



constructing **better** health

IMPROVING HEALTH IN CONSTRUCTION

***Occupational Health Standards for the
UK Construction Industry***

Part One: Fitness For Work Standards

FOREWORD	4
PURPOSE, SCOPE AND APPLICATION OF THE CBH STANDARDS	5
PURPOSE	5
SCOPE OF THE DOCUMENT	5
APPLICATION	5
INTRODUCTION TO THE CBH STANDARDS	6
BACKGROUND	6
KEY FINDINGS FROM THE PILOT:	6
CBH VISION STATEMENT AND OBJECTIVES.....	7
CBH'S COMMITMENT TO THE INDUSTRY IS TO:.....	7
DEFINITIONS AND GLOSSARY	8
OCCUPATIONAL HEALTH	10
WHAT IS OCCUPATIONAL HEALTH?	10
WHAT IS HEALTH SURVEILLANCE?.....	11
LEGAL REQUIREMENTS FOR HEALTH SURVEILLANCE	11
<i>Health Monitoring</i>	12
<i>Night Workers</i>	12
<i>General Health Checks</i>	12
<i>Occupational Health Referral</i>	13
<i>Occupational Health Recording and Reporting</i>	13
HEALTH RECORDS.....	14
THE REPORTING OF INJURIES, DISEASES AND DANGEROUS OCCURRENCES REGULATIONS 1995 (RIDDOR).....	16
PRE PLACEMENT HEALTH /BASELINE ASSESSMENT	16
DISABILITY DISCRIMINATION ACT.....	17
INFORMATION, INSTRUCTION AND TRAINING REQUIREMENTS IN WORK-RELATED HEALTH.....	20
<i>Employers Duties to Employees</i>	20
<i>Employers Duties to Other Employees</i>	21
<i>Employers Duties to Non-Employees</i>	21
COMPETENCY OF OCCUPATIONAL HEALTH SERVICE PROVIDERS	21
OCCUPATIONAL HEALTH IN THE CONSTRUCTION INDUSTRY	22
KEY WORK-RELATED HEALTH RISKS.....	22
<i>Hand-Arm Vibration Syndrome</i>	22
<i>Noise-Induced Hearing-Loss</i>	23
<i>Skin Disorders</i>	24
<i>Respiratory Disease</i>	26
<i>Musculoskeletal Disorders</i>	28
<i>Work-Related Stress</i>	28
SAFETY CRITICAL WORKERS IN THE CONSTRUCTION INDUSTRY	29
NON-SAFETY CRITICAL WORKERS	31
GUIDANCE ON THE USE OF THESE STANDARDS.....	32
HEALTH ASSESSMENT MATRIX	32
<i>Coding</i>	32
<i>Section 1 - Job Role</i>	33
<i>Section 2 - Hazards</i>	33
FITNESS FOR WORK STANDARDS	33
FITNESS FOR WORK STANDARDS FOR SPECIFIC MEDICAL CONDITIONS.....	33
FLEXIBILITY OF DECISION MAKING FOR OCCUPATIONAL HEALTH PROFESSIONALS	34
TABLE OF APPENDICES:	36
APPENDIX 1: COMPETENCIES	ERROR! BOOKMARK NOT DEFINED.
APPENDIX 2 HEALTH ASSESSMENT MATRIX	37

APPENDIX 3: SUMMARY OF FREQUENCY OF HEALTH SURVEILLANCE/FITNESS FOR WORK ASSESSMENTS.....	42
APPENDIX 4: KEY TO FITNESS FOR WORK CATEGORIES AND INTERPRETATION.....	44
APPENDIX 5: FITNESS FOR WORK STANDARDS.....	45
APPENDIX 6 'AT A GLANCE' FITNESS FOR WORK GUIDANCE FOR SPECIFIC MEDICAL CONDITIONS..	64
REFERENCES	74
ACKNOWLEDGEMENTS	77

FOREWORD

Construction is a sector populated by small businesses, managed through complex contractual chains in many cases by a small number of larger contracting entities, and large numbers of mobile workers. These 3 factors are fundamental in discouraging all but the largest employers from recognising the potential benefits of investing in taking greater care of the long term health of the workforce.

Construction workers have one of the highest rates of work related illness of all occupational groups. An estimated 2.8 million working days are lost due to an illness caused or made worse by a current or most recent job in construction. A further 1.2 million days are lost due to workplace injury. The estimated annual cost of work related ill health to the construction industry is £760 million; with the overall cost to society being significantly higher (HSE) The industry also faces a skills and staff shortage. CITB Construction Skills have predicted that each year a further 87000 workers will be required to replace those leaving the industry through retirement and other reasons, in order to maintain the industry's development (Blueprint for UK Construction Skills 2007-2011 (Construction Skills Network Model, 2006; Experian)).

It is therefore critical that skilled and experienced workers are retained in the industry through an improvement in the way construction employers manage occupational health.

PURPOSE, SCOPE AND APPLICATION OF THE CBH STANDARDS

PURPOSE

The purpose of the CBH Standards is to provide key stakeholders with a best practice guide for work-place health and fitness for work requirements within the UK Construction Industry.

The CBH Standards are intended to empower employers with the knowledge to meet legislative and non-legislative requirements, and to provide employers both within the Construction and Occupational Health Industries with a point of reference for fitness for work standards.

SCOPE OF THE DOCUMENT

- The Standards define Safety Critical Workers (SCW) within the industry and the Fitness For Work (FFW) requirements
- The Standards outline the competencies required of Occupational Health Service Providers (OHSP's) delivering health assessments to the Construction Industry.
- The Standards outline the minimum (legal) requirements for health surveillance for construction industry employers with further guidance on best practice.
- The Standards outline the health assessments and procedures used in health surveillance and monitoring the health and fitness of workers in relation to their respective roles within the construction industry.
- The Standards do not address risk prevention and control measures.

APPLICATION

The CBH standard may be applied to all sectors across the Construction Industry as well as to those providing Occupational Health Services.

INTRODUCTION TO THE CBH STANDARDS

BACKGROUND

CBH commenced in October 2004 with the launch of a £1million pilot in Leicestershire, funded by industry, government and trade unions. One of the aims being to explore work related health needs of the construction industry, another to identify and develop a robust business case for a national scheme. The pilot worked with more than 360 construction employers, delivered over 1700 free and confidential health checks, with approximately 2800 workers attending awareness raising toolbox talks centred on work health topics.

The results of the health checks saw over one third of those tested referred for further advice, either for general health such as raised blood pressure, undiagnosed diabetes, or for work related issues such as Hand Arm Vibration syndrome (HAV's) or hearing loss.

KEY FINDINGS FROM THE PILOT:

A key finding of the Pilot identified construction industry employers are uncertain as to exactly who, when and how occupational health management should be provided. This is compounded by the complexity of the supply chain; the transience and mobility of the workforce; and approximately half of the workforce working in companies employing 5 or less.

The Pilot also highlighted inconsistency and a lack of co-ordination in the approach to the management of occupational health within the industry, with few employers having robust occupational health policies and procedures in place. It also identified inconsistency in the way in which data relating to work place health was collected, reported and transmitted.

The Pilot recognised free health checks could not continue to be funded on a national level and perhaps more importantly would not encourage the changes necessary in the management of risk to health by employers.

CBH VISION STATEMENT AND OBJECTIVES

“To improve the work-place health and well-being of the construction industry workforce”

CBH’S COMMITMENT TO THE INDUSTRY IS TO:

- Set the industry standards for consistent management of work-place health, including standards not only for work related health assessments for fitness to work, but also the quality and competencies of occupational health service providers.
- Administer a national database providing valid, reliable data for improving the management of work-place health
- Provide fitness for work information to all construction sectors via a workplace card scheme, (Construction Skills Certification Scheme (CSCS))
- Administer an industry wide workplace health knowledge platform incorporating education and awareness raising tools, access to advice and guidance, signposting and referral routes to expert assistance and validated research data.

DEFINITIONS AND GLOSSARY

COMPETENCE means the possession of skills and knowledge and the application of them to the standards required in employment.

ENSURE means to take all reasonable action insofar as controllable factors will allow.

HEALTH MONITORING is about monitoring an individual's health for signs or symptoms that may be related to the work being undertaken, but where there is no specific test to detect the onset of a recognised disease, and recording those findings.

HEALTH PROFESSIONAL means a health professional typically with a qualification in medicine or in nursing with a post graduate qualification in occupational health, who has been accredited on the basis of their compliance with the standard.

HEALTH SURVEILLANCE is a process involving a range of strategies and techniques used to detect signs or symptoms of work-related ill-health where; there is a valid way to detect a disease or condition; and it is reasonably likely that damage to health will occur under the particular conditions at work; and health surveillance is likely to benefit the employee, thus enabling steps to be taken to eliminate, or reduce, the probability of further damage.

INFORMATION means providing factual material which tells people about risks and precautions.

OCCUPATIONAL HEALTH NURSE ADVISOR (OHNA) is a qualified nurse working in the specialised field of Occupational Health

OCCUPATIONAL HEALTH PHYSICIAN (OHP) a Doctor working in the specialised field of Occupational Health

OCCUPATIONAL HEALTH SERVICE PROVIDER (OHSP) An organisation or qualified individual contracted to deliver occupational health services.

RESPONSIBLE PERSON A 'responsible person' is an employee who has had specific training in the recognition of symptoms of work related ill health, which may require referral to a health professional. The responsible person must not make a diagnosis and must keep any records confidential.

RISK means the combination of the frequency or probability of occurrence and the consequences of a specified hazardous event.

RISK ASSESSMENT means the overall process of risk analysis and risk evaluation.

SAFETY CRITICAL WORKER (SCW) “Where the ill health of an individual may compromise their ability to undertake a task defined as safety critical, thereby posing a significant risk to the health and safety of others”

SHALL is to be understood as mandatory.

SHOULD is to be understood as non-mandatory, that is, advisory or recommended.

OCCUPATIONAL HEALTH

WHAT IS OCCUPATIONAL HEALTH?

Occupational Health (OH) is about assessing and advising on the effect work might have on an employee's health, and what effect an employee's health might have on his/her work.

The International Labour Organisation and World Health Organisation Committee on Occupational Health in 1950 produced the following definition of Occupational Health which demonstrates the scope of the task:

'Occupational Health should aim at – the promotion and maintenance of the highest degree of physical, mental and social well being of workers in all occupations; the prevention among workers of departures from health caused by their working conditions; the protection of workers in their employment from risks resulting from factors adverse to health; placing and maintenance of a worker in an occupational environment adapted to his physiological and psychological equipment and, to summarise, the adaptation of work to people and of each person to their job.'

The HSE state that good occupational health services are central to the effective management of workplace health. They can:

- *protect and promote the health and well-being of the working population, creating a healthier workplace and a healthier workforce which will also protect and enhance your image and reputation as a good employer;*
- *provide early intervention to help prevent staff being absent for health-related reasons, and improved opportunities for people to recover from illness while at work;*
- *provide critical support to the process of effective absence management and increase the number of staff returning to work earlier;*
- *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.*

{Source: Healthy workplace, healthy workforce, better business delivery: Improving service delivery in universities and colleges through better occupational health. MISC743}

WHAT IS HEALTH SURVEILLANCE?

Health surveillance is the process of monitoring the health of employees exposed to specific health risks during the course of their work. Where appropriate, employers need to provide health surveillance to demonstrate they are meeting their duty of care for their employees. The purpose of health surveillance should be clearly explained to employees.

Health surveillance might involve examination by an Occupational Health Physician (OHP) or Occupational Health Nurse Advisor (OHNA). In some cases appropriately trained employees, i.e. a site supervisor (the 'responsible person') could, for example, check employees' skin for dermatitis, or ask questions about breathing difficulties where work involves substances known to cause asthma.

Workers can also be trained to look for and self report any signs of work related ill health. Whilst these are an important part of any health surveillance programme, self checks alone are not sufficient to comply with regulations for health surveillance.

It is important that the purpose of health surveillance should be covered in the employers Occupational Health Policy arrangements, making reference to the workers considered to be at risk, and the form of health surveillance to be done. It should also clearly identify how results will be fed back to employees and managers and describe how grouped non-identifiable (anonymised) results will be handled. Finally, it is essential that the policy describes the actions in the event of an employee being diagnosed with the relevant work related illness.

