

Occupational health assessment of new police officer applicants

A clinical framework



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Introduction

This guidance is to assist police occupational health services perform clinical assessments of new police officer applicants prior to the confirmation of appointment. It is intended for this use only. It builds upon and updates the medical standards published by the Home Office, in 2004.¹ In this guidance the term police officer is used mainly. However, it should be noted that, in law, police powers are given to constables. Where necessary the term constable is used with reference to specific guidance.

The advent of the Police Covenant has provided a framework and a mechanism for quality assuring clinical activity performed within policing, in England and Wales.^{2,3} There is a clear need for guidance that is centred upon the expected role of a police officer; in particular the activities performed in the first years of their service. The Police Uplift Programme has delivered a total of 20,000 police officers across the 43 Home Office-affiliated police forces.⁴ Additional recruitment will be required. This has brought into stark relief the need for an updated efficient and effective national approach to medical assessments of applicants. Whilst recruitment decisions remain with individual forces, it is essential that the approach to assessment is consistent across all forces. This will ensure the health, safety and future wellbeing of police officers and will avoid

unlawful discrimination. The assessment will ensure that health-related employment risks are assessed, and that reasonable and suitable support is provided to new starters, where necessary, thus contributing to the recruitment and retention of the next generation of a more diverse police workforce, in line with the policing vision 2030.⁵ Vision 2030 has been developed by the sector-led Strategic Policing Partnership Board as part of the drive for transformative change across the whole of policing. Pillar 4 is concerned with the development and inspiration of the police workforce and evolution of culture. The intended outcome is a talented, representative, and inclusive workforce that feels supported and has the capabilities to meet future policing challenges. Objective 5 is to safeguard the workforce with a strong focus on their physical and mental health and wellbeing.

This guidance adopts an evolutionary approach. Versions of national medical standards date from 1988. Home Office circular 9/1995 introduced a revised version and a model procedure for forces to adopt to establish the medical fitness of applicants. This iteration contained a list of medical conditions that would lead to rejection of applicants, as well as those requiring careful consideration. There was further updating in Home Office circular 7/98 and, subsequently, in Home Office circular 59/2004.

1 'National recruitment standards – medical standards for police recruitment' (Home Office, 16 September 2004) <National recruitment standards - medical standards for police recruitment - GOV.UK (www.gov.uk)>

2 'Police Covenant published to support policing community' (College of Policing, July 2022) <Police Covenant published to support policing community | College of Policing>

3 'Clinical Governance Group' (Oscar Kilo, 2023) <Clinical governance group | Oscar Kilo>

4 'Police Uplift Programme' (NPCC, 2023) <Police Uplift Programme (npcc.police.uk)>

5 Policing vision 2030 (Strategic Policing Partnership Board, APCC, CoP, NPCC, 31 March 2023) [policing-vision-2030.pdf](#) (npcc.police.uk)



It is of note that the 2004 circular highlighted revision of medical standards in order to take account of the implementation of the employment provisions of the Disability Discrimination Act that would include police officers from 1st October 2004.⁶ The main change was the acknowledgement that it would be unlawful to automatically exclude an applicant on the basis of a medical condition or disability. The guidance stated that each case should be looked at individually and assessed on its merits. The standards also reflected fitness to serve at the time of recruitment, and for a reasonable time.

It is important to note that as the guidance has evolved, and will continue to evolve, that the principle of not recruiting applicants who are medically unsuitable for the duties of a constable is a golden thread linking all of them. There is a fundamental duty of care to safeguard the health and safety of police officers. A core element of the assessment of the fitness of new recruits is the successful participation in personal safety training.⁷ A new safety training programme has been developed by the College of Policing – Public and Personal Safety Training (PPST).⁸ The curriculum covers the core activities of front-line policing. The functional capabilities associated with these activities are used as a basis for assessing the potential impact of health conditions on the physical fitness to be a police officer. There are, of course, other considerations, such as the ability to sustain high levels of physical activity during confrontation and the risk of incapacitation whilst on duty. The latter links to

the fitness to drive a vehicle, including vehicles equipped with blue lights or advanced vehicles. However, it should be noted that driving a vehicle is not part of the ordinary duties of a constable. (See functional requirements of a police officer) Assessment of mental health and its relevance to being a police officer is less clear cut. There is a scarcity of good research evidence on which to attribute the development of ill health to police activities. Occupational hazards, such as working long hours, shiftwork, and night work, must be considered, as must exposure to a range of distressing and traumatic occurrences. A schema to assist this difficult area of assessment has been produced. (See Annex B)

Police forces are also likely to value advice about the impact of a health condition or disability on future performance and attendance. Early versions of the guidance stipulated that assessments should ensure, as far as reasonably possible, applicants did not have medical conditions that were likely to initiate early ill health retirement. This then changed to predicting the likelihood to remain fit for the full duties of a police constable for the foreseeable future. The current guidance introduces a finite definition of a “reasonable time” as being for a period of 5 years. This is based on consensus that this is both reasonable and would be an acceptable return on the investment made in training police officers.

6 Disability Discrimination Act 1995. <Disability Discrimination Act 1995 (legislation.gov.uk)>

7 'Personal safety training programme' (College of Policing, 2023) <Personal safety training programme | College of Policing>

8 'New safety training for officers' (College of Policing, 11 April 2023) <New safety training for officers | College of Policing>



The 2004 guidance introduced the need to consider reasonable adjustments to working when assessing fitness to be a police officer. The Home Office circular sets out the requirement to assess applicants in terms of ability based on the role, functions, and activities of an operational constable as set out in the then relevant competency framework – The Police Integrated Competency Framework (PICF) – and fitness for work based on the framework of the national medical standards for recruitment. This guidance considers the current competency framework – Competency and values framework (CVF) – which describes the behaviours expected of police officers to be effective in their roles.⁹ The CVF recognises that all people have different strengths and preferences in terms of skills, abilities, and personal attributes. It reinforces the requirement to make reasonable adjustments for people who have disabilities that have an impact on their ability to demonstrate competencies. The current guidance will expand on the section on reasonable adjustments contained in the 2004 standards and will introduce consideration of neurodiversity.

This guidance will provide a framework to be used to plan and shape individual clinical assessments of fitness. However, it is important to recognise that individual medical assessments of fitness are reliant on the knowledge, skills, and competencies of individual clinical practitioners. A stepped approach to clinical assessment is advocated which aligns with the targeted operating model for police occupational health services.¹⁰ The expectation is that all assessments are performed by suitably trained and experienced clinicians, in accordance with the Foundation and Enhanced Occupational Health Standards, published by the National Police Wellbeing Service.¹¹ Advice on medical fitness will be communicated to the host force which is ultimately responsible for making the decision to recruit and for the robustness of the recruitment process. This guidance introduces the role of an Appointments Panel for decision making in complex cases.

9 'Competency and values framework (CVF)' (College of Policing, 2024) <Competency and values framework (CVF) | College of Policing>

10 'Target operating models for occupational health units' (NPWS, 2024) <Target operating models for occupational health units | Oscar Kilo>

11 'Foundation Occupational Health Standards' (Oscar Kilo, 2023) <Foundation occupational health standards | Oscar Kilo>



1. Elements of assessment

1.1 Background

The Home Office medical standards, published in a circular 59/2004, have provided points of reference for police occupational health clinicians for the last 20 years, although they were superseded, to some extent, by what was meant to be interim guidance from the College of Policing, during the COVID-19 pandemic to support the Police Uplift programme.¹² They are an elaboration of consensus-based medical standards devised by occupational physicians in the northwest of England. They aimed to address a lack of national guidance for occupational health services and the consequent disparity in outcomes of assessment due to each police force applying its own medical standards. The standards set out a rationale for decision making and the clinical processes to be followed. The limitations of the standards, due to a lack of an evidence base, were acknowledged.

The aim of assessment was, and remains, to ensure that persons selected as police officer recruits could /can meet the operational demands of policing. (Reference is made to the “ordinary duties of a constable” in the section on functional requirements.)

The UK Health and Safety at Work Act 1974 places a general duty on police forces to ensure, as far as reasonably practicable, the health, safety and welfare at work of members of the police workforce.¹³ (The Police (Health and Safety) Act 1997 establishes that the Chief Officer of a force is to be treated as an employer of police officers for the purposes of the Health and Safety at Work Act.¹⁴) The Management of Health and Safety at Work Regulations require police forces to identify the risks that police officers and staff, contractors, volunteers and the public may face and to take steps to control or mitigate those risks through a formal risk assessment process.¹⁵ The clinical assessment of fitness to be a police officer should align to these formal risk assessments. Police Regulations require that candidates for appointment to a police force “must be certified by a registered medical practitioner approved by the local policing body to be in good health, of sound constitution, and fitted both physically and mentally to perform the duties on which he will be employed after appointment”.¹⁶ There is a legal requirement to meet the standard of eyesight determined by the Secretary of State.

12 Doctors (FMAs), nurses (FNAs and Mental Health nurses) and occupational health technicians

13 Health and Safety at Work etc. Act 1974 < Health and Safety at Work etc. Act 1974 (legislation.gov.uk)>

14 ‘Application of health and safety law to the Police Service’ (HSE, 2024) < Application of health and safety law to the Police Service - Police Service - HSE>

15 The Management of Health and Safety at Work Regulations 1999. < The Management of Health and Safety at Work Regulations 1999 (legislation.gov.uk)>

16 The Police Regulations 2003. < The Police Regulations 2003 (legislation.gov.uk)>



The 2004 guidance made clear that the objective of medical screening was not to identify all applicants with a medical condition, but those with a medical condition that will prevent or restrict them in fulfilling the functions of a police constable.¹⁷ The starting template for the 2004 standards was the Armed Forces PULHHEEMS medical assessment.¹⁸ This benchmark has been discarded for the 2024 guidance. Individual assessments of medical fitness should relate to the requirements of police roles and the risk assessments described above. (See section 2.1)

Candidates for recruitment are covered by the employment provisions in part 5 of the Equality Act 2010 (EA).¹⁹ Direct discrimination against a person with a protected characteristic is always unlawful. However, the most relevant form of discrimination against applicants is discrimination arising from disability (s15) and indirect discrimination (s19). In the case of police officer applicants, a significant amount of indirect discrimination will occur because of the demands of the police officer role and the need for applicants to have the health to perform the role. Occupational health (OH) assessments of candidates and discrimination against certain applicants is lawful if it represents a proportionate means to achieve a legitimate aim. It is necessary for forces to identify what are reasonable adjustments in the workplace. (See section 1.3.1.) There is case law about which reasonable adjustments a Chief Constable must consider for applicants.

In the Employment Appeal Tribunal (EAT) case of Hart vs Chief Constable of Derbyshire Constabulary the judgement was that the Chief Constable has a duty to consider only those reasonable adjustments necessary to enable the applicant to be an operational police officer.²⁰ There is no duty to appoint someone who is not able to perform the duties of an operational police officer if no reasonable adjustments are available. Such discrimination is lawful.

The Equality Act 2010 requires that questions concerning the health of job applicants should not be asked until a job offer is made.²¹ The health assessment should be fit for purpose and information requested should be relevant to the job. A more extensive health assessment (questionnaire or medical examination) should, in general, only be needed where there are specific health requirements – such as safety-critical work. The role of a front-line police officer is safety critical. The recruitment and subsequent training of police officers prepares them for a response role. Where there is direct entry into detective roles, the expectation is that officers are competent to perform front-line roles and are fit to do so. They will spend part of their training in response roles.

The 2004 standards give advice on the phrasing of recommendations based on an occupational health assessment detecting a health condition.

17 A.2.25.1. Home Office Medical Standards of Entry Guidelines.

18 Medical assessment for PULHHEEMS. Medical assessment for PULHHEEMS (publishing.service.gov.uk)

19 Equality Act 2010. <[Equality Act 2010 \(legislation.gov.uk\)](https://legislation.gov.uk)>

20 'Hart v Chief Constable of Derbyshire Constabulary EAT' (brightmine, 2024) <[Hart v Chief Constable of Derbyshire Constabulary EAT/0403/07 | Employment law cases | Tools | HR & Compliance Centre.co.uk \(brightmine.com\)](https://brightmine.com/cases/hart-v-chief-constable-of-derbyshire-constabulary-eat/)>

21 'Occupational Health' (CIPD, 21 June 2021) <[occupational-health-factsheet_20220817T072501.pdf](https://www.cipd.co.uk/media/1000/occupational-health-factsheet_20220817T072501.pdf)>



These are:

- Likely to be suitable – the health condition should not prevent the applicant from carrying out the duties of a constable
- Unlikely to be suitable – the health condition may prevent the applicant from carrying out the duties of a constable
- Likely to require further information – the health condition is likely to require further information and reports before a decision can be made

The current guidance will continue this approach. Interpretation of the Faculty of Occupational Medicine ethical guidance suggests the following phraseology:

- Fit for the role of front line police officer
- Fit for the role of front line police officer subject to defined adjustments
- Decision pending receipt of further information
- Likely to be unfit for the role of front line police officer

The final recruitment decision is not the responsibility of occupational health practitioners. It should be made within a multidisciplinary process balancing operational needs with the duty of care to individual applicants. (See annex C) The Faculty of Occupational Medicine ethical guidance notes that it is the responsibility of prospective employers to determine whether it is reasonable to apply workplace adjustments.

In straightforward cases, there should be no need to refer to an Appointments Panel. There should be a process of fast-tracking decisions about appointment. (See figure 2)



1.2 The functional requirements of a police officer

The 2004 standards were compiled with reference to the framework of police officer job profiles and core operational tasks within the Police National Competency Framework (PNCF). The modern equivalents are the CVF, and the professional profiles published by the College of Policing.²² Values- based recruitment and selection links to the CVF.

²³ Role-specific accountabilities, objectives, knowledge, and skills sit outside the CVF but complement the framework in organisational processes such as recruitment, development, and performance management. Policing professional profiles (PPP) have been developed that define the expectations and accountabilities for all police officers and police staff.²⁴ The PPP have been designed to help individual post holders to understand what they are accountable for, and to know the essential skills, experience, and qualifications for any role.

Professional profiles describe generic roles across policing. These profiles have been sub-classified into national levels of policing, Job families and job family sub-groups.

Level 1 – service deliverer – is relevant for the assessment of applicants for the role of police constable. It includes the following:

- police constable
- special constable
- police community support officer (PCSO)

- specialist practitioner, such as an authorised firearms officer (These roles require separate occupational health assessments)

The following job families are contained within this level of policing:

- core: rank profiles
- community policing – crime reduction, local policing, response policing, roads policing
- investigation
- business support

Within the core: rank profiles information may be found for a police constable. This sets out the purpose of the role, the key accountabilities, expected behaviours (linked to the CVF) and the required level of education, qualifications, skills, and experience.

A review of the key accountabilities reveals that cognitive and behavioural functions predominate. The ability to gather information and to risk assess, plan, and implement appropriate actions are central to the role. Effective communication within teams and with the public are essential capabilities. The ability to provide appropriate initial and on-going frontline responses to a wide range of incidents that may include complex confrontational situations is a clear accountability. The list of skills needed to underpin the described accountabilities are largely cognitive and neuro- muscular in nature, albeit there is a requirement to successfully apply personal safety tactics, including the use of equipment and restraints.

