Investigating Occupational Skin Problems
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From The President

RAML, New Board Appointments and Resilience

We are counting down to our celebration of the 25th academic memorial lecture in which Dr Nerina Ramlakhan will talk to us about the occupational psychology and physiology of sleep.

It seems such a natural progression from 2018, where Nancy and Angus showed us about the glorious diversity that is the human being and considering this in the context of iOH, our members and the Board and Activist teams.

On a personal level it has been an interesting year. I have been supporting my neuro-diverse children through the maze that is young adulthood. I have been establishing my business, having taken a plunge into the world of digital health and finding my feet in leadership of iOH with its future friendly agenda from the impressive heritage and legacy of AOHNP. They say that if you need something doing you should ask a busy woman – and I made the decision to step back from my roles as school governor, trustee of a community charity and fostering panel member.

Board news

Marisa Stevenson has had to step back from her board role but continues to actively support us on behalf of the University of the West of Scotland. She joins us in welcoming Neil Loach as our new Director for Education from the University of Derby. These are exciting times for academic collaboration.

Professional volunteering is a very rewarding activity but, like work, it can feel like trying to fill a leaky bucket. Work does not stop for personal circumstances and, as is likely for many of our members, we have all had our personal challenges during our service to you. Please do take a moment to visit the new website, register your details, join the forum and give us feedback on how we are doing.

In recognition of the profes-
sional challenges we all encounter, don’t forget that you have access to the iOH Support Line. This service enables all members to access one-to-one advice and peer support and is a service that is included in your membership fee!

**Putting members at the heart of what we do**

We have all read how the uncertainty and economic situation in the UK has led to less employer resource and support for professional development away from the workplace. This led to the poor sign up for the AGM and Good Practice Forum in October. With the financial and practical support of our sponsor Guy Osmond, we realised the opportunity for web-AGM, which was exceptionally well attended, and members had the opportunity to hear directly about the decision not to merge with the newly forming FOHN. The Board took the opportunity to hold an extraordinary board meeting on the same day using web-communication to minimise travel costs.

We have been following the discussions in the fori on social media and the website. In response to several threads, I thought it would be helpful to give some background on the rebranding as a result of a root and branch analysis of our constitution, aims and objectives.

**Resilience**

Your Board team has weathered an incredibly stormy year. It has given us a number of occasions to refer back to and reflect on the Code. “You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the profession from patients, people receiving care, other health and care professionals and the public to uphold the reputation of your profession at all times.”

On your behalf, we had to make the difficult decision that the tabled proposal for a merger represented a takeover that did not offer best value for membership subscriptions. This does not mean that we regret our gifts of £8000 and investment of our time to help FOHN set up the development group and its social media platforms, nor that we do not continue to support the objectives of the newly formed board of trustees and we look forward to collaborating with them on projects of shared interest in due course. We continue to operate to our values of i-TRUST.

We are focussing on teamwork to deliver to our updated objectives for iOH and we look forward to welcoming members, interested in adding some volunteering or professional development towards a Board Director role to their CV, to our Activist team.

We couldn’t do any of this without our sponsorship partners People Alchemy, who continue to provide members with access to their Performance Assistant and resources as an exclusive membership benefit. You no longer need to log into the site directly, because you can link to it directly from the membership area of your web-

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### iOH Code

"You should be a model of integrity and leadership for others to aspire to"
This week’s Alchemy homepage for iOH asks us to reflect on how we react to situations that we find ourselves in.

This week’s Alchemy Assistant: Do you operate like a thermostat or a thermometer?

A thermometer measures the current temperature but has no control over it. Do you measure (notice) your current reality and just tolerate it, like a thermometer? What are you tolerating now in your life that you are doing nothing about changing? “But I can’t .........” (you fill in the blank)

A very common human coping strategy is deflection. Do you blame someone or something else for your situation?

A thermostat measures the current temperature, then acts to reach a set temperature. Do you act like a thermostat when you want things to be different? What is your first step today that you will add to your reflective practice for your validation portfolio?

The future

Let’s start as we meant to go on! iOH is a national membership association for professionals and scientists who work and study in the field of occupational health and wellbeing, we are working with an increasingly diverse range of health professionals as colleagues and look forward to offering them an association that is relevant to their practice and professional development.

We look forward to seeing you at this year’s Health and Wellbeing at Work Exhibition in early March where we will be on stall 109 with a special members-only giveaway. If you would like to join us for this year’s special anniversary RAML, we still have a very small number of tickets available to buy here.

RAML

The iOH Annual
Ruth Alston Memorial Lecture

Tuesday 5th March 2019 - iOH RAML & Dinner
There are still a few tickets remaining for the 25th Anniversary of The Ruth Alston Memorial Lecture and Dinner on Tuesday 5th March 2019. It is to be held at the Crowne Plaza Hotel, NEC Birmingham during the 2-day Health and Wellbeing at Work event.

Poor sleep has a dramatic effect on health and wellbeing and Sleep Hygiene is becoming one of the most important factors in Occupational Health practice. The Sleep Foundation reports that “Sleepiness is also thought to have played a role in some of the most devastating environmental health disasters in history”.

BOOK NOW to hear guest speaker Dr Nerina Ramlakhan, author of Tired but Wired and the sleep expert for Silent Night beds. She also manages the ‘Sleep Matters’ section of the Silentnight website. In addition to running The Capio Nightingale Clinic she has previously run an auditorium session on ‘The Art of Happiness’ for Bank of America Merrill Lynch.

Congratulations to Johanna Warren who has won the iOH free ticket to the Health and Wellbeing at Work 2 day conference.

With thanks to our Main Event Sponsors for RAML 2018, Vitalograph, along with our raffle sponsors.

Dr Nerina Ramlakhan is a physiologist who has specialised in maximising individual and organisational performance for almost two decades exploring the impact of sleep deprivation in her blog. She is also the sleep advisor to the Silent Night bed company.

Angus Baskerville has a ‘superpower’ - he has Autism. Angus is a regular speaker to charities, education groups and health groups, and is a non-executive director of iOH. Angus will be entertaining us with his magic.
Let us assume that we have one or more persons who have reported a skin problem that they are associating with their work. How should we investigate this? As a first step, we should be clear just what we mean when we speak of occupational skin disease. Our definition reads:

**Occupational Skin Disease:**
A clinically recognisable skin condition caused entirely, or significantly, by the interaction between the skin and conditions in the working environment.

