technically, the whole of the Falklands – which is the size of Wales – but, in practice, mainly Stanley (2,000 people) and the civilian population at the Mount Pleasant military base. I am the only Maritime and Coastguard Agency approved doctor in South America and conduct ENG1s for ships working in Falkland Islands territorial waters.

What are the particular challenges? The main challenges are the weather – regular storm-force winds that close roads – and the remoteness. There is not only the question of whether an individual is fit to do their job but also whether it is safe for them to do it in this particular remote setting, where the only hospital on

the Islands has 28 beds and is staffed by five GPs, a surgeon and an anaesthetist, with no other resident consultant staff. Patients with serious medical problems are either flown to Chile or to the UK.

Do you provide OH services for particular professions? Local and UK-based seafarers, but also nationals from Chile working on UK-registered ships (I speak Spanish); offshore oil and gas; company medicals for the service industry at the military base; and, increasingly, the construction industry.

What are the most unusual OH issues you have dealt with? So far, it was for the government of South Georgia and the South Sandwich Islands. It involved medicals for about 10 personnel – carpenters/plumbers who were all going down to South Georgia for eight months to renovate one of the old Norwegian whaling stations. With only one keen young doctor and no possibility of aeromedical evacuation, I had to be as sure as possible that all health issues had been dealt with before they disappeared down south.

How do you see your role changing? Compared to practice in UK, OH here is still in its infancy. There is virtually no health and safety legislation, some employers are only dimly aware of their responsibilities while others – eg the fledgling oil industry – are very aware. So I hope to become more involved with the offshore industry but also to help local businesses adjust to the UK standards, which are likely to be thrust on them. I also want to encourage more management referrals with emphasis on prevention rather than dealing with OH-related issues once they have developed.

Would you recommend your role to a graduate UK doctor? Yes and no! No because they might take business away from me! But yes if you would like to work in a remote part of the world with little legislation and minimal backup – although I have found far more help and advice available in the world of OH than there ever was from the world of general practice.

In the first of a new series, Occupational Health [at Work] meets Dr Bernadette Paver, occupational physician and director of Medical South, OH providers in the Falkland Islands.

Questions by
Rebecca Ghani

Collaborative research

Occupational health practitioner and academic research collaboration – can it work?

Occupational health practitioners are ideally placed to identify contemporary 'real-world' research questions and facilitate studies but rarely get involved in research. In this article OH practitioner and PhD student Karen Coomer examines the benefits of, and barriers to, practitioner–academic collaboration and what needs to be done to encourage these mutually beneficial relationships.

RESEARCH is a common word used by occupational health (OH) practitioners and academics. Conferences across the world have the best people in the academic field presenting their latest findings in a scientific fashion. Research articles are written and published, predominately by the academic community, in many different journals and websites. The expectation of OH practitioners is to read, listen and apply the 'latest research' to practice. OH professional Helen Kirk¹, for example, recently found that more than 90% of OH nurses were of the view that implementing evidence-based care is important to the advanced nurse practitioner role.

Moreover, a similar proportion indicated that participation in research would be an important future requirement of the practitioner role. There is little argument then that research, in the context of evidence-based practice, is seen by practitioners as a core component of their professional practice and yet active research by OH practitioners is not a common activity.

OH practitioners have a valuable contribution to make to the design and execution of OH research, but in reality rarely get involved with academic studies. If research is to be of relevance and practical use in the workplace it is arguable that practitioners should be involved. So why is it not common practice for researchers, academics and practitioners to carry out research together? The divide that exists has its roots in different priorities, ways of working and the benefits of the eventual outcomes for both parties. This article explores the barriers that exist, and ways in which they can be broken down in order that academics and practitioners can work together effectively.

THE PRACTITIONER SIDE

Practitioners usually have busy jobs which are dominated by the objectives and priorities of the organisations in which they work. Whilst conducting literature searches and applying research in practice is common, designing, conducting and evaluating research is often not part of the day job. What are the reasons for this?

Identifying the problem

OH practitioners are well placed to identify the organisational problems that need answers and can have a holistic sense of the problem from many different layers of the organisation and their own practical experience. They may even have a hunch as to how to solve the problem and/or understand causality. However, this approach can seem vague and woolly to the academic who will instead start by defining the research question – usually by seeking the key variables through a comprehensive literature review that incorporates both theory and evidence.

A barrier can therefore develop if the same issue is seen through different lenses without a mutual appreciation of different skill sets. A successful collaboration has no place for either party to feel a sense of deference to each other. One of the strengths of a successful relationship is the acknowledgement that each party will have a different approach to the issue and can therefore contribute in different ways.

Knowledge of the research process

Curiosity about how, why and what is necessary to improve health and prevent ill health is an asset in OH practice. The knowledge of how to convert that curiosity or 'hunch' into a formal scientific research design is all too often beyond the knowledge or experience of OH practitioners. This is particularly relevant to OH nurses who are often not taught research skills to the standard required to demonstrate an outcome acceptable to the constructive criticism of the larger OH community. Regression analyses, mediating and moderating variables and confidence intervals are not everyday language for the OH practitioner. It is, therefore, not surprising that a review of papers published in the journal *Occupational Medicine* from 2006 to 2011 found that universities and research-focussed organisations contribute most new UK occupational health evidence². Furthermore, OH nurse practitioner-led research has contributed only two papers to the peer-reviewed journal, *Occupational Medicine*, in recent times^{1,3}. In order to understand the perspective of the academic and 'the research

question', an understanding of the research process and language is therefore needed to ensure that the OH practitioner is enthusiastically involved rather than being merely a confused observer.

Time and pace

Research is time-consuming and an OH practitioner with time to spare during the working day is a very rare thing. The negotiation to create the time necessary to conduct research against all the other priorities of a business can outweigh the initial enthusiasm, effort and energy.

Another factor is the incompatibility of the pace at which business organisation's work and academic research is conducted. Waiting months for a decision from an ethics committee or the results from complex statistical analysis can risk losing the stakeholders' initial enthusiasm for the study as today's problem can all too easily become yesterday's issue.

Models of OH delivery

With the increasing trend of outsourcing occupational health there has been a decline of the generic in-house OH role in favour of measurable OH activities, easily purchased like a menu. The focus is often related to legislative and business need, which very rarely includes research. As a review of papers published in the journal *Occupational Medicine* demonstrates, in the last decade no papers arose from the work of established specialists employed by the large commercial providers of OH services². From the commercial OH provider's perspective, there is little incentive to undertake research, as it is questionable as to whether it can make a profit and, indeed, can cost the provider money for no apparent benefit. It is no surprise then that most OH providers do not offer research as a commercial OH product.

Commercial sensitivity

The results of research conducted within an organisation can be contentious from a commercial and internal public relations point of view. It takes a robust and secure organisation to report negative research results, particularly if the next question is: 'What action are you going to take?' For the OH practitioner it can be disheartening if, after months of burning the midnight oil, no action is taken, and there is no publication or acknowledgement, because the results do not match expectations or are viewed as too 'sensitive'.

THE ACADEMIC SIDE

Unlike the OH practitioner, research for the academic is an essential part of the day job. The pursuit of new knowledge and a deeper understanding of a topic or issue is what academics do. If it is accepted that there

is a role for research to be accessible and applicable in the real world then it makes sense for both parties to work together. From an academic perspective why is this not common practice?

Research Excellence Framework

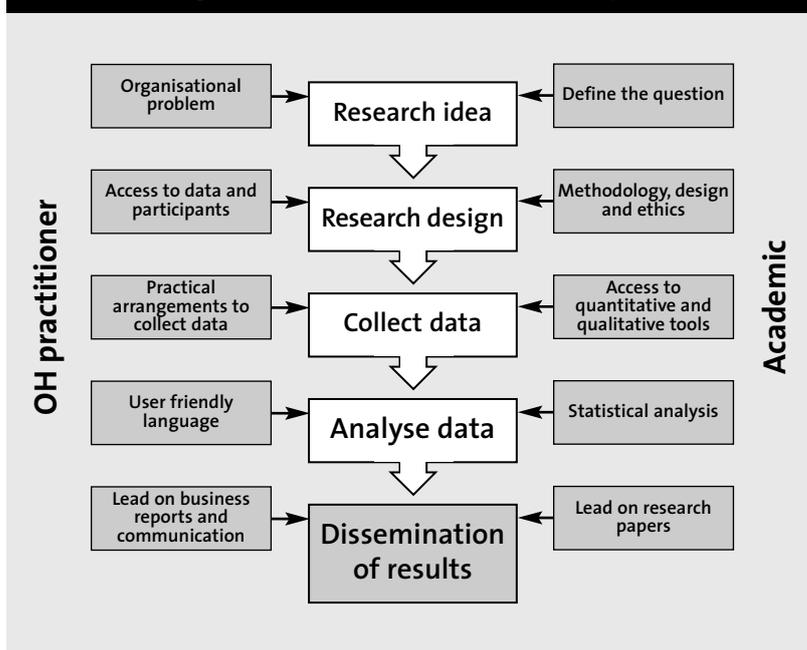
In the UK, the system for assessing the quality of research in higher education institutions – Research Excellence Framework⁴ (REF) – drives much of the research funding process. The REF assessment evaluates research outputs, impact and research environment in a five-year cycle. Academic researchers are therefore required to build up a portfolio of work which takes them into the next cycle of assessment. The demonstration of research outputs are typically in the form of articles published in 'top tier' academic journals which often have exceptionally high standards of quality and rigour with regard to research design. Herein lays a barrier that may well discourage academic-practitioner collaboration.

The research design

Publication, in academic journals, as a demonstration of research activity is unlikely to be an initial key priority for OH practitioners. This is not so for the academic because, as explained above, it counts towards his or her research output. It is therefore important that the research design is worthy of an academic paper and so inevitably it will influence the methodological approach to the research.

Top-tier journals often prefer studies that involve large participant samples, as a small sample size can increase the margin of error when mathematical procedures are used to test the reliability of the study and generalise the results to a larger population. However, gaining access to large employee populations can be difficult and so in reality organisational OH research may involve small participant samples. Furthermore, practitioners may prefer to use single-item measures. This is where one question, instead of a set of multiple questions, is used to capture information, which can reduce the time required to complete a survey and encourage a good response rate. For employee-based research single-item measures are therefore practical as they are quick and easy. From an academic theoretical perspective the question is whether they are a reliable predictor of the information reported; and for this reason are sometimes frowned upon by academic journal reviewers. Academic journal editors' preference for state-of-the-art research, design and analysis can therefore present a problem for the academic who has to decide whether it is worth the commitment to carrying out practice-led research if the consequent results cannot be written up for submission to the more prestigious academic journals.

Model showing the different roles in the research process



Dissemination of information

For the OH practitioner, dissemination of research for practical application is a sensible objective. Publication in a practitioner-based journal, and in the form of a short business report, may be preferred over publication in an academic journal, which is unlikely to be read by many other practitioners. This is because one of the problems with many academic journals is the inaccessibility to practitioners, unless they subscribe or pay per article. Practitioners also may not have the time to keep up with the large volume of research published, which may or may not be relevant. Research articles offer a factual account of the research which those unfamiliar with academic language may find rather dry and lifeless. To engage organisational stakeholders and the practitioner community, dissemination of research needs to be attractive and easy to read, using plain English rather than technical academic language.

For the academic the focus is different. The REF process drives the academic to publish in academic journals with high 'impact factors'; ie those whose articles are most frequently cited in other journals. The citation frequency is often used as a proxy for the relative importance of a journal within its field and so by implication indicates the quality of its authors.

For the OH professional, who agrees to co-author a paper as part of the deal for collaboration, there are some challenges ahead, which may be beyond the skill set and experience of some practitioners if required to write at this level.

When submitting a paper to an academic journal there will be a peer-review process, which is standard

practice to an academic. However, working up an article to the standards and perfection that is required by this process is no easy task. It is time consuming and requires a thick skin when overly critical reviewer comments are considered. For the OH practitioner, this process can seem unnecessary and complicated and can dent the enthusiasm for even the most resilient individual. In addition, the time frame from submission, peer review and acceptance to eventual publication can be up to a year. For the academic it is the rules of the game, but for the more practically minded practitioner who is used to a quick turnaround this can be frustrating.

A WAY FORWARD

At the University of Nottingham, academics have addressed the lack of OH practitioner research by actively pursuing the notion of the 'mutually beneficial research group'⁵. Much of this research has been conducted in the context of the MSc in Workplace Health and Wellbeing. This course provides for the needs of occupational health (and safety) practitioners who wish to advance their knowledge and skills on the management of contemporary challenges to workplace health and wellbeing. Students have tackled and published practitioner-orientated journal papers on topics as diverse as sun safety behaviours among construction workers⁶, relationship between overtime and psychological wellbeing⁷, the BMI profile of UK firefighters⁸, predictors of attendance at a worksite HIV voluntary counselling and testing service⁹, and work-related stress among prison officers¹⁰. Furthermore, at the University of Nottingham accessibility to published articles has been facilitated by an open access fund that removes the barrier of affordability and the need to subscribe to journals; an arrangement that has helped to promote the author's own research among the practitioner and academic communities³.

There are other examples of different models in which OH research is conducted and published. The British Occupational Health Research Foundation (BOHRF) and the Health and Safety Executive (HSE) have published stand-alone reports accessible to all. The Department of Work and Pensions (DWP) regularly publishes serial reports on subjects such as GPs' attitudes to health and work¹¹, and the Centre for Workplace Health (CWH) in Sheffield¹² has moved the emphasis away from the academic discipline of occupational medicine to multidisciplinary working, which includes practitioners. There are also excellent examples of academic-practitioner collaboration in the pages of practitioner-orientated journals, as the recent example of the recommendation to vaccinate welders against pneumonia demonstrates¹³.

For academics and practitioners to work together outside the boundaries of an academic course, there needs to be a commitment to work collaboratively from the genesis of a research idea to an outcome understood by all. The OH practitioner has the front-line experience of identifying the problem in the first place, and has access to organisational data and the stakeholders that can facilitate the research process. The practitioners can also be in the workplace encouraging participation, collecting the data and keeping the stakeholders up to date with progress. In return, the academic can ensure the research idea is methodologically sound and can take the lead on data analysis and the write-up of research papers. The model shown on p.16 summarises the different roles each party can take in the process.

WORKING IN COLLABORATION

Practitioner–academic collaborations may have much to offer both parties. The projects that arise out of mutually beneficial research groups have the potential to address issues that occupational health practitioners face in the contemporary workplace. It is important for such research to be shared with the wider occupational health community. Dissemination of research outcomes to inform best practice can be at different levels, and communicated in different ways to satisfy the needs of both the academic and OH practitioner. Practitioners may lack the confidence or skills necessary to design and analyse research and to write up the findings for journals. For this reason, a working relationship with an academic who can provide methodological expertise and is well versed in the process of technical writing can be beneficial as a learning process.

These types of relationship can help to keep the researcher connected to the realities of organisational life, aware of current OH priorities and challenges, and engage with the very people their research is designed to inform. It can also provide the academic with valuable data that can form the basis of not only practitioner-orientated journal articles but also the purely academic ones necessary for the requirements of the Research Excellence Framework.

Finally, it should be noted that academic–practitioner relationships can be rewarding! They are usually characterised by a collaboration of equals in which both parties bring their own experiences and perspectives to the table and in this way contribute to the development of their own and the other's knowledge and skill base.

Karen Coomer is an occupational health nurse practitioner, director of KC Business Health Ltd, and a PhD student at the University of Nottingham.

CONCLUSIONS

- **There** is a divide between OH practice and research due to different priorities and the benefits to each party
- **Active** research is not part of the day job for the majority of OH practitioners
- **The Research** Excellence Framework may prioritise 'perfection' in research design over the pragmatism required for real-world organisational research
- **There may be** little incentive for academic researchers to publish in practitioner-orientated journals
- **The combination** of practitioners' and academics' knowledge and skills can result in important applied OH research

Acknowledgement

The author gratefully acknowledges comments received on a draft of this article by Dr Jonathan Houdmont, lecturer in occupational health psychology at the University of Nottingham.

Notes

1 Kirk H. *The role of advanced nursing practice in occupational health. Occupational Medicine* 2012; 62(7): 574–577.

2 Preece R. *Who contributes to the occupational health evidence base? Occupational Medicine* 2012; 62(1): 57–59.

3 Coomer K, Houdmont J. *Occupational health professionals' knowledge, understanding and use of work ability. Occupational Medicine* 2013; 63: 405–409.