22 'Police Constable – role and purpose' (College of Policing, 2023) <Police Constable - College of Policing>

23 'Values-based recruitment and selection' (College of Policing, 2018) <6.4232_COP_Value_Based_Recruitment_Guidance (college.police.uk)>

24 'Professional Profiles' (College of Policing, 2023) <Professional Profiles - College of Policing>



Notwithstanding the above, it should be noted that the “ordinary duties of a constable” have been defined in case law relevant to the medical retirement of police officers. The judgements were made at a time before the current Police Pensions Regulations (2015) and when the PNCF was in operation. Section 76(2) of the Police Pensions Regulations 2015 states that the selected medical practitioner (SMP) must decide that the member is permanently medically unfit for performing the ordinary duties of a member of the police force if s/he meets the specified criteria.²⁵ The “ordinary duties of a constable” comprise the following:

- Patrol/supervising public order
- Arrest and restraint
- Managing processes and resources and using IT
- Dealing with procedures, such as prosecution procedures, managing case papers and giving evidence in court
- Dealing with crime, such as scene of crime work, interviewing, searching, and investigating offences
- Incident management, such as traffic and traffic accident management

Linked to the above list, the following capabilities have been itemised against any of which permanent inability to perform satisfactorily, because of infirmity of mind or body, is likely to lead an SMP to conclude that an officer is permanently medically unfit.

- the ability to run, walk reasonable distances, and stand for reasonable periods
- the ability to exercise reasonable physical force in restraint and retention in custody

- the ability to sit for reasonable periods, to write, read, use the telephone and to use (or learn to use) IT
- the ability to understand, retain and explain facts and procedures
- the ability to evaluate information and to record details
- the ability to make decisions and report situations to others

Scenario-based personal safety training (PPST) has been introduced which all police officers must pass to be able to carry out front line policing. It aims to provide authentic, safe replication of the operational environment starting with a radio call through to resolution of the incident being played out. There are five scenarios that require skill sets needed in commonly encountered incidents for front line officers in the United Kingdom. The scenarios are:

- “Fight in the street”
- “Domestic”
- “Stop and search”
- “Vulnerable person”
- “Custody”

In playing out these scenarios, officers are confronted by and must address subject behaviours that are increasingly threatening to and physically demanding of the officer. They are:

- Compliance
- Verbal resistance and gestures
- Passive resistance
- Active resistance
- Aggressive resistance
- Serious / aggravated resistance

25 Police Pensions Regulations 2015 <The Police Pensions Regulations 2015 (legislation.gov.uk)>



Provision of First Aid is embedded within the training package. Tasers fitted with resettable training cartridges only are available as a tactical option, although it is not expected that use of a Taser will be appropriate in every setting and each officer is expected to display a rounded skill set utilising a range of use of tactical options.

Competencies that should be demonstrated during training include:

- De-escalation through effective communication
- Upper arm control tactics
- Safe and effective unarmed take downs into control and restraint
- Grounded officer tactics
- Rear handcuffing techniques
- Escorting persons in handcuffs
- Strategies to deal with ambush assaults
- Recognition of medical implications and treatment

The functional requirements linked to the scenarios and the required competencies are set out in appendix 1. Criterion tasks (standard tasks and abilities used to assess fitness for role) are set out in appendix 2.

Police officers will be deployed as part of a 24/7 365 days a year emergency response service. As such, there will be a requirement for shift working and to work at night. This should be made clear to all applicants at the outset.

It should be noted that neither the “ordinary duties of a constable” nor the College of Policing profile for a police constable includes the ability to drive a vehicle. A response constable is required to be skilled in applying specialised driving skills, where trained, to provide an appropriate response to incidents.²⁶ It should be clarified whether the OH assessment addresses the ability to function as a police constable or as a response constable.

It should be evident that being a police officer is challenging physically and psychologically. The five scenarios used in PPST are examples of some of situations in which police officers will find themselves. They can provide a basis for objective assessments of physical functioning of applicants. However, they do not adequately describe the psychological and emotional stressors that will face operational police officers. When dealing with public order, police officers may be working alone or be in small teams where they have to quell large crowds. They may witness serious threats to life, either directly or vicariously and they may be subject to moral injury.²⁷ Assessment of the mental health of applicants with respect to suitability to become police officers is not straightforward.

Annex B addresses the assessment of mental health and sets out a schema to assist this important process.

²⁶ ‘Response Constable’ (College of Policing, 2024) < Response Constable - College of Policing >

²⁷ Daniel M Blumberg. ‘What should clinicians who care for police officers know about moral injury?’, AMA Journal



1.3 The recruitment and selection process

The process to recruit and select a new police officer is a long and involved one.²⁸ Figure 1 sets out the different stages and shows the positioning of the occupational health assessment. The precise process may vary between police forces.

The occupational health component of the process should begin with the pre-joining stage, that is with the publication of information for potential applicants advising them about the functional requirements of a police officer. Applicants should be aware of health conditions or disabilities that might impact on their ability to perform the role. There should be an explanation of the health assessment process

and of typical workplace adjustments that might be implemented to offset certain functional limitations.

The positioning of the occupational health assessment is important. Section 60 of the Equality Act 2010 makes it generally unlawful to ask questions about health or disability before a job offer has been made.²⁹ Section 60 applies to any job recruitment process in England, Scotland or Wales involving internal or external applicants, and to selecting a pool of candidates who may be offered work in the future. Police officers are protected under the provisions of the Equality Act 2010 in respect of unlawful discrimination at work because of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.³⁰

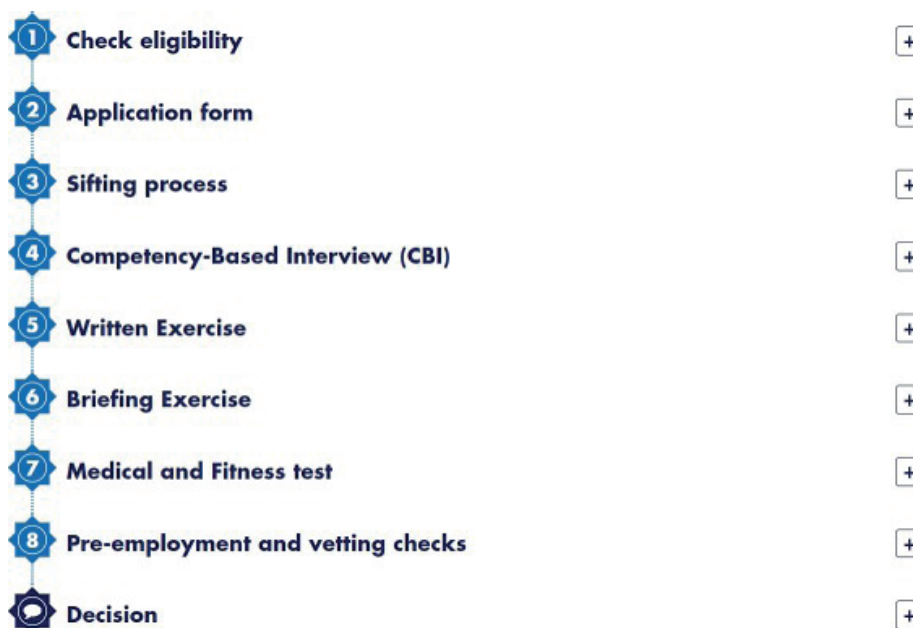


Figure 1. Police application and selection

28 'Police – How to apply' (Plan for Jobs, UK Government, 2023) <How to apply to join the police | Join The Police (joiningthepolice.co.uk)>

29 'Pre-employment health questions. Guidance for job applicants on section 60 of the Equality Act 2010' (Equality and Human Rights Commission, June 2014) <updated_pre-employment_health_questions_for_job_applicants.pdf (equalityhumanrights.com)>

30 'Equality' (Humberside Police Federation, 2020) <Equality (polfed.org)>



It is permissible to make the job offer conditional on medical checks and to then ask health-related questions without being in breach of section 60. It is also permissible to ask health questions to find out whether an applicant can take part in an assessment to test their ability to do the job and/or to ask about an ability to carry out an intrinsic part of the job. Information collected to find out if an applicant can take part in an assessment must be collected separately from other information given in the application for the job. Thus, it may be permissible to ask health questions about the ability to take part in the fitness test, which is the gateway to personal safety training. In addition, it may be permissible to ask health questions about functional capabilities that are intrinsic to the role of a police officer, such as those required to pass personal safety training.

The responsibility for making a job offer to an applicant rests with the recruiting police force. This will consider advice from their occupational health service as well as other factors, such as the outcome of vetting. It is recommended that police forces establish a recruitment decision panel (Appointments Panel – see annex C) to facilitate the final decision-making process.

1.3.1 Reasonable workplace adjustments

The ACAS website contains a lot of useful information about disability at work.³¹ There are sections about supporting disabled people at work, what disability means by law, reasonable adjustments, disability discrimination, supporting mental health at work, accessibility at work, when an employer may make a

decision based on disability, improving equality, diversity, and inclusion, and whether long COVID is treated as a disability.

The Equality Act 2010 sets out when someone is considered to have a disability and is protected from disability discrimination. Certain conditions and impairments are automatically protected under disability discrimination law: cancer, an HIV infection, multiple sclerosis, and a visual impairment: if someone is certified as blind, severely sight impaired, sight impaired or partially sighted. Someone with a progressive condition is considered by law to have a disability as soon as it starts to have an impact on normal day-to-day activities, as long as it is a long-term condition. The effect does not have to be substantial as long as it will be, in the future. In the main, someone has a disability if they have a physical or mental impairment, and the impairment has a substantial (more than trivial) and long-term (more than 12 months) on their ability to carry out their day-to-day activities. It should be noted that long-term includes fluctuating conditions that may wax and wane in severity. Normal day-to-day activities include things that people do at home, in their social life and participating in working life. Many of the examples given are relevant to the activities of a police constable.

- communicating with other people
- driving
- filling in forms
- following instructions
- sitting down or standing up
- using a computer
- writing

³¹ 'Disability at work' (ACAS, 2024) <Disability at work | Acas>

People who are no longer disabled, but who have had a disability in the past, have protection from the Equality Act 2010. The Equality and Human Rights Commission provides guidance to employers about making reasonable adjustments to work.³² There is a duty on employers to take steps to remove, reduce or prevent obstacles to work faced by a disabled worker or a job applicant, where it is reasonable to do so. (This applies when the employer knows, or has reason to know, that a worker or applicant has a disability.) There are three areas to consider:

- Changing the way in which things are done. (Organisational policy)
- Making changes to overcome physical barriers at work (E.g., making changes to IT equipment for people with dyslexia)
- Providing extra equipment or assistance – auxiliary aids and auxiliary services. (E.g., provision of additional software to assist reading or report writing.)

Reasonable adjustments are specific to an individual person. They can cover any area of work. It's not enough for employers to provide disabled people with exactly the same working conditions as non-disabled people. Employers must make reasonable adjustments by law.

An employer is required to:

- make reasonable adjustments for anything linked to someone's disability
- make sure other people do what's needed

for a reasonable adjustment to work – for example if someone needs information presented in a certain format, making sure other people at work do that

When considering what is 'reasonable', an employer (the employing force) must take into account whether the adjustment:

- will remove or reduce the disadvantage – the employer should talk with the person and not make assumptions
- is practical to make
- is affordable
- could harm the health and safety of others

An employer does not have to make adjustments that are unreasonable.

Examples of reasonable adjustments to be considered for applicants to the police may be found in appendix 8.

³² 'Employing People: workplace adjustments' (Equality and Human Rights Commission, 18 November 2018)
<In employment: Workplace adjustments | Equality and Human Rights Commission (equalityhumanrights.com)>



1.3.2 Neurodiversity

Neurodiversity is the concept that brain differences are natural variations. Each person has a brain that is unique to them.³³ Variations in the performance of brains may be relevant to the functional requirements of policing. It is estimated that, for at least 20% of the adult population in the UK, differences in brain performance may mean that they are diagnosed with conditions, such as dyslexia, being on the autistic scale, Developmental Coordination Disorder (formerly known as dyspraxia) and attention deficit hyperactivity disorder (ADHD). Whilst these diagnostic categories may be regarded as neurological conditions, they are not illnesses.

Such conditions may be associated with impairment in certain settings and environments and may constitute a workplace disability for which reasonable adjustments should be explored.³⁴ It should be recognised that there may be considerable benefits from having a neurodivergent workforce in policing. The variations in brain performance mean that there may be enhanced performance in areas important to policing, such as attention to detail, strong technical abilities, high levels of concentration and steadfastness, creativity, and the ability to view the bigger picture.

The NPCC policing vision 2025 aims to create a police workforce that is more representative of the communities that are served. This is reinforced in the NPCC publication Diversity Equality Inclusion Strategy 2018-2025.³⁵ It rehearses the view that a diverse workforce representing people of all backgrounds and groups goes right to the heart of the principle of policing by consent. In addition to the moral basis for a diverse and inclusive approach to recruitment, it emphasises the legal duties with respect to the Equality Act 2010 and the Public Sector Equality Duty which came into force in April 2011. This is the legislative basis requiring the individual assessment of neurodiversity and the consideration of reasonable adjustments at work. (See reasonable workplace adjustments) The National Police Autism Association promotes neurodiversity in policing.³⁶ This is an inclusive approach, and it is not restricted to addressing issues to autism.³⁷ Police occupational health services also have a role to play.

Whilst neurodiversity is a manifestation of normal variation of brain development and, as such, is not an illness, it may be associated with illness. The term neurodiversity has developed with reference to the social model of disability and the proposition that society will benefit from recognising and developing the strengths of conditions, such as dyslexia or autism, rather than pathologising weaknesses.

33 'What is neurodiversity?' (The Brain Charity, 2023) <Workplace neurodiversity training from The Brain Charity - The Brain Charity>

34 'Definition of disability under the Equality Act 2010' (UK Government, 2023) <Definition of disability under the Equality Act 2010 - GOV.UK (www.gov.uk)>

35 2018-2025 NPCC Diversity Equality Inclusion Strategy (NPCC, 2018) 15 <npcc-diversity-equality--inclusion-strategy-2018-2025.pdf>

36 National Police Autism Association. <Our Aims | National Police Autism Association (npaa.org.uk)>

37 James Bird, 'Dyslexia – the bigger picture' (National Police Autism Association, 15 November 2020) <Dyslexia - the bigger picture | National Police Autism Association (npaa.org.uk)>



Looking through the prism of this model, people are disabled by barriers in society and not by their differences.³⁸ Illness associated with neurodiversity should be a focus for police occupational health services.

The impact of social barriers may give rise to common mental health conditions. Neurodivergent conditions are underdiagnosed in females; they are more likely to present with anxiety, depression, or an eating disorder. Being on the autistic spectrum is associated with the occurrence of clinical anxiety and depression, for example.³⁹ In addition, dyslexia, dyspraxia, autism, and attention deficit hypersensitivity disorder are more likely to occur together, thus adding to the difficulties of dealing with societal barriers.

