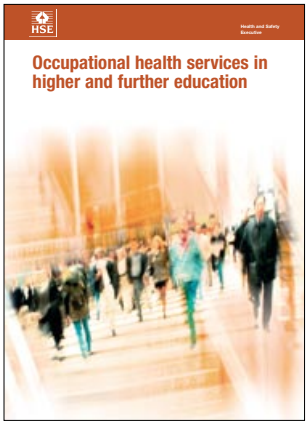
Occupational health services in higher and further education



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This book is for employers in further and higher education. It aims to promote and explain the need for them to provide occupational health (OH) services. It advises on assessing the need for such a service, which will vary depending on the size and nature of the activities undertaken in each institution.

The bulk of the book is aimed at senior managers with responsibility for managing occupational health risks. As large and diverse organisations, colleges and universities are likely to need competent and comprehensive occupational health advice and support.

This guide helps you to identify occupational health needs and how to meet them. It will also be of use to the following groups working in the higher and further education field:

- occupational health professionals;
- health and safety professionals;
- human resources professionals;
- trade union and employee representatives;
- general practitioners; and
- other people with an interest in preventing work-related ill health.

An OH checklist is included, which will act as a prompt to help you identify the occupational health needs in your organisation. The appendices contain further detailed practical guidance and information, with illustrative case studies.

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This guidance is issued by the Health and Safety Executive. Following the guidance is not compulsory and you are free to take other action. But if you do follow the guidance you will normally be doing enough to comply with the law. Health and safety inspectors seek to secure compliance with the law and may refer to this guidance as illustrating good practice.

Contents

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Dedication

This guidance is dedicated to the memory of Les Fountain, a member of the working group responsible for drafting this guidance. Les died suddenly in November 2003. Les was proud to represent UNISON on the group. In dedicating this guidance to Les we wish it to be a lasting memory of someone who cared very much for his fellow workers and colleagues in higher education.

Executive summary

Occupational health provision in higher and further education

Universities and colleges need healthy and well-motivated workers if they are to deliver high-quality services. Effectively managing occupational health is key to achieving this. Improving service delivery through better occupational health is high on the Government's agenda and the Health, Work and Well-being (HWWB) strategy,[2] a joint initiative between the Department of Health (DoH), Department for Work and Pensions (DWP) and the Health and Safety Executive (HSE), encourages good management of occupational health and improved opportunities for people to recover from illness while at work.

As large, diverse organisations, universities and colleges are likely to need competent and comprehensive occupational health (OH) advice and support. OH services vary and the level of support needed depends on the size and nature of the institution and the range of hazards associated with the work.

Occupational health is concerned with how work and the work environment can affect an employee's health, and with how an employee's health can affect their ability to do the job. Universities and colleges need occupational health input in relation to:

- the occupational health risks, which are varied and may include clinical risks, laboratory risks, workshop risks, overseas fieldwork, research animals, stress and intensive computer work;
- employment or student enrolment, which may include fitness to practise for medical and other healthcare students and staff, fitness to teach for student teachers and lecturers working with young people, night working, lone working, driving public service vehicles and issues arising from the employment of staff on short-term contracts; and
- health promotion in the workplace.

Why do you need occupational health support?

Business case

Occupational health support can assist in controlling and reducing sickness absence and its costs, freeing resources for delivering the aims and objectives of the organisation.

Taking positive steps to improve employees' health will impact on key human resource (HR) objectives such as performance management, recruitment and retention of key skills and expertise. It can protect and enhance your image and reputation as a good employer.

Civil claims for compensation for work-related ill health such as stress and musculoskeletal disorders (MSDs) cost dearly - these losses can be prevented.

Legal reasons

You are required by law to identify and control significant and substantial risk factors that can contribute to ill health at work.

You are required by law to appoint competent people to assist you in complying with your statutory duty in regard to health and safety, including, for example, the provision of health surveillance, accommodating disabled workers' needs and pre-employment checks for teachers.

Effective occupational health risk management can make a significant contribution to your risk management strategy through legal compliance and the prevention of work-related ill health.

Moral reasons

Providing a healthy and supportive working environment for employees is the ethical thing to do in a civilised society. Everyone will gain from the improved business and health benefits of being in work.

Benefits of having a comprehensive and competent occupational health service

Good occupational health services are central to the effective management of workplace health. They can:

- provide early intervention to help prevent staff being absent for health-related reasons;
- provide critical support to the process of effective absence management;
- protect and promote the health and well-being of the working population;
- fulfil the statutory requirement to have access to 'competent' occupational health advice as part of the organisational arrangements to ensure that the health of staff and others is not adversely affected by their work.

What type of occupational health support do you need?

Occupational health practice is a specialist field. Its primary role is the prevention of work-related injury and disease, which makes it different from the general health service provided by general practitioners (GPs) and student health facilities. Occupational health services vary and should be targeted to your business needs. This guidance describes some common OH service arrangements and provides advice on how you can assess your needs, the different levels of expertise available and ways of sourcing it.

How do you provide it and what you can expect of it?

Read the guidance. It provides practical advice, illustrated with case studies, on:

- identifying your OH needs;
- matching provision to your needs;
- identifying what an OH service can offer;
- integrating OH provision into the organisation; and
- technical issues, eg competence, ethical and legal considerations.

What action should you take?

Whether or not you have an existing occupational health service, this guidance should be used to review your needs, identify your requirements and provide an effective and relevant service.

Involving and consulting staff is central to this process.

A university/college's occupational health strategy should be integrated into its broader risk management strategy. This guidance can help in the development of this strategy.

A guide outlining the benefits of effectively managing workplace health is available for university vice chancellors and college principals. *Healthy workplace, healthy workforce, better business delivery: Improving service delivery in universities and colleges through better occupational health*[1] is available online at www.hse.gov.uk/pubns/misc743.pdf.

Introduction

Purpose of this guidance

1 This guidance has been produced to promote and explain the need for universities and colleges to provide occupational health services. It advises on assessing the needs for such a service. These will vary depending on the size and nature of the activities undertaken in each institution.

2 Many universities and colleges have set up occupational health services since the first Health and Safety Commission (HSC) guidance document *Occupational health services in higher education* was published in 1990. However, there is room for improvement, both in existing services and in setting up new occupational health services.

3 Since 1990, health and safety legislation and employment legislation has developed further. Appendix 1 lists legislation relevant to occupational health. Vocational health standards have also evolved to take into account these changes in legislation, eg for nurse and teacher training (see Appendix 3).

How to use this guidance

4 The main body of this guidance is aimed at senior managers with a responsibility for managing occupational health risks. It helps you to identify occupational health needs and how to meet them.

5 It will also be of use to the following groups working in the higher and further education field:

- occupational health professionals;
- health and safety professionals;
- human resources professionals;
- trade union and employee representatives;
- general practitioners; and
- other people with an interest in preventing work-related ill health.

6 An OH checklist can be found on pages 10-12. This will act as a prompt to help you identify the occupational health needs in your organisation. The appendices contain further detailed practical guidance and information, with illustrative case studies.

7 In general, all references to staff, employees or workers should be taken to include students.

8 Separate guidance is available for vice chancellors and college principals, which outlines the benefits of effective management of workplace health. *Healthy workplace, healthy workforce, better business delivery: Improving service delivery in universities and colleges through improved occupational health*[1] is available online at www.hse.gov.uk/pubns/misc743.pdf.

What is occupational health?

9 Occupational health has been defined by HSC[3] as embracing the following:

- the effect of work on health, whether through injury or long-term exposure to agents with latent effects on health;
- the prevention of occupational disease through techniques which include health surveillance, ergonomics, and effective human resource management systems;
- the effect of health on work, bearing in mind that good occupational health practice should address the fitness of the task for the worker, not the fitness of the worker for the task alone;
- rehabilitation and recovery programmes;
- helping the disabled to secure and retain work; and
- managing work-related aspects of illnesses with many potential causes (eg musculoskeletal disorders, coronary heart disease) and helping workers make informed choices regarding lifestyle issues.

10 Occupational health practice is fundamentally different from GP-type services. It is a specialist field where the primary role is the prevention of ill health in the workplace.

