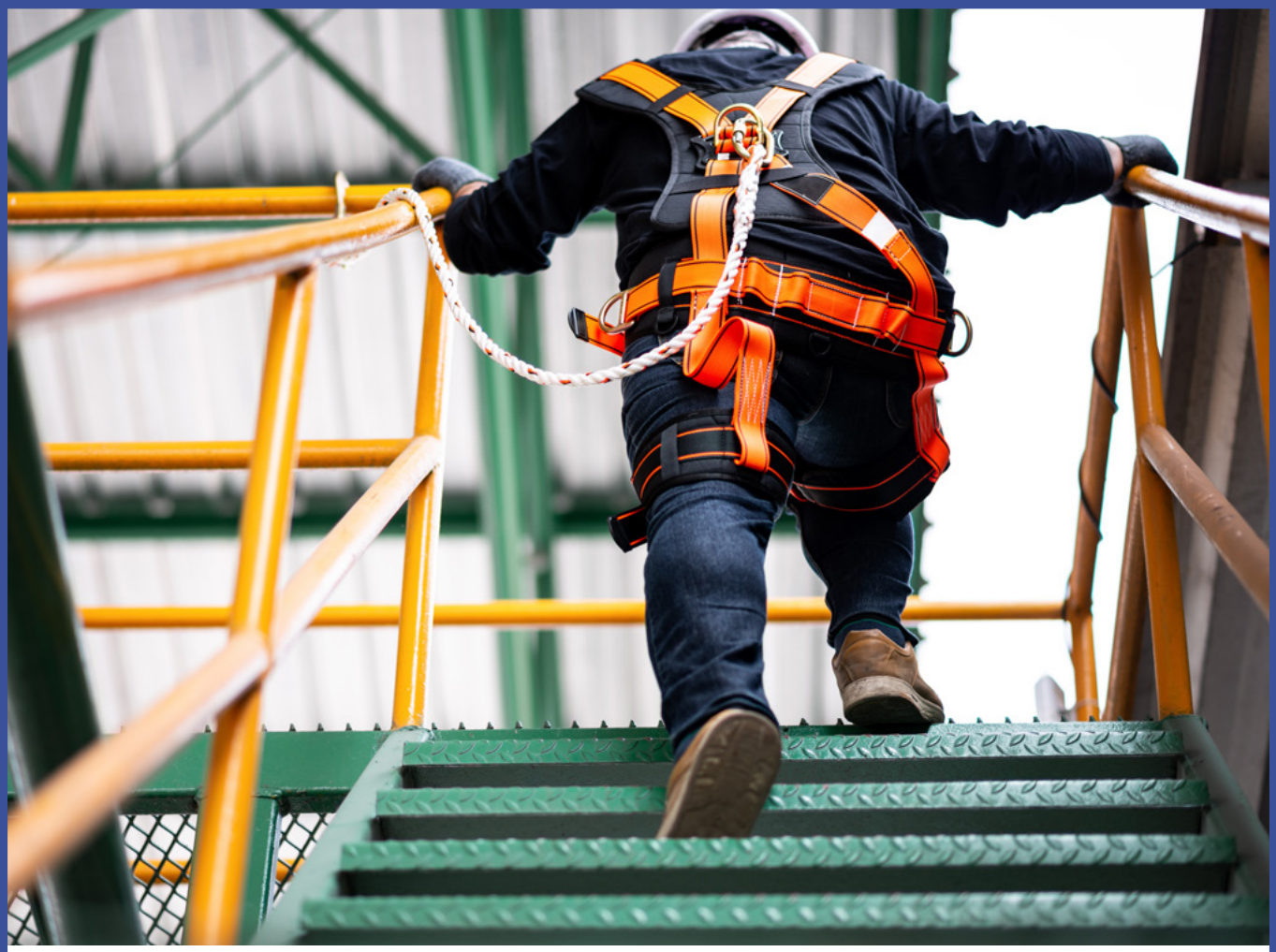
Supporting occupational health and wellbeing professionals



Construction Worker Health Assessment Guidance

Version 1.0: launch copy

The SOM Construction Special Interest Group was formed in July 2020 to produce the Construction Worker Health Assessment Guidance. A multidisciplinary team worked on the project: occupational health (OH) physicians and OH nurses with experience in policy and construction with input from occupational hygienists and health and safety professionals. There is currently no health assessment guidance in place for 'Fitness for Work in Construction'. This is not a legal requirement but has become custom and practice for many sectors of the construction industry. It is hoped this guidance will assist OH professionals working in construction and guide construction professionals in the industry.

SOM would like to acknowledge the Special Interest Group, Chaired by Professor Anne Harriss, specifically:

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1. PREAMBLE

This Guidance has been produced by members of The Society of Occupational Medicine Construction Special Interest Group (SIG) as a resource. This guide is intended to provide background information and assist the practitioner. This is intended to represent good practice at the time of publication.

The group makes no assumption that its recommendations represent the views of all the members of the SOM. While the guidance is presented in good faith, it is the responsibility of the reader to ensure that their approach to matters relating to construction health accords with best current practice, and legal requirements, and the SOM will accept no responsibility resulting from the failure of any reader to ensure that they do so.

The SOM would like to thank the members of the SIG who gave their time and expertise in developing these guidelines. The views expressed do not necessarily represent the views of any particular member of the SIG but are considered best practice by members at the time of publication. Members are encouraged to seek further specialist advice where appropriate.

2. PURPOSE AND SCOPE

The purpose of this document is to provide construction industry guidance for those undertaking occupational health (OH) fitness for task assessments relating to key personnel within the construction and allied industries.

It aims to ensure consistency of approach, terminology & interpretation of results in relation to the fitness for task assessments.

The type of health assessment should be determined in conjunction with the employer or principal contractor purchasing the OH services. It should be based upon the risk of the specific task being undertaken and the consequences of any adverse event relating to the health of the worker.