Applicants known to be neurodivergent should be assessed to explore the occurrence of any co- morbidities that might influence the discussion about reasonable workplace adjustments. In addition, applicants with a medical history of bipolar disorder, anxiety, depression and/or eating disorder may be undiscovered and unsupported neurodiverse individuals. As with the assessment of mental health conditions (See section 2.3) the relevance of social conditions and the existence of appropriate coping strategies should be factored into decisions about suitability to join the police.

A formal diagnosis of a neurodiverse condition, such as autism or dyslexia, is not mandatory and should not delay recruitment decisions. The charity The Autistic Society advises that it is up to individuals whether they seek a diagnosis.⁴⁰

Professor Nancy Doyle argues that it should not be necessary to obtain a formal diagnosis of neurodiversity to secure reasonable workplace adjustments. The Equality Act defines disability in relation to functional impairment, not diagnosis. Professor Doyle highlights the difference between neurotypical cognitive scores, where the variation is relatively small, and those of neurodiverse individuals who have “spiky profiles”. This means that there is a larger variation across the domains of cognitive function testing: some scores will be higher than neurotypical scores, some lower. It is argued that this spiky profile characterises neurodiverse people; diagnosis of specific conditions – E.g., dyslexia, DCD, ADHD – focuses on the most prominent deficits belying the fact that there is poor correlation between formal diagnosis and work performance. Rather than focus on obtaining formal diagnoses, police forces should assess the needs for workplace adjustments by simply asking neurodiverse applicants about their needs. They should structure such assessments with regards to the cognitive and behavioural functions of a front-line officer. (See appendix 9) Consideration of reasonable adjustments should involve police tutors, who can provide support, and people with expertise in neurodiversity issues. Determination of suitability would comprise assessing the ability of an applicant to learn the skills and requirements of the role and to advise on the provision of reasonable workplace adjustments. It is recommended that there is upskilling of occupational health teams to increase understanding of how different cognitive abilities might impact on role requirements and of their relationship to symptoms of ill health.

38 'Social model of disability' (Scope, 2023) < Social model of disability | Disability charity Scope UK >

39 'Autism and mental health' (MIND, 2023) <Autism and mental health - Mind >

40 Pre-diagnosis support – a guide for adults who think they might be autistic. Adults (autism.org.uk)



Formal diagnoses may be required prior to sitting examinations. This ensures that candidates are given a level playing field. This can be carried out post-recruitment. There is often a considerable waiting time for such assessments. The National Institute for Health and Care Excellence (NICE) advises that for adults without a moderate or severe learning disability a screening tool, such as the Autism-Spectrum Quotient – 10 items may be used to triage those people who would benefit from a comprehensive assessment of autism.⁴¹ Similarly, there are screening tests for dyslexia and ADHD. Referral for a formal diagnosis of dyslexia is available via the NHS and a GP referral. ADHD differs from dyslexia and autism in that pharmacological treatment is available following specialist assessment. NICE recommends that suspected cases of ADHD in adults should be referred to suitably trained mental health specialists; primary care practitioners should not make an initial diagnosis nor begin treatment.⁴² In the context of an occupational health assessment of an applicant, the most likely scenarios will be someone who has already been referred and who is waiting for an appointment or someone who has been assessed and is receiving support. The potential impact of a delay in receiving treatment on the ability to train effectively / sit exams should be factored into the planning of workplace adjustments.

41 'Autism spectrum disorder in adults: diagnosis and management' (CG 142, NICE, 14 June 2021) <Key priorities for implementation | Autism spectrum disorder in adults: diagnosis and management | Guidance | NICE>

42 'Attention deficit hyperactivity disorder: diagnosis and management' (NG87, NICE 13 September 2019) <Recommendations | Attention deficit hyperactivity disorder: diagnosis and management | Guidance | NICE>



2. Clinical assessment

2.1. Occupational health assessment framework

The purpose of a pre-placement health assessment is to assess the impact of any health conditions on the ability to carry out the ordinary duties of a constable, including the performance of safety critical tasks, and to advise on reasonable adjustments that can offset any relevant functional impairment associated with a disability. Data protection legislation requires a legal basis for processing personal information. (The principles of data protection must be complied with.)⁴³ In addition, the purpose for obtaining the information must be specified.

Occupational health advice to police forces on the fitness of applicants and on reasonable workplace adjustments should be in the context of an overall risk assessment. Risks will include health and safety, financial and reputational risk / public confidence in policing. Risk assessments should be consistent with and support the Peelian principles of policing. The risk framework for an occupational health assessment will comprise:

- Assessment against the functional requirements of the scenario-based personal safety training curriculum
- Assessment of the risk of sudden incapacitation / fitness for “blue light driving”
- Assessment of the likelihood of providing regular and efficient service

2.1.1. Components of the occupational health assessment

2.1.1.1. A stepped approach to assessment

Most candidates to become police officers will be fit and well. Use of a stepped approach will make best use of occupational health resources by identifying the candidates that need further assessment, gathering additional information and allocating the right occupational health skill set for the assessment. (See figure 2) This is a re-framing of the approach taken in the 2004 standards. The aim is to ensure efficiency of process whilst managing risk effectively.

The starting point for the occupational health assessment is a health questionnaire. This will be completed by all candidates. It is medically confidential, and the lead occupational health practitioner should determine how the questionnaire will be assessed. Consideration should be given for the role of an Occupational Health Technician to undertake this task, or a clinic nurse, within a clinical governance framework. Responses to the questionnaire that indicate that the candidate has no relevant health conditions require no further action other than the performance of basic clinical biometric assessments.

43 'A guide to the Data Protection principles' (ICO, 2023) <The principles | ICO>



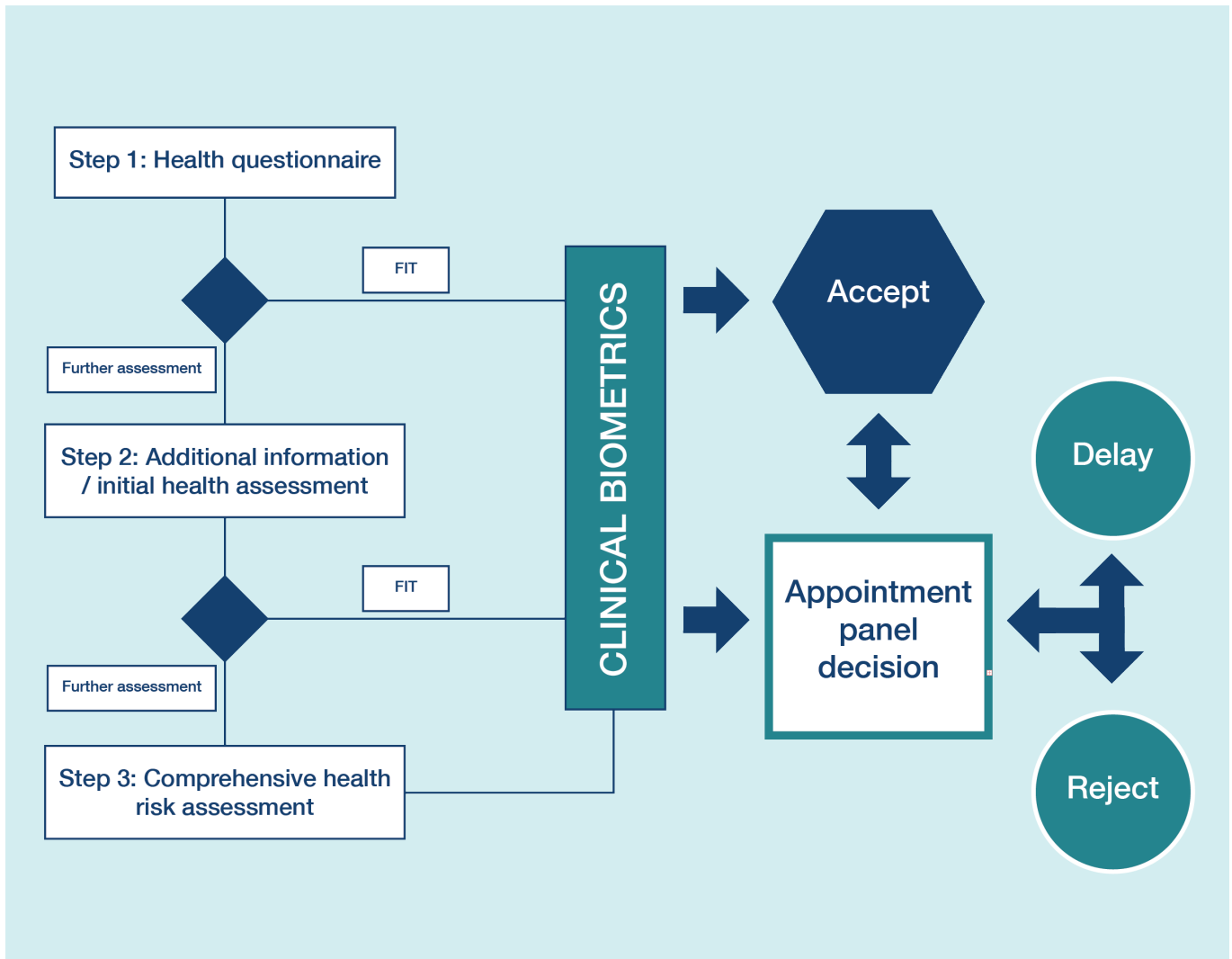


Figure 2. Stepped occupational health assessment

Step 2 of the process is to follow up those responses that require further information. It is not a diagnostic step; it identifies which applicants should be referred for a formal clinical assessment or are suitable for appointment without this. This might be by telephone, TEAMS, an in-person assessment, or a combination of these. Initial enquiries and / or health assessments may determine that the candidate is fit to join the police, subject to the performance of basic clinical biometric assessments. Step 2 might be carried out by

a suitably trained occupational technician, clinic nurse, junior occupational health nurse or physiotherapist.

Step 3 will be required when the medical information gathered and / or the initial health assessment indicates that a comprehensive clinical assessment by a Force Medical Advisor (FMA) or senior occupational health nurse, perhaps working alongside a registered mental health nurse with occupational health experience, is necessary to determine fitness in relation to the risk framework.



Final decisions about recruitment should be made by force recruitment, informed by occupational health advice, using an appointments panel, where necessary. They will consider the feasibility of implementing workplace adjustments and the ability of the force to accommodate candidates with functional disabilities.

2.1.1.2. Occupational health questionnaire

The standard approach to assessing the health of applicants at the pre-placement stage is the completion of a confidential health questionnaire. The personal information collected must be for specified, explicit and legitimate purposes. These are to identify and assess the presence of health conditions that adversely affect functional ability and negatively impact the ability to pass the personal safety training undertaken by recruits, raise the risk of sudden incapacity beyond an agreed threshold and impair the ability to render regular and efficient service. The information collected must be adequate, relevant, and limited to these purposes.

The health questionnaire in appendix 3 is a modification of the questionnaire that was produced by the College of Policing / NPCC during the COVID-19 pandemic, in 2020. Section 3 looks explicitly at functional abilities and at symptoms affecting functions relevant to the functions of a police response officer. Section 4 explores health conditions that might be relevant with respect to incapacitation or the ability to render regular and efficient service.

The health questionnaire is intended to be used as an initial assessment tool. Answers to the questionnaire suggesting functional impairment or the existence of medical conditions must be followed up by suitably trained and experienced occupational health clinicians. (See National Police Wellbeing Service targeted operating models and link to the police occupational health standards)⁴⁴

2.1.1.3. GP verification of occupational health questionnaires

It has been custom and practice for completed occupational health questionnaires to be verified by the applicant's GP. A recent survey of police occupational health services indicates that there is no consensus on whether this practice should continue or cease.

Police occupational health services, in conjunction with their Human Resources and operational colleagues, should make local risk assessments and decide whether this aspect of the assessment process should continue. Reference to the College of Policing National Decision Model is encouraged.⁴⁵ The benefit of a GP-verified health questionnaire is that any omissions of information may be identified by reference to the full GP record by the general practitioner. A potential disadvantage of adopting this process is the delay in receiving a response that sometimes occurs. In some forces areas this has been identified as a significant problem.

It is recommended that in either case (continue / discontinue) there is an audit of the outcome.

44 'Target operating models' (NPWS, 2023) <Target operating models for occupational health units | Oscar Kilo> accessed 21 November 2023

45 'National Decision Model – authorised professional practice' (College of Policing, 2023) <National decision model | College of Policing> accessed 21 November 2023



2.1.1.4. Occupational health clinical assessment

A suitable and sufficient clinical assessment must be carried out when answers to the health questionnaire suggest an underlying health problem. The assessment must conform to guidance published by relevant regulatory bodies (The General Medical Council, The Nursing and Midwifery Council, The Health and Care Professions Council). In addition, it should comply with any ethical and practice guidance issued by the respective Faculties of Occupational Medicine and Occupational Health Nursing.

All clinical assessments must be tailored to individual circumstances and should be based on the judgement of the assessing clinician, considering their knowledge, skills, and competencies. The specific requirements of section A.2.2 of the Home Office Medical Standards of Entry Guidelines - Guidance for Occupational Health Departments: Medical Assessment for Potential Police Recruits are not necessary in every individual assessment. Section A.2.7 is no longer appropriate; the approach to medical assessment is a matter of judgement for clinicians. Clinical assessments should be part of a clinical governance structure and process to ensure patient safety. (See Occupational Health Standards)⁴⁶

Assessments of the risk of sudden incapacitation will use the Driver and Vehicle Licensing Agency (DVLA) guide for medical professionals.⁴⁷ The DVLA defines the risk of a sudden disabling event as 20% in one year for group 1 licensing and 2% per year for group

2 licensing. Thus, by aligning the medical assessment to DVLA group 2 standards, it might be inferred that the risk of a sudden disabling event for a front-line officer will be 2% per year. This level of risk to the public is deemed appropriate for people licensed to drive large lorries and buses. Of course, when considering the risk to police officers, reference to police activities must also be factored in. Thus, the impact of strenuous activity, the risk of collapse in a hostile / safety critical environment or the risk of collapse when working alone must be considered. Use of the DVLA group 2 standards should be considered as a pragmatic starting point for risk assessment and the determination of suitability to become a front line police officer.

The role of a response or patrol officer usually requires driving a police vehicle fitted with blue lights and a siren, although this is not part of the ordinary duties of a constable. The College of Policing Police Driving authorised professional practice permits qualified and authorised drivers to drive without observing speed limits, observing keep right/left signs and complying with traffic lights (including pedestrian controlled crossings and red X matrix signs).⁴⁸ Consequently, in the absence of other medical standards for this purpose, there is a face validity for using the group 2 medical standards for this purpose. It should be noted that this is not a legal requirement. The DVLA requires that “the same medical standards for drivers of police, fire, coastguard, ambulance, and health service vehicles as they do for all drivers holding group 1 and group 2 licences.

