



FUTURE DIRECTIONS FOR OCCUPATIONAL HEALTH CARE IN THE UK

A strategic overview

January 2010

FOREWORD

The Faculty of Occupational Medicine is the professional and academic body in the UK that is responsible for developing and maintaining high standards of training, competence and professional integrity in occupational medicine. Its objectives are:

- To act as an authoritative body for consultation in matters of education and public interest concerning occupational medicine;
- To promote for the public benefit the advancement of education and knowledge in the field of occupational medicine; and
- To develop and maintain for the public benefit the good practice of occupational medicine, providing for the protection of people at work by ensuring the highest professional standards of competence and ethical integrity.

More broadly, the Faculty aims to maximise people's opportunities to benefit from healthy and rewarding work while not putting themselves or others at unreasonable risk, and to eliminate preventable injury and illness caused or aggravated by work.

In pursuing its objectives, it is important that the Faculty should have a clear vision of how occupational health care can best be organised and delivered nationally. The Faculty's Board has previously agreed an aspiration that everyone of working age in the UK should have access to advice from a competent occupational physician as part of comprehensive occupational health and safety services. Looking beyond this, there is a need for more detailed consideration of the ways in which provision of occupational health could be optimised, taking into account value for money and the availability of professional expertise.

This paper, which has been agreed by the Faculty Board following consultation with the wider Faculty membership and a limited number of external stakeholders, sets out our current thinking in this area. It will be used to guide our activities and communications, and will at the same time be shared with our partners in the Council for Work and Health, and with other relevant professional organisations, and Government departments and agencies. Our intention is that it should be reviewed and revised at intervals in the light of feedback received and as external circumstances evolve.

David Coggon
President

1. INTRODUCTION

1. When the National Health Service was first established, occupational health was excluded from its remit, perhaps because the protection of workers was considered primarily a responsibility of employers. As a consequence, provision of occupational health services in the UK has been less coordinated and much less comprehensive than most other areas of healthcare. Currently, only a minority of the working population have access to specialised occupational health advice, coverage being especially limited for people employed by small and medium-sized enterprises (SMEs). Moreover, there is virtually no provision for people who are unemployed as a consequence of health problems and who need guidance on career choices and how best to overcome limitations on employment arising from their disability.
2. Funding for specialised occupational health care* continues to come principally from employers, but there have been major changes over the past 20 years in the ways in which occupational health services are organised, and in the focus of their activities.
3. One major driver for change has been the decline of industries such as coal mining, metal manufacture and heavy engineering, and the growth of employment in the generally less hazardous service sector. This transition, combined with the success of measures to control the most hazardous exposures and activities that still occur in the workplace, has led to a reduced emphasis on health protection, with more attention now being paid to assessment of fitness for employment and the management of incapacity for work.
4. A second important change has been a shift from the provision of occupational health care by “in-house” teams to contracted-out services delivered by independent practitioners or larger external providers.
5. In the future, further developments can be expected that will impact on the needs for occupational health care and the ways in which it is

* Throughout this document, the term “care” is taken to include both the delivery of advice and treatment (including medication, physical and psychological therapies) to individuals, and also the formation and implementation of policies at an organisational or population level, with the aim of minimising illness and disability and maximising health and well-being.

provided. These include: the evolving epidemic of obesity; the rapid growth in health problems caused by alcohol; the changing demographic profile of the national population with a need for people to work to older ages; the impact of EU expansion on migrant labour; the emergence of new infectious diseases; opportunities offered by continuing advances in information technology; and the growing importance of China and India as economic superpowers.

6. Against this background of continuing change, it is important for the Faculty of Occupational Medicine to have a clear vision of the ways in which it believes that national provision of occupational health care would best be organised, both in the immediate future and in the longer term.
7. This paper sets out such a vision. It follows on from, and builds on, discussion at a conference on the topic in December 2008, and has been modified following initial consultation with Faculty members and with a limited number of external stakeholders. As well as being used to guide the activities and communications of the Faculty, it will be opened up to wider discussion and comment from external organisations. It is our intention that it will subsequently be reviewed and revised at intervals as appropriate.

