**Occupational health: the thin line protecting the front line**

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The decline in numbers of UK occupational health (OH) professionals has been well-documented as has the consequent reduction in research capacity [1,2]. In consequence, NHS OH services have been pared to the bone, are lean, cost-effective and are accustomed to finding innovative ways to use the multi-disciplinary team as effectively and efficiently as possible. Indeed, in situations where they have not been able to do so, they have often been replaced by cheaper, privately-contracted services.

The Covid-19 pandemic has put NHS staff in the spotlight as never before. The “front line” have received well-deserved praise and support from, among others, our government, politicians, professional athletes, celebrities and the Queen. However, the very thin line of NHS OH services has needed to stretch to pick up completely new workloads: screening the health of staff for their risk of working in their existing roles; screening and on-boarding large numbers of volunteers and returners; and administering and reporting antigen test results to make return to work decisions.

Our tertiary NHS Foundation Trust which provides care to 1.9 million locally and 3.7 million people regionally has 11,000 staff, all of whom were invited to submit “health notification” forms at the onset of the pandemic. On recruitment, everyone completes staff health screening so that the burden of unknown conditions was not expected to be massive but >1800 forms were returned by >16% of staff with undeclared diagnoses ranging from recurrent malignancy to cardiomyopathy and a large burden of diabetes, asthma and hypertension. With such overwhelming need for risk assessment, our safest approach was to triage everyone who had submitted a form as “at increased risk of complications”, pending an individualised risk assessment. Subsequently, a process needed developing to evaluate individual risk according to the declared condition(s), medication(s) and/or complication(s), based on developing guidance from: the Faculty of Occupational Medicine [3]; royal colleges, professional societies and faculties; rapid reviews of available evidence and from the Association of Local Authority Medical Advisors (ALAMA) [4].

To start, the team of 5 (none working on this full-time) telephoned those 60 staff in the highest risk clinical areas e.g. emergency department and intensive care. Risk was graded as RED (equivalent to sheltering), AMBER (should not be working with COVID-19 positive patients, aerosol generating procedures or patients in whom COVID-19 status unknown and GREEN (risk not significantly greater than that of staff member without the health condition).Two things emerged quickly: clinical decision-making was generally quick and was mostly possible from the staff declarations, rarely overturned after a conversation (unless insufficient information was provided) and that the most time-consuming part was getting a telephone response and moving in and out of folders on the clunky, but secure, on-line server. Subsequently, calls were only made in cases of doubt or if we thought that the risk rating could be adjusted to “low” or needed to be “very high”. Templates were developed for each clinical area describing the controls needed for each risk rating, facilitating efficiency. With the refined process, 5 staff completed individualised risk assessments amongst >400 staff working in the most high-risk areas in 4 days. Telephone consultations with staff required skill, patience and an assessment of psychosocial factors and we encountered colleagues with similar conditions who were willing to remain in their acute role, despite a perceived higher risk of complications if they were to become infected, whist others were not. However, conversations were positive, rewarding and well-received. Staff feedback was tremendously appreciative of what was perceived as personal support from OH.

We conservatively estimate that the workload in OH increased 20-fold since the pandemic. Our experiences show just how important it is that we retain the UK OH workforce, because of our ability to deal with assessment of unknown risk whilst exercising empathy and compassion.

**References**

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