46 'Foundation Occupational Health Standards' (Oscar Kilo, 2023) <Foundation occupational health standards | Oscar Kilo>

47 Assessing fitness to drive – a guide for medical professionals (DVLA, May 2022) 136 <Assessing fitness to drive – a guide for medical professionals (publishing.service.gov.uk)>

48 'Police driving' (College of Policing, 6 February 2023) <Police driving | College of Policing>



Any responsibility for determining higher medical standards, over and above the licensing requirements rests with individual forces.”

Assessment of the impact of health conditions on the ability of individuals to render regular and efficient service is problematic. The CIPD notes that “employees may need time off (work) for a variety of reasons, from short-term sickness to longer-term health issues”.⁴⁹ A careful bio-psycho- social assessment will be required, noting that evidence of past-absenteeism may be highly predictive of future absenteeism.⁵⁰ The time frame against which such an assessment might be carried will probably vary between police forces. There is a consensus view that five years might be a reasonable period as this would provide a return on investment for the recruitment and training of police officers.

2.1.1.5. Occupational Health resources

Applicants to the police will generally be fit and healthy people. An efficient and effective occupational health assessment process will, therefore, ensure that decisions about suitability are taken at the lowest level appropriate within a robust clinical governance structure. The NPWS has produced a target operating model to assist police OH services adhere to the Foundation OH Standards. (And the Enhanced and Advanced Standards launched in 2023) The model includes guidance about staffing levels and required competencies. Suitably trained occupational health technicians can carry out an effective first line triage of health questionnaires and conduct initial enquiries where answers indicate a need for follow up.⁵¹ This provides intelligence for further assessment by Force Nursing Advisors, at a level dictated by the complexity of the case, or by a Force Medical Advisor.

49 Absence measurement and management. CIPD Factsheet May 2022. Absence Measurement & Management | Factsheets | CIPD

50 Spurgeon A. Managing attendance at work: An evidence-based review. British Occupational Health Research Foundation. 2002. attend (oshresearch.co.uk)

51 Careers for Occupational Health Technicians (Society of Occupational Medicine, 2019) 2



2.2. Assessment of neurological and musculoskeletal symptoms

A step 2 assessment of symptoms should focus on red flags and functional impairment relevant to the criterion tasks listed in appendix 2.

Neurological

- Motor or sensory deficits
- Balance and coordination
- Fine motor movements
- Aphasia / dysphasia
- Strength / grip strength Musculoskeletal
- Red flags
- Range of joint movement
- Evidence of hypermobility

The following schema may be used for the assessment. Red flag symptoms:

Neurological	Musculoskeletal ⁵²
<ul style="list-style-type: none"> • Change in balance or coordination • Numbness or tingling in the arms or legs • Decrease in movement of the arms or legs • Weakness • tremor • Injury to the head, neck or back. • Urinary symptoms • Blurred or altered vision • Seizures • Red flag headaches⁵³ 	<ul style="list-style-type: none"> • Thoracic pain • History of osteoporosis • History of severe trauma / previous spinal fractures • Past history of cancer • Unexplained weight loss

52 Laura M Finucane et al, 'International Framework for red flags for potential serious spinal pathologies', Journal of Orthopaedic and Sports Physical Therapy 50, no. 7 (2020): pp. 350-372. International Framework for Red Flags for Potential Serious Spinal Pathologies (jospt.org)

53 'Headaches' (East and North Hertfordshire CCG) <Headache Pathway.pdf (enhertsccg.nhs.uk)>

Red flags are symptoms and signs that raise suspicion of possible serious pathology. They should be used in combination with a thorough history and examination. They have limited use when used singly and in isolation of the presenting context. The purpose of red flags in the context of an occupational health assessment is to ensure appropriate referral of applicants for a full medical assessment. A step 2 assessment is not intended to be diagnostic.

An overall rating of musculoskeletal health may be obtained using the Musculoskeletal Health Questionnaire (MSK-HQ).⁵⁴ The assessment is based on symptoms and functioning in the previous 2 weeks. Enquiry about symptoms and level of functioning over a longer period (3 months, 6 months, 12 months) might assist the assessment of suitability for joining the police.

Generalised joint hypermobility in the age range typical of most police officer applicants (18 – 25 years) has a reported prevalence of 12.5% - 39.5% in university students. It is part of a spectrum of disorders due to laxity of connective tissue. Research evidence suggests that generalized joint hypermobility is associated with an increased risk of injuries, particularly sports-related injuries in sports, such as rugby. However, this is not a universal finding. Ankle sprains or fractures, anterior cruciate ligament knee injuries and shoulder joint injuries have been reported.⁵⁵ The presence of generalised joint hypermobility may be assessed by a suitably trained nurse or doctor using the Beighton score. (See appendix 4)

An overall approach to an objective assessment of neurological and musculoskeletal functioning may be found in annex A accompanying this guidance document.

2.3. Mental health assessment

A schema for the assessment of the mental health of police officer applicants has been developed. It is contained in Annex B to this guidance document.

The assessment of suitability to join the police should be based on the three risk considerations as for physical health conditions, that is:

- Assessment against the functional requirements of the scenario-based personal safety training curriculum
- Assessment of the risk of sudden incapacitation
- Assessment of the likelihood of providing regular and efficient service

The 2004 guidelines highlight stressors associated with the role of police constable, namely:

- Being required to work at any time and sometimes for long periods
- Working alone
- Working under conditions of physical or emotional distress

⁵⁴ "Versus Arthritis Musculoskeletal Health Questionnaire (MSK-HQ)", versusarthritis.org, 2023, Musculoskeletal Health Questionnaire (MSK-HQ) | Versus Arthritis.

⁵⁵ Peter R Reuter and Kaylee R Fichthorn, 'Prevalence of generalized joint hypermobility, musculoskeletal injuries, and chronic musculoskeletal pain among American university students', PeerJ (2019): e7625, doi: 10.7717/peerj.7625



- Working rotational shift patterns that include night working
- Working unscheduled overtime, sometimes at short notice
- Working in inclement weather

All of these stipulations remain relevant for policing in 2024. In addition, exposure to psychological trauma has probably increased, compared to 2004, as the expectations of the police have evolved. Police involvement in cases of domestic violence, sexual assault, child sexual exploitation and on-line pornography are important additions to the litany of psychological traumatic exposures that police officers must confront.

A step 2 assessment should collate evidence relating to symptoms and medical histories that may indicate possible unsuitability to join the police. These include:

- Disabling anxiety
- Impaired memory, concentration, multi-tasking
- Fatigue, reduced stamina, low self-drive, emotional instability

Aspects of medical histories that may be relevant to the possibility of unexpected decrements in function or attendance include:

- Continuing / frequently occurring common mental health conditions
- Poorly controlled bi-polar disorder
- Recent substance misuse

The issue of substance misuse must be addressed against the background of national guidance and local substance misuse policies and vetting criteria and requirements.

When assessing the impact of a health condition on suitability to join the police, assessment of individual risk factors will be important including the response to diagnosis and treatment and choice of lifestyles. The

development of appropriate coping strategies is a key consideration when assessing suitability to join the police. Occupational risk factors – occupational stressors – may have to be modified and reasonable workplace adjustments considered. There are many social stressors and ability to cope with these, as well as maintain work-life balance, is important.

Reliance on continuing or recent prescription of antidepressant medication as a sole reason for rejecting an application to join the police is inappropriate. Other health reasons relevant to the performance of the duties of a response police officer must be explored: functional impairment, risk of sudden incapacitation or inability to render regular and efficient service. (See annex B)

An individual step 3 occupational health assessment is likely to be required for applicants with current or previous mental health conditions that impact / have impacted on normal functioning.

2.4. Assessment of cognitive function

Assessment of cognitive function is unlikely to be routine. However, it may be required for applicants who have a history of significant head or traumatic brain injury, or who have health conditions that have the potential to impact on cognitive functioning, such as a cerebrovascular accident or transient ischaemic attack, multiple sclerosis, multi-system disorders such as Systemic Lupus Erythematosus, or post-infectious disorders, including long COVID. Moderate to severe mental health conditions may also affect cognitive function. Formal initial assessment of cognitive functioning may be performed in clinic



at the step 3 occupational health assessment using validated and simple assessment tools. Where a first line assessment gives cause for concern a definitive assessment will require referral to external expertise. Administration of tests, such as the Wechsler Adult Intelligence Scale (WAIS) is carried out by clinical neuropsychologists within the NHS, and they are usually performed in tertiary referral centres. This is likely to lead to significant delays in a recruitment decision and the recruitment panel should be advised to defer the application pending further medical information.

Testing in primary care is focussed on the detection of mild cognitive impairment or dementia. However, the tests assess important aspects of cognitive function that are relevant to the police, such as short and long-term memory, concentration and attention span, language and communication skills, and orientation. A quick screening tool is the GPCOG on-line test.⁵⁶ Such screening tests will detect marked impairment. There are others, such as the six-item cognitive impairment test (6CIT).⁵⁷ A more sensitive tool is the Addenbrooke's Cognitive Examination (ACE-111). It is free to use for clinical purposes. There are assessments of attention, orientation, memory, language, visual perception, and

visuospatial skills.⁵⁸ It takes approximately 20 minutes to complete, administered by a suitably trained administrator. Training is estimated to take a few hours.^{59 60} An ACE-111 score of 88, or less, suggests the need for external referral for a full neuropsychological assessment. It should be noted that impairment of cognitive function may be due to a functional rather than organic disorder. Consequently, a holistic assessment of applicants is required. ACE-111 scores should not be relied on alone when making the clinical assessment.⁶¹

Assessment of possible impaired executive cognitive function is important when assessing police officer applicants with a relevant medical history. This aspect of cognitive function testing is lacking in most primary care level screening tools. The following tests may be used to assess executive function:

- Trail Making Test (TMT) Form B
- Verbal Fluency Test (VFT) - F, A and S (ACE-111)
- VFT Animals category (ACE-111)
- Clock Drawing Test (CDT) (ACE-111)
- Digits Forward and Backward subtests (WAIS-R or WAIS-III) (ACE-111)
- Stroop Test
- Wisconsin Card Sorting Test (WCST) and its variants⁶²

56 'General Practitioner Assessment of Cognition' (gpcog.co.au, 2023) <GPCOG | Home>

57 'Screening for cognitive impairment' (Patient, 2024) < Screening for Cognitive Impairment (Cognitive Function Tests) (patient.info)>

58 Addenbrookes Cognitive Examination – ACE 111, (Cambridge: 2013): p 5. ace- iii_uk_remote_admin_protocol_versionb_2020.pdf

59 UK ACE 111 and M-ACE administration and scoring guide, (Cambridge: 2017), p 9. ACE-III ScoringUK2017.pdf

60 Peter Noone, 'Addenbrooke's Cognitive Examination – 111', Occupational Medicine, 65 No. 5 (2015): 418- 420, doi: 10.1093/occmed/kqv041.

61 Lucy C Beishon et al, 'How accurate are the Addenbrooke's Cognitive Examination 111 (ACE-111) and mini ACE for the screening of dementia and mild cognitive impairment (MCI)?', Cochrane Database of Systematic Reviews 12 (2019), Art. No.: CD013282. DOI: 10.1002/14651858.CD0132

62 Camila de Assis Faria et al, 'The most frequently used tests for assessing executive functions in aging', Dement Neuropsychol 9, no. 2 (2015): pp. 149-155, doi: 10.1590/1980-57642015DN92000009



Verbal fluency tests are part of the ACE-111 test, as is the clock drawing test, which also features in the GPCOG test. An additional test of executive functioning may be undertaken using the Hayling and Brixton tests. They assess response initiation, response suppression and thinking times, and the ability to detect rules in a sequence of stimuli. They take 5 minutes and 5 – 10 minutes to administer, respectively.⁶³

2.5. Other considerations

The 2004 standards make specific reference to medical conditions requiring special consideration. These are diabetes, asthma, and epilepsy. (A.1.6.2) It is noted that people with these conditions may be well in between exacerbations. However, exacerbations may be incapacitating.

2.5.1. Diabetes Mellitus

The 2004 standards comment that the recommendations are based on current medical practice. On that basis separate considerations about employment were made with respect to type 1 and type 2 diabetes. Medical practice has developed significantly since 2004. Advice about the deployment of police officers with diabetes to blue light driving is contained in the 2013 Faculty of Occupational Medicine

document Guidelines for Assessing Fitness for Blue Light Driving.⁶⁴ Appendix 1 of that document contains recommendations for the medical risk assessment for blue light drivers with diabetes mellitus with treatment regimes that may lead to hypoglycaemia. Of course, assessment of suitability for the police is not only concerned with blue light driving and must relate to all the duties of a constable.

Current medical standards from the Driver and Vehicle Licensing Authority (DVLA) for group licenses can be found in the Assessing fitness to drive – a guide for medical professionals publication.⁶⁵

- There must be full awareness of hypoglycaemia
- There must be no episodes of severe hypoglycaemia within the preceding 12 months
- The applicant practices blood sugar monitoring regularly (as defined)
- The applicant must use a blood glucose meter with sufficient memory to store 3 months of readings (as defined)
- The applicant demonstrates an understanding of hypoglycaemia
- There are no disqualifying complications of diabetes
- There should be an annual examination by an external consultant specialist in diabetes and a 3-yearly examination by the applicant's usual doctor

⁶³ "Hayling and Brixton tests", Wikipedia – The Free Encyclopedia, 2023, Hayling and Brixton tests - Wikipedia

⁶⁴ GUIDELINES FOR ASSESSING FITNESS FOR BLUE LIGHT DRIVING, (London: Faculty of Occupational Medicine, 2013), p. 11. FOM-Guide-re-blue-light-driving.pdf.

⁶⁵ Assessing fitness to drive – a guide for medical professionals, (Swansea: DVLA, 2022), p. 136. Assessing fitness to drive – a guide for medical professionals (publishing.service.gov.uk).



Flash GM and RT-CGM interstitial fluid glucose monitoring systems are not permitted for the purposes of group 2 driving and licensing. Police officers may use such systems, if they choose to do so, but the readings cannot replace the need for blood sugar monitoring, as specified by the DVLA.

Notwithstanding the requirements relating to driving, careful assessment of glycaemic control and the occurrence of side-effects and possible safety issues must be undertaken. Consideration of workplace adjustments, such as ability to eat regularly and working safely alone, should be considered. The impact on working of any secondary complications must be assessed.

2.5.2. Asthma

Police officers may drive group 2 licensed vehicles as long as they have not suffered from cough syncope, disabling dizziness, fainting or loss of consciousness. Individual risk assessment will review known triggers for asthma exacerbations, such as exposure to cold air or smoky environments, and the level of control achieved with, or without medication. Incapacitant sprays may exacerbate asthma when used in confined spaces. Local force risk assessments will determine how and when sprays should be deployed and any mitigating actions to be taken with regard to the control of substances hazardous to health.