This takes account of the fact that we have our skin for 24 hours each day, of which only a part will be spent at work and that there are many hazards to our skin that we will encounter when away from the workplace. In most cases, when someone develops a skin problem that they believe is caused by conditions in their workplace they are expecting a quick and simple answer as to the actual cause. Whilst in some cases this is possible, as this document will show, there are many situations where:

- There may be no single cause, but a combination of factors that combine to cause the skin problem;
- The problem may be only partly due to occupational conditions and non-occupational exposures may be a significant (or the) significant contributory factor;
- Constitutional factors, e.g. atopy or dermographism, about which the employee may have had no prior knowledge, may play a significant role.

Given that an incorrect diagnosis may lead to consequences that can have a negative effect on that person’s recovery and ability to remain at work or lead a normal life, it is essential that any suspected occupational skin problem is correctly investigated. It is also important in order to ensure that others carrying out the same, or similar, work will not also develop an occupational skin disease.

Figure 1 illustrates just some of the factors that we need to consider when investigating a suspected case of occupational skin disease. As an example, suppose a worker develops a hand dermatitis. Let us assume that they work on a construction site and have contact with cement. Cement contains chromates that are well documented as sensitisers. The worker has been patch tested and is positive to chromium. So they may have some allergic contact dermatitis due to skin contact with the cement. However, cement is also a potent skin irritant, so almost certainly there will be some irritant contact dermatitis forming part of the skin condition. How much of the skin problem is allergic and how much is irritant is impossible to state with any certainty, given the limited diagnostic techniques currently available. Furthermore, their skin will almost certainly have been exposed to irritant chemicals away from work and these may have contributed to the skin condition.

We may also need to include consideration of physical factors, such as skin abrasion from handling rough cement blocks, exposure to wind, cold and low humidity in winter on the construction site. They may also be predisposed to develop skin problems, due to a genetic condition known as atopy, but up to now have been unaware of this. Also, they may suffer from some other constitutional condition that has not previously been identified,
but that has caused a significant reduction in the ability of their skin to resist damage from both occupational and non-occupational factors. We should not ignore psychosomatic factors. It is well established that stress can cause or contribute to what appears to be contact dermatitis. The stress need not be from workplace conditions, but due to familial problems or other causes. Ingestion can also contribute to allergic skin reactions, particularly if that person has become sensitised to a particular substance and this is contained in their diet. Not uncommon with those allergic to nickel is a change in diet that increases their nickel uptake and results in allergic contact dermatitis.

Now bear in mind that during the week they might spend 40 to 48 hours at work, out of a total of 168 hours for the complete week. So it will be necessary to ascertain and evaluate any potential non-occupational conditions and exposures that might either be the cause of or a significant contributory factor, to their skin problem. This illustrates some of the complexity that can exist when an investigation into a suspected occupational skin problem is required. Given our limited range of diagnostic techniques, it is not unusual that we find ourselves in a position where we cannot be certain about the true cause, or causes. In such cases, all we can do is to ensure that any potential contributory factors are identified and suitable measures are taken to neutralise these. We can then attempt to ‘manage’ the condition through appropriate measures such as changes in operating procedures, provision of suitable personal protective equipment, high standards of skin care, etc.

What is required is a structured approach to the investigation. Figure 2 illustrates one way of doing this.

Space does not permit a detailed explanation of each step in this sequence. However, the author’s experience gained in investigating many cases where one or more of the workforce were suffering from what had been assumed to be an occupational skin problem indicates the importance of close liaison between those responsible for the management of health and safety within the workplace and those involved in any clinical investigation. This is essential so that those conducting the clinical investigation are adequately informed about, and can take into account, the working environment, chemical exposures that might occur and other relevant factors. Otherwise, it is all too easy to end up with what can be
termed a ‘clinically accurate, occupationally irrelevant’ diagnosis. Were this to happen then the treatment that might follow would be unlikely to result in any positive effect and might actually make the problem worse. In more than one case adequate briefing of the investigating dermatologist has resulted in a clear decision that the working environment was not the cause of the skin problem.

Another factor that must be considered is that the information on chemical exposures reflects reality. In this, merely providing the safety data sheets is rarely sufficient. Indeed, this is confirmed by the following extract from the Approved Code of Practice for the Control of Substances Hazardous to Health regulations. This states:

**Paragraph 10 - Employers should regard a substance as hazardous to health if it is hazardous in the form in which it may occur in the work activity. A substance hazardous to health need not be just a chemical compound, it can also include mixtures of compounds, micro-organisms or natural materials, such as flour, stone or wood dust.**

Almost inevitably, when we use a chemical for a task we will change its character and hence the hazard that this represents. Table 1 illustrates just some of the changes that can occur. The real hazard to which the skin is being exposed may be very different from that on the safety data sheet. Indeed, the causative chemical may not even have been shown on any safety data sheet. In his book on skin sensitisers (Patch Testing, 4th edition,) Anton de Groot lists 4,900 chemicals known to dermatologists as skin sensitisers. Only a small minority of these will have been assigned H317 and thus appear as such on a safety data sheet. As it happens, the most common chemical as a cause of occupational contact dermatitis, water (wet work and wearing of occlusive gloves) does not even merit a mention under current regulations.

Unless the investigating dermatologist has been provided with the correct information about the real chemical – or chemicals – to which the patient has been exposed how will they know what to test for?

Additionally, we must not forget what can be termed the 24:8 rule. We have our skin for twenty-four hours every day, perhaps eight of which are spent at work. To what might the skin be exposed to during the other 16 and those days, such as weekends and holidays, what the affected person is not at work at all?

In conclusion, investigating a case of skin disease suspected of occupational causation will almost inevitably require a team approach involving more than just the occupation health practitioner. This might require the involvement of others, such as the health and safety advisor, occupational hygienist, a dermatologist experienced in contact dermatitis (not all are), and possibly someone with the necessary specialist knowledge to be able to identify the real chemical hazards that the affected person has been exposed to.