4 *The Research Excellence Framework. www.ref.ac.uk*

5 Anderson N, Herriot P, Hodgkinson G. *The practitioner-researcher divide in industrial, work and organizational (IWO) psychology: Where are we now, and where do we go from here? Journal of Occupational and Organizational Psychology* 2001; 74: 391–411.

6 Madgwick P, Houdmont J, Randall R. *Sun safety measures among construction workers in Britain. Occupational Medicine* 2011; 61: 430–433.

7 Houdmont J, Hassard J, Zhou J. *Overtime and psychological wellbeing among Chinese office workers. Occupational Medicine* 2011; 61: 270–273.

8 Munir F, Clemes S et al. *Overweight and obesity in UK firefighters. Occupational Medicine* 2012; 62 (5): 362–365.

9 Houdmont J, Munir F, Grey M. *Acceptance of repeat worksite HIV voluntary counselling and testing in a rural South African factory. AIDS Care* 2013; 25(9): 1199–1202.

10 Bevan A, Houdmont J, Menear N. *The Management Standards indicator tool and the estimation of risk. Occupational Medicine* 2010; 60 (7): 525–531.

11 Hann M, Sibbald B. *General practitioners' attitudes towards health and work. Department of Work and Pensions 2011: Research report no. 733.*

12 *The Centre for Workplace Health. ohaw.co/1f45mRh*

13 Palmer K, Cosgrove M. *Vaccinating welders against pneumonia. Occupational Medicine* 2012; 62(5): 325–330.

Protecting the sexual health of workers

Sub-Saharan Africa and other high HIV prevalence regions

When industry bases its employees in high HIV prevalence areas, what is the role of OH, particularly when workers have little access to primary care? Rebecca Ghani looks at when sexual health becomes a workplace issue.

WORKERS who live away from home for their work often require a particular package of occupational health (OH) services, ranging from immunisation against infectious diseases and protective equipment to cope with hostile environments, to counselling support on their return home¹. But there is also a wider public health role for OH professionals in protecting their employees from out-of-hours hazards, particularly in environments where workers have little access to primary care. This could include exposure to sexually transmitted infections (STIs) and human immunodeficiency virus (HIV) associated with local risk factors, including using the services of sex workers. While not strictly an occupational hazard, for some working populations – including the armed forces and mining industries – sexual health and the use of sex-worker services is an acknowledged issue.

HIV/AIDS in particular presents a very real threat not only to workers' health but also to commercial activity. The global oil and gas industry association for environmental and social issues, the International Petroleum Industry Environmental Conservation Association (IPIECA) says, for example: 'This growing and very real business issue must be carefully and responsibly managed to maximise the protection afforded to our employees, and to minimise the social, business and economic impacts on oil and gas industry operations.'

This article therefore discusses the importance of sexual health promotion and the role of OH professionals. It examines the population risks and focuses on working populations in Sub-Saharan Africa and other high-prevalence regions where, arguably, the approach to the sexual health of workers should reflect the greater risks of transmission.

RISK FACTORS

Prevalence of sexually transmitted infections, and HIV in particular, in the local population is a key risk factor for industrial populations, and Sub-Saharan Africa bears a significant burden. Based on World Health Organization (WHO) regions, HIV prevalence among adults aged 15 to 49 across Africa is 4.6% (4.9% in

Sub-Saharan Africa) compared with a prevalence of 0.4% across Europe, 0.5% across the Americas, and 0.8% globally².

Workers in high-prevalence regions are therefore at greater risk of HIV infection, and when coupled with high-risk behaviours, including use of sex-worker services, the risk increases again. A WHO study estimated that 106,000 deaths from HIV in 2008 resulted from female sex work globally, 98,000 of which occurred in Sub-Saharan Africa³.

This risk increases again in industries where large numbers of men work away from home for long periods of time in industrial settings. Mining is an example of such an industry: in Australia, for example, men are estimated to make up 97% of the blue-collar mining workforce⁴; and a study by the National Institute of Health in Mozambique found that the HIV prevalence among mineworkers in Mozambique was 22.3%, against a prevalence of 11.5% in the general adult population in that country⁵.

IPIECA states that the risk of HIV/AIDS transmission for employees is linked to programmes of work that separate employees from their partners for extended periods of time. Other risk factors include: a sudden increase in economic activity, 'particularly in areas of high unemployment or where income of expatriates is high compared to that of local workers'; a migrant workforce that permanently alters the demographic of an area; and activities that involve regular transport of materials across distances⁶.

OH INTERVENTIONS

Businesses with large away-from-home industrial populations often include STI- and HIV-prevention in their employee health strategies – recognising the health (and business) risks of a workforce and community exposed to an increased level of STIs. For example, BP has had a global HIV/AIDS policy since 2002⁷, and Shell has a company-wide HIV/AIDS programme. The Shell programme includes the provision of medical treatment and prevention programmes for employees, their families and communities as well as a mandate of non-

Key principles of the ILO Code

- **Recognition of HIV/AIDS as a workplace issue.**
- **Non-discrimination:** in the spirit of decent work and respect for the human rights and dignity of persons infected or affected by HIV/AIDS, there should be no discrimination against workers on the basis of real or perceived HIV status.
- **Gender equality:** more equal gender relations and the empowerment of women are vital to successfully prevent the spread of HIV infection and enable women to cope with HIV/AIDS.
- **Healthy work environment:** the work environment should be healthy and safe, so far as is practicable, for all concerned parties, in order to prevent transmission of HIV, in accordance with the provisions of the Occupational Safety and Health Convention, 1981 (no. 155).
- **Social dialogue:** the successful implementation of an HIV/AIDS policy and programme requires cooperation and trust between employers, workers and their representatives and government.
- **Screening for purposes of exclusion from employment or work processes:** HIV/AIDS screening should not be required of job applicants or persons in employment.
- **Confidentiality:** there is no justification for asking job

applicants or workers to disclose HIV-related personal information.

■ **Continuation of employment relationship:** HIV infection is not a cause for termination of employment. As with many other conditions, persons with HIV-related illnesses should be able to work for as long as medically fit in available, appropriate work.

■ **Prevention:** HIV infection is preventable. Prevention of all means of transmission can be achieved through a variety of strategies which are appropriately targeted to national conditions and which are culturally sensitive.

■ **Care and support:** solidarity, care and support should guide the response to HIV/AIDS in the world of work. All workers, including workers with HIV, are entitled to affordable health services. There should be no discrimination against them and their dependants in access to, and receipt of, benefits from statutory social security programmes and occupational schemes.

Note: taken from an ILO code of practice concerning HIV and AIDS and the world of work. Geneva: International Labour Organization 2001. ohaw.co/1gvodoC

discrimination against infected employees.

A leading HIV prevention programme is run by the diamond mining company Debswana in Botswana. Between 1996 and 1999, Debswana looked at HIV-related admissions to its hospitals, and found that HIV/AIDS-related morbidity and mortality were on the increase among its employees⁸. Following this, and after an extensive communications programme, Debswana undertook a voluntary and anonymous survey of employee HIV seroprevalence. The survey, which had a 74.6% participation rate, found that over a quarter (28.8%) of employees were infected with HIV. This highlighted an immediate need for a company-wide prevention and treatment plan. Debswana stated that 'without such a strategy, the company could not survive.'

As well as a comprehensive education programme and an 'openness' agenda, a key component of the strategy was the provision of antiretroviral (ARV) drugs to both HIV-positive employees and 'their one legally married spouse'. This was pioneering in that it was one of the first company-sponsored programmes in Africa to provide ARV treatment to its workforce. The UNAIDS case study report suggests that the 'open atmosphere, management concern and continued interventions [were] all having an influence' in helping to reduce prevalence⁸.

Debswana carried out a second survey in 2001.

Compared to 1999, there was a decline in prevalence from 28.8% to 22.6% in 2001. A further survey in 2007 found that 21% of permanent employees and 22.6% of contract employees were HIV positive, underlining both the scale and longevity of the problem⁹.

A separate study into the Debswana programme found that ARV therapy provision had produced a positive effect on absenteeism¹⁰. It found that while employees enrolled in the scheme initially had significantly higher absence than non-enrolled (ie healthy) employees, this was followed by a large reduction in absenteeism at six to 12 months after treatment initiation. In subsequent follow-up, at years one to four, absenteeism was found to be low and similar to non-enrolled workers. The authors suggest, therefore, that ARV drugs had been effective in improving workers' health and their ability to work.

Using worker attendance as proxy for productivity, the paper concluded that an ARV treatment programme is effective in 'restoring the productivity of infected workers over a considerable duration', and additionally, that provision of treatment can be cost-effective.

DISCRIMINATION

Ensuring non-discrimination against workers because of their actual or perceived HIV status is crucial to the success of any occupational intervention. According to

IPIECA⁶, it is ‘the cornerstone of any effective HIV workplace programme, underpinning campaigns to promote the take-up of voluntary counselling and testing as well as treatment’. It also says companies need to go beyond paperwork and policies. Its guidance states: ‘To be fully effective the active endorsement of senior management who “walk the talk” is needed centrally, regionally and locally.’

The principle of non-discrimination or stigmatisation against workers with HIV is also central to the 2010 International Labour Organization (ILO) *Recommendation concerning HIV and AIDS and the world of work*¹¹ and its 2001 Code of Practice¹² (see box on p.19). This seeks to prohibit mandatory screening for HIV at recruitment or during employment, but recommends that employers offer confidential, voluntary HIV counselling and testing, provided by qualified health services.

Compulsory screening is not only impractical and unethical, but it also sends a discriminatory message that there is a risk in employing workers who are HIV positive, undermining any non-discrimination education programme. Voluntary testing for existing employees, however, is encouraged to ensure appropriate treatment can be given.

PUBLIC HEALTH AT WORK

When industrial populations and local communities overlap, for example in the mining, gas and oil industries, there is also a shared responsibility for public and occupational health services. To what extent does industry have a responsibility to the wider community, and is this a moral, or an economic imperative?

Occupational Health [at Work] spoke to Dr Femi Oduneye, a public health specialist, and a regional health manager at Shell Nigeria, to discuss these issues. (His comments here are his personal views in his capacity as a public health specialist, and not on behalf of Shell.)

Oduneye is adamant that the sexual health of employees is a topic that employers with large industrial populations need to address: ‘The reality is that if you have a large population of men – or women – that are away from home for long periods, the use of sex workers will be an issue,’ he says.

He believes that occupational health is an important partner to public health authorities in tackling STIs and HIV in places where there are large numbers of workers linked to a particular industry. ‘It is important that OH and public health authorities collaborate on managing sexual health issues for workers and the wider community,’ he says.

He explains the relationship: ‘The occupational health professionals can educate; they can put in place interventions to do with the workers – while the

public health physician can begin to look at the root cause of that arrangement itself,’ he says. The public health function would also look at wider community issues such as inequality, poverty, education, exploitation and abuse, he says.

Oduneye acknowledges the difficulty of tackling risky personal behaviour – for example, the use of sex worker services – with employees who work in high-risk industries. ‘I remember having a conversation with somebody from the army who said to me – on one hand you want them to go out and do their [dangerous] job – and on the other hand you don’t want them to take risks like smoking and having sex,’ he recalls. People who risk their lives as part of their work may, understandably, not respond well to public health interventions. ‘It’s just not well-aligned,’ he says.

Given the realities of away-from-home workers and their use of the sex industry, the question is how to make the interactions safe. ‘Sex itself is not the issue,’ says Oduneye. ‘The issues are what I refer to as the complications of sex – which could be STIs or pregnancy. So it’s about how to minimise the risks. That’s why education, and the use of condoms and contraception is important.’

But is it an employer’s responsibility to look beyond specific work-related health issues? Oduneye says that while it is not a statutory responsibility, it is a duty of care that is important. ‘If employers are interested and care about their employees then they will put in place mechanisms to protect them,’ he says. ‘You’ve got to go beyond just paying salaries and getting people to come in and work.’ As well as raising awareness, good practice, therefore, would also be to provide education and condoms.

SEEKING HELP

Stigma and fear of discrimination – by colleagues and managers – are common reasons why employees may shy away from seeking help from occupational health on the issue of STIs. That is particularly the case if a worker contracts HIV. Oduneye says health interventions should go hand-in-hand with strict confidentiality and firm anti-discrimination policies. ‘The main reason that people don’t want to speak out is fear of how others will react,’ he says, ‘so the services must be confidential.’

‘HIV and AIDS is no different from any other chronic condition now. There’s very good treatment available,’ he says. ‘So there is no valid reason why anyone who is HIV positive in the workplace should be discriminated against, just as any person with any particular illness, [such as] diabetes, hypertension [or] hepatitis B.’

Oduneye says employers must take a very strong position on discrimination. ‘Because you cannot, on

one hand, preach diversity and inclusiveness – and on the other hand discriminate against people with chronic conditions. Those two positions are not compatible.’

JUST FOR EMPLOYEES?

Following the establishment of its global HIV/AIDS policy in 2002, BP set up a HIV-prevention project at its operation in Tannguh, a remote area of the Papua province in Indonesia⁷. The project recognised the reliance of the project on indirect employees and contractors – and ensured that they were included in the HIV/AIDS workplace programme.

Oduneye agrees with this approach. ‘My view is that this should be open to everyone,’ he says. ‘It does not make sense to compartmentalise your health promotion initiatives – because people do not work like that. They work closely, they go out together, they are out in the field together. We cannot necessarily separate contractors from employees – so why would you want to separate them when it comes to health promotion interventions?’ he asks.

Furthermore, says Oduneye, an exclusive health service in an area like sexual health is doomed to fail. ‘Look at it from an epidemiological point of view: if you protect your folks but not the subcontractors and contractors that are infected, you cannot win that battle, because you’re still maintaining the pool of infected people,’ he says.

To make an impact, Oduneye believes that employers must work with subcontractors and the local community. ‘That’s if we’re serious about really addressing the issues, and we’re not just trying to tick a few boxes,’ he says.

Sexual health of employees should be prioritised according to the risk, in the same way as any other occupational hazard. While provision of testing, sexual health clinics and condoms, along with education, are important to any industry that has a large away-from-home industrial population, employers should also focus on the non-discrimination agenda to help to remove the associated stigma of HIV infection. This, along with open and straightforward communication, and proper assurances of confidentiality, can facilitate the uptake of voluntary testing, the early seeking of treatment, and improved awareness and understanding – ultimately leading to a reduction in occupation-related STIs and HIV/AIDS, and a healthy and productive workforce. ■

Rebecca Ghani is news and features writer at Occupational Health [at Work].

Notes

¹ Patel D. Workers abroad. Part 2: the role of occupational health. *Occupational Health at Work* 2008/2009; 5(4): 26–30.

CONCLUSIONS

- **Workers** in countries with high HIV prevalence are at raised risk of infection, and employers should consider what they can do to protect the health of workers, particularly in industries with large away-from-home populations
- **A study** by the National Institute of Health in Mozambique found that the HIV prevalence among mineworkers in Mozambique was 22.3%, against a prevalence of 11.5% in the general adult population
- **Providing** antiretroviral therapy to workers at the Debswana mining company in Botswana was not only of direct benefit to the individuals, but also helped reduce long-term absenteeism
- **The ILO Recommendation and Code of practice on HIV and AIDS in the world of work** seek to prohibit mandatory screening for HIV at recruitment or during employment to avoid discrimination
- **The Recommendation and Code** also encourage confidential voluntary screening for existing employees to enable access to treatment
- **A mandate** of non-discrimination against infected employees is a key element of a corporate HIV/AIDS policy, helping to reduce stigma and encourage testing and treatment

² *Data on the size of the HIV/AIDS epidemic. Data by WHO region by WHO region.* Geneva: WHO, 2013. ohaw.co/HxoLLF

³ Prüss-Ustün A, Wolf J et al. *HIV due to female sex work: regional and global estimates.* Geneva: WHO, 2013. ohaw.co/19CR2hy

⁴ Murray G, Peetz D. *Coal rushes: progress report on women miners, miners' women and their communities.* Brisbane: Griffith University, 2007. ohaw.co/1cRpcoQ

⁵ Baltazar C, Young P. *HIV prevalence and risk factors among Mozambican mineworkers working in South Africa, 2012.* Kuala Lumpur: IAS, 2013. ohaw.co/1a7As8K

⁶ OGP-IEECA Health Committee. *HIV/AIDS management in the oil and gas industry.* London: IPECA/OGP, 2005. ohaw.co/1bbmDUG

⁷ DeYoung P. *Developing an HIV prevention strategy for an oil and gas construction project in a remote area of Papua province in Indonesia.* Geneva: World Economic Forum, 2004. ohaw.co/1cEeFTW

⁸ Barnett T, Fantan T et al. *The private sector responds to the epidemic: best practice collection Debswana – a global benchmark.* Geneva: UNAIDS, 2002.