2.5.3. Epilepsy

The 2004 standards advise that applicants with a medical history of recurrent seizures are unlikely to be suitable to be police officers, although an individual assessment is required. Applicants who have had a single seizure require further investigation and it is advised

that the application be deferred for 18 months. For applicants who have had more than one seizure, the type of seizure, the frequency and the time of occurrence should be assessed. In general, applicants with seizures occurring during the daytime involving loss of awareness and/or loss of consciousness are unlikely to be fit for front-line policing in light of its safety critical nature. The DVLA medical standards, which act as a proxy for assessing fitness in such circumstances, provide detail about criteria for possible fitness.

DVLA standards for group 2 licenses state that people with epilepsy or multiple unprovoked seizures must remain seizure-free for a period of 10 years (without epilepsy medication) before licensing can be considered. Restrictions are much less stringent for group 1 licenses, where being seizure free for 12 months permits driving. If there is an established pattern of seizures only occurring whilst asleep, or that seizures occur without loss of consciousness, or any functional impairment, they may resume driving. Driving is not included as an ordinary duty of a police constable. However, many police forces recruit police officers in the expectation that they will be able to drive in response roles, as part of their duties.

- Applicants with a history of recurrent seizures are unlikely to ever be fit to undertake blue light driving. For a first seizure, there must be a seizure free gap, without reliance on medication for at least 5 years. Any deferral should be based on when the first seizure occurred
- Applicants may be suitable for many other police roles contingent on their medical histories and the risk assessment for specific roles



Police forces should make it clear to all potential candidates whether blue light driving is an essential part of the job description for which they are being recruited.

2.5.4. Bleeding diatheses

Applicants with haemophilia or platelet disorders will require individual assessment to review risk of haemorrhage. The Haemophilia Society highlights the police as having restricted recruitment requirements, as well as the Armed Forces and front-line prison service. It advises members to think laterally and to consider roles that are not associated with physical trauma. Applicants with haemophilia or blood coagulation disorders associated with either spontaneous bleeding or bleeding due to everyday trauma exposure will not be suitable for front line policing.

The 2004 standards advise that applicants taking anticoagulant medication are unlikely to be suitable as police officers. Applicants may be taking warfarin, one of the direct acting anticoagulants, aspirin or another antiplatelet (sometimes potent) medication. People taking warfarin or one of the newer direct anticoagulants are at an increased risk of intracranial haemorrhage, following head injury. A recent systematic review and meta-analysis found a two-fold increase in overall mortality and in-hospital mortality for trauma patients taking oral anticoagulants.⁶⁶ For applicants

taking warfarin, the risk of intracranial haemorrhage will correlate with the level of the International Normalized Ratio (INR) – the degree of anticoagulation based on the time it takes blood to clot.

There is a lack of research looking into the risks of operational deployment of police officers taking oral anticoagulant medication. However, because of the risks of intracranial haemorrhage for people taking long-term warfarin or a direct acting anticoagulant, a precautionary approach is advocated.

This means that such applicants are unlikely to be suitable to be front line police officers.

For people taking antiplatelet therapy, bleeding is a known side effect, mainly gastrointestinal. However, whether this causes an increased risk of intracranial haemorrhage in mild head injury is controversial. People taking such medication tend to have other risk factors such as increased age and / co-morbidity. There is an on-going debate about the optimal prescription of dual antiplatelet therapy (DAPT) associated with percutaneous coronary intervention with drug-eluting stents (PCI-DES).⁶⁷ Major and minor risk criteria for high risk bleeding for patients on DAPT have been developed. High risk means a 4% risk of a serious bleed (BARC 3 – 5) or 1% risk of intracranial haemorrhage at 1 year.⁶⁸ The high risk factors include old age and the presence of significant organ damage, haematological abnormalities, or previous risk of bleeding. These seem unlikely to be

66 Zong Huan Lee et al, 'The effect of preinjury anticoagulation on mortality in trauma patients: a systematic review and meta-analysis', *Injury* 51, no. 8 (2020): pp. 1705-1713, doi: doi.org/10.1016/j.injury.2020.06.010

67 Luis Ortega-Paz et al, 'Dual antiplatelet therapy for the general cardiologist: recent evidence, balancing ischaemic and bleeding risk' (*European Society Cardiology*, 1 Aug. 2023) < Dual antiplatelet therapy for the general cardiologist: recent evidence, balancing ischaemic and bleeding risk (escardio.org)>

68 Dual Antiplatelet Therapy Following Percutaneous Coronary Intervention: Clinical and Economic Impact of Standard versus Extended Duration [internet] (Appendix 10 Bleeding Classification System Definitions, Bleeding Academic Research Consortium, Mar 2019) < Bleeding Classification System Definitions - Dual Antiplatelet Therapy Following Percutaneous Coronary Intervention: Clinical and Economic Impact of Standard Versus Extended Duration - NCBI Bookshelf (nih.gov)>

relevant to the population applying to be police officers. However, a careful and thorough risk assessment will be required should this be necessary. Contingent on a careful individual risk assessment, taking a single antiplatelet drug is unlikely to be a contraindication to joining the police and being a front-line police officer.

2.6. Clinical biometrics

All applicants must have a core set of clinical biometric data gathered, as part of the occupational health assessment: eyesight tests, height, weight, blood pressure measurement and hearing.

Assessment of urinalysis and spirometry should be based on clinical judgement and risk assessment of individual applicants.

2.6.1. Eyesight tests

Eyesight standards for police officers are contained within Police Regulations 2003. (Regulation 10, e.) Further guidance was issued by the Home Office, in 2019.⁶⁹

Please refer to appendix 5.

2.6.2. Measurement of blood pressure

Measurement of blood pressure is a frequently performed clinical task. It is important that blood pressure is measured accurately and consistently, as decisions about suitability for the police may depend upon the results.

Guidance on the diagnosis and management of hypertension may be found in the NICE guideline (NG 136).⁷⁰

- Blood pressure should be measured manually if there is pulse irregularity. Devices for measuring blood pressure should be validated, maintained, and regularly calibrated.
- Blood pressure readings between 140/90 mmHg and 180/120 mmHg require referral for ambulatory monitoring if this has not been done already.
- Blood pressure readings of 180/120 mmHg, or higher, require assessment by a doctor on the day that the measurements are taken. Further management will be determined by the presence or absence of symptoms or signs of target organ damage. This is likely to require immediate referral to the applicant's GP for further management, if there are symptoms of concern or the need to assess the presence of end organ damage, or a follow up appointment for further assessment in 7 days.

If blood pressure is not controlled, it may be necessary to take time to bring it under control. Thus, a deferral of the application

69 'Determinations of the Secretary of State under the Police Regulations 2003' (Home Office, 16 September 2019) < Determinations of The Secretary of State under the police regulations 2003 - GOV.UK (www.gov.uk)> accessed 21 November 2023

70 "Hypertension in adults: diagnosis and management", NICE, 2022, Recommendations | Hypertension in adults: diagnosis and management | Guidance | NICE.

may be required. If there is evidence of end organ damage, an assessment on the impact on functional capability and ability to render regular and efficient service will be required. The aim of the management of hypertension is to maintain clinic blood pressure readings to below 140/90 mmHg. Consider the potential impact of shift work, including night work, and the stresses of policing on blood pressure control when advising on suitability. (See appendix 6)

2.6.3. Height, weight, BMI

The College of Policing issued guidance to forces about the use of the body mass index when assessing the suitability of police officer applicants, in July 2023. The following were noted:

1. Home Office guidance is that the assessment of the likelihood of early ill health retirement, as part of the OH pre-placement, will no longer be undertaken.
2. This means that forces should be cautious in rejecting applicants based only on the existence of an elevated BMI, in the absence of other symptoms or signs of impaired function or disease.
3. Forces should use section 3 of the recommended medical history questionnaire (Appendix 1 of the interim guidance, September 2020) to assess the likelihood of relevant functional impairment relating to personal safety training. Any impairment should be investigated to identify relevant underlying health conditions that would be material to the existence of an elevated BMI and a health-related reason for rejection of the application.

4. In the absence of:
 - a) relevant functional impairment
 - b) the existence of relevant medical conditions
 - c) a significant past medical history that would throw doubt on the ability of the applicant to cope with demands of being a front-line officer

it is unlikely that the finding of an elevated BMI would be sufficient grounds for rejecting an application, on health grounds.

An updated version of the health questionnaire referred to in the College statement is part of this guidance document.

2.6.4. Hearing tests

A police officer needs to be able to hear well enough to communicate with fellow officers and the public, and to hear warnings. Front line police officers need to be able to hear and communicate using the Airwave radio, as well as being able to communicate with the public simultaneously. This requires sufficient binaural hearing to achieve this effectively. The functional requirements for hearing have not been formally determined, although an applicant must be able to hear well enough to pass safety training and to drive a police vehicle safely.

The occupational health questionnaire includes questions about the ability to hear. It should detect most applicants who have difficulty with hearing, although this is not fool proof as some applicants may not realise that their ability to hear differs from normal. Consequently, all applicants will have a hearing test, using pure tone audiometry when they attend for clinical biometric assessments.



Audiometric testing is performed in the occupational health service. The PULHHEEMS audiometric standards should no longer be used as a routine benchmark of suitable hearing. Any abnormality (hearing loss greater than 20 dB HL at any frequency) should be referred to NHS audiology departments for further assessment, via their GP. Determining the relevance of a detected hearing impairment will require a functional assessment of hearing. The threshold for referral will be an average hearing threshold level of 35 dB HL across the frequencies 500, 1000, 2000 and 4000 Hz. This level is based on the H2 hearing thresholds used in the 2004 guidance and has been chosen as a pragmatic cut off point balancing the hearing requirements of front line policing with the operational impact of delaying appointment decisions and the costs associated with a functional hearing test. This will be subject to clinical audit. All cases of detected hearing loss must be referred for a step 3 clinical assessment.

A speech-in-noise (SiN) audiometric test, which may simulate the impact of the hearing loss on the ability to carry out certain duties of an officer, has been developed by Amplivox in association with the Civil Nuclear Constabulary. However, this assessment was developed primarily for officers whose role requires the carrying of firearms. The Amplivox SiN test is an amended version of the British English CRM (Coordinate Response Measure) test developed by Semeraro and colleagues for use in the military.⁷¹ The test has been modified to ensure the speech stimuli and background noises represent the hearing critical tasks carried out by authorised

firearms officers in a specialised branch of the Police Force. It is reported that this test has good face validity. The safety critical tasks analysed include radio communications and communicating with colleagues and the public on foot and in a vehicle.

Applicants who have hearing aids, or who are recommended to wear hearing aids, will require assessment with respect to their ability to use the Airwave radio and to communicate effectively in role. Advice from an audiologist about the suitability of hearing aids, should be sought. In addition, the fitting of hearing aids should be checked. The practicalities of using hearing aids, whether worn behind the ear (BTE) or in the ear (ITE), should be considered. Some hearing aids are completely in the canal (CIC) or invisible in the canal (IIC). Bone anchored hearing aids (BAHA) and cochlear implants may also have been used to improve hearing. Suitability of hearing aids must be in the context of frontline response or patrol policing, as all police officer recruits will be expected to perform these roles, even if a direct entry detective applicant. National guidance on the wearing of hearing aids and the use of police radios is expected. Where an applicant that wears a hearing device is deemed suitable, occupational health clinicians should contact their force airwave and reasonable adjustment teams. This is to ensure equipment can be purchased, if required, to allow direct streaming of audio through their aids. Unfortunately, the Amplivox functional hearing test is not validated for use with hearing aids.

Guidance on the assessment of AFFD is provided in appendix 7.

71 Hannah D Semeraro et al, 'Development and evaluation of the British English coordinate response measure speech-in-noise test as an occupational hearing assessment tool' *Int J Audiology* 56, no 10 (2017): 749-758, doi: 10.1080/14992027.2017.1317370.



2.6.5. Urinalysis

This is usually done using a chemical strip that is put into a sample of freshly collected urine. It is easy and cheap to do. Positive findings (glycosuria, haematuria, or proteinuria) will usually require further information and may require investigation. It should be noted that population studies have found that there may be false positive and negative results in otherwise healthy young people.

For example, the sensitivity of a self-administered urine glucose test strip in a randomly selected population of adults was found to be 14%; the specificity was 99%.⁷² This means that the ability of a test strip to detect clinical cases is low, whereas a positive result is reliable. The sensitivity for the detection of haematuria is said to be over 80%, with a specificity between 65% and 99%. This is because the test strip can detect haemoglobin due to haemolytic conditions and myoglobin from crush injuries, rhabdomyolysis, or myositis.⁷³ Proteinuria on dipstick testing in primary care is frequently an incidental finding and is often benign and transient. Urine dipstick testing is a highly specific (97 – 100%) method for detecting proteinuria, however, the sensitivity of the test for detecting low-end, but clinically significant proteinuria is reported to be 32 – 46%.⁷⁴

In a study of a cohort of young adults attending a UK student health centre, 1% of 3570

samples (36) had persistent abnormalities: there were 14 cases of haematuria, 16 cases of proteinuria and 8 cases of haematuria and proteinuria. Students with either isolated haematuria or proteinuria did not have significant pathology; students with both haematuria and proteinuria had identifiable renal disease.⁷⁵ Thus, 8/3570 (0.22%) had clinically significant pathology. For the Police Uplift Programme, this would have been 44 applicants.

Urine test strip assessment is not considered to be a core requirement. Forces adopting a policy of routine urinalysis as part of the occupational health assessment should do so in the knowledge that the detection of a clinically relevant health conditions is small and carry out their own risk-benefit analysis. Its use is more appropriate for assessment of individual cases when combined with other clinical information. Either way, forces should audit the outcomes to inform future practice.

2.6.6. Spirometry

The routine use of spirometry is no longer recommended as part of the occupational assessment of response officers. The use of spirometry should be reserved for individual assessments to assist clinical decision making when assessing an applicant with respiratory symptoms.

72 Helen L Storey et al, 'Diagnostic accuracy of self-administered urine glucose test strips as a diabetes screening tool in a low resource setting in Cambodia', *BMJ Open* 8, no. 3 (2018): pp. e019924, doi: 10.1136/bmjopen-2017-019924

73 "Interpreting urine dipstick tests in adults: a reference guide for primary care", bpac.org.nz, 2013, Interpreting urine dipstick tests in adults - Best Tests Issue 19 (bpac.org.nz)

74 "Interpreting urine dipstick tests in adults: a reference guide for primary care", bpac.org.nz, 2013, Interpreting urine dipstick tests in adults - Best Tests Issue 19 (bpac.org.nz)

75 Peter S Topham et al, 'The value of urine screening in a young adult population', *Family Practice* 21, no. 1 (2004): pp. 18-21, doi: doi.org/10.1093/fampra/cmh105



Police forces that are assessing police officers for specialist roles, such as CBRN duties, may wish to include spirometry as part of the assessment of suitability to establish baseline levels as part of an ongoing health surveillance programme.

2.7. The Appointment Panel

The role of the Appointment Panel is very important. It will ensure that appointment decisions are based on a careful consideration of both clinical and organisational risk assessment and that the potential for the provision of reasonable workplace adjustments are always considered, where appropriate. Where workplace adjustments are deemed to be appropriate, the panel will ensure, via the Force's HR function, that this information is conveyed to the training department and to line managers.