<table>
<thead>
<tr>
<th>Contamination</th>
<th>e.g. in cleaning chemicals, solvents used for degreasing items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reaction</td>
<td>between two or more chemicals, e.g. mixing bleach and acid based toilet cleaner</td>
</tr>
<tr>
<td>Processes</td>
<td>that change the properties of the chemicals, e.g. vulcanising rubber</td>
</tr>
<tr>
<td>Heating</td>
<td>Can affect the properties of the chemical and cause release of sensitisier, e.g. solder flux</td>
</tr>
<tr>
<td>Metabolisation</td>
<td>Within the skin, e.g. methanol can metabolise to formaldehyde, a sensitisier</td>
</tr>
<tr>
<td>Oxidisation</td>
<td>Changing the chemical introucing sensitisers, etc.</td>
</tr>
<tr>
<td>Changes</td>
<td>That occur over time, e.g. biocides that are formaldehyde releasers</td>
</tr>
<tr>
<td>Physical changes</td>
<td>Such as leaching of metals into metalworking fluid, grinding dust, etc.</td>
</tr>
</tbody>
</table>

**Table 1**
Mary* was diagnosed with a Cortical Visual Impairment in 2017. Although she had had this since birth, her opticians did not correctly identify there was an issue until later in her life, although she attended on a regular basis. Before her diagnosis Mary found it took her longer to carry out some tasks at work and regularly worked extra hours, thinking that she was just clumsy, stupid, slower than other people and not realising it was the result of a visual impairment.

When she was diagnosed she had to tell her employer immediately as she could no longer drive, although she was driving for 30 years without knowing she had a visual impairment. Mary’s manager’s attitude was immediately unhelpful and started to make changes to her work which impacted on her negatively. She wanted Mary to work in a more remote office which was difficult to get to and was away from the support of her colleagues.

There was no workplace assessment carried out to establish reasonable adjustments that she may require. During a meeting with her manager, HR and union rep, Mary’s manager questioned her capability to do her role which upset her greatly. Mary requested adjustments around her working hours to help her work more easily, these were refused. Mary also had recommendations for adjustments from occupational health, these were also refused.

By this time, Mary had become so upset by her situation at work she was signed off sick, having not to just deal with her sight loss and not knowing what support she could receive. She contemplated resigning, as she thought that her sight loss meant she wouldn’t be able to her job anymore.

Losing My Vision But Not My Mind
Unfortunately this a common experience that people will encounter as they lose sight not being aware of their rights under the equality act and aware of the vast range of equipment/assistive technology that can empower people with sight loss and keep them in work. This is why a workplace assessment is so important at this time in a persons sight loss journey.

Luckily, Mary spoke to her local RNIB Eye Clinic Liaison Officer, who encouraged her not to hand her notice in and referred her to the local RNIB employment advisor. Mary recalls on speaking to her local Employment Advisor “It just made me think, finally somebody knows understands sight loss! It was the way to go as they had seen similar situations before, they knew the law. I had no idea what to do.”

The Employment advisor advised on Access to work and Mary’s rights under the Equality Act 2010. Mary contacted Access to Work, but Mary’s manager was once again unsupportive of the process. Mary had to attend a panel with her employers to appeal the decision made about the adjustments requested. The RNIB Employment Advisor worked with the union representative and provided a statement for the panel hearing outlining Mary’s entitlements under the Equality Act 2010 and how they should be supporting her. The panel reversed the manager’s decision not to provide reasonable adjustments and Mary was granted the majority of the adjustments she requested and has been able to remain in her role. “Without RNIB support I wouldn’t have known where to start. The union were great, with specialist knowledge and advice from RNIB, they helped me stay in work. Without the support, I wouldn’t have my job. I couldn’t fight, I would have given up.”

This case study explains the importance of why people require a workplace assessment in a timely manner of their sight loss to ensure they remain in employment with the correct equipment, technology and support. Sight loss should not equal job loss.

If you are an employer, occupational health provider or individual experiencing sight loss in work, visualise training and consultancy can provide workplace assessments to ensure the correct adjustments are put in place.

For more information visit http://www.visualisetrainingandconsultancy.com/consultancy/workplace-assessments/

Or call Dan Williams on 07472 305 268

Or email daniel@visualisetrainingandconsultancy.com
New iOH Lead on Education

iOH are delighted to welcome Neil Loach to the Board as Director of Education. The editorial team caught up with Neil to get to know a bit more about him.

How did you get into OH?
I started my nursing career in 1984 initially training as an Enrolled Nurse. I managed to get my dream job in Accident & Emergency in Leicester. I was astounded by the amount of people that came in to the department who had been injured at work. I researched careers in OH and went to my local OH department in Leicester and by chance they had E grade nurse jobs at all 3 hospital sites. Being an Enrolled Nurse I didn’t think I’d get the job. How wrong I was! Someone saw potential, clearly! That was the start of my journey into the wonderful world of OH.

Who has inspired you in your career?
Bashyr Aziz was my tutor whilst I was studying BSc Honours Specialist Practice in Occupational Health Nursing at Wolverhampton in 2003. He set me on my journey into the realms of education in OH. The passion and enthusiasm from Bashyr encouraged my learning and his ability to bring out my quest for learning was immense. My passion for continuing professional development came from him. This shows me that however much there is to learn, without the mentor’s ability to show that they care, our students will never learn.

What has been challenging for you?
I’ve worked in a variety of OH settings, including in a lead acid battery factory, for a provider in Nottingham and worked on a number of contracts including British Waterways in the North and Mid-
lands, UK Coal and several manufacturing plants in and around the Midlands. The majority of my work in OH has been in the NHS. The challenges we face every day are astounding but if you cut me in the middle, I am sure you will find NHS branding, like the proverbial stick of rock. Despite the frustration working in the NHS can bring, we still endeavor to make a difference to the UK’s biggest group of workers.

What has inspired your teaching passion?

My role as Senior Nurse in Leicester in 2005 embraced being education lead. It was here that I set up teaching programmes and competency based assessment in all roles associated with new nurses coming into the specialty. The University of Derby approached me in April 2018 to become Pathway Lead for OH on the level 6 and 7 SCPHN course, and so begins my journey into academia

What can you bring to iOH?

I hope to promote education, learning and continuing professional development for the members and prospective members of the group. Anyone can, with hard work get a qualification, but we need to ensure that the future OH nurses are fit for purpose. We shall be continuing our work on competency based assessment and learning and this will hopefully bridge the theory practice gap that often exists. We will be working on bringing together a comprehensive list of ongoing learning resources for our membership and promoting this within the specialty.

The standards set by the Nursing and Midwifery Council are pivotal in ensuring that all nurses have the same level of knowledge and understanding.

Competency-based standard setting and assessment is the work that needs to be done to ensure that a wide and varied skill set is assured for the future. This is where my focus will be.

What now and for the future?