LEGAL REQUIREMENTS FOR HEALTH SURVEILLANCE

Employers have a legal duty to reduce (so far as reasonably practicable), the risks to the health and safety of employees and others who may be affected by work activity. The starting point is to assess the risks and if the risk assessment is carried out properly it will show where there is a significant residual risk to health even after reasonably practicable control measures have been applied. Employees need to understand their role and responsibilities within a health surveillance program and it is best practice to include employee representatives in these discussions.

Health surveillance should be considered wherever there is a significant residual health risk to employees. Employee's attendance for health surveillance is mandatory where a risk assessment has established that a genuine need for health surveillance exists. An employee does not however have to undertake any tests or answer medical questions, but in this case the occupational health provider would inform the

employer of this fact and that they could therefore not make a fitness for work statement. It then becomes a management decision under the relevant Employment legislation.

Section 2 of the Health and Safety at Work Act 1974 (HSAWA) states that employers have a general duty of care to ensure (so far as is reasonably practicable) the health, safety and welfare of all their employees. Health surveillance is about having procedures in place to detect work-related ill health at an early stage and acting on the results. As such, health surveillance is not an end in itself but shows whether control measures to reduce and avoid workplace health hazards are working.

Health Monitoring

Where there are no specific legal requirements to undertake health surveillance as defined in the Regulations, the implementation of health monitoring is strongly recommended as best practice as this may protect the individual from further damage. One example of where health monitoring can be implemented successfully is for Musculoskeletal Disorders (MSD's).

Night Workers

Under the Working Time Regulations, a night worker is defined as someone who normally works at least three hours at night on a regular basis. Occasional work at night does not constitute a night worker. Night time is defined as the period between 11pm and 6am. (*Working Time Regulations 1998, SI 1998/1833, ISBN 0 0794109*)

Under these regulations, all night workers are entitled to be offered a health assessment before starting night work, followed by health assessment at regular intervals thereafter, the frequency is not specified but annually is considered acceptable.

The health assessment usually takes the form of a health questionnaire completed by the employee, followed if necessary, by a medical examination. The questionnaire should be designed to protect night workers by identifying any conditions that might mean that working at night poses a potential risk to their health and safety.

General Health Checks

There are no legal requirements to undertake general health checks, however these can contribute to the promotion and overall improvement of the health of the workforce, but these must not be mistaken for occupational health surveillance or monitoring related to specific workplace exposures.

General health assessments should take a holistic approach and include such checks as weight and blood pressure, past medical history and lifestyle should be discussed and risk factors identified and advised upon. Different considerations apply to the handling of health information and results that arise from such checks and the OHSP should have carefully considered this aspect. For example the clinical information obtained cannot generally be used in relation to fitness for work, nor can it be fed back to the employer as it is medically sensitive data. The OHSP should also have a process for advising employees, where necessary, to visit their GP.

Occupational Health Referral

The purpose of a referral to an OHSP is to provide support and work related advice to employers and the individual referred but should not be considered as a substitute for an employee's normal primary care provision. The responsibility for investigations, diagnosis and treatment for general health and well-being remains with the employee's GP/ Hospital Specialist.

Before an occupational health referral, it is important that the referral and the reason for the referral including the sickness absence record are discussed with the employee concerned.

In order for employers to receive the best advice from occupational health service providers, it is essential that referral information includes sufficient written detail to enable an appropriate assessment to be made. This might include reasons for the referral, specific questions to be answered and an up to date attendance record for the employee. It is also recommended that details of the employee's current job, including hazard exposure, is provided to allow the clinician to understand what is required of an employee in their work and whether any ill-health conditions have been caused or made worse by their work.

If an employee refuses to attend the referral, then this should be discussed with either HR or the OHSP. An employee is entitled and obliged to attend an occupational health appointment within paid working time.

Occupational Health Recording and Reporting

Prior to commencing a programme of health surveillance the employer should agree with the OHSP what will be produced in the form of reports, to comply with relevant legislation, including individual employee records.

Feedback from the OHSP should be factual but not reveal clinical details. It should be limited to outcome statements related to an individual's functional ability and

fitness for specific work, with any advised restrictions. Clinical details should only be disclosed when a real benefit of doing so has been identified and this should always be with the individual's informed consent.

Grouped results (e.g. average, range, and numbers of abnormal results which may be attributable to work), may form the basis of reports to an employer to allow the identification of health risks to employees and the need for subsequent corrective action. Grouped anonymised results provide important information against which to assess the effectiveness of control measures. It is important to ensure that the 'group' is big enough to protect anonymity. This information can be particularly useful for comparisons over time i.e. year to year.

HEALTH RECORDS

Whenever health surveillance is needed a health record should be set up for each employee. In some circumstances this may be the only requirement. These records are different from medical records as they do not contain confidential medical information and can therefore be kept securely with other confidential personnel records.

A health record includes:

(1) Surname, forenames, sex, date of birth, permanent address, postcode, National Insurance number, date of commencement of present employment and a historical record of jobs involving exposure to substances or processes requiring health surveillance in this employment.

In situations where further health surveillance procedures are required it should also include:

(2) Conclusions of all health surveillance procedures and the date on which and by who they were carried out. Conclusions should be expressed in terms of the employee's fitness for work and will include the conclusions of the occupational health professional or responsible person, but NOT "confidential clinical data."

As a general rule, individual health records should be kept for employees for 40 years from the date of last entry and if necessary, i.e. if the employer goes out of business, passed to the Health and Safety Executive (HSE) for storage. Some regulations - COSHH and those for lead, asbestos, ionising radiations and compressed air - state that records should be retained for much longer (up to 50 years) as ill health effects might not emerge for a significant period after exposure.

- Medical Records

In situations where health surveillance procedures are required, medical records (occupational health records/case notes) may be created. These are entirely separate from the health record as they contain clinical information about the individual. These will be held by or on behalf of the OHSP. Employees can have access to their own medical record on written request under the Data Protection Act (1998), but details would only be released to third parties on receipt of the informed written consent of the employee or a court order.

THE REPORTING OF INJURIES, DISEASES AND DANGEROUS OCCURRENCES REGULATIONS 1995 (RIDDOR)

The purpose of this section is to provide a basic understanding of RIDDOR.

RIDDOR place a legal duty on:

- Employers;
- Self-employed people;
- People in control of premises;
- To report work-related deaths, major injuries or over-three-day injuries, work related diseases, and dangerous occurrences (near miss accidents).

The information enables the Health and Safety Executive (HSE) and local authorities, to identify where and how risks arise, and to investigate serious accidents. They can then help you and provide advice on how to reduce injury, and ill health in your workplace.

Certain cases of disease are reportable to HSE or local authorities and are listed in section 3 of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). The duty comes into effect when an employer receives a written statement from a registered medical practitioner e.g. the employee's general practitioner (GP) or Occupational Health Physician, stating that an employee suffers from one of the listed diseases and where the employee is currently doing a job involving a specified activity, which is also listed in the schedule. Such statements can be used as a trigger to review the management of the health risks within the workplace.

The OHSP will be able to provide further advice to the Employer about the reporting of work related disease.

For further information visit: <http://www.hse.gov.uk/riddor/index.htm>

PRE PLACEMENT HEALTH /BASELINE ASSESSMENT

The purpose of a pre-placement assessment is to ensure the physical and psychological capacity of the employee meets the demands of the proposed job and that any disability, as defined in the Disability Discrimination Act (DDA), are identified enabling reasonable adjustments to be made.

For certain specific activities there are legal duties to carry out pre-placement assessments of an individual's fitness for work (for example, under the, Asbestos at Work Regulations, 2006; Control of Lead at Work Regulations (CLAW) 2002 and The Work in Compressed Air Regulations 1996). However, CBH recommend that pre-placement assessments are undertaken for all 'safety critical workers'.

Baseline health surveillance assessments are also recommended (subject to a suitable risk assessment) for individuals exposed to a number of hazards including hand-transmitted vibration (L140), noise (L108), and silica (G404). For low risk workers the provision of a health questionnaire is considered suitable and sufficient. For medium and high risk (Safety Critical Workers) a completed health questionnaire will be required in addition to health assessments (medical checks).

It should be noted the use of medical selection to narrow the choice of job applicants is wasteful of clinical resources. More importantly, it may lead to discrimination on the grounds of disability, which may be difficult for an employer to defend legally. Therefore pre-placement health screening is preferred after conditional offer (subject to occupational health assessment) and acceptance of the job.

The OHSP should be provided with a job description for the post applied for, with identified hazards.

Health questionnaires should be reviewed by a "competent person" (a qualified occupational health professional) to allow appropriate decisions on management on fitness for work issues and compliance with the Disability Discrimination Act 1995. Applicants should not be expected to reveal clinical details to non-clinical staff (who are not bound by medical confidentiality); they are **not** qualified to interpret medical data and should not do so.

On receipt of a completed questionnaire, The OHSP must deal with enquiries into medical issues and may include verbal clarification of the health information received from the employee, or by requesting a report from the employees' GP under the Access to medical reports Act 1988.

As information on the health of an individual is 'sensitive personal data', its processing, which includes obtaining it, is subject to strict controls under the Data Protection Act (1998).

Assessment should only be made after a job offer has been made

DISABILITY DISCRIMINATION ACT

The purpose of this section is to provide an overview of and a basic understanding of The Disability Discrimination Act 1995.

The Disability Discrimination Act 1995 (DDA) came into force in December 1996, there have since been significant amendments.

According to the DDA, a person has a disability if “He has a physical or mental impairment which has a substantial and long term adverse effect on his ability to carry out normal day to day activities.

One other highly significant consideration is the impact of treatment on the condition. The DDA looks at an individual as though they were not on medication. Therefore, if a person is using medication, and without the medication would be significantly more ill, the DDA may apply. Specific examples to consider include the insulin-dependent diabetic, and the person suffering from depression. (In the latter case, it is always helpful to try and establish the degree of benefit gained from the medication. If it is minor, and the degree of dysfunction is minor, the DDA may not apply).

The statutory definition of disability discrimination is when “A person directly discriminates against a disabled person, if, on the ground of the disabled persons disability, he treats the disabled person less favourably than he treats or would treat a person not having that particular disability whose relevant circumstances, including his abilities are the same as, or not materially different from, those of the disabled person.”

Changes to the DDA that took effect from December 2005 include:

- Removal of the requirement that a mental illness must be ‘clinically well recognised’ before it can amount to a mental impairment
- Amendment to the definition of ‘disability’ so that a person with HIV, certain types of cancer or multiple sclerosis is deemed to be disabled from the point of diagnosis.

Impairment is taken to affect the ability to carry out normal day to day activities if it affects:

- Mobility
- Manual dexterity
- Physical co-ordination
- Continence
- Speech, hearing or eyesight
- Memory or ability to concentrate, learn or understand
- Perception of the risk of physical danger
- Ability to lift, carry or otherwise move every day objects

The following are currently excluded from the definition of impairment:

- Addiction to or dependency on alcohol, nicotine, or any other substance (other than as a result of it being medically prescribed)
- Tendency to set fires; to steal; to physical or sexual abuse of other persons; exhibitionism; voyeurism.
- Seasonal allergic rhinitis (hay fever) except to the extent that it aggravates the effect of another condition.

Long term impairment is described as that which:

- Has lasted at least 12 months; or
- Is likely to last at least 12 months; or
- Is likely to last the lifetime of the person; or
- Has ceased to have a substantial effect but is likely to recur.

The employer has a duty to consider reasonable adjustments when it knows, or could reasonably expected to know, that an employee has a disability and is likely to be substantially disadvantaged.

The DDA provides examples of the kinds of adjustments an employer may be required to make:

- Making adjustments to the premises,
- Allocating some duties to another person,
- Transferring the person to fill a more suitable existing vacancy,
- Altering the persons working hours,
- Assigning the person to a different place of work,
- Allowing the person to be absent from work for rehabilitation, assessment or treatment,
- Arranging appropriate training or retraining,
- Acquiring or modifying equipment,
- Modifying instructions or training manuals,
- Modifying procedures for testing or assessment,
- Providing a reader or interpreter, and
- Providing supervision.

The OHNA or OHP should give advice to the manager regarding what adjustments are indicated. It is up to the manager though to decide if the adjustments required are reasonable. (The DDA does not require an employer to implement unreasonable adjustments).

