LIBERATING THE NHS: DEVELOPING THE HEALTHCARE WORKFORCE

RESPONSE FROM THE FACULTY OF OCCUPATIONAL MEDICINE

The Faculty of Occupational Medicine welcomes the opportunity to respond to this consultation. In giving our response, we focus first on the implications of the proposed changes for occupational health specifically, and then make a number of more general observations.

Implications for occupational health
The Faculty accepts that changes to training and workforce development are necessary, if nothing else because the SHAs in which Postgraduate Deans are currently based are to be disbanded. Furthermore, we agree with the overall objectives for workforce planning, education and design, as set out in Section 2.3 of the consultation document. However, we are concerned that the proposed revisions will not deliver those objectives satisfactorily, particularly in a specialty such as ours, which has an important role in the NHS but operates largely outside it. There is a danger that in moving away from professional silos, a new "NHS silo" will be created.

Organisation of occupational healthcare
By way of background, it may help to summarise the current organisation of occupational healthcare nationally.

Unlike most branches of healthcare, occupational health services operate largely outside the NHS. Thus, of about 800 specialist occupational physicians in the UK, approximately 80 provide services to the NHS. Most of these are employed directly by NHS trusts, but some work for externally contracted providers in the private sector. Most specialist occupational physicians provide services to other large employers outside the NHS, in either the public or private sectors. Some are directly employed by these organisations, but most work for external contractors of varying size, or as independent consultants. In addition, a few specialist occupational physicians work for other organisations such as the military, universities, the Health and Safety Executive and the Department for Work and Pensions.

The deployment of specialist occupational physicians is in continual flux.

- Individuals frequently move between different areas of practice over the course of their career.
- There is a regular turnover of providers – for example, an NHS trust may move from an in-house service to an external contractor in the private sector, and then change to an external contract with a service based in another trust.
- There is free movement of personnel between countries within the UK, and some occupational physicians work for employers with business not only across the UK but also internationally.

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Other personnel who contribute importantly to the delivery of occupational healthcare include GPs with a special interest (of whom there are perhaps 2000 nationally), occupational health nurses (about 5000), allied health professionals with a special interest in work and health (e.g. physiotherapists, occupational therapists, psychologists – much fewer in number), ergonomists, occupational hygienists and safety professionals. Again, most work outside the NHS, where they may be employed in-house or externally contracted. Each group has its own arrangements for training and qualifications, but those for occupational health nurses and for the allied health professions with a special interest in work and health are widely acknowledged as being unsatisfactory.

In general, occupational health services do not fall within the ambit of the Care Quality Commission.

Manpower planning
Manpower planning for occupational health is challenging because of the diversity of employment and mobility of the workforce. Estimating current provision is far from easy, and predicting future needs (and willingness of employers to pay for services) is fraught with uncertainty. Nevertheless, the Faculty is attempting to do this for occupational medicine, and will share its work with CfWI, with which it is already in liaison. We do not think that CfWI could achieve the task satisfactorily without our input. There remains a need for authoritative review of future manpower requirements in other occupational health professions. Recruitment and training for these other professions is currently determined almost entirely by market forces, although to the extent that the training is shorter and simpler, this is less of a problem than would be the case for specialist occupational physicians.

Training posts
An important part of training in occupational health is delivered through supervised "on the job" experience. This requires a willingness of employers to engage and support professionals while they are in training, and recent increases in the demands on trainers and in the bureaucracy associated with supervised training, especially for specialist doctors, have made the option less attractive to employers. Thus, over the last decade, we have seen a substantial decline in the numbers of training posts for occupational physicians in the private sector – both in in-house services and at larger external providers such as Atos and Capita. Such organisations see little value in investing in training, and currently manage to recruit the specialists they need from the pool of doctors who have trained elsewhere (including in the NHS). The same applies to HSE, which no longer has any training posts. Even in the NHS, provision of training posts can be unattractive to employers, and only in the military and a few special industrial sectors such as civil aviation, do employers recognise a need to train in order to meet their future needs.

As regards occupational health nurses and allied health professionals, some employers will pay for postgraduate training (insofar as it is available – as already indicated, it is not satisfactory at present), but training for many practitioners is self-funded.