The academic team here at Derby are phenomenal and have embraced OH into an already established and successful SCPHN programme. The course is very OH focused and I hope to build on this going forward to ensure that we deliver nurses fit for a demanding future in OH. Occupational Health has given me phenomenal opportunities and education and continuing development has been at the heart of my progression. PGCert and FHEA Registered Nurse tutor course starts in September and then the Master’s beckons!
Have you ever wondered if the way you carry out your day-to-day work is the correct way? Have you ever wondered who sets the standards for this work in Occupational Health (OH)? Have you looked at your skill set when doing health surveillance and health monitoring? If you have an interest in Skills-Based Competency in OH and would like to see your name in print this is your chance.

We have an opportunity for YOU to be influential in the future assessment of skills-based competency and we would love you to be part of it. This is an ideal way to start your journey into writing as part of your requirements for reflection and revalidation for the future. It will also count towards your hours of continuing professional development and offer you the chance to be part of something that can change the future of the specialty. We intend to publish this work as a benchmarking tool for the future enhancement of the professions working in the field.

The standards set down for the roles of Specialist Community Health Nurses (SCPHN) and other such training courses in the specialty of Occupational Health are set by governing bodies such as the Nursing and Midwifery Council (NMC). SCPHNs enter a practice-based profession at a level beyond initial registration as a nurse or midwife. These SCPHN standards of proficiency must be achieved within the context of the practice route followed by the SCPHN student. This includes working with a Practice Teacher who signs off the competencies required in order to gain registration onto Part 3 of the NMC Register. This provides comparability of proficiency at the point of entry to the register while ensuring that the specific knowledge, skills and proficiencies pertaining to OH specialist community public health nursing are achieved for safe and effective practice.

However, these competencies do not necessarily govern practical skills and the competencies re-

“IOH believes that it is entirely feasible that we can work to establish a skills and competency framework.”
quired to practice safely. Currently, there is nothing that the author could find that aligns these practical skills and competencies to defined standards.

This is where a skills and competency skills framework sit alongside the measures required for effective practice. This is highlighted in section 6 of the NMC (2018), The Code that specifies registrants should always practise in line with the best available evidence. Sections 6.2 and 13.5 also states that registrants should complete the necessary training before carrying out a new role whilst maintaining the knowledge and skills needed for safe and effective practice. These standards need to apply to all clinical staff working in OH, whether on a professional register or not.

IOH believes that it is entirely feasible that we can work to establish a skills and competency framework. This will uphold The Code and ensure the safety of our patients, clients and service users. This will also ensure that we are trained and working to defined standards.

We should consider a definition of skills and competencies. The following definitions may be useful.

**What is a skill?**

- Proficiency, facility, or dexterity that is acquired or developed through training or experience.
- The ability, coming from one’s knowledge, practice, aptitude, etc., to do something well
- An ability and capacity acquired through deliberate, systematic, and sustained effort to smoothly and adaptively carry out complex activities or job functions involving ideas (cognitive skills), things (technical skills), and/or people (interpersonal skills).
- A skill is the learned capacity to carry out pre-determined results
- A learned ability to bring about the result you want, with maximum certainty and efficiency
- Proficiency, facility, or dexterity that is acquired or developed through training or experience.

Therefore, a Skill is something Learned in order to be able to carry out one or more job functions.

**What is a Competency?**

Again, these definitions were extracted from several different sources:

- A cluster of related abilities, commitments, knowledge, and skills that enable a person (or an organization) to act effectively in a job or situation.
- Competencies refer to skills or knowledge that lead to superior performance.
- Measurable skills, abilities and personality traits that identify successful employees against defined roles within an organisation
- A competency is more than just knowledge and skills. It involves the ability to meet complex demands, by drawing on and mobilising psychosocial resources (including skills and attitudes) in a particular context.
- A measurable pattern of knowledge, skills, abilities, behaviours, and other characteristics that an individual need to perform work roles or occupational functions successfully.
- Competencies specify the “how” (as opposed to the what) of performing job tasks, or what the person needs to do the job successfully.

Competencies, therefore, may incorporate a skill, but are MORE than the skill, they include abilities and behaviours, as well as knowledge that is fundamental to the use of a skill.

**Types of Competencies**

Competencies effectively fall into three groups:

**Behavioural (or Life Skills) Competencies**—Life skills are problem-solving behaviours used appropriately and responsibly in the management of personal affairs. They are a set of human skills acquired via teaching or direct experience that are used to handle problems and questions commonly encountered in daily human life. Examples are Communication, Analytical Ability, Problem Solving, Initiative, etc.

**Functional (or Technical) Competencies** – Functional Compe-
tencies relate to functions, processes, and roles within the organisation and include the knowledge of, and skill in the exercise of, practices required for successful accomplishment of a specific job or task. Examples are Audiology, Spirometry and other such technical roles in OH Nursing.

**Professional Competencies** – Professional competencies are competencies that allow for success in an organisational context. They are the accelerators of performance or – if lacking in sufficient strength and quality – are the reason people fail to excel in jobs. Examples are Business Environment, Industry and Professional Standards, Negotiation, People Management, etc.

**Levels of Criticality**

In any organisation there are some Competencies that are more important than others, based on different criteria:

**Core Competencies** – Core competencies are those competencies that any successful employee will need to rise through the organisation. These Competencies would generally relate in some way to the business of the organisation.

**Key Competencies** – Key competencies contribute to valued outcomes of the organisation, defining the abilities of individuals to meet strategic demands, and are important not just for specialists but for all individuals.

**Critical Competencies** – Critical competencies are competencies without which the organisation will be unable to achieve its goals and strategy.

Once you learn a new skill in OH Nursing, how do we know that we are skilled practitioners? How do we audit the compliance to the relevant guidelines, standard operating procedures or policies?

It is the intention of iOH to develop a tool that would allow any skills to link to a competency framework.

If you would like to take part in this new and exciting piece of work, please email Neil Loach at n.loach@derby.ac.uk

**References**


Thank you to the following businesses who are kindly sponsoring the RAML raffle.
A DATE FOR YOUR DIARY

MID DOWNS OCCUPATIONAL HEALTH GROUP

ANNUAL STUDY DAY AND LEGAL UPDATE

Thursday 27TH JUNE 2019

Joan Lewis is an HR and Employment Law Consultant and will be providing the much-applauded annual Legal Update for MDOHG. Joan’s sessions are always well received.

