Health Surveillance and Fitness for Work Assessments

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Summary and Key Messages

1. **The statutory requirement for employers to undertake appropriate health surveillance is unchanged.**

2. **The same principles will apply to all OH clinical assessments,** whether for statutory health surveillance, fitness for work assessments, including safety critical workers or immunisations of employees.

3. **A tiered approach is recommended, as follows:**

    a. **Stage 1** - remote questionnaire which may be undertaken as previously by responsible person, OH technician or OH professional.

    b. **Stage 2a** - **In the absence of any relevant symptoms**, and no further assessment is necessary the previously agreed date of review is appropriate, or alternatively full assessment can be deferred for up to 6 months, **OR**

    c. **Stage 2b Where relevant symptoms are declared at questionnaire,** further assessment should be undertaken remotely by an OH professional. Following that assessment, a clinical judgement should be made as to whether advice can be given, or whether a face-to-face assessment is required.

    d. **Stage 3** - **A face-to-face assessment will be justified** only if additional clinical information is likely to be obtained that will alter the OH advice given, or where occupational immunisation is required.

4. It is recommended that **the decision to undertake a face-to-face assessment should be confirmed as part of a defined clinical triage system**.

5. **If face-to face assessment is required a full risk assessment (RA) should be undertaken** to assess risk to both the employee and the OH professional. That must take into account Covid risk reduction including PPE. The outcome of that RA should be included in the employee's OH record.

1. **Introduction**

a. This document has been prepared for the Society of Occupational Medicine (SOM), and reviewed by members of the SOM Commercial Providers group. It is intended to supplement recent SOM guidance with specific advice about health assessments for statutory health surveillance and fitness for work assessments during period of continuing restrictions resulting from Covid-19 [i] ,[ii].

b. Guidance and recommendations are changing rapidly as the pandemic/ epidemic progresses. This document is based on evidence and opinions available at the time of writing. It will be revised as necessary to reflect any changes.

c. Health surveillance under the Control of Asbestos regulations 2012, Control of Lead at Work regulations 2002, and the Ionising Radiation regulations 2017 will be addressed by an HSE appointed doctor, so does not need to be addressed directly, although the principles must be the same as one applies to other regulatory surveillance. Separate advice has been published by SOM and FOM in respect of the remote assessment of HAVS and CTS [iii].

2. **Legal duties in respect of health surveillance.**

a. The legal duty to ensure appropriate health surveillance rests with the employer (or self-employed person).

b. It is clear that there is an expectation by HSE that health surveillance will continue wherever required by virtue of the nature of work undertaken. Simply deferring health surveillance because of Covid is likely to be legally non-compliant. Employers should be made aware of that obligation.

c. Employers should consider whether work requiring health surveillance is essential at this time.

d. The role of the OH provider is to ensure that appropriate advice is given about health surveillance, and to ensure that the health surveillance provided is also appropriate. That must relate to the actual service provided, and consideration must also be given to any risk to the healthcare providers undertaking the health surveillance.

e. The latest HSE guidance dated 18th June 2020 states that “this guidance outlines a framework for how you can conduct health/medical surveillance and safety critical medicals remotely. It does not prevent you from carrying out face to face medical assessments where you have carried out a suitable and sufficient RA and put in place appropriate controls, taking into account PHE advice on coronavirus”.

3. **<u>Occupational health risk assessment</u>**

a. A formal risk assessment (RA) will be regarded as part of the OH provider's legal duty when undertaking health surveillance, or other OH assessments. The standard hierarchy of risk reduction must be used as in all other RAs.

b. The decision to undertake an OH assessment, the way in which that is done, and therefore the RA, must consider the potential outcomes of that assessment, being

- Does the employee have a condition related to occupational exposure or likely to affect his/ her ability to undertake the work without risk to him/ herself or others and, if yes

- Is this a new diagnosis, and

- What is the effect on ability or safety to work/ undertake specific tasks?