2. GUIDING PRINCIPLES

8. Thinking about the future organisation of occupational health care at a national level should be guided by the following principles.
 - o The starting point for any system of occupational health care should be the needs of the population to be covered
 - o Services should be cost-effective from the perspective of whoever will pay for them
 - o Plans for services must take into account the availability of personnel, who must have the necessary skills and competencies to deliver them
 - o Systems of occupational health care should be sufficiently flexible to keep pace with changing patterns of employment and economic circumstances
 - o Employment prospects for occupational health staff should be sufficiently secure that potential new recruits are not deterred from undertaking the necessary training

- o Where possible, arrangements should build on those existing structures that are working well

3. THE NEED FOR OCCUPATIONAL HEALTH CARE

9. In broad terms, occupational health is concerned with a) protecting people from risks associated with work and with industrial products; and b) promoting health and well-being by maximising people's opportunities to benefit from healthy and rewarding work. Future needs for occupational health care in the UK extend across both these areas of activity.

Health protection

10. Historically, occupational activities and exposures in the UK were a major cause of serious and sometimes fatal injury and disease. Over the past 50 years, this toll of morbidity and mortality has been reduced substantially, partly through a decline in the numbers of people employed in the most hazardous industries, and partly through the success of occupational health interventions. Nevertheless, occupational hazards remain significant preventable causes of ill-health and death. For example, it has been estimated that during 1991-2000, more than 470 deaths per year in England and Wales were attributable to work [1]; and each year, some 500 new cases of occupational asthma are diagnosed by respiratory and occupational physicians in Great Britain [2].
11. Where hazards have been successfully controlled, the maintenance of a safe working environment often depends on continuing occupational health input. For example, regular health surveillance is an important component of strategies to prevent noise-induced hearing loss and hand-arm vibration syndrome, while prevention of accidents and injuries in the transport industry depends importantly on appropriate health screening for occupational groups such as pilots and train drivers.
12. Furthermore, as the impact of "classical" occupational diseases has reduced, major new challenges have emerged in the form of illnesses such as back pain, arm pain and mental health complaints, which are widely attributed to work, and which cause substantial distress and disability. Such illnesses differ from classical occupational diseases in that they do not occur as a simple function of over-exposure to hazardous

environments or activities. Rather, they depend on a complex interaction between aspects of work (e.g. physical activities, psychological demands), the psychological characteristics of the worker, and culturally determined health beliefs and expectations. It follows that their prevention and management requires a more subtle approach, demanding special expertise.

13. In addition, new processes and products continually emerge, requiring careful assessment and management to ensure that any associated health risks are identified and controlled, while at the same time not unnecessarily delaying or limiting the benefits from technological progress. Recent examples include the rapid growth in mobile telephony and the emerging exploitation of nanomaterials.

14. Occupational health expertise is required to address all of these needs, although the level of input that is necessary will vary between industrial sectors. Most office-based jobs are low-risk. On the other hand, many manufacturing businesses and some service industries (such as healthcare) involve hazards that demand more specialised management. Of particular concern are some higher risk categories of work that currently have relatively low levels of occupational health care, such as construction, agriculture and commercial fishing.

Health promotion

15. Most employed people spend a substantial part of their waking time at work. Employment provides income for them and their families, and economic benefits for the wider community. Moreover, there is growing recognition that participation in work directly promotes health. Becoming unemployed is associated with higher morbidity than remaining in employment [3], and early return to work following illness or injury can accelerate recovery [4].

16. Inevitably, health problems render some people incapable of work, either temporarily or in the long-term. These individuals require financial support, which may be provided by their employers, or through social security or private insurance. Determination of who should be eligible for such support is a challenge. If eligibility criteria are too stringent then some people will suffer unreasonable hardship. On the other hand, if payment schemes are too generous, they create a perverse incentive to

disability, and may generate illness that would not otherwise have occurred.