The case for managing occupational health

11 The Government has pledged to:

- reduce sickness absence levels in the public sector;
- advance the prevention of work-related ill health and injury;
- encourage good management of occupational health;
- provide opportunities for people to recover from illness while at work, so maintaining their independence and sense of worth.

12 Challenging national targets are set out in the Government's *Revitalising health and safety strategy*[4] to reduce the incidence rate of fatal and major injuries, the incidence rate of work-related ill health and the rate of working days lost from work-related injury and ill health. The targets relating to ill health are also featured in HSE's *Securing health together: A long-term occupational health strategy for England, Scotland and Wales.*[5]

Revitalising health and safety targets

By 2010:

– Reduce the incidence rate of fatal and major injury by 10%.
– Reduce the incidence rate of work-related ill health by 20%.
– Reduce the number of working days lost per worker due to work-related injury and ill health by 30%.

13 It is a key priority for universities and colleges to establish baseline sickness absence data, and to have systems in place for recording up-to-date and accurate sickness absence data that operate in real time and allow it to be broken down by area and cause on a regular basis. Real-time reporting will enable the institution to proactively target specific action to problem areas, and it is the best way to measure progress towards tackling sickness absence.

Business case

14 Universities and colleges are increasingly required to demonstrate effective management of their business risks, including occupational health risks. Effective occupational health risk management can make a significant contribution to your risk management strategy through legal compliance and the prevention of work-related ill health. A key component of higher and further education's 'efficiency and change agendas' is to do more to manage and reduce levels of sickness absence caused by work-related ill health and to get employees back to work earlier.

15 The health, safety and welfare of workers can have a significant impact on the performance and delivery of an organisation's aims and objectives. Appropriate occupational health support can improve the quality of staff performance, aid their availability for work, help retain key skills and expertise, and enhance or protect your reputation as a good employer.

16 It is possible for staff who are disabled, or are temporarily incapacitated, to remain within or return to work. Disability discrimination considerations are central to any discussions on occupational health provision.

Criminal and civil liabilities

17 Universities and colleges must comply with a wide range of legislation, eg on employment, health and safety, disability discrimination, and data protection (see Appendix 1). Under the Management of Health and Safety at Work Regulations 1999 (MHSWR),[6] there is a specific requirement for employers to have access to competent advice in relation to occupational health and safety.

18 Criminal liabilities can be personal as well as against the institution. Civil claims for compensation are on the increase from staff and students. Litigation is often not restricted to a single aspect. Apart from any insurance costs, legal costs and fines, there can be significant use of staff resources in defending claims or prosecution, such as salaries and opportunity costs. For illustrative purposes, data for the NHS is available from the NHS Litigation Authority (www.nhsla.com). Early intervention can limit or avoid litigation, including claims raised many years down the line, particularly where the institution is working at the forefront of technologies where the effects on health may not be fully recognised or understood.

Case study

A research student developed occupational asthma following exposure to laboratory animals.

The higher education institution involved was prosecuted under the Control of Substances Hazardous to Health Regulations (COSHH) for failing to ensure adequate arrangements for identifying exposed employees and failure to put adequate health surveillance systems in place.

The institution was found guilty and fined £4500 plus costs.

Moral case

19 Providing a healthy and supportive working environment for employees is the ethical thing to do in a civilised society. This will translate into benefits relating to recruitment and retention of high-quality employees.

20 There are many restorative benefits associated with being at work. Work should not make people ill; it should make them feel good about themselves.

Occupational health in higher and further edcation

21 Universities and colleges are likely to have a wide range of OH issues to manage because of the nature and diversity of their activities and staff. While many issues are common to most employment sectors, there are some that are specific to universities and colleges. Issues arising from teaching and research hazards include:

- laboratory hazards, including ionising and non-ionising (eg lasers) radiation, microbiological and chemical;
- workshop hazards, including machinery, equipment, electrical and chemical;
- fieldwork and site work;
- clinical activities;
- allergies, including asthma, eg:
  - animal handlers are one of the groups of workers most commonly reported to be at an increased risk of developing asthma as a result of exposure to animal allergens. Guidance on the control of laboratory animal allergy is available in HSE guidance note EH76[7] and on HSE's website at www.hse.gov.uk/asthma;
  - technicians are also at risk of developing asthma, through exposure to substances such as latex, wood dust, glues and resins.

22 A study[8] by the University of Oxford describes the needs of universities in relation to planning the provision of OH services.

23 Occupational health issues that are common to all employment sectors and are priority areas for action in universities and colleges are:

- Work-related stress:
  - Research[9] by the University of Plymouth suggests that university staff are more likely to suffer from work-related stress than people in comparable jobs, such as those in the police force or county councils.
  - HSE has developed *Management standards for work-related stress* to help employers assess their performance in managing stress, identify problem areas. and work in partnership with staff to make improvements. Advice on the Management standards is available at www.hse.gov.uk/stress/standards.
  - The Universities and Colleges Employers' Association (UCEA) has published guidance titled *Preventing and tackling stress at work: An approach for higher education.*[10]
- Ageing workforce:
  - Older workers are more susceptible to ill health. Changes in pension arrangements are likely to mean that increasing numbers of people are working longer.
- Musculoskeletal:
  - Ergonomic hazards, which may cause joint and muscle problems from lifting, carrying and working at IT and other equipment.
- Physical environment:
  - Potential exposure to asbestos and other hazardous materials in the built environment.
  - Slips, trips and falls.
  - Noise and vibration.

Matching provisions to needs

Steps to take

24 Your organisation should have policy arrangements for occupational health and safety (see Appendix 2 for an example of a university's policy statement). These will include processes for identifying and resolving health and safety issues. The following steps should be taken to ensure compliance with the statutory requirement under MHSWR:

- risk assessment;
- a review of your occupational health needs (see checklist on pages 10-12);
- consult with workers and/or their safety representatives;
- identify what the health priorities are;
- set out what you need to do to address these health priorities;
- provide the skill mix/expertise for dealing with the health priorities;
- define and communicate your health policy to workers; and
- evaluate and review performance.

25 If your institution has not gone through this process, then it is important that it does so now. Whether you are starting from new or reviewing your OH needs, the checklist on pages 10-12 is designed to help you.

Employee consultation

26 There are regulations (see Appendix 1) that require employers to consult with workers on matters relating to their health and safety at work. There is clear evidence that safety representatives and arrangements for employee involvement and consultation prevent accidents and ill health. The role of safety representatives is essential in helping with the development and implementation of an occupational health policy. They will be able to identify the occupational health risks and bring the workers' perspective to the policy-making process.

Levels of occupational health support and advice

27 Figure 1 shows how support and advice can be provided at three levels. Some problems may only need input at level one while others may require help at all three levels. Universities and colleges, because of their complexity and diversity, will need at least some access to all three levels of provision. You are likely to need an occupational health service with a skill mix and staffing that allows it to provide a proportionate policy and practical response to the university/college's needs.

Example: An experienced occupational health physician (MFOM or FFOM - Member or Fellow of the Faculty of Occupational medicine)

Example: Nurse with occupational health qualification (OHN Degree/ OHNC/Diploma, MSc), physician with an occupational medicine qualification (AFOM, DOccMed), health and safety adviser, occupational hygienist, ergonomist, microbiologist, psychologist, counsellor, radiation protection adviser

Example: Trained supervisor/manager, trade union representative, local health and safety co-ordinator, helpline, suppliers' information

Involvement of employees in awareness of risks and self-assessment and reporting of symptoms

Figure 1 The tiered approach to delivery of occupational health support (adapted from *Report and recommendations on improving access to occupational health support* Occupational Health Advisory Committee, HSC 2000)[11]

Occupational health service provision

28 Occupational health services can help with a wide range of issues. See Appendix 3 for detailed information on the following:

- Policy and guidance development.
- Health risk assessment.
- Health surveillance.
- Health assessment and fitness for work – consider the interaction between an individual's health characteristics and the job ie:
  - pre-employment;
  - work-related ill health, eg musculoskeletal disorder or similar;
  - attendance management and return-to-work programme;
  - advice on adjustment under discrimination law – age, gender and disability;
  - ill-health retirement.
- Clinical services.
- Liaison and advice.
- Information, instruction and training.
- Knowledge management – audit, record keeping and data analysis.
- Vocational advice to students.