- Consequent on the above, advice should be offered to employee and employer regarding workplace RA, further exposure and RIDDOR reporting where appropriate.

c. In addition, a RA must be undertaken of the OH assessment, in which several matters must be considered – being in line with the generally accepted principles

i. Ensuring whether or not the task is essential,

ii. Whether the process and equipment used is essential or whether replacement by another process is more appropriate, and

iii. Remembering that the provision of personal protective equipment (PPE) is the last stage of the hierarchy of risk reduction.

d. The RA must consider risks to the employee and risks to the OH professional. This must include a Covid-19 RA if face-to-face assessment is being considered; this is likely to include consideration of responses on a Covid-19 symptom questionnaire completed by the employee immediately prior to the assessment.

e. Where appropriate, issues of employee literacy or difficulty in communication (eg language difficulties) can be addressed as part of the RA. Telephone consultations may be able to overcome literacy issues, and translators may be available for telephone consultations as for face-to face, so these issues are not in themselves justification for a face-to

face consultation. Where a translator is required for face-to-face assessment, this should be included in the RA

4. **COSHH**

a. The HSE have issued four relevant guidance documents relating to health surveillance.

b. The latest guidance dated 18th June 2020 states that regulation 11 health surveillance can be undertaken by an OH professional, OH technicians or responsible persons administering an appropriate questionnaire remotely. Hence, the role of the OH technician in health surveillance is unaltered by the Covid-10 guidance.

c. The current highest risk surveillance appears to be for respiratory and skin conditions.

d. Currently, where the questionnaire identifies issues requiring further assessment, that assessment should be undertaken remotely.

e. Only if remote assessment does not allow appropriate OH advice to be offered, and additional clinical evidence would be obtained by face-to-face assessment should arrangements be made for face-to-face assessment.

f. HSE guidance of 18th June states that *"a face to face medical examination with spirometry should only be necessary in exceptional circumstances".* Given the recognition that spirometry is recognised as an aerosol generating procedure, full PPE commensurate with such procedures, and according with current ARTP guidelines, is required if that is to be undertaken.

g. It is fundamental that the RA relating to undertaking spirometry in the OH setting addresses the question *"will the results of spirometry directly alter OH or clinical management of this case?"* If the answer is "no" then it seems unlikely that the risks associated with undertaking spirometry will be justified.

h. Serial peak flow measurements are likely to remain appropriate, although considerable caution is required when instructing employees on the use of such devices, which will be aerosol producing.

i. Skin assessment should be undertaken initially by questionnaire. Where responses suggest either deterioration of a skin condition, or occupational causation consideration should be given to redeployment of that individual, pending further investigation. Skin inspection can be undertaken by an OH professional using appropriate PPE, ideally including a screen.

j. In cases in which relevant symptoms are identified, it may be more appropriate to advise discontinuation of relevant exposure, until further assessment can be arranged.

k. The alternative may be to undertake face-to-face assessment. The rationale for undertaking face-to-face assessment will have to address whether or not discontinuation of exposure has been considered. HSE advice is that a second deferment of 3 months is acceptable.

l. For new employees undergoing health surveillance for the first time, the same questionnaire approach can be adopted, with a medical certificate issued for 6 months. It is important to note that this approach will only identify fitness for the role, and will not provide baseline physiological measurements for future comparison; those will need to be undertaken at a later date.

m. On all medical reports prepared as the output from such health surveillance there should be a statement explaining the rationale for the method of health surveillance, and that it accords with current HSE advice and other recommendations in respect of Covid-19. The outcome of RAs should be included as part of the employee/ patient record.

5. **Blood borne viruses and immunisation**

a. One of the measures taken in accordance with COSHH to reduce risk from biological hazards is immunisation.

b. The UK Advisory Panel on Bloodborne Diseases has issued a statement on health clearance and monitoring [iv], in which it is noted (*inter alia*) that

- Appropriate monitoring of healthcare workers living with BBVs should continue in line with current UKAP practice.

- All staff undertaking exposure prone procedures including redeployed staff or those returning to the NHS must undertake health clearance before doing so

c. Implicit in those recommendations is that face-to-face assessment will be required, including venesection. The use of appropriate PPE will be required for that.

d. The World Health organisation (WHO) has issued guidance for immunisation activities during the Covid-19 pandemic [v], and states that where feasible influenza vaccination of health workers, older adults and pregnant women is advised.

e. There are a number of occupational groups that are considered to be at high risk of hepatitis and other infectious diseases. Failure to maintain immunity against such diseases presents a nosocomial risk, as well as a risk to the worker. Given appropriate PPE, the Covid risk of face-to-face clinical contact when giving an immunisation is likely to be small, on which basis it is reasonable for such immunisation programmes should continue/ recommence. It will be important to ensure that other Covid-19 measures are in place, such as ensuring that there is reduction of contact within waiting areas; the SOM guidance will be helpful in that regard.

f. As with any vaccination programme, consideration will be required of how to address adverse reactions and anaphylaxis. Although such events are rare in the context of occupational settings, appropriate measures should be in place to allow treatment of such reactions in the context of Covid restrictions and PPE.