Dr A Samuel Thayalan MRCP MFOM – Consultant Occupational Health Physician
5 Case Studies

Dr Peter J Venn MBBS FRCA - Clinical Director - The Sleep Disorder Centre
Sleep Disorders Part 2

Miles Atkinson – Physiotherapist ACPOHE, Head of Corporate MSK services
Functional Restoration – the Mind Body Connection

Sofia Syed – Employment Law Workshops

Early Bird - £95.00 (Payment must be received by End of 31st March 2019 to Qualify)

If you would like a booking form, please go on to the website www.middownsohg.net to download or email alexmillerbks@btinternet.com

Study Day location:

The Reigate Manor Hotel – there is plenty of FREE parking
Reigate Hill, Reigate
Surrey RH2 9PF
Tel: 01737 240125E-mail: hotel@reigatemanor.co.uk
Launch of a New UK Hearing Conservation Association

To coincide with World Hearing Day on the 3rd March 2019 – The UK Hearing Conservation Association (UKHCA) has launched which aims to be a credible, independent source of information, providing practical advice and solutions to common noise and hearing problems inside and outside the workplace.

About the UKHCA

Their mission is to prevent damage to our Nation’s hearing health and to reduce other noise related health conditions by promoting practical, evidence-based and cost-effective solutions. The UKHCA has been established to provide impetus for action against wholly preventable hearing health harm, both at work and across our society. Their experience has shown that the approach to managing work related noise is often based on outmoded ideas and there is a general lack of knowledge about or respect for our hearing and how it can be harmed.

Why hearing health is such a problem

Disabling hearing loss currently affects more than 10 million people in the UK and the problem is growing. By 2031 it is anticipated that 14.5 million people in the UK will have a hearing loss.

Over 1 million workers in the UK are exposed to noise that puts them at risk of hearing damage. In addition, an increase in social and leisure noise exposure, particularly for younger generations, and an increasingly ageing working population means that more people will exhibit signs of hearing impairment in our workplaces.

Recreational hearing loss is also on the rise primarily as a by-product of rapidly increasing headphone use. The risk to the hearing of individuals who work in high ambient noise environments and who also wear headsets escalates dramatically, through additional exposure received recreationally at live events or using headphones to listen to music.

• Hearing impairment results in high personal, societal and economic costs.
• Hearing loss has a significant effect on communication and may result in exclusion and disadvantage in education, employment, social care and public life.
• Hearing loss substantially increases the risks of accidental injury.
• Hearing loss has been shown to increase the risk of developing dementia by up to 5 times.
• Hearing loss impacts labour productivity and economic growth, costing the UK an estimated £18 billion in lost productivity and unemployment annually.
• The UK insurance industry is currently paying £70 million per year in hearing related claims and there has been a substantial increase in the number of claims for noise induced hearing loss in recent years.

Who are the UKHCA?

The UKHCA are a group of passionate and experienced professionals from across a variety of disciplines and associations, brought together to provide a unified and coherent approach to tackling noise and its effects.

Follow us at:
Website: http://hearingconservation.org.uk/
Twitter: @uk_hearing
LinkedIn: https://www.linkedin.com/company/uk-hca/

#loveyourears
The NHS 10 Year Plan Outlined

The NHS has outlined its 10 year long term plan in a bid to make the NHS fit for the future. £20.5bn of extra funding is promised for NHS England by 2023/24. Their aim is to make sure everyone gets the best start in life, there is delivery of world-class care for major health issues and supporting people to age well. The plan sets out how NHS challenges can be overcome with concentration on the following areas:

Doing things differently

By giving people more control of their health and the care they receive. Encouraging more collaboration between GPs, their teams and community services, as ‘primary care networks’, to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as ‘Integrated Care Systems’, to plan and deliver services which meet the needs of their communities.

Preventing illness and tackling health inequalities

Tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.

Backing the workforce

The NHS workforce, training and recruiting more professionals will be increased. There will be more clinical placements for undergraduate nurses, medical school places, and more routes into the NHS such as apprenticeships. The aim is to make the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.

Making better use of data and digital technology

To provide more convenient access to services and health information for patients, with the new NHS App as a digital ‘front door’, better access to digital tools and patient records for staff, and improvements to the planning and delivery of services.

Getting the most out of taxpayers’ investment in the NHS

Reducing duplication in how clinical services are delivered and making better use of the NHS’ combined buying power to get commonly-used products cheaper, and reduce spend on administration.

The plan recognises that staff, the conditions under which they work and the support given to them in the workplace are vital. There is commitment to support Trusts to access fast-track Occupational Health (OH) services for their staff and to provide development opportunities for line managers. There is no mention of specific funds for this.

Next Steps

Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs), which are groups of local NHS organisations working together with each other, local councils and other partners, now need to develop and implement their own strategies for the next five years. These strategies will set out how they intend to take the ambitions that the NHS Long Term Plan details, and work together to turn them into local action to improve services and the health and wellbeing of the communities they serve – building on the work they have already been doing.

Find out more

More information is available at www.longtermplan.nhs.uk
When nurses suffer hardship, Cavell Nurses’ Trust gives help. We’re #HereForNurses.

Cavell Nurses’ Trust is the charity supporting UK nurses, midwives and healthcare assistants, both working and retired, when they’re suffering personal or financial hardship often due to illness, disability, older age and domestic abuse.

From simple, essential support like money to repair a broken cooker or boiler, to vital life changing aid like helping a family flee their home due to domestic abuse, Cavell Nurses’ Trust is here to help.

In 2018, around 3,300 people sought help from Cavell Nurses’ Trust, that’s the highest number ever. On average, that’s more than 60 every week, or 9 nursing professionals looking for help, each and every day. The numbers seeking our help increase year on year so it’s clear there’s a need for nurses to access our support.

Of the people we’ve helped over the last 3 years:

- 83% said the support they received positively affected their physical health
- 91% said the support positively affected their mental health
- 76% said the support they received helped them get back to, or stay in, work

To find out more about the support Cavell Nurses’ Trust can provide visit www.cavellnursestrust.org or call 01527 595 999.
Case Study

Georgina Jones loved her job. The thirty-nine-year-old single mother of two loved her job in one of the many healthcare organisations in England. So much she never minded working the long hours, sometimes braving snow and ice and navigating closed roads, fitting her personal, family and home life around the requirements of her job. Yes, she was tired, she knew she needed more sleep, but she knew everyone else was doing long hours and it was expected. She loved her work, and for seven years, her workplace was, simply, her second home. Georgina was often feeling exhausted as a result of insufficient sleep. Her job involved prolonged mental work, and for the past three years she had often felt stressed. Georgina’s work demands seemed never ending and there was less and less people to do the work. Georgina was suffering from fatigue.