17. Decisions on fitness for work and eligibility for sickness benefits and ill-health retirement pensions impact critically on the health and well-being of workers, the unemployed and their families, and also on the productivity of employing organisations. Optimal decision-making requires the expertise of occupational health professionals who have the necessary understanding of illness, injury and disability; of the mental and physical demands of work, and the ways in which they can be modified and adapted; and of the impacts of work on health.

4. CURRENT PROVISION

4.1 Funding

18. Funding for occupational health care in the UK is currently provided principally by employers and by the state, with an additional small contribution from charities.

Employers

19. Most of the input from employers is provided by larger organisations in both the private and public sectors. This resource is directed at activities which the funders view as cost-effective – mainly the control of health hazards associated with their business, and the management of sickness absence and ill-health retirement.

Government

20. Financial input from the state comes via several routes. The Health and Safety Executive (HSE) is funded primarily to promote and oversee the protection of health in the workplace, a task in which, for some industries, it is assisted by local authorities. The National Health Service (NHS) contributes through the diagnosis and treatment of occupational injuries and illness, and the provision of guidance on fitness for work, these inputs being delivered through both primary and secondary care services. In addition, the Department for Work and Pensions (DWP) and the devolved Governments in Wales, Scotland and Northern Ireland have supported various initiatives aimed at promoting health in the workplace and preventing unnecessary incapacity for work. Examples include the Job

Retention and Rehabilitation Pilot Study, Pathways to Work, Healthy Working Lives in Scotland and Health Working Wales.

Charities

21. Charitable funding for occupational health services has tended to focus on geographical locations or specific industrial sectors. Examples include the Sheffield Occupational Health Project, and the Dreadnought Medical Service, which provides care for seafarers. In addition, some charities, such as the Colt Foundation and the British Occupational Health Research Foundation (BOHRF), fund research on work and health.

4.2 Organisation of occupational health care

Employer-funded services

22. Occupational health care funded by employers has traditionally been delivered through in-house services, with size and skill-mix varying according to the size of the funding organisation and the nature of its business. Over the last two decades, however, there has been a major transition to contracted-out services delivered by external providers, which range from single-handed independent practitioners through to corporate organisations with staff from a variety of occupational health professions. Some employers have chosen to contract-out all specialised occupational health input to their business. Some have retained a small nucleus of in-house expertise, to ensure that external services are appropriately commissioned and delivered. Others have opted for a “mixed economy” with, for example, in-house services at some geographical locations and contracted-out provision at others. And some have continued with in-house services, in some cases, also providing outsourced care for other employers.

23. Each of these models for the delivery of occupational health care has its advantages and disadvantages. In-house services tend to have a deeper understanding of the organisation that they serve, and to share its objectives and values, with skills well matched to its business needs. Moreover, they offer greater continuity of staff, who are able to develop closer relationships with managers, and more control for the funder over their activities. And, for the same level of service, they are generally cheaper. On the other hand, outsourced services may offer a broader skill-mix and experience than could economically be delivered in-house, greater flexibility to provide services across a range of geographical

locations, and professional management for occupational health staff at a level that may not be possible in-house. A potential drawback of contracting-out is that employers could be misled by a profit-motivated external provider into purchasing services that were unnecessary or not of the highest priority. On the other hand, in-house services that are unchallenged by competitive tender or external audit, may be inefficient.

The Health and Safety Executive

24. HSE has responsibility for the planning and implementation of national policy on occupational health and safety, including the drafting and enforcement of regulations. To inform these activities, it also collects, analyses and interprets statistical data on occupational injuries and illness, and conducts or commissions research. Implementation of policy includes the provision of information and guidance to employers on the management of hazards in the workplace. However, staff numbers limit the extent to which individual workplaces can be visited and inspected. Moreover, there has, over the past two decades, been a substantial decline in the numbers of doctors and nurses employed by HSE, which restricts the level of advice that can be offered on clinical aspects of occupational illness and its prevention.