This guidance relates to fitness for task assessments and not statutory health surveillance.

3. DEFINITIONS

Term	Definition
Clinical governance	A framework for continuous improvement of the quality of professional service. This should be achieved by applying evidence-based practice, implementing clinical standards and guidelines, and workforce planning and employee development.
Risk rating	The level of risk for each role dependent on the work undertaken, place of work, and risk to others.
Data	All records and correspondence; including anything that is, or represents, a fact, for example text, numbers, graphics, sound, video. This includes clinical notes, certificates, emails.
Fitness for task	Checks to ensure a person remains fit to carry out tasks without risk to themselves or others. Results of health checks to be checked against a set of standards for tasks.
Informed consent	Consent to an assessment or release of a report/certificate, freely given following a full explanation and documentation of this process in clinical notes.
Line manager	The person who has personal responsibilities for an individual.
Health and safety manager/ responsible person for construction contractor	When a line manager is not on duty, this might be a responsible on-call manager.
(in the context of medical fitness)	The person who has responsibility for ensuring that medical fitness is assured before works commence and any records are received, stored and recommendations/restrictions are adhered to. They will communicate with the managers, principal contractors etc. on health and safety matters arising from medical fitness assessment outcomes. They are responsible for ensuring that medical fitness can be managed and assured before works commence and that health checks are in place and in date.
Occupational health manager	The person who manages the occupational health service; this is generally a registered health professional with additional specialist qualifications in occupational health / occupational medicine.
Occupational health provider	An approved occupational health service that has met the minimum requirements set out to undertake fitness assessments for individuals working in construction and allied industries.
Occupational physician	A physician registered with the General Medical Council (GMC) holding an additional qualification in occupational medicine. They are competent to give advice on fitness for work in general and safety critical work in particular. As such, will be able to show current evidence of knowledge, experience, skills and understanding relevant to occupational health practice in the construction industry. If not on the specialist register, the OH physician should have access to an accredited specialist in occupational medicine on the specialist register of the GMC (FFOM or MFOM) for escalation or guidance as required.
Occupational technician (OT)	A member of the OH team working in a non-medical/non-nursing capacity, often employed to undertake the practical elements of a health assessment. Their work must be supervised by an occupational health physician or nurse. They are not currently subject to statutory regulation.
Occupational health nurse	A nurse registered with the Nursing and Midwifery Council, who may hold an additional post registration specialist qualification in occupational health.
Safety critical work	Any task identified by risk assessment that could result in harm to the individual worker and to other employees and third parties should the individual worker experience incapacity.
Safety critical area	An area onsite identified by risk assessment that could result in greater harm to the individual worker should they experience incapacity.
Sudden disabling event	The DVLA defines the risk of a sudden disabling event as: • 20% likelihood of an event in 1 year for Group 1 licensing, • 2% likelihood of an event in 1 year Group 2 licensing.
Stable medical condition	The individual's long-term condition is predictable, does not change rapidly, and medical treatment is established and not likely to involve frequent change or modifications.

4. BACKGROUND

Background

In 2000/2001 the government announced the Securing Health Together strategy for reducing the incidences of work-related health.

The construction industry responded by setting its own targets to reduce ill health, recognising that perhaps like many other industries, the health part of health and safety was not being given the same attention as safety.

A successful pilot study ran between 2004-2006, which looked at the possibility of implementing a National OH scheme for construction and raising awareness of OH issues. It highlighted an inconsistent and uncoordinated approach to OH risk management.

A further period of consultation followed with both the construction industry and OH providers discussing the main issues. Several key requirements were determined including the provision of a solution for the consistent and coordinated approach to construction work related health risks through the development and publication of industry standards.

On 1st August 2007, Constructing Better Health (CBH) became a not-for-profit organisation delivering the National Scheme for the management of OH in the construction industry, with the aim of improving the health of the industry workforce.

CBH continued working with interested parties; several OH providers applied to become members of the CBH scheme, and they were enlisted as members following a desktop audit of their services. Further guidance was produced.

Other initiatives were also being considered. In March 2008 Dame Carol Black's review of the health of Britain's working-age population, 'Working for a healthier tomorrow' was published. This promoted clear standards of practice and a formal system of accreditation for all OH providers who support working age people.

This was then endorsed in the response from the Government in their review, 'Improving health and work: changing lives'.

The Faculty of Occupational Medicine (FOM) responded by forming and leading a broad, multi-disciplinary stakeholder group to develop standards and an accreditation scheme for OH services.

The original standards were launched as SEQOHS (Safe, Effective, Quality OH Services) in 2010 and the scheme was launched in December 2010.

Since that time SEQOHS accreditation has been perceived as a key component in strengthening quality improvement initiatives within OH by the formal demonstration of competence and compliance with the standards set by FOM.

The original SEQOHS standards were revised in 2015 and incorporated the recommendations of CBH. In September 2014 CBH and SEQOHS announced a collaboration to encourage and enhance the accreditation of OH service providers to the construction industry.

The CBH Scheme closed on 31 August 2020 and B&CE is no longer trading in the OH space. All members of the CBH Scheme (employers, contractors, and OH providers) [and the public] were advised of the scheme closure and the requirement to cease use of any CBH materials, which includes the CBH Construction Standard.

B&CE own the rights in the CBH Construction Standard and unless an occupational health service (OHS) is licensed by B&CE to use the standards, B&CE have requested that OHS's should refrain from making use of or referring to the CBH Construction Standard.

The SOM Construction Special Interest Group (SIG) was formed in July 2020 to produce the Construction Worker Health Assessment Guidance.