Where the occupational health assessment of an applicant identifies concerns about the impact of a health condition or disability on the suitability of an applicant, the application should be referred to the panel. Guidance on the role of the panel and the procedure to be followed can be found in annex C.

2.8. Eligibility for full health benefits – Police Pensions Regulations 2015

The Police Pensions Regulations 2015.36(3) give the option to force pension scheme managers to refer an applicant to the Selected Medical Practitioner (SMP) for an assessment

and a report. This enables the scheme manager to make a decision about eligibility for full health benefits, based on the advice of the SMP about the relevance of underlying medical conditions with respect to early ill health retirement.

The Home Office has indicated that this will no longer be done.

2.9 Clinical audit

This guidance has been produced to assist the clinical governance of occupational health practice in the police. Clinical audit is an important component of the clinical governance process. NHS England defines clinical audit as a way to find out whether healthcare is being provided in line with standards and lets care providers and patients know where their services are doing well and where there could be improvements. In the NHS, there are more than 30 national audits of healthcare relating to the most commonly occurring conditions. There is a National Quality Improvement Network N-QI-CAN which is a professional network of clinicians undertaking clinical audit and other quality improvement work in England. With the launch of this guidance there is an opportunity to plan to create a clinical audit structure that will stimulate and support clinical audit in police occupational health.



Conclusion

The occupational health assessment of applicants to become police officers is carried out within a statutory framework. The first objective is compliance with health and safety duties. Compliance with the Equality Act 2010 and the Data Protection Act 2018 requires that the purpose of the assessment is explicit and transparent and that it occurs at the appropriate point of the recruitment process. Discrimination in the appointment of applicants based on disability, following an appropriate occupational health assessment and consideration of the need for reasonable workplace adjustments, is lawful. It is a proportionate means to achieve a legitimate goal, that is ensuring that individuals recruited to be police officers are fit to perform their role and they do not have health problems that adversely impact their functional performance which would pose health and safety risks to them, their colleagues or the public being served.

The health standards against which police officer applicants will be assessed are based on the ordinary duties of a constable and the CVF. Surrogate measures of assessment have been taken from the curriculum for the Public and Personal Training Programme. Criterion tasks have been identified that are used to determine the physical functional capability of applicants and the relevance of any underlying health conditions on their fitness to begin training as a police officer. It is also recognised that front-line police roles may place officers in dangerous or high-risk situations or that they may be required to act in challenging situations to safeguard the public. The relevance of a health condition in such situations and the likelihood of sudden incapacitation will be assessed. Pragmatically, reference to the DVLA medical standards for driving will be used to assist such assessments.

The third element of the occupational health risk assessment framework is the ability to render regular and efficient service. This will be an individual bio-psycho-social assessment linked to an agreed timeframe of service: the national reference period will be five years.

The occupational health assessment process will identify those applicants requiring further enquiries and assessment of their health and will fast-track the remainder for final sign off as fit to be a front-line police officer. Applicants whose health status needs further assessment will be matched with appropriate occupational health practitioners according to complexity and/or risk assessment. The starting point of the health assessment will be the deployment of a national health questionnaire.

To comply with the Equality Act 2010, the occupational health assessment should take place after a provisional job offer has been made. The responsibility for making a final job offer to an applicant rests with the recruiting police force. This will be based on advice from their occupational health service as well as other factors, such as the outcome of the vetting process. It is recommended that police forces establish an appointment panel to assess complex cases. The approach to the recruitment of applicants with a disability or with neurodiversity needs should be part of forces' diversity and inclusion strategies. Awareness of these strategies and an understanding of the operational implications for effective implementation should be a priority.



Appendices



Appendix 1: Functional requirements of scenarios

Fight in the street

Approach to scenario	Murphy moment	Solution	Breakout drill	Functional requirements
What do you see?	Haymaker attack	Upper arm control	Upper arm control	Sensory: vision, hearing, speech
Threat appraisal			Takedowns	Cognitive: memory, executive functioning
Plan			Ground pins and prone handcuffing	Neurological: full motor and sensory functioning, balance, strength hand-eye coordination
		Ambush defence	SPEAR	Musculo-skeletal: Full range of movement of upper limbs, good grip, manual dexterity, functioning spine and lower limbs.
			Baton strikes	Psychiatric: absence of anxiety or PTSD linked to assaults.
			PAVA development	Other: good cardiorespiratory fitness, good stamina, absence of abdominal pathology / conditions.

Domestic

Approach to scenario	Murphy moment	Solution	Breakout drill	Functional requirements
What do you see?	Introduction of knife	Reaction	C.U.T. principles	Sensory: vision, hearing, speech
Threat appraisal		C.U.T. principles		Cognitive: memory, executive functioning
Plan				Neurological: full motor and sensory functioning, balance, strength hand-eye coordination
				Musculo-skeletal: Full range of movement of upper limbs, good grip, manual dexterity, functioning spine and lower limbs.
				Psychiatric: absence of anxiety or PTSD linked to assaults, knife attacks.
				Other: good cardiorespiratory fitness, good stamina.



Stop and search

Approach to scenario	Murphy moment	Solution	Breakout drill	Functional requirements
What do you see?	Passive resistance - refusal to release hands	Handcuff pain compliance	C.U.T. principles	Sensory: vision, hearing, speech, smell
Threat appraisal		Bottom cuff application	swallowing drugs	Cognitive: memory, executive functioning
Plan		Mechanical leverage	Haymaker attack	Neurological: full motor and sensory functioning, balance, strength
	Attempt to swallow drugs	UDT resistant		Musculo-skeletal: Full range of movement of upper limbs, good grip, manual dexterity, functioning spine and lower limbs.
	Haymaker attack	Flinch converted into side takedown		Psychiatric: absence of anxiety or PTSD linked to assaults, knife attacks.
				Other: good cardiorespiratory fitness, good stamina.

Vulnerable person

Approach to scenario	Murphy moment	Solution	Breakout drill	Functional requirements
What do you see?	Ambush attack	Communication models	BUGEE principles	Sensory: vision, hearing, speech
Threat appraisal		Ambush defence	Takedowns	Cognitive: memory, executive functioning
Plan			Convert flinch defence into side ground guard position	Neurological: full motor and sensory functioning, balance, strength
	Trip hazard	Grounded officer defence	Bridge and roll technique	Musculo-skeletal: Full range of movement of upper limbs, good grip, manual dexterity, functioning spine and lower limbs.
			Rear handcuffing	Psychiatric: absence of anxiety or PTSD linked to assaults, knife attacks.
			Safe escort	Other: good cardiorespiratory fitness, good stamina, absence of abdominal pathology / conditions.

Custody

Approach to scenario	Murphy moment	Solution	Breakout drill	Functional requirements
What do you see?	Assaults	Ambush defence	Handcuffing	Sensory: vision, hearing, speech
Threat appraisal			Limb restraints	Cognitive: memory, executive functioning
			Convert flinch defence into side ground guard position	Neurological: full motor and sensory functioning, balance, strength hand-eye coordination
	Medical emergency	CPR and use of AED, positional asphyxia	Use of WIN acronym	Musculo-skeletal: Full range of movement of upper limbs, good grip, manual dexterity, functioning spine and lower limbs.
				Psychiatric: absence of anxiety or PTSD linked to assaults, knife attacks
				Other: good cardiorespiratory fitness, good stamina



Appendix 2: Criterion tasks

- **Flinch reactions and self-protection**
- **Limb control**
- **Takedowns**
- **Rear handcuffing**
- **Grounded officer defence / Bridge and roll**
- **First aid**
 - Cardio-pulmonary resuscitation
 - Life-saving manoeuvres
- **Communication criteria**
 - Receiving information from airwave radio
 - Effective communication within team / with public
 - Issuing commands / taking control
- **Cognition / taking control**
 - Threat / risk appraisal and planning
 - Recall of legislative powers and ability to apply to specific scenarios



Appendix 3: Pre-placement health questionnaire

Confidential occupational health questionnaire

OFFICIAL SENSITIVE TO THE OCCUPATIONAL HEALTH DEPARTMENT (WHEN COMPLETED)

Introduction

This questionnaire is a health assessment to determine that you can give regular and effective service as a police officer. To do this, we ask you to provide details of your health. Only occupational health staff will see this questionnaire.

The questions are chosen to establish that you do not have any health conditions that will, or might, prevent you from carrying out the ordinary duties of a constable. Do not be concerned if you find yourself answering “yes”, or “no” to certain questions that might suggest that you have a problem. This does not necessarily mean that you are unfit for the job. We will contact you if we need further details and, if necessary, ask for a report from your GP or treating specialist.

The health of each candidate is considered individually and no decision to reject a candidate is made without referral to a medical advisor. Anything you disclose on this form will be treated in the strictest medical confidence and will not be shared with the recruitment or training team.

You may be contacted by an occupational health specialist, or invited to attend, or take part in, a medical assessment, in line with force policy.

Please note that you will be required to sign a declaration at the end of this form. It is important that your answers are accurate, honest, and truthful, and you do not withhold any information (see declaration).

We are an inclusive organisation and recruit on the basis of ability, not perceived disability. Any information given in your medical history about any disability will assist us in assessing whether recommendations for adjustments can be made, if appropriate, to the role you have applied for.



Role applied for: Police Officer (new-recruit) / Special Constable / Direct Entry / Re - Join Officer (Delete as applicable)	
Section 1 – Your details	
Surname:	Forename:
Date fo birth	Gender at birth: Male / Female
	How do you identify: Male / female / non-binary / prefer not to say / other (Delete as appropriate)
Full postal address including postcode:	
Telephone:	Email address:
Section 2 – GP’s details	
Name:	Telephone:
Full postal address including postcode:	



Instructions on completing this questionnaire

Please answer ALL the following questions. If you have difficulty carrying out some of your normal daily activities, or have ANY underlying health conditions, you will need to give details in Section 5, linking the additional information to the question number.

The Equality Act defines a disability as ‘a physical or mental impairment which has a substantial and long-term adverse effect on [a person’s] ability to carry out normal day-to-day activities.’ Substantial means more than minor, e.g., it takes longer to do something, such as getting dressed. You may or may not be on treatment. In this context, long-term means 12 months or more and may be physical or a psychological health problem. Disability in this context also refers to neurodiverse conditions such as dyslexia and autism.

Do you consider you have a disability which may affect your ability to undertake the role of police constable, or which may require special adjustments?

If yes, what facilities / adjustments / equipment do you consider might enable you to perform the role of police officer?

Section 3 – Assessing functional ability					
You are asked to indicate whether you believe that you can carry out the following activities without any restriction or difficulty:					
1	Walk briskly (4 mph) on the flat for 12 minutes (without stopping).	Y		N	
2	Run, at jogging speed, on the flat for five minutes (without stopping).	Y		N	
3	Run 100 metres in 20 seconds on the flat.	Y		N	
4	Sit for 60 minutes without discomfort.	Y		N	
5	Stand for 60 minutes without discomfort.	Y		N	
6	Read (with glasses or contact lenses, if necessary) a car number plate (manufactured after 1 September 2001) from 20 metres.	Y		N	
7	See with a full field of vision in both eyes.	Y		N	
8	Read printed text in a book or magazine and read text on a computer monitor without difficulty (with glasses or contact lenses, if necessary).	Y		N	



9	When it is dark: I have no difficulty finding my way in a familiar environment. I have no difficulty noticing traffic at road junctions.	Y		N	
10	Do not experience problems going from light to dark.	Y		N	
11	Understanding normal conversation (without a hearing aid). a. With one person in quiet b. With one person in noise, such as a crowded street c. On the telephone	Y Y Y Y		N N N N	
12	Hearing the TV when set at a normal level	Y		N	
13	Hear equally well in both ears when wearing headphones.	Y		N	
14	Lift a two-year-old toddler, or 12kg medicine ball, from the floor and place them on your shoulders.	Y		N	
15	Walk a mile carrying a 10kg rucksack.	Y		N	
16	If lying down, get up off the floor quickly.	Y		N	
17	Stretch out your arms in front of you.	Y		N	
18	Clasp your hands behind your back.	Y		N	
19	Unscrew a tight-fitting jar lid.	Y		N	
20	Use a desktop PC, tablet, and mobile phone.	Y		N	
21	Write with a pen or pencil.	Y		N	
Are your daily activities (e.g. washing, dressing, working) affected by any of the following:					
22	Dizziness, giddiness, or problems with balance.				
23	A lack of energy or tiredness.				
24	An inability to give or understand instructions.				



25	Poor memory.	Y		N	
26	Inability to concentrate.	Y		N	
27	Broken or unrefreshing sleep.	Y		N	
28	Feeling down, depressed, or hopeless.	Y		N	
29	Loss of interest, or enjoyment of life.	Y		N	
30	Feeling anxious or scared about any aspect of life.	Y		N	

Section 4 – Assessing medical fitness

31	Do you have, or have you had, any medical condition that has been diagnosed by a medically qualified practitioner?	Y		N	
32	Are you currently taking any prescribed medication? (You do not need to tell us about medicines like cough and cold remedies, vitamins or hay fever tablets for example, unless they are prescribed)	Y		N	
33	Have you ever experienced fainting, seizures or blackouts or been told you have epilepsy, heart problems, an abnormal heart rhythm (arrhythmia) or diabetes?	Y		N	
34	Have you noticed ANY changes in your general physical and / or psychological health which give you cause for concern?	Y		N	
35	Are you visiting your GP regularly / have you visited your GP recently (in the last 12 months)?	Y		N	
36	Do you have symptoms or a health complaint that is being investigated?	Y		N	
37	Have you ever had problems with any of your joints, back or neck, including hypermobility? (double-jointed)	Y		N	
38	Have you ever consulted an orthopaedic surgeon, rheumatologist, chiropractor, osteopath, or physiotherapist?	Y		N	
39	Have you had any operations or surgical procedures in the last 5 years?	Y		N	

40	Have you ever been told by a doctor, therapist, counsellor, or mental health nurse that you suffer, or have suffered from, anxiety, depression, bipolar illness, schizophrenia or personality disorder, or any other mental health condition?	Y		N	
41	Have you ever been diagnosed, by a medical doctor or psychiatrist, with post-traumatic stress disorder (PTSD)?	Y		N	
42	Have you ever been told that you have an eating disorder?	Y		N	
43	Have you ever self-harmed or attempted to take your own life?	Y		N	
44	Have you used 'recreational' drugs, misused prescription drugs or taken any other 'controlled' drugs?	Y		N	
45	Have you ever sought support for an addictive behaviour such as drinking too much or gambling excessively?	Y		N	
46	Are you seeing, or under the care of, any NHS or private specialist for any sort of health condition or treatment, for example osteopath, nurse specialist, private physiotherapist, private counsellor, rehabilitation therapy?	Y		N	
If you are functionally restricted or have ANY underlying health conditions, you will need to give details in Section 5 (see below), linking the additional information to the question number.					



Section 5 – Details of any restrictions and/or medical conditions

If you answered Yes to any of the questions above, please provide additional information in this section.