The National Health Service

25. Within the NHS, occupational health care is provided on occasion by various professional groups, including general practitioners (GPs), specialist doctors, nurses, physiotherapists and occupational therapists. This care includes the diagnosis and treatment of occupational diseases and injuries, and advice on return to work following illness. In particular, most primary diagnosis and treatment of work-related conditions is delivered by GPs. In addition, GPs provide certification for workers who are unfit for their normal job beyond a minimum period, enabling them to access sick pay from their employers or through the social security system. However, NHS practitioners currently have little direct contact with employers, and limited familiarity with workplaces and job demands. A few NHS trusts (e.g. Southmead, Central Manchester) have offered specialist referral services for GPs and other doctors seeking advice on patients with occupational health problems. However, such services have been geographically localised, and few and far between, perhaps partly because financially pressed trusts do not regard them as sufficiently cost-effective.

Other services funded by Government

26. Other Government-funded initiatives on work and health have been organised on an ad hoc or trial basis, and delivered by specialist occupational health staff employed by the NHS, academic institutions or private providers.

4.3 Staffing

27. Like almost all areas of healthcare, the promotion and protection of health in relation to work is a multi-professional activity, and the optimal organisation of occupational health care will depend in part on the availability of different categories of trained staff to deliver services. The exact numbers of occupational health professionals practising in the UK are uncertain. Currently, some 850 doctors are Associates, Members or Fellows of the Faculty of Occupational Medicine practising in the UK, approximately a further 1100 doctors (mainly GPs) hold the Diploma in Occupational Medicine, and there are between 6000 and 8000 nurses with training in occupational health. In addition, the Institute of Occupational Safety and Health (IOSH) has some 33,000 members, and there are approximately 50,000 GPs. However, the main interest of most members of IOSH is the prevention of occupational injuries rather than illness, while most GPs have had little or no training on the inter-relation of work and health.

5. PROBLEMS WITH CURRENT PROVISION

28. Current provision of occupational health care in the UK is unsatisfactory in several ways.

5.1 Coverage

29. First, and most important, apart from the limited advice that can be obtained from HSE, there is no access to specialised occupational health care for some 70% of the national workforce, nor for almost all of the unemployed. This means that protection from hazards in the workplace is unsatisfactory, especially in some more dangerous industries such as construction, agriculture and commercial fishing. These industries continue to experience high rates of preventable injury and disease. In addition, many workers more generally, and also the unemployed, are

liable to be excluded from work unnecessarily, leading to financial hardship, reduced productivity, and adverse effects on health, including delayed recovery from illness.

5.2 Integration and coordination

30. A second problem is the fragmentation and incoordination of services for the delivery of occupational health care. This can lead to inconsistent and sub-optimal practice, and makes it harder to organise effective audit and quality improvement.

5.3 Training for general practitioners

31. Given that they are the main source of advice on work and health for the majority of the national workforce, GPs are for the most part inadequately trained in occupational medicine. The roots of this problem lie in medical school curricula, most of which provide little if any grounding in the subject. Nor is the deficit consistently addressed in GP training or in continuing professional development (CPD) for GPs. In a survey of 1500 GPs carried out for Government by Doctors.net.uk, two-thirds of those questioned were unaware of recent evidence showing that work is good for health [5].

5.4 Quality assurance for specialist services

32. Because most specialist occupational health services are outside the NHS, they are not subject to the same quality assurance as other clinical services. In particular, they are not monitored by the Care Quality Commission. As a consequence, there is a danger that resources will be used inefficiently, with poor evidence of benefits and inadequate use of technology.

5.5 Inadequate assessment of needs

33. Most occupational health care is funded by employers, but employers are not always well placed to assess and prioritise their occupational health needs, especially when they have no in-house occupational health expertise. Some may assess their needs without competent input, and then call for tenders to provide services that are inappropriately specified. Others may be persuaded by effective marketing to purchase services from external providers that are not ideal.

5.6 Medical input to the Health and Safety Executive

34. As would be expected, HSE employs staff with expertise in a wide range of disciplines relevant to health and safety in the workplace. However, as already described, there has been a substantial decline over the past two decades in the number of occupational physicians working for HSE. This may have been driven in part by a perception among senior management that doctors were an expensive asset (because of their relatively high salaries), who could be replaced by staff with other relevant training, and perhaps also by a reluctance of some doctors to embrace changes in the organisation. However, many of the most difficult problems that now confront HSE (e.g. the prevention and management of work-related musculoskeletal disorders, mental health problems, chronic obstructive pulmonary disease and asthma) require strong medical input, without which, HSE cannot be fully effective. External medical advice, e.g. through expert advisory committees, can only partially compensate for a shortfall in expertise internally.