⁹ *HIV/AIDS programme milestones, 2007.* Debswana, ohaw.co/1b9cp8H

¹⁰ Habyarimana J, Mbakile B. *The impact of HIV/AIDS and ARV treatment on worker absenteeism: implications for African firms.* Columbia University, 2009. ohaw.co/19CX3e5

¹¹ *Recommendation concerning HIV and AIDS and the world of work. ILO recommendation no. 200.* Geneva: International Labour Organization 2010. ohaw.co/HJErOE

¹² *An ILO code of practice concerning HIV and AIDS and the world of work.* Geneva: International Labour Organization 2001. <http://ohaw.co/1gvodoC>

Hygiene matters

The health and future of the occupational hygiene profession

Steve Perkins and president-elect Mike Slater answer questions on how the occupational hygiene profession can best serve industry and forge closer ties with other OH professions in the post-industrial era.

It might be argued that UK occupational hygiene had most to offer industry and the workforce during the years of large-scale manufacturing, heavy industry, mining and energy production. *Occupational Health [at Work]* asked BOHS chief executive Steve Perkins and president-elect Mike Slater how the profession should move forward in this post-industrial era.

What would you say is the single most important issue for contemporary occupational hygiene to tackle?

Steve Perkins (SP): ‘The latest HSE statistics show that 13,000 people die each year from occupational diseases which are preventable with the application of good occupational hygiene practice. These figures dwarf the 148 dying from workplace accidents. Furthermore, there is the spectre of an *increasing* occupational cancer burden, with a warning from Dr Lesley Rushton from Imperial College, that, in the absence of action, annual deaths from preventable occupational cancers in 2060 will have risen by 5,000 more than the current level of 8,000. Tackling this occupational disease burden to protect the workers of today and tomorrow is the single most important issue.’

How can occupational hygiene take on emerging risks – particularly psychosocial issues? Are occupational hygienists equipped to address these issues?

Mike Slater (MS): ‘Traditionally, occupational hygiene has been concerned with controlling exposure to hazards such as chemicals and dusts, and to physical agents such as noise and vibration. Most occupational hygienists are not currently involved in managing psychosocial risks, but occupational hygiene is about protecting worker health and it needs to encompass all relevant hazards, so this is something we need to address. In my view there are two things we need to do. First, the occupational hygiene community should seek to embrace those who have experience of addressing these emerging issues. BOHS should welcome everyone involved in preventing ill health at work under its broad umbrella of “worker health protection”. Secondly, although I believe professional occupational hygienists have the analytical and problem-solving skills, they don’t have the underlying knowledge

to assess and manage psychosocial factors and we need to find ways of incorporating this within our skill set.’

With the economy oriented to the service sector, coupled with the decline of manufacturing, mining and heavy industry, is there still an opportunity to grow the occupational hygiene profession in the UK?

SP: ‘Yes, most certainly. In fact, during 2013 BOHS membership grew by 10%. Although the world of work is changing, workers in both the traditional and new sectors are exposed to health hazards. Large numbers of people are still employed in high-risk sectors such as construction, car paint spraying, baking and recycling, where they are exposed to hazards such as harmful dusts, respirable crystalline silica, asbestos, isocyanates, asthmagens such as flour dust, chemicals and so on. There are health risks in most workplaces including those in the service sector. For example, in retail, workers are at risk from musculoskeletal injuries. The need for occupational hygiene is as great today as it ever has been, and as a profession we have to recognise that the types of risks are changing and ensure we adapt and develop our competencies to be able to address them effectively.’

MS: ‘In terms of growing the profession, there is a large number of people who practise elements of exposure control, not full time but as one aspect of what they do. I believe that BOHS must reach out and welcome everyone who plays a role in preventing ill health at work – whether that’s full time or part time.’

How can BOHS and the other professional bodies make the case that health and safety regulation should not be seen as a burden on business, but something that can make workplaces not only safer but also more productive?

SP: ‘According to the latest HSE statistics, occupational ill health currently costs the UK economy at least £34bn. Keeping staff healthy and in work can only be a good thing from a financial perspective and there is evidence which shows that businesses can actually save money by implementing good occupational health and hygiene solutions. The 2012 Olympic Park and village project is a prime example of this. Cost–benefit analysis showed the benefits of employing occupational

Questions by John Ballard

hygiene experts to prevent ill health far outweighed the cost. The net benefits were estimated to be around £7million – a £7 saving for every £1 invested.’

The number of HSE enforcement actions has declined dramatically over the past decade¹. Does BOHS believe that occupational health and safety can flourish without rigorous health and safety enforcement?

MS: ‘We believe that the UK requires a strong and politically independent organisation to act as the nation’s work-related health and safety watchdog, and robust enforcement is a vital part of that. However, 2014 will begin with the HSE struggling to deliver on some of its statutory duties hindered by cumulative budget cuts and a trend of reducing specialist occupational health and occupational hygiene resources. It is, therefore, apparent that a new approach is needed and we suggest priorities should be re-evaluated, including how the HSE approaches workplace inspections.’

Can you suggest how that could be achieved?

MS: ‘We would like to see the HSE’s inspectors giving more emphasis to those hazards that can cause occupational diseases – like silica, wood dust, carcinogens and asthmagens. In workplaces where workers are potentially at risk from such hazards, a critical evaluation of the controls being used is required, as they are often lacking or poorly designed. To do this, general inspectors would probably need more in-depth training to improve their knowledge of these issues, as well as the support of specialist occupational hygienists.’

How do you make the business case for occupational hygiene – can’t the work be done by more generalist health and safety practitioners, perhaps at lower cost?

MS: ‘There is definitely a role for more generalist health and safety practitioners in protecting workers from exposure to health hazards. The number of qualified occupational hygienists is limited and health and safety practitioners, OH nurses and others certainly have a key role in identifying health hazards. With the appropriate training, they can do a certain amount to monitor and assess exposures and recommend appropriate controls. One of our roles should be to help them to do this, but there will always be a need for specialist support. However, a generalist’s knowledge is broad, and they can’t be experts in everything. So there is inevitably a point where the issues become too complex and require the skills of specialists, for issues such as fire and explosion, ionising radiation and occupational hygiene.’

The BOHS has voiced its concern over the toll of work-related ill health, which, as you say, exceeds 13,000 deaths a year in Britain. But how do you transform concern into action that will help reduce this burden?

SP: ‘We face a huge task as we strive to convert this

evident need for change into a demand for real practical preventative solutions. Encouragingly, we are beginning to notice a gentle groundswell in awareness of occupational disease, with the HSE and some of the other professional bodies highlighting certain exposure issues. However, making a real impact is going to take everyone – workers, employers, government and ultimately, the wider public – pulling together.’

MS: ‘We plan to work with other stakeholders on an initiative which tackles, head on, the burden of ill health from occupational disease, and the associated disability and long-term impact on sufferers. Watch this space for further details!’

Much of this disease burden will have been caused by past exposures, but Britain, like other post-industrialised countries, is arguably exporting hazardous exposure to developing countries, now manufacturing goods destined for the UK. What can BOHS do to address hazardous exposure in the wider, global context?

SP: ‘We recognise this and we are committed to doing what we can to spread knowledge and understanding about occupational hygiene around the world, including through our International Partners scheme. In addition, the BOHS Faculty has been heavily involved in developing the international occupational hygiene modules which provide a framework and resources for the dissemination of occupational hygiene education globally, through the Occupational Hygiene Training Association’.

Is there still a need for a distinct occupational hygiene organisation, and one that is clearly demarcated, say, from IOSH? In any case, should hygienists work more closely with other occupational health professionals?

SP: ‘Occupational hygiene is unique in that it is science-based and focuses on disease prevention. As a discipline it’s been around for many years – Lord Robens recognised occupational hygiene as pivotal in his report in 1972 leading to the *Health and Safety at Work etc Act 1974*. Occupational hygienists are specialists with knowledge and skills acquired over many years and maintained through ongoing CPD. Through its Faculty, BOHS is responsible for the education and training of competent hygienists, which is a role no other body could fulfil. The Society’s recent award of a Royal Charter is testament to its unique and pre-eminent role. We do, however, recognise the importance of working with other organisations in the field. We complement each other and will only be successful in addressing the challenges we all face by working together through partnerships.’

Is occupational hygiene a good career choice?

MS: ‘For someone who is a good communicator, has an interest in/understanding of science, and wants a career that allows them to actually make a difference, occupational hygiene could be the career for them.’

Notes

¹ A total of 8,810 enforcement notices were issued by the HSE in 2012/13 compared with 13,263 in 2002/03. Source: HSE Annual Statistics report for Great Britain, 2012/13, and Health and safety statistics highlights 2002/03. Bootle: HSE 2003 and 2013.

Health screening at recruitment

Part 2: health questionnaires, declarations, medical reports and cost–benefit

In part 2 of our exclusive 2013 survey of employers' policies and practice in pre-employment health screening, Occupational Health [at Work] editor John Ballard examines the reasons for carrying out health screening at recruitment, GP reports and medical examinations, how much time practitioners spend doing recruitment health screening and whether or not it is worth the time and effort.

PART 1 of this report on employment practice on pre-employment health assessment¹ revealed that the vast majority of employers are now asking job applicants or new recruits to complete health questionnaires or declarations after a conditional job offer or before starting work – in keeping with their duties under the *Equality Act 2010* (EqA). It also found that significantly fewer questions are now included in questionnaires compared to when the survey was first carried out in 2006^{2,3}.

The second part of the report examines the main purposes for carrying out health screening at recruitment, requests for GP reports and medical examinations, quality assessment and review, how much time practitioners spend doing recruitment health screening and whether or not they consider the results justify the time and resources spent on it. It also reveals OH professionals' views on using genetic testing as part of the recruitment process.

The survey results are based on the responses of 164 practitioners, predominantly OH nurses (75%) and occupational physicians (18%) from the NHS, other public sector (ie excluding NHS), commercial OH providers, other private sector and the military, and from in-house and outsourced OH services. Where respondents work for a commercial provider or have more than one employer, they were asked to answer most of the questions with respect to one main organisation. The detailed methodology was presented in part 1.

MAIN AIMS

There are many and varied reasons why an organisation might wish to carry out some form of health assessment either before confirming a job offer, or at least before the individual starts work. Survey respondents were asked to state the main reasons for using health questionnaires or declarations in their organisations. They could select any of 10 options (table 1 on p.26).

By far the most common reason for using pre-employment or pre-placement health questionnaires or declarations is to identify where the individual might need adjustments to work or the working environment because of a disability or health condition, cited by 82% of all respondents – a similar figure to that recorded in 2006.

In 2006, the most commonly cited reason for using questionnaires or declarations was to assess the applicant's/new recruit's ability to undertake the duties of the post, which was cited by 91% of respondents. In 2013, just over half of respondents (53%) say this is an important reason.

Only 4% of respondents in 2013 say the purpose is to advise managers of likely future attendance – down from 26% in 2006.

Just under half of respondents now say that health questionnaires or declarations are useful to provide a baseline health record (46%) or to advise managers on fitness to work (44%) – fewer than in 2006 (64% and 73%, respectively).

WHAT'S IN THE QUESTIONNAIRE?

In part 1, it was reported that the vast majority of surveyed organisations (88%) either use pre-employment or pre-placement health questionnaires or declarations. But what questions are asked?

Simple health declarations

According to survey respondents nearly one in three organisations (31%) do not use complex health questionnaires at all, but ask applicants or recruits to complete a simple declaration of health, with no other specific health questions.

There is no overall sector effect on whether or not the organisation uses a simple health declaration ($p =$ non-significant). However, 44% of NHS respondents say that only simple health declarations are used, compared with 39% of commercial providers, 29% of employers in the other public sector and 20% in the other private sector.

A case example of a simple health declaration is included in box 1 (see p.25).

Generic questions

Although some organisations have dispensed with detailed recruitment health questionnaires, they are still used by many others. The types of questions can be either general – such as age, current medications, eyesight and whether or not the individual takes regular exercise – or specific, where applicants or recruits are asked to state if

they have a particular named condition, such as diabetes, hand–arm vibration syndrome (HAVS), or asthma. Survey respondents were asked to state the general questions in their health questionnaires.

The 12 most frequently asked general questions in 2013 and 2006 are given in table 2 on p.26 (the complete data are included in supplementary table 2a⁴). Key findings include:

- just as in 2006, the most commonly asked general question in 2013 is age or date of birth
- for NHS respondents, the most frequently asked question in 2013 is vaccination/immunisation history – 70% of NHS respondents compared with 39% for all employers. The trend was the same in 2006, though the figures were higher (95% of NHS employers, compared with 57% of all employers)
- in 2006, 80% of questionnaires asked about previous hospital admission or surgery – in 2013, this is included in just 27% of them
- in 2006, three out of four employers (75%) asked about the applicant's/recruit's sickness absence record; in 2013, just one in five (21%) ask this question
- compared with 2006, far fewer organisations now ask about: height and weight; alcohol consumption; smoking habit; and family health history.

Symptoms and conditions

The Information Commissioner's guidance on handling workers' health information under the *Data Protection Act 1998* states that pre-employment and pre-placement health questionnaires should 'only elicit information that is relevant and necessary'⁵. Processing answers to a plethora of health questions irrelevant to the role is thus likely to be unlawful.

In the 2006 survey, 52 paper-based pre-employment questionnaires were returned with the survey responses. These questionnaires together included 160 different specific conditions, symptoms or syndromes that workers were required to indicate whether they currently, or had ever, suffered from. The most common specific conditions were tabulated – for example, 97% of questionnaires asked candidates if they had diabetes, and 85% if they had a hearing condition or impairment. The 2013 questionnaire listed the 40 most commonly cited conditions (in alphabetical order) from the 2006 table and asked practitioners to select those that were currently named in their pre-employment questionnaires. The top 16 specific conditions are shown in table 3 on p.27, with the full breakdown given in supplementary table 3a⁴. Key findings are as follows (note that the analysis *only* applies to organisations that do ask about specific health conditions and/or symptoms):

- asthma, allergies, diabetes, skin conditions, musculoskeletal disorders, back complaints and mental

Box 1: case example – simple health declaration – NHS trust

This NHS trust uses a simple health declaration form ('part A') for all workers, and an additional section ('part B') only for those workers involved in direct patient care or laboratory workers involved in handling samples. The form also includes a section for the manager to complete giving details of the job, manager's contact details and whether or not the risk assessment identifies the need for health surveillance (eg exposure to noise or respiratory sensitisers). It also asks for consent for the previous OH records to be 'copied and used to assist in the assessment for your new position'. The form is marked 'confidential to OH'.

Part A has four questions:

- Do you have any illness/impairment/disability (physical or psychological) which may affect your work? If yes, please give details with dates.
- Have you ever had any illness/impairment/disability, which may have been caused or made worse by your work? If yes, please give details with dates.
- Are you having, or waiting for treatment (including medication) or investigation at present? If yes, please provide further details of the condition, treatment and dates.
- Do you think you may need any adjustments or assistance to help you to do the job? If yes please give details.

Part B includes a detailed list covering the worker's vaccination record, infectious diseases and blood test results.

health feature highly in the data from 2013, following a similar pattern to 2006

- asthma and allergies have replaced diabetes as the most commonly asked-about conditions
- among NHS respondents, 70% say their organisation asks specifically about tuberculosis; 50% about bloodborne viruses; and 50% about latex allergy. These proportions compare with 18%, 19% and 23% respectively among all employers, reflecting the greater significance placed on these conditions in the healthcare environment
- around one in five organisations (18%) continue to ask individuals if they have colour vision impairment, compared with two in five (38%) in 2006
- additional comments suggest that some organisations target the more specific questions at particular categories of workers. For example, an OH nurse working in the NHS explains that questions relating to bloodborne viruses are only addressed to workers carrying out exposure-prone procedures, while those concerning diarrhoea, skin and ear infections are only asked of those doing food handling.