Include date(s)* of illness/conditions, frequency, duration, what treatment was given and by whom (e.g., hospital/GP), whether you are still undergoing treatment or continue to be affected and length of absence from work/school (if appropriate). Continue on a separate sheet if required.

Question number	Details *Approximate dates are acceptable. E.g., November 2021, or spring 2014



Section 6: Height and weight	
Please state your height and weight	
Height (metres)	Weight (kgs)

Section 7: Alcohol history
How much alcohol on average do you consume over a seven-day period? Units per week (1 unit = 1/2-pint beer (lower strength ABV 3.6%) = 1 glass of wine (80ml of average strength – 12%) = 1 measure of spirits) Answer: units per week

Section 8 – Sickness absence		
Please list how many days you have been absent from work, school, college etc. in the last three years due to sickness. For each absence, please also indicate the dates and the reason.		
Number of days absent	Dates of absence (mm/yy)	Reason (please state if related to a disability)



Section 9 – Declaration

The information I have provided is accurate and I have not withheld any details. I understand that deliberately giving false information, or deliberately withholding information, is likely to be considered an integrity issue which will be reported to the vetting / professional standards department (As appropriate). This could subsequently result in my application for vetting clearance being declined, current vetting clearance being withdrawn or dismissal.

I give permission for the Force’s Appointment Panel and the vetting / professional standards department to be notified about apparent misinformation or missing information.

I will notify you immediately if any of my answers change on my completed form.

I consent to this data being held by an Occupational Health Unit of a police force on a computer or manual filing system, in accordance with the confidentiality requirements of the General Data Protection Regulation. (EU)

Unsuccessful candidate’s questionnaires will only be held for a maximum of 2 years then destroyed.

Signature of applicant

Date

Section 10 - Additional medical information

Depending on the answers you have provided above, it may be necessary for occupational health to contact your general practitioner or treating specialist for additional information to help further assess your fitness for the post you have applied for. If you are happy for one of the OH clinical team to contact your GP or other specialist, please complete the section below.

I do / do not give permission to my General Practitioner, or treating specialist, to disclose relevant information to the Occupational Health Department in accordance with the Access to Medical Reports Act 1988. I do/do not wish to see my General Practitioner’s comments before the form is returned to the Occupational Health Department.

Signature of applicant

Name of applicant

Date



Occupational health use only

NOTE ABOUT THE OPTIONAL GP SECTION				
General Practitioner's comments Please note that a medical examination is not required.				
Are you in possession of this patient's complete medical history? If no, or you hold part of their medical history please state how long? On record we have <input type="text"/> years' worth of medical history	Y		N	
From the medical records available, is there any medical reason why your patient should not undertake strenuous physical exercise?	Y		N	
According to these records and your knowledge of the applicant, do the answers given by him/her in the questionnaire appear correct?	Y		N	
Are you aware of any other medical information which might be relevant to this application?	Y		N	
If so, please give details.				
General Practitioner's signature	Practice stamp*			
Date				
Please note: any fee required for the completion of this form will be paid by the applicant. A medical examination is not required. *Questionnaires not stamped by the practice may not be accepted. If no stamp is available an electronic version can be sent directly from the practice email address to the OH department.				

OH assessment outcome		
Fit / unfit / further assessment required	Name	Date



Appendix 4: Assessment of joint hypermobility using the Beighton criteria

The Beighton criteria for joint hypermobility.

1. **Passive dorsiflexion of the little fingers beyond 90°** (one point for each hand)—two points
2. **Passive apposition of the thumbs to the flexor aspects of the forearm** (one point for each thumb)—two points
3. **Hyperextension of the elbows beyond 10°** (one point for each elbow)—two points
4. **Hyperextension of the knee beyond 10°** (one point for each knee)—two points
5. **Forward flexion of the trunk with knees fully extended so that the palms of the hands rest flat on the floor**—one point

A score of 5 or more is indicative of hypermobility and further clinical assessment.

See also annex A.



Appendix 5: Standard procedure for assessing police officer eyesight standards/vision screening.

<p>Occupational Health Clinical Procedures: Standard operating protocol/ procedure/task instruction</p>		
<p>Title: Vision screening purpose:</p> <ol style="list-style-type: none"> 1. To ensure consistency of screening methods and accuracy of results and information given 2. The results of these measurements support clinical decision making. 		
Responsibility	Action	Measure
<p>Occupational Health Nurse (OHNA)</p> <p>Clinic Nurse (RN)</p> <p>Occupational Health Technician (OHT) under supervision of OH Nurse</p>	<p>Equipment:</p> <p>Equipment used for vision screening should be able to test</p> <ul style="list-style-type: none"> • Visual acuity • Visual fields • Colour perception <p>This may be achieved by a single multipurpose device or by using:</p> <ul style="list-style-type: none"> • Snellen chart for visual acuity • Confrontation test for visual fields • Ishihara 38 Plate, City University (3rd edition) • Low contrast acuity testing chart 	<p>Manufacturer guidelines and user information</p>



Responsibility	Action	Measure
<p>Occupational Health Nurse (OHNA)</p> <p>Clinic Nurse (RN)</p>	<p>Quality control:</p> <p>All electrical multipurpose devices should be serviced and calibrated as per the manufacturer’s instructions and or manually with a record.</p>	<p>Calibration record</p>
<p>Occupational Health Technician (OHT) under supervision of OH Nurse</p>	<p>Equipment maintenance:</p> <p>All testing equipment will be visually checked daily, including leads, connections if appropriate.</p> <p>Equipment will be surface cleaned daily with appropriate anti - bacterial cleaning wipes and in between users as appropriate.</p>	<p>Equipment Log Sheet</p>
	<p>Testing procedures</p> <p>All staff undertaking vision screening should undertake training either internal or external before undertaking screening and ensure annual refresher training is maintained.</p> <p>It is essential that personnel undertaking testing are aware of all current guidance and information.</p> <p>Preparation for testing</p> <ul style="list-style-type: none"> • Explain the procedure and obtain verbal consent. • Obtain a brief history • Provide a relaxed environment • Good lighting if using Snellen and colour perception tests 	<p>Training record for staff undertaking procedure</p>
	<p>Undertaking Visual Acuity testing:</p> <p>Snellen testing</p> <p>The chart should be appropriately sited, wall mounted and illuminated.</p>	<p>Audit of clinical notes/records</p>



Responsibility	Action	Measure
<p>Occupational Health Nurse (OHNA)</p> <p>Clinic Nurse (RN)</p> <p>Occupational Health Technician (OHT) under supervision of OH Nurse</p>	<p>Health surveillance/assessment procedures</p> <p>The testing point should be 6 metres from the chart and clearly marked on the floor.</p> <p>Ask the individual to cover one eye with the palm of their hand, so that they do not inadvertently peep through their fingers, (instructing them not to press too hard) and ask them to read each line as far as they can comfortably without squinting or leaning forward to be closer to the chart starting at 6/7.5.</p> <p>Record findings using the lowest line read as a fraction: e.g., 6/6.</p> <p>If the individual misses any letters on a line, it should be recorded.</p> <p>Repeat process with the other eye and then binocularly.</p> <p>Allow a few seconds for the individual to re-focus between each part of the test.</p>	<p>Audit of records/ notes</p>
	<p>Visual field testing Confrontation visual field:</p> <p>The term “confrontation” in this test just means that the person giving the test sits facing the person having the test, about 1 meter away.</p> <p>The tester holds their arms straight out to the sides. The individual looks straight ahead,</p> <p>The tester moves one hand and then the other inward toward the individual.</p> <p>The individual gives a signal as soon as they see the tester's hand.</p> <p>The confrontation visual field test measures only the outer edge of the visual field. This method is not exact, therefore alternative methods may need to be considered.</p>	<p>Audit of records/ notes</p>



Responsibility	Action	Measure
<p>Occupational Health Nurse (OHNA)</p> <p>Clinic Nurse (RN)</p>	<p>Contrast testing</p> <p>Conduct testing using a chart such as Logarithmic Low Contrast Acuity Chart calibrated for testing at 40cm (16")</p> <p>Refer to testing instructions in respective product documentation and as per stipulated in Regulation 10 Annex A below.</p>	<p>Audit of records/ notes</p>
<p>Occupational Health Technician (OHT) under supervision of OH Nurse</p>	<p>Colour perception testing:</p> <p>Refer to detail instructions in respective test documentation.</p> <p>Ishihara 38 Plate Book – using plates 1- 21 Pass =17+ no further action</p> <p>Below 16 conduct City University test Fail=3 errors in pages 5-10</p>	<p>Audit of records/ notes</p>
	<p>Contrast testing</p> <p>Conduct testing using a chart such as Logarithmic Low Contrast Acuity Chart calibrated for testing at 40cm (16")</p> <p>Refer to testing instructions in respective product documentation and as per stipulated in Regulation 10 Annex A below.</p>	<p>Audit of records/ notes</p>
	<p>Multipurpose Vision screening device</p> <p>Conduct testing as per manufacturer’s instructions</p> <p>Referral criteria: See standards below.</p> <p>Document appropriate records the result and recommendations given.</p>	



Notes, references, and further reading

Regulation 10 (Annex A) September 2019 Eyesight standards, police recruitment

The standard of eyesight which must be met by a candidate for appointment to a police force in respect of each of the matters specified in the first column of the following table is that specified in the second column of the table.

Eyesight	Mandatory requirement
Static Visual Acuity [footnote 1]	Corrected distance visual acuity must be 6/12 in either eye and 6/6 or better, binocularly. Corrected near static visual acuity must be 6/9 or better, binocularly. (Applicants who do not reach the standard should not be rejected but should be invited for a further test after obtaining a stronger prescription]). Corrected low contrast distance visual acuity must be 6/12 or better for a 10% contrast target, binocularly.
Visual Field [footnote 2]	A field-of-view of at least 120 degrees horizontally by 100 degrees vertically is required. The field-of-view should be free of any large defective areas, particularly in the fovea. Single defects smaller than the physiological blind spot, and multiple defects that add to an area smaller than the physiological blind spot, should be acceptable.
Colour Vision [footnote 3]	Monochromats should be rejected. Mild anomalous trichromats are acceptable and should be treated as normal. Severe anomalous trichromats and dichromats are also acceptable and should be instructed in coping strategies. (Applicants who show a lowered discrimination for blue colours should be referred to an ophthalmologist for further assessment. This should include a measure of their dark adaptation performance).
Spectacles and contact lenses	Correction should be worn where necessary to achieve 6/6 binocularly. Corrective spectacles and contact lenses are acceptable for the tasks of an Operational Police Constable.

1. Acuity should be measured using a Snellen eye chart, or equivalent □
2. The field of view may be tested using a confrontation test. However, it is recommended that forces use more sophisticated testing equipment, where possible. If the results of the confrontation test suggest that there is a reduced visual field, or if the results of the medical questionnaire suggest an increased risk of reduced visual field, applicants should be referred to an ophthalmologist for a thorough examination of their visual field. □
3. Applicants should not wear 'colour correcting' lenses during the colour vision test. □

Minimum eyesight standards (all drivers) and higher standard of visual acuity – bus and lorry drivers. (DVLA. Assessing fitness to drive – a guide for medical professionals. February 2024. < Assessing fitness to drive – a guide for medical professionals (publishing.service.gov.uk)>

Appendix 6: Measurement of blood pressure

<p>Occupational Health-Clinical Procedures: Standard operating protocol/ procedure/task instruction</p>		
<p>Title: Measuring blood pressure purpose:</p> <ol style="list-style-type: none"> 1. To ensure consistency of screening methods and accuracy of results and information given. 2. The results of these measurements support clinical decision making. 		
Responsibility	Action	Measure
<p>Occupational Health Nurse (OHNA)</p> <p>Clinic Nurse (RN)</p> <p>Occupational Health Technician (OHT) under supervision of OH Nurse</p>	<p>Equipment:</p> <p>Equipment for measuring blood pressure will be a <u>clinically validated</u> digital automatic monitor with an upper arm cuff or manual anaerobic manometer if alternative equipment is required. Mercury sphygmomanometers have generally been phased out.</p> <p>All staff undertaking blood pressure measurement should be proficient in automatic and manual methods of blood pressure measuring.</p>	<p>Manufacturer guidelines and user information</p> <p>Training records</p>
	<p>Quality control:</p> <p>All equipment used for blood pressure measurement must be maintained in good working order by weekly checks and annual calibration or as indicated by manufacturers.</p>	<p>Calibration record</p>
	<p>Equipment maintenance:</p> <p>All blood pressure measuring equipment will be visually checked daily, including any leads and connections.</p> <p>Equipment will be surface cleaned daily with appropriate anti - bacterial cleaning wipes and in between users as appropriate.</p>	<p>Equipment Log Sheet</p>



Responsibility	Action	Measure
Occupational Health Nurse (OHNA) Clinic Nurse (RN)	<p>Testing procedures</p> <p>All equipment to be used during the procedure shall be prepared in accordance with quality control instructions and testing conducted in line with this SOP.</p>	<p>Training record for staff undertaking procedure</p>
Occupational Health Technician (OHT) under supervision of OH Nurse	<p>Preparation for testing – Automatic Digital Monitor:</p> <ul style="list-style-type: none"> • Explain the procedure and obtain verbal consent • Obtain a brief medical history • Provide a relaxed environment with the person quiet and seated without crossed legs, and arm outstretched and supported • Allow the person to rest quietly and comfortably for 5 minutes with their arm resting on a firm surface level with the heart • Ensure that the arm is supported and free from any restrictive clothing 	<p>Audit of clinical records/notes</p>
	<p>Undertaking the testing:</p> <ul style="list-style-type: none"> • Locate/palpate the brachial artery • Select the appropriately sized cuff for the individual’s arm • Ensure that the cuff is fully deflated with no kinks in the tubing and the tubing is securely fixed to the measuring device before commencing • Position the cuff on the bare left arm with the centre of the indicator mark over the brachial artery • The indicator of the cuff should encircle at least 80% of the arm but not more than 100% • Ensure there is enough space between the cuff and the elbow – about 2 cm • Advise no talking or moving • Take two readings about 2 minutes apart • Average the readings and record • Express readings as systolic/diastolic • Give health advise to individuals with consistent readings above 130/85 mm/Hg 	<p>Audit of records/notes</p>



Responsibility	Action	Measure
Occupational Health Nurse (OHNA) Clinic Nurse (RN) Occupational Health Technician (OHT) under supervision of OH Nurse	<p>Referral criteria:</p> <p>Refer to individual's own general practitioner (GP) if blood pressure/pulse is outside the criteria below on three occasions for further assessment and advice.</p> <ul style="list-style-type: none"> • At or above 140/90 mmHg • Pulse - Over 100 beats per minute (bpm) or irregular 	Audit of records/notes

Notes, references, and further reading cuff sizes guide:

Upper arm circumference	Cuff size
<23cm	Small adult/child
>23cm and < 33cm	Standard/regular
>33cm and <50cm	Large adult cuff

Nice Guideline (NG136) updated March 2022

American Heart Association, Monitoring Blood Pressure, reviewed March 2023

Blood Pressure UK, a guide to automatic blood pressure monitors <www.bloodpressureuk.org>

British and Irish Hypertension Society, information about blood pressure monitors <bihs@in-conference.org.uk>



Appendix 7: Assessment of auditory fitness for duty (AFFD)

This guidance on the assessment of AFFD is concerned with carrying out a suitable and sufficient risk assessment of applicants who have hearing loss. It will inform the occupational health advice presented to the force recruitment panel.