6. A STRATEGY FOR THE FUTURE

35. To address these problems, various changes are needed to the way in which occupational health care is organised and to the training of professionals who provide occupational health care. These changes should build on the strengths of current arrangements, and should if necessary be piloted and evaluated, with widespread adoption only if they are judged to be cost-effective.

6.1 Funding

Health protection

36. There is a clear rationale for requiring that employers continue to fund occupational health services that are necessary to protect their employees and the public from hazards associated with their activities and products. Making employers responsible for health protection in this way, and liable both criminally and financially for the adverse consequences if protection is inadequate, is a motivation to best practice. It also ensures that the costs of managing risks are appropriately reflected in the pricing of products or services that employers provide. Furthermore, it would be unrealistic to expect Government or any other body to take on this expense, particularly at a time of economic downturn.

37. If this funding model is followed, the major challenge will be to ensure better coverage of SMEs, especially in the most hazardous industries such as construction, agriculture and commercial fishing. A series of actions are needed to promote better practice.
38. First, it is necessary to ensure that the right level of advice is readily available to employers at a fair price, which is proportionate to the health benefits that will ensue. Determining what level of service is appropriate will require a preliminary review and evaluation of evidence, at least for some industries.
39. Second, consideration must be given to how this level of service could be delivered most effectively and conveniently. It may be, for example, that for geographically clustered industries, a collective service would be preferable to one that was individually contracted by each employer.
40. Third, a convincing case must be made to employers that the proposed level of occupational health care is reasonable and not just a bureaucratic burden. This may be assisted by demonstration of practicality and benefit in a pilot exercise.
41. Fourth, it may be possible to encourage uptake through fiscal incentives (e.g. tax concessions or reduced insurance premiums*), and through input from larger organisations that purchase products or services from the SMEs that are being targeted. For example, a supermarket supplied by a farm might insist on compliance with specified standards of occupational health care in the same way that some supermarkets specify what pesticides suppliers can use on crops.
42. Finally, HSE investigation of accidents, injuries and occupational diseases should routinely consider whether the expected level of occupational health input was being received.

Promotion of health and wealth

43. With regard to fitness for work and the management of sickness absence and ill-health retirement, it would again be an advantage if employers who

* Although it should be noted that when the possibility of differentials in insurance premiums was explored previously, there appeared to be little scope for progress because employers' liability insurance was not sold very competitively, and was often offered as a loss leader to attract other business.

currently pay for advice in this area, continued to do so. The justification for this would lie in the financial benefits to the employer through better attendance, morale and productivity, and reduced costs of recruitment and training for staff to replace workers who are obliged to leave their jobs because of illness or disability.

44. Many employers quite reasonably conclude that occupational health input of this sort is not cost-effective in the short-term, and therefore cannot be justified. Nevertheless, there could still be important societal benefits in the longer term (e.g. from reduced social security costs, improved health and well-being of employees, and enhanced economic output). In these circumstances, there is a case for greater state funding to support guidance on fitness for work for employees who do not have access to occupational health advice through their employers. Such funding could be used to improve the quality and extent of advice on work and health that is provided by primary care, and/or to provide a new route for advice (e.g. through geographically based fit-for-work services of the type that are currently being piloted). Additional expenditure of this sort would need, however, to be justified by reasonable evidence that the returns on investment were worthwhile. Furthermore, if enhanced state funding in this area were deemed justifiable it would be important to integrate it with employer-funded services. In particular, it should not act as a disincentive to investment in occupational health care by employers. This would be unlikely if the service provided by the Government was relatively limited. However, if necessary, employers could be given a fiscal incentive to fund their own services.