5. OBJECTIVES

The aim of this document is to:

- Promote consistency of approach to the assessment of specific workers ensuring they are suitably medically assessed to perform the specified tasks without damage to self or others. These workers are collectively referred to as safety critical workers (SCW).
- Ensure that results from assessments are interpreted to draw meaningful consistent conclusions from the information supplied.
- Promote evidenced based best practice in line with professional standards.
- Assist the employer in meeting health and safety legislative requirements and Health and Safety Executive (HSE) guidance.

6. RESPONSIBILITIES

The ***purchaser (construction client/employer)*** is responsible for:

- Undertaking risk assessments in line with relevant legislation.
- Arranging site safety Medical/Health Assessments with their chosen OH provider as necessary.
- Ensure that those working in a safety critical role have been declared medically fit to do so and that the health certificates are kept securely.
- Maintaining site safety medical fitness certification for those working onsite and referring them back for reassessment when required.
- Ensure the worker attends for health assessment as directed and that the worker can attend.
- Referring workers back, before expiry of their current certificate, for site safety medical/health assessment when there is a change in health or medication that may affect fitness depending on their tier.
- Referring workers back, before expiry of the current certificate or after four or more weeks of ill health related absence, depending on their level of site safety fitness.

The ***worker*** is responsible for:

- Attending for site safety medical assessment when instructed to by their employer/client.
- Declaring their state of health honestly.
- Agreeing to undertake a clinical assessment, which may include:
- physical examination,
- biometric assessment,
- providing additional information, drug and alcohol testing as part of their site safety health assessment. This is dependent on the required tier of fitness.
- Reporting a change in health status and medication to their manager (this can be done without disclosure of the condition) for referral back for site safety medical assessment.
- Complying with safe systems of work and adjustments directed on their site safety certificate.
- Alerting their manager to behaviour or symptoms observed in another worker that may place that worker and others at risk, for referral for site safety medical assessment.
- Understanding that failure to attend or comply with site safety medical/health assessment will result in a report to their employer/manager, advising that fitness cannot be determined.

The ***occupational technician*** is responsible for:

- Undertaking biometric assessments and recording the results as part of the site safety medical/health assessment.
- Acting upon the results in line with clinical protocols set by the employing OH provider. This may vary subject to the competence of the OH technician and whether there is a clear clinical decision-making tool that they can follow and declare a suggested outcome based on this.
- Their work must be supervised by an OH physician or OH nurse.
- Escalating outcomes against a set of criteria for each tier level required and according to the escalation process of their employing occupational health service (OHS).

The ***occupational health nurse*** or ***occupational physician*** is responsible for:

- Conducting site safety medical/health fitness assessments in accordance with best practice.
- Escalate the assessment to the occupational physician or lead occupational physician if deemed necessary following their assessment and level of competence.
- Notifying the employee and relevant manager/HR/H&S of the outcome of the assessment with a written statement of fitness including any adjustments, restrictions and recommendations required. This may include a functional capability test for the employer to undertake.
- Determining the frequency of medical/health assessment (periodic medical) review and for stating this on the site safety medical certificate.

7. RELEVANT LEGISLATION

In addition to the employer's common law duty to provide a safe place of work with safe plant, equipment, management systems and a competent workforce, they also must meet the requirements of relevant legislation.

When the employer makes decisions based on 'safety critical work' or 'safety critical workers', they will need to use the relevant legislation as a source of information to assist them in their hierarchical approach to risk assessment and to enable them to eliminate or reduce the risk with an attempt to declassify the 'safety critical' aspects.

HSE ACOPs provide guidance and practical advice in relation to managing people with pre-existing conditions, for example the HSE ACOP and guidance for confined spaces explains:

The competent person should also consider other factors about an individual, for example concerning pre-existing medical conditions (claustrophobia, respiratory conditions like asthma etc.) or physical strength and abilities (e.g. wearing heavy breathing apparatus), and other advice on an individual's suitability for the work. (Reference L101, third edition, published 2014.)

The following list (not exhaustive) gives examples of such legislation:

- Health and Safety at Work etc. Act 1974 (HSWA) - an 'Umbrella' Act from which all other occupational health and safety legislation is created. The HSWA sets out the very general duties and requirements and imposes general duties on employers under Section 2 to ensure, so far as is reasonably practical, the health, safety, and welfare at work of their employees. This specifically includes ensuring that:
  - » there is a safe system of work,
  - » there is a safe place at work,
  - » staff are given information, instruction, and training on matters of health and safety and are adequately supervised,
  - » there is a safe system for the handling, storage and transport of substances and materials,
  - » there is a safe working environment.

  Based on applying Section 2 of the HSW Act 1974, the employer has a duty to ensure that an employee is fit to carry out the duties that they are asked to carry out once a relevant risk assessment has been carried out.

  Employees have duties under section 7 and 8 to 'take reasonable care' of their own health and safety and the safety of others; to cooperate on any matter of health and safety.
- The Management of Health and Safety at Work Regulations (2006 Amendment & 1999) - which set out the responsibilities of all employers to manage health and safety, to carry out risk assessments, decide to implement necessary measures, appoint competent people, and arrange for appropriate information and training.
- **Common Law Duties of employers:** Employers have a common law obligation to take reasonable care of all their employees and to guard against the risk of injury to their workers if the risks are reasonably foreseeable, this could include ensuring that the employee does not have a physical or mental impairment affecting their ability to carry out the role.
- Management of Health and Safety at Work Regulations 1999.
- Equality Act 2010 - Legally protects people from discrimination and refers to 'protected characteristics'.

8. DATA PROCESSING

The Data Protection Act 2018 and The General Data Protection Regulation (UK GDPR) 2018 Article 9 (2) (h): of the GDPR 2018 processing is necessary for the purposes of: (h) preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services on the basis of domestic law or pursuant to contract with a health professional and subject to the conditions and safeguards referred to in paragraph 3.

Legitimate interest is the most flexible of the GDPR's lawful bases for processing personal data.