At work, there was no such thing as flexitime, no family-friendly policies to help employees manage work and life demands. When her children were poorly, she said the organisation didn’t allow her to take sick days to care for them. Georgina’s devotion to her job was recognised in her performance reviews “I always give 150 percent” she says matter-of-factly over a cup of coffee with a friend she doesn’t often get chance to see. “Georgina you look tired”, her friend said. Georgina smiled and simply replied “I’m fine, I just haven’t had much sleep”.

So, it came as a shock when her organisations managers called her into their office in November 2018 and announced out of the blue that they’d created a new position in her department and she had a new boss – her younger, less experienced co-worker. Stunned, Georgina protested they hadn’t given her a chance to apply for it. The new position, they said, would require a minimum of fifty to sixty hours of work each week, with lots of travel, and possible relocation to another city. Georgina felt disappointment, rejected and as usual didn’t sleep well that night.

Measuring sleepiness

Sleepiness and fatigue are terms commonly used in clinical practice and research. At times sleepiness and fatigue are used interchangeably; however, each of them has distinct
implications for diagnosis and treatment.

Objective measurements of sleepiness have been available since the 1970s.

**Multiple Sleep Latency Test**


The Multiple Sleep Latency Test (MSLT) was first described by Carskadon and Dement in 1977. The underlying background of establishing the MSLT is that sleepiness is a physiological need for sleep, while increasing tendency to fall asleep indicates greater sleepiness. During the test, an individual is required to lie down in a dark room to fall asleep. An MSLT includes four or five sessions; each session lasting 20–30 min and performed at two hourly intervals. Sleep latency is measured by standard electrophysiological means and is defined as the time elapsed from lights out to the first epoch of any stage of sleep. The two important outcome variables are the mean sleep onset latency and the number of rapid eye movement sleep episodes that occur. MSLT is a useful tool to assess sleepiness induced by various conditions, including acute and partial sleep deprivation, circadian rhythm disorders, disrupted sleep, sleep apnoea, and narcolepsy, use of hypnotics and alcohol usage and idiopathic hypersomnolence. A mean sleep latency of 5 min or shorter on the MSLT represents severe pathological sleepiness. Although MSLT is a reliable, valid and accurate test, it may fail to measure some aspects of sleepiness. For instance, MSLT may not separate an individual’s ability to fall asleep (sleep propensity) from his need to sleep.

**Epworth sleepiness scale**


The ESS was developed by Johns in 1991. The background of establishing the ESS was driven from the observations of the nature and occurrence of daytime sleepiness. This simple self-administered scale is used to measure general level of daytime sleepiness. The ESS has a set of eight situations commonly encountered in daily life. Some of them are very soporific, others less so. On a scale of 0–3, subjects rate how quickly they would fall asleep or doze off in each of the eight situations. The total score is between 0 and 24. A score of 10 or higher indicates abnormal or pathological sleepiness. The ESS tries to deal with the fact that people have different daily routines; some of these routines promote sleep while others are more activating.

**Maintenance of Wakefulness Test**


The major function of the Maintenance of Wakefulness Test (MWT) is to measure the strength of the arousal system. While some may view MWT as a useful tool in estimating daytime sleepiness some academics do not share this view. Although there are some correlations between sleepiness and decreased level of alertness, sleepiness is not the reverse of alertness. Clinically, many patients who have significant sleepiness, have little impairment of alertness. During the process of doing the MWT, subjects are instructed to sit in a dimly lit room for 30 min and attempt to stay awake. The duration may be set at 20, 30 or 40 min. A mean sleep latency of the MWT is determined by the mean value of the sleep onset latency on the four naps. A mean sleep latency between 19 and 24 min indicates mild impairment of alertness; between 15 and 18.9 min indicates moderate impairment of alertness; and 12.9 min indicates severe impairment.

**Fatigue**

Fatigue is common in physical and psychiatric disorders. Symptoms of fatigue are commonly reported in patients with depression, chronic fatigue syndrome, HIV, cancer. Fatigue may be a side effect of a number of medications. Generally, fatigue is not specific in its presentation and symptomatology. Fatigue may be induced by physical, physiological and psychological causes; it often presents as a feeling of tiredness and exhaustion. Fatigue is the most common symptom reported to the health professionals.

The HSE states that “Fatigue needs to be managed, like any other hazard” and provides guid-
ance, information and resources to assist the management of fati-
tigue: http://www.hse.gov.uk/
humanfactors/topics/fatigue.htm

In 2006 the HSE developed a fatigue index (FI) to measure the effects of fatigue. RR446 - The development of a fatigue / risk index for shiftworkers (HSE, 2006) describes the work carried out to revise and update the HSE Fatigue Index (FI) http://www.hse.gov.uk/research/rrhtm/rr446.htm

Extensive changes have been made to the previous FI version, incorporating recent information relating to a variety of issues including cumulative fatigue, time of day, shift length, the effect of breaks and the recovery from a sequence of shifts. The index has been implemented in the form of a spreadsheet and was updated in January 2013.

The legal duty is on employers to manage risks from fatigue, irrespective of any individual’s willingness to work extra hours or preference for certain shift patterns for social reasons. Compliance with the Working Time Regulations alone is insufficient to manage the risks of fatigue.

Fatigue and professional nursing practice

Long hours, fatigue and lack of rest breaks or time to recuperate between shifts are associated with an increased risk of errors. Healthcare professionals therefore need to be vigilant about the impact of fatigue on their professional practice.

Nurses should, for example, consider their obligations under the Nursing and Midwifery Council (NMC) Code regarding the management of risk.

You should also consider the impact of multiple jobs and your working hours on your ability to practice safely.

Issues such as an inability to take scheduled rest breaks, insufficient rest periods between shifts and pressure to carry out excessive overtime - or to stay on after the shift has ended - are legitimate issues to act on and raise professional concerns about.

Evidence base to inform OH practice

The Cochrane Library is a collection of high-quality, independent evidence to inform healthcare decision-making.