45. In parallel with Government support to improve advice on fitness for work from GPs or fit-for-work services, there is a need to increase employers' understanding of how to communicate with external advisors, so as to make most effective use of such advice. In addition, workers themselves need to understand that effective communication between their employer and their medical advisors can be to their personal benefit. Coordinated interventions directed at all three parties – GPs, employers and workers – seem more likely to bear fruit than efforts aimed at one of these groups in isolation.

46. Government must also ensure that it provides the funding (through HSE and other routes) that is needed to support the academic base for

occupational health practice. Otherwise, there will be a long-term threat to evidence-based decision-making both in health protection and in the promotion of health and wealth through work.

47. Charitable funding for occupational health services and research should continue where it is effective, but cannot realistically be expected to expand significantly in the foreseeable future.

6.2 Organisation of services

Employer-funded services

48. There is no good reason why employer-funded occupational health care should not continue to be delivered by services of the type that currently operate. In particular, there remains a place for both in-house and externally contracted services working to a variety of models as described in Section 4.2. However, there is a need to assure the standard of services, and to help ensure that they are properly tailored to the needs of employers and their employees.
49. As a step towards this, the Faculty of Occupational Medicine, with financial support from DH and input from other occupational health professions, is currently developing and piloting a system of standards and voluntary accreditation for occupational health services. Once this has been achieved, the next step will be to produce guidance for employers on how to commission high quality occupational health services that are appropriate to their needs.
50. In addition, as described above, there may be a case for developing new models whereby advice on the management of hazards can be provided efficiently and more extensively to SMEs in high-risk industries (e.g. through contracting by consortia of employers). This type of arrangement would need to be properly tested and evaluated.
51. It will be important that occupational health professionals provide the necessary leadership in shaping employer-funded services as they continue to evolve.

Contribution from primary care

52. For employees who do not have access to specialised occupational health advice through their employer, the main source of occupational health

advice in the short term will, of necessity, continue to be primary care. There are insufficient trained occupational health professionals to deliver the breadth of coverage that is needed, even if funds were available to pay for them. It is vital, therefore, that occupational health competencies in primary care be improved. This requires better training on work and health for medical undergraduates, for GP trainees, and through continuing professional development (CPD) for established GPs. The Faculty of Occupational Medicine is currently active on all three of these fronts. In particular, we have been pressing for the inclusion of core elements on work and health in the undergraduate curriculum, establishing a network of local "champions" to promote the coverage of occupational health by individual schools of medicine, liaising with the Royal College of General Practitioners regarding the inclusion of occupational health topics in GP training, and developing CPD training on work and health, both face-to-face and on-line, for GPs.

53. Depending on funding arrangements, GPs might in some cases decide to appoint or designate a non-medical member of staff to coordinate advice on work and health within their practice. Ideally, however, this would again be piloted and evaluated. Moreover, it would not eliminate the need for better understanding of occupational medicine by GPs.
54. In addition to improved training, GPs might also benefit from access to specialist occupational health advice on referral. One way of providing this would be through a geographical network of regional occupational physicians, an idea that is explored further below.
55. It is unclear to what extent the delivery of occupational health advice in primary care can be improved without additional targeted funding. In recent years, Government has increasingly used payments for achieving targets in relation to specific aspects of service as a way of focusing GPs' efforts on high priority tasks. While this has achieved desired changes in practice, it is to some extent de-professionalising, and may encourage a tendency to underperform in areas of practice that do not attract special payments. An alternative strategy would be to educate GPs about the benefits to their patients from good occupational health advice, and to appeal to their professional values. Further evaluation may be required to establish which approach is best in practice.

Contribution from secondary care

56. While general practice should be the main source of occupational health advice for most of the working age population, secondary care services must continue to play their part. In addition to the training in diagnosis and medical treatment that is already provided as part of their professional training, doctors and other practitioners in secondary care need a better awareness and understanding of the impact of illness on capacity to work, and how this can best be managed. The Faculty of Occupational Medicine should therefore work with other Royal Colleges and Faculties to promote this aspect of training.