6. **Control of Vibration at Work regulations**

a. Guidance on remote assessment of HAVS and CTS has been issued by the Society of Occupational Medicine and Faculty of Occupational Medicine.

b. Use of that approach will ensure that organisations maintain up to date health surveillance and receive appropriate feedback.

c. While the results of a full audit are awaited, initial impressions are that many cases can be addressed in this way without the need for face-to-face assessment.

d. Two groups of employees are likely to require further clinical assessment – those with newly diagnosed or worsening sensori-neural HAVS, and those with clinically diagnosed carpal tunnel syndrome. In each of those situations a decision can be made regarding further exposure to vibration while awaiting more detailed assessment. The safe option is for the employee to avoid further exposure until full normal tier 4 assessment can be undertaken. If the employee can be redeployed until all restrictions on clinical practice have been lifted, then further telephone review may be undertaken at appropriate intervals before then.

e. All those using this approach to HAVS are encouraged to participate in the audit by contacting the SOM at the email address given in the document.

7. **Control of Noise at Work regulations**

   a. HSE guidance is that "providing the worker does not identify any relevant problems, the OH professional/ audiologist can defer audiometry for up to 6 months". It is assumed that this will reflect a remotely administered questionnaire.

   b. Particular care should be taken to identify employees with conditions that would normally merit immediate referral to their GP – eg sudden onset of unilateral deafness and tinnitus. In such cases, audiometry is not likely to influence the need for such referral.

   c. The Covid-19 risks of audiometry are poorly defined. However guidance has been offered by the UK's audiology professional bodies, dated 1st June 2020 [vi]. That states that *"face to face appointments should not be offered at this time to adults without ear or hearing symptoms. These patients should be offered remote digital only provision".*

8. **Fitness for work assessments**

   a. Where appropriate, current industry guidelines should be considered.

   b. The same tiered approach to health assessment is likely to be appropriate for these assessments. Hence, a questionnaire and telephone consultation will be the initial approach.

   c. As with initial health surveillance, it is important to note that this approach will only identify fitness for the role, and will not provide baseline physiological measurements for future comparison; those will need to be undertaken at a later date.

   d. Where there is a safety critical element to the work further assessment may be required in line with the comments below.

   e. Currently there is no place for face-to-face fitness for work assessment without appropriate risk assessment. The decision to undertake face-to-face assessment for health surveillance should be made by a senior clinician, with clear evidence that there has been previous telephone consultation, and very clearly documented rationale for the decision to undertake the face-to-face assessment, given the outcome of that telephone consultation.

9. **Safety critical assessments**

a. There is a lack of clear definition as to the scope of health assessment for safety critical roles, or even what constitutes such a role. However, as a general principle such work is likely to involve risk to the individual employee and also potentially to others, such as colleagues or the public.

b. The level of risk will vary considerably, with groups such as railway trackside workers, being subject to clearly defined assessments, and others less so. Where appropriate industry guidelines should be considered.

c. HSE Guidance dated 18th June 2020 states that "you should conduct a task analysis of the role the individual is performing to determine if it is appropriate to undertake assessments remotely by telephone or video consultation (using information from previous medicals where applicable) and defer a face to face medical examination. Following the assessment, you can decide whether to issue a 'fitness to work certificate' and if you do, whether you should restrict it (for example by duration) until you conduct a face-to-face medical. If you decide a face-to-face examination is justified, you should carry out a suitable and sufficient risk assessment, and put in place appropriate controls, taking into account PHE advice on coronavirus."

d. That RA should include consideration of whether or not the employee is likely to have to undertake the safety critical work within the next 3-6 months. If that is not likely, the appropriate course is to defer the health assessment until the employee is likely to do such work.

e. Where the RA indicates that health assessment is required without deferment, the same tiered approach to health surveillance as above is likely to be appropriate.

f. A RA will be required prior to undertaking such screening, to include assessment of risk of Covid infection in the employee. Risk reduction procedures including social distancing, screens, and PPE are likely to be necessary – see SOM Guidance .Insert LINK

g. In these circumstances, the three most likely conditions to be detected at these health assessments, and which may not be recognised by the employee, and which are amenable to simple health screening are defects of vision, diabetes, and hypertension.