Excessive or plainly bad?

Part 1 of this report revealed that most organisations are now using slimmer, more focussed health questionnaires or simple health declarations. However, judging by some of the questionnaires submitted to the journal, this is not always the case.

One pre-placement questionnaire from a large

Table 1: the main purposes of questionnaires/declarations

Rank 2013	Rank 2006	Purpose	% of employers 2013	% of employers 2006
1	2	To identify where individuals might need adjustments to work or working environment	82%	81%
2	1	To assess ability to undertake duties of post	53%	91%
3	4	To provide baseline health record	46%	64%
4=	3	To advise managers on fitness to work	44%	73%
4=	5	To identify if applicant/new recruit might be covered by EqA or Disability Discrimination Act 1995	44%	64%
6	n/a	To trigger further investigation (eg medical examination or more detailed questions)*	30%	n/a
7	6	To provide health advice to individuals	23%	36%
8	7	To exclude people unfit for post	13%	35%
9=	8	To advise managers on likely future attendance	4%	26%
9=	9	To assess suitability for pension fund	4%	11%

* Not ascertained in 2006 survey.

Note: based on 116 respondents in 2013 and 187 responses in 2006.

Table 2: frequently asked general questions

Rank 2013	Rank 2006	Type of question	% of employers 2013	% of employers 2006
1	1	Age/date of birth	74%	93%
2	5	Disabilities	71%	77%
3	14	Current medical conditions	70%	51%*
4	3=	Medication (current/ongoing)	62%	80%
5	2	Past medical history	50%	88%**
6	11	Occupational history	46%	63%
7	10	Work-related health conditions	40%	66%
8	13	Vaccination/immunisation history	39%	57%
9	8=	Alcohol consumption	33%	69%***
10	7	Eyesight	32%	70%
11	8=	Smoking	31%	69%***
12	3=	Previous hospital admission or surgery	27%	80%

* This wording was changed: in 2006 it read 'current medical record'.

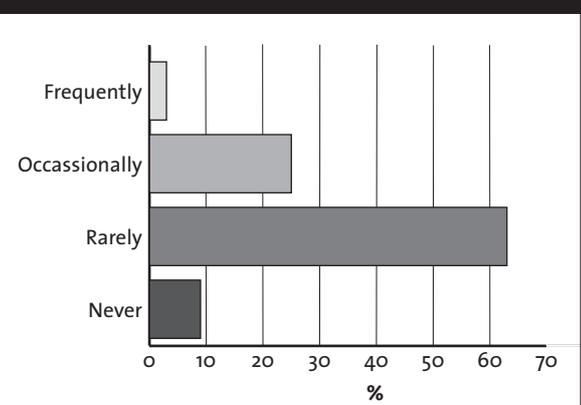
** In 2006 the wording read: 'medical history (general health)'.

*** Smoking and alcohol consumption were combined in a single category in 2006.

Note: based on 114 respondents in 2013 and 187 in 2006. Some of the most frequently asked questions in 2006 (eg sickness absence: 75%) do not feature in the top 12 for 2013.

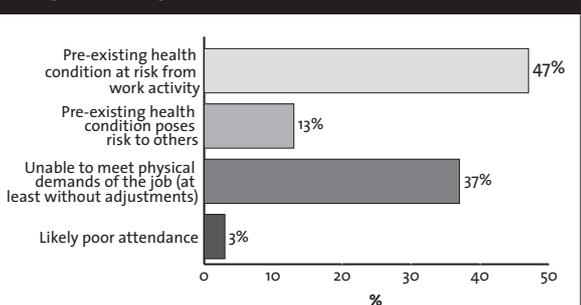
manufacturing firm has 89 health-related questions, plus 47 about occupational history, in addition to personal identification questions. It includes general questions about hobbies and pastimes, sports and exercise, smoking

Figure 1: how often are applicants considered unfit for the job, or fit but only with adjustments?



Note: based on 110 responses.

Figure 2: what is the most common reason for applicants being considered unfit or fit but only with adjustments?



Note: based on 30 responses.

and alcohol consumption and substance misuse. There are 11 questions on family history (ranging from anaemia to epilepsy and tuberculosis), which asks for the family relationship and details.

It also asks if the individual is disabled, has a work-limiting health condition, previous workplace adjustment, rejection or discharge from work due to ill health, workplace accident or work-related condition, compensation for work-related injury/condition, travel abroad and sickness absence over past two years. The work history section includes questions on whether the individual has ever worked with a range of substances and processes (eg asbestos, isocyanates, welding, radiation, noise) and which personal protective equipment they had previously been issued with (eg ear muffs, gloves, respirators). A list of 63 specific health questions covers everything from varicose veins and rectal bleeding/black stools, to eczema, epilepsy, anxiety, depression, insomnia, high/low blood pressure, back problems, diabetes, tingling/numbness in fingers, menstrual or pregnancy problems, hearing loss and alcohol/drug problems (repeated from an earlier section). The questionnaire is to be returned to the OH department.

Another questionnaire asks if the candidate has a disability, has ever had to give up work due to a medical condition, a work-related condition, and any of 50 specific questions, including weight and height, colour blindness, tinnitus, hay fever, high/low blood pressure, angina, anaemia/haemophilia, depression/anxiety, dysentery, hernia, tennis/golfer's elbow, current medication and sickness absence over the past five years. As well as warning candidates that giving false information 'may render me liable to dismissal', they are asked to consent to the following statement:

'I give my consent for the occupational health nurse/advisor and/or doctor to reveal to company management any medical fact that may have a bearing on my own personal health and safety and that of others as long as I am employed.'

This questionnaire is to be returned in a 'confidential envelope' to the personnel officer.

Both questionnaires might be judged as 'excessive' in light of the Information Commissioner's code of practice on workers' health information⁵ and requesting blanket consent for an indefinite period is unethical (see *Discussion on p.34*).

OUTCOMES

As we have seen, there are various potential reasons for carrying out pre-employment or pre-placement health screening, including determining if the individual is fit for the work or fit with adjustments. Survey respondents were asked to state how frequently candidates were considered unfit for the job on the basis of the health questionnaire or declaration and what were the main reasons for someone being considered unfit or fit but only with adjustments. Highlights include that:

- in two-thirds of respondents' organisations it is rare for a job applicant to be found unfit for the job, or fit but only with adjustments (see figure 1 on p.26)
- the most likely reasons for advising that a person is unfit for the work, or fit but only with adjustments, is that a pre-existing health condition would put the individual at risk from the work activity, or that the individual would be unable to meet the physical demands of the job, at least without adjustments (see figure 2 on p.26)
- only rarely is a person deemed unfit, or fit with adjustments, because the health condition would pose a risk to others or due to likely poor attendance.

FAIRNESS

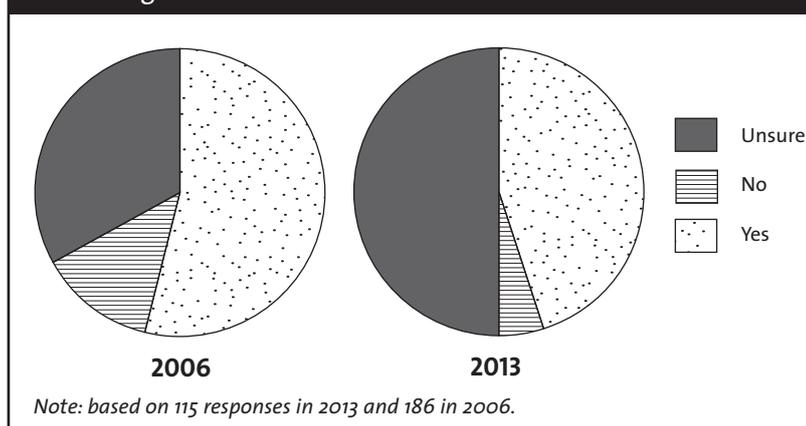
It is rare in most organisations that a job applicant will be denied employment on grounds of their health. However, should this be the case, good practice is to allow the individual a chance to challenge the decision to ensure that it is fair and not based on misinformation or misinterpretation. The survey results reveal that such an appeal mechanism is available in just under half of

Table 3: frequently asked symptoms and conditions

Rank 2013	Rank 2006	Condition/symptom	% response 2013	% response 2006
1=	2	Asthma/bronchitis	79%	95%
1=	8=	Allergies	79%	85%
3	29=	Musculoskeletal disorder	73%	27%*
4	3=	Skin condition/eczema/dermatitis	70%	90%
5=	1	Diabetes	63%	97%
5=	3=	Mental health conditions	63%	90%
7	3=	Back pain/condition	61%	90%
8	6=	Heart/circulatory problem	58%	87%
9=	8=	Blackouts/fits/faints/giddy spells	56%	85%
9=	6=	Epilepsy	56%	87%
11=	10=	Depression	53%	80%
11=	10=	Mental illness/psychiatric disorder	53%	80%
13	10=	Anxiety	51%	80%
14	8=	Hearing loss	46%	85%
15	14=	Eyesight/vision disorder	44%	70%
16	20=	Stress/stress-related illness	42%	45%

**Note: based on 75 respondents in 2013 and analysis of 52 questionnaires provided to us in 2006.*

Figure 3: is there an appeal mechanism for those denied recruitment on health grounds?



organisations – similar to that recorded in 2006 (figure 3). However, half of those answering the question are unsure of the situation in their organisation or at the employer where they provide OH services.

Lying or withholding information

How an organisation approaches cases where it later emerges that an individual has lied or withheld relevant and requested health information provided at recruitment

Box 2: is pre-employment health screening a useful tool that justifies the time and resources invested in it?

- 'Pre-employment health screening is essential in order to get a baseline health record and to be able to prevent any harm to the individual and to others' (*occupational physician, other public sector*)
- 'Exposure to certain agents or substances can cause greater susceptibility to developing occupationally induced diseases. For example, a diabetic on insulin and using hand-held vibratory tools is at greater risk of developing HAVS than someone without diabetes. It allows the control measures to be implemented correctly' (*OH nurse, food and drink sector*)
- 'It asks masses of largely irrelevant questions, it does not alter the recruitment decision, it is time consuming and only very occasionally are there any adaptations needed. I have decided to scrap the big questionnaire and go for the simple non-medical disability-related questions on the job acceptance form, as this will meet our needs more effectively' (*OH nurse, higher education*)
- 'I work on a relatively small site of 480 employees. Whilst I have encountered very few incidences where fitness for role was an issue, I contact those with long-term medical conditions [identified by the screening] to discuss further, with regard to fitness and adjustments. It allows me to promote the work and purpose of the OH unit and serves as an introduction to an often misunderstood service' (*OH nurse, commercial provider, food and drink industry*)
- 'If there were no situations in which health affected work, and vice versa, there would be no need for OH provision – this is clearly not the case. It would be farcical to pretend that there is no relevance to establishing any health-related need prior to day one of employment' (*occupational physician, insurance industry*)
- 'Essential for safety critical roles, health professionals and emergency services staff. But of little value in white-collar roles' (*OH nurse, healthcare*)
- 'As our screening is carried out on potential recruits for the army it is essential that pre-employment screening has been instigated to ensure the applicant can undertake the rigorous training required' (*OH nurse, armed forces*)
- 'Our pre-placement questionnaire incorporates a disability questionnaire which is useful, [but] other than this we only need to do baseline health surveillance and assess fitness for task – ie healthcare workers, working at height, vocational diving etc. We could save a lot of time if our organisation would allow us to review/revise the situation' (*OH nurse, higher education*)
- 'Allows for adjustments for the individual and the working environment especially in safety-critical roles; protects the individual and avoids exacerbating their underlying health conditions; and protects others and the public' (*OH nurse, public sector organisation 'doing police-type work'*)
- 'I think that it is a waste of my valuable time. New employees can declare what their needs are in the workplace to help with the intrinsic functions of their role. It really depends on how the questions are phrased. I find some HR staff are too inquisitive about employees' past mental health' (*self-employed OH nurse, education sector*)
- 'Quite useful – because it highlights to us the employees who require health surveillance or assessment at an early stage in their contract; however this could also be achieved by other means. This activity ensures that occupational health remains integral in the organisation. Managers have come to rely on us offering support to new employees who have a disability or health support needs, giving them a sense of security that we will assist them to manage something that might be alien to them' (*OH nurse, education sector*)

Figure 4: does the questionnaire/declaration ask for consent to contact the individual's GP or any other doctor involved in his/her healthcare?

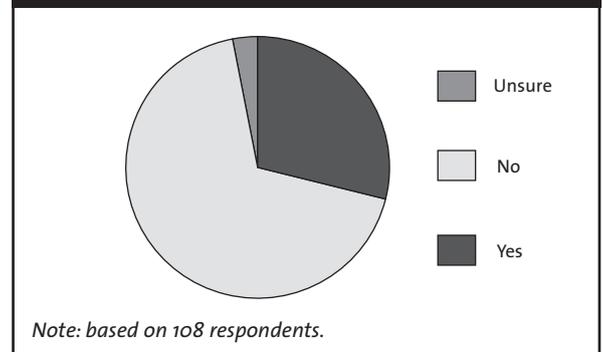
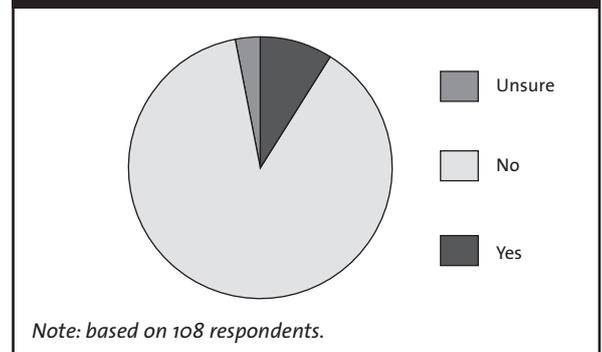


Figure 5: does the questionnaire/declaration ask for consent to contact the individual's former employer or former employer's OH department?



can be controversial. On the one hand it might suggest untrustworthiness, but on the other may simply be a matter of opinion as to whether the individual is 'disabled' or has a condition that could be made worse by work. We asked respondents to explain how such instances are generally dealt with at the organisation where they provide OH services (see table 4 on p.29).

The majority of organisations (60%) address this situation by implementing OH measures or adjustments to ensure the individual's health condition or disability is managed in the same way as if it had been declared at pre-employment. This is a higher figure than recorded in our 2006 survey (41%).

Although there is no significant sector effect overall, respondents in the other public sector are least likely to report that disciplinary measures are used to address this issue (11%); whereas 38% of respondents in the other private sector say such action would be used.

Some respondents note that the action would 'depend on the circumstances', while others say it would hinge on the severity of the lie or failure to disclose. An OH nurse in the NHS says that the occupational health department would normally manage the situation as if declared at pre-employment, but adds: 'However HR would be likely to investigate if serious enough'.

Table 4: what is the most likely outcome if an individual is found to have lied or withheld relevant and requested health information?

	2013	2006
Nothing	8%	4%
Disciplinary action short of dismissal	15%	18%
Disciplinary procedures started	10%	16%
OH measures/adjustments put in place to ensure the individual's health condition or disability is managed in same way as if declared at pre-employment	60%	41%
Other action	6%	21%

Note: based on 115 responses in 2013 and 188 in 2006. Excludes those who were unsure of the organisation's response. Percentages rounded to whole number.

Other written comments include:

- 'May be considered an integrity issue in police' (OH nurse, police)
- 'Disciplinary action may be commenced by HR' (OH nurse, manufacturing)
- 'If an employee is undertaking a safety critical/airside/ confined space role and found to have lied on the pre-employment, and the condition omitted has been identified, then I believe the individual would be dismissed or reassigned by the subcontractor' (OH nurse, construction)
- 'Fraudulent entry to the armed forces is a criminal offence' (occupational physician, armed forces).

A number of recruitment health questionnaires uploaded with the survey responses ask candidates/ recruits to sign a statement verifying the information provided, with a warning about the consequences of providing misleading information. For example:

- 'I declare all the above answers to be true and correct to the best of my knowledge. I understand that false or misleading answers may render me liable to dismissal'
- 'Please note that failure to disclose all relevant information covering your health could result in the termination of your employment'.