Regional occupational physicians

57. The Department of health (DH) is currently piloting geographically based fit-for-work services aimed at improving advice for patients who face difficulty in working or are absent from work because of health problems. If one or more of the models that is tested proves cost-effective then there will be a strong case for rolling out such services on a wider scale.

58. In addition, consideration should be given to the appointment of "regional occupational physicians", each of whom would be responsible for the oversight and coordination of all occupational health care in a specified geographical area. These doctors could be employed as consultants by the NHS, working as part of the public health team at SHA level, and might be jointly appointed by the NHS and HSE. Their role could include:

- Provision of advice and training for staff in primary care
- Oversight of fit-for-work services
- Provision of a clinic to which more difficult occupational health problems could be referred by NHS doctors in primary and secondary care
- Provision of medical advice to local HSE inspectors
- Provision of independent advice to employers and/or their occupational health services in relation problems such as workplace clusters of disease (in a the way that this has been done in the past by HSE Employment Medical Advisers)

59. One advantage of such posts would be to restore much needed medical input to HSE, especially in the field, and at the same time, to bring HSE doctors into the mainstream career structure for physicians. At present, HSE doctors are significantly less well paid than NHS consultants, making it difficult to recruit and retain them. The existence of regional

occupational physicians would also move us towards our aspiration of access to specialist occupational advice for all people of working age.

60. In the first place, the appointment of regional occupational physicians could be piloted and evaluated in one or two regions, with extension more widely if it were shown to be cost-effective. If successful, the establishment of a network of regional occupational physicians could be an important first step towards better coordination and integration of occupational health care nationally.

6.3 Academic base

61. To sustain the future delivery of occupational health care that has been identified as desirable, there must be an adequate underpinning academic base in the UK. Both primary and secondary research will be needed to ensure that policy and clinical practice are appropriately evidence-based. For this purpose, it will not be possible to rely entirely on research carried out in other countries, since circumstances and systems of care in the UK are different from elsewhere.

62. Academic resource is needed also to train the clinicians who will deliver occupational health care, including specialist occupational physicians and nurses, as well as clinical staff working in other disciplines, who will advise patients on matters relating to work and health.

63. As highlighted in Dame Carol Black's review, "Working for a Healthier Tomorrow", the academic base for occupational health in the UK has been shrinking, and the demographic profile of staff currently employed in academic occupational medicine suggests a further diminution over the next ten years. The Faculty is already attempting to address this threat, but more will be needed if the trend is to be reversed. The Faculty's Academic Forum has recommended that as a minimum, we should be aiming for at least three secure academic departments of occupational medicine in the UK.

6.4 Recruitment and training

64. The other prerequisite for delivery of future services is satisfactory recruitment into disciplines that will staff the services, and in particular to occupational medicine and occupational health nursing. Exactly how many clinicians will be required in these disciplines will depend on the way in

which services are configured (e.g. whether regional occupational physician posts are created and in what numbers). However, the number of specialist occupational physicians needed is likely at least to match current capacity.

65. This is a concern because there are indications that recruitment into training posts in occupational medicine may at present be declining. One driver for this is a growing reluctance of occupational health services in the private sector to take on the costs associated with training specialist occupational physicians, especially when the national economy is performing poorly and business prospects are uncertain. In addition, because occupational medicine is practised largely outside the NHS, and because NHS services in teaching hospitals must exercise particular care about the confidentiality of their patients, many of whom are members of clinical staff in those hospitals, the exposure of medical students to occupational medicine is relatively limited. Thus, entry to the specialty has tended to occur later in doctors' careers, often following part-time work in occupational medicine as a GP.

66. To address the potential shortfall in recruitment, there is a need to increase the profile of occupational medicine among medical undergraduates and newly qualified doctors. The scope should be examined for creation of a number of Foundation Year training posts in occupational medicine, and for optional appointments in occupational medicine as part of GP training (as has already been done in Aberdeen).

67. In addition, the case should be explored for funding of all non-military specialist training in occupational medicine through the NHS (as happens for almost all other specialties). Training posts could still rotate through attachments in industry to give the necessary breadth of experience, but NHS funding would ensure a more consistent supply of posts, and would enable tighter control than at present on the quality of training.