There is a three-step process to determine if there is a legitimate interest.

- Purpose test - is there a legitimate interest behind the processing?
- Necessity test - is the processing necessary for that purpose?
- Balancing test - is the legitimate interest overridden by the individual's interests, rights, or freedoms?

Data should be processed and stored in accordance with the OH provider's privacy statement.

9. THE CONSTRUCTION INDUSTRY

Key Facts from House of Commons Briefing Paper 01432 - Construction Industry Statistics and Policy - December 2019.

The construction sector includes the development and construction of residential and non-residential buildings; construction work on civil engineering projects; and specialist construction activities (such as plumbing and electrical installation). NOTE: this is based on Standard Industrial Classification (SIC): Construction, Section F, made up of codes: 41; 42; 43.

In 2018, construction contributed £117 billion to the UK economy, 6% of the total.

There are 2.4 million construction industry jobs in the UK (in Q2 2019), 6.6% of all jobs.

The construction industry is unusual because of the high proportion of self-employment in the sector - 36% (in Q2 2019), compared to the average for the whole economy of 13%.

New orders to the construction industry were worth £61.7 billion in 2017. New housing orders accounted for 35% of all construction orders, commercial orders accounted for 25% and infrastructure orders accounted for 19%.

In very simple and general terms the 'construction industry' can be broken into two main areas:

- The 'Civil Engineering Industry' deals with the design, construction & maintenance of infrastructure and structures that serve society such as roads, railways, bridges, tunnels, aqueducts, canals, docks, ports, harbours, breakwaters, power stations, windfarms etc. The term 'Civil Engineering' is used to differentiate it from 'Military Engineering' which would relate to the design and construction of fortifications, military earthworks, transport, and communications systems etc. designed to aid the military.
- The 'Construction/Building Industry' is a sector that deals with the design, construction, maintenance (and demolition) of public and private structures such as dwellings, shops, offices, schools, hospitals, carparks etc.

The purchase of OH services may come from the employer of a construction industry worker or from the principal contractor overseeing the project to which the worker has been contracted to deliver a service.

Health surveillance is the responsibility of the employer. It is a process of monitoring employee health where they are exposed to a specific health risk to detect work-related ill health at an early stage and act on the results. In other words, to ensure the worker's health is not affected by the work activity. Whereas the principal contractor may commission an OH service to ensure the medical suitability of contractors to undertake specific tasks on their sites to promote safety.

10. DETERMINING THE RISK AND APPROPRIATE HEALTH ASSESSMENT

As part of their risk assessment process employers are obliged to identify safety critical workers and tasks to enable them to implement suitable controls to ensure that individuals are fit to carry out their work, therefore reducing the risk of harm to co-workers and members of the public including emergency services. Fitness may be affected by ill health (so far as is foreseeable) or a side effect of medication, or impaired as a result of alcohol consumption or the use of non-prescribed and prescribed drugs.

The employer may find it useful to take a multi-disciplinary approach to risk assessment involving health and safety professionals, OH service providers and HR departments, whilst also engaging and involving workers through consultation, which will foster ownership and understanding.

A suitable risk assessment of any job role, activity or task should identify whether there could be a significant risk of harm to the worker, or others, in the event of incapacity of the worker undertaking those activities.

Examples of jobs which may be associated with such harm includes, but is not limited to:

- Driver
- LGV/HGV driver
- Maritime operative
- Plant operators
- Scaffolder/Rigger/Roofer
- Slinger/Signaler/Banksman/Traffic Marshall
- Steel Erector Structural /Fabricator
- Steeplejack/Masons
- Tunnel Boring Gangs
- Roadside (highspeed)
- Tunneling/Miners
- Confined space workers
- Working at Height where collective measures are not practicable
- Tower crane operators
- Others identified by the risk assessment process.

Risk Management

When making a clinical decision regarding the outcome of a fitness for task/SCW health assessment, a risk assessment approach should be used; the following approach may be considered:

- *What is the likelihood of any type of medical event that might lead to incapacitation?*
- *What would be the likely impact of that incapacitation in relation to safety?*
- *What would the consequence be for the individual/others/ the community?*
- *Consider the scale of harm that might result.*

Risk level	Example/consequence:
High	Sudden incapacity, ill health or other impairment could cause significant loss, including multiple fatalities.
Medium	Sudden incapacity, ill health or other impairment could cause injury to self and result in significant difficulty to rescue worker/workers, e.g. from confined space. Fatality unlikely as a result other than to individual if the medical incident itself was fatal.
Low	Sudden incapacity, ill health or other impairment could cause injury just to self, others would not be affected.

11. QUALITY ASSURANCE

Quality assurance is a necessary part of any service, especially for services that offer health advice on workers undertaking 'safety critical' tasks.

Broadly, service providers can implement a process of quality assurance by:

- mapping of quality approved business processes to set standards/policies,
- auditing compliance with these standards/policies and any other industry specific standards (such as those for calibration & clinical practice) to ensure they are met,
- internal review of service via surveys and focus groups to ensure internal stakeholders agree that documented processes deliver a high-quality service,
- external review of service to ensure external stakeholders, such as clients, agree that processes deliver a high-quality service,
- Reporting and action-tracking on a regular basis,
- regular reviews.

12. GOVERNANCE

Robust clinical governance is key to the provision of a high quality, safe and effective service.

A service can approach clinical governance using a range of audit and assessment tools to provide a structured framework in which to proactively manage risks to health of workers.

The core to clinical governance is a set of robust clinical standard operating procedures (SOPs). These SOPs will provide the basis to which clinical governance will be assessed and determined.

Equally important is a clinical governance framework. A framework should outline how (i.e. audit and/or observation) & when (i.e. frequency) clinical governance activities are undertaken, which is often determined by the level of risk as specific to the individual delivering the clinical service.