29 Various options for provision of occupational health services are referred to in paragraph 30, both in-house and external. The type of service and the history of its development all have an influence on where it is located in the organisational structure.

30 Examples of occupational health provision include:

- a full 'in-house' service – direct employment of an occupational physician and occupational health nurse adviser(s) and supporting administrative staff;
- a partial 'in-house' service – direct employment of an occupational health nurse adviser(s) and support staff with a sessional occupational physician contracted in for a limited number of hours;
- a contract with an occupational health service (eg from the local NHS trust or NHS Plus, or from a private-sector provider of OH services) to work on the institution's premises or off site on the provider's premises; or
- sharing occupational health services with neighbouring institutions or organisations.

31 An example of a tendering process is provided in Appendix 4.

32 There may be tax implications for work-funded rehabilitation schemes and other occupational health support. For guidance on tax rules and the purchase of occupational health support go to HSE's website at www.hse.gov.uk/pubns/taxrules.pdf.

Organisation of an occupational health service

33 If the occupational health service is to be effective, it has to engage with the institution and contribute to the planning and decision-making process. In addition to having clinical and technical skills, an understanding of the organisation, how it works and how to influence it is vital. The occupational health service should have:

- access to relevant senior managers;
- a voice and influence on relevant committees, working groups and decision-making bodies;
- interaction with:
  - health and safety advisers;
  - human resources advisers;
  - student health services and primary care provision for staff and students; and
  - workers/safety representatives.

34 The occupational health service should be viewed as one component of a team, working closely with other relevant services, eg health and safety advisers and disability advisers. Good team working is probably more important than the precise location within the organisation. Several different models are known to work well in universities and colleges.

35 A critical competency, in addition to clinical and technical skills, is an understanding of the organisation, how it works and how to influence it.

Staffing

36 The appropriate number of professional staff and clinical facility time for the occupational health service depends on:

- the number and turnover of employees;
- the nature of the work of the institution; and
- the occupational health needs of employees.

37 The level of staffing should be balanced against the number of workers using the service.

38 Similar criteria would apply to the provision of adequate secretarial and clerical backup.

39 While occupational physicians will normally provide the clinical lead, the day-to-day practice management does not require the physician to be the sole responsible manager, and large parts of that responsibility could be delegated to a practice manager.

Competence

40 Doctors and nurses must meet the requirements of the respective professional bodies for registration, revalidation, continuing professional development, professional indemnity, and audit. HSE guidance on the Management of Health and Safety at Work Regulations 1999, regulation 7, reinforces this requirement. See Appendix 5 for further information on clinical competence.

Ethical considerations

41 Occupational health nurses and physicians work within the ethical guidelines of their respective professions. These are defined by the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) respectively.

42 Doctors and nurses are bound by the code of strict confidentiality with respect to personal medical information. Although advice can be given to an organisation about the employee's functional capacity and its relationship to work, the informed written consent of an employee must be obtained before any medical information can be disclosed.

Accommodation and equipment

43 The accommodation for the occupational health service should ideally be located in a quiet area that is easy for staff and students to reach and should have disabled access. It should provide an acceptable standard of confidentiality for a clinical examination in privacy and also for a private conversation with reception and clerical staff. It should also provide waiting rooms, examination rooms, and clinical, storage and office facilities, and should be equipped with adequate hand-washing and toilet facilities.

Financial arrangements

44 There should be a regular review of the match between the institution's occupational health strategy and the demands on the service against resources provided.

Further information

45 Further detailed information and advice and illustrative case studies are provided in the appendices.

Occupational health needs checklist

46 The following checklist is a prompt to help you identify the occupational health issues in your organisation. For your organisation to be sure that it is managing occupational health adequately, you need to be able to answer the following questions. There may be other issues that your organisation would want to include in the checklist.

Management of occupational health	Have the occupational health issues in your organisation been clearly identified and prioritised? Have senior managers and governing bodies been made aware of the occupational health issues in your organisation? Has the provision of professional occupational health services in your organisation been assessed against the guidance in this document? Does your organisation have policies on occupational health and occupational health provision, and arrangements for the management of occupational health?
Health outcomes	How many days were lost in your organisation last year due to sickness absence? What were the causes of sickness absence? How much does work-related ill health cost your organisation each year? How does your organisation compare with the national average for the sector? Has your organisation agreed targets for improving work-related ill health in line with the Government's *Revitalising health and safety strategy?*
Hazards	What ergonomic hazards are there, which could cause joint and muscle problems from handling and lifting activities? What hazards are apparent in the office environment, eg display screen equipment? What hazards could cause occupational respiratory disorders, eg animal allergens, wood dust, flour, silica, asbestos dusts, irritant or allergenic chemicals and soldering fumes? What hazards could cause occupational skin disorders, eg chemical and biological sensitisers, cement, oils and engineering fluids? Are there likely to be staff who could be suffering from mental health problems? Could there be employees who feel under stress from their workload or their working environment? What are the hazards from work equipment, eg noise, vibration, ionising and non-ionising radiations (such as UV, infrared, lasers and microwaves)? Which workers are likely to be exposed to infection as a result of their work, eg medical and dental students, student nurses, people working with biological agents or handling blood, body fluids and tissues or animals? Is there potential for a major incident, eg a chemical, biological, GMO or radiation incident?

Legal requirements	Has your risk assessment, as required under MHSWR, identified risks to health? Is there a requirement for health surveillance under MHSWR, ie in response to the identified risks to health? What health assessments are required, eg night workers, health surveillance (eg respiratory health surveillance for allergens under COSHH), and statutory medical surveillance (eg lead, ionising radiation)? Do you have people who require medical assessment under other regulations, such as drivers of public service vehicles, medical and dental students, student nurses and trainee teachers? Have you considered the risk assessment requirements for young workers and women of childbearing age? Is there a requirement for biological monitoring under any other regulations, eg COSHH, lead, asbestos regulations? Is there a requirement for environmental monitoring under any regulations, eg COSHH, lead, asbestos regulations? Have you access to competent occupational health advice in relation to compliance with health and safety legislation and the Disability Discrimination Act? Have you consulted with employee safety representatives?
Employment issues	Are your pre-employment health checks carried out by occupational health professionals and in line with requirements of data protection legislation and guidance relating to medical confidentiality? Do you and your workers have access to competent occupational health advice: ■ To resolve situations where health issues are claimed as justification for people being unable to fulfil their job roles? ■ Where there are concerns about a worker's health being affected by the job? ■ About adjustments to individual jobs that are necessary for the health of the individual? ■ To carry out medical assessments for people with disabilities and advise on adjustments? ■ About termination of employment/retirement on grounds of ill health? ■ To provide evidence of fact in potential civil claims and employment tribunal cases, eg relating to sickness absence, work-related ill health and injuries at work? (It is not good practice for an occupational physician to accept instructions as an expert witness in a case involving their own university/college. They can however, recommend an occupational physician or medico-legal specialist with no connection to the university/college.)
Other	Do you have workers travelling abroad? If so, are you providing adequate and competent health advice and appropriate services, eg immunisations, first-aid kits? Do you have competent advice on occupational health policies, strategies, procedures, standards and ethics? Do you have competent occupational health advice about arrangements for the response to dangerous incidents or other emergencies, eg chemical spills, action necessary in the event of a needle stick injury, an acute ill-health event? Do you have competent occupational health advice to investigate and manage outbreaks of possible work-related ill health, eg 'sick building syndrome'?

Other (continued)	Do you have competent occupational health advice on fitness to practise and related issues, eg food handlers, medical and dental students, student nurses, trainee teachers or others working with susceptible people? Do you have competent occupational health input to relevant committees and working groups, eg health and safety, personnel, student health, disability, risk management? Do your workers know how to maintain or improve their health, ie through healthy lifestyle options?