MEDICAL EXAMINATIONS AND GP REPORTS

Apart from health questionnaires and declarations, other ways of assessing fitness to work at recruitment include carrying out medical examinations and tests, requesting reports from the individual's GP or specialist, and requesting health information from a former employer or its OH department.

Survey respondents were asked to state whether their organisations' pre-employment and pre-placement health

Figure 6: does the organisation ever seek a GP's report in connection with the recruitment process?

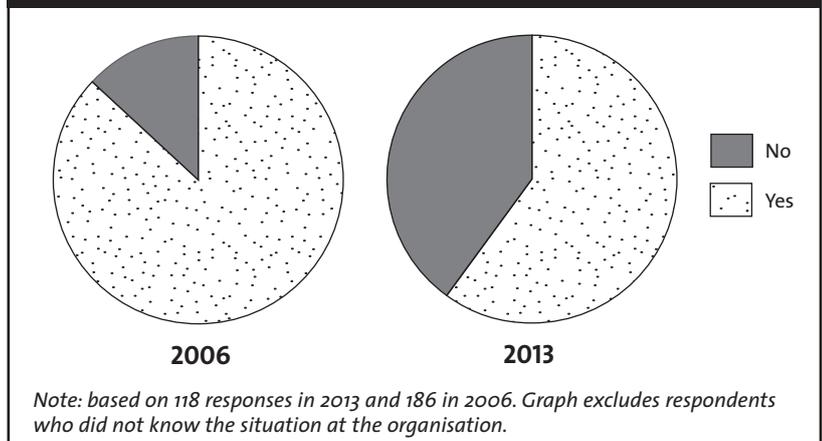


Figure 7: does the organisation ever carry out, or request, health or medical examinations and/or tests in connection with the recruitment process?

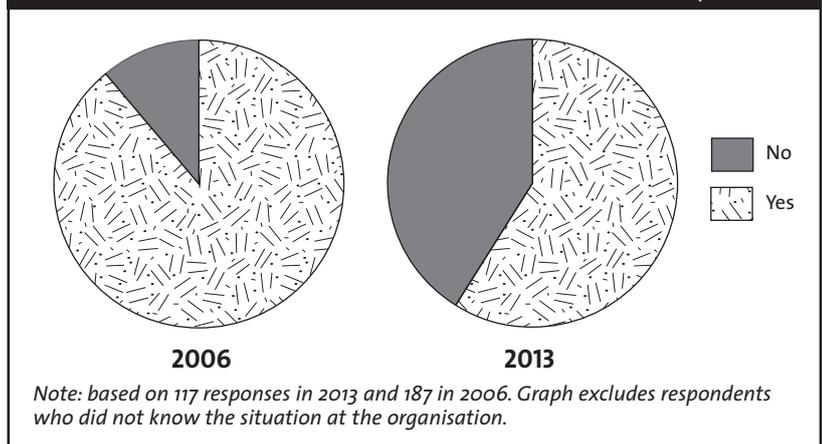
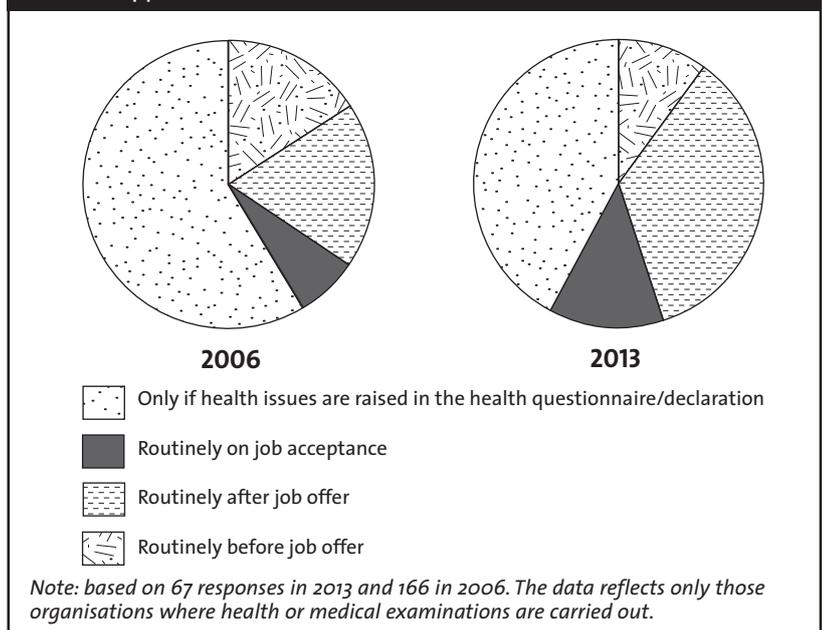


Figure 8: if medical tests/examinations are carried out or requested, when does it happen?



Box 3: BMA specimen health and capability declaration

ABC plc is an equal opportunities employer. We recruit and promote people irrespective of any personal factors, including gender, race, disability or sexual orientation. ABC plc aims to promote and protect the health and wellbeing of all its people.

This declaration aims to identify people who have pre-existing health-related capability issues before they start their job, so that the company's occupational health service (OHS) can advise management how to adjust people's work accordingly and help people work to their full potential.

You should have had the opportunity to read the job description for the role to which you are being recruited and to discuss practical matters with your recruiting manager. Please tick the statement that you think applies to you and sign and date the declaration.

Either:

A. I am not aware of any health condition or disability which might impair my ability to undertake effectively the duties of the position which I have been offered.

or:

B. I do have a health condition or disability which might affect my work and which might require special adjustments to my work or at my place of work.

If you have ticked B, you may provide details below and send the completed form to OH service in the sealed envelope marked 'confidential for OH only'. Occupational health staff may then contact you to discuss your health further in confidence in order to determine if any special measures are required to accommodate you at work.

I consent to providing this information and declare to the best of my knowledge that the answers to the questions above are complete and accurate. I also understand that any false declaration may result in my service being terminated.

Signature and date:

Reproduced with permission of the BMA Occupational Medicine Committee⁹.

questionnaires or declarations ask applicants or new recruits to consent to contact being made with their GP or treating physician. The majority of organisations (68%) do not do this (figure 4 on p.28). There are no major differences by sector, other than for the armed forces, where the three respondents answering the question say this happens in all cases.

Similarly, only a minority (9%) of health questionnaires/declarations ask for consent to contact the individual's former employer or former employer's OH department (figure 5 on p.28). The only sector difference is with NHS respondents, 28% of whom say that consent is sought to contact the previous OH department or employer. One NHS respondent comments that this is for vaccination history only.

A majority (60%) of organisations at least sometimes seek a GP report in connection with the recruitment

process, though the figure is lower than it was in 2006 (87%) (figure 6 on p.29). Written comments suggest that where this does happen, it occurs only occasionally or rarely.

While there is no overall sector effect ($p =$ non significant), 71% of NHS respondents say GP reports are sometimes sought, compared with 48% of those working in the other private sector.

A similar majority (59%) of organisations also carry out or request health or medical examinations and/or tests in connection with the recruitment process, but again the figure is lower than in 2006 (89%) (figure 7 on p.29). The written comments indicate that this either happens rarely, or where there are specific health criteria and/or where there is a requirement for statutory health surveillance – for example, working offshore or in passenger transport. One respondent says it is done to identify pre-existing HAVS.

There are no significant differences between sectors, other than for the armed forces where the four respondents answering the question state that medicals are routinely carried out in all cases and mostly before the job offer. The armed forces are not subject to the prohibition on asking health-related questions under section 60 of the EqA.

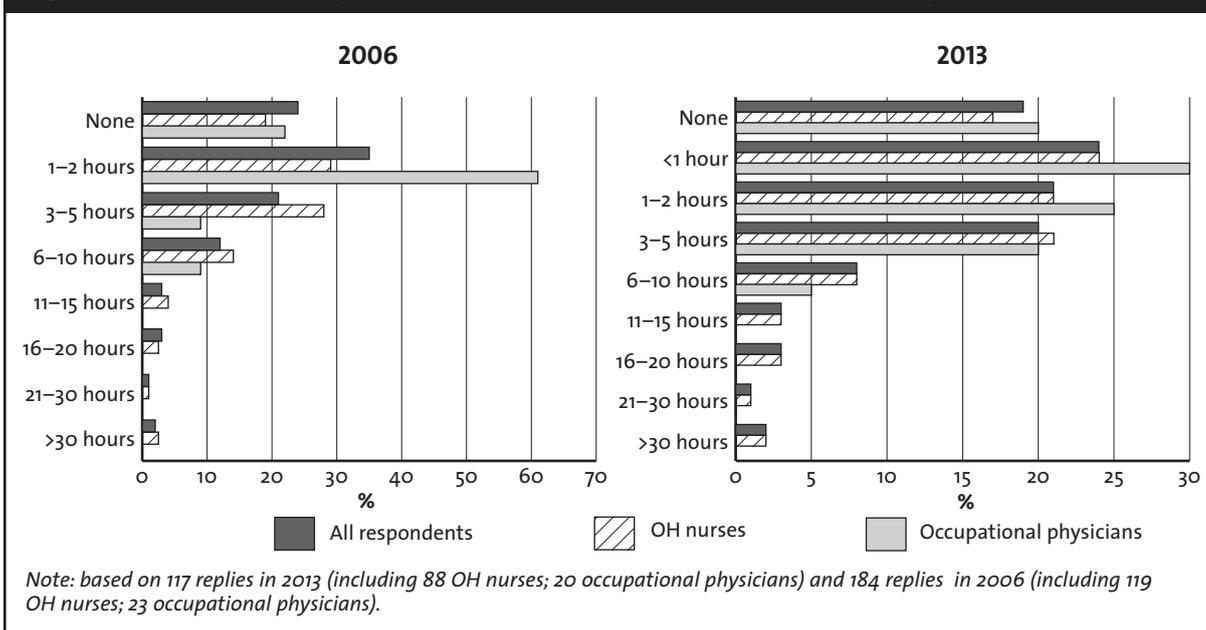
Of the 67 respondents reporting that examinations or tests could be undertaken in their organisations or where they provide OH services, the majority say that this occurs either routinely on the job offer, routinely on job acceptance or only if issues are raised in the health questionnaire or declaration (figure 8 on p.29). Seven respondents say that this occurs routinely before the job offer. Of these, three provide OH services to the armed forces, two to the police, one to the NHS and one in construction.

COST–BENEFIT

The 2006 survey results suggested that many OH nurses were spending considerable amounts of their working time carrying out pre-employment health screening. The 2013 survey investigated whether the restriction on when questions can be asked under the EqA, as well as recent evidence reviews, have had an impact on current workload. It also asked practitioners whether the time and resources spent doing recruitment health screening is worthwhile.

Both the 2006 and 2013 survey questionnaires asked respondents to state how many hours they had spent on recruitment in their previous working week (based on a 35-hour working week, pro-rata for part-time workers). Although there is large variation in practice, the latest figures suggest that overall OH nurses are now spending slightly less working time on recruitment health screening compared with 2006 (figure 9 on p.31). However, while the average time spent has dropped, some OH nurses are still spending many hours on such activity. There is little change in occupational physicians' practice.

Figure 9: how many hours per week are spent on recruitment health screening



Time spent in previous week on recruitment health screening in 2013 survey:

- OH nurses: mean = 3.9 (sd 6.2); median = 1–2 hours
- OH physicians: mean = 1.7 (sd 2.0); median = 1 hour

Time spent in previous week on recruitment health screening in 2006 survey:

- OH nurses: mean = 4.7 (sd 6.0); median = 3–5 hours
- Occupational physicians: mean = 2.0 (sd 2.1); median = 1–2 hours

In both 2013 and 2006, one in 10 nurses had spent at least 11 hours in the previous week working on recruitment health screening. In 2013, two of the 88 OH nurses answering the question report having spent more than 30 hours, while in 2006 three in 119 respondents had spent more than 30 hours.

In both 2013 and 2006, only one occupational physician reported spending more than three to five hours on recruitment health screening, and none had spent more than six to 10 hours in either year.

When asked if OH practitioners personally think that pre-employment health screening is a useful tool that justifies the time and resources invested in it, respondents' views varied between rating them as essential and considering them useless (figure 10 on p.32). The 2006 survey found a similarly mixed picture.

Comparing data from the two survey years identifies a significant difference between the patterns of responses for OH nurses ($p = 0.01$). This difference can mostly be explained by fewer OH nurses in 2013 than in 2006 describing screening as essential, and more rating them as of little value or useless.

There is no significant effect due to survey year for

occupational physicians ($p =$ non significant), though the numbers of responses are too low for a reliable comparison.

Looking at the industry sectors of the 19 organisations where screening is considered essential, seven are in healthcare, four from defence, with others from construction, passenger transportation and manufacturing. By contrast, nine of the 38 respondents describing recruitment health screening as of little value work in the healthcare sector, five in education, five in local government, four in food and drink manufacturing and three in engineering. Other than the 100% response from the military that screening is essential, there appears to be little consensus among practitioners as to its value, even among those in the healthcare sector.

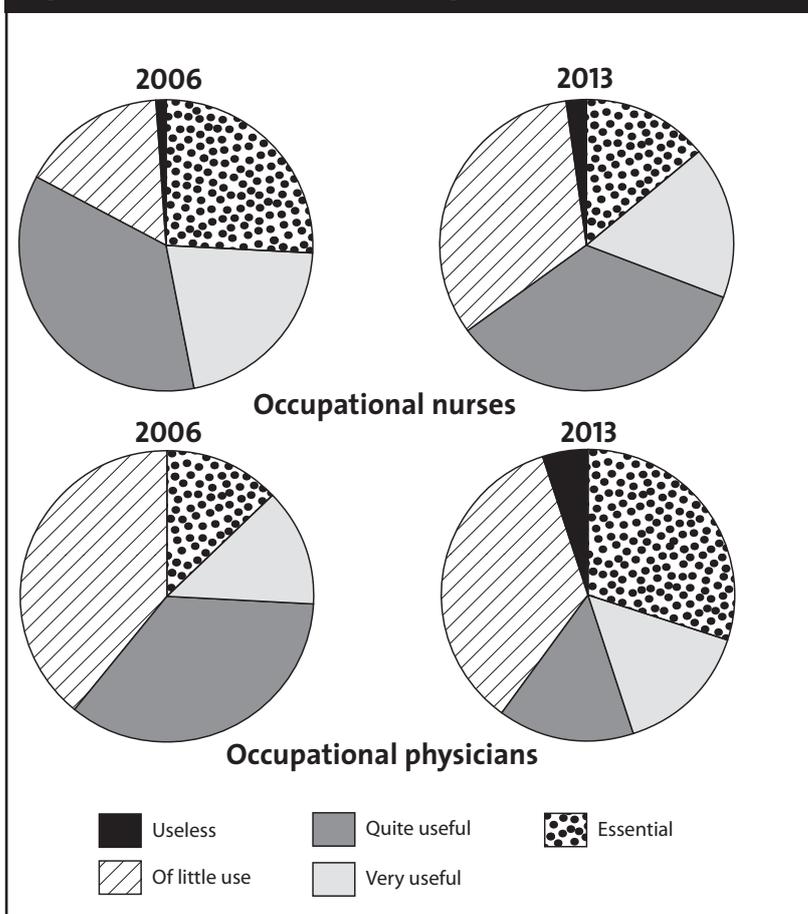
Of the nine nurses spending at least 11 hours on health screening, four describe the process as essential, four as of little value and one as being quite useful.

The written comments are similarly varied, ranging from one respondent who describes the process as 'illegal' to another who says pre-employment health screening is a 'cornerstone' of OH practice. Others variously describe it as an important part of supporting those with disabilities, providing a baseline health record, or meeting fitness requirements in safety-critical roles. A selection of written responses is given in box 2 (see p.28) with more responses given in supplementary box 2a⁴.

QUALITY CONTROL

Given the importance placed by many practitioners on recruitment health screening, and the time and resources spent carrying it out, it would be prudent for organisations to assess whether the process is achieving what is intended. When the survey was conducted in

Figure 10: is recruitment health screening worth the time and resources?



2006, only one-quarter of respondents confirmed that their pre-employment or pre-placement health screening questionnaires had been evaluated for their effectiveness. There has been little change, with just 26% of respondents to the 2013 survey confirming that their recruitment health questionnaires have been evaluated for effectiveness (figure 11 on p.33).