Under the DDA, what may be considered as reasonable in the circumstances will consider:

- The effect of steps taken
- Practicability
- Cost and disruption
- Employer resources

The Disability Employment Adviser can be contacted through the local Job Centre and can give advice to both employees and employers.

INFORMATION, INSTRUCTION AND TRAINING REQUIREMENTS IN WORK-RELATED HEALTH

The Health and Safety at Work etc Act 1974 (HSW Act) and the Management of Health and Safety at Work Regulations 1999 (the Management Regulations) place general duties on employers and others to provide information, instruction and training in order to ensure health and safety. This must be carried out by competent persons. Other regulations address specific hazards and require associated information and training. Where such specific requirements overlap, compliance with the most detailed regulations will probably suffice.

Employers Duties to Employees

- (a) To provide relevant and comprehensible information about:
 - risks to **health** and safety
 - preventive and protective measures
 - emergency/evacuation procedures
 - health and safety law (via a poster or leaflet)
 - their responsibilities to comply with site rules
 - how to use work equipment and personal protective equipment
- (b) To provide adequate health and safety training on induction and as required (including refresher training where appropriate). Some regulations may specify the content of training.

Employers Duties to Other Employees

Where workplaces are shared, each employer must take all reasonable steps to inform the other employers concerned of the risks to their employees' health and safety arising from work activities as part of his/her business. (Reg. 11 of the 'Management' Regulations 1999)

Employers Duties to Non-Employees

To provide information, instruction and training, where necessary, for health and safety (general requirement of Section 3 of HSW Act or more specific requirement of legislation (e.g. COSHH Regs 2002)) so far as is reasonably practicable.

COMPETENCY OF OCCUPATIONAL HEALTH SERVICE PROVIDERS

The Management of Health and Safety at Work Regulations 1999 (MHSAWA) state that, "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 the providers can offer evidence of sufficient level of expertise or training in occupational health". This is reinforced by the Health Surveillance at Work Guidance (HSG 61, HSE Books) which states that it is the duty of the employer to provide health surveillance for those employees considered at risk and that it is essential that the people who carry out health surveillance are competent to do so. The competence required will depend on the tasks performed and specific standards can be found within guidance associated with regulations.

OCCUPATIONAL HEALTH IN THE CONSTRUCTION INDUSTRY

KEY WORK-RELATED HEALTH RISKS

Musculoskeletal conditions, asbestos related diseases and the effects of noise and vibration exposure are the dominant work-related health conditions in construction.

The following sections provide a brief overview of those health risks that can result from work processes within the Construction Industry.

Hand-Arm Vibration Syndrome

Hand-arm vibration (HAV) is vibration transmitted into an individual's hands and arms when using hand-held powered work equipment. Regular and frequent exposure to hand-arm vibration can lead to hand-arm vibration syndrome (HAVS) and carpal tunnel syndrome (CTS).

It can be caused by operating hand-held power tools (such as road breakers), hand-guided equipment (such as compactors), or by holding materials being processed by machines (such as pedestal grinders) and this is most likely when contact with a vibrating tool or work process is a regular part of a person's job. Occasional exposure is unlikely to cause ill health.

HAVS affects the nerves and blood vessels of the hand. It can become severely disabling if ignored. It includes vibration white finger, which can cause severe pain in the affected fingers.

Carpal tunnel syndrome is a nerve disorder which may involve pain, tingling, numbness and weakness in parts of the hand, and can be caused by, among other things, exposure to vibration.

Identifying the signs and symptoms at an early stage is crucial to preventing serious long-term health effects.

The Control of Vibration at Work Regulations (COVWR, 2005) has established the necessity for health surveillance at exposure action value (EAV) over an average eight hour working day, (A8) of 2.5 m/s² using triaxial measurements or where deemed necessary by risk assessment. The introduction of the lower EAV together with a reduction in the exposure limit value (ELV) of 5.0 m/s² means that many more workers will require health surveillance.

Where risk assessment has demonstrated a need for health surveillance, where individuals have presented with symptoms or already have HAVS, then the tiered

approach to HAVS (L140, HSE) should be followed. The tiered approach to health surveillance for HAVS includes the following elements:

- Tier 1 Administration of a pre-placement Questionnaire
- Tier 2 Administration of a Routine Questionnaire (Annually)
- Tier 3 OHNA led clinical assessment
- Tier 4 Diagnosis by an OHP
- Tier 5 Standardised tests (optional)

Current HSE guidance has also suggested that, in addition to the minimum qualifications health professionals conducting health surveillance should have certification from a Faculty of Occupational Medicine approved training course in HAVS or equivalent level of competency.

For further information about HAVS visit:

<http://www.hse.gov.uk/vibration/hav/advicetoEmployers/index.htm>

Noise-Induced Hearing-Loss

Noise at work can cause hearing loss which can be temporary or permanent. People often experience temporary deafness after leaving a noisy place, known as temporary threshold shift. Although hearing recovers within a few hours, this should not be ignored as it can be a sign that if they continue to be exposed to the noise their hearing could be permanently damaged, hearing loss is usually gradual because of prolonged exposure to noise. Noise induced hearing loss is not reversible.

Health surveillance is a requirement under The Control of Noise at Work Regulations (2005) for those workers regularly exposed to noise over the upper exposure action value of 85 dB(A).

Other workers should have health surveillance provided where their exposure is either

- (1) between the lower exposure action value of 80dB(A) and the upper action value of 85dB(A), and the individual may be particularly sensitive to noise;
- (2) or only occasionally exposed above the upper exposure action value, and the individual may be particularly sensitive to noise.

Sensitivity to noise may be indicated by audiometry results from previous jobs, medical history, history of exposure to noise above 85dB(A); or in a very few cases, a family history of becoming deaf early on in life.

Suitable health surveillance means regular hearing tests (audiometry testing over a range of sound frequencies), the maintenance of suitable records, informing workers about the state of their hearing and also the proper fitting, cleaning and maintenance of any hearing protection used. Employees are required to co-operate with a health surveillance programme for noise by attending such hearing test appointments. CBH accredited OHSP's are able to assist the Construction employer as to the level of health surveillance required.

Audiometry is the measurement of hearing thresholds for pure tones of normally audible frequencies. The purpose of which is to identify workers in the early stages of hearing loss and allow intervention before the loss becomes worse.

The results of each audiometry test should be explained to the worker, including the condition of their hearing, the significance of hearing damage, the importance of compliance with the employer's noise-control and hearing protection programme and the need for any further referral.

HSE has devised a categorisation scheme for the interpretation of audiometry testing (HSE guidance L108). Essentially each worker is categorised as 'Category 1- acceptable hearing ability', 'Category 2- mild hearing impairment', 'Category 3-poor hearing' or 'Category 4-rapid hearing loss'. A worker within category 2 should be given a formal notification regarding the presence of hearing loss. Workers falling into categories 3 or 4, or workers with 'Category U' unilateral hearing loss, should be referred for further medical assessment according to the agreed process with the OHSP. The referral should be initially to the occupational doctor involved in the health surveillance programme or audiologist where available. For those employees who fall into category 4 or for some other reason identified by the OHSP, the frequency of testing will need to be reviewed and may be more frequent than three yearly.

For further information visit: <http://www.hse.gov.uk/noise/index.htm>

Skin Disorders

The HSE state that occupational skin disease may be defined as a disease in which workplace exposure to a physical, chemical, or biological agent or a mechanical force has been the cause of or played a major role in the development of the disease.

Work related dermatitis (sometimes called eczema) forms 80% of occupational skin diseases and is caused by the skin coming into contact with certain hazardous substances at work, because of this it is sometimes also called 'occupational contact dermatitis'. It is not infectious, so it cannot be passed from one person to another.

Irritant dermatitis is caused by a non-infective agent, physical or chemical, capable of causing cell damage if applied to the skin for sufficient time and in sufficient concentration. (Medical aspects of occupational skin disease guidance note MS24 [HSE]). The fine particles of cement, often mixed with sand or other aggregates to make mortar or concrete, can abrade the skin and cause irritation resulting in dermatitis. With treatment, irritant dermatitis will usually clear up. But if exposure continues over a longer period the condition will get worse and the individual is then more susceptible to allergic dermatitis. Allergic dermatitis (in susceptible individuals) is caused by initial contact with a skin sensitiser (such as epoxy resins and their hardening agents, acrylic resins, formaldehyde and hardwoods), which provoke a chain of immunological events leading to sensitisation. Further skin contact with that particular sensitiser can then cause allergic contact dermatitis.

Under COSHH (2002) and MHSAWA (1999) Regulations an employer must make an assessment of the risks to any employees liable to be exposed to a substance hazardous to health. In order to do this, the presence of any agents (used in or given off by processes or activities) with known risks of skin damage needs to be established.

It should then be determined whether health surveillance is required. Health surveillance is for the protection of individuals, to identify as early as possible any indications of disease or adverse changes related to exposure, so that steps can be taken to treat their condition and to advise them about the future. It may also provide early warning of lapses in control and indicate the need for a reassessment of the risk. The purpose therefore of health surveillance is to assess whether the use of particular substances has caused an adverse reaction, and identify early any sign of the onset of occupational skin disease. CBH accredited OHSP's are able to assist the Construction employer as to the level of health surveillance required.

It is recommended however that all employees who may be exposed to certain substances undergo an initial skin assessment. This provides an opportunity to inform the employee of the hazards of exposure to certain substances as well as establish baseline data.

For further information visit: <http://www.hse.gov.uk/skin/index.htm>

Respiratory Disease

Occupational respiratory diseases include a broad spectrum of conditions, of which perhaps the most well known is occupational asthma.

Respiratory diseases amongst construction workers may also include pneumoconiosis arising from silica (silicosis) or asbestos exposure, as well as asthma and other allergic reactions (e.g. due to isocyanate paint or resin exposure) and chronic obstructive pulmonary disease. Smoking may contribute to the respiratory damage and the risk of some allergic responses.

As outlined previously under COSHH (2002) and MHSAWA (1999) Regulations an employer must make an assessment of the risks to any employees liable to be exposed to a substance hazardous to health. It should then be determined whether health surveillance is required. CBH accredited OHSP's are able to assist the Construction employer as to the level of health surveillance required. Where occupational respiratory disease has been identified as a hazard the OHSP will ascertain an individual's respiratory health using a questionnaire and where necessary perform a lung function test (spirometry). Spirometry measures how much and how quickly air can be expelled following a deep breath, it can help diagnose various lung conditions

- Occupational Asthma

Occupational Asthma (OA) is an important occupational health problem with serious implications for both affected individuals and their employers. For the affected individual, continued exposure to the causative agent usually leads to deteriorating asthma and the risk of severe (or, on rare occasions fatal) asthma attacks. Even if exposure ceases, the more severely affected individuals may still be left with persistent asthma and chronic disability.

- Silica

Occupational exposure to silica in construction work occurs in concrete removal, demolition work, tunnel construction, concrete or granite cutting, drilling, sanding and grinding. Where workers are regularly exposed to respirable crystalline silica levels greater than 0.1 mg/m³, 8-hour TWA, then health surveillance which includes a respiratory questionnaire and lung function testing should be provided. The requirement for mandatory chest X-rays are still under discussion at the time of publication of these standards, any future advice/guidance will be reviewed and incorporated into these standards.

Source: <http://www.hse.gov.uk/pubns/cis36.pdf> where further, more detailed information can be obtained.

- Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is a common chronic progressive lung disease which is mainly caused by smoking. It is a lung condition that encompasses chronic bronchitis (regular phlegm production) and emphysema (damage to the air sacs in the lung)

As well as smoking, COPD may be caused by chronic exposures to certain substances in the workplace such as Coal-mine dust, silica, flour dust, grain, wood dust, metal fumes, and irritating gases such as nitrogen oxides and sulphur dioxide can all cause COPD. In particular construction work, welding and stonemasonry are associated with COPD.

COPD by definition results in slowly progressive irreversible decline in lung function. The main emphasis should therefore be on primary prevention, which is best achieved by smoking cessation, and the elimination or reduction of exposures to causative substances in the workplace. Where there is a strong evidence base for a link between specific exposures and COPD then statutory health surveillance will be appropriate.

Source <http://www.hse.gov.uk/copd/index.htm> where further, more detailed information can be obtained.