Appendix 1: Legal framework

Summary of legislation relating to occupational health

1 The Health and Safety at Work etc Act 1974 (HSW Act) places a wide-ranging duty on employers to protect the safety, health and welfare of their employees. Regulations made under the HSW Act and other legislation place specific duties on employers relating to risk assessment, health surveillance, managing health in certain sectors, fitness for work in occupations entrusted with public safety, protecting the vulnerable and employing the disabled. The Management of Health and Safety at Work Regulations 1999 (MHSWR) require employers to appoint competent people to fulfil their statutory responsibilities.

2 Table 1 sets out the relevant legislation.

Table 1 Legislation relevant to occupational health

Health and Safety at Work etc Act 1974 (HSW Act)	Section 2 of the HSW Act places a duty on every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all employees.
Management of Health and Safety at Work Regulations 1999 (MHSWR)	■ Regulations 3 and 5 of MHSWR require employers to undertake an assessment of the risks to the health and safety of their employees and to give effect to adequate health and safety arrangements to control these risks. ■ Regulation 6 requires every employer to ensure that their employees are provided with such health surveillance as is appropriate, having regard to the risks to their health and safety identified by the risk assessment (as required by regulation 3). For example, health surveillance may be needed for employees exposed to noise or hand-arm vibration. A competent person acting within the limits of their training and experience should determine the appropriate level, frequency and procedure of health surveillance. ■ Regulation 7 requires that employers appoint competent people to assist them in complying with their statutory duty with regard to health and safety, including, for example, the provision of health surveillance.
Control of Substances Hazardous to Health Regulations 2002 (as amended) (COSHH)	■ Regulation 6 requires employers to identify and prepare an assessment of risks to health posed by the hazardous substances to which their employees may be exposed while at work. ■ Regulation 11 requires that, where it is appropriate for the protection of the health of employees who are (or are liable to be) exposed to a substance hazardous to health (eg solvents, fumes, dusts and biological agents), the employer shall ensure that such employees are under suitable health surveillance. (Regulation 11 goes on to specify the circumstances in which health surveillance is appropriate and when health surveillance has to include medical surveillance under the supervision of an (HSE) employment adviser or an appointed (by HSE) doctor). The employer's duties to other people at the premises who are not employees in respect of regulations 6, 7, 8, 9, 10 and 12 are to meet the requirements 'so far as is reasonably practicable'. It is good practice to extend this provision to students, academic visitors, and others whose work exposure is comparable to that of an employee.

Health and Safety (Display Screen Equipment) Regulations 1992, as amended by the Health and Safety (Miscellaneous Amendments) Regulations 2002 Manual Handling Regulations 1992 Personal Protective Equipment Regulations 1992	These Regulations cover areas where OH advice has proved important.
Control of Lead at Work Regulations 2002 Control of Asbestos Regulations 2002 Work in Compressed Air Regulations 1996 Ionising Radiations Regulations 1999 Diving at Work Regulations 1997 Working Time Regulations 1998	All of these Regulations require regular medical examinations to be carried out for some groups of workers. In the case of work with ionising radiations or diving, fitness-for-work medical checks are also required.
Control of Vibration at Work Regulations 2005	Employers are required to assess the risks from vibration and plan how to control them. Regulation 7 requires suitable health surveillance where the risk assessment indicates that there is a risk to the health of employees who are (or are liable to be) exposed to vibration.
Control of Noise at Work Regulations 2005	Employers are required to assess the risk to health and safety created by exposure to noise at the workplace. Regulation 9 requires suitable health surveillance where the risk assessment indicates that there is a risk to the health of employees who are (or are liable to be) exposed to noise.
Disability Discrimination Act 1995 (DDA)	The Disability Discrimination Act requires employers with 15 or more employees to treat disabled people and non-disabled people equally in all employment matters and to make any reasonable changes to the premises, job design etc that may be necessary to accommodate the needs of disabled employees. The Act extends the definition of disability to include progressive conditions where disability develops some time after first diagnosis. Excessive selection procedures to exclude the disabled may be an offence under DDA.

Access to Medical Reports Act 1988	The Act puts duties on those who seek medical reports and on those who write them. It allows individuals to see medical reports written about them for employment or insurance purposes by a doctor whom they usually see in a 'normal' doctor/patient capacity. This right can be exercised either **before** or **after** that report is sent to the person who requested the information.
Data Protection Act 1998 and associated Code of Practice on Workers' Health Information	This gives a living individual the legal right to access to any personal information data held about them. The Employment Practices Data Protection Code – Part IV: *Information about workers' health*[12] gives employers clear and practical guidance about how to comply with data protection law when handling information about workers' health. This includes the operation of occupational health schemes, medical testing of workers, drug and alcohol testing and genetic testing in the workplace. See www.ico.gov.uk.
Special Educational Needs and Disability Act 2001 (SENDA)	This amends Part 4 of the Education Act 1996 to make further provision against discrimination, on the grounds of disability, in schools and other educational establishments, and for connected purposes. Chapter 2 is relevant to further and higher education.
Education (Teachers) Regulations 1993 (as amended)	DfES circular 4/99 Physical and mental fitness to teach of teachers and entrants to initial teacher training[13] gives guidance on procedures for assessing the physical and mental fitness to teach of those applying for teacher training, of existing teachers, and of other staff working with young people under 19, and covered by the Education (Teachers) Regulations 1993 (as amended). It explains the implications of regulations 7 to 10A of the Education (Teachers) Regulations and the Disability Discrimination Act 1995, both of which are relevant to employing teachers. It outlines the procedures for barring or restricting employment as a teacher on medical grounds.
European Union Framework Directive 89/391 (in Article 7) health and safety legislation	This requires employers to designate one or more workers to carry out activities related to protection from and prevention of occupational risks. If there are no competent people in-house, employers must enlist competent external services. The Framework Directive was significantly influenced by ILO Convention 161 on Occupational Health and is essential to the EU's health and safety legislation. The Directive has been implemented in all Member States but the methods of implementation have reflected national practices and legal procedures.
Safety Representatives and Safety Committees Regulations 1977	These Regulations specify the rights of safety representatives. Employers must: ■ consult the safety representative on arrangements for co-operating on health and safety matters; ■ permit time for the safety representative to carry out their functions and to undergo training; ■ make necessary information available; ■ provide facilities and assistance; and ■ set up a safety committee, if requested by two or more safety representatives.
Health and Safety (Consultation with Employees) Regulations 1996	These Regulations require employers to consult with workers, either directly or indirectly through elected representatives of employee safety, on matters relating to their health and safety at work.

Appendix 2: Policy statement

1 The following is an example of an actual university policy statement on occupational health and can be adapted to suit local circumstances. It has been developed independently of HSE. The information it contains may be useful to universities in drawing up such statements.

Example of a policy statement on occupational health

Introduction

Occupational health has been described by the Occupational Health Advisory Committee to the Health and Safety Commission as embracing:

- the effect of work on health;
- the effect of health on work;
- rehabilitation and recovery programmes;
- helping the disabled to secure and retain work;
- managing work-related aspects of illnesses and helping staff to make informed choices regarding lifestyle issues.

Occupational health provision cannot replace an individual's general practitioner. Staff and students need to be registered with a general practitioner.

Purpose

This document sets out university policy and arrangements to deal with occupational health issues arising from university activities or premises.

Principles

- The university is committed to ensuring that the potential for ill health or injury arising from university activities or premises is minimised at source to the lowest level that is reasonably practicable. It recognises that this duty of care for its staff extends to mental health as well as physical health at work and that this duty of care applies in certain circumstances to its students.
- The university aims to ensure early identification and management of occupational ill health and to enable staff to raise, discuss and resolve issues, through the involvement of and consultation with safety representatives.
- The university aims to develop a framework to ensure that managers and staff are aware of the nature, causes and effects of ill health. This is achieved through provision of information and guidance in the form of university policies and through the use of risk assessments to identify risks to health and to establish appropriate health checks. The university provides training, support and health education to inform managers and staff about the issues.
- The university will ensure that individuals whose health is identified as particularly at risk at work are provided with appropriate management and advice, while recognising the need for confidentiality to be maintained.
- The university will monitor the scale of occupational ill health and the effectiveness of its measures to reduce it.
- The university provides competent specialist occupational health advice and services to staff and managers. This support is extended to students in situations where they are carrying out activities that could pose a risk to their health as part of their coursework.
- The occupational health service will ensure that medical information relating to individuals is treated by the occupational health service in strict confidence in line with medical ethics and data protection requirements.