The key outcome to clinical governance is that steps are taken to rectify and/or improve any outcome that is deemed to fall below the required standards.

Occupational health physicians:

Occupational health physicians (OHPs) are required by law to possess skills and expertise including an understanding of the health hazards that can arise at work, the ability to assess risks relating to the health of individuals and groups, knowledge of the law relating to workplace issues and an awareness and understanding of the way business operates.

There are currently three levels of qualification in occupational medicine for doctors:

- the Diploma in Occupational Medicine (D.Occ.Med.)
- the Associateship of the Faculty of Occupational Medicine (AFOM)
- Membership of the Faculty (MFOM).

In addition, the Fellowship of the Faculty (FFOM) is awarded to those occupational physicians with MFOM who have made a distinguished contribution to the specialty and who demonstrate a greater depth of experience and expertise in occupational medicine.

Doctors without these qualifications who rely solely on experience gained in the workplace may not meet the requirements for competence that are demanded by many aspects of health and safety legislation.

It is recommended therefore, that the Diploma in Occupational Medicine be used as the minimum standard for the construction industry. However, individuals should work within the limits of their competence and be cognisant of the need to access specialist occupational physician advice as needed. The level of OH expertise will need to be commensurate with the level of health risk identified for the project e.g. for a complex construction project it would be usual for the OH provision to be led by a consultant OHP who appears on the GMC Specialist register.

The GMC (www.gmc-uk.org) can confirm the qualifications and specialist status of a medical doctor.

Revalidation is the mechanism whereby doctors demonstrate, at regular intervals, that they remain up to date and fit to practice. Revalidation is required every five years.

Occupational health nurses:

Nurses carrying out OH activities should hold current registration with the Nursing and Midwifery Council (NMC), as a minimum. They may also hold an OH qualification at Certificate, Diploma or Degree level.

If they do not have an OH qualification, then they should be working under the supervision of an appropriately qualified clinician (doctor or nurse). Nurses will need to renew their registration every year and revalidate every three years with the NMC. A nurse led OH service should have access to a specialist OHP for advice as needed.

Occupational health technicians:

The occupational health technician (OHT) is a developing role. With the expert supervision of OH qualified nurses and doctors and the correct training, they may be able to carry out aspects of OH activity required within an OH programme. They are often considered as valued members of the OH team and skilled in the 'hands-on' assessments integral to both health assessments and statutory and non-statutory health surveillance. Unlike health care professionals, including medicine and nursing, they are not currently subject to statutory regulation. As they are not yet members of a regulated profession their practice should be restricted to following specific written protocols and under the supervision of a regulated health care professional such as a doctor or nurse who takes responsibility for their acts and any of their omissions. Where a registered nurse is working as an OHT, they remain accountable to their professional body and code of conduct.

Arrangements for information governance

Standards relating to information governance is included within the SEQOHS standards set by FOM and can be used for bench marking purposes.

All OH providers shall maintain OH clinical records. This shall include:

- maintaining records to meet legal and regulatory compliance and professional best practice recommendations,
- arrangements for backing up computer data, backup verification, a safe backup system and authorisation for loading programmes where a computer is used, and
- procedures for the transfer of records on change of contract or close of business.

All approved OH providers shall make arrangements to protect the confidentiality of OH clinical records including:

- briefing their employees of their responsibility to protect confidentiality,
- the safe and secure storage, transportation, and disposal of all hard copies of OH clinical records in accordance with organisational policy and any statutory requirement,
- preventing unauthorised access to digital data, and
- processes to protect the intellectual property of customers.

Arrangements for the clinical governance of Medical Examiners

All approved OH providers shall have a Responsible Occupational Physician.

The Responsible Occupational Physician shall make arrangements to assess the competence of Medical Examiners, audit their work and provide Medical Examiners with advice in case of doubt.

The OH provider shall make and document arrangements for quality assurance and clinical governance that reflect current evidence-based guidelines and national guidelines. This shall include the following:

- processes for the management of competence, recruitment, supervision and continuing professional development of staff and contractors,
- OH professionals shall carry identification cards for all site visits detailing their name, job role and the name of the approved OH provider they work for,
- a defined management structure for the delivery of clinical protocols, risk management, internal audit, and review of their delivery, and
- arrangements to detect and address, as early as possible, unacceptable clinical practice and concerns regarding a member of staff's conduct, performance, and health, and that of any contractors.

13. TRAINING/COMPETENCY

The Health and Safety Executive (HSE) states:

> *Occupational Health professionals can work as independent professionals or as part of an Occupational Health Provider service, and can include doctors, nurses, and technicians.*
>
> *Occupational Health professionals have duties under section 3(1) of the Health and Safety at Work etc. Act 1974, which covers the general duties of employers and self-employed to people other than their employees.*
>
> *These duties require Occupational Health professionals to carry out their undertaking in such a way as to ensure, so far as is reasonably practicable, that they don't expose people not in their employment to risks to their health and safety.*

The FOM state within the 2015 SEQOHS Standards:

> *C1.2 "An OH service must ensure that its staff have the knowledge, skills, qualifications, experience and training for the tasks they perform."*

Each OHS should have a training plan in place with a method for reviewing competencies. This should form part of the clinical audit cycle.

14. THE REQUIREMENTS FOR UNDERTAKING HEALTH ASSESSMENTS

The Facility:

The room used for undertaking any health assessment should be suitable. Some OH providers might use a mobile unit or their own facilities.

If a room on the client site is used, it should have as a minimum a table and two chairs with space to set up all the equipment, access to power points, with access to toilet facilities.

Adequate natural/day light for the colour vision test and sufficient space for assessing visual acuity; in some instances, the viewing distance may only be possible in a location outside of the assessment room. In these cases, all reasonable steps should be taken to ensure privacy and dignity for the individual to be tested.