Survey respondents were asked if the organisation's pre-employment health screening policy and/or questionnaire had been updated in the past three years, and if so what were the chief reasons.

A total of 118 respondents answered the question; they could select more than one option. The vast majority of respondents (89%) say their policies and/or questionnaires have been updated.

In organisations that had updated their policies/questionnaires, the most common reason was to meet the requirements of the *Equality Act 2010* (or *Disability Discrimination Act 1995* in Northern Ireland), with four in five respondents (81%) citing this as a key reason. This is followed by 'to make our recruitment process more effective' (31%), research evidence (19%); requirements of the *Data Protection Act* (17%); equal opportunities (12%); and previous policy did not meet business needs (12%). There is little variation between sectors although 95% of

other public sector respondents cite the EqA as the reason for updating the policy and/or questionnaires.

GENETIC SCREENING

Looking to future possible developments, around one in six practitioners say that if genetic information could give a reliable indication of future health and fitness for work then it would be an appropriate tool for use in the recruitment and selection process (figure 12 on p.33). Most practitioners were against this idea or unsure if it would, or would not, be acceptable, however.

One occupational physician says: 'I am very dubious that a gene or marker would have useful predictive purpose under real life work conditions'. An OH nurse describes it as 'a dangerous and morally debateable procedure'.

DISCUSSION

There are many potential reasons – or perhaps aspirations – for employers undertaking health screening at recruitment, including: ascertaining if the applicant or recruit is fit for the role; establishing if they will need adjustments to the work, equipment or conditions; to risk assess their likelihood of future poor attendance; as a baseline health check, especially in cases where the work may cause or exacerbate existing conditions, or for health surveillance purposes; eligibility for the pension scheme; as a basis for providing advice on health and wellbeing; and where there are regulatory fitness requirements, for example in passenger transport and food handling.

Madan and Williams have extensively reviewed the evidence underpinning pre-employment health screening⁶ and their overriding conclusion is that it is only valuable where there are 'clear and explicit health criteria'. It is expensive and can be unlawful if used to discriminate against people with disabilities in situations where health criteria cannot be justified. Screening in an attempt to remove people at risk from future work-related ill health because of pre-existing susceptibility is also likely to generate many false positives, thereby deselecting many candidates whose health would not be affected in order to remove the one whose health might be made worse⁷. And barring certain exceptions, it is now unlawful under EqA section 60 to ask about a person's health or disability before at least a conditional job offer has been made.

The 2013 survey results show that despite these caveats, health screening at recruitment continues to be widely used and is valued by many practitioners. By far the biggest reason for doing so is to identify where an individual might need adjustments to the work or working environment because of a disability or health condition, though other reasons include providing a baseline health record and assessing fitness for the role. One respondent suggests that it helps maintain the profile of OH within the organisation.

Surprisingly few respondents – just one in four – say their recruitment health questionnaires had been evaluated for effectiveness, though nine out of 10 say that they have been updated in the past three years, chiefly to bring them into line with the EqA.

Our survey finds that pre-employment or pre-placement health screening can be time consuming – though there appears to have been a slight reduction in time spent on it by OH nurses compared with our 2006 survey. There is little consensus on whether or not pre-employment health screening is worth the time and resources, and even those who invest the most time on it (more than 11 hours in the week preceding the survey) were divided in describing it either as essential or of little value.

As we saw in part one, health screening is now done almost exclusively after the conditional job offer – the military being the key exception – and for the large part employers have moved away from using lengthy health questionnaires, with many (31%) now preferring to use simple health declarations.

These declarations include generic questions without reference to specific health conditions and avoid the ‘shopping list’ style questionnaires commonly reported in our 2006 survey. Now, they typically ask applicants or recruits to reveal information considered relevant to the role or future attendance. For example:

- Do you have any current physical or mental health conditions or disabilities that would affect your ability to perform the duties of the role?
- Do you require an adjustment or adaptation to the work, work equipment or workplace to enable you to do the job?
- Do you have, or have you ever had, any health problems that may have been caused, or might be made worse by your work?
- Are you undergoing or waiting for any medical treatment or investigation, or taking any medication?

Some employers also ask about recent sickness absence, such as:

- How many days off sick have you had in the past 12 months?

The benefit of such declarations is that they avoid the need to process long lists of specific questions, much of which may be irrelevant to the job and are probably in breach of the *Data Protection Act*. Information revealed in the declaration can be used to trigger further investigation by the OH professional or team if necessary. Supplementary questions can be reserved for specific roles, for example vaccination history for healthcare workers or where there are statutory health requirements.

NHS Employers recently issued new guidance⁸ on ‘work health assessments’. It recommends an even slimmer

Figure 11: has the organisation ever evaluated the effectiveness of its pre-employment/pre-placement health-screening questionnaire?

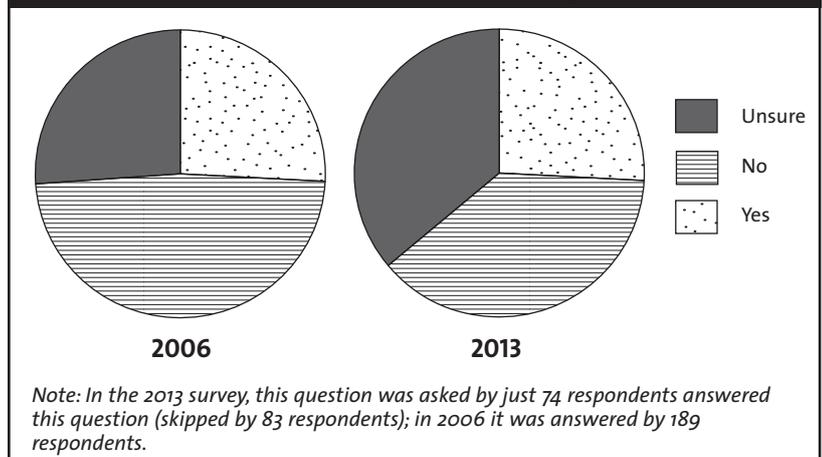
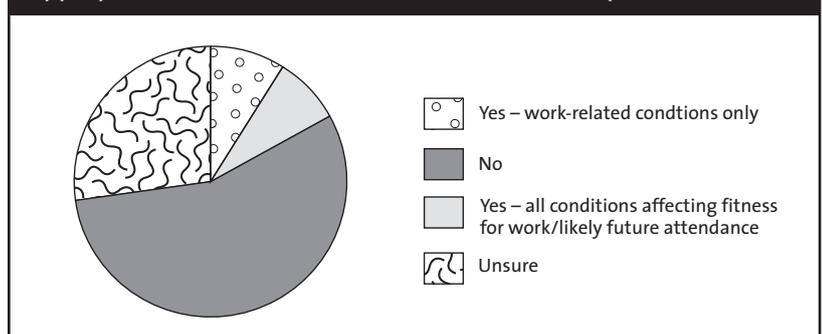


Figure 12: if genetic information could give a reliable indication of future health and fitness for work, would genetic screening be an appropriate tool in the recruitment and selection process?



version, where candidates are asked to tick either of two statements, essentially whether or not the individual has a health condition or disability that might affect their work, and if so do they need an adjustment. It advocates specific additional pre-placement screening for healthcare workers involved in exposure-prone procedures, patient care, patient contact, or body fluid sample handling. The BMA Occupational Medicine Committee also advocates just two basic questions in its specimen ‘health and capability declaration’ (see box 3 on p.30).

Aside from requiring individuals to give their age or date of birth, the most commonly asked generic questions concern disabilities, current medical conditions and medications. Only one in five employers carrying our health screening at recruitment now ask about the individual’s previous sickness absence record, compared with three in four in 2006. And where employers ask specific health questions, these tend to focus on conditions perceived as having the greatest potential impact on work, or likely to be exacerbated by work, such as asthma, allergies, diabetes, skin conditions, musculo-skeletal disorders, back complaints and mental ill health.

Although most employers with access to OH now use slim work-focused health questionnaires or declarations,

some employers continue to prefer lengthy surveys. We report two such questionnaires, which, on grounds that they ask over 80 and 50 health questions, respectively, are likely to be judged as excessive under the *Data Protection Act* – and particularly so in light of the Information Commissioner's code of practice on workers' health information⁵.

The second of these lengthy questionnaires requires applicants to sign a statement giving blanket consent, for an indefinite period, for the release of any relevant 'medical fact' to the company's management. This is unethical.

The Faculty of Occupational Medicine's (FOM's) *Ethics guidance for occupational health practice*¹⁰ notes, for example, that:

- ▶ 'consent applies only to the time, condition and circumstances when it was obtained' (*para 2.14*)
- ▶ 'a widely drawn or blanket form of consent is ethically unacceptable' (*para 3.39*)
- ▶ 'OH professionals may clarify a report or give general advice to management or human resources about a condition but no further disclosure of confidential information can be made without seeking refreshed consent from the worker' (*para 3.44*).

In most organisations, it is rare that a job applicant is found unfit for the job or requiring reasonable adjustments, suggesting that health is not being widely used as a barrier to employment by most employers – or at least those with access to OH. One improvement that many organisations could make, however, is to offer an appeal mechanism whereby those denied recruitment on health grounds can challenge the decision if they feel they have been treated unfairly. Only 45% of respondents confirm that an appeal mechanism exists at the organisation where they work or provide OH services. The prohibition of pre-job-offer questions on health or disability, under section 60 of the EqA, should make transparent any decision to refuse employment on health grounds since such enquiries must now be made after a job has been offered. Providing an appeal mechanism should help ensure decisions are fair and perhaps reduce the likelihood of claims of this nature ending up at an employment tribunal.

The question of managing cases where an individual is alleged to have lied on his/her health questionnaire or declaration or deliberately withheld information remains controversial. Does the 'lie' or omission indicate that the individual cannot be trusted, or is it simply that they did not understand an ambiguously worded question? Alternatively, it might be argued that an individual deliberately chose not to reveal certain information, or to conceal it, because he or she expected to be treated unfairly if a health condition was revealed, or that the employer had no right asking health questions unrelated to the role.

A majority of respondents to the 2013 survey say that their organisation would manage the situation as if it had

been declared at pre-employment – essentially avoiding the controversy – though others state that disciplinary action might be initiated and make this clear in the questionnaire or declaration. The issue comes down to professional judgment and certainly highlights the need to ask clear and unambiguous questions that are relevant to the role.

Our findings reveal that a majority of employers sometimes seek a GP report in connection with the recruitment process, or request a health or medical examination, either routinely or triggered by the health questionnaire or declaration. Just as with pre-employment health questionnaires, there is little evidence that routine medical examinations serve a useful purpose, other than those 'specific to certain jobs and health problems'⁷. A Cochrane evidence review, for example, concluded that 'unfocussed medical examinations do not decrease sickness absence but come at a considerable cost of denying employment to a high proportion of job applicants'⁷. And a World Health Organization evidence review stated: 'Medical examinations are only justified when the job involves working in hazardous environments, requires high standards of fitness, is required by law or when the safety of other workers or of the public is concerned'¹¹.

Only a minority of respondents would favour the use of genetic tests in the recruitment screening process – assuming they were available – and some practitioners express concern over the ethical issues this might pose.

To date, there has been very little use of genetic screening in employment, though with the growth in the number of genetic tests being developed for other purposes the possibility of using them for job selection remains an area of commercial interest¹⁰. A 2007 'horizon scanning' report by the Health and Safety Executive found no evidence that any UK employer was carrying out genetic testing, with the exception of aircrew testing for sickle cell disease, but has not revisited the issue since¹². It noted the potential benefits of being able to screen out people susceptible to specific work-related diseases, such as occupational asthma, but that some employers might 'think that recruiting "non-susceptible" people means they can relax their controls.' The FOM reports 'isolated instances of testing being used to discriminate against job applicants' though provides no details¹⁰.

A recent systematic review did find some evidence of 'genetic discrimination' for life insurance, albeit restricted to a small number of conditions (eg Huntington's disease and familial hypercholesterolemia), but found little evidence of there being a 'systematic problem' in the industry¹³.

Concluding remarks

Our 2013 survey of employment practice on pre-employment health assessment demonstrates how practice has changed since the survey was first carried out

in 2006. In general, the process is leaner and more focused and – at least in organisations with access to OH – is invariably carried out after the employer had made at least a conditional offer of employment.

Recent guidance from the BMA Occupational Medicine Committee⁹ now prefers the term ‘post-offer health assessment’ reflecting this more modern approach. That said, health screening has not been completely pared down to the basics in all organisations and many still use detailed questionnaires. As to whether the practice is worthwhile, opinion is divided among practitioners between those who say it is essential and those who feel their time could be better spent doing other OH work.

Available research evidence points to a focused approach where post-offer health assessment is limited to those roles where there are clear health criteria. Less than half of respondents say their organisations had evaluated the effectiveness of their health assessments and this report highlights the need for regular review to ensure that recruitment health screening remains fit for purpose. ■

John Ballard is editor of Occupational Health [at Work].

Acknowledgement

Occupational Health [at Work] thanks all those practitioners who took the time to complete the survey and to Sue Hillman, Karen Coomer and Dr Marianne Dyer who kindly reviewed the draft questionnaire.

Notes

1 Ballard J. Health screening at recruitment, part 1: pre-employment and pre-placement health questionnaires and declarations. *Occupational Health at Work* 2013; 10(4): 26–35.

2 Ballard J. Pre-employment health screening, part 1: pre-employment questionnaires. *Occupational Health at Work* 2006; 3(3): 18–25.

3 Ballard J. Pre-employment health screening, part 2: quality assurance, GP reports and medical examinations. *Occupational Health at Work* 2006; 3(4): 22–30.

4 Health screening at recruitment: supplementary tables and boxes. www.atworkpartnership.co.uk/healthscreening

5 Data Protection: the employment practices code. Supplementary guidance. Part 4 – information about workers’ health. London: Information Commissioner, 2005. ohaw.co/1dplTyK

6 Madan I, Williams S. A review of pre-employment health screening of NHS staff. London: TSO, 2010. ohaw.co/H6JjoS

7 Mahmud N, Schonstein E et al. Pre-employment examinations for preventing occupational injury and disease in workers. *Cochrane Database of Systematic Reviews* 2010; 12: CD008881.

8 Work health assessments. London: NHS Employers, 2013. ohaw.co/1l8VxDo

9 BMA Occupational Medicine Committee. The occupational physician: guidance for specialists and others practising occupational health. London: BMA, 2013. ohaw.co/1fjNNqhy

10 Ethics guidance for occupational health practice. London: Faculty of Occupational Medicine, 2012.

CONCLUSIONS

- **The most** common reason for using pre-employment or pre-placement health questionnaires or declarations is to identify where the individual might need adjustments to work or the working environment because of a disability or health condition
- **Only** 4% of respondents say the purpose of the health assessment is to advise managers of likely future attendance; around half say it is useful to provide a baseline health record
- **One-third** of surveyed organisations now ask applicants/recruits to complete a simple declaration of health rather than answering a health questionnaire
- **Where** questionnaires are used, the most commonly asked generic questions (aside from age/date of birth) are whether or not the person has any disabilities or current medical conditions, or is on medication
- **In the NHS** the most frequently asked question is vaccination and immunisation history
- **Where** specific health questions are asked, the most common conditions referred to are asthma, allergies, diabetes, skin conditions, musculoskeletal disorders, back complaints and mental health
- **Half** of survey respondents say individuals can appeal against a decision to deny them employment on grounds of their health
- **Most** organisations (60%) would not discipline an individual who lies about, or withholds, relevant health information at recruitment but would instead manage the situation as if it had been declared at pre-employment/pre-placement
- **Less than one-third** of organisations’ health questionnaires or declarations ask the applicant/recruit for consent to contact his/her GP or other doctor; however, most would seek a GP report if considered necessary
- **OH nurses** are spending less time on average doing recruitment health screening than they were in 2006; however, some nurses spent more than 11 hours on the activity in the week preceding the survey, and two respondents had spent more than 30 hours
- **Practitioners** are divided over the question of whether recruitment health screening is worth the time and resources spent on it
- **Only** a minority of organisations had evaluated the effectiveness of the recruitment health screening questionnaires
- **The most** common reason for organisations to have updated their recruitment health screening policies and questionnaire was to meet the requirements of the *Equality Act 2010*
- **Most** practitioners would be against using genetic screening at recruitment even if it could predict future health and fitness for work
- **Asking** a plethora of personal health questions irrelevant to the job is both unethical and unlawful (under the *Data Protection Act 1998*)
- **It is** also unethical to ask applicants or new recruits to sign statements giving blanket and time-unlimited consent to release health information to employers

11 Pachman J. Evidence base for pre-employment medical screening. *Bulletin of the World Health Organization* 2009; 87: 529–534.