Responsibilities

Deans, managers, and heads of departments must ensure that the health of their staff is not adversely affected by their work. They must:

- ensure that work activities and premises are assessed and designed so far as reasonably practicable so that they will not lead to ill health;
- ensure that their staff are advised of the risks and are provided with appropriate training;
- address ill health as it arises among their staff; and
- ensure that there are appropriate work plans for individuals at significant risk.

Staff are responsible for their own health and for taking advantage of the occupational health support provided by the university.

The occupational health service manager (or appropriate title) ensures the provision of professional occupational health services to staff and managers. These services include medical and counselling referrals, advice on health, stress and risk assessment, health education programmes, and monitoring the effectiveness of the occupational health and stress policies.

Students are responsible for their own health and safety and should ensure that they are registered with a general practitioner. Students should contact the occupational health service if they are concerned that their health is at risk from activities they carry out as part of their coursework.

Arrangements

- The university employs the services of an occupational health adviser who is recorded on the professional register maintained by the Nursing and Midwifery Council (NMC) as a 'specialist practitioner (occupational health nursing)' and an occupational health physician who is a member of the Faculty of Occupational Medicine.
- Staff experiencing ill health that they believe may be related to work should obtain advice by calling the occupational health service.
- Within the management function, any manager can obtain support and guidance on health and stress issues, return-to-work plans, and medical or counselling referrals by contacting the occupational health service.
- Cases are referred to the occupational health physician by the occupational health adviser where necessary.
- In response to medical and fitness-for-work referrals, the member of staff will be asked to sign a consent form, which sets out their options. The occupational health adviser or physician issues a written response to managers and human resources with a copy to the member of staff.
- Occupational health records are held in the occupational health service and are not available to other members of the university.
- Sickness absences are reported and recorded as set out in the current sickness absence procedure and absence may result in a referral to the occupational health service.
- Pre-activity and pre-employment screening is carried out by the occupational health service with, where necessary, internal referral for medical assessment. Note that all medical questionnaires should be returned confidentially in a sealed envelope directly to the occupational health service.
- Occupational health and medical surveillance is organised by the occupational health service based on risk assessment.
- Health education schemes are considered by the Health and Safety Management Committee and the Health and Safety Consultative Committee and developed and implemented by the occupational health service.

Occupational health staff liaise as appropriate with the health and safety adviser, eg in relation to advising on the need to report a notifiable disease under the Reporting Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR).

Appendix 3: Scope of an occupational health service

Policy and guidance development

1 All employers should have policies and guidance in place for health risk management, which should integrate fully with the broader occupational health and safety strategy. The policies should be developed in collaboration with occupational health professionals and employee representatives, who should also be involved with their implementation and review.

Occupational health services in higher education

The *Survey of occupational health services in higher education*[14] indicated that the main areas where OH services took the policy lead in universities in 2001 were:

- stress/mental health issues;
- blood-borne viruses;
- laboratory animal allergy;
- sickness absence;
- DSE;
- pre-employment health assessment;
- travel medicine;
- smoking;
- new and expectant mothers.

OH services also contributed to institutional policies on health and safety, alcohol and drugs and harassment.

Health risk assessment

2 Risk assessment is simply an examination of the hazards present in your workplace that could cause harm to people. This allows you to weigh up whether you have enough precautions in place or whether you need to do more to prevent harm occurring. Risk assessments are required under the Management of Health and Safety at Work Regulations 1999 and other specific legislation (see Appendix 1: *Legal framework*). Conducted for significant hazards in each job type, a risk assessment establishes what the risks are and identifies ways to control them.

3 As part of your assessment of occupational health needs, you will have identified the **health hazards** in your institution. The next step is to assess what the **health risks** are and decide how they can be controlled. Although it is not necessary to have a qualification in occupational health to undertake a health hazard and risk assessment, it is recommended that qualified occupational health professionals take on the role, as they are likely to have a greater appreciation of the hazards and risks.

4 Occupational health risk assessment establishes what the health risks are and identifies ways to control them.

Health surveillance

5 Health surveillance is a control measure that may be needed in some situations where health risks cannot be eliminated or adequately controlled. A specialist occupational physician can advise on an appropriate surveillance scheme. It will usually need an OH nurse to devise and implement but many of the routine procedures can be carried out under supervision by unqualified staff. Some health and safety regulations require health surveillance.

6 Higher and further education institutions have a wide range of health risks, such as animal care, work with lead, isocyanates, biological agents, pesticides and chemical agents, the adverse effects of which are potentially detectable at an early stage by health surveillance. Health surveillance is likely to be necessary where there is exposure to:

- carcinogens (in practice, valid tests and techniques may not exist so the maintenance of a health record by the employer may be all that is required);
- dangerous pathogens;
- sensitisers, eg:
  - substances causing occupational asthma (including animal sources); and
  - substances causing allergic dermatitis;
- noise/vibration;
- substances with recognised systemic toxicity, eg lead.

7 More information on health surveillance is available in the HSE guide *Health surveillance at work*.[15]

Health assessment

Pre-employment

8 Pre-employment health screening evaluates the fitness of an applicant's declared health in relation to the hazards and risks of the job, environment or activities.

9 Pre-employment health screening allows the occupational health service to advise on and provide appropriate support measures for people where they have identified a vulnerability. 'Pre-employment functional ability questionnaires' administered by management are appropriate in low-hazard work, and referral to the occupational health service will be required only where the person declares that they have a functional limitation.

10 There are some regulations that require a person's fitness for work to be assessed, eg the Ionising Radiations Regulations 1999, the Diving at Work Regulations 1997, the Education (Teachers) Regulations 1993 and the Working Time Regulations 1998 (night workers) – see the legal framework at Appendix 1.

11 Institutions will be aware of the interrelation that exists between recruitment, disability and making reasonable adjustments. The university's policy on the recruitment of disabled people should be in line with the Disability Discrimination Act 1995. The occupational health service will have a good knowledge of this legislation and how it works in practice and will advise accordingly.

12 Medical ethics guidance[16] and the Information Commissioner emphasise that pre-employment health screening questionnaires form part of medical records and should only be opened by occupational health professionals or the OH department's clerical staff who have signed confidentiality agreements.

Case study

Pre-employment functional ability questionnaire

Job applied for:

Full-time teaching post in a college of further education.

Health problem:

History of depression declared on pre-employment health questionnaire.

Occupational health service role:

- Assessment of the applicant, undertaken in accordance with the *Fitness to teach* OH guidance for the training and employment of teachers 2000, showed a history of mental health problems including anxiety and depression, panic attacks, mood swings and verbal aggression.
- GP report obtained by the OH service as a supplement to the OH service's assessment.

OH conclusions:

- Applicant at higher risk than normal from excessive workloads and other workplace stressors because of previous vulnerability.
- Risk of aggression towards students if applicant's mental health deteriorated - likelihood minimal.
- Regular monitoring of workload, progress and ability to cope in the classroom could reduce risk of the applicant's mental health deteriorating.

Action:

- Applicant's consent obtained to provide manager with brief outline of problem and signs and symptoms of a relapse.
- Arrangements put in place to ensure:
  - adequate monitoring;
  - regular management reviews to provide feedback and support; and
  - access to the OH service by both applicant and management for review assessment.

Outcome:

Successful employment benefiting both the applicant and the organisation, facilitated by the OH service.

Work-related ill health

13 Individuals who believe their health is being adversely affected by their work should be referred to the occupational health service. Either the individual employee or management can initiate referral. The following case studies illustrate the beneficial effects of early intervention by an occupational health service in a case of upper-limb disorder exacerbated by a high level of computer use, and in a case of work-related stress.

Case study

Upper-limb disorder

Job:

University administrator – work involves a high level of computer use including databases and e-mail.

Health problem:

Presented to the OH service with intermittent right wrist, forearm and elbow discomfort. No specific diagnosis.