- Asbestos

Asbestosis is a serious, long-term lung disease caused by inhaling asbestos dust over a prolonged period of time. Asbestosis is one of a number of conditions that can be caused by exposure to asbestos. Other related conditions include cancer, mesothelioma (a malignant tumour in the lung) and benign pleural thickening (the lining of the lung is thickened and hardened).

The Control of Asbestos Regulations 2006 came into force on 13 November 2006 (Asbestos Regulations - SI 2006/2739). These Regulations require a Statutory medical under Regulation 22 for Employees exposed to asbestos above the action level must be placed under adequate medical surveillance by a relevant doctor in accordance with the regulations. This will include a past history, respiratory questionnaire and a lung function test. Chest X-rays are no longer mandatory, and are only undertaken on clinical requirements. The Regulations require that anyone undertaking a statutory medical for asbestos is an 'Appointed Doctor'. This could be

an Employment Medical Adviser, i.e. a medical inspector from the Health and Safety Executive (HSE), or a doctor appointed by the HSE. CBH can provide further guidance on finding an appointed doctor.

For further information visit: <http://www.hse.gov.uk/asbestos/index.htm>

Musculoskeletal Disorders

Musculoskeletal disorders (MSD's) are problems affecting the muscles, tendons, ligaments, nerves or other soft tissues and joints. MSD's are the most common occupational illness in Great Britain, affecting 1.0 million people a year. They include problems such as low back pain, joint injuries and repetitive strain injuries of various sorts. Injury can happen while doing any activity that involves some movement of the body, from heavy lifting to typing. There are certain tasks and factors that increase the risk such as:

- (1) repetitive and heavy lifting
- (2) bending and twisting
- (3) repeating an action too frequently
- (4) uncomfortable working position
- (5) exerting too much force
- (6) working too long without breaks
- (7) adverse working environment (e.g. hot, cold)
- (8) psychosocial factors (e.g. high job demands, time pressures and lack of control).
- (9) whole body vibration

Because there are no valid methods for detecting MSD's there are no legal requirements for undertaking mandatory health surveillance, however, symptoms can and should be regularly monitored in order to detect symptoms early and ensure the worker gets appropriate advice and treatment and importantly, modifying the work where practicable.

For further information visit: <http://www.hse.gov.uk/msd/index.htm>

Work-Related Stress

Pressure is part and parcel of all work and helps to keep us motivated, but excessive pressure can lead to stress, which undermines performance, is costly to employers and can make people ill.

HSE defines work-related stress as 'the adverse reaction people have to excessive pressure or other types of demand placed on them'. Compared to other industries, the construction industry is not a sector known to be at high risk of work-related stress.

There is however, anecdotal evidence and recent survey research to suggest that stress may be a concern within the construction industry. A recent study conducted by the Health and Safety Laboratory found that around 10% of their sample of construction industry workers found their job very or extremely stressful. The 'top five' most stressful aspects of work for respondents were:

- (1) Having too much work to do in the time available
- (2) Travelling or commuting
- (3) Being responsible for the safety of others at work
- (4) Working long hours
- (5) Having a dangerous job

In their sample, management grade employees, along with road maintenance staff, designers and administration staff report more stress than other job roles, primarily construction labourers/operatives.

For further information visit: <http://www.hse.gov.uk/stress/index.htm>

SAFETY CRITICAL WORKERS IN THE CONSTRUCTION INDUSTRY

A Safety Critical Worker (SCW) within this Standard is defined as:

“Where the ill health of an individual may compromise their ability to undertake a task defined as safety critical, thereby posing a significant risk to the health and safety of others”

Organisations have a duty under the Health and Safety at Work Act (1974) (HSAWA) to ensure a safe system of work. It is implicit in this duty that the medical fitness of employees is a component of such a safe system of work, to the extent that the effects of a medical condition are foreseeable. Not only do employers have duties towards their employees but under Section 3 of the HSAWA employers also have a duty to ensure that the safety of third parties is not compromised. In the current context, therefore, the employer needs take into account the individual employee's fitness both in respect of those activities where an employee's fitness may be likely to

affect their own health and safety and those where it may affect others' health and safety.

In some activities the consequences of adverse events may be serious and the term "Safety Critical Work" has been used. Safety critical work (or roles) were defined in the Faculty of Occupational Medicine's "Guidance on alcohol and drug misuse in the workplace" 2006 as "those involving activities where, because of risks to the individuals concerned or to others, the employees need to have full, unimpaired control of their physical and/or mental capabilities...".

In the construction industry it would seem appropriate to make a distinction between those employees who, by virtue of the nature of their work, are potentially in a position which could increase the risk to the health and safety of others, whether these are other employees or third parties, and those employees where the increased risk is only to themselves. In the former situation the employer, and employee, would have responsibilities to meet standards of best practice whilst in the latter there would be a need to fulfil required health surveillance and a need for employees to be made aware of any health issues that arise.

The risk assessment that identifies an activity as safety critical in the construction industry should therefore distinguish between the risk of harm to the individual worker and from that to other employees and third parties.

Whilst the use of professional judgment would help to ensure that an individual is fit to perform a task effectively and without risk to their own or others health and safety in broad terms, although there are general duties of care under the HSAWA, it is likely that only those exposed to safety critical work would need be subjected to a full medical assessment. In this situation the medical fitness standards for the rail industry (Railtrack PLC 2000) may be broadly applicable to safety critical work in the construction industry:

"Candidates shall not be suffering from medical conditions, or be taking medical treatment likely to cause:

- Sudden loss of consciousness;
- Impairment of awareness or concentration;
- Sudden incapacity;
- Impairment of balance or co-ordination;
- Significant limitation of mobility"

In construction the following have been defined as 'safety critical':

- All mobile plant operators
- Hi-speed road workers
- Rail track-side workers
- Asbestos licensed workers
- Tunnellers, or those working in a confined space
- Tasks carried out at height where collective preventative measures to control risk are not practicable
- Others as identified by the risk assessment process

NON-SAFETY CRITICAL WORKERS

Having defined safety critical workers in the previous section, non safety critical workers are therefore workers involved in tasks where any ill health of the individual that compromises their ability to undertake a task would not pose a significant risk to the health and safety of others.

GUIDANCE ON THE USE OF THESE STANDARDS

The purpose of this section is to act as a quick reference guide to the Standards for example a summary of the frequency of health assessments can be found at Appendix 3.

The CBH standard for competency of any occupational health professional or organisation delivering health surveillance / fitness for work assessments to the construction industry can be found at Appendix 1. OHSP's meeting these standards will be accredited and listed on the CBH website, which all employers within the construction industry have free access to.

HEALTH ASSESSMENT MATRIX

The purpose of the health assessment matrix shown at Appendix 2, is in two sections, and is to be used to provide a guide to the relationship between job roles within the construction industry and the type of health assessment that may be required subject to the risk assessment process. The matrix can be used by both employers and occupational health providers as a means of quickly identifying the health assessments required for an individual undertaking a particular job role. It demonstrates the application of health surveillance / fitness for work and general health checks related to the various job roles found within the construction industry and more typical hazards encountered.

The employer should use this as a reference point to establish what obligations they have regarding health surveillance for employees, this will ensure when contracting with the OHSP the employer has an understanding of what is required for them to comply with current legislation and what health checks are desirable but NOT mandatory.

Coding

The coding within the body of the matrix identifies: which health assessments are:

- ▲ Legally required i.e. there is a legal requirement to undertake health surveillance / statutory medicals
- ® Best Practice (Strongly recommended)
- Discretionary – makes good Business sense to do this, but is not mandatory
- ☐ Fitness for Work Assessments (SCW)

Section 1 - Job Role

Section 1 of the health assessment matrix outlines the health assessment requirements according to job role. Having identified the relevant job role from the list, the employer may choose as a minimum to carry out the health surveillance (▲) in order to comply with basic legislative requirements, or may choose to include and encourage employees to participate in general health checks which when added to the recommended health surveillance take a more holistic approach to the health and well being of the workforce.

Section 2 - Hazards

Section 2 outlines health assessment requirements according to the hazard exposed to and can be used where an individual undertakes a task and an additional hazard has been identified in the risk assessment process that is not normally associated with their job role, e.g. plumber, (section 1) who works nights (hazard), (section 2).

Each health assessment in the matrix has an allocated Fitness Standard code (A-R).

FITNESS FOR WORK STANDARDS

Having identified from the health assessment matrix the type of health surveillance required, and whether it is statutory, strongly recommended or discretionary, or following medical assessment for other reasons; the outcome needs to be established.

The fitness standards outlined in Appendix 5 provide guidance to the Occupational Health Professional when determining the outcome of a medical assessment and the subsequent compatibility of an individual, in relation to work-place related health, with the demands of their job. (See flexibility of decision making for OH professionals below). It must be noted however that an Employer shall not make decisions based upon these but refer to a competent OHSP for further advice as required. The key to the fitness to work standards and interpretation can be found at Appendix 4.

FITNESS FOR WORK STANDARDS FOR SPECIFIC MEDICAL CONDITIONS

The table shown at Appendix 6 is not intended to address all possible conditions likely to be encountered on construction sites or all potentially disqualifying medical conditions: it should be only used as a general guidance.

Occupational Health Professionals should determine fitness, taking into account the proposed role on site. If in doubt, the examining Occupational Physician should attempt to quantify the degree of severity of any disqualifying impairment by objective

tests, whenever such objective tests are available, or by referring the candidate for further assessment.

When considering fitness for work and any obligations under the Disability Discrimination Act (DDA), precedence is given to the Health and Safety at Work Act 1974 (HSAWA) when safety issues arise. Any decision should be based on risk assessment and specialist medical evidence, and not on prejudice or assumption. It is possible any decision may have to be defended in court.

It is vital therefore that that sufficient consideration is given to making reasonable adjustments to the workplace. There are examples however where there would be a statutory bar as outlined in the following tables. It is recommended however that specialist medical evidence is always sought and any proposed restrictions be fully discussed with the employee.

FLEXIBILITY OF DECISION MAKING FOR OCCUPATIONAL HEALTH PROFESSIONALS

These Occupational Health Standards have been designed by CBH to reflect best practice, taking into account the requirements for safety and the practical needs of employers and employees. It is recognised that there are specific circumstances where it would be safe for someone to carry out a work task whilst not meeting the health standard. For example, someone with a systolic blood pressure above the standard may not necessarily be unsafe to work in a specific job in a specific area for a specific period of time. Thus, Occupational Health Professionals will in some circumstances be required to make a judgment on whether it is safe for a person to carry out a specific job with a specific health issue.

In such circumstances the Occupational Health Professional should follow the process outlined below:

- Clearly identify the medical issue and all of its facets that could affect the work situation e.g. medication, degree of disability
- Identify, and have a clear understanding of the tasks of the job, and the location
- Identify and have a clear understanding of those aspects of the job that could be affected by the medical issue
- Undertake a risk assessment and make a judgment of whether or not it is safe and practicable for the person to be allowed to do the job, and any modifications that are required. For example, it may be that the person should not work shifts

- Make written notes in the person's occupational health record to explain the relevant factors and the reasons for the judgment
- Advise the person about the decision and ensure that the restrictions, if any, are clearly explained to the person
- Advise the management in writing of the decision, the restrictions that will apply and the review date
- Examples of restrictions that could be applied are: limited location, limited time period before health re-examination, limitation of some duties, not to work in isolation

The Occupational Health Professional undertaking such flexible judgments shall be appropriately qualified and competent to make such a decision. If in doubt then the Occupational Health Professional shall discuss the case with a more qualified or more experienced Occupational Health Professional.

TABLE OF APPENDICES:

Appendix 1	Minimum competency standards for occupational health service providers to the construction industry
Appendix 2	Health Assessment Matrix
Appendix 3	Summary of frequency of health surveillance / fitness for work assessments
Appendix 4	Key to fitness for work categories and interpretation
Appendix 5	Fitness for work standards
Appendix 6	At a glance fitness for work guidance for specific medical conditions

APPENDIX 1: COMPETENCIES

MINIMUM COMPETENCY STANDARDS FOR OCCUPATIONAL HEALTH SERVICE PROVIDERS TO THE CONSTRUCTION INDUSTRY

In addition to the fulfillment of the necessary legal requirements of employment of clinical staff, the construction industry should apply the following minimum levels of competence: All CBH accredited OHSPs shall be assessed to these minimum requirements:

Occupational Health Physicians

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

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

- The Diploma in Occupational Medicine (DOccMed.)
- the Associateship of the Faculty of Occupational Medicine (AFOM)
- Membership of the Faculty (MFOM).