ISO guidance states that when undertaking audiometry ambient background noise must not exceed 35db. This should be checked via the noise dosimeter app and the noise level recorded as part of the daily checks. It is recognised however, that ensuring this level on site may be difficult to attain as the rooms may not have been purpose designed for undertaking audiometric testing programmes. The location of the room can have a significant impact on the required levels of acoustic isolation. Where possible, rooms used for audiometric testing should be located as far away from possible noise sources such as busy corridors, adjacent roads, traffic noise and mechanical plant. The test may still go ahead if the levels are greater than 35 decibels provided all reasonable steps have been taken to reduce background noise. Background noise levels should be recorded on the health questionnaire.

All reasonable steps should be taken to ensure the privacy of the facilities. This may include, but not be limited to, screening of glass in doorways, positioning of desk and chair away from view of the door.

All reasonable steps must be taken to ensure the work area is clean. Antibacterial wipes should be provided for this purpose.

All reasonable steps should be taken to ensure health and safety is maintained. Safe access and egress to the room should ensure that the floor is free from trip hazards, such as open floor power points, hanging wires and walkways should be free of obstacles. Furniture should be stable and secure, and the room should have adequate lighting, heating, and ventilation.

It is the responsibility of the employing OH service to check and monitor the suitability of facilities as outlined in the SEQOHS 2015 standards set by FOM.

Equipment:

Each OH provider should ensure that equipment is suitably maintained, calibrated, and fit for purpose.

The results of pre checks, verification and validation should be recorded in line with their local policies and procedures.

Documentation:

Each OH service will have their own documentation/ questionnaires, whether paper format or electronic. The need to meet professional standards, best practice and evidence-based guidance should be considered and include compliance with professional codes and guidelines such as those published by the NMC, GMC and FOM.

Record keeping should be subject to regular audit in line with professional bodies and as outlined in the SEQOHS 2015 standards set by FOM.

Consent:

Informed Consent should be obtained prior to the assessment and in line with Data Protection Legislation and your own organisation's Consent Policy. The FOM Ethics Guide provides further detail about consent.

15. CLINICAL PROCEDURES

All OH practitioners should follow the policies and standard operating procedures set by their employing OH service.

As stated in the SEQOHS Standards set by FOM, each OH provider should *"demonstrate clinical governance and compliance with evidence-based and consensus-based guidelines, as well as with professional legal requirements. This includes compliance with the Faculty of Occupational Medicine's guidance on ethics."* Standard C2.4 2015 Standards.

16. THE FITNESS FOR TASK / SAFETY CRITICAL WORKER / SITE SAFETY HEALTH ASSESSMENT

Undertaking any assessment of health should be conducted and overseen within the governance structure of each OH service provider.

Please refer to Appendix 2 for guidance on health assessment criteria.

The following list is the recommended elements of the SCW health assessment based upon the tiered approach.

Clinical History

The aim is to identify any possible medical conditions, previous medical history or medication that could result in an adverse event, e.g.

- sudden loss of consciousness,
- impairment of awareness or concentration,
- sudden incapacity,
- significant limitation of mobility,
- temporary visual impairment, or
- impairment of balance or coordination

that could lead to the safety of the individual or that of others being compromised. The recommendation may be such that it enables the worker to be restricted to non-SCW hence removing that risk. Any restrictions or adjustments to workers tasks remain entirely the decision of the Employer. OH doctors and nurses should manage medical and general health conditions in accordance with guidance for Group 2 DVLA medical standards, as they are a comparable risk to working in a construction situation.

Mental health assessment

The aim is to establish the worker's current mental health and wellbeing status to detect any concentration/cognitive affects, psychiatric condition etc. or suicidal ideation that may pose a risk. This should be overseen by a suitably qualified, competent, registered practitioner and in-line with risk assessment and the tiered approach to risk.

Blood pressure and manual pulse

The aim is check to identify any likelihood of collapse or underlying medical condition.

Hearing/Audiometry

The aim is to ensure any warning sounds, alarms, instructions can be heard, as opposed to health surveillance which aims to identify whether noise has contributed to hearing loss and whether sufficient control measures are in place.

Respiratory Health

To determine physical condition, functional ability, and aerobic capacity to tolerate specific situations, i.e. climbing steps to undertake specific tasks etc.

Visual acuity

Individuals should be assessed against visual standards relating to the role to ensure they are safe to work in the environment and competently carry out the requirements of the task safely. Visual assessments to include central visual acuity distance or near dependent on the tasks required. Peripheral fields, clinical history of aetiology of vision loss, impairment, visual discomfort, and their effects on visual function.

Colour perception

Colour perception assessment is required for any tasks that require colour differentiation as essential to task competence.

Urinalysis

Urinalysis is not mandatory for assessing safety critical work.

Height, weight, and BMI

BMI can be used to screen for weight categories that may lead to health problems, but it is not diagnostic of the body fatness or health of an individual. In addition, obesity may modify the risk for vibration-induced injury and certain occupational musculoskeletal disorders.

It is also a method to check functional ability in line with the demands of a specified task including working in confined spaces.

Mobility and co-ordination assessment

Assessment should be undertaken to ascertain if the individual experiences any condition that is likely to impact on balance, mobility, and co-ordination, to ensure that the individual is safe to work in the environment and carry out the requirements of the task competently and safely.

Drugs and alcohol testing

This is subject to the employer alcohol and drugs policies and procedures including the use of random and for-cause testing techniques.

17. CONTRAINDICATIONS TO ASSESSMENT

Information regarding any contraindication should be clearly set out in the procedure set by the employing OH service provider and based upon best practice, for example the British Society of Audiology.

18. FREQUENCY

The following guidance can be applied but remains subject to the clinical judgement of the OH clinician:

Periodic examinations on employment and 3 yearly.

Shorter expiry dates may be issued for health reasons or for over 65s.