68. Another innovation that could encourage stronger recruitment to occupational medicine would be to allow GPs who wish to transfer to the specialty to train half-time while retaining a part-time position in primary care as a way of maintaining income.

69. It may also be timely to review manpower requirements, recruitment and systems of training for other occupational health professions. In particular, thought should be given to establishing a national qualification in occupational health nursing. The newly established Council for Work and Health has agreed to undertake a review of training and qualifications for occupational health nurses, and the Faculty should contribute actively and constructively to this work.

7. MAIN CONCLUSIONS

70. In summary, the main conclusions and actions for the Faculty to take forward are as follows:

- 1) Funding for health protection in the workplace should remain the responsibility of employers.
- 2) There should be review and evaluation of the optimal model and level of occupational health service delivery for SMEs in hazardous industries, followed by its promotion to employers, supported if necessary by a demonstration of practicality in pilot exercise.
- 3) Other methods should be explored to encourage SMEs to obtain and apply occupational health advice for the protection of their workers, including fiscal incentives and imposition of standards by larger organisations that they supply.
- 4) HSE investigation of occupational injuries and diseases should routinely consider whether appropriate levels of occupational health input were being received.
- 5) Employers should be encouraged to continue funding high quality occupational health services to help manage fitness for work, sickness absence and ill-health retirement, where this is cost-effective.
- 6) There should be increased state funding for advice on fitness for work to employees who do not have access to such advice through their employers, where research indicates that this will bring worthwhile returns in health and economic prosperity.
- 7) There is a need for a system of standards and voluntary accreditation for occupational health services, as is currently being developed by the Faculty. This should include measures to ensure as far as possible that services are planned on the basis of a competent assessment of the employer's needs. Once an accreditation scheme has been developed, it should be a point of

reference in guidance to employers on engaging occupational health services.

- 8) For the majority of the working age population who do not have access to specialist occupational health services through their employers, advice on work and health should be provided or commissioned by the NHS, principally through primary care services.
- 9) To support this, there is a need for enhanced training of medical students, GPs and other specialists on topics relating to work and health. The Faculty is already active in this area on several fronts, including promotion of a core component on work and health in the undergraduate curriculum, and development and implementation of training for GPs.
- 10) There is also a need to evaluate incentives that would most effectively encourage GPs to become more involved in advising patients on work and health.
- 11) To improve the use that is made of advice from NHS clinicians on work and health, there should be a coordinated educational intervention aimed at both employers and employees.
- 12) Consideration should be given to piloting the appointment of NHS regional occupational physicians, based in departments of public health, who would coordinate services relating to health and work in their areas, and provide a source of advice to other NHS clinicians, and also to HSE inspectors.
- 13) To encourage adequate recruitment into specialist training in occupational medicine, there is a need to promote the specialty better to medical undergraduates and newly qualified doctors. This could include the creation of occupational medicine posts as an option for Foundation Year and general practice trainees. In addition, the Faculty should conduct a review of manpower levels and trends in recruitment that explores the case for transfer of responsibility for funding of all non-military specialist training in occupational medicine to the NHS.
- 14) Steps are needed to strengthen the future academic base for occupational health in the UK, as a provider both of the research that is needed to underpin policy and clinical practice, and also of training for occupational health practitioners.
- 15) The Faculty should contribute actively and constructively to the planned review of training and qualifications for occupational health nurses that is being carried out by the Council for Work and Health.

REFERENCES

1. Coggon D, Harris EC, Brown T, Rice S, Palmer KT. Work-related mortality in England and Wales 1979-2000. Submitted for publication.
2. Health and Safety Executive. Occupational asthma: overall scale of occupational asthma.
<http://www.hse.gov.uk/statistics/causdis/asthma/scale.htm>.
3. Waddell G, Burton AK. Is work good for your health and well-being. London: TSO, 2006.
4. Black C. Working for a healthier tomorrow. London: TSO, 2008 (page 65).
<http://www.workingforhealth.gov.uk/documents/working-for-a-healthier-tomorrow-tagged.pdf>

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