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

Physicians without these qualifications who rely solely on experience gained in the workplace may not meet the requirements for competence that are demanded by many aspects of health and safety legislation. Therefore, the Diploma in Occupational Medicine has been identified as the minimum standard for the construction industry. However, all physicians practising in the construction industry should work within the limits of their competence and be cognisant of the need to have access to a nominated Accredited Specialist Occupational Physician (Accredited Specialist in Occupational Medicine who is on the GMC Specialist Register) for advice as needed. The level of occupational health expertise will need to be commensurate with the level of health risk identified for the project e.g. for a complex construction project it would be usual for the occupational health provision

to be led by a Consultant Occupational Health Physician.

For a physician led occupational health service (physician led is defined as the situation whereby the occupational health services are being managed and controlled by a physician), the lead physician must be either an Accredited Specialist in Occupational Medicine (Accredited Specialist in Occupational Medicine who is on the GMC Specialist Register) or have the necessary access to a nominated Accredited Specialist Occupational Physician for advice as needed.

Occupational Health Nurse Advisors

OHNAs carrying out occupational health surveillance should hold current registration with the Nursing and Midwifery Council (NMC), as a minimum. They may also hold an occupational health qualification at Certificate, Diploma or Degree level. If they do not have an occupational health qualification then they should be working under the necessary level of supervision of an appropriately qualified clinician (Doctor or Nurse). Nurses will need to renew their registration every year with the NMC.

For a nurse led occupational health service (nurse led is defined as the situation whereby the occupational health services are being managed and controlled by a nurse.), the lead nurse should also be registered as a Specialist Community Public Health nurse (Occupational Health) with the NMC and have access to a nominated Accredited Specialist Occupational Physician (Accredited Specialist in Occupational Medicine who is on the GMC Specialist Register) for advice as needed.

Occupational Health Technicians

The occupational health technician is a developing role. With the expert supervision of OH qualified nurses and doctors and the correct training, they may be able to carry out aspects of health surveillance required within an OH programme, which in turn frees-up the OH clinicians for other, more appropriate tasks. Currently there are no minimum standards available to follow although there are academic organisations currently looking to develop a training programme for technicians. CBH will review and revise these standards as it is developed.

Some aspects of health surveillance also require additional competences to be demonstrated e.g.

- HAVS: a Faculty of Occupational Medicine approved training course in HAVS or equivalent level of competency
- Noise induced hearing loss: a British Society for Audiology approved course

for industrial audiometricians or equivalent level of competency.

- Respiratory: Association for Respiratory Technology and Physiology (ARTP) diploma or equivalent level of competency.

Occupational health service providers (OHSP) must hold appropriate business and professional indemnity insurance, comply with applicable legislation, and should not undertake work without having seen or had access to the employer's relevant Health and Safety policies to determine how Health and Safety is managed.

The Health Professional should be able to demonstrate awareness of legislation, policies or programs that might interfere with or affect the performance of the health assessment for example, drug alcohol policy, critical incident management programs, anti-discrimination legislation, medical ethics and privacy legislation.

Occupational health service providers should have:

- appropriate quality monitoring processes i.e. a clinical audit programme
- clinical training programmes
- business and professional indemnity insurance
- appropriate registration under the Data Protection Act (1998)
- a health and safety policy for those with five or more employees
- access to construction industry occupational health policy and procedures to which they provide a service.

Construction Industry Knowledge:

The health professional should demonstrate familiarity with the CBH Occupational Health Standards for the UK Construction Industry and working knowledge of it's Assessment Procedures and Medical Criteria, including:

- Appreciation of the role of health assessments in ensuring construction safety.
- Familiarity with the risk management approach used to identify the level of health assessment required.
- Familiarity with the tasks in construction operations and with major

tasks of Safety Critical Workers.

- Knowledge of construction safety worker Risk Categories and the rationale for health assessments applied.
- Knowledge of ability to perform the Safety Critical Worker Health Assessment.
- Understanding of requirements and reporting options for fitness for construction safety duty.
- Knowledge of the assessment's administrative requirements, including form completion and record keeping.
- Understanding of ethical and legal obligations and the ability to conduct health assessments accordingly, including appropriate communication with the worker and the employer.
- Understanding of ethical issues in relationships with the treating doctor/general practitioner.

For an OHSP to be accredited with CBH it is a condition that their record keeping meets the requirements set out in the various regulatory bodies, i.e. The Nursing and Midwifery Council (NMC), and the General Medical Council (GMC), the OHSP will also be familiar with the recommendations made by the HSE in relation to the keeping of health records that form part of a health surveillance programme.

It is expected that the Faculty of Occupational Medicine's guidance on ethics for occupational doctors is followed regarding the provisions for transfer and storage of records and the confidentiality of health data.

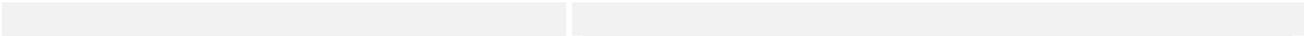
There may be occasions where an OHSP may not meet all the criteria above. However the OHSP may demonstrate the required knowledge, skills and experience, and have the relevant procedures in place to enable them to provide an occupational health service which is considered by CBH to be at least equivalent to the minimum industry standards and compatible with registration with CBH.

APPENDIX 2 HEALTH ASSESSMENT MATRIX

APPENDIX 3: SUMMARY OF FREQUENCY OF HEALTH SURVEILLANCE/FITNESS FOR WORK ASSESSMENTS

The following table provides ‘at a glance’ guidance on the frequency that the various health assessments and surveillance should be undertaken.

ASSESSMENT	FREQUENCY
Pre-placement Health Questionnaire	Pre-placement
Pre-placement Health Assessment	Pre-placement based on response to questionnaire, or if a SCW
Baseline Health Assessment	Pre-exposure to workplace identified hazards
Blood Pressure	3 yearly as part of FFW assessment if SCW
Routine Urinalysis	3 yearly as part of FFW assessment if SCW
Visual Acuity	3 yearly as part of FFW assessment if SCW
Visual Acuity – Intermediate (DSE)-	2 yearly.
Colour Perception	3 yearly (if required by risk assessment).
Respiratory Health	Pre-placement, 6 weeks (for high risk / exposure), 12 weeks and repeated annually.
Hearing	Pre-placement, annually for the first 2 years then 3 yearly intervals
Hand Arm Vibration Assessments Level 1	Pre-placement, then annually. Tiered approach to be followed if symptoms identified
Skin Health Assessments	Monthly by a responsible person Annually skin questionnaire
Musculoskeletal Questionnaire	Annually
Statutory Medicals Lead Asbestos Ionising radiation	As required in Approved Code of Practice (ACOP) under relevant Regulations. {LINK}
Work-place Stress Assessment - Drug and Alcohol Screening -	Following risk assessment or symptoms reporting Pre placement and for cause testing post accident. (Subject to local policy)
Safety Critical Workers (SCW)	Fitness for Work assessment - 3 yearly. At pre-placement and /or during employment if it is identified the employee will be required to undertake safety critical roles due to a change in the employee’s job/work activity. Assessments may be repeated at any time that an employee informs their employer {occupational health department and/or his/her manager} about a medical condition that would affect his/her ability to work, and /or when there is any concern that an employee may no longer be fit for physical, mental or psychological reasons i.e. post accident.



APPENDIX 4: KEY TO FITNESS FOR WORK CATEGORIES AND INTERPRETATION

CATEGORY	FITNESS STANDARD	INTERPRETATION
1	Fit for work without restriction	Passed assessment.
2	Fit for work, though some restrictions and recommendations apply	Assessment indicates need to advise job / worker restrictions and / or recommendations to prevent exacerbation of health issues and / or re occurrence of health issues and / or to promote safety of self and others.
3	Temporarily does not meet fitness standards	<ul style="list-style-type: none"> • An employee may present with symptoms that could have implications for their job but the diagnosis is not clear. Each situation will need to be assessed individually with due consideration to the probability of serious disease in particular where this may affect safety critical tasks. • Assessment of health history may require further investigation / tests and operational risk assessment. Outcome may include modifications to work / job role as above. • Auspices of Disability Discrimination Act may be applicable. E.g. Consideration to transfer to non SCW or be removed from exposure to certain hazards. • Generally workers who present with symptoms of a potentially serious nature should be classified Category 3 until condition can be adequately assessed however they may be fit for alternative duties.
4	Unable to meet the fitness for work standard	<ul style="list-style-type: none"> • Requires case by case assessment based on health issue and job requirement by OH Physician. • Operational risk assessment and liaison / case conference with management required to discuss appropriate consideration for SCW transfer / redeployment to non safety critical / reduced risk work environments and duties / capability / Ill health retirement. • Management to make final decision on future employment in accordance with relevant Employment legislation/DDA.

APPENDIX 5: FITNESS FOR WORK STANDARDS

FITNESS STANDARD A:	
PRE-PLACEMENT HEALTH QUESTIONNAIRE	
Frequency: Pre-placement	
CATEGORY	INTEPRETATION
1	No medical conditions or past medical history declared that would in any way affect ability to do or be made worse by proposed job
2	A medical condition or past medical history declared that having obtained further information or medical evidence indicates need to advise job / worker restrictions and / or recommendations to prevent exacerbation of health issues and / or re occurrence of health issues and / or to promote safety of self and others. May be covered by disability legislation.
3/4	A medical condition declared that required assessment with an OHP, who may / may not have obtained further information and / or medical evidence, that indicated that exposure to hazards identified in proposed job role could exacerbate the medical condition or pose a safety risk to self or others. May be covered by disability legislation.

FITNESS STANDARD B:**PRE-PLACEMENT HEALTH ASSESSMENT / MEDICAL**

Frequency: Pre-placement

CATEGORY	INTEPRETATION
1	No medical conditions or past medical history declared that would in any way affect ability to do or be made worse by proposed job, all baseline health surveillance within normal ranges
2	A medical condition / past medical history declared that having obtained further information or medical evidence, and / or baseline health surveillance indicates need to advise job / worker restrictions and / or recommendations to prevent exacerbation of health issues and / or re occurrence of health issues and / or to promote safety of self and others. May be covered by disability legislation.
3/4	A medical condition declared / or baseline health surveillance that required assessment with an OHP, who may / may not have obtained further information and / or medical evidence, that indicated that exposure to hazards identified in proposed job role could exacerbate the medical condition or pose a safety risk to self or others. May be covered by disability legislation.

FITNESS STANDARD C:**SAFETY CRITICAL WORKERS****Frequency:**

It is recommended that reassessment of fitness for safety critical construction workers is set at a fixed periodic review, after first assessment, of 3 yearly, unless otherwise advised by relevant legislation. Reassessment of fitness for safety critical construction workers with any substantial change in medical circumstances is also recommended. Such an assessment need only address the specific change in those medical circumstances with full re-assessment when next scheduled.

HEALTH ASSESSMENT	REQUIRED STANDARD
Health Questionnaire	No evidence of ill health reported. Refer to specific medical conditions below
Blood pressure	Diastolic below 95mmHg Systolic below 150mmHg
Hearing	Requires pass test result HSE Category 1 or 2
Respiratory Health	FEV1% greater than 70% of predicted value. No evidence of respiratory symptoms on questionnaire
Visual acuity	Achieves an aided or unaided binocular visual acuity 6/12
Colour perception (where required through risk assessment process)	Achieves a pass red / green using Ishihara test plates
Mental Health	No evidence of mental ill health which is likely to impact on ability to work
Urinalysis	No evidence of blood, glucose and / or protein in urine
Mobility and co ordination assessment	No evidence or reporting of musculoskeletal or neurological disorder.
Drug and Alcohol Screening	Negative test result. No evidence of OTC or prescribed medication likely to cause symptoms

FITNESS STANDARD D:**STATUTORY MEDICALS**

Frequency: As required under the relevant approved code of practice (ACOP)

TYPE	
ASBESTOS	Asbestos medicals are required under Regulation 22 of The Control of Asbestos Regulations (CoAaW) 2006 and shall be carried out by an Appointed Doctor. Refer to ACOP
LEAD	Under the Control of Lead at Work Regulations (CLAW) 2002 each employee who is likely to be exposed to lead at work requires assessment by a doctor. Where this exposure is 'significant' as defined by the Lead at Work regulations, the doctor must be an Appointed Doctor. The action level is if the amount of lead in the individuals blood reaches 50 µg/dl Refer to ACOP
IONISING RADIATION	Employees who are likely to receive an effective dose of more than 6mSv per year, or an equivalent dose which exceeds three-tenths of any relevant dose limit should be designated 'classified persons' under The Ionising Radiation Regulations 1999. Classified workers must have health surveillance by an appointed doctor. The detailed requirements can be found in the Health and Safety Executive (HSE) approved code of practice and guidance L121 'Work with Ionising Radiation'.