Quality of training
When training is delivered through on the job experience, there is always a danger that trainees will be exploited for the delivery of services at the expense of their personal training needs – for example, leaving them with insufficient time for mentoring or to attend academic courses. Currently, this is managed through oversight of training by Postgraduate Deans, who can withdraw approval for training posts if they are unsatisfactory. If Postgraduate Dean posts are to be abolished then it is important that effective controls on the quality of specialist training of doctors be maintained by alternative mechanisms.

Impact of proposed changes
As we understand it, because occupational medicine is a small specialty, responsibility for management and oversight of training in the discipline will lie with Health Education England (HEE). If this is the case, HEE will need effective input from people with a good understanding of occupational health (this is currently provided to Postgraduate Deans though Regional Specialty Advisors), and should include representation of private and public sector employers, who are the main purchasers of occupational health care, as well as the other stakeholders listed in Section 6.6 of the consultation document.

It is currently unclear how HEE will persuade employers (including those in the private sector) to take on trainees and deliver satisfactory training. We suggest that a regulatory approach would be difficult to enforce, could have perverse and unpredictable effects on the uptake and organisation of services, and could create a culture of poor quality – doing the minimum to satisfy the regulator. A much better alternative would be to incentivise employers by paying an attractive price for the delivery of training, but with the threat that a contract could be withdrawn if training were unsatisfactory.

Also unclear at present is the proposed source of funding for training in occupational health. The consultation document mentions a levy, but it is unclear to whom this levy would apply. Possibilities would include: all employers (e.g. a small subvention nominally from NI contributions); employers who use occupational health services (but this might be a disincentive to use of services, and would be complex to administer); all organisations who employ occupational physicians or other occupational health professionals (but this could lead to distortions in the market with increased use of externally contracted single-handed practitioners); and NHS trusts (but then they would be subsidising non-NHS employers). Another option would be to move to self-funding by trainees, but that would make occupational health extremely unattractive in comparison with other areas of healthcare where training was funded by NHS employers.

On balance, we suggest that the best arrangement would be to fund specialist training in occupational medicine, and perhaps also for other specialist occupational health professionals, from central Government (DH, or DH plus DWP) funds. Arguments for this include:

- The public benefit from occupational healthcare, even when provided by individual employers (as highlighted in Dame Carol Black's report, Working for a Healthier Tomorrow).
- The fact that many specialist occupational physicians will work for the public sector at some time in their careers.
- It would avoid unreasonable administrative costs.
- It would avoid unintended perverse distortions of practice.
- The increased cost to Government would be relatively small (currently there are15-30 new entrants to specialist training in occupational medicine each year, of whom just over half are in the NHS or military, and therefore indirectly funded by Government already).

General points
In addition to the above comments, which relate specifically to occupational health, we also make the following more general observations.

1. There is a danger that local skills networks will end up being more bureaucratic and administratively expensive than Postgraduate Deaneries. Ideally, the system would be trialled in one or two areas before wider roll-out.

2. We have major reservations about the value of healthcare providers consulting patients and local communities about plans to develop the healthcare workforce. Again some trialling could be useful. How often would such consultation generate inputs that had material impact? Would it become just a "tick-box" exercise?

3. Section 5.21 suggests that healthcare provider skills networks will contract for provision of education and training with healthcare providers (i.e. their member bodies). This raises the possibility that they will be less than assiduous in assuring the quality of training that is provided. For example, they might unreasonably tolerate sacrifice of training needs for service provision, since effectively they would be policing themselves.

4. Small specialties such as our own have limited resources and manpower to carry through major reorganisations to training, and lack the economies of scale that occur in larger disciplines. This needs to be taken into account when planning and implementing reforms.

5. We see no mention of arrangements for trainees in academic medicine.

Overall, we consider this consultation to be by far the least satisfactory of the recent White Papers on reorganisation of health services. We are keen to assist in trying to work out some of the problems that have been identified, especially in our particular field of occupational health, and to that end would be happy to engage in meetings with officials if it was thought helpful.

Faculty of Occupational Medicine
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