10. **Specific examples of health screening**

a. **Driving/ DVLA**

i. The approach of DVLA is that routine D4 medical assessments may be deferred for 12 months for those with licences that expired after 1/1/2020. Drivers with health issues still need to declare those, and drivers must ensure that they are medically fit to drive [vii]. It is unclear how drivers achieve that without the D4 medical.

b. **Vision Screening**

i. In the OH setting, vision screening is frequently undertaken by Keystone or similar. The matter of cleaning between tests need to be addressed, and a simple Snellen's test may be easier in this context, albeit that does not address peripheral vision or depth perception. Assessment of visual fields by confrontation is not likely to be possible while maintaining social distancing.

ii. The College of Optometrists have issued guidance about vision testing[viii]. Specifically the advice is that only patients with urgent eye or sight related symptoms should be seen and advises optometrists not to see patients without eye or sight related symptoms for routine sight test.

iii. It seems unlikely that visual acuity in relation to occupation will be considered to be an urgent problem; it is not included in the list in the College of Optometrists document. Until that is changed so that opticians/ optometrist can undertake such tests, it may be necessary to advise temporary unfitness for safety critical work in those with inadequate visual acuity.

c. **Urine testing**

i. There have been suggestions that coronavirus may be present in the urine of those in the pre-symptomatic and symptomatic phase of Covid-19 infection [ix].

ii. Nevertheless, pending further specific information, and subject to the usual standard infection control measures, including wearing a mask, routine urine testing is likely to be acceptable.

d. **Blood pressure measurement**

i. Measurement of blood pressure may be undertaken using a wrist sphygmomanometer, which is applied by the employee under

instructions, who then takes their own blood pressure. Such a device may be more easily cleaned than a traditional brachial sphygmomanometer. Such a process will be possible with social distancing.

e. **Spirometry**

Spirometry should not be undertaken as a routine for safety critical assessments at this time. Please refer to paragraphs 4f – 4h above.

f. **Hearing**

i. Consideration may be given to a modified whisper test in place of audiometry – see section 7 above.

g. **Musculoskeletal and neurological assessment**

i. Passive movements can be assessed while maintaining social distancing – eg cervical and lumbar spine, upper and lower limbs.

ii. Tests such as for tremor or balance can be assessed while maintaining social distancing

h. **Other**

i. Assessments such as auscultation of chest, abdominal palpation are unlikely to be useful in asymptomatic individuals and should not be undertaken