**FITNESS STANDARD E:
MUSCULO- SKELETAL HEALTH, MOBILITY AND CO-ORDINATION**

Frequency:

- 3 yearly for SCW or sooner if required i.e. symptoms reported
- pre-placement for new employees whose work will include a significant amount of handling or repetitive movement, a pre-placement “fitness for work” assessment should be conducted to determine any MSD’s already present which may preclude the intended employment
- Employees should be encouraged to report symptoms of any MSD’s to the nominated person at any time. Their attendance for other health surveillance should be used as an opportunity to discuss any symptoms of MSD’s which have not previously been reported. When a problem is detected a full assessment of all possible causes should be undertaken

CATEGORY	FITNESS STANDARD INTERPRETATION
1	No evidence or reporting of Musculoskeletal / nervous disorder.
2	Musculoskeletal / nervous disorder identified that does not render individual unable to perform work but requires job / worker restrictions and / or recommendations to prevent exacerbation of health issues and / or re occurrence of health issues and / or to promote safety of self and others. For example it may be recommended individual does not lift above a certain weight, or is unable to work in confined spaces. Advice should be provided on an individual basis following functional assessment.
3/4	<p>Musculoskeletal: Does not have full movement of the trunk, neck, upper and lower limbs. Chronic pain or restriction of joint movement interferes with mobility. Employees with limb prosthesis may still be able to operate machinery but this should be based on an individual functional assessment with an OHA, manager and operator.</p> <p>Nervous system: Vertigo, giddiness and balance disorders are a bar to SCW Ataxia, diplopia, significant tremor, paralysis, generalized or localized muscular weakness, and peripheral/autonomic neuropathy are all a bar to machinery / SC operations.</p> <p>Employees who have had a CVA/TIA should be restricted until assessed by an OH Physician.</p> <p>Identifiable long term / current medical problem which restrict capability and ability to stand, walk sit for periods, and may affect safety of self or others.</p> <p>DDA applies. Operational risk assessment indicated</p>

FITNESS STANDARD F:**SKIN ASSESSMENTS****Frequency:**

- prior to placement if it is identified the potential employee may be at risk of contracting allergic contact dermatitis (e.g. those with a history of atopic eczema or a past history of work-related skin disorders)
- within two weeks of employment if it is known the employee will be working in an environment where they could be exposed to possible occupational skin irritants/allergens
- a 'responsible person' to carry out regular (at least monthly) skin checks and annually to use a brief skin questionnaire
- employees should be educated to examine their skin on a regular basis in-between these intervals
- when an employee informs their manager and/or occupational health of any skin symptom which may be occupational
- employees identified as being at risk of developing occupational dermatitis and/or skin disorders should be seen annually by an OHNA

CATEGORY	INTERPRETATION
1	No evidence or reporting of skin problems- e.g. dermatitis
2	<p>Skin disorder identified that does not render individual unable to perform work but requires job / worker restrictions and / or recommendations to prevent exacerbation of health issues and / or re occurrence of health issues and / or to promote safety of self and others. For example it may be recommended that an individual with irritant contact dermatitis may need to avoid contact with the particular agent that caused irritation whilst skin heals, but can work normally with that restriction in place. Could then return to normal duties with adequate control measures in place</p> <p>Advice should be provided on an individual basis following assessment</p>
3/4	<p>Skin disorder identified that renders individual unable to perform a certain task either on a temporary or permanent basis. For example someone with allergic contact dermatitis. The allergic reaction begins with a process called sensitisation. Sensitisation starts when an allergic substance (e.g. chromium in cement) penetrates the skin. When a sensitised person is re-exposed to an allergenic substance, a response occurs which causes itching, pain, redness, swelling and blisters on the skin. Once sensitised, the allergic reaction is likely to remain with the individual for life, therefore they should not come into contact with that agent.</p> <p>Advice should be provided on an individual basis following assessment</p> <p>Skin disease is not usually a reason to bar from safety critical work unless a sign of underlying disease or illness which could exclude SCW.</p> <p>Dermatitis needs to be reported as a case of disease for the purposes of RIDDOR</p>

FITNESS STANDARD G:**RESPIRATORY HEALTH****Frequency:**

- respiratory health surveillance should be undertaken at pre-placement on those employees whose occupations are known to involve exposure to respiratory hazards at work and/or who wear respiratory protection at work
- health surveillance should include assessments, by questionnaire and Spirometry
- 3 months post employment
- 6 months after date of employment for the first 2 years
- Yearly review thereafter provided there are no problems identified,
- on any employee who notifies Occupational Health of respiratory symptoms which may or may not be occupationally related
- Respiratory health surveillance will cease when the employee is not longer exposed to hazards requiring surveillance or when employment is terminated.
- An exit test should be undertaken for all employees who have undergone a programme of respiratory health surveillance if an interval of 6 months has elapsed since their last health surveillance appointment
- Employees who fail to produce results within the normal range and/or have respiratory symptoms should be referred to an OH Physician. Referral to their GP may also be necessary in order that treatment can be considered
- Procedures should be in place to enable employees to report any symptoms that occur between tests.

CATEGORY	STANDARD INTERPRETATION
1	Normal Spirometry results. No history or evidence of Respiratory illness.
2	<p>Further investigation required/ referral to Occupational Health Physician if employee has ;</p> <ul style="list-style-type: none"> • Abnormal spirometry: a drop of 20% from predicted VC and FVC • FE1/FVC ratio of less than 70% • Any individual diagnosed asthmatic with impaired lung function • Any individual diagnosed with impaired lung function related to a respiratory disease or where it is likely lung function may deteriorate as part of the natural disease process • Any individual with a history of workplace respiratory sensitisation (asthma/rhinitis)
3/4	<p>Respiratory disorders may affect ability to perform safety critical work, partly because considerable exertion may be required to work safely; normal blood gases are required to enable vigilance to be maintained and appropriate decisions made and communicated. Dyspnoea / acute respiratory failure would be a bar to SCW.</p> <p>Clinical judgement required on a case by case basis. Workers should be excluded from SCW until a clear diagnosis is made, and transferred to other duties until then.</p>

FITNESS STANDARD H:**HEARING**

Frequency: An audiometric programme should consist of a baseline audiogram conducted before employment [or free from noise exposure for at least 16-24 hours] where noise is a hazard, followed by a schedule of audiometric testing to monitor hearing threshold levels following exposure to noise at work. The schedule of audiometric testing should include annual tests for the first two years of employment and at three yearly intervals thereafter

CATEGORY	STANDARD INTERPRETATION
1	<p>HSE Category 1. Acceptable hearing limits for lower frequencies and upper frequencies. Continue with good use of PPE and monitoring as per risk assessment / health matrix. Provided that the standard H1 is met without the use of a hearing aid, a hearing aid may be used (i.e. at work) to improve hearing further.</p>
2	<p>HSE Category 2 indicates a warning i.e. there is evidence of mild hearing impairment / noise induced hearing loss. Emphasise to be made to maintenance/ good use of PPE and increased frequency of audiometric monitoring.</p> <p>For safety critical roles the Hearing loss should not exceed 30dB averaged over frequencies of 0.5, 1 and 2kHz in either ear. If it is difficult to determine the ability of a worker to hear safety instructions and auditory warning signals a functional assessment may be appropriate to determine an employee's safety and the safety of others in the workplace. Drivers / Operators must be able to hear instructions and warning signals. The use of a hearing aid is not a bar to FLT operation.</p> <p>The functional assessment would be conducted by a manager / safety professional familiar with health and safety issues in the employee's working environment.</p> <p>If noise-induced hearing loss is deemed to be stable, continuing exposure to noise will usually be acceptable where adequate hearing protection is used and where residual hearing ability is not so poor as to make the risk of further hearing loss unacceptable.</p> <p>Meticulous use of PPE advised, particularly where noise cannot be removed at source.</p> <ul style="list-style-type: none"> • Further investigation required with Occupational Health Physician. • Repeat / more frequent audiometry indicated. <p>GP / Specialist referral / report may be required.</p>
3/4	<p>Where employee has not met criteria 1 and / or 2, for example</p> <ul style="list-style-type: none"> • evidence from previous audiometric testing of rapid / reduced hearing loss in higher and/ or lower frequencies • unilateral hearing loss • presence of a pathological condition - condition may be likely to cause unpredictable fluctuation in hearing levels or permanent reduced levels of hearing; <p>An employer will ultimately determine if an employee should continue working in a noise hazard area. The role of the OH practitioner is to provide the employer with a competent assessment of an employee's hearing in relation to their job and work environment. A competent assessment of an individual with significant hearing loss would include advice from a Hearing specialist. Consideration to DDA applies.</p>

FITNESS STANDARD I:**HAND ARM VIBRATION**

Frequency: HAVS assessments should be provided

- at pre-placement –Level 1 assessment if the employee’s job if they are at risk of vibration from any part of their job
- For newly-exposed workers should be reviewed 6 months after commencing work with vibrating tools or earlier if there is any indication of HAVS developing.
- The HAVS screening questionnaire should be carried out annually. This may be done by a responsible person who has received training on HAVS by an occupational health professional. If any signs or symptoms arise at this stage, then the employee must be referred to an Occupational Health Advisor
- Every third year (whether symptoms have been reported or not) that the employee be assessed by a qualified person (OHA or OH Physician) (HSE Tier 3).

Additionally, if an employee consults occupational health/management complaining of symptoms which could be associated with HAVS

CATEGORY	INTERPRETATION
1	No signs or symptoms of HAVS
2	<p>Stage 1 symptoms</p> <ul style="list-style-type: none"> • Advise the employer to review the risk assessment, and to reduce further exposure to a level that is as low as reasonably practicable. Advise change work practices to eliminate exposure to vibration and where there is a residual risk despite control measures, consider job rotation to reduce an individual’s exposure. • If there is a suggestion that the disease is progressing rapidly, then arranging a review in 6 months rather than 1 year may be indicated. • Stage 2 symptoms, exposure must be reassessed, and there needs to be close monitoring for symptom progression and worsening functional impairment. • The OH Physician needs to consider whether the individual is fit to continue to be exposed to hand transmitted vibration (HTV). However, normally the individual will only become unfit if he/she has reached late stage 2. Tier 5 testing may help to confirm the severity of symptoms. However, it is important to recognise that the tests are not necessarily precise, and therefore the decision as to whether a case is late stage 2 will always be based to a large extent on clinical judgement. • Management of current cases of Stages 2-3 might be different, as the disease progression may be clearer. If the employee is approaching retirement age, continued fitness to work may be acceptable, particularly if further exposure can be limited, and the individual undergoes regular health surveillance. The situation and risks need to be explained fully to the employee, who should be asked to sign his acceptance of the risks.

- Stage 3 symptoms. Normally individuals with Stage 3 HAVS will be unfit for further exposure to HTV. It is suggested that if this stage is diagnosed, a meeting is arranged for the individual, management, Trades Union and possibly company legal representative.
- Unfit for further exposure. If the OH Physician recommends that exposure to HTV ceases, the employer needs to consider what action to take. This might include redeployment to an alternative role. Consideration will need to be given to whether the employee symptoms of reduced grip strength and / or manual dexterity may implicate safety of self or others
- Carpal Tunnel Syndrome (CTS) - If a diagnosis of CTS is made, the individual should be removed from further exposure, and referred to his/her GP for specialist treatment. Surgical decompression for CTS secondary to HAVS is less effective than for primary CTS. Recommendations about returning to work need to be made on an individual basis, and the employee must be advised about the risk of developing further symptoms.
- DDA may be applicable
- Cases of HAVS or CTS caused by HTV are RIDDOR-reportable. They should be reported once the diagnosis has been confirmed by an OH Physician.
- Specialist testing may be indicated. Employee should cease working with vibrating tools until further notice.