Pure tone audiometry is one of the tests of the tests of hearing. A recommended procedure for pure tone air conduction threshold audiometry has been produced by the British Society of Audiology (BSA).⁷⁶ Some level of variability in thresholds across the population is expected, and hearing thresholds up to 20 dB Hearing Level are considered normal. The BSA advise that the hearing threshold levels of an individual ear are often described in general terms rather than in terms of the actual numbers at different frequencies on a pure tone audiogram. Four audiometric descriptors are used with reference to bands of average hearing impairment:

Descriptor	Average hearing threshold levels (dB HL)
Mild hearing loss	21 - 40
Moderate hearing loss	41 - 70
Severe hearing loss	71 - 95
Profound hearing loss	In excess of 95

The descriptors are based on the average of the pure tone a – c (air conduction) hearing threshold levels at 250, 500, 1000, 2000, and 4000 Hz. (In determining the five-frequency average value of hearing loss, if at any frequency no response is obtained due to the severity of the loss, this reading shall be given a value of 130 dB HL.)

The BSA advise that the ability to detect pure tones using earphones in a quiet environment is not in itself a reliable indicator of hearing disability and audiometric descriptors alone shall not be used as the measure of difficulty experienced with communication in background noise, the primary complaint of individuals with hearing loss. A functional hearing test should be used to assess the impact of detected hearing loss on police operational capability and AFFD. AFFD has been defined as the possession of hearing abilities sufficient for safe and effective job performance.⁷⁷ It is a qualitative, rather than a quantitative, term. Currently, the only available functional hearing test is produced by Amplivox.

⁷⁶ 'Recommended Procedure. Pure-tone air-conduction and bone-conduction threshold audiometry with and without masking' (British Society of Audiology, August 2018) pp. 39 <Front page (thebsa.org.uk)>

⁷⁷ Jennifer B Tufts et al, 'Auditory fitness for duty: a review', J Am Acad Audiol 20, no. 9 (2009): 539-57, doi: 10.3766/jaaa.20.9.3.



Speech in Noise (SiN) (functional hearing) assessment

The 'SiN' assessment should be carried out using the single ear method, rather than the interleaved method. (In the single ear test all the sounds are played to one ear at a time, whereas in the interleaved approach, the sounds fluctuate between the ear in which they are played test) This assists an assessment of whether individuals can hear sufficiently to discharge their duties safely.

There are two tests making up the SiN assessment, which are both implemented on all occasions standard industrial background and speech babble in the background. The SiN assessment should be carried out by a suitably trained person using calibrated equipment specifically designed and validated for this purpose.

The pass mark for the SiN assessment has been defined as $< / = -22\text{dB SNR}$. However, it must be noted that the results of the SiN alone are not enough to demonstrate AFFD and the results must be considered alongside all other available information regarding the individual case. If the SiN pass mark is not reached on the first test, individuals should be given the opportunity to carry out a second test, within a short period of time.

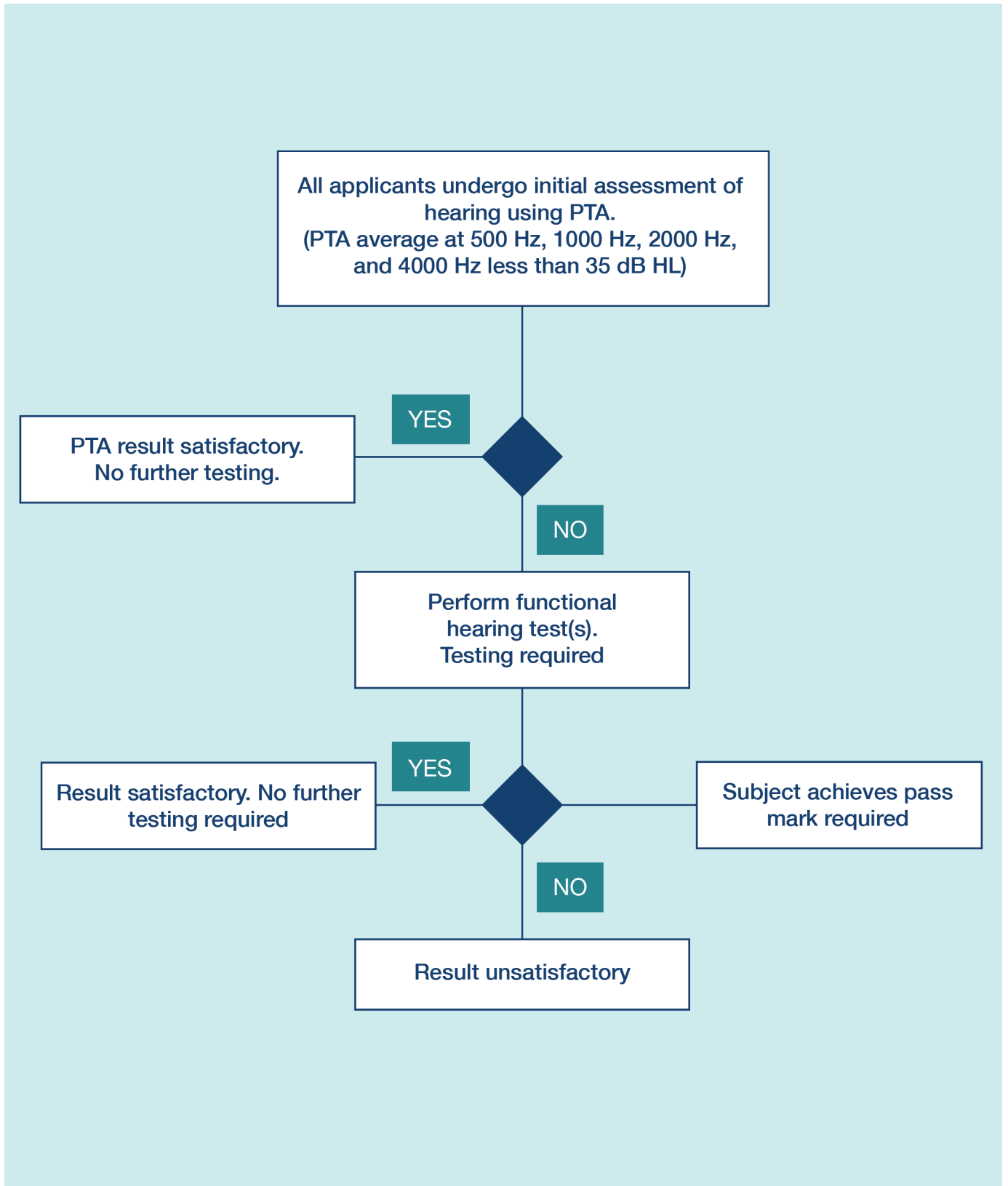
It is important to note that the SiN test has been shown to be able to differentiate between different hearing ability levels in complex listening environments. It does not consider the use of assistive listening devices or ear protection. It is also important to consider that, whilst testing is for each ear singularly, people hear in a binaural manner and therefore this should be taken into consideration when considering AFFD.

Cases of applicant hearing loss should be referred to the Force Appointments Panel. Passing the SiN assessment does, not in itself, provide assurance that the individual will be able to carry out their safety critical post. The SiN assessment should not be used as an employment 'standard'. All available information should be considered by a Force in reaching a decision, supported by appropriate expert medical advice from the FMA. The appointment decision should be based on both the clinical assessment of the hearing loss and any associated medical condition, and an occupational assessment of the impact of the hearing loss using the three risk areas:

- Assessment against the functional requirements of the scenario-based personal safety training curriculum
- Assessment of the risk of sudden incapacitation / fitness for "blue light driving"
- Assessment of the likelihood of providing regular and efficient service

AFFD should include assessment of using hearing aids to compensate for hearing loss. This may require empirical real world assessment as there is currently no validated functional hearing test for people wearing hearing aids. The recruitment panel must be satisfied that wearing hearing aids enable a front line police officer to function effectively and safely and should consider any harm (the product of threat and likelihood) that might arise in the event of a malfunction or a displacement of the aid.





Assessment of AFFD



Appendix 8: Examples of reasonable workplace adjustments for applicants for the role of a police officer

A workplace adjustments toolkit has been developed by the College of Policing.⁷⁸

The resources in the toolkit include:

- guidance about forces' legal workplace adjustments duties, good practice for workplace adjustment passports, and process maps for achieving Disability Confident scheme levels 2 and 3
- case studies from forces
- links to other helpful resources and organisations

Three areas affected by the duty to make reasonable adjustments are:

- Provision, criteria, or practice (PCP)
- Physical features
- Auxiliary services or aids

When considering a duty relating to a PCP, a workplace policy or a course entry requirement might be relevant. Physical features might include thinking about how someone with a disability is able to move around a building. Providing equipment, services or support might involve assessing the need to wear hearing aids and for the provision of hearing loops in police stations. Other examples might include provision of adapted equipment (chairs, computer software or phones) or providing e-mails and documents in an accessible format.

A case study about a police officer who is dyslexic may be accessed via College Learn. Salient features of this case study are:

1. A history of struggling with paperwork and taking statements
2. Failing the sergeants' exam
3. Slow at reading and getting words mixed up
4. Mixing up left and right

⁷⁸ 'Workplace adjustments resources support diversity in policing' (College of Policing, 2022) <Workplace adjustments resources support diversity in policing | College of Policing>



5. A dyslexia assessment
6. Use of Access to Work to implement workplace adjustments
7. Lack of organisational awareness of the issues relating to dyslexia and delays in implementing adjustments
8. Career has gone from strength to strength since the assessment and implementation of reasonable workplace adjustments

“Adjustments allowed me to work to my strengths and helped to remove barriers to my success. Feeling listened to, valued, supported and understood also had a massive impact on my confidence. Dyslexic officers and staff have made – and will continue to make – an invaluable contribution to policing. This is something that should be celebrated, due to our out-of-the-box thinking and our natural attention to detail. It’s important to have an inclusive work environment and effective policies that allow dyslexic officers and staff to make this contribution and to unlock their potential.

The Advisory, Conciliation and Arbitration Service (ACAS) provides generic guidance about reasonable adjustments.⁷⁹

Making changes to the workplace.

For example:

- changing the lighting above someone’s desk or workstation
- changing the layout of a work area or the entrance to a building
- providing an accessible car parking space

Changing someone’s working arrangements.

For example:

- changing someone’s working patterns
- distributing someone’s breaks more evenly across the day
- flexible working
- working from home or hybrid working
- reasonable adjustments for absence – including time off for medical appointments and treatment
- a phased return to work after absence

Finding a different way to do something.

For example:

- distributing work differently within a team
- giving someone different responsibilities or offering another suitable role
- giving someone more time to do written or reading tests that are part of an interview
- finding a different way to train someone if they find classroom-based training difficult

⁷⁹ ‘Reasonable adjustments at work. What reasonable adjustments are’ (ACAS, 1 November 2022) <What reasonable adjustments are: Reasonable adjustments at work - Acas>



Appendix 9: Background information about neurodiversity

In assessing neurodiverse applicants, it is likely that most will be high functioning with respect to being able to progress with education and secure employment. They will have successfully negotiated the police assessment process, although this is not a guarantee of absence of relevant impairment. In such cases, the focus will be on any cognitive or behavioural aspects relevant to the functions of a front-line police officer. (See appendix 1 and 2) In cases of dyslexia, the focus will be on:

- reading and writing abilities
- language development and vocabulary
- logical reasoning
- memory
- the speed they can process visual and auditory (sound) information
- organisational skills
- approaches to learning

For applicants on the autistic spectrum, the issues are:

- communication
- social interaction
- sensory difficulties
- need for routine.

In cases of ADHD, the symptoms are of hyperactivity, impulsivity and/or inattention that meet the diagnostic criteria of DSM-5 or ICD-11. There will be evidence of at least moderate psychological, social and/or educational or occupational impairment occurring in two, or more, important settings. Where relevant, responses to therapy or medication should be considered when advising on suitability to begin training.

In a minority of cases, neurodiverse applicants may have a more severe level of impairment that might be accompanied by co-morbid conditions. A full and comprehensive assessment of all the issues will be required, involving referral to specialists, if that has not already happened. Police force recruitment services should be warned that such assessments will take time and that decisions about suitability to begin training should be deferred until a comprehensive picture is available that will inform recruitment decisions.



The occupationally relevant functional challenges of a neurodiverse population relate to cognitive functioning and work self-regulation. There may also be difficulties with emotional relationships. Thus, attention to the following may be required:

- Short-term and working memory
- Attention regulation
- Planning
- Prioritisation
- Organisation
- Time management

Typical workplace adjustments include:

- Work environment flexibility
- Schedule flexibility
- Supervisor / co-worker support
- Support from different stakeholders
- Executive functions coaching
- Training
- Work-station adjustments
- Assistive technology and tools
- Literacy coaching

Insights into what this means in a police context may be found in the College of Policing Discovery report into workplace adjustments.⁸⁰ It is of note that the research underpinning this report found that 85% of respondents stated that their force had guidance on workplace adjustments. However, 65% of respondents answered that there was only limited understanding of the adjustment approach and only 31% indicated that the policies were accessible. Strategically, this links to the diversity and inclusion strategies which all forces have in place. However, what is clear is that there is a lack of awareness of how these strategies include disability and neurodiversity. Neurodiversity was highlighted as an important issue with a small number of forces setting a high bar for best practice, with access to specialist leads to help with autism, dyslexia, and ADHD. There is an opportunity to share best-practice road maps.

⁸⁰ Discovery report into workplace adjustments (College of Policing, 2021) 132 <Discovery report into workplace adjustments (college.policing.uk)>



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Occupational health questionnaire

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Julie Feechan (NPWS)

Guidance on step 2 neuromuscular assessment

Liz Eades (NPWS)
Eleck Dodson (NPWS)
Julie Feechan (NPWS)
Sophie Mawle (Gloucestershire Police)
Angela Power (Durham Police)
Dr Zahid Iqbal (Metropolitan Police)



Procedure for vision screening

Liz Eades (NPWS)

Helen Vasey (Durham Police)

Procedure for measuring blood pressure

Liz Eades (NPWS)

Helen Vasey (Durham Police)

Assessment of hearing

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Functional requirements of the police personal safety training curriculum

Gaynor Wardle (College of Policing)

David Bulpitt (Avon and Somerset Police)

Appointments panel procedure

Bedfordshire Police, Cambridge Constabulary and Hertfordshire Constabulary

Vetting guidance

Marcus Griffiths (Policing Standards Manager: Ethics, Integrity, and Professional Standards, College of Policing)

Sarah-Jane Aston (Vetting Assurance Manager, College of Policing)

Jonathan Gupta (Head of Vetting, Staffordshire Police)

Legal advice

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