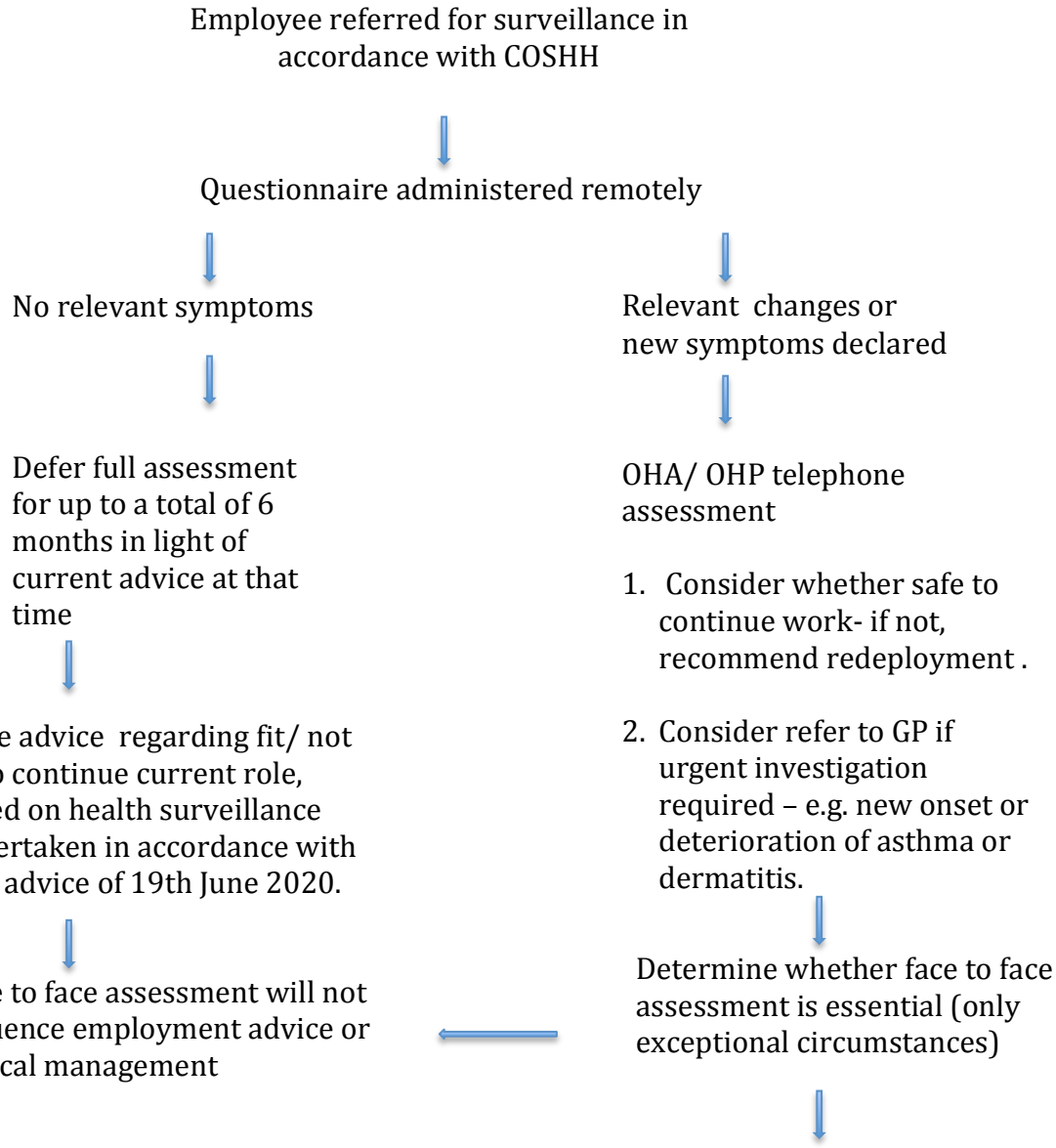
11. **Audit**

a. Adopting these approaches to health assessment is a change of clinical practice / service development, and it behoves all concerned to monitor the efficacy and outcome of such changes.

12. **Foot note**

While commercial pressures may be great, it is important that OH practitioners maintain the highest level of integrity when making decisions about the need for health surveillance, and particularly any face-to-face consultations. Careful use of PPE is essential in situations of face-to face assessment.

Appendix 1 – Flow chart for health surveillance in accordance with Control of Substances Hazardous to Health (COSHH) regulations



Face to face assessment considered essential for clinical or workplace management due to exceptional circumstances. Undertake full Covid RA in respect of face-to face assessment, including documenting reasons for "exceptional circumstances", and why such assessment is essential.

Appendix 2 - Flow chart for health surveillance in accordance with Control of Noise at Work regulations

Employee referred for surveillance in accordance with Control of Noise at Work regulations

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Questionnaire and telephone consultation

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No relevant changes or new symptoms

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Defer audiometry for 3 months and then review with further questionnaire and telephone assessment in light of current advice at that time

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Issue advice regarding exposure to noise, use of hearing protection and fit/ not fit to continue current role, based on health surveillance undertaken in accordance with HSE advice of 19th June 2020.

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Relevant changes or new symptoms declared

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OHA/ OHP telephone assessment

1. Consider whether safe to work.
2. Consider refer to GP if urgent investigation required – e.g. onset of unilateral tinnitus and deafness.
3. Refer for audiometry in 3 months time, subject to current advice at that time.

References

[i] https://www.som.org.uk/Returning_to_the_workplace_COVID-

[ii] https://www.som.org.uk/SOM_RTW_guide_health_professionals_COVID-19_FINAL.pdf

[iii]https://www.som.org.uk/sites/som.org.uk/files/Remote_assessment_of_HAVS_CTS_final_SOM.pdf

[iv] https://www.gov.uk/government/publications/covid-19-ukap-statement-on-health-clearance-and-monitoring/ukap-statement-to-healthcare-workers-and-occupational-health-departments-during-the-covid-19-pandemic

[v] https://apps.who.int/iris/bitstream/handle/10665/331590/WHO-2019-nCoV-immunization_services-2020.1-eng.pdf?ua=1

[vi] https://www.bshaa.com/coronavirus/practitioners

[vii] https://www.gov.uk/guidance/dvla-coronavirus-covid-19-update

[viii] https://www.college-optometrists.org/the-college/media-hub/news-listing/coronavirus-covid-19-guidance-for-optometrists.html

[ix] Amir H Kashi, Morteza Fallah-karkan, Erfan Amini, Maryam Vaezjalali The Presence of COVID-19 in Urine: A Systematic Review and Meta-analysis of the Literature The Lancet infectious Diseases
doi: https://doi.org/10.1101/2020.05.15.20094920