FITNESS STANDARD J:	
BLOOD PRESSURE	
Frequency: 3 yearly as part of FFW assessment if SCW or more frequently where symptoms / history have been reported	
CATEGORY	INTERPRETATION
1	Normal Blood pressure. Blood Pressure below 140/85mmHg (140 systolic and 85 diastolic). No Cardiac symptoms presented or reported
2	Asymptomatic and stable conditions e.g.: <ul style="list-style-type: none"> • fully recovered myocardial infarct or well controlled uncomplicated hypertension • arrhythmia if symptoms are controlled and cardiac function is satisfactory • a single, uncomplicated myocardial infarction • Angina, unless symptoms are brought on by work duties and/or medication produces side effects which may interfere with work duties. The above are not considered a bar to SCW.
3/4	The following are a bar to safety critical work : <ul style="list-style-type: none"> • Uncontrolled hypertension (diastolic remains > 110mmHg) likely to cause health symptoms and / or sudden collapse, which could potentially endanger the safety of others. • Syncope, transient ischaemic attacks and complete heart block unless successfully treated with a pacemaker for which follow-up is satisfactory • A second or complicated myocardial infarction may be, and the employee should be referred to an OH Physician. • Conditions which limit exercise tolerance or which are likely to lead to Syncope are incompatible with work in SCE, as are symptomatic arrhythmias which distract the patient or cause temporary incapacity. • A stress ECG should be conducted using the Bruce protocol. The exercise capacity should be \geq a 90% of the age/sex predicted capacity. [Bruce et al 1973]. When a stress ECG is positive, or clinical assessment indicates, referral to a cardiologist should be made for further assessment and report. • Individuals who are experiencing symptoms of hypotension due to medication should not be allowed to work in safety critical roles or environments until their condition is stabilised. Peripheral vascular insufficiency might affect the ability to move or react quickly to a place of safety if the person's limit of exercise tolerance has been reached by physical exertion.

FITNESS STANDARD K:**URINALYSIS**

Frequency: 3 yearly as part of FFW assessment if SCW or more frequently where symptoms / history have been reported

CATEGORY	INTERPRETATION
1	Normal results; Urine test shows negative test result to blood, glucose and / or protein.
2	Positive Urine test results requires GP referral and occupational health case management If the test indicates a trace, or greater, of Glucose, but the employee is asymptomatic then a BM stick (blood) test should be undertaken or referred to GP for further investigation and subsequent case management via the employees GP as required.
3/4	Is diagnosed with / receiving treatment for a medical condition which is not under control and may influence safety of self or others.

FITNESS STANDARD L:	
VISUAL ACUITY	
<p>Frequency: 3 yearly as part of FFW assessment if SCW and/or sooner if</p> <ul style="list-style-type: none"> • prior to placement for those driving / undertaking safety critical tasks • the employee complains of eyestrain, focusing difficulties, headaches or similar conditions 	
CATEGORY	INTERPRETATION
1	<p>Safety Critical Workers standard : Corrected visual acuity At least 6/9 one eye and 6/12 in the other Uncorrected visual acuity -at least 3/60 in each eye Near vision =N8 Visual field No pathological defect. Corrected visual acuity</p> <p>Non-safety critical standard 6/18= is considered sufficient to undertake normal duties If dependent on contact lenses to meet these requirements, spectacles of an equivalent prescription shall be carried when in critical safety roles. (This is so that, if, for any reason, the contact lenses have to be removed, the person is still able to achieve the necessary visual performance to continue working safely. The order of testing should be – unaided – with spectacles – with contact lenses.) No pathological condition of the eyes likely to cause visual impairment should be present. The use of tinted or photo chromic prescription spectacles.</p>
2	<p>Has not met the criteria above. Monocular vision must be assessed on an individual basis Uncontrolled diplopia and binocular field defects would be a bar to FLT operation. Those who have not met the above standards should not be allowed to return to driving duties / safety critical duties until it has been satisfied that their vision has been corrected/ improved. An occupational health reassessment is required following referral to optician.</p>
3/4	<p>Has a pathological condition of the eyes likely to cause visual impairments, which cannot be corrected with the use of spectacles and /or contact lenses.</p>

FITNESS STANDARD M:**VISUAL ACUITY (DISPLAY SCREEN EQUIPMENT) USERS****Frequency:**

Visual acuity testing should be undertaken for DSE users:

- as soon as possible after employment commences
- at two yearly intervals or when requested by the employee i.e. reports eyestrain, focusing difficulties, headaches or similar conditions

CATEGORY	INTEPRETATION
1	Employee has satisfactory visual acuity for Intermediate distance with or without spectacles/ contact lenses. For those with spectacles and/ or contact lenses their current prescription applies.
2	Employee has a medical condition or visual impairment that indicates need to advise job / worker restrictions and / or recommendations to prevent exacerbation of condition or visual impairment and / or re occurrence of condition or visual impairment, i.e. large monitor, frequent changes of activity. May be covered by disability legislation, therefore consideration given to obligations under DDA
3/4	Employee has a medical condition or visual impairment which necessitated further specialist assessment, which may / may not have required further information and / or medical evidence which indicated that use of display screen equipment could exacerbate the medical condition or visual impairment. May be covered by disability legislation, therefore consideration given to obligations under DDA.

FITNESS STANDARD N:**COLOUR PERCEPTION****Frequency:**

3 yearly or sooner if required i.e. symptoms reported

CATEGORY	FITNESS STANDARD INTERPRETATION
1	Has passed Ishihara (24) plates / City test standard for colour perception, no colour deficiency noted. Employee identified as potentially safe, milder degrees of anomalous trichromatism.
2	Employee has very poor colour discrimination (dichromats and severe anomalous trichromats) and is unable to distinguish from Red / Green. Employees who fail Ishihara test or City University tests will require an operational risk assessment: this will test the extent to which their visual defect impacts upon their safe working.
3	SCW should be excluded from aspects of safety critical work where colour perception red/ green is a key requirement.

FITNESS STANDARD O: BIOLOGICAL MONITORING

Biological monitoring may be required if exposure to chemical hazards is identified during the risk assessment process, it is difficult to detail every situation where monitoring is necessary. The decision should be taken on an individual basis.

The following list, which is not definitive, gives a general idea of where biological monitoring is required and the type of sample, however further guidance can be obtained from CBH/OHSP

Biological sample	Examples of parent compounds
Urine	Heavy metals, e.g. organic lead, mercury, cadmium, chromium, cobalt Metaloids, e.g. arsenic Ketones,
Blood	Heavy Metals Aromatic compounds, e.g. toluene, benzene Chlorinated solvents, e.g. trichloroethylene
Breath	Aromatic compounds Chlorinated solvents
Hair and nail	Arsenic Mercury
Fat	Polychlorinated biphenyls

Frequency: On exposure to hazard

CATEGORY	FITNESS STANDARD INTERPRETATION
1	No abnormalities detected
2 / 3 / 4	Case by case assessment of each individual

**FITNESS STANDARD P:
WORK-RELATED STRESS / MENTAL HEALTH FITNESS**

Frequency:

As identified through risk assessment process or symptoms reported

CATEGORY	FITNESS STANDARD INTERPRETATION
1	No evidence of mental ill health which is likely to impact on ability to work in a safety critical environment
2	<p>Has shown evidence / reported of one or more of the following:</p> <ul style="list-style-type: none"> • deterioration in behaviour • changes in relationships with colleagues • irritability / sudden mood swings / hypermania • reduced performance • inability to make decisions or pay attention to detail / altered perception / short-term memory or concentration difficulties • currently undergoing psychiatric assessment • current symptoms of stress related illnesses. • hypomania • significant intellectual impairments <p>Maintenance therapy which is not causing side effects will usually be compatible with unrestricted SCW duties provided that the individual remains asymptomatic.</p> <p>Depression: this will be dependent on effects on concentration and mental alertness and any medication side-effects.</p> <p>Case by case assessment required</p>
3	Symptoms as detailed above, but more severe. Case by case assessment is required by a qualified person
4	<p>Confirmed long term and unstable mental disorders or medication causing one or more of the following are incompatible with some employment, and in particular Safety critical environments:</p> <ul style="list-style-type: none"> • deterioration in behaviour • changes in relationships with colleagues • irritability / sudden mood swings / hyper mania • reduced performance • unable to make decisions or pay attention to detail / altered perception / short-term memory or concentration • currently undergoing psychiatric assessment • current symptoms of stress related illnesses. • hypomania • significant intellectual impairments

FITNESS STANDARD Q:
SUBSTANCE USE / ALCOHOL AND DRUGS MISUSE
 (dependant on employers policy)

Frequency:

Pre placement, 3 yearly and for cause testing post accident in SCW. Screening for illicit drugs may be required for Pre-placement or Change of Risk Category Health Assessments depending on local legislative requirements and organisational practices. Screening may also be required by management at a Triggered Health Assessment

CATEGORY	INTERPRETATION
1	No evidence of substance or alcohol misuse / abuse using chain of custody procedures
2/3/4	<p>Evidence of substance misuse / impairment due to illegal/ prescription or OTC medication using chain of custody procedures. Control level: The current UK limit for drink-driving is 80mg/100ml blood alcohol concentration or 35mcg/100ml breath alcohol concentration. There is no legal or safe limit for drugs.</p> <p>Alcohol/drug dependence would be a bar from SCW until a period of freedom from dependence (e.g. 1 year) is verified by a GP report and further medical assessment.</p> <p>May be fit for duty subject to review. Requires reference to company drug and alcohol policy for further guidance and management. The severity of the addiction, response to treatment and the working requirements need to be taken into account. May be suitable for alternative duties.</p>

FITNESS STANDARD R:**GENERAL HEALTH ASSESSMENT / LIFESTYLE**

General Health Assessments can include blood pressure, urinalysis, cholesterol, height, weight, Body Mass Index (BMI), history taking and health promotion/education, and the following are guidelines which can be followed to determine the type of advice / health promotion

Frequency: 3 yearly for SCW 'Fitness for Work' assessment

CATEGORY	FITNESS STANDARD INTERPRETATION
Blood Pressure	See Fitness Standard J
Urinalysis	See Fitness Standard K
Cholesterol	<p>The National Institute for Health and Clinical Excellence (NICE) and Department of Health cholesterol guidelines</p> <ul style="list-style-type: none"> • total cholesterol: less than 5.0mmol/l • LDL cholesterol: less than 3.0mmol/l <p>However, the Joint British Societies (a group of the main UK expert societies involved in cardiovascular disease) recommend different cholesterol limits for people who have, or are at risk of, coronary heart disease:</p> <ul style="list-style-type: none"> • total cholesterol: less than 4.0mmol/l • LDL cholesterol: less than 2.0mmol/l • HDL cholesterol: more than 1.15mmol/l • Triglycerides: less than 1.5 mmol/l <p>These guidelines match the more stringent recommendations used in Europe. NICE is currently reviewing its national policy guidelines.</p>
Height/Weight BMI	A person's weight is commonly assessed by using BMI, which is the person's weight in kilograms divided by the square of their height in metres (kg/m ²). A BMI of over 25 is defined as overweight, and a BMI of over 30 as obese.
History taking	The past medical and family history of a person can indicate the likelihood of recurrence or the likely risk of the person developing a medical condition, this should be evidence based.
Health Promotion/ Education	In line with Government strategies, health promotion / education activities can empower an individual to improve their lifestyle and promote well being. Any advice should be evidence based.

