23rd July 2020

Clinically vulnerable groups, workplace and COVID-19 Risk
Clinical Principles, informed by DCMO Roundtables

Key Conclusions

a) Employers have a responsibility to protect all workers from harm by carrying out workplace risk management (of which risk assessment is a part) and providing a COVID-secure workplace.

b) Current Government, HSE and clinical guidance is that when shielding is 'paused' on 1st August, clinically extremely vulnerable employees can return to workplaces if they are COVID secure, but should be supported where possible to work from home.

c) All workplaces should be COVID secure and as a result optimal protections should apply equally to all workers. Whilst some employers have implemented a policy of individual risk assessments for staff, there are concerns that this may exacerbate inequalities if it results in mandatory changes to an individual's role. The emphasis should instead be on individual 'COVID conversations' which are culturally competent, bi-directional and which promote reduction of risk in all environments (not just the workplace). This recognises the complex interplay of social, behavioural and environmental factors which impact on what may appear to be 'high risk' settings at first glance. This also helps reinforce the importance of workers and groups of workers being diligent in the application of risk controls and reinforce behaviours that are needed in the community.

d) High risk environments (e.g. clinical settings) as identified by a workplace risk assessment should lead to management of the risk ,using the principles of hierarchy of control, for all workers. It is not desirable to try to identify high risk settings either by category or principles for the purposes of additional protections for workers. This could lead to a false sense of security as workers and employers may consider they can have lesser standards of COVID risk management in "low risk" settings. High risk settings may be useful as a concept to aid 'COVID conversations' (eg working in clinical environments)

e) The forthcoming CMO/NERVTAG QCOVID risk stratification tool will be a welcome adjunct to clinical conversations about risk with patients/individuals and which may facilitate consultations in both occupational health and GP settings. Occupational health should be utilised in the same way as it already is for other workplace hazards, recognising that the scale and scope of COVID-19 makes this a high profile issue. These would enable the individual to be well equipped for a meaningful "COVID conversation" with their employer.

f) It is important to be clear about terminology: workplace risk assessment, risk management, clinical risk assessment and culturally competent conversations mean different things and should be used consistently. There is currently a focus on 'individual risk assessment' (eg in the NHS) and the purpose and scope of this should be re-evaluated (is it more proportionate and appropriate to ask for COVID conversations in clinical workplaces)

g) Responsibility for translating these principles into guidance and communicating them to employers, employees and occupational health / primary care sits across government departments and their specific industry interests. HSE does provide advice and guidance on achieving compliance and appropriate workplace standards as it fulfils its primary role as a workplace regulator / enforcement body.

Context

1. England will be pausing advice to shield for the Clinically Extremely Vulnerable (CEV) cohort from 1st August. This will effectively mean that the CEV cohort will follow the same advice we currently give to the Clinically Vulnerable (CV) cohort - they can now return to school, work and daily life, although they should still take particular care to minimise their risk of exposure (maintain social distancing, hand hygiene, etc.). Where this population can continue to work at home, they should be enabled to do this by their employer.