12 Bradbrook S. HSE Horizon Scanning Intelligence Group – genetic testing in the workplace. *Horizon Scanning SR014*. London: HSE, 2007. ohaw.co/1csr3MX

13 Joly Y, Ngueng Feze I, Simard J. Genetic discrimination and life insurance: a systematic review of the evidence. *BMC Medicine* 2013; 11: 25. ohaw.co/1csr5yF



Disability: known and unknown knowns

When does the employer know of an employee's disability and can it rely on OH opinion?

An employer's knowledge that an employee is disabled is crucial to questions of disability discrimination and the duty to make reasonable adjustments. But what if OH says the employee is not disabled? Diana Kloss explores the statute and case law.

MANAGERS cannot in general unlawfully discriminate against job applicants or workers with a disability if they neither know nor ought to know (constructive knowledge) of it. This applies to direct discrimination, discrimination arising from disability under section 15 of the *Equality Act 2010* (EqA), and failure to make reasonable adjustments.

DEFINITION OF DISABILITY

Disability is defined in the EqA as a physical or mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities. The person's condition must be assessed without the assistance of medication or prosthesis, except for spectacles or contact lenses. Cancer, HIV infection and multiple sclerosis (MS) are disabilities from diagnosis. In an important recent case in the European Union court (ECJ), *Ring v Dansk almennyttigt Boligselskab*¹ the court held that the word 'disability' in the Equal Treatment in Employment Framework Directive (2000/78/EC), on which our law is based, should be interpreted consistently with the United Nations Convention on the Rights of Persons with Disabilities. This defines disability not just in terms of the impairment to the individual but also on the interaction between the individual's impairment and barriers (such as environmental or attitudinal barriers) that hinder their full and effective participation in professional life on an equal basis with other workers.

The test of disability is a complex legal one, about which there is now considerable case law interpreting the *Disability Discrimination Act 1995* (DDA) and its successor (except in Northern Ireland) the EqA, and several cases have been referred to the ECJ for clarification of the meaning of the Directive. In more than one case, UK courts have held that the opinion of an occupational health (OH) professional, about whether the definition is satisfied, is not decisive and that the ultimate decision is for the court or tribunal. One example was *Abadeh v BT plc*² where an employment tribunal accepted without question the opinion of the employer's regional medical officer that the employee's impairments were not substantial enough to amount to a disability. The

Employment Appeal Tribunal held that this was a decision for the tribunal, not the doctor, to make, taking into account all the evidence before them, including the doctor's opinion.

It has become standard practice for many OH professionals to advise employers that the classification of a worker as disabled or not is a legal question and not a medical one. The recent decision of the Court of Appeal in *Gallop v Newport City Council*³ is, therefore, not out of line with previous authority, though it has caused considerable comment among the human resources fraternity.

Mr Gallop had been employed since 1997. In 2004 he became unwell, describing a number of symptoms, including lack of sleep and appetite, headaches and eye strain, and an inability to cope with simple tasks. He was diagnosed by OH as suffering from stress and referred for stress counselling. He had several periods of absence from work, and in 2006 his GP diagnosed him as suffering from depression. He was regularly referred to OH, who repeatedly stated in reply to the manager's request to know whether he was covered by the DDA that he was not a disabled person within the statutory definition, but gave no explanation of the reasons for this advice.

Gallop was accused by colleagues of bullying and was dismissed in 2008. He claimed unfair dismissal and disability discrimination. His claim for unfair dismissal was upheld, but his claim of disability discrimination failed. The tribunal held that, although in their view he was disabled from 2006, the employer could not reasonably be expected to know that, because of the OH advice that he was not. The Court of Appeal held that the OH opinion that Gallop was not disabled was 'worthless' because no reasons were given.

It is for the employer to form its own judgment on whether the employee is disabled. When making that judgment it will need the assistance of OH or other medical advice, but should ask more specific questions, for example:

- Has the employee a physical or mental impairment? How long has it lasted, or how long is it likely to last?
- Does the impairment in your view substantially interfere with normal day-to-day activities?

In my opinion, the OH adviser in the *Gallop* case should have been reporting on those issues without being prompted, as I have been regularly advising for some years now. It is not vital, expressly, to mention the EqA, but it is important to give an opinion about the factors listed above.

EMPLOYER’S KNOWLEDGE

So when will the employer be deemed to know that a worker has a disability? As has been demonstrated there are no simple answers, and cautious employers – and their OH advisers – may be counselled to give the worker the benefit of the doubt in a borderline case, especially when it comes to suggesting possible adjustments to the working environment or provisions, criteria and practices, like hours of work. Only when the worker has been diagnosed with cancer, HIV or MS will there be no scope for argument. If the worker gives consent, OH should report to management that he/she has a health condition which amounts to an impairment, is likely to last for at least a year, and substantially interferes with day-to-day activities. The OH professional should give thought to whether any adjustments would assist the worker to remain/return to work, and make suitable recommendations, while stating that it is for the manager to decide whether the adjustments are practical and affordable for the business. They may also give an opinion that it is likely that the worker has a disability, with the caveat that this is a legal and not a medical question.

Even where there is no such report, managers may be put on notice that the worker has a disability by his or her behaviour or other factors. One example was *Department of Work and Pensions v Hall*⁴, where the employer was deemed to have knowledge that the employee was suffering from disabling depression through her eccentric behaviour at work and her application for a disabled tax credit. However, where a worker unreasonably refuses to engage with OH or to provide medical reports either from OH or the GP it is easier for the employer to plead ignorance, as in the case of *Wilcox v Birmingham CAB Services Ltd*⁵.

A worker who confides in OH that he or she is suffering from a disabling illness may assume that some information will be given to the employer in order to support a request for adjustments, and this may be held to be implied consent. For that reason it is important for the OH professional to explain that it is in the worker’s interest to make recommendations to the manager and to ask for express consent to do so. If the worker is adamant that no information should be given and refuses to agree to such a report it is important that a note is made in the file to protect the health professional who may otherwise be accused of failing in their duty under the EqA. In *Hartman v South Essex Mental Health Trust*⁶, a personal injury claim, it was held that the employer did not have knowledge of Ms Hartman’s history of

CONCLUSIONS

- **Managers** cannot in general unlawfully discriminate against job applicants or workers with a disability if they neither know nor ought to know of it
- **Ultimately**, it is for the courts to decide if someone is disabled, not the opinion of the OH professional or other medical practitioner
- **In the case of *Gallop v Newport City Council***, the Court of Appeal held that the employer could not rely on an OH opinion that the employee was not disabled, because OH had given no reasons
- **OH should** always advise whether the employee has an impairment, and if it is long-term and substantially interferes with normal day-to-day activities
- **OH should** always seek consent from the employee before revealing to a manager that he/she has a disability, but should also explain that it is in the worker’s interest to make recommendations for reasonable adjustments

depression because the OH physician had not revealed it. Though a previous code of practice suggested that managers are automatically deemed to know what OH knows, the most recent EqA statutory code of practice on employment, paragraph 6.21, appears to state that this is subject to the worker’s consent⁷.

This development has led to a few employers specifically ordering OH not to tell them about any disability and not to suggest adjustments. This creates an ethical dilemma if the OH professional believes that adjustments may assist the worker to be at work. It is also a dangerous policy for employers because a tribunal may later decide that they should have known about the disability and made adjustments. In addition, as the employer is vicariously liable for the acts of his servants and agents, if the employer is held to have contravened the EqA by not making reasonable adjustments the OH professional may also be personally liable (EqA section 110). The contrary argument is that all that OH does is to make recommendations, and the decision about what is reasonable is one for the manager, so that OH cannot be personally liable for management decisions.

The only kind of discrimination which does not require proof of knowledge of the disability is indirect discrimination under EqA section 19. If the employer applies a provision, criterion or practice which puts a disabled person at a disadvantage compared with non-disabled persons he will have to defend it as a proportionate means of achieving a legitimate aim. A simple example is a rule that employees must start work at 8 am. The employer must justify this as reasonably necessary for their business. In practice, someone whose disability makes it difficult to start work early will ask for an adjustment to allow them to come in later, but in that case they will have to prove that the employer had actual or constructive knowledge of their disability.

Diana Kloss is a barrister, former part-time employment judge, Acas arbitrator and author.

- Notes**
- 1 [2013] IRLR 571.
 - 2 2000/78/EC.
 - 3 [2001] IRLR 23.
 - 4 [2013] EWCA Civ 1583.
 - 5 [2005] UKEAT 0293.
 - 6 [2005] IRLR 293.
 - 7 *Equality and Human Rights Commission. Equality Act 2010: employment statutory code of practice. London: The Stationery Office, 2011. ohaw.co/HuyvZO*

SURVIVING COLD WATER IMMERSION

Cold water immersion significantly increases the risk of hypothermia – when the body's core temperature falls below 35°C – and your chances of surviving a capsized or falling overboard in deep water are improved if you can stay warm. It is generally recommended that remaining relatively still is a good strategy to prevent heat loss – swimming is counterproductive unless there is a prospect of reaching the shore, boat or raft. Huddling together with others is advised, but that may not be an option. So, what else can you do to improve your survival chances?

Presenting research funded by the Colt Foundation¹, MSc student Rebecca Neal described an investigation looking at how different modes of exercise and rest affect core body temperature and metabolic response. Her study used 11 fully clothed volunteers immersed in a swimming pool at 18°C. Rectal body temperature and oxygen consumption (VO₂) were recorded every five and 10 minutes, respectively. Each participant completed three experimental conditions – rest, leg-only swimming and whole-body swimming – in a randomised counterbalanced design.

Mean rectal temperature declined over 40 minutes by around 0.5°C, but with considerable variation between participants and with no significant difference overall between strategies. However, Neal then looked at participants according to their body fat percentage. She found that, when adopting the rest strategy, those with high body fat (greater than 22% for men and 27% for women) had significantly lower heat production (ie lower oxygen consumption) compared to those with average body fat (12%–22% for men and 12%–27% for women). Despite the greater heat production in the average body fat group, rectal temperature fell more slowly in the high body fat group.



Isabel Smith

'Those with average body fat were cooling significantly faster,' said Neal.

Turning to the different strategies, Neal found that individual factors were very important. A 21-year-old female with average body fat and high shivering response (shivering increases VO₂) used more oxygen when adopting leg-only or whole-body swimming, compared to when she was resting. Importantly, however, she maintained her rectal temperature over 60 minutes when doing the leg-only swimming compared with either rest or whole-body swimming.

A 29-year-old male with high body fat and low shivering response also used more oxygen when leg-only or whole-body swimming, but rectal temperature was maintained over 60 minutes regardless of strategy. Another male with average body fat and described as having 'intense [cutaneous] vasoconstriction' (the narrowing of blood vessels in the skin is a thermoregulatory response to cold exposure) retained body temperature for longer regardless of strategy, but performed best with leg-only swimming.

Neal explained that using arms when swimming raises the rate of cooling as it increases the surface

area and provides a conduction pathway from the core to the surface. By contrast, arms wrapped around one's torso provides insulation.

According to Neal, leg-only swimming produces similar amounts of heat as whole-body swimming, but results in a lower rate of cooling among participants 'because they are not using their arms'. She suggests that the research might lead to more specific advice for cold-water survival, certainly at the relatively modest sub-20°C water temperature explored in her investigation. It might be possible, she said, to 'provide more tailored advice to different types of people', depending on body fat and physiological response.

¹ Colt Research Day. The Colt Foundation, 10 January 2014, King's College London.

WORKING TIME

A comparison of occupational and health aspects before and after the implementation of the EU Working Time Directive on German hospital physicians has found that their work changed significantly between 1997 and 2007. During this period, working time fell by an average of 4.5 hours, to 55.8 hours per week, but this was

not accompanied by a reduction in doctors' stress or in risk of burnout.

The researchers involved 328 physicians on the Hamburg medical register, who were asked to complete the survey in 1997 and 2007 (response rates 55% and 46%, respectively). All participants filled in a 22-item version of the Maslach Burnout Inventory. Results of multivariate covariance analyses are reported.

The research found that junior physicians benefitted most from the decline in working hours, with on-call duties increasing for senior physicians. But, the reduced hours were at the expense of fewer rests. Junior, as well as senior, physicians reported significantly higher scores for emotional exhaustion in the 2007 survey.

The researchers conclude that changes in working conditions following the introduction of the Working Time Directive were not accompanied by a reduction in stress and risk of burnout for physicians.

Richter A, Kostova P et al. Less work: more burnout? International Archives of Occupational and Environmental Health, 2013; online first: doi: 10.1007/s00420-013-0849-x. ohaw.co/1eGPJY

WORK AFTER HEART DISEASE

Researchers in Germany and the Netherlands are working on a Cochrane systematic review of interventions to support the return to work of patients with coronary heart disease.

The review team is looking at both person-centred and work-directed interventions – or combinations of the two. It will consider the impact of workplace adjustments, including modified working hours or tasks, changes to the workplace and improved communication with managers, colleagues and health professionals. Person-directed interventions will cover those aimed at psychological

as well as physical health. The reviewers expect to publish their findings by late 2014.

Euler U, Wegewitz UE et al. Interventions to support return-to-work for patients with coronary heart disease. Cochrane Database of Systematic Reviews 2013; 9: CDo10748. ohaw.co/1gDy7rw

DIVERS' PTSD

Search and recovery divers whose work includes the recovery of missing persons' remains are not at an elevated risk of symptoms of post-traumatic stress disorder (PTSD) when compared with divers with no such experience, a study by the Department of Epidemiology and Public Health at University College Cork in Ireland has found.

The cross-sectional study issued questionnaires to 206 active Irish Underwater Council search and recovery divers (75% response). The 22-item questionnaire addressed three symptom groups – intrusion, avoidance and hyper-arousal – and incorporated questions from the revised Impact of Event Scale (IES-R) and an amended Coping Factor questionnaire, reproduced from a study of American divers.

The results did not support the hypothesis that accumulated exposure to critical events increases the risk of PTSD symptoms. In fact, divers with recovery experience scored lower for all three PTSD dimensions – although only intrusion scores were statistically significant. The paper notes that this may be due to a survivor bias, or possibly a 'wear-off effect' of PTSD symptoms for the most experienced divers. It recommends further research into this area. The study also found that the three highest-rated coping factors were training, support from peers/search unit and sense of duty.

The paper acknowledges that no normative values have been established for the IES-R and, therefore, that the absolute level of

PTSD symptoms in the study should be interpreted with caution. The results may also be subject to selection bias, say the authors, as all divers had passed a diving medical before taking part in search operations.

Carey T, Gallagher J et al. Post-traumatic stress and coping factors among search and recovery divers. Occupational Medicine 2013; 64(1): 31–33. ohaw.co/1hupggj

FOOTBALL MEDICALS

Research exploring the content of medical examinations performed by professional football clubs in the Netherlands has found that few meet Dutch guidelines for periodic medical examinations of workers.

Researchers at the Coronel Institute of Occupational Health in Amsterdam sent a questionnaire to physicians working for the 36 clubs in the top two divisions of Dutch professional football. Physicians from 26 clubs participated, but only 15 responses were analysed because of incomplete data. They were asked which of 14 listed physical and psychological elements were assessed during medical examinations.

The study found that cardiovascular and respiratory examinations of players take place in most Dutch professional football clubs – reported by 15 and 13 physicians, respectively. However, other types of examinations, such as neurological (four clubs) and urinary (two) and mental health (one), occur much less frequently.

The researchers recommend that minimum standards for medical examinations in professional football should be developed and implemented to ensure consistency between clubs.

Gouttebarga V, Sluiter JK. Medical examinations undertaken by Dutch professional football clubs. Occupational Medicine 2013; doi: 10.1093/occmed/kqt129.