The following are a selection of Cochrane reviews or protocols useful to OH practice:

**Caffeine for the prevention of injuries and errors in shift workers**
Review 12 May 2010; Katharine Ker, Philip James Edwards, Lambert M Felix, Karen Blackhall, Ian Roberts

**Flexible working conditions and their effects on employee health and wellbeing**
Review 17 February 2010; Kerry Joyce, Roman Pabayo, Julia A Critchley, Clare Bambra

Comparative efficacy and acceptability of pharmacological treatments for insomnia in adults: a systematic review and network meta-analysis
Protocol 23 July 2013; Thomas C Erren, Christine Herbst, Melissa S Koch, Lin Fritschi, Russell G Foster, Tim R Driscoll, Giovanni Costa, Mikael Sallinen, Juha Liira

Antidepressants for insomnia in adults
Protocol 22 September 2016; Franco De Crescenzo, Francesca Foti, Marco Ciabattini, Cinzia Del Giovane, Norio Watanabe, Monica Sañé Schepisi, Dighy J Quested, Andrea Cipriani, Corrado Barbui, Laura Amato

Workplace lighting for improving alertness and mood in daytime workers
Review 14 May 2018; Hazel Everitt, David S Baldwin, Beth Stuart, Gosia Lipinska, Andrew Mayers, Andrea L Malizia, Christopher CF Manson, Sue Wilson

Adaptation of shift work schedules for preventing and treating sleepiness and sleep disturbances caused by shift work
Review 2 March 2018; Daniela V Pachito, Alan L Eckeli, Ahmed S Desouky, Mark A Corbett, Timo Partonen, Shantha MW Rajaratnam, Rachel Riera

Sleep

Sleep is essential for good health and wellbeing. The amount of sleep people need varies widely and usually reduces with age.

Most people have difficulty sleeping at some point in their life. Poor quality sleep has a harmful effect on mood, memory and performance.
What causes poor sleep?
Poor sleep can be caused by many things including, poor sleep habits, stress, anxiety, depression, alcohol, substance misuse, pain or certain medicines.

Insomnia is when a person has difficulty falling or staying asleep, wakes too early, or feels unrefreshed in the morning.

It is not uncommon for people to experience these symptoms every now and then. Insomnia is when these symptoms have been present for at least a month (a chronic problem) and are interfering with the ability to function during the day.

How age influences sleep
The amount and quality of our sleep is affected by age. Sleep becomes shorter and lighter as we get older. This is quite normal but means older adults are more likely to naturally wake during the night and be disturbed by noise, discomfort or pain.

How sleep problems become chronic
Some people are more prone to sleep problems than others. Certain life events can trigger episodes of poor sleep such as emotional stress, anxiety, low mood, a change in the environment or routine and ill health. Alcohol, substance misuse and some medicines also cause sleep problems.

Once a sleep problem has developed, common habits or behaviours people adopt to cope with the problem tend to make the problem worse. These habits can prevent recovery.

Habits and sleep
People who sleep poorly at night often develop habits like lying in later in the morning or napping during the day, drinking lots of tea, coffee and high energy drinks during the day to stay alert, which reduce sleepiness at bedtime. These habits help to compensate for the lack of sleep at night but they also help to maintain the problem.

Tips to encourage good sleep
• Try to take regular exercise during the day.

• Try to spend time in daylight (or bright artificial light) during the day. If you spend a lengthy time sitting, try to sit near a window.

• Do something relaxing before bedtime e.g. have a warm bath or listen to soft music.

• Keep a regular time for going to bed. This is usually when you feel sleepy.

• Try a hot, milky or decaffeinated drink near bedtime. Cherry juice and bananas are also good.

• Keep the bedroom cool, quiet, and dark at night. Make the bed as comfy as possible.

• Try wearing earplugs at night to block out external noises.

• Put any worries to one side until morning. A “worry journal” next to the bed can be helpful.

• Get up at the same time each morning regardless of how long you slept.

Things to avoid
• Bright light in the evening.

• Watching TV, listening to radio, or eating in the bedroom. Keep the bedroom mainly for sleeping.

• Artificial light from computer screens, iPads, mobile phones in the evenings before bed.

• Heavy meals, sugary foods and drinks, alcohol, caffeine and energy drinks (e.g. coffee, tea, chocolate, cola) in the evening. Sensitivity to caffeine increases with age.

• Snacks if you wake in the night.

• Smoking around bedtime and first thing in the morning.

• Napping or long periods of inactivity during the day.

• Vigorous exercise within 2 hours of the usual bedtime.

Bedtime routine
Develop a good routine and stick to it. This is particularly important when caring for someone else with a sleep problem, for example someone with a learning disability.

Establish a set order of events which lead to bedtime. Provide a peaceful, calm atmosphere. Try to choose a short routine; have a
bath, pyjamas on, warm milky drink, brush teeth, listen to soft music in a dimly lit room. The routine should always have a clear end point that signals it is now time to go to sleep, such as turning the light off and having a set goodnight phrase, “sleep well, see you in the morning”.

People who don’t fall asleep until late tend to sleep-in later in the morning when they get chance. This is not a good idea as it makes it likely they won’t go to sleep until later the following night, reinforcing a bad habit. Try to have a fixed time for getting up and stick to it during the week and weekends.

Exposure to bright light in the morning may be helpful and avoid day time napping. The length of time a person sleeps during the day will usually reduce night time sleep by a similar amount.

Further information

The Sleep Council
www.sleepcouncil.org.uk

Insomnia Therapy Workshops
https://thesleepschool.org/

Royal College of Psychiatrists
www.rcpsych.ac.uk/mentalhealthinformation/mentalhealthproblems/sleepproblems/sleepingwell

NHS website
www.nhs.uk/LiveWell/Insomnia/Pages/insomniahome.aspx

Dr Nerina Ramlakhan
Physiologist and sleep therapist
http://www.drnerina.com/

NHS Moodjuice – sleep problems
https://www.moodjuice.scot.nhs.uk/SleepProblems.asp

How to cope with sleep problems
https://www.mind.org.uk/information-support/types-of-mental-health-problems/sleep-problems/#.XHM6xbjgqUk

Public Health England – One you
https://www.nhs.uk/oneyou/for-your-mind/sleep/

The Sleep Health foundation

The TUC

HSE fatigue pages
http://www.hse.gov.uk/humanfactors/topics/fatigue.htm

Bibliography


Like all of you, I wear many hats and juggle a busy home and work life. Following my own experiences of success and adversity in both my personal and professional life, I became aware of the importance of developing and maintaining resilience. I had always been passionate about health, fitness and wellbeing, however, I found that I needed to be better able to take care of my mental fitness in order to protect and increase my resilience.

On behalf of iOH on **Wednesday 6th March 4.30-5.00pm** at the Health and Wellbeing at Work NEC event, I will try to share some of my mindfulness journey and practices with you. My intention is to help you thrive.