APPENDIX 6 'AT A GLANCE' FITNESS FOR WORK GUIDANCE FOR SPECIFIC MEDICAL CONDITIONS

CONDITION	RATIONALE / RISK BASIS	COMMENTS	SAFETY CRITICAL /	NON-SAFETY CRITICAL
INFECTIONS				
Gastro intestinal	Risk of infection to others, acute disability (e.g. absence from post for toilet breaks)		3 whilst symptomatic	1 non-catering 3 catering (may need bacteriological clearance of faecal specimens)
Other infection	Risk of infection to others, acute incapacity		3 until resolved	1
HIV	Progression to AIDS, may affect the ability to perform Safety Critical Work due to impairment of mental function or other affects on the body	Advice on safe sex and risk to others	1 HIV if no side effects from treatment	1
CANCERS / TUMOURS				
Malignant neoplasms	Acute complications e.g. risk to self from bleeding or to others from fits	Advice on sun exposure, smoking, control of asbestos exposure. Screening for breast, cervical or bowel cancer	3 pending assessment of progress, prognosis and measure of disability and specialist report	3 pending assessment of progress, prognosis and measure of disability and specialist report
ENDOCRINE AND METABOLIC				
Endocrine (thyroid, adrenal, pituitary, ovaries, testes)	Risk of disability or complications		3 until treatment in hand. Case by case with specialist advice if uncertainty	1 Case by case with specialist advice if uncertainty about prognosis or

			about prognosis or side effects of treatment	side effects of treatment
CONDITION	RATIONALE / RISK BASIS	COMMENTS	SAFETY CRITICAL	NON-SAFETY CRITICAL
Diabetes – non-insulin treated(diet or oral medication)	Progression to insulin use, of visual, neurological and cardiac problems	Screening at medical.	1 when stabilized in the absence of complications, the employee has an awareness of (sensation of) hypoglycaemia/ diary of blood sugars is recorded/ absence of end organ effects that may affect work as per standards. Annual surveillance	1 when stabilized in the absence of complications.
Diabetes – insulin using	Safety-critical risk from hypoglycaemia. Risk to self or others from loss of control	May be classed Fit if there is sufficient evidence that the condition is well controlled the employee has an awareness of (sensation of) hypoglycaemia/ diary of blood sugars is recorded/ absence of end organ effects that may affect work as per standards.	4 If criteria not met	3 from start of treatment until stabilized, depending on individual assessment
Obesity	Accident to self, reduced mobility and exercise tolerance in routine and emergency duties	Dietary and lifestyle advice	2/3 consider as IHD risk factor	

CONDITION	RATIONALE, RISK BASIS	COMMENTS	SAFETY CRITICAL	NON-SAFETY CRITICAL
BLOOD DISORDERS				
Blood forming organs	Varied – recurrence of abnormal bleeding. Acute disability		2 coagulation disorders	1 Case by case judgment
Anaemia	Reduced exercise tolerance, acute disability		3 until investigated and treated	1 Case by case judgment
Splenectomy	of certain infections	Antibiotic prophylaxis	1 Case by case judgment	1 Case by case judgment
MENTAL DISORDERS				
Psychosis (acute) schizophrenia, bipolar disorder	Recurrence, accidents, erratic behaviour, safety performance		4 for minimum of 3 years. Specialist report on prognosis and risk of side effects of treatment	3 until investigated and stabilised
Alcohol abuse (dependency)	Recurrence, accidents, erratic behaviour, safety performance	Advice on safe drinking. Policies on alcohol use	3 until investigated and stabilized with normal blood parameters for 3 years 4 if persistent and affecting health	3 until investigated and stabilized 4 if persistent and affecting health
Drug dependence / persistent substance abuse	Recurrence, accidents, erratic behaviour, safety performance	Advice. Policies on drug use	4 if history in last 3 years	3 until investigated and stabilized 4 if persistent and affecting health
Neurosis	Decrement in performance	Personal and organizational advice on stress management	3 while under investigation or acute. Consider effects of medication	1 case by case assessment

CONDITION	RATIONALE / RISK BASIS	COMMENTS	SAFETY CRITICAL	NON-SAFETY CRITICAL
DISEASES OF THE NERVOUS SYSTEM				
Organic nervous disease e.g. Parkinson's disease, multiple sclerosis	Limitations on muscular power, balance, co-ordination and mobility		3 whilst under investigation and until stable. Case by case assessment informed by specialist advice and based on job requirements	2/3 Case by case assessment informed by specialist advice and based on job requirements
Epilepsy	Risk to self and others from seizures		1 if free from fits for 10 years, no anti-epileptic treatment for 10 years, and no continuing liability to seizures. Normal EEG. Withdrawal from anti epileptic Rx not considered compatible with SCW unless cleared by Neuro consultant.	2 no working at heights until 1 year after fit or 1 year after end of treatment. Hand held power tools may be a hazard if they can be fixed in the 'on' position.
Cranial surgery (including treatment of vascular anomalies or significant traumatic brain damage)	Of epilepsy. Defects in cognitive, motor or sensory function		3 for one year	1 case by case assessment
Migraine (frequent attacks causing incapacity)	Risk of disabling recurrences		3 until investigated and stabilized Consider 4 if persistent	1 case by case assessment

CONDITION	RATIONALE / RISK BASIS	COMMENTS	SAFETY CRITICAL	NON-SAFETY CRITICAL
Syncope and other disturbances of consciousness	Recurrence causing injury to self or others through loss of control		3 until investigated and specific neurological or cardiovascular causes excluded (for minimum 3 months). 4 if persistent	3 until investigated and stabilised 2 (no working at heights) if persistent
Menière's disease	Inability to balance causing immobility and nausea		3 during acute phase 1 if completely symptom-free for 1 year 4 if frequent and incapacitating	2 (no working at heights) if frequent and incapacitating
Narcolepsy / Cataplexy / Sleep apnoea	Recurrence causing injury to self or others through loss of control		4	2 no working at heights until symptoms controlled
Encephalitis / Meningitis	Acutely disabled		3 until fully recovered	3 until fully recovered
Intracranial haematoma	Of epilepsy. Defects in cognitive, motor or sensory function		3 with specialist assessment when epilepsy risk less than 2%	2 no working at heights for 1 year
CARDIOVASCULAR SYSTEM				
Heart – congenital and valve disease	Limit on exercise, risk of bacterial endocarditis.	Advice on prophylaxis	4 if symptomatic 3 for 1 year after cerebral embolism	1
Hypertension	Risk factor for IHD, stroke, eye or kidney damage	Screening at medical. Early treatment	3 until stabilized then 1 with annual medical	2 (no working at heights) until stabilized, then 1

CONDITION	RATIONALE, RISK BASIS	COMMENTS	SAFETY CRITICAL	NON-SAFETY CRITICAL
Cardiac event (myocardial infarction, ECG evidence of old MI, newly diagnosed Left bundle branch block, angina, cardiac arrest, CABG, angioplasty)	Risk of recurrence leading to sudden loss of capability, reduced exercise tolerance	Risk factor screening, lifestyle advice, smoking cessation advice	3 until investigated and stabilized and successful completion of Bruce protocol without ischaemic changes. Annual review.	1/2 no working at heights for 6 weeks
Cardiac arrhythmias (and conduction defects, including those with pacemakers)	Risk of recurrence and sudden loss of capability, exercise limitation. Pacemaker activity affected by strong electromagnetic fields		4	2 (no working at heights) until stabilized, then 1
Other heart disease e.g. cardiomyopathies, pericarditis, heart failure	Risk of sudden loss of capability, exercise limitation		4 if symptomatic and no ischaemia during completed Bruce protocol	2 (no working at heights) until stabilized, then 1
Ischaemic cerebrovascular disease	Risk of sudden loss of capability, mobility limitation. Risk of other circulatory disease causing loss of capability	Risk factor screening, lifestyle advice, smoking cessation advice	3 for 1 year after TIA or stroke, provided fully recovered and no significant risk factors 4 if not fully recovered / remaining risk factors	2 (no working at heights) for at least 1 month, until stabilized, then 1
Intermittent claudication	Mobility limitation. Risk of other circulatory disease causing loss of capability	Risk factor screening, lifestyle advice, smoking cessation advice	1 provided no ischaemia on successfully completed Bruce protocol	1
Deep vein thrombosis or pulmonary embolus	Risk of sudden loss of capability from embolus, temporary limitation of mobility		3 until treated and stable 4 if recurrent	3 until treated and stable

CONDITION	RATIONALE, RISK BASIS	COMMENTS	SAFETY CRITICAL /	NON-SAFETY CRITICAL
RESPIRATORY SYSTEM				
Chronic bronchitis and emphysema COPD	Reduced exercise tolerance and disabling symptoms	Advice on smoking cessation	Case by case assessment	1
Asthma	Unpredictable episodes of severe breathlessness. May be occupational disease	Early detection of occupational and other remediable causes	3 until stable 2 restrictions if occupational cause	2 restrictions if occupational cause
Pneumothorax spontaneous / traumatic	Acute disability from recurrence		4 if recurrent unless pleurectomy performed for spontaneous 3 until resolved for traumatic	3 until resolved
DIGESTIVE SYSTEM				
Stoma			Case by case assessment	Case by case assessment
Cirrhosis of liver	Liver failure, bleeding	Advice on safe drinking. Policies on alcohol use	4 if severe or complicated by ascites or oesophageal varices	Case by case assessment
Pancreatitis	Recurrence		4 if recurrent or alcohol related	Case by case assessment

CONDITION	RATIONALE, RISK BASIS	COMMENTS	SAFETY CRITICAL	NON-SAFETY CRITICAL
GENITO-URINARY CONDITIONS				
Proteinuria, glycosuria	Indicator of renal or other diseases		3 until investigated and causes resolved	Case by case assessment
SKIN				
Infections	Exacerbation, risk to others	Advice on hygiene	Case by case assessment	Case by case assessment
Eczema, dermatitis	Consider occupational causes	Advice to individual and employer on occupational allergens and irritants. Advice on skin care	1 if not occupational 2 if occupational	1 if not occupational 2 if occupational
MUSCULO-SKELETAL				
Osteo-arthritis, other joint diseases and subsequent joint replacement	Pain and limitation of mobility reduce capability. Risk of dislocation of replaced joints		Case by case assessment, based on history and job requirements	Case by case assessment, based on history and job requirements
Recurrent instability of shoulder or knee joints	Sudden disabling loss of mobility with pain		3 until satisfactorily treated	Case by case assessment
Limb prosthesis	Mobility limitation		Case by case assessment, based on history and job requirements	Case by case assessment, based on history and job requirements

CONDITION	RATIONALE, RISK BASIS	COMMENTS	SAFETY CRITICAL	NON-SAFETY CRITICAL
Back pain	Mobility limitation, risk of exacerbation	Manual handling advice. Early intervention and rehabilitation to reduce risk of chronicity	3 if incapacitating	3 if incapacitating
SENSORY				
Speech defect	Limits to communications – may be safety critical		Case by case assessment based on defect and job requirements	Case by case assessment based on defect and job requirements
Recurrent ear infections	Risk to others		1 provided hearing is adequate	2 (no food handling)
Deafness	Limits to routine and emergency communication, may be safety critical. May be occupational noise induced hearing loss	Advice to individual and employer about noise reduction	1 if to HSE category 1 or 2 If to HSE category 3 or above then case by case assessment based on defect and job requirements	Case by case assessment based on defect and job requirements
Eyesight	Safety critical loss of visual information	Provision of appropriate correction safety glasses	4 if standards not met 3 for 3 months after laser refractive surgery 1 with surveillance for specific conditions (e.g. glaucoma) where standards are met	4 if standards not met

CONDITION	RATIONALE, RISK BASIS	COMMENTS	SAFETY CRITICAL	NON-SAFETY CRITICAL
GENERAL				
Pregnancy	Should not be a bar to SCW but case by case assessment in cases of fainting / hyperemesis gravidarum, hypertension, post caesarean section	Should be based on 'New and Expectant Mothers' risk assessment	Caution regarding SCW dependant on severity of symptoms. Assessment required. 3	4 if standards not met / evidence of increased risk to mother and unborn child. Refer to Diabetes/ post natal depression
Prescribed medication	Varied – performance decrement, other side effects,	Policy for reporting medicine use, advice on restrictions	3 for duration of medication if package notes indicate risk when driving / operating machinery or other relevant side effects	Case by case assessment based on side effects and job requirements
Transplants	Risk of rejection, side effects of medication		Case by case assessment	Case by case assessment
Conditions not specifically listed			Use analogy with related conditions as a guide. Consider excess risk of sudden incapacity, or limitations on performing normal or emergency duties	
Progressive conditions that are currently within standards	Varied – e.g. Huntington's chorea including family history, keratoconus		Case by case assessment with specialist advice. Such conditions do not bar if harmful progression before next medical is judged to be unlikely	

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