Introduction The National Health Service (NHS) is the biggest employer in the United Kingdom (UK). Depression and anxiety are the most common reasons for sickness absence in the NHS. As part of a trial feasibility study, we developed an intervention to facilitate an earlier return to work (RTW) in NHS staff absent with common mental health disorders (CMHD).

Methods We used iterative methodology, based on MRC guidance. Evidence was sought from systematic reviews, guidelines, and work known to the research team on the key components of the case-management (Stage 1). During Stage 2, the evidence from Stage 1 was mapped onto the proposed intervention together with input from international experts and key stakeholders.

Results Evidence suggests that an intervention based on a case-management model using a biopsychosocial approach could be cost-effective and lead to earlier RTW. In our study, specially trained occupational health nurses will deliver the intervention. Case-management will be conducted during regular consultations (every 2 to 4 weeks). Key components will include: identifying care obstacles to RTW, collaborative problem solving, based on cognitive behaviour principles focussing on work outcomes, work-focused goal setting, development of a RTW plan, and peer support to increase return to work self-efficacy. Work adjustments, work visits or therapeutic RTW will be considered. The case-manager will communicate with the line and human resources managers and treating healthcare professionals after each consultation. A bespoke information leaflet will be developed and given to line managers and workers emphasising the therapeutic importance of early RTW.

Discussion To our knowledge WB2W is the first intervention addressing RTW among UK healthcare staff with CMHDs. A key output from this research will be a complete specification of the intervention package including a manual for training the case managers and practical service information to guide the design of a randomised controlled trial.
Abstracts

Introduction The risk of transmission of blood-borne pathogens, including hepatitis B virus (HBV) to healthcare workers (HCWs) is well known. Under current European Union (EU) legislation, all employers have to perform a risk assessment to identify workers exposed to HBV and offer them vaccination. Immunisation should be done as early as possible after the start of their career to avoid HBV infection and the development of an infectious carrier state. In 2005 we performed a survey on HBV prevention in HCWs in the EU; in 2010, a new EU Directive (2010/32/EU), on sharp injuries, to be implemented in national legislation by 11 May 2013, made an update of the 2005 survey necessary.

Methods We performed an electronic survey of national representatives from the Occupational Medicine section of the European Union of Medical Specialists (UEMS) in all countries, to find out how policies have been put into practice in the European countries.

Results Answers were received from 21 countries, representing 78% of the population in the EU-28. HBV vaccination was mandatory for medical and nursing staff in 10 countries, mandatory for other paramedical staff, medical and nursing students in nine countries, for paramedical students in eight countries, for cleaning staff in 6 countries, for technical staff in 5 countries. It was recommended in all other participating countries. Serotesting before vaccination was done in eight countries. The vaccination schedule most often used was 0, 1, 6 months (18 countries). Serotesting after vaccination was done in 18 countries, boosters were recommended in 14 countries. A non-responder policy, including testing for carrier state, was present in 18 countries.

Discussion More consultation between key actors from countries at EU level could help to optimise the way this matter is dealt with in different countries in order to contribute to further reducing HBV transmission to HCWs.

Result Each RCT violated the basic mathematical principle of dilution by reporting greater percentage reductions with less influenza-specific patient outcomes and/or patient mortality reductions exceeding even favourably derived predicted values by at least 6–15-fold. Contextual factors more likely to explain the RCT results were ignored. The prioritisation of quantitative data masks the economic and political agendas of policy makers.

Discussion This policy is a case of (mis)use of RCT evidence as a weapon against workers while transferring large amounts of public funds to a questionable program and ultimately to pharmaceutical companies. We argue that worker acceptance of influenza vaccination should be voluntary, and public resources be more appropriately allocated to measures more likely to result in greater public health benefit, such as improved sick leave to encourage ill workers to stay home, or more staffing to allow HCWs to be more vigilant with infection control procedures.

S31 (MIS)USING RANDOMISED CONTROLLED TRIALS AS A HECOMOMIC WEAPON: THE CASE OF MANDATORY INFLUENZA VACCINATION FOR HEALTHCARE WORKERS IN CANADA

Annalée Yass*, Karen Lockhart. School of Population and Public Health (SSPH), University of British Columbia (UBC), Vancouver, BC, Canada

Introduction In 2013, British Columbia, Canada, instituted a Policy requiring healthcare workers (HCWs) to accept influenza vaccination or wear a mask at work throughout the influenza season. The Policy’s stated objectives (prevent influenza transmission to vulnerable patients; reduce influenza morbidity and mortality; reduce worker absenteeism) did not refer to the health of HCWs. Moreover, the four randomised controlled trials (RCTs) cited as evidence supporting this influenza vaccine-or-mask policy were misinterpreted (or misrepresented) by its proponents, which, we argue, not only threatens the health of workers, the public and patients, but jeopardises the credibility of public health institutions.

Methods Plausibility of the four RCT findings attributing indirect patient benefits to HCW influenza vaccination were assessed by international experts comparing percentage reductions in patient risk reported by the RCTs to predicted values; we synthesise the results of the analysis and discuss the political factors that may explain the (mis)use of the RCT evidence.

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