**Session Title:**

**Personal Resilience: Can this help OH practitioners to thrive and survive?**

**What my session is about:**

- Many OH practitioners report high levels of occupational stress in their work environment.
- Feeling overwhelming stress for a long period of time can impact on both physical and mental health.
- Can mindfulness and resilience training help and support OH practitioners?
- As part of preparation for this session I have been looking at the evidence base for mindfulness and resilience. Here are a few of the research studies that I have particularly found helpful.

I hope you can join me on the afternoon of Wednesday 6th March, kind regards Carol.
What outcomes have mindfulness and meditation interventions for managers and leaders achieved?

There is a range of definitions of mindfulness. Perhaps the most commonly used is that of Kabat-Zinn (1994 Kabat-Zinn, J. (1994) who defines mindfulness as “the awareness that arises from paying attention on purpose in the present moment and non-judgementally” (p. 34). Research about applying mindfulness and meditation interventions for management and leadership development is in its infancy. The purpose of this study was to systematically review research on mindfulness or meditation interventions for managers and leaders. Findings indicate some encouraging signs that mindfulness and meditation interventions may improve aspects of leaders’/managers’ well-being and resilience. However, research results are very variable in quality and strength, and there was no evidence on benefits for participants’.

The studies reviewed explored a diversity of interventions, but provided little insight into which mindfulness and meditation interventions for managers and leaders are most effective, in what context they are best applied, or for whom they are most suitable. The application of mindfulness and meditation interventions to leadership and management development is a relatively new area of practice and research. Despite the significant amount of research on mindfulness in clinical settings and an increasing body of literature around mindfulness in workplace settings, the exploration of mindfulness and meditation for leaders and managers has received relatively little rigorous research attention. There is therefore a need for considerable further research to be conducted in this area.

**Psychological interventions for resilience enhancement in adults.**

This is a protocol for a Cochrane Review (Intervention).

Since the introduction of a salutogenic (an approach focusing on factors that support human health and well-being, rather than on factors that cause disease) orientation (focusing on factors that promote health and well-being), as a basis for health promotion (Antonovsky 1979), and the Ottawa Charter for Health Promotion (WHO 1986), the concept of resilience has stimulated extensive research. Resilience describes the empirically observable phenomenon under which an individual does not or only temporarily, experiences mental health problems despite being subjected to psychological or physical stressors of short (acute) or long (chronic) duration (Kalisch 2015). By definition, resilience always presupposes the exposure to substantial risk or adversity (Earvolino-Ramirez 2007; Jackson 2007; Luthar 2000; Masten 2001). Thus, the psychological resilience of a person can only be determined if the individual was exposed to previous or current stress or trauma. The development and evaluation of interventions that aim to foster or enhance psychological resilience and prevent stress-related mental dysfunctions are the focus of the third wave of resilience research (Bengel 2012; Waite 2004). Resilience-training programmes have been developed, and conducted in, a variety of clinical and non-clinical populations using various formats, such as multimedia programmes or face-to-face settings, and delivered in a group or individual context (see Bengel 2012 and Southwick 2011 for an overview). However, the empirical evidence regarding the efficacy of these interventions is still unclear and requires further research. To date, two systematic reviews (Macedo 2014; Robertson 2015) and two meta-analyses (Leppin 2014; Vanhove 2015) have investigated the efficacy of resilience interventions in adults, each concluding that resilience interventions can improve personal resilience, mental health and performance. This review aims to focus psychological resilience interventions offered to clinical as well as to non-clinical populations in different contexts (i.e. the workplace as well as a student or military context).
Mindfulness mediates the physiological markers of stress: systematic review and meta-analysis.


Meditation is a popular form of stress management, argued to mediate stress reactivity. However, many studies in this field commonly fail to include an active control group. Given the frequency with which people are selecting meditation as a form of self-management, it is important to validate if the practice is effective in mediating stress-reactivity using well-controlled studies. Thus, authors aimed to conduct a meta-analysis investigating the neurobiological effects of meditation, including focused attention, open monitoring and automatic self-transcending subtypes, compared to an active control, on markers of stress. In this meta-analysis and systematic review, authors included randomised controlled trials comparing meditation interventions compared to an active control on physiological markers of stress.

Studied outcomes include cortisol, blood pressure, heart rate, lipids and peripheral cytokine expression. Forty-five studies were included. All meditation subtypes reduced systolic blood pressure. Focused attention meditations also reduced cortisol and open monitoring meditations also reduced heart rate. When all meditation forms were analysed together, meditation reduced cortisol, C-reactive protein, blood pressure, heart rate, triglycerides and tumour necrosis factor-alpha. Overall, meditation practice leads to decreased physiological markers of stress in a range of populations.

Mindfulness in politics and public policy


Wherever mindfulness training finds popularity in public life, the necessary conditions usually include an advocate with a strong desire to share the benefits they have personally experienced through mindfulness practice - and an accompanying sense that those benefits will improve the functioning of their organisation or institution. In the British Parliament, since 2013, cross-party groups from both the Houses of Commons and Lords have attended eight-week mindfulness courses adapted from Mindfulness-Based Cognitive Therapy (MBCT). As of October 2018, over 200 politicians had received training, delivered by Professor Mark Williams and Chris Cullen from the Oxford Mindfulness Centre. A key factor in the popularity of mindfulness training in public life is the conviction of grassroots advocates seeking to pass on the benefits they have experienced through personal practice. In this manner, mindfulness training has found its way into the realm of government, with parliamentary programmes seeding ambition amongst politicians to research and employ its transformative potential at both interpersonal and policy levels.

In a high-stakes, adversarial setting, mindfulness practice helps elected representatives to cope with specific challenges, and an inquiry by the UK Mindfulness All-Party Parliamentary Group has contributed to the emergence of mindfulness training in numerous policy narratives. By developing a new kind of familiarity with their own inner lives, a growing number of politicians are finding a new way to approach political discourse, and a corresponding enthusiasm for policy that tackles society’s problems at the level of the human heart and mind. Some are starting to ask whether mindfulness might be more than a targeted intervention for specific issues, and may in fact contribute to the flourishing of society more broadly — marking an important development from concern with individual benefits to benefits for the whole.

The potential benefits of mindfulness in the workplace and for leadership have already been discussed at length, and are increasingly being tested. Skills cultivated by interventions like MBCT — mindfulness, empathy, compassion, self-regulation — are finding a place in a number of emerging policy narratives.