Back injury link to daily patient transfers

A prospective cohort study of 5,017 female eldercare healthcare workers (HCWs) in Denmark identified an increased risk of back injury associated with daily patient transfer. Baseline data collected in 2004–05 and follow-up data in 2006–07. Information on low-back pain at baseline, patient handling, use of assistive devices and back injury at work in the previous 12 months was gathered by questionnaire (78%–80% response). At follow-up, 3.9% of HCWs reported a recent back injury at follow-up (0.5% recurrent cases, 3.4% new incidents) – the figure was higher (5.0%) among those doing daily patient handling. The estimated population attributable fraction (ie the proportion of back injuries caused by daily patient transfer) was 36%. Frequent and very frequent use of assistive devices reduced risk in those doing daily patient transfer: odds ratios = 0.59 (95% confidence interval (CI) 0.36–0.98) and 0.62 (CI 0.38–1.00) respectively. *Scandinavian Journal of Work Environment and Health* 2014; 40(1): 74–81.

Work-related upper limb disorders

There is no consistent evidence that conservative therapies (rather than clinical interventions) provide any benefit for work-related disorders of the neck, arm or shoulder, according to this Cochrane systematic review. It includes 62 papers covering 44 studies with a combined total of 6,580 participants, and assesses 25 different interventions, including exercise, ergonomics, behavioural therapies (eg relaxation, cognitive strategies, biofeedback), massage, electrical therapy and manual therapy. There is very low quality evidence that exercise does not affect pain, sick leave, disability or recovery. There is low quality evidence that ergonomic interventions do not decrease short-term pain, but can improve it in the long term. There is no evidence for any consistent effects of behavioural or other interventions. *Cochrane Database of Systematic Reviews* 2013; 12: CD008742.

Feeling poorly predicts employment exit

A systematic review of 44 studies finds that a perception of being in poor health is predictive of becoming unemployed, retiring early or going on disability benefits. Self-perceived poor health is a significant risk factor of leaving work through: unemployment in 14 out of 17 studies (pooled relative risk (RR) = 1.44; CI 1.26–1.65); disability pension in 13 out of 13 studies (RR = 3.61; CI 2.44–5.35); and early retirement in six out of nine studies (RR = 1.27; CI 1.17–1.38). The estimated population attributable fractions (ie the proportion leaving the labour market due to self-perceived poor health) are 36.9%, 7.0% and

4.7%, respectively for disability pension, unemployment and early retirement. Workers with mental health problems are at increased risk of leaving through unemployment (RR = 1.61; CI 1.29–2.01) and disability pension (RR = 1.80; CI 1.41–2.31). No studies reported on possible associations between mental health and exiting via early retirement.

Occupational Environmental Medicine 2013; online first; doi: 10.1136/oemed-2013-101591.

Back pain absence variability

A systematic review (45 included papers) and meta-analysis (34 papers) of research evidence on low-back pain and sickness absence in different working populations and settings finds that around one in three (32%) affected workers remain absent after one month, but that the ratio falls to one in 14 (7%) after six months. Methodological differences between the various studies are important in explaining much of the variation in reported return-to-work (RTW) outcomes. Notably, participation bias (a measure of how representative the studies are of the actual populations under investigation) is significantly associated with the pooled RTW estimate. For example, studies with a low risk of bias had a pooled estimate of 59% RTW (CI 46%–70%) after one month, whereas those with a moderate risk of bias had a pooled estimate of 90% RTW at one month (CI 57%–98%). Methods of data collection and study setting also explain some of the variation, with higher RTW rates found in studies using electronic compared to self-reported data.

Occupational Environmental Medicine 2013; online first; doi: 10.1136/oemed-2013-101571.

Head injury increases PTSD risk in military personnel

Traumatic brain injury (TBI) during an individual's most recent military deployment is the most significant predictor of post-traumatic stress disorder (PTSD), even when accounting for pre-deployment symptoms, previous TBI and combat intensity, a longitudinal study of 1,648 US marine and navy personnel finds. The study was carried out between 2008 and 2012 with personnel deployed to Iraq or Afghanistan, with data analysed one week before deployment and at one-week and three-month follow-up. PTSD symptoms were assessed using the Clinician-Administered PTSD Scale (CAPS). Forty participants (2.3%) had CAPS scores over 65 (indicative of PTSD) at three months follow-up; 295 individuals (17.9%) reported a TBI during their deployment. PTSD risk was highest for participants with severe pre-deployment psychiatric symptoms, high combat intensity, and deployment-related TBI. Mild TBI raised the predicted CAPS score by 23% ($p < 0.001$; OR = 1.23; CI,

Research Plus, funded by a grant from the British Occupational Health Research Foundation, is freely available to all OH professionals.



www.bohrf.org.uk

We would also like to thank NHS Health at Work for their help with the review process.



Health at Work

1.11–1.36), and moderate/severe TBI raised it by 71% ($p < 0.001$; OR = 1.71; CI, 1.37–2.12).

JAMA Psychiatry 2013; online first: doi: 10.1001/jamapsychiatry.2013.3080.

No lung cancer link in baking industry

Male bakers are not at increased risk of lung cancer, according to this international research project. Data were drawn from the SYNERGY study of occupational cancers being carried out in 16 countries. The analysis involved 974 individuals – 852 men and 122 women – doing baking jobs (bakers, pastry cooks etc). For male bakery workers, there was no increased risk of lung cancer (OR = 1.01; CI 0.86–1.18). There was an increased risk in women (OR = 1.87; CI 1.02–3.42), but the reported raised risks were down to a single study from Italy, which the authors put down to a ‘chance finding’.

Occupational Environmental Medicine 2013; 70(11): 810–814.

Modifiable risk factors for sciatica

A systematic review finds both modifiable and non-modifiable risk factors for new-onset sciatica. Eight papers met inclusion criteria, seven of which were from Finland. Incidence rates range from 0.64%–4.1%, when restricted to hospitalised cases, and 5.7%–37% when sciatica is defined as referred pain in the leg. Identified modifiable risk factors are smoking status, obesity/overweight and working in a manual occupation. Non-modifiable risk factors are age and history of back pain. Evidence quality is generally good or moderate, with low risk of bias in two papers and moderate in five. The authors advise caution in interpreting the results because the identified modifiable risk factors are also associated with other potential contributory factors, such as lower socioeconomic status and unhealthy lifestyle choices.

Physiotherapy Research International 2013; online first: doi: 10.1002/pri.1572.

Return to work after injury

Patients’ own assessments of the severity of an accident and their ability to cope with their injury strongly predicts how much time they will take off before returning to work, according to this prospective follow-up study from a Swiss hospital. A total of 221 working-age participants hospitalised with an unintentional injury (traffic, home or work accident) were assessed using the Injury Severity Score (ISS) and the Glasgow Coma Score (those with a GCS below 9 were excluded). Socioeconomic characteristics were assessed by semi-structured interview; self-perceived injury severity and ability to cope were measured on five-point Likert scales; and post-traumatic psychological

symptoms were evaluated using the Impact of Event Scale (IES). Sickness absence was measured at six months, and varied from six to 183 days (mean = 96 days). Regression analysis revealed that ISS, sex, age, type of accident and IES intrusion scores together predicted about 25% of the variance in the time off work at six months ($p < 0.001$), with the individual’s perception of their injury severity and ability to cope together accounting for an additional 9% ($p < 0.001$). Patients who perceived their accident severity as higher and their coping skills as lower had twice as many days off compared with those who rated their accident severity as lower and coping skills as higher – mean difference = 68 days ($p < 0.001$).

BMJ Open 2013; 3: e003635.

Occupational asthmagens

A huge systematic review and evidence grading covering 865 papers, provides the first evidence-based list of substances as well as worksites causing allergic occupational asthma. The selected papers were rated for quality using the Scottish Intercollegiate Guideline Network (SIGN) grading system, with the evidence strength for each causative agent subsequently graded according to the modified Royal College of General Practitioners three-star classification. The strongest evidence (three stars) was found for co-exposure to various laboratory animals; with 18 agents or worksites given a moderate (two-star) rating, including reactive dyes, flour and latex. A further 78 agents were variously rated as having very weak to moderate supporting evidence, with 275 agents, worksites or professions having no scientific evidence.

International Archives of Occupational Environmental Health 2013; online first: doi: 10.1007/s00420-013-0866-9.

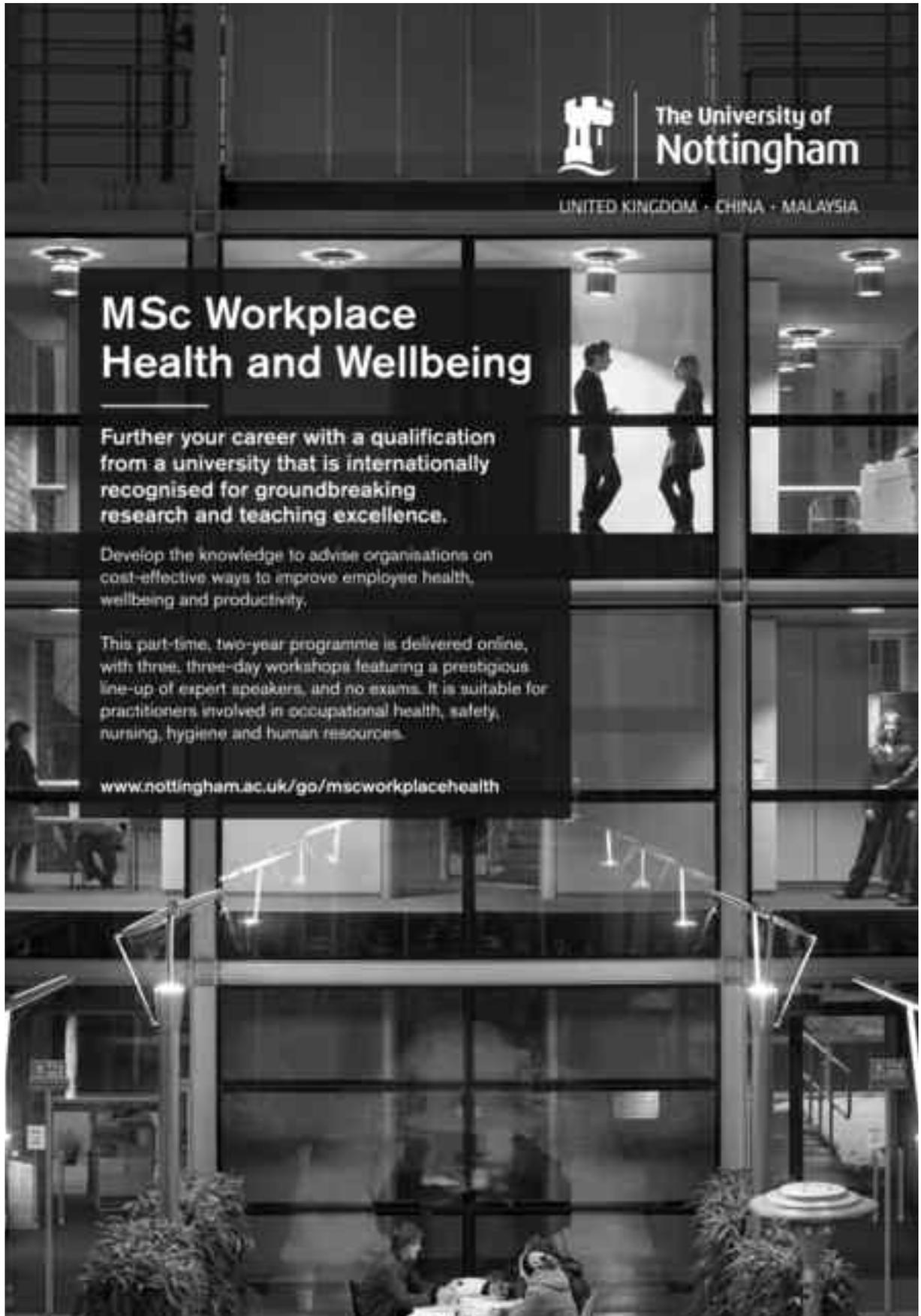
Trainee nurses’ wet work risks hand eczema

Wet work is a significant risk factor for new hand eczema, according to this Dutch prospective cohort study involving 533 trainee nurses followed up for one to three years. Participants completed health questionnaires, as well as pocket diary cards charting occupational wet work and skin symptoms. Those reporting symptoms were seen by an occupational physician specialising in dermatology. Eighty-
▶ one new cases of hand eczema were identified, mostly in the first year of training. Frequent hand washing (more than eight times per shift) was associated with hand eczema (odds ratio (OR) = 1.5; CI 1.02–2.25). However, frequent hand washing at home (OR = 2.3; CI 1.5–3.7) and having a job ‘on the side’ involving wet work, such as healthcare not associated with their training, bar or restaurant work (OR 1.6; 1.0–2.4), were independent risk factors.

Contact Dermatitis 2014; 70(1): 44–55.

Research Plus
signposts
original
research
and systematic
reviews from a
wide range of
current
publications.
Only peer-
reviewed papers
meeting
evidence quality
criteria are
included.

To advertise your job vacancies, academic courses and tender invitations in *Occupational Health [at Work]*, please call us on 0845 017 6986, or e-mail info@atworkpartnership.co.uk



The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

MSc Workplace Health and Wellbeing

Further your career with a qualification from a university that is internationally recognised for groundbreaking research and teaching excellence.

Develop the knowledge to advise organisations on cost-effective ways to improve employee health, wellbeing and productivity.

This part-time, two-year programme is delivered online, with three, three-day workshops featuring a prestigious line-up of expert speakers, and no exams. It is suitable for practitioners involved in occupational health, safety, nursing, hygiene and human resources.

www.nottingham.ac.uk/go/mscworkplacehealth

BRIEFING your need-to-know guide to this issue

The most common reason for using pre-employment or pre-placement health questionnaires or declarations is to identify where an individual might need adjustments because of a disability or health condition, finds the latest research from *OH [at Work]*.

The government has confirmed that the proposed tax exemptions for interventions recommended by the forthcoming Health and Work Service will extend to medical treatments recommended by employer-arranged OH services.

A review by the government strongly supports the use of telephone-based assessments, citing evidence that such arrangements can help facilitate a timely return to work.

A Scottish appeal court has outlined the key issues a 'reasonable' employer should take into consideration when deciding how long to wait before dismissing an employee absent on long-term sick leave.

The first triennial view of the HSE concludes that there remains a very strong case for the functions set out in the *Health and Safety at Work etc Act 1974* to continue to be delivered by an 'arms-length body' such as the existing regulator.

Occupational
Health [at Work]

ISSN 1744-2265

Editor: Dr John Ballard

Contributing editor:
Paul Suff

News and features writer:
Rebecca Ghani

Production director:
Claudia Philips

Editorial enquiries:
email: editorial@atworkpartnership.co.uk

Occupational Health [at Work] is published six times a year by The At Work Partnership Ltd. We aim to publish authoritative and accurate information, but our publications are for guidance only and are not official information sources and we do not accept liability for the consequences of any errors or omissions. All rights reserved. It is not permitted to reproduce, store or transmit any part of this journal, in any form or by any means.

The At Work Partnership Ltd
Elwood House
42 Lytton Road
Barnet EN5 5BY
tel: 0845 017 6986

© The At Work Partnership
2014



Subscription form

I would like an annual subscription to *Occupational Health [at Work]* at the rate of:

Main rate:

£199 (UK) per annum £209 (overseas, including ROI) per annum

Discounted rate for sole traders/self-employed practitioners, charities and universities:

£129 (UK) per annum £139 (overseas, including ROI) per annum

Guarantee: If at any time, and for any reason, you need to cancel your subscription, you will receive a full refund for unmailed issues

Payment options

Please invoice me/my organisation
 I enclose a cheque made payable to: **The At Work Partnership Ltd**

Title: _____ First name: _____ Surname: _____

Position: _____

Organisation: _____

Address: _____

Tel no: _____ Fax no: _____

e-mail: _____

Signature: _____ Date: _____

This form is not valid unless signed. Prices valid until 31.12.14.

Occupational
Health [at Work]

Please complete the form and send to:

The marketing department
The At Work Partnership Ltd
Elwood House
42 Lytton Road
Barnet EN5 5BY
tel: 0845 017 6986
fax: 020 8275 8469

e-mail:
subscriptions@atworkpartnership.co.uk

website:
www.atworkpartnership.co.uk

To process this order, your details will be held on our database. We would like to keep you informed about relevant publications, conferences and special offers from The At Work Partnership by post, telephone, fax or e-mail. Please contact us if you do not want to be kept up to date with this information.