Reassessment is required in the following circumstances:

(1) any episode of convulsion, loss of consciousness, disturbance of consciousness or dizziness;

(2) any episode of visual disturbance;

(3) prescription of long-term medication or newly diagnosed long-term health condition;

(4) any incident or accident where there is reason to believe that the physical or mental health of the person might have been a causal factor or adversely affected by it;

(5) any other circumstances or medical condition which might impair the person's ability to carry out safety critical duties; whether the person has been absent from duty;

(6) any absence certified as being due to a psychiatric disturbance;

(7) any medical absence of more than four weeks.

19. MEDICAL STANDARDS

Each OH service provider should have their own policy on assessment of medical fitness and escalation procedure for further medical evidence.

It is considered that the acceptable risks for being employed in safety critical activities in the rail industry are comparable to those that the DVLA use for group 2 drivers and therefore their guidelines on all the common medical conditions are invaluable to give some level of credibility and justification for decision-making in these very qualitative and not quantitative decisions. This is also considered an acceptable approach within the construction industry.

20. INTERPRETATION OF RESULTS

Each OH service provider should have their own policy on assessment of medical fitness and escalation procedure for further medical evidence.

It is considered that the acceptable risks for being employed in safety critical activities in the rail industry are comparable to those that the DVLA use for group 2 drivers and therefore their guidelines on all the common medical conditions are invaluable to give some level of credibility and justification for decision-making in these very qualitative and not quantitative decisions. This is also considered an acceptable approach within the construction industry.

21. FITNESS OUTCOMES

If the worker reports no health condition and meets the agreed health standards, they may be deemed fit to undertake safety critical work.

If the worker does not meet any of the chosen health standards or reports any health condition which could adversely affect performance or safety the following options should be considered:

- Recommend reasonable adjustments to support the worker in the role.
- Recommend the employer carry out a risk assessment to identify the level of risk that may affect performance or safety.
- Recommend that the worker is temporarily restricted from working in the safety role whilst undergoing further investigation.

Some suggested outcomes are included in Appendix 1.

Each OH service provider should have their own internal procedures for the escalation of cases to a suitably qualified physician.

It would be up to the physician to make a judgement on an individual basis, subject to what the medical condition is, how well controlled it is, likelihood of relapse etc. compared against the type of tasks undertaken and level of risk.

22. GUIDANCE TO EMPLOYER/CLIENT

A fitness for task certificate should be supplied; this should not include any clinical information, just the fitness of the individual for the proposed work and whether any restrictions or adjustments are recommended.

Any restrictions or adjustments should be clearly detailed; it is for the employer/client to decide if they are reasonably practicable.

See Appendix 1 for examples of different outcomes.

23. GUIDANCE TO EMPLOYEE

The worker should be informed of the outcome and the next stage. They must understand the need to notify their manager of any changes to their health.

Any relevant health education, including the use of PPE, should be given, as well as the outcome of the health assessment.

There are many different Medical Assessments, some are required by law, and others are simply recommended as good practice. The OH advisor should assess an individual for the work they will be doing. The assessment will include physical and mental capabilities, existing and past health conditions including medication and previous employment risks. The Advisor will then provide the employer with an outcome report.

The report will indicate one of the three outcomes:

- Outcome 1 - Employee is fit for identified task/role.
- Outcome 2 - Employee is fit with restrictions for identified task/role.
- Outcome 3 - Employee is unfit for identified task/role.

Recommendations for outcomes 2 or 3 could be temporary or permanent for the foreseeable future dependent on the circumstances.

As part of the assessment, the OH advisor should provide health education advice to the worker verbally supported by leaflets and/or signposting to relevant bodies. The report should also advise the employer about PPE, statutory Health Surveillance, or any other related advice.

24. EQUALITY

Consideration must be given to ensure that equality legislation is not breached, although there may be circumstances where an individual is not suitable for the safety critical role.

It is anticipated that each OH service will have their own Equality and Diversity policy, and that each clinician will have been suitably trained.

When assessing fitness for task there are two main applicable laws, they are the Health and Safety at Work Act 1974 and the Equality Act 2010.

Firstly the Health and Safety at Work Act 1974 (HSWA) imposes a duty of care of employers to their employees and others who may be affected by the work they carry out. They are responsible for making sure that all their employees are safe at work and are protected from possible dangers to their health. This includes making sure that the job and the work environment are safe and has no avoidable health risks. Employees are also responsible for their own safety at work, and the safety of their work colleagues.

Secondly, the Equality Act 2010 - a person is considered disabled under the Equality Act if they have "a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to do normal daily activities". For the Act 'impairment' may be a physical or mental impairment, or both. It is not necessary to establish the cause of the impairment and it does not have to be the result of an illness; 'substantial' is more than minor or trivial, e.g. it takes much longer than it usually would to complete a daily task like getting dressed, but it may fluctuate or change, and may not be present all the time; 'long-term' means 12 months or more.

In summary, the HSWA states that every employer must ensure the health and safety of all their employees, whether they have a disability or not, so far as reasonably practicable, and the Equality Act states the employer mustn't discriminate against any employee with a disability, so this means balancing the level of risk against the measures needed to control the risk, as safety must remain paramount, whilst making reasonable adjustments, where possible.

25. AUDIT

Audit measures current practice against a defined (desired) standard. It forms part of clinical governance, which aims to safeguard a high quality of clinical care for patients.

Clinical audit is a process that has been defined as *"a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change".*

Source: http://www.nice.org.uk/media/796/23/BestPracticeClinicalAudit.pdf

Audit should be undertaken of all clinical practice in line with best practice, National Standards, and professional recommendations.