Occupational health service role:

- Clinical assessment by occupational physician.
- Workplace assessment and recommendations on:
  - posture;
  - regular breaks;
  - trial of different computer mouse.
- Involvement of *Access to Work* (available via Jobcentre Plus).
- Introduction of voice-activated software with training.
- Further adjustments to the workstation including a trial of different types of computer mouse and keyboard.
- Rotation of task and regular breaks.
- Management support.

Outcome:

Employee remained in full employment in the same job, facilitated by the OH service, benefiting both individual and organisation.

Case study

Work-related stress

Job:

Senior laboratory technician.

Problem:

Work-related stress – work performance deteriorating, deadlines missed, errors in work. Disciplinary process initiated by management causing employee to go on long-term sick leave.

Occupational health service role:

- Clinical assessment revealed serious personal stress combined with the additional demands and pressures at work causing the employee to become overwhelmed and suffer anxiety and depression.
- Correspondence with GP initiated.
- Counselling support set up.
- Management informed of situation with employee's consent.
- Employee's progress monitored.
- Phased return to work with appropriate adjustments facilitated.
- Stress management course offered.

Outcome:

- Disciplinary procedures stopped.
- Timescale for recovery established and temporary cover provided.
- Return-to-work programme developed.
- Employee recovered and returned to full responsibilities within six months.

Attendance management

14 Absence attributed to sickness is often the largest single area of cost for employers.

Self-reported work-related illness in 2004/05 – Results of a household survey[14] provides a useful perspective on the occurrence of work-related illness and injury in education

- Estimated number of working days lost due to workplace injury and work-related ill health in education = **2.2 million**.
- Estimated average annual loss = **1.2 days** per education worker.
- Estimated number of people suffering from an illness caused or made worse by a job in education = **158 000**.

Stress is the predominant cause of work-related illness in the education sector.

15 All universities and colleges should have policies in place for managing sickness absence, together with systems for capturing data. Early intervention has been shown to be effective in preventing prolonged and recurrent short-term sickness absence. Key steps are:

- a comprehensive reporting system to identify the number of people off sick, why they are off sick and what proportion of sick leave is work related;
- case management – assessment of an individual's health in relation to the demands of their job, with the aim of ensuring a prompt and safe return to work;
- management training on:
  - attendance management;
  - return-to-work interview techniques;
  - telephone interviews;
  - case conferences;
  - return-to-work plans;
  - using professional advice including that from OH providers.

16 A best practice guide, *Managing sickness absence and return to work*,[17] is available from HSE Books.

> Less than 10% of individuals who are absent from work through ill health for six months ever return to work.
>
> *Source: Department for Work and Pensions*

17 The control of sickness absence is a management responsibility. The occupational health service can provide management with the medical advice needed to enable them to discharge their responsibility in a way that is equally fair to the worker and to the institution, and that is in accordance with their statutory obligations.

18 The occupational health service can provide specialist input to return-to-work programmes that address the physical, psychological and social elements of return-to-work issues such as:

- guidance to employers on the development of appropriate policies and strategies for minimising absence and achieving the earliest possible return to work;
- assessment of individuals who are absent from work;
- specific guidance on the individual's return-to-work plan provided to the individual, their GP and their employer;
- where resources permit, provision of rehabilitation services such as fast-track or on-site physiotherapy provided by the occupational health service team;
- liaison with the individual's treatment provider (hospital/GP) and with Jobcentre Plus for guidance on return-to-work programmes;
- consideration of reasonable adjustments to work including flexible working hours.

Case study

Making a difference: Back into action

Problem:

High level of sickness absence from musculoskeletal disorders (MSDs), including back pain, at a college of further education.

Occupational health service role:

Analysis of:

- number of days lost in sickness absence due to MSDs; and
- number of reported accidents resulting in MSDs.

This showed MSDs to be the biggest cause of absence over the last three years.

Action:

Review of health and safety arrangements for all moving and handling tasks and computer work. Business case for implementing an active rehabilitation programme presented to director of human resources and director of finance. A physiotherapy service and a fitness instructor with specialist knowledge of MSDs contracted to implement the programme at a cost of £15 000 per year. Staff were allowed to access the programme during work time.

Outcome:

- Significant reduction in lost time due to work-related MSD problems, leading to savings in costs related to sickness absence.
- Organisation demonstrated a real commitment to its most valuable resource, its employees.

Adjustments under the Disability Discrimination Act

19 The majority of disabled people become disabled during their working life, and the incidence of disability increases steadily from age 45. Employers need to consider how best to make reasonable adjustments to retain an employee who has become disabled or whose condition changes or deteriorates, so that the employee is not disadvantaged in their job. Some of the most effective adjustments include:

- changes to duties;
- transfer to another post;
- providing practical aids and technical equipment;
- involving *Access to Work* (available through the Jobcentre Plus service).

Case study

Court of Appeal case

Nottingham County Council v Meikle [2004]

A teacher's sight was deteriorating but reasonable adjustments were not made, eg to lighting in the classroom. The teacher was signed off sick. After a while, pay was reduced and eventually the teacher was dismissed.

The Court of Appeal found that the employer's decision not to pay full sick pay without considering adjustment at work was discriminatory.

Case study

OH facilitation in redeployment

Job:

Administrator dealing with student course enquiries and registration.

Problem:

There was a long history of chronic low-back pain, which became disabling when the department was restructured into a call centre and the employee's freedom of movement became restricted.

Occupational health service role:

- Detailed workplace risk assessment made.
- Recommendations for adjustments to workstation and working practices.
- Clinical assessment by occupational physician to determine level of disability.
- Reports obtained from hospital specialist treating the employee.
- Advice to management on suitable adjustments, including a recommendation that the employee should be redeployed to basic office work.
- Further workplace assessment obtained from *Access to Work* (via Jobcentre plus).
- Advice to management/human resources to improve understanding and compliance with disability legislation.
- Advice to management on the practical effects of the employee's disability and reasonable adjustments to work practices to enable continued employment.

Outcome:

Employee redeployed in a job that allowed flexibility of movement. This reduced the level of disability, enabling individual to remain in employment. Organisation complied with their responsibilities under the Disability Discrimination Act 1995.

Ill-health retirement

20 If an employee is no longer able to do their job for health reasons, ill-health retirement may be an appropriate option. The occupational physician will collect the necessary information from GPs and/or consultant specialists, to help form an opinion. The occupational physician will advise HR and the individual's manager on the suitability of rehabilitation and redeployment. The final decision on ill-health retirement is a management decision.

Clinical services

21 Protecting the health and safety of medical, dental and nursing students, and the patients they encounter in their training, will require occupational health support including health assessment and vaccination to protect them and meet the control of infection infection (CoI) policies of the hospitals where clinical training is provided.

22 Students on other vocational health care courses involving contact with patients during training, eg physiotherapy, radiology, will also require similar CoI clearance and vaccination services.

23 Providing immunisations to research staff and students will also be an important health and safety measure for any higher education institute that has active research in biosciences. Many will require immunisation against pathogens they work with or may come into contact with through handling blood specimens.

Liaison and advice

24 The occupational health service can provide useful advice at corporate, senior and line manager level on strategic and practical management of work-related health issues. Auditing and monitoring are seen as key functions within a health and safety management system and the occupational health service should be an integral part of this with right of access to senior management to raise concerns.

25 Occupational health professionals need to be provided with information on new starters and sickness absence. Incidents, environmental monitoring results, or the start of new work projects may be reported by departmental staff, the safety adviser, the hygienist or the radiation protection adviser; COSHH assessments with implications for health surveillance may be forwarded by the hygienist, the health and safety adviser or the department concerned; more personal concerns may be reported through a counselling service or trade unions etc. Although it is not possible to prescribe exactly how such information should be transferred, it is essential that agreed channels of communication are established and confirmed in the occupational health service's operational policy.

26 To remain effective, occupational health professionals need to have good communication with a wide range of workers, employers, and experts in various disciplines. They will need to have links with, for example:

- education trade unions and professional bodies, safety representatives;
- health-care providers – GPs, physiotherapists;
- hospital consultants in relevant specialties, eg respiratory medicine, dermatology, psychiatry, rheumatology;
- other local external occupational health providers;
- public health authorities;
- HSE and local authority inspectors;
- relevant government departments, such as the Department for Education and Skills (DfES), DoH;

- professional bodies in occupational health;
- *Access to Work* via Jobcentre Plus.

Information, instruction and training

27 Provision of information, instruction and training is required under various regulations and the occupational health service can advise on, or in some instances, act as the provider. OH can be powerful champions, promoting awareness of issues such as upper limb disorders, back and skin care etc. It can also support training programmes for line managers, safety managers and safety representatives on managing health issues and risks. Some examples of topics covered in HE and FE include:

- animal allergy;
- explanation of health risks from DSE use for DSE assessors;
- noise-induced hearing loss;
- voice strain;
- manual handling;
- health and safety for medical students;
- correct management of needle-stick injuries;
- managing stress (both at an individual and management levels);
- making an effective management referral.

28 The Health and Safety (First Aid) Regulations 1981 require suitable first aid arrangements to be made. Advice on the appropriate level of provision can be found in the Approved Code of Practice (ACOP)[18] and the Guidance Notes that support the Regulations. The occupational health service will advise on specialist aspects of first aid, eg in relation to certain laboratory hazards, and may play a co-ordinating or advisory role in managing first-aid training (which may be contracted out) but will not necessarily be involved in the actual provision of first aid.

29 A qualified occupational physician or OH nurse can recommend arrangements other than those described in the ACOP. This is acceptable to HSE providing they are of at least an equivalent standard to those in the ACOP. Establishments wishing to train first-aiders in-house must obtain HSE approval. See the HSE website www.hse.gov.uk/firstaid/training.htm for more information.

Knowledge management – audit, record-keeping and data analysis

Monitoring and audit

30 Monitoring and audit are mechanisms for continuous improvement. They provide a way of measuring how effective actions are against a set standard. Monitoring and audit can be carried out on issues such as manual handling or stress and will serve to increase the recognition of risks to health. It will also assist in monitoring whether preventive programmes (such as DSE assessments or attendance at health surveillance appointments) are being realised in practice. From monitoring and audit results, recommendations can be made to ensure continuous improvement is made.

Record keeping

31 An occupational health service will keep both clinical (medical-in-confidence) records and health records (as required by COSHH and not medical-in-confidence). These will help to:

- provide a baseline for the health status of employees and to identify those with specific health needs;
- provide an effective health surveillance system;
- identify patterns of ill health and work areas with specific risks;
- help management in their statutory responsibility for the notification of accidents and ill health and for medical examinations required by law;
- provide advice on adjustments in the workplace; and
- monitor the use and effectiveness of the occupational health service.

32 There are a variety of electronic data management systems available.

33 The occupational health service is responsible for keeping, in confidence, individuals' records that include medical information. Records need to be kept for at least as long as the worker is under health surveillance. Some regulations, such as those for COSHH, lead, asbestos, ionising radiations and compressed air, require records to be retained for much longer (up to 50 years) as ill-health effects might not emerge until a long time after exposure.

Analysis of data

34 The occupational health service can use the data generated by themselves or elsewhere in the organisation to identify trends and inform the development of safe systems of work, in order to prevent ill health and protect the workforce as far as is possible.

35 Reviewing available routine data will assist in the identification of health risks and the evaluation of controls. Data sources might include, for example:

- sickness absence records;
- any ill-health and accident records (including statutory reports under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR));
- ill-health retirements;
- internal grievances;
- legal and insurance claims; and
- the reasons for referrals to first-aiders or the student health service.

Data protection

36 The Data Protection Act 1998 places requirements on those people who hold information on health and medical records. Such information must not be released to anyone without the informed written consent of the employee concerned, unless directed by a court, in accordance with the ethical guidance issued by the Faculty of Occupational Medicine.

37 The Employment Practices Data Protection Code – Part IV: *Information about workers' health* gives employers clear and practical guidance about how to comply with data protection law when handling information about workers' health, including the operation of occupational health schemes, medical testing of workers, drug and alcohol testing and genetic testing in the workplace (see www.ico.gov.uk).

Vocational advice to students

38 Occupational health advice is usually quite distinct from advice provided in primary care. The occupational health service can advise universities and colleges on policies on fitness to undertake certain courses (such as medicine, nursing, and teaching) which are in line with current governmental or other guidelines. It should liaise closely with the employers who will take on the organisation's students, eg NHS trusts for medical and nursing students. Providing occupational health advice to students is a major part of the OH role in higher education institutions with health-care faculties, and an increasing part of its role in other subject areas. Occupational health professionals may also offer advice to students on other aspects of the occupational health demands of their chosen vocations.

Fitness to practice

39 Educational establishments which train, appoint or employ health-care professionals and teachers are responsible for ensuring that the health, safety and well-being of those they care for/teach is not jeopardised by their being physically or mentally unfit to practice.

Guidance for teachers

- The Education (Health Standards) (England) Regulations 2003[19] introduced under section 141 of the Education Act 2002.
- The Teacher Training Agency guidance *Able to teach*[20] aimed at providers of initial teacher training on disability, discrimination and fitness to teach.
- The DfES guidance *Physical and mental fitness to teach of teachers and entrants to initial teacher training*.[21]

Health-care professionals

- The General Medical Council (GMC), General Dental Council (GDC) and Nursing and Midwifery Council (NMC) require education providers tosatisfy themselves that applicants have good health and character to ensure they carry out their work safely and effectively. Each council provides guidance in this area.
- Department of Health draft guidance *Health clearance for serious communicable diseases: New health care workers*[21] proposes that all new health-care workers will need to have standard health clearance for serious communicable diseases. Additional health clearance for blood-borne viruses will be needed for new health-care workers who will perform exposure-prone procedures.

Appendix 4: Tendering

1 A proactive service is required that will actively engage with managers and staff. They will often have to change the perceptions of occupational health away from 'the people you see when you are to be sacked' to 'people who help you remain healthy and stay in work'.

Case study

Tendering for occupational health services

An organisation identified its main hazards to health, and produced an assessment of its needs that addressed many of the points included in the checklist on pages 10-12. A specification was discussed and developed by a subcommittee of the Health and Safety Committee. This subcommittee comprised personnel, health and safety, disability, and occupational health professionals. The specification was approved by the Health and Safety Committee.

Issues that were considered included:

- whether the need was primarily for a physician or for a nurse adviser;
- whether a nurse adviser should be perceived primarily as a nurse in a clinic, or as an adviser out in the field; and
- whether the nurse should be based on site with an open door or whether staff would travel off site and possibly book appointments.

Several providers were approached, including a local NHS trust, a local general practice that had occupational health expertise, and commercial specialist occupational health companies. The tender documentation contained a set of questions aimed at clarifying the nature of the service and the qualifications of those who would provide it. Short-listed organisations were invited to give presentations to a panel, which contained a senior occupational health nurse adviser from another higher education institution, and answer their questions. They were also required to explain the nature and scale of the service that they had included in their costing. Members of the panel gained a good understanding about the common features and the differences between the potential providers.

Key learning points:

- go out to a range of different types of provider;
- involve an occupational health practitioner from a similar institution to advise you;
- quiz your potential providers about the service they are offering.

Case study

How a metropolitan council provided occupational health services to local further and higher education establishments

A large metropolitan borough council sells occupational health services to two local educational establishments within its area:

- an institute of higher education with some 7000 students and approximately 800 staff spread over two campus sites close to the centre of town. The institute offers academic courses from HNC through to undergraduate and post-graduate degrees. Courses are offered in the areas of arts, science, education, business and technology;
- a community college with approximately 15 000 students and 750 staff. The college is spread over many sites across the borough and offers numerous different courses to students from a wide age range and varying backgrounds. There is a strong emphasis on vocational education.

The occupational health services offered to both establishments fall into two groups:

- core services – sold on a contract price basis and regulated by a service level agreement;
- tailored services – offered on a 'pay as you use' basis.

Services are only provided to staff and are located at the council's clinic in their offices. Student health services are not part of this arrangement.

Core services include:

- pre-employment assessments;
- sickness absence management;
- advice on further interventions;
- post-illness advice, eg rehabilitation and redeployment, ill-health retirement;
- health promotion;
- general occupational health advice.

Tailored services include:

- psychological support;
- critical incident counselling;
- medical health surveillance;
- immunisation and vaccination;
- blood tests;
- fitness to attend disciplinary panels;
- gatekeeper to rehabilitation schemes.

The occupational health service is delivered by:

- a part-time occupational health physician;
- three occupational health nurse advisers;
- clinical psychologists;
- other professionals, eg counsellors, are retained.

The occupational health unit is part of the occupational health and safety unit.

Appendix 5: Staffing and competence

Doctors

1 Where the need for a specialist occupational physician has been identified, the level of expertise of the doctor professionally leading (though not necessarily managing) the OH service clinical team would normally be that of a registered medical practitioner who is eligible to be entered on the General Medical Council's specialist register in occupational medicine. The qualifications associated with specialist status are:

- Fellow of the Faculty of Occupational Medicine (FFOM); or
- Member of the Faculty of Occupational Medicine (MFOM) or overseas equivalent; and
- experience of working in higher or further education is desirable but not essential because the FOM curriculum covers all the core competencies of a specialist occupational physician.

Core responsibilities of the specialist occupational physician

2 This may be a full-time or part-time appointment. The physician may be a direct employee, or may be employed on a contracted-out basis. Responsibilities are:

- professional responsibility for all medical decisions made in the occupational health service, eg:
  - input into recruitment of medical staff for the service;
  - ensuring documented delegation of duties to occupational health service medical staff;
  - ensuring documented procedures/management systems for each of the OH service functions, eg health surveillance programmes;
- input to policy and committee work through personal involvement and delegation where appropriate;
- ensuring satisfactory lines of communication and other health and safety functions within the institution management.

3 It is not necessary for all the clinical work of the occupational health department to be conducted by a specialist physician in occupational medicine.

Experienced non-specialist occupational physicians

4 Many experienced occupational physicians are Associates of the Faculty of Occupational Medicine (AFOM) but have chosen not to progress to specialist status and usually have not followed the FOM training curriculum, which ensures core competencies. Appointment of such doctors to a leadership role may be appropriate depending on local circumstances.

General practitioners

5 General practitioners with or without qualifications in occupational medicine are competent to perform a wide range of duties with oversight from a specialist. All doctors working in the service must hold current registration with the General Medical Council. General practitioners working under the supervision of a specialist should at least hold, or be working towards, the Diploma in Occupational Medicine.

Nurses

6 Any nurse in an occupational health service should hold current registration with the Nursing and Midwifery Council (NMC). It is advisable that at least one nurse should have previous experience of working in the higher/further education industry.

7 At least one nurse in the OH service should hold a post-registration qualification in occupational health nursing at degree level or equivalent, and be recorded as a specialist practitioner with the NMC. Such qualifications are:

- Occupational Health Nursing Certificate (OHNC);
- Occupational Health Nursing Diploma (OHND);
- Occupational Health Nursing Degree (BSc Occupational Health/Public Health);
- PG Dip/MSc (Occupational Health).

8 The appropriate number of professional staff for the service depends on the number and turnover of employees, the nature of the work being done in the institution and the occupational health needs of employees. The checklist on pages 10-12 will help you to identify the level of hazard for which competent OH advice would be needed. The same criteria would apply to the provision of adequate secretarial and clerical backup, which is also important. The status of professional and clerical staff should match the real level of their responsibility. Guidance for employers about pay and conditions for doctors and nurses is available from the British Medical Association, and from the Royal College of Nursing.

9 While occupational physicians are expected to provide the clinical lead in an occupational health service, they should not automatically be seen as the managers of the service. For instance, a full-time nurse specialising in occupational health may be well placed to manage most aspects of service delivery.

Competence

10 Paragraph 49 of the Management of Health and Safety at Work Regulations 1999 provides the following guidance:

'Employers who appoint doctors, nurses or other health professionals to advise them of the effects of work on employee health, or to carry out certain procedures, for example, health surveillance, should first check that providers can offer evidence of sufficient level of expertise or training in occupational health.'

11 Doctors and nurses must meet the requirements of the respective professional bodies for registration, revalidation, continuing professional development, professional indemnity, and audit. Higher and further education employers should allow paid study leave to allow these obligations to be met.

12 It is important for clinical staff to be able to keep up with current developments relevant to occupational health. Computer and library access to relevant bibliographic databases and search engines is essential. It is an advantage for those in charge of an occupational health service to be familiar with management skills and suitable development should be made available to relevant staff.

Ethical considerations

13 Doctors and nurses are bound by the code of strict confidentiality with respect to personal medical information. Although advice can be given to an organisation

about an employee's functional capacity and how this could affect their work, the informed written consent of an employee must be obtained before any medical information can be disclosed. The following text is a modified quote from *Guidance on Ethics for Occupational Physicians.*[22]

'The status of a nurse or physician acting as occupational health adviser to an organisation must be that of impartial professional adviser concerned with safeguarding the health of employed persons and others who may be affected by work activity. Demonstrable professional competence, independence and integrity, as well as openness in matters of concern, are necessary to command the confidence of management, employees and their representatives.'

14 The occupational health service cannot work properly unless the employees trust it and its procedures are such that confidentiality of information is ensured.

References and further information

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12 *The Employment Practices Data Protection Code: Part 4: Information about workers' health. Supplementary guidance* Information Commissioner's Office 2005 www.ico.gov.uk

13 *Physical and mental fitness to teach of teachers and entrants to initial teacher training* Circular 4/99 DfES 1999 www.dfes.gov.uk

14 *Survey of occupational health services in higher education* (see project website www.dphpc.ox.ac.uk/ohshe)

15 *Health surveillance at work* HSG61 (Second edition) HSE Books 1999 ISBN 0 7176 1705 X

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17 *Managing sickness absence and return to work: An employer's and manager's guide* HSG249 HSE Books 2004 ISBN 0 7176 2882 5

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19 *Education (Health Standards) (England) Regulations 2003* SI 2003/3139 The Stationery Office 2003 ISBN 0 11 048264 6

20 *Able to teach: Guidance for providers of initial teacher training on disability discrimination and fitness to teach* Teacher Training Agency 2004 www.tda.gov.uk

21 *Health clearance for serious communicable diseases: New health care workers* 29921 DoH 2003 (Draft) www.dh.gov.uk

22 *Guidance on Ethics for Occupational Physicians* (Fifth edition) Faculty of Occupational Medicine 1999 (replaced by Sixth edition 2006)

Further reading

Control of substances hazardous to health (Fifth edition). The Control of Substances Hazardous to Health Regulations 2002 (as amended). Approved Code of Practice and guidance L5 (Fifth edition) HSE Books 2005 ISBN 0 7176 2981 3

Working safely with research animals: Management of infection risks Guidance HSE Books 1997 ISBN 0 7176 1377 1

Managing sickness absence in the public sector. A joint review by the Ministerial Task Force for Health, Safety and Productivity and the Cabinet Office Cabinet Office, DWP and HSE 2004 www.hse.gov.uk/gse/sickness.pdf

Managing sickness absence and return to work in small businesses Leaflet INDG399 HSE Books 2004 (single copy free or priced packs of 20 ISBN 0 7176 2914 7)

Off work sick and worried about your job? Steps you can take to help your return to work Leaflet INDG397 HSE Books 2004 (single copy free or priced packs of 15 ISBN 0 7176 2915 5)

Website addresses

General Medical Council (GMC)
www.gmc-uk.org

Faculty of Occupational Medicine
www.facoccmed.ac.uk

Society of Occupational Medicine
www.som.org.uk

British Medical Association (Occupational Health Committee)
www.bma.org.uk

Nursing and Midwifery Council
www.nmc-uk.org

Royal College of Nursing
www.rcn.org.uk

Association of Occupational Health Nurse Practitioners
www.aohnp.co.uk

Health and Safety Executive
www.hse.gov.uk

Data Protection Act
www.informationcommissioner.gov.uk

Securing health together: A long-term occupational health strategy for England, Scotland and Wales www.ohstrategy.com

While every effort has been made to ensure the accuracy of the references listed in this publication, their future availability cannot be guaranteed.

Further information

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