25. REFERENCES

https://www.hse.gov.uk/research/rrpdf/rr584.pdf

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960015/inf4d-d4-medical-examination-information-notes.pdf

https://www.fom.ac.uk

https://www.seqohs.org

https://www.gov.uk/transport/driving-and-medical-conditions

https://www.nice.org/guidance/ng136

APPENDIX 1: FEEDBACK EXAMPLES

The following are examples of feedback the OH advisor may provide back to the construction client:

- Should refrain from safety critical tasks pending outcome of further assessment by OH physician.
- Suitable and sufficient corrective visual appliances to be worn.
- Task assessment to ensure satisfactory visual requirement to undertake safety critical tasks.
- Recommend referral to GP with follow up in {subject to OH service procedure}.
- Functional assessment required to determine whether audible instruction or warning signals can be heard.
- Functional assessment to determine physical capacity to undertake task.
- Task assessment to be undertaken prior to undertaking tasks that require colour distinction.
- Functional assessment required in relation to mobility to undertake specific safety critical tasks.

The following are examples of feedback the OH advisor may provide back to the worker.

Following the health assessment you had in relation to the safety critical work you do:

- *you are reminded that you must wear any corrective glasses as advised by your optician.*
- *your manager has been advised to check that you can see safely when doing actual safety critical tasks.*
- *your blood pressure was found to be raised and you should make an appointment to see your GP to investigate this.*
- *you were found to have some hearing loss; therefore, your manager has been advised to check that you can hear safely when carrying out safety critical tasks.*
- *your manager has been advised to assess that you can safely undertake the safety critical tasks from a physical perspective.*
- *following the colour vision part of the health check you had, your manager has been advised to assess that you can determine colours safely, as you need to be able to be able to differentiate colours as part of the safety critical tasks you will be undertaking.*

APPENDIX 2: SUGGESTED MEDICAL/REQUIRED STANDARDS

Category	Interpretation
Clinical history	There should be no evidence of ill health that would affect safety of self or others and could result in an adverse event. • Sudden loss of consciousness. • Impairment of awareness or concentration. • Sudden incapacity. • Significant limitation of mobility. • Temporary visual impairment; or • Impairment of balance or coordination.
Mental health	Should be assessed on individual basis. No evidence of mental ill health, which is likely to impact on ability and safety to self and others.
Blood pressure	**Readings that exceed 180/100** Risk assesses temporary removal from role until further assessment and referral for treatment to reduce blood pressure.
	Readings should not exceed 140/90. Risk assesses temporary removal from tasks involved with the role, such as exertion lifting, until further assessment and referral for treatment to reduce blood pressure.
	Individuals who are experiencing symptoms of **low blood pressure** should not work in safety critical roles until condition is stabilised.
	For **normal range blood pressure** the worker is fit to continue in the safety critical role.
Hearing	Hearing loss not to exceed 30db average over frequencies 0.5, 1 & 2. This threshold is to be met in each ear. Hearing technology can be used to meet the required threshold. Individual must have successful adaption to use of hearing technology. No evidence of a health condition likely to cause a sudden or unpredictable change in hearing. Must be able to understand normal conversation, use a telephone, work radio & hear alarms above background noise.
	When the threshold standard is not met consider the following: • Employer risk assessment to consider adverse effect on performance and safety. • Temporary removal from role or certain tasks. • Onward referral for further investigation.
Respiratory health	Should be assessed on an individual basis and consideration of the following capabilities to tolerate specific situations: • Functional ability to carry out aspects of role. • Ability to complete duration of shift and manage exertion tasks. • Ability to use relevant RPE.

Category	Interpretation
Visual acuity	Workers near **rail track lines** should follow PTS guidance. Distance visual acuity should be at least 6/9 in better eye, 6/12 in weaker eye. HGV drivers, crane operatives and heavy plant drivers should follow DVLA visual standards. Distance visual acuity should be at least 6/7.5 in the better eye, 6/60 in the weaker eye. Corrective lenses can be used to meet the standard, they should have a corrective power not exceeding +8 dioptres in any meridian of either lens. No evidence of a health condition that is likely to cause unpredictable change in vision. Peripheral vision defined as a pass of 70 degrees on both sides. Following a risk assessment where monocular vision is present, fitness for role can be assessed based on an individual basis. Monocular vision dependent on 'Grandfather Rights'. HGV Class 2 worker must have been awarded an HGV or Large Plant Operating Licence before 1 January 1991, with the monocularity declared before this date. Visual acuity should be assessed with use of Snellens or Vision screener equipment.
	General construction workers: Distance visual acuity must be at least 6/12 with both eyes open and in the only eye if monocular. Monocular vision is acceptable if the individual meets the requirements for binocular vision and after the clinical advice of successful adaption to the condition. Corrective glasses can be worn to meet the required standard. Dioptres level not required. No evidence of a health condition that is likely to cause unpredictable change in vision. Peripheral vision defined as a pass of 70 degrees on both sides.
Colour perception	**Where required for colour specific tasks** Normal (< 3 errors on 17 plate Ishihara test).
Diabetes	The risks associated with hypoglycemia must be minimised where a diagnosis of diabetes has been identified. The following diabetes medications can cause hypoglycemia, Insulin, Sulfonylureas and Prandial glucose regulators, hence agreed procedures should be in place and included within the advice given by OH.
Height, weight, and BMI	Individual should not be impacted by weight; in that they are unable to safely function and carry out tasks associated with role. *"Obesity will be a factor in determining adequate cardiovascular and respiratory function."* Water UK - Medical standards for Confined Space Work (2019)
Mobility and coordination assessment	No evidence of Musculoskeletal or neurological condition that could affect safety of self or others. Ability to cope with full working day or shift work. Ability to safely work at height, access & egress sites, and plant. Ability to safely undertake postural constraint tasks. Ability to safely push, pull, lift in line with tasks required.
Drug and alcohol screening	Refer to organisational or Occupational Health Alcohol & Drug policy. No evidence of over the counter or prescribed medication which can cause impairment.

Supporting occupational health